

Briefing: Policy Options To Expand Health Insurance Coverage

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MALE VOICE: Kaisernetwork.org.

LAUREN LEROY: I think it's time to get started. I want to welcome all of you who are here with us in Washington and those who are viewing the webcast in other parts of the country to our webcast today. We're going to spend the next 90 minutes talking about the spectrum of policy options for expanding the number of people in the United States who have health insurance coverage.

We as a nation have been debating this issue and the various policy solutions for years as the number of uninsured have risen. Currently we have 44 million people who are uninsured. 8 out of 10 of them live in families where 1 or more adults are working and among those who are poor those who are working are more likely to not be covered or have less coverage than non-workers.

This is a national problem but it plays out differently from state to state. And there is significant variation as we look around the country at the number of people and the proportion of people without health insurance.

These conditions and the rising costs of coverage and erosion of benefits for both employees and retirees in recent years have once again reinvigorated interest in looking for solutions to this problem. And this is where our webcast comes in today, a focus on solutions and their implications.

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We have a panel of experts from philanthropy and the policy world who will talk about potential solutions and their implications. And our intention today is to provide information to help people think critically about the key issues and implications related to alternative policy options. And in those cases where we have group viewings of this webcast to stimulate discussion among those who are gathered together.

We have foundations around the country that are hosting events centered on the webcast for health care providers, policymakers, advocates, community leaders, and other stakeholders. Others will be viewing this on their personal computers at their desk. There will be an opportunity for viewers to send in questions over the Internet and also for those who are gathered here in the audience to take the card that was on your seat and write a question on it and pass it to various staff members who will be coming through the audience.

This event is taking place in the Barbara Jordan Conference Center of the Kaiser Family Foundation in Washington, D.C. And I want to both thank the Kaiser Foundation for making this webcast possible. It's a real opportunity for us and all those who are viewing. And also to point out that the Foundation is a national resource to all of us on issues related to access, coverage and the uninsured, both through the publications and the expertise of the Kaiser Commission on Medicaid and the uninsured and through its website,

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Now let's turn to our panel. I'm going to briefly introduce the panelists and then refer you to their bios for further information on their background and expertise. They're a very impressive group of people and I'm really thrilled that they were able to join us today. Also their bios along with lists of selected resources and links to key organizations can be found on the GIH website at www.gih.org.

Karen Davis who is sitting next to me here is the President of the Commonwealth Fund and she will begin our discussion today by helping to frame the issues. Then she and Linda Bilheimer sitting next to her, a Senior Program Officer at the Robert Wood Johnson Foundation will draw on research supported by their foundations to review potential solutions, their scope, costs, and in some cases, feasibility.

I should also note that this webcast is taking place during Cover the Uninsured Week sponsored by the Robert Wood Johnson Foundation and its many partners around the country. And so we're particularly pleased that Linda was available to actually be with us today. And also I want to make the point that the discussion today is about prototypical proposals or options, not the proposals of specific Presidential candidates, legislators or private organizations.

After Karen and Linda have given us a sense of the options and some of their implications we'll turn to Vickie

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Gates who is the Senior Consultant for the State Coverage Initiative Program at Academy Health who will talk with us about state efforts to expand coverage. And finally, to help bring the choices and the tradeoffs inherent in these options more clearly into focus, to help us think critically about the options before us we've invited Judy Feder who is the Dean of the Georgetown University Public Policy Institute and Robert Helms, Director of Health Policy Studies at the American Enterprise Institute for Public Policy Research to share their different perspectives on the strengths and weaknesses of the various approaches before us. And so with that, I'll turn it over to Karen.

KAREN DAVIS: Thank you, Lauren. The Commonwealth Fund is pleased to join the Grantmakers in Health webcast and focus on what I think is one of the most pressing issues in America today, and that is access to health care.

The U.S. spends more on health care than any other country and yet it's the only major nation not to provide health coverage for all of its citizens. And as a result, we're really experiencing an affordability crisis in health care today.

It's reflected first of all in the rapid increase in health care costs. Health care costs are going up faster than they have in over a decade. Health insurance premiums in 2003 went up 14% and that's leading employers to make changes in

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health benefits for workers. They're having an effect both on employers and on working families. About 160 million Americans rely on employers for health insurance for themselves and their family members, but the Commonwealth Fund by any old health insurance survey found that in fact if workers are increasingly paying very high premiums for their share of that coverage, increases in deductibles before health benefits come into play and a reduction in the benefits that are covered. Half of working individuals indicated that they have experienced this erosion in coverage in the last year.

The second concern is the increasing numbers of people without any health insurance coverage. As Lauren indicated 44 million Americans are without health insurance coverage. That's up 10% from 2000 when there were 40 million Americans without health insurance. But even that is just the tip of the iceberg. We know that over a 4-year period 85 million Americans are without health insurance at some point in time. And many others are underinsured. They have insurance, but insurance doesn't service basic functions of helping them get access to needed care and protecting them from financial bills.

And in fact, that leads to the third major concern that Commonwealth Fund by any old survey also documented that access to care is a growing problem. 37% of non-elderly adults in 2003 said that there was a time that they didn't go to the doctor when they needed to because of costs, they didn't fill a

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prescription that was given to them by their physician to treat their condition, or they didn't go to a specialist, or they didn't get a recommended follow-up test or other kinds of services that their physician felt that they should have. This is up dramatically from 2001 and in a 2-year period it increased from about 29% of non-elderly adults experiencing access problems to 37% in 2003.

Access to care is not only a human problem and a moral problem; it's a health and economic problem. The Institute of Medicine estimated this year that 18,000 Americans die each year as a direct result of the fact that they are uninsured and often delay care from something that could have been prevented or detected at an early stage.

Another serious and growing problem is the problem of medical bills and the problems of medical tests. The Commonwealth Fund by any old survey found that 2 in 5 Americans have difficulty paying their medical bills or they've been contacted by a credit collection agency about their bills, or they are paying off medical debts that have been incurred in the last 3 years. This is not just a problem for the uninsured, in fact, 2/3 of those people who say they are struggling with medical bill problems were insured at the time that they experienced that medical problem, but it was either for service that wasn't covered or wasn't well covered by their insurance.

Finally, we have in this country a very fragmented

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health care system that is costly, expensive and wasteful. The churning in health insurance coverage creates administrative costs every time that somebody has to enroll in health insurance, disenroll from health insurance, and reenroll. There are administrative costs involved in that. They may also have to change their source of care. Administrative costs are the single most rapidly growing component of all health care spending, up 16% last year.

We also know that our fragmented health care system leads to waste and medical errors. We've been very slow in this country to adopt a modern information technology that would help prevent medical errors, would eliminate duplication of tests because test results would be available, and that would help remind patients of the need for preventive care, and help intervene with chronic conditions avoiding the need for emergency room or hospitalization.

Our surveys underscore the urgency of acting on these problems. 87% of Americans in our most recent survey said that health care will be an important issue to them as they make decisions in this election year. 57% said it was a very important issue for them. Furthermore, the survey shows that people are willing to make some sacrifices to ensure that there is health security for all. 62% of Americans said that they were willing to roll back all of the tax cuts that they have received in the last couple of years and 69% were willing to

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roll back part or all of the tax cuts in order to guarantee health security for all. And these views are shared across a broad spectrum of American society; both high income and low-income individuals expressed support for this. There is wide support across all geographic regions of the U.S. and there is wide support across political affiliations. So I think that we recognize there is a fundamental problem facing our nation. There's a sense of urgency about it, a demand on the part of the American public that something be done about it. And I'm now going to turn it to Linda Bilheimer to lay out some of the strategies, but I will come back and comment on a few of those.

