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Health Reform Turns Two: Monitoring the Impact of Expanded Coverage
Session II
Blue Cross Blue Shield of Massachusetts Foundation
June 3, 2008

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LIZ WALKER: Good morning everyone. My name is Reverend Liz Walker and I am delighted to be here. Thank you. [Applause] Like Larry Tye I am a recovering journalist and as fate would have it, I did not have to seek medical treatment. The twitch ended on its own.

The Bay States Landmark Health Care Reform Initiative, as we know, is well on its way to providing adequate health care for everyone and that is a good thing. One of the words used this morning was revolution. With any revolution, with any monumental change there will be monumental challenges. Fortunately here in the Bay state we have the kind of leaders that can step in the gap and take them on.

I want to introduce two more of our leaders who are in the audience this morning. Katherine London, who is the Executive Director of Health Care Quality and Cost Council. [Applause] Please stand up or wave. And Commissioner Janet Labreche, who is a Commissioner with the Mass Commission for the Blind. [Applause]

Here to introduce our next keynote speaker is Nancy Turnbull, the past President of the Blue Cross Blue Shield of Massachusetts Foundation. [Applause]

NANCY TURNBULL: Good morning. Okay, still awake. That is good. It is my pleasure this morning to get to

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introduce Senate President Therese Murray. You have a bio of the Senate President in your packet, so I will just try to hit a few of the highlights. She is currently in her eighth term as the state senator from the Barnstable and Plymouth districts. You all know she became the Senate President last spring. The first woman, I will point out, to ever hold this post. [Applause] And before that she served as the Chair of the Senate Ways and Means Committee for four years.

For her entire career in the legislature, the Senate President has been a leading voice on many important issues, particularly those affecting families and children and elders. And it is very appropriate that she be with us today not only because of her leadership post in the legislature, but also because she has long been a passionate and effective advocate on health care and health access issues, whether it be newborn hearing screening, mental health parody, drug coverage for elders, improving long-term care options for seniors and people with disabilities. She has a long record of legislative accomplishments.

I first got the opportunity to work with her a little bit back in 2000 when she authored and then successfully passed the state's Catastrophic Illness and Children Relief Fund, which is a financing mechanism that provides financial assistance for families who have children with special health

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care needs and whose medical expenses are really catastrophic in scope and there is no other funding available for them. And I had the privilege of chairing the commission that oversees that fund and really saw the Senate President's effective and passionate advocacy and caring for these children who are very, very vulnerable and whose families just endure incredible responsibilities in order to care for them.

As Chair of the Senate Ways and Means Committee, the Senate President was a major force in passing Chapter 58. Now she is showing her incredible courage in taking up the major challenge that we all know confronts health reform, and that is trying to control health care costs. And this is really I would say the third rail of health care and health policy. We heard this morning from a number of speakers how cost control and affordability really are the major challenges that lie ahead.

The Senate President in early March introduced a very comprehensive cost control bill and then working with her Senate colleagues passed major cost control legislation in April. The legislation is very, very broad in scope ranging from statewide adoption of electronic medical records to banning pharmaceutical marketing gifts to improving primary care to increasing transparency to really trying to promote more efficient use of resources and medical technology.

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It was encouraging to hear Speaker DiMasi tell us this morning that the House plans to take the legislation up shortly. In focusing on the imperative for cost control, the Senate President has said that there has to be climate change, otherwise our health care reform will implode under the costs. And in doing this, she indeed I think identified the Massachusetts health care equivalent of an inconvenient truth.

Now I am not sure if the Senate President has a PowerPoint presentation that as glitzy as Al Gore’s but she certainly is bringing an incredible amount of focus, energy and commitment to the need for dramatic change in this area. So please join me in welcoming the Senate President Therese Murray. [Applause]

SENATE PRESIDENT THERESE MURRAY (D): Thank you for those very kind words, Nancy. As all of you know, I do not mind stepping on third rails. And I was very happy that I was able to be here this morning to hear Dr. Spain, who is still with us, because a lot of what we did in our health care bill, Doctor, is right on the mark of what you were talking about. But nothing we do in the Senate is done by ourselves. Senator Dick Moore, who is at the table here, is a main mover and shaker for health care, as all of you know, in Massachusetts and has been for a long time. And was the Chair of the Senate Health Care Committee as we did Chapter 58 and sat for months

and months and months and months in that room all of us just together and getting along so well. But we put out a product that we are talking about today and I am going to talk about the second phase of that. So thank you for inviting me. Thank you for being here.