LINDA BILHEIMER: Thank you, Karen, very much. And I would like to express the Robert Wood Johnson Foundation's appreciation to Grantmaker's in Health for sponsoring this event as part of Cover the Uninsured week and also to the Kaiser Family Foundation for their generosity in providing us with this wonderful facility. Thank you both.

What I'd like to talk to you about briefly is some work that we sponsored over the past couple of years contracting with the Lewen Group to estimate the costs and coverage implications of ten proposals to expand coverage significantly across a very broad philosophical spectrum of ideas. These proposals were developed by a diverse group of leading health policy experts through the Covering America Project at the Economic and Social Research Institute.

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Now, obviously, modeling doesn't produce exact projections. And no one is saying that this exercise produces numbers that one would want to hang one's hat on in perpetuity. What it allows one to do though is to explore the relative performance of different proposals along a range of criteria. So looking at the proposals that we had, we had incremental proposals that built on the current system with combinations of public program expansions and tax credits. And those proposals really focused very specifically on the uninsured. But then we had other proposals that introduced more systemic changes that effected much larger swaths of the population including broad voluntarily purchasing pools with subside schemes tied to those pools, proposals that would revamp the current system of tax subsidies making employer's contributions to health insurance taxable and substituting tax credits tied to income and health expenditures, so called play or pay proposals that require employers to contribute to health insurance for their employees or pay a payroll tax so that their employees can participate in a public plan, and we also had an entirely tax finance system administered by the states.

The proposals differed in many ways, very particularly in their mandatory or voluntary nature. The two play or pay proposals, for example, impose a mandate on employers and one of them would also make a basic plan available free of charge to all who don't have access through an employer.

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One of the proposals repealing the tax exemption would impose an individual mandate meaning everyone would have to have health insurance and there would be severe tax sanctions for those who did not make themselves insured.

And then the tax finance system would assess a payroll tax on all employers and employees and a mandate on the states to cover at least 98% of their population.

We classified the proposals according to their dominant features, but several of them share certain building blocks. And again, this is important as we think about how to come together on solutions. So we see proposals whose primary focus is restructuring the tax system as it relates to health insurance, but some of those proposals also have Medicaid expansions attached to them as well. Some of the mandatory proposals also use purchasing pools, which is a strong feature of a lot of the voluntary proposals. And some proposals would cap the amount that an employer could contribute on a tax-free basis, rather than going the whole way to eliminating the exemption for employer contributions.

So what did we learn from this exercise? First of all, all proposals would make a significant dent in the number of uninsured and I think that's really important. Regardless of where they came from philosophically, they all would make a big difference if any one of them were to be implemented.

If we assume that they were fully implemented in 2002,

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which is what our cost estimates were looking at which had a base of about 42 million uninsured, the reduction in the number of uninsured from these proposals would range between about 12 million and about 40 million. The range for the voluntary proposals is about 12-27 million and the range for the mandatory or the guaranteed coverage proposals is about 37-40 million. And that difference really highlights one of the fundamental tradeoffs that policymakers face - A very difficult one. Whether to keep a health care financing system that is voluntary versus maximizing coverage by introducing some form of mandate or guaranteed coverage proposal.

The impact on national health expenditures of these proposals would all be relatively small, between 23 billion or 57 billion - about 1.5-4% of annual health care spending. And the factors driving those changes would be greater use of services by the uninsured, changes in the use of services by the previously insured who may now have more generous or less comprehensive plans than previously, changes in the efficiency with which health services are produced, and also changes in provider payment rates. But the redistributive consequences in terms of shifts of costs and savings among households, employers and the federal government in many cases would be large. And they reflect the tradeoff the authors were willing to make and the objectives they sought to promote in addition to expanding coverage. And it's important to recognize that

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nearly all of these proposals combine coverage with other goals. They all to some degree provide subsidies to low-income people, high-risk individuals or small or low-wage employers raising federal and sometimes state costs. And all subsidies benefit more than just those who are uninsured. Some policy experts seek to limit subsidies to the already insured through measures to promote target efficiencies. Focusing on let's get those who are uninsured covered and keep our subsidies targeted to that group. For others, horizontal equity - making sure that everyone at the same income level receives the same amount of subsidy is a greater priority. Again, those two are difficult tradeoffs for policymakers to consider.

Some authors seek to turn the existing system of tax subsidies, which benefits wealthier families more on its head. Others seek to maintain at least some of the existing subsidies to gain political and public support. And some authors believe that access to some level of coverage without an income test is a right and others do not hold that view.

Proposals also differ in the priority they assign to maintaining the employer-sponsored system. One of them would eliminate the employer's role entirely. Some would restructure incentives so that employer coverage would probably erode over time. And others would provide incentives that support or expand the employer's role.

Another area of difference is the priority they place

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on slowing the growth of health care spending, with some giving consumers incentives to enroll in lower cost plans either by tying subsidies to a basic or an average cost plan and requiring people to pay more if they want to go into higher cost plans or by ending or restricting the tax exemption for employer-sponsored coverage.

When making comparisons based on cost it's important to understand all of the flow of funds involved and not to make comparisons solely on the basis of the increases in federal spending, which can be quite misleading if taken in isolation. For employers the overall impact on spending taking changes in payroll taxes and premium payments as well as premium subsidies into account ranges among these 10 proposals from an annual savings of 77 billion to an annual increase in spending of 69 billion. For households if we look only at changes in premium payments in out-of-pocket costs, savings range from 3 billion to 187 billion. But that represents only a partial picture of the impact.

If we take changes in payroll taxes, taxes on employer benefits and wage changes that are likely ultimately to result into account, the range becomes a savings of 101 billion to an increase in spending of 12 billion by households. And if we go one step further and assume that all of the federal spending that the authors didn't account for in their proposals is paid for out of an income tax increase, then we see that all of the

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proposals would lead to an increase in household spending ranging from 21 billion to 80 billion dollars.

The message there is that households will end up paying in some form for coverage initiatives over time, but the proposals allocate the initial cost impact quite differently. Depending upon when you take the snapshot different proposals come out looking more or less financially beneficial to households. And even that can be somewhat misleading, as it doesn't indicate the change in benefits that some households would experience.

Proposals also differ in the extent that they would provide fiscal relief to state and local governments and then federal spending increases show the largest range from 34 billion to 552 billion. But those numbers, again, must be interpreted carefully. Don't just hear of a number and think, my goodness, that proposal must be much more expensive than this proposal and it's going to have this type of impact on my taxes. The 552 billion dollar proposal, for example, results from the proposal that would end the employer-sponsored system and establish a tax finance system instead. So employers and households pay payroll taxes instead of premiums and those funds are channeled through the federal government to the states. The net general revenue-financing requirement under that proposal is actually among the lowest. So that is just one example of how one needs to look a little bit below the surface

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to understand what is going on.

The bottom line is there is no single best solution. These proposals all address somewhat different priorities or weight priorities differently and people will judge them accordingly. They would all make a significant reduction in the number of uninsured. And the other important message is that despite quite different philosophical orientations they all share some common building blocks and we should start looking for areas of agreement to see if there are steps that we could take to move forward in the future.

KAREN DAVIS: Well, in fact, I think the public is interested in a number of these approaches. The Commonwealth Fund 2003 survey asked whether individuals thought this should be the responsibility of government or of employers or of individuals or whether it should be a shared responsibility, and overwhelmingly the American public thought it should be a shared responsibility. So Linda talked particularly about different strategies and different roles of the employers, but when asked, the American people felt that everyone should be contributing to a solution. We asked about specific policy strategies and interestingly enough, $\frac{3}{4}$ of Americans liked all of them so there were variations of 75-79%, but we asked about expanding the state-run children's' health insurance program to cover uninsured individuals. And again, $\frac{3}{4}$ of people supported that. We asked about letting the uninsured be covered under the

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Medicare program for the elderly and disabled. About $\frac{3}{4}$ of Americans supported that. We asked about giving individuals tax credits to buy health insurance on their own. About $\frac{3}{4}$ of Americans supported that. And we asked about requiring employers to provide health insurance to their workers and about $\frac{3}{4}$ of Americans supported that. So there were small variations, but I think what this is really telling us is that a mixed approach, not one single solution, not one silver bullet is likely to be most acceptable to individuals.