This is a very proud moment for Massachusetts. I am happy to be here with all of you to celebrate the success of health care reform and address the key challenges that are still ahead of us. Who would have thought that we would be standing here today with more than 350,000 newly insured individuals, more than half of the uninsured from two years ago. The Urban Institute Report released today confirms that we are moving in the right direction. From 2006 until 2007 uninsurance for working aged adults is down by almost half. Low income adults have seen the greatest drop in uninsurance and are less likely to have unmet medical needs because of more affordable health plans. And more than 70-percent of Massachusetts adults at all income levels continue to support health care reform.

These are encouraging statistics. And all the more reason for us to continue working together and remain committed to our goal of insuring every individual in the Commonwealth. And as we move forward together, we must be ready to confront the rising costs of health care, which continue to be a burden

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on our system. We must recognize that not everyone has access to the care they need. We must contain costs and increase access to primary care if we expect to keep our health care system viable and sustainable. I am confident that we are ready for the challenge.

Two years ago, when Health Care Reform became law and we set out on this mission, we understood that costs and access will become a greater concern as more and more people enter the system. We understood that costs drivers and the primary care shortage have been threatening our system long before we had the courage to set health care reform in motion. Now because of our bold steps we have a foundation to build upon and a plan to help deliver us from the ills of our healthcare system.

Any effort to expand coverage and improve access must be combined with measures to contain health care costs. And these costs are squeezing our state and municipal finances and impeding our economic growth. They are cutting into resources for education, for public safety and transportation, and making it increasingly difficult for young people, families and businesses to make ends meet. The double-digit growth in health care costs is outpacing the increase in workers wages and the overall inflation rate.

The Health Care Costs Containment bill that Senator Moore and I worked on together along with our Senate colleagues

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is the beginning of a new conversation on health care reform. And I talked about that last year here. It represents the critical first steps that we must take to establish the second phase of health care reform and set us on the right path toward affordability and sustainability. The Senate has already passed the bill and I was very happy to hear the Speaker say that he is getting ready to pass it. I asked him if he is going to do it tomorrow when we are all in, but I do not think he is quite ready. But I am encouraged by his actions. And it is my hope and my expectation that this legislation will get done before the end of this legislative session so that we can begin to address the growth in health care costs, which is fueled by a number of factors.

One of the primary drivers is the innovation of new technology in therapies and the increasing utilization of these services, both in terms of volume and severity. The duplication of services is something we address in the Senate Health Care bill. Demanding a stronger determination of need process. I know that is not palatable to a lot of people. It is not popular. But we can no longer afford the cottage industry of specialty services where outpatient surgery centers and MRI stations are opening up sometimes across the street from each other, around the corner from the hospitals with good doctors fleeing those hospitals.

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We must create a new emphasis on primary care to balance the lure of specialty medicine. 20-percent of U.S. medical students went into internal medicine in 2005 compared to 55-percent in 1998. Young physicians, interns and residents are going into ROAD specialties; radiology, oncology, angioplasty and dermatology because they are the road to prosperity. They know that is where they will make the most money and spend the least amount of time. There is a clear indication that current financial incentives favor specialty over primary care even though hospital based specialists depend on referrals from primary care physicians. And Dr. Spain mentioned the need for primary care physicians and we certainly recognize that in the Senate bill.

[Inaudible] access for undocumented and we still when we look at the emergency room numbers and see that they are not going down, it is not just an educational change that we need. It is the competition between the hospitals, the doctors and the clinics as who gets to be paid more for what services. So when you cannot get into to see your primary care doctor because he or she is already booked, they will say go to the emergency room. That is not what we want to have happen. When we have undocumented workers that are going to the emergency room, they are going to use the free care pool. That is continuing in particularly Chicopee, Holyokes, Springfield and

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areas where there are large immigrant populations. That is something we do not have control over right now and of course the federal government insists that we care for these individuals, and we should, but we do not get paid for it. And there are a number of hospitals who are taking most of those patients and the pressures on them are significant. We have to figure out a better way.