We also had a survey in 2003 nationally of employers and asked employers what they thought, particularly about employer responsibility and it was interesting to us that 59% of employers thought that employers did have a responsibility to provide or contribute to a pool for health insurance for their workers. And many of them think that employer health benefits are very important to them in a business sense. It's very important for them to be able to recruit and retain employees. That it's good for worker health. It's particularly good for employee morale and it also increases employee productivity. So as the employer community while they've been struggling with costs and not all employers do provide coverage, but they were supportive of having this as a responsibility for business.

In fact, we asked them about their preference between a mandate, which many businesses are concerned about being

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required to provide health insurance to their workers. Would they rather have that or would they rather have expansion of public programs? And again, a majority of employers came down in favor of expanding employer coverage rather than an expansion of public program coverage. Now that differs by whether those employers are now already providing the coverage. But even among those that don't about 40% of employers that do not now provide coverage would favor having employers provide it as a solution to covering the uninsured. And one of the things I think that tells us is that many employers would be willing to do it if their competitors were also required to do it and it didn't put them at a competitive disadvantage in the market.

Many employers indicated that they were willing to help their low-wage employees find out about and enroll in any public programs that they might be eligible for. They would be willing to administer tax credits. And many were interested in new group options that would make health insurance cheaper or more readily acceptable to businesses, such as the ability to buy into the federal employee health benefits plan or state employee health benefits plan.

So I think what we see is that there are a wide range of strategies out there. Different strategies may work better for certain populations group than for others. For example, for young adults many employers overestimate what would happen to

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their premiums if parents covered young adults up to age 23, but only increased premiums by an estimated 3-5%. So that's one strategy. For older adults who have retired early and are not yet age 65 and eligible for Medicare there's the option of buying into Medicare early. Another idea would be to eliminate the 2-year waiting period that the disabled now face to obtain Medicare coverage.

For small businesses there is a lot of interest in new group options, purchasing pools, such as having access to what some have called the Congressional health plans to differentiate it from the federal employee health benefits plan, but particularly for these pools to have re-insurance so that premiums don't go up if a small business happens to have a particular sick employee or a very ill family member.

For unemployed workers there have been strategies proposed, tax credits or premium assistance to help them keep their Cobra coverage from a previous employer in force. Many times unemployed workers really can't afford to pay that full premium themselves, but could with substantial financial assistance.

Others look towards programs such as the Children's Health Insurance program as a way of expanding coverage to the entire family, parents and very low-income individuals as a way of improving stability of coverage and enhancing family-based care.

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And most recently we've seen proposals to find new pooling mechanisms for part-time workers although that could perhaps be facilitated best with employer-graduated premiums. So I think there are no shortage of ideas out there and certainly the bottom line from our surveys is that there's broad-based support. Americans want action. They are less invested in any particular solution applying benefits and merits to all of them, suggesting that perhaps the best way to proceed is a combination strategy.

LAUREN LEROY: Thanks Karen and Linda. Linda, any final comments or are you? Okay. Great. Then we'll turn to the state perspective with Vickie Gates.

VICKIE GATES: Well, I must confess this put me in sort of an introspective mood having spent the last decade in a state and working with states to try and find solutions for the problem of people who don't have health care insurance. And as I look back over that decade it really seemed to me that we had some broad trends that were probably worth talking about and we had some periods when certain types of things were happening. And so rather than give you a list that tries to detail what particular states have done, which would be a very long list and there are wonderful websites that are available to you for that. I want to talk in a little bit more general way.

It is interesting if you look back because it is almost a decade ago that we really saw kind of the beginning of state

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health reform and state being actually talked about its laboratories and the place that we were actually going to start the learning process. That was the period, in fact, where we began to see major waiver projects in states like Hawaii and Oregon and Tennessee and Rhode Island and Minnesota were asking the federal government, let us take a new strategy. Let us move away from categorical. Let us, in fact, have an income based or a new way of looking at this set of issues. And often they chose 100% of federal poverty level as their baseline.

These strategies were also often part of a comprehensive look. And it's interesting how much discussion there's been today about the cost issues that we have in health care today, the quality issues that we have in health care and those original state discussions were very much focused about cost, quality and access. But in fact, they wanted strategies that dealt with all of them and they were at that point in time willing to talk about solutions that really addressed most of the population. And you had states talking about mandates, employer mandate strategies and looking at a broad series of things that might make the difference. Some even going so far as a state like Washington with a basic health program to say we know what we want to do, we know what fits our state. We're going to do it with our own money.

I think from there we actually moved into what I consider to be a little bit of a bridge period when some of

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that thinking resulted in a break with [Inaudible] between welfare and health care reform. Welfare reform. Health care is for health insurance. It's a way for getting people into the workforce. You can use it for new policy directions. We'll give you a new policy tool to allow you to expand coverage to families and to use it as a tool to keep the working poor [Inaudible]. We'll offer a new tool for children from a statewide basis. And it's interesting because this is probably one of the most successful of the state federal partnerships. You've got 100%. There's almost nothing with states where you get 100%. And of course people have speculated but I think we all think the reasons are simple. Very attractive population children, low costs, high investment, state flexibility, and a financial carrot. Certainly some things that I think provide some lessons for what we might look at. And we still saw a kind of series of one at a time, [badger] [misspelled?] care, New York, et cetera, new initiatives that people were developing.

Now it's interesting to me that in 2000 after all of this and kind of a hiatus in real activity we saw two federal initiatives that were, I think, designed to spur some action. One was HIPAA. The HIPAA waivers. The new kind of flexibility. More controversial, but essentially an effort to say let's have some more comprehensive strategies. Let's see if there are better ways to use Medicaid and SCHIP funding. Not a lot of flexibility for states in terms of more money, but some under

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the kind of screen ways to make it easier to meet federal neutrality, which of course in that earlier way had basically been managed care. Even in a state like Oregon who is famous for the prioritized list, managed care was the option that made the difference. And targeting the 200% population and really encouraging states to try and find a way to work with employers. And at the same time, the same kind of August and September 2000, a program that turned to states and said, hey, here's some money. Go out. Take a look at the uninsured. Develop options. Here are some resources to work with the public to try and build consensus. I mean, it should have been an ideal fertile environment if we hadn't had our economy basically put states in a position where I think they really began to say, how are we going to preserve what we've got? How are we going to find some way to keep this investment that we've made together?

So we might have had a different kind of blooming and we didn't. But we did still continue to see some things happening. And I think these are the hallmarks. They're much more targeted. They're smaller scale. They're often dependent on enrollment camps. They're often focused on the working poor and small employers. Much discussion of less expansive benefit packages both in terms of cost sharing and scope. This allows states like Tennessee; this loosening of the federal perspective allows states like Tennessee and Oregon to maintain

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[Inaudible]. To go in and restructure and to think about different populations. They might not actually have been able to do that given their financial circumstances. And it allowed states like Oregon and Utah to use money that they had put into state-only programs to expand more broadly.

Now these are not nearly as exciting when you look at them as examples of what states have done. A primary care program capped at 25,000 people by the state of Utah, only prevention and primary services. New Mexico struggling to create a low-cost package for working adults and still not having been able, having that waiver approved but not implemented. A voucher program from Idaho for parents between 133 and 185%. You either got an SCHIP package or \$100 to spend on your employer. Severely constrained proposal options in states like Arkansas. 6 outpatient visits, et cetera. We have states now like Virginia and West Virginia who are looking at existing local government pools and saying how do we build on it? So there's a real difference in the level of ambition and the types of proposals that states have brought forward.

It's interesting to me that now we have Maine who looked more to me like the early pioneers, much more focused on a broader strategy and much more aggressive goals about what they might be able to do by expanding public programs and combining that with strategies for employer based insurance.

Now, what do I think that we might have learned over

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this period of time? You know, this is kind of basic, but in fact just like any other major political initiative the stars do need to align. You need to have a series of things that come together at your state level to make it possible to do this and one of the most critical and important has to be leadership. The political champions. The ability to bring people together around the table and get them to commit to something that may not be their absolute favorite, but has enough of a core that they can support it.

We have learned much more about the uninsured, their diversity and their complexity. That sweeping strategies are much more difficult to implement and that multiple strategies may be the way to go. And so what states are now doing is niching their less ambitious. That they are trying to find small niches in groups that they can address programs to.

Every state has wanted and then struggled to find that kind of magic public/private partnership that makes building an employer sponsored insurance work and gives you really major expansion. We have not found it. It is much more difficult and it's a more difficult group to reach. The states' taxing strategies are not as persuasive as the federal. It has been administratively complex, but you can look at states like Massachusetts and Rhode Island and New York and their reinsurance efforts and see what states who really make an effort have been able to do.

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I think the reality is too we have learned some of the limitations of voluntary strategies and the implications of adverse selections both in public and private pools. It is a constant challenge to these options and to Medicaid programs, particularly if Medicaid programs have been forced to look at cost sharing as a way to maintain. And they have made it more likely that those programs suffer from adverse selection and certainly it is still many a good idea for a voluntary pool.

States have also learned that in fact you do have to keep your eye on what RWJ's board likes to call the Iron Triangle. Top quality and access are key. We cannot get away from them. As much as employers, and I have listened to small employers to offer in focus groups many times with a high level of commitment. They know their workers. They want to do this. But in fact they are worried. And if they are not offering, they are just as worried about what it will cost tomorrow. They want predictability. They value cost containment. And when it's runaway health care costs it's very difficult to bring them into the marketplace. And it's very difficult to bring states in for new initiatives at that point also. Because the one thing that is more painful than anything else, it's much more painful to cut a program than it is not to start one. So this predictability, this ability to look at this issue is critically important. And I think it's one of the reasons states have turned to things like disease management,

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struggling for a way to say, can we help contain costs and still feel that we're delivering some kind of quality?

I think we've also learned something about the limitations of state fiscal resiliency. Balanced budgets make programs that have major pressures during counter cyclical periods difficult. It is a constraint. Only one state is not forced to do that.

And I guess the other thing I'd say is we learned that as much and as important as it is that there are models and how states can be models for each other. When you see one state you've seen one state. They really do have their unique aspects, their unique windows and their unique political environments.

I think the states have made progress. They've had some innovations. They've had some great learning's, but you know the truth of the matter is we still have to look out and say, we have a very uneven landscape. And in spite of the constant fact that Americans say they believe that everyone in this country should have access to health care, the deeper part of our values if you really cared about health care, if you really worried about your health care, you'd go to one of the excellent websites and figure out which state you ought to live in. And with that, I'll turn to the people that wanted to show you the options that are out there.

LAUREN LEROY: Well, actually, before we get to that I

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just wanted to check with Karen and Linda and anybody else if you have any comments or anything to add?

FEMALE SPEAKER: I would just add to Vickie's that I think the states have had a lot of interest and a lot of creative ideas. That one of the difficulties of moving forward at the state level is the absence of federal funding for that. A lot of the initiatives are budget neutral so they don't really permit states to draw on new funds. And I think there are a number of people who are thinking about state demonstrations that would come with federal funding to try some of these ideas. And I just wonder about your reaction to that?

VICKIE GATES: I think you've raised a really key issue because even with the first waiver and certainly with the HIPAA waivers, the box has always been the existing level of funding. And there's been some under the radar kind of loosening because of allowing states in fact to include their statutory ability to do a state plan amendment, I mean their ability to do a state plan amendment and assume they had those populations. But that's limited. If we really want states to once again look at much more comprehensive strategies, I totally agree we need not to make the box so tight and we need to constantly use them to test the strategy.

LINDA BILHEIMER: Just to follow up on that, I was actually speaking at another meeting yesterday to one of the major proponents of state demonstrations and we got to talking

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about the difficulty that one faces with a demonstration project which is something that we experienced back in the last decade with some of the demonstrations that we sponsored, that unless people believe that this is going to be permanent it's very difficult to make a commitment to something that is only going to be around for 3 years and change everything that you do in order to meet that. And you made a very good point which was if one focuses, if one has demonstrations that focuses on employers and wanting employers to change their behavior that is certainly the case, that was our experience, that it was very difficult and understandably to convince small employers to change what they were doing for a demonstration project that was going to provide subsidies for 3 years or something like that. As Vickie says, it's very hard to take something away and just as it is for the states it is for employers as well. But he made the point that one could certainly have demonstrations where the subsidies or programs focused on individuals, because anybody who was uninsured would certainly not say, well, this is only going to last for 5 years, I'm not interested. It's a very different worldview and I was very glad you put it so straightforwardly because I haven't been thinking about it in those terms. But I think there are issues with demonstrations that we certainly should think about; about how they might be a useful tool and which ones probably couldn't work in a relatively short-term environment.

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LAUREN LEROY: Thanks, Linda. Now we're going to turn to our last 2 panelists and the way we're going to structure this part of the program is by my asking them a couple of questions and giving them the opportunity to respond to them.

The first feeds off of a recent report that was published by the Institute of Medicine called "Insuring America's Health" that set out a set of principals that any proposal or any policy that would be adopted to provide insurance coverage should meet. And those include coverage that is universal, continuous, affordable to individuals and society, sustainable, and offers access to high quality care. Obviously this is a serious mandate and one that we would all hope could be achieved, but it is a challenge to try to get there. At the same time we heard Linda say that all of the proposals that she talked about made a serious dent in this problem, at least in terms of the numbers who would be touched by that particular proposal. So from the point of view of the two of you, Judy and Bob, which of the options of the proposals do you think best meet these criteria? And tell us a little bit about why.

JUDY FEDER: I think that the criteria that the Institute of Medicine has laid out are certainly the right ones for evaluating our health care system, but they are one mean feat for any kind of political proposal. And because Lauren asked me to keep the answers short and because I am an honest

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woman, whatever one's politics, the only thing that comes close to meeting all these criteria I would say would be a single payer system. It could be Medicare for all, but it would be substantially improved benefits than Medicare now offers even with the new drug benefit. So if you really are going to hold yourselves to those criteria, you don't have a lot of choices. But I'm not going to stop there. I would say that as Linda made very clear there are tradeoffs to be made in any proposals. And I think the way to look at these criteria is in terms of the values and the tradeoffs that are made. And I would say briefly that my priorities in looking at a proposal is that there are adequate subsidies to make coverage affordable. My priority is always for the lowest income and those who are currently left out of the system, but the subsidies are adequate. I would put subsidies above mandates any time because I think one of the discussions of mandates is to ignore that you have to make - you can't get blood from stone. You have to give enough money to people to enable them to purchase. Just telling them they must is insufficient. So I'd look at the subsidies. I'd look at the place; do they have a place to buy? A market in which they truly will have access to coverage with those subsidies that will be available to them without regard to their health status so that it is a marketplace that really works for them without discriminating among people. And that it offers them meaningful, by which I mean comprehensive coverage. So those

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are the things that I would look at. And finally, just as a rule to live by, I would look at any proposal to see what its consequences, what its unintended negative consequences are because I believe a first order of business is that we should do no harm.

ROBERT HELMS: Okay. I'd like to start by also thanking Grantmakers in Health for putting this on. It's a good opportunity I think to explore what is a very complicated and difficult problem. But I'm also happy to provide a little balance to this panel. You know, being uninsured is not just a problem for women. [Laughter] okay. I'm sure somewhere around the country there are some men in the audience, but there aren't any here except the staff. Okay. Let me say I don't disagree with Judy's assessment of this. I do think you have to look at subsidies and so on, but I want to back up just a - and I also agree that we have to target the poor. But I want to back up just a little bit about why I think that and use it as an opportunity to say a little bit more about tax policy.

Just so you know where I'm coming from, I used to teach economics before I came to Washington and so I tend to look at these things in terms of well, how do you make a system work? And I spent time in the government, so I'm a little skeptic about the ability of the government to do things. Judy talked about the problem with mandating things, but also just the notion of price controls and command and control regulation,

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I'm a real skeptic about trying to make those work.

Particularly in a way that the American consumer or American voter, if you will, would accept. We are not England. We are not even Canada. And I think trying to copy some of those systems wouldn't work here.

But just a little bit about the history of tax policy. The reason I bring this up, there's already been a good bit of discussion about these proposals. That several of them say, let's go back and do something about tax policy. And for most people in the country who are not health policy [walks] [misspelled?] and so on, they probably sort of say, what does tax policy have to do with health care policy? And my view is that it has a lot to do with it. And that you have to take a historical view of this. Health insurance didn't start with World War II, but it actually had a little bit started in the '20's and '30's and so on. But there were several events around the early '40's, particularly during WWII that affected our health policy today some 60 years later. And they had to do somewhat of a historical accident that we had wage controls during the war to try to keep production costs down and so firms figured out if they could provide fringe benefits, and they happened to be pensions and health insurance, that it wouldn't count toward the wage caps. And so this was started and it was adopted by government policy, even the IRS by the early '50's that health insurance provided through your

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workplace would not be counted as part of your taxable income. Now historically, this went in at a time when health insurance didn't cost very much and it didn't do very much. But the other thing that happened in WWII was the development of penicillin. And this was followed by the development on the scientific side in the '50's and '60's of the modern antibiotics, lots of things that we do in health care now were made possible, there was a big growth not only in income but also the scientific capacity of medicine to do things. And that upped the cost. And then they grew up this demand for health insurance. But why did health insurance end up in the employment sector when life insurance, automobile insurance, and those other things were still sold to individuals? It's because of this tax policy. And it sort of says if you get your health insurance through your employer, you're getting it at basically after-tax dollars, but if you buy it yourself you have to pay a - I'm sorry, if you get it through your employer it's before taxes. So you get what for most people is a very large subsidy for getting your insurance through your employer. But it also affected the type of insurance we had. So I'm trying to give a historical example or explanation of why I agree that we now have a very inefficient and costly system. But we also have a system where most consumers view this as something paid for by somebody else. It's not like most of the other consumer decisions we have in the marketplace and so I think that's part of the

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explanation of the inefficiency. But it's a long-winded way of saying that's what we have to get back to when we talk about reform. We've got to do something, I think, to bring individual decision makers back into the system. It's not strictly individuals, because I do think there is a role for government for taking care of the very poor and the helpless and those kinds of things. There's a very strong tradition for doing that. But to make this system work, I think we've got to think about how to make this system more efficient. If we can do that, have more choices for people, better insurance options, a different kind of insurance, and let this sort of innovation that's now going on in the market. Let it play it self out. So I think it will be both better for the individual consumers. It will be better for employers. And I also think it will be better for the government, because if we had cheaper alternatives and more efficient care we would be able to - we could afford more on the public side. So I'll stop there and then we've got.

LAUREN LEROY: Judy?

JUDY FEDER: Bob, I share your view and have other conclusions from the history that I think we'll probably talk more about in a few minutes, but the focus of your concluding remarks gives me some pause. In that, I think that it's very important to keep somewhat separate the issue of those who are without coverage, the 44 million Americans who lack coverage or

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more over an extended period of time. And the issue of the efficiency of the health care system. The reality is that through employer-sponsored insurance and the combination of public programs we've built around that insurance, that's the history. Pretty much 85% of us have coverage. 15% don't. And the 15% who don't are largely working Americans who are in low and modest wage jobs that do not offer health insurance. To hold them hostage in terms of waiting for us to fix the efficiency of this system and slow down its cost growth before we let them in, I regard as morally unconscionable. And I think it's very important when we talk about the costs of expansion or about rising health care costs and how can we possibly put more money into the system, we're talking about retaining something that we have and are benefiting from, and I think I'm safe in this audience in saying we have it. I certainly hope so. That we have while waiting for us to get around to have some political courage to do something about health care costs before we let the others in. And I just think it's unfair.

ROBERT HELMS: Well, let me tell you. The other thing I think I have learned from this study of history is it takes a very long time for markets to really change and for people to change. And I think there are lots of things to do. The Covering America project had a lot of good ideas of things that I think can begin to make changes. I think tax credits are one of them to try to get people, particularly targeting these

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subsidies to the low-income people, which I thought you were supporting, but I don't think you have to wait for efficiency before you do something with the uninsured. It's all a process. You start it in the right direction and if you get some efficiencies it makes the whole thing more affordable. I don't think it's an either/or choice in terms of policies, Judy.

JUDY FEDER: Well, I worry a bit about that.

LAUREN LEROY: Well, I think this is a good opening to my next question, which is why is this problem so hard to resolve?

ROBERT HELMS: Well, not to repeat everything I just said, but it's so hard because people are vested in the present program and when you get to thinking about the proposals to really change the tax treatment of health insurance, to take away the tax exclusion and say that everybody who gets insurance through their employer would have to pay tax on the value of that just like they do wages, that would bring about more efficient change very fast. But the politics of that is just; I'm convinced, not going to happen in my lifetime to quote an old joke. But it's so people get vested in these various kinds of things. It's going to be a tough thing. The employment sector is employers, particularly human resource experts, are very opposed to changing anything about the tax treatment of health insurance. But I don't think you have to eliminate the tax exclusions, but there are some versions that

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were discussed in some of the plans in Covering America that would put like a tax cap on it or attempt to limit the subsidy.

JUDY FEDER: We agree a lot on some of these issues, but I want to go beyond pursuing a particular policy. I think that the question is when there are so many when you listen to the speakers you can do it this way or you can do it that way. It makes you think then why the hell don't we do it. There are so many choices. I think that the simple answer goes back to this 85% have coverage and 15% don't. And it goes back to it in 2 ways. Even though any of us can lose coverage any time because of a change in our circumstances or job change or marital status. There are lots of reasons we can lose coverage unexpectedly. The reality is that there is a disproportionate likelihood of low and modest income people, as I said, who don't have coverage through their jobs to be without that coverage. That's pretty much us and them. And it's very difficult to get them coverage without in some way affecting us. Bob has spoken about one way and I could talk more about what I think are the values of employer-sponsored insurance in terms of being able to pool risk, but it does mean that we have a stake in the particular way of getting our insurance coverage and that people are very concerned about strategies that would undermine or alter that coverage. So, for example, when there's an insurance in tax credits, there is a concern that offering tax credits outside, tax advantages outside the employer, the

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employer, some employers, by no means necessarily all of them, would lead some employers to say, well, wait. There is some other way that my employees can get this benefit, so I'm going to pull back on mine. The same time if you look at what offering such a credit might do to the current state Medicaid program or SCHIP programs. That if there are federal dollars available through the tax system in a situation in which states are pressed to continue for all the reasons Vickie said, pressed to sustain the coverage they've got, they too might drop back. And what you find is that a mechanism that set out to expand coverage bumps up against that existing system and it led some people to be dropped at the same time it might have led some others to gain coverage. It makes it a very, very difficult political issue, a policy issue to design the strategy that doesn't cost someone something at the same time it benefits others. And I think it's a reason that, whether it's the value issue that Linda was talking about, the cost issues in terms of whether you're really adding coverage or you think you're adding but you're subtracting, or you're substituting public dollars for private. It makes all those value and technical issues very, very challenging. And it makes it hard - and I live this you know, and I've lived it for my whole career. And I even get high on looking at these complicated issues and sorting them out, but what I think you have to do if you look at them is to not drown in the

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complexities. You can let some of us guide you through them. That's what we do. But you don't be confused yet mired in the technicalities. Look at the big picture values and see if you are moving forward. If you really think you are making some kind of dent, be willing to pay for it and watch out. Watch out that you're not going backwards when you think you're going forward. If that's not the case and even in a very stalled stalemated political system, it's not the case that any action is better than no action. And so you have to make those choices based on your analysis and your values.

LAUREN LEROY: Well, I think this leads into the next question. It may be actually part of it, which is if you were going to look at the various types of approaches, what do you think is most politically feasible?

ROBERT HELMS: Okay. What is most politically feasible? This is actually more a fear of mine than what I would propose, but what is the most political feasible is sort of business as usual for Washington. Sort of think in terms of how can you hide the costs of this reform? In other words, its' politically popular to say we want to expand coverage for the uninsured, so mandates are popular with a lot of politicians. The trouble as Judy has said when you go mandating things you really have a big effect on small business, particularly on their ability to maintain their businesses and their employment. I mean, you could have big employment effects if you go mandating things.

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The other sort of thing is sort of like what they do in Medicare, sort of ship the cost somewhere else. Don't deal with the issue right now. Let later people deal with it. Sort of put it off. But the other kind of thing is a kind of for an economist a very sort of naïve approach - well, if things cost too much let's just put in price controls. Lower the prices. And besides, those doctors out there don't need that much money. The hospitals get too much. We'll just ratchet down the rates. You see it in Medicare all the time and I think there are a lot of people that would somehow like to impose those kinds of controls more on the private sector. And that's sort of the easy political approach. That's what scares me because that is not the road to getting a more efficient system.

And let me tell you what I mean about efficiency, economic efficiency. I can imagine a kind of system where I would like to have a kind of competition that puts a lot more emphasis on serving patients and increasing quality. And I think under these sort of regulatory approaches, the incentives are just the opposite. The providers sort of say, well, I can't get the prices, so let's slack off on the service and the quality and that's what scares me.

JUDY FEDER: Well, I wonder if what we're afraid of is a function of our disciplines, because I'm a political scientist and I don't know where you think all these price controls are coming from because I've been trying for them for

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years and haven't had any success. I think, but I will start with what I'm afraid of. I think that sadly there is, has been in the last decade a move away from the understanding that insurance is about pooling risk and that this is one of probably many social problems. And that we ought to proceed as all being in it together. I think that there is an enthusiasm that I consider dangerous for holding individuals responsible for their own circumstances and with a bowing to arguments about choice, competition and efficiency having individuals rely to a much greater extent on themselves, when what we know from lots of experience is that we need policy rules to make the system work. We need insurance pools, otherwise insurance discriminates against individuals. We need to pool our income so that we can take care of people across the income scale. We need to take care of people across genders, across ages. We need to really be in this together. And my concern is that move in the direction of reliance on tax breaks and letting individuals do their own thing, tax breaks whether consume or whether tax credits for health insurance, so called consumer-driven health care where people have accounts and it's going to make them responsible and that's going to somehow drive the system, never mind that most of it is catastrophic costs anyway. I think that those are devices that lead to less of a community and more of everyone having to protect him or her self and I find that really concerning.

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On an optimistic note, hoping that Bob's fears are more reasonable than my fears I'm going to go for what I hope is likely in a community in a communal way. And there I think that we have the greatest chance of success in terms of taking mixed approaches, mindful all the time that it's a mix that works and doesn't undermine, that we strengthen the mechanisms that we have that do pool risks. So whether it be employer-sponsored health insurance or new pools that do pool risk or Medicaid for the lowest income population, which by the way since we haven't said this do not go away with the impression that Medicaid covers all poor people, because in a quick word if you are a mom and a kid you're not doing too badly - a kid you're not doing too badly up the income scale. If you're a pregnant woman - so, so. If you're a parent, in most states the income standards are too low for most people on the minimum wage to get eligible. And if you are an adult who is not a parent of a dependent child, and except in some of those waiver states that Vickie was talking about, you are out of luck. So let's not exaggerate, but with that [Inaudible] aside, that strengthening that program, providing since there is so much variation and risk at the state level, and variability in terms of who's covered and who's not. More federal money, that's money that we put it in as national taxpayers to achieve national goals. It is not revenue sharing for states to do what they want with. More federal money means more even coverage across the nation,

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so that's just my pitch on a few of the ways to improve.

LAUREN LEROY: Well, thanks, Judy and Bob. And now what I'm going to do is turn to the questions. I'm quite pleased that we've received a number of questions while you've all been talking. So you've generated a lot of interest. And these questions are for everyone on the panel, so feel free to speak up.

One, actually, that's my question. I'll take the prerogative as the chair after listening to you that I'd like to pursue a little bit more. We heard Karen say at the outset that $\frac{3}{4}$ of Americans seem to like all of the strategies and so a mixed approach might make sense. And then we heard Vickie echo that from the state experience. And when I think about trying to put together, to structure a policy or a set of policies that include these mixed approaches, I have some questions about that that have to do about segmenting the population depending on where they fit under these different approaches and the complexity of what we might end up with, where people find it very hard to figure out where they fit. And so I'd just like to hear a little bit more about that and how this might work and how we would address those issues if this seems to be the most likely or the most feasible way to cover more people.

KAREN DAVIS: Well, I think it's very difficult for private insurance to take on the worst health risks. I know that 10% of the people account for 70% of the outlays. And in

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fact public programs have stepped in to cover the elderly, which have more health problems, to cover the disabled, to cover low-income including people with serious mental illnesses, HIV/AIDS, those are disproportionately addressed through public programs. I think we can get better pooling in the private market if we would design reinsurance mechanisms. To take a specific example, the state of New York has a program called "Healthy New York" for small businesses and the New York state government picks up the expense when any individual goes over 20,000 per year - the state pays 90% of the bills above that threshold. And that lowers the premiums for small businesses and induces more insurance companies to want to participate because they know if they happen to get the transplant patient, the premature infant who's going to require a lot of neonatal intensive care, that it won't affect that insurance company's cost. So I do think one of the ways of getting pooling reversing this segmentation that Judy rightly raises is to have the federal government take on more responsibility for financing reinsurance and to just realize that there are certain population groups that are going to be very difficult to make private insurance work and to turn to programs like Medicare, like Medicaid, to be the safety net for those very seriously ill individuals.

JUDY FEDER: Lauren, I'd add another or just focus on a different design concern raised by your point and that is that

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when we talk about creating pools, insurance pools, or places for people to buy and it's consistent in some ways with what Karen was saying is that we have to recognize that when we create a new place to buy and is fair and will take all comers or a public program that will take on the higher risk populations, that they are going to in unattractive words, they're going to get dumped into. They're going to get selected against. It's not going to be an even level playing field. And if we want to go that way, that's just fine. We have problems with trying to make rules for insurers and haven't been so successful with that. It may be better to not do that and create pool or places, these alternative places. But we have to recognize as the authors and Linda I believe did, we have to recognize then these other places that are not playing by those rules are going to get sicker people and we have to be very concerned that the subsidy structure is adequate and that they don't get trashed as inefficient government programs when their costs are higher because they would be treating different populations. So we have to be willing, I think, to pay appropriately in the different circumstances and to subsidize adequately so that if individuals shift in circumstances, that they will have affordable access wherever they fall.

LINDA BILHEIMER: Just to follow up on that point and also to sort of pick up on one of the things that Vickie said talking about states with their multiple strategies and their

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issues, I think one of the things that has impressed me over pieces of research that have impressed me over the passed year is something that Karen made reference to, which is some work that Pam Short did that came up with the estimate that 85 million people were uninsured at some time between 1996 and 1999 - over the 4 year period. And one of the points that she makes, which I think is really important is that it is very important to understand the nature of coverage gaps. And she says if we focus on people rather than on the nature of the gap, we may miss the boat. And I think that's a really, really important message. And she has 7 different types of coverage gaps and those really need, particularly if we're looking at incremental approaches, need very different solutions. The figure that really stuck in my mind was the 28 million people who came into the group that she called multiply uninsured and these were people who moved in and out and in and out of coverage over the 4-year people. That's very different than someone who is between 2 good jobs and had one period of 2 and 3 months when they were uninsured between jobs and really had an expectation of good coverage both before and after that period. And the strategies that one looks at for those 2 different groups of people or for people who were uninsured for 2 years or more at a stretch, another group, are different. And one really needs to think when one looks at proposals, will they really address this churning of people in jobs and how

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that affects coverage or are they really only going to focus on certain types of these coverage gaps and leave some of these coverage gaps to continue.

LAUREN LEROY: All right. We'll turn to a couple other questions and actually it tees off of something that Linda just said. I'm going to put 2 questions out there because I think that they can be addressed in the same, not in the same answer, but they're similar. And the first one speaks just to what you were saying. It comes from New Hampshire and the question is, a significant portion of the uninsured are between jobs or otherwise in transition. You know, this was ESP I guess. Could unemployment insurance programs be expanded to include health coverage on an interim basis? And the other one which comes from the group that's viewing the webcast with the Rhode Island Foundation and the Neighborhood Health Plan is what are the advantages and I would add, disadvantages, of expanding coverage by broadening or opening up successful Medicaid managed care programs? So who would like to take on one or each of these? Judy?

JUDY FEDER: I want to thank that person for that question because it was exactly what I wanted to talk about. I wanted to talk about what I think is a surprising area, policy initiative where the results aren't what you think they might be and that's what Linda was triggering for me. And that is the area of people between jobs and we tend to think that people

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when they lose a job that had coverage that that's an uninsured group that we could target on and be very effective in getting to them. The reality is that the analysis tells us that when we target on that group a large number of them already have coverage. They either have coverage because their employer extends it and they've been able to carry it forward because it's a short gap in coverage, or because they can get it from their spouse, their spouse has coverage. It's not to say that it's not a problem and whenever I look upstairs I mean a higher power and not the Kaiser Family Foundation. If anybody's listening I do not want to fall into that gap, but it is a policy that on its face looks as though you're going to really have an efficient getting of dollars and it is I think has been demonstrated to be an extremely inefficient use of dollars. Most of the dollars go to replacing, would go to replacing private coverage that people already have and you are extension of people with coverage or the dent you'd make in the uninsured would be very small.

LAUREN LEROY: Other comments?

FEMALE SPEAKER: Well, I do think the idea of building on successful models such as the Rhode Island Neighborhood Health Plan is an excellent suggestion. Rhode Island has been a leader in using its Medicaid and its RIHC Care, Rhode Island Care program for children to really both improve coverage, improve continuity of coverage, but also improve quality of

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care. It's a state that has set goals for its managed care plans to improve prenatal care, to reduce lead poisoning, more effective lead screening, it increase immunization rates and has had dramatic success in doing that. It gives bonuses to its managed care plans for reaching quality targets. And they found that they saved money for example by covering women for two years after pregnancy by being able to give them some of the services including family planning services that helped them have better spacing of their children. So they've reduced what's called low-parity birth from 40% to 20% so the second child comes at least 18 months after the prior child. So I think there is a way to build on these models that have worked very well, and particularly those that have been designed around the particular strengths of some of the provider groups like Community Health Centers or their managed care plans have been formed by groups of Community Health Centers and giving them real rewards for reaching quality goals and meeting the needs and being culturally responsive to the needs of the communities that they serve.

VICKIE GATES: Lauren, I think the other thing too is that states not only buy health care because they provide Medicare services. They buy health care because they run in many cases large pools for other employee groups. Either their own teachers throughout the state, local public employees, et cetera where they have an arm that is used to organizing and

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making coverage available and those are also places that are worth thinking about in terms of an organizing building block in an larger pool. And in some cases they're more attractive depending on how good. Rhode Island has a wonderful Medicaid program. There are some Medicaid programs that you would have real difficulty selling to a broader group of uninsured, so again it's really an issue where you look at the strengths within your state and what the building blocks might be that you have available to say this is the place to start and we're going to save some money and be more efficient by taking advantage of what we already know.

LAUREN LEROY: Let me move on because we have a couple more questions that I'm going to try to squeeze into the time that we have left. We actually heard from a couple different people on a similar theme, so I want to make sure to ask that one and that has to do with what should be done to cover undocumented children and undocumented adults who make important contributions to the local economy but don't have access to a number of these programs.

JUDY FEDER: Well, I'm not running for office. I'd cover them all. I would say based on experience it is a very challenging political issue and I can still recall being in rooms where I had to be more diplomatic in that answer and in other times representing an administration. I think that the more politically viable answer is to recognize that there are

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certain parts of the country in which there are concentrated groups of undocumented people and that they are making contributions to the economy and even when they aren't, we ought to be a caring nation and take care of people when they are sick. And that there is likely a need for money at the national level to make it possible for institutions and providers to take care of them. And if we are not willing to follow my preferred approach.

FEMALE SPEAKER: I would at least stress the important of restoring federal matching funds for legal residents. Those were eliminated in 1996 with the Welfare Reform Bill. And I think one thing that we could do to really improve accessed care for many immigrant populations would be to restore federal matching funds, certainly for legal residents. And I certainly agree with Judy that the vibrancy of our economy is very much dependent upon attracting an immigrant's workforce. And if we don't invest in the health of children, if we don't make them ready to go to school, if we don't help them be able to attend school, if they're missing school because they're sick or they have asthma or other health problems, dental problems that keep them out of school, we're simply not going to have the productive labor force that we need to have a vibrant and healthy economy. We focused a lot on the retirement of the baby boom population starting after 2010, but we also need to be able to attract a labor force that will be able to produce the

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goods and services that all of us will need not just older people when that happens. So I would view paying for health care for immigrants to the U.S. as really in our own economic interests to ensure a healthy and productive labor force that we need in the future.

ROBERT HELMS: Could I just? A quick response. Judy's right that these are, we've got to remember that these are people we're talking about who are actual individuals and they need care and they need insurance, they need health coverage. It's easy to understand why a politician just sort of says, wow, let's just draw the line. These people don't vote, so it's easier for us to leave them out. And that's sort of the brutal politics of this. But given my preference for sort of a private sector solution, I can't help to think of particularly those of you out there in the states and so on, there's a real problem I think with a lot of sort of, in the state legislatures a lot of mandates, state mandates, a lot of special interest and so on, and it's very hard for sort of innovative health insurance to come in and offer a more cost-effective kind of policy that might be bought by some, not all of the really poor, but some of these people that are working out there that don't have health insurance through their employer. They can't get it. They're not eligible for public programs, but they might be able to buy this if you could get a more cost effective and cheaper policy offered. But a lot of that has to do with very

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costly state mandates that prevent a lot of the entry of new insurance products into state markets.

FEMALE SPEAKER: Could I comment on that, because actually I don't believe that there are some mandates that add costs? There are however mandates that are so basic that most insurance companies don't sell policies that don't include them. And a lot of the research that's been done tends to indicate that in fact it's not the nature set of cost issues. I think there is a huge amount of interest right now and we're going to see some experiments in states that basically have allowed insurers to come forward with mandate-free policies and do new designs. With that option available we are not seeing a huge number of people who, in fact, are doing that. Because this is still a difficult market and where you have to go to get a policy that would be affordable for many of these workers, it's cutting the scope of benefits enough to get that kind of savings in today's cost care environment provides a policy that you might be surprised. Mandates aren't going to get you there.

LAUREN LEROY: I'm going to turn to 2 questions again that are related as the last question we'll have time for. The first one is how about cost shifting? Is that a persuasive anecdote to the concern of insured people that covering others will hurt them? And a broader question that relates to this is, what have you learned about what are the critical messages that

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might convince the us, the 85% who are insured about the value of covering them, the 15% to shift political will a bit? And maybe we can have each of you try to address that to help wrap this up. Who's going to start?

ROBERT HELMS: On cost shifting, I've been on a personal campaign to try to ban the word from the lexicon of health policy. No, if you cover that I don't think that really has any effect on. I know everybody thinks there is a victim of cost shifting or it's going on, but the economics of that I find very hard to believe. So I don't think covering is going to cause any change in the existing rates to charge by hospitals and so on. If they could lower, if it paid them to lower the rates, they would do it.

LAUREN LEROY: Judy?

JUDY FEDER: I think that the question is I'm not going to go into semantic differences or a semantic argument. I think that the issue that the question is raising is whether we are indeed paying for care that is provided to uninsured people already in some sense. And whether we can recapture it is Bob's point and it's not clear that we can. But we are indeed paying for it in part and but we should not fool ourselves into thinking that that's good enough. That we can either get it or that we don't need to give them new money or that they're getting all the care that they ought to have. So I think that wherever you are, the questioner, I don't know if that was from

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in the room or out of the room, go for it. That is a perfectly fine argument and I can even state it in a way that Bob will accept. So I think that you're right to make that. I think that to extend and to do my piece for closing this down in terms of messages, I haven't found the ones that are successful. What I believe is to start where the questioner asked about what is in it for me who has insurance and we do need more stability. We do want lower costs. We do want to know that our coverage will be secure for us and there are policy proposals that do make coverage more affordable and more secure for those of us who have it at the same time that we bring in other people. And I think being explicit about that is fine. I think that it is and I am persuaded by others who have been making this argument longer than I. I think that we have to be willing to mobilize people around what's the right thing to do. And what kind of a society do we want to live in. And I think that if we avoid that question and try to con people into it'll be okay. We're not going to get from here to there. And so I would urge everybody if you believe that to start saying it and to say it loud and often and to tell elected officials you are willing to pool your resources to make that possible.

VICKIE GATES: The argument that in fact we are spending money has been used effectively, I think, in the health care reform debate and has typically been accompanied by the argument that in fact we are spending it in the most foolish

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way that we could spend it. We are spending it in the least productive ways. We are spending it in the part of the health care system that deals with things that are already way down the path. And I think that some of the recent research that RWJ supported with IOM and their series of reports on coverage certainly prove that. And so I think that argument does have some validity. But also I think there is a point at which that you do have to deal with one of our most serious and significant issues are right now. That we do have a loss of community. A loss of a sense of community. A loss of a sense that we are all in this together and some of the things, that in fact, I mean, there's a reason why it's the public health community that have picked up our immigrants who don't have coverage because they have a way of looking at values that, in fact, assumes that the whole community is at risk when others are at risk. And there is an element of truth to that. So until we can begin to put some of these issues out there, I don't know. I think my experience says that we do better when we get the values issues on the table and we are willing to talk about them, because in fact, it is often not rationality that leads to making the decision, it is our underlying values and the values that we use to make our decisions. And so I would argue that we need to get these things on the table and make them a legitimate part of the debate because we won't find a solution because somebody came up with a magic option, we'll find it

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because we want to and we believe we should.

LINDA BILHEIMER: I believe with Judy and Vickie that it is a moral issue and that until we are prepared to say that it is a moral issue we're not going to get there. That said, I think we need to take advantage of when there are times that it seems as if we might be going to get the political will back again. And I think that this is one of those times and I think that one of the reasons for that is that people across a much broader income range are beginning to feel scared that they're going to lose coverage. The last time that that happened was back over a decade ago and we saw some galvanizing among the population wanting to see some action taken because people were afraid that they were going to lose coverage. And I think we should both put our values on the table, put the moral issue on the table and take advantage of times when it seems as if the population is ready to move to take action.

FEMALE SPEAKER: Well, I agree. The number one reason to do this is simply that it's the right thing to do. But it's also a national embarrassment to be the only country to fail to cover all of our people. And I'm in many international meetings and I have to stand there and say the U.S. cannot do what every other country in the world has done just does not hold up. And I'm not just talking about England or Canada or Germany or France. Korea, Taiwan, every major country provides health coverage for all and it's something American can do ingenuity.

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We can certainly do. So that's one reason. The second reason it is in our economic benefit to do this. The Institute of Medicine has estimated that we lose 65-130 billion dollars a year because of premature death, premature retirement, when people leave the labor force with a health problem, a stroke, a heart attack that could have been prevented with better care, they are not producing. They are not contributing to economic growth. They are not paying taxes so that we all benefit by keeping people healthy and able to make productive contributions to their families, their communities, and the workforce. And then finally having been in New York City on September 11th, I think we all realize that in times of emergency we need a strong and vibrant, prepared health care system. And we cannot have a strong nation without a strong health care system. One that has adequate facilities. One that has emergency rooms that don't have to turn people away. And the presence of the uninsured is sapping the financial strength of our health care system. The burden of caring for the uninsured is increasingly concentrated on a few hospitals and because of that they are just stretched thin and unable to afford the kind of staff, the kinds of capacity that all of us plan on having when we need it. So I don't think it's just, we're okay. We're taken care of. We have insurance. The hospitals, the providers, the places we need to turn when we're sick or our families are sick are very much affected by their

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capacity to get that care because of the unevenness of financing care in this country.

LAUREN LEROY: We've gone a few minutes over the time that we had planned, but I want to take just another minute or two to extend thanks to a number of people who made this webcast possible. First of all to our terrific panel, which I think really gave us a rich and stimulating discussion. In addition I want to thank the staff of the Kaiser Family Foundation and particularly Larry Levitt, Barbara Gilbert, Ken Kensall, and Sean Walens for all of the help that they've given us over the last couple of months to be able to make this event happen. I also want to thank the GIH staff who participated in today's event. And in particular I want to thank Osula Rushing who took the lead for putting together this webcast and I think really did a terrific job. And Rhea Penarus who has been working with her to make this day a success. Finally, I want to thank the foundations around the country and those in this room who helped sponsor viewing events and also who helped spread the word about this webcast to their colleagues and grantees in different parts of the country. And finally, the webcast is going to be archived on kaisernetwork.org so if you know of others who didn't have a chance to see this, please feel free to tell them to tune in. And thank you very much. Thank you again.

[END RECORDING]

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