This is one of the major reasons why the Senate Health Care bill supports the medical home model. Employing a holistic approach that empowers primary care physicians to take center stage in a patient's care directing treatment and managing chronic illnesses with a team of health care professionals. This model goes along with our feeling as a society that every citizen should have access to the best care available and that we should continue to improve the quality and the effectiveness of health care treatments.

Rationing health care services, while the most direct approach to controlling costs, is not an option that the public will accept. What we can do, however, is transform our payment system from one that rewards volume and severity to one that emphasizes value and quality. This requires a comprehensive approach focusing on primary care and efficient use of existing health care resources.

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It also requires us to address information technology and transparency in the health care industry, which are two other important areas that the Senate Health Care bill addresses. For example, the statewide adoption of electronic medical records, computerized physician ordering systems and uniform billing will save us hundreds of millions of dollars a year, year after year with just a fraction of initial investment. And requiring annual public hearings with health care providers and insurers will allow us to investigate cost drivers and explore cost reduction remedies. It is true that we have identified some cost drivers and that we know some areas where we can save money. But the reality is that we just do not know all the reasons for the double-digit increases we see every year. We need to find out why. And transparency is the key to getting some answers.

We must stay together and be fully committed to the second phase of health care reform. When we started our journey two years ago we took bold steps as a broad coalition of stakeholders, including citizens, businesses, providers, insurers and state officials alike. Our next steps require the same commitment. With our renewed determination and some new tools in place, we can attack the escalating costs that threaten to derail our hard work and accomplishments of the past two years and deliver access and affordable quality care

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to even more residents. Together we will reach our shared goal of making health care sustainable and affordable for everyone.

So let us make the commitment, roll up our sleeves and get to work. Thank you. [Applause]

LIZ WALKER: Thank you Senate President Murray. It is now time to meet our panel and if you would like to submit a question for one or all of our panelists, please use the index cards on your table and alert a staff member and, of course, Mike and Jeff and the panel can start coming up now as we continue our conversation. Mike and Jeff are standing by on both sides of the room to collect your questions at any time.

We are pleased today to have five panelists to represent different aspects of health reform. Each sector has been instrumental in passing health reform and is an integral part of the puzzle moving forward. As our panelists make their way. Our first panelist is charged with carrying out the Governor's goal that all Bay state residents receive access to high quality health care as well as promoting good health for all residents. Secretary Judy Ann Bigby is a member of the Governor's Cabinet and oversees the 17 state agencies within the Executive Office of Health and Human Services. Her broad range of experience as a physician, a professor, a researcher and a health policy expert give her a unique perspective as Massachusetts forges ahead in health reform. Secretary Bigby,

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tell us what is the overall plan for reform. And you have only got a few minutes to tell us that.

SEC. JUDY ANN BIGBY: Good morning everyone. Thank you very much Liz and for giving me the right direction here. I want to thank everyone this morning. As Anya indicated there are a lot of people who have been recognized, but a lot of people who have not been recognized who are very important in this path on health care reform. And you all know who you are and I want to acknowledge who you are.

We have heard a lot about the first phase of health care reform and the need to move onto the second phase. And I want to point out that while we see the success of the number of people who are enrolled, a lot of people are concerned about cost. I want to say that we cannot acquiesce to the naysayers who say health care reform is too expensive and we do need to address both the short-term and the long-term cost of health care. How could we ever have considered that we would insure more than 300,000 more people without spending any more money? That seems a little unbelievable and it is. So let us move on with the next phase.

I also want to talk about people who call health care reform the next big dig. I can tell you that we can account for every person who is covered as a result of health care

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reform and there are no leaks in this initiative, so shame on you. [Applause]

During the break someone said gee, we are not talking much about the challenges of health care reform. So here I am about to put some of those challenges on the table. Many of you know that last week we filed a supplemental budget that would allow us to address the deficit that we see in Mass health. This is due in large part to the number of unexpected enrollees in Mass health. We also know the Commonwealth Care will cost about 150 million more dollars than we budgeted this year and that our projections for FYO9 also project a significant deficit. Again this is because we are covering more people than projected.

In response to these real problems the Governor asked me to explore ideas and possibilities for sustaining the financial future. About two months ago we convened a group of business and civic and health care leaders to discuss ideas for number one, addressing the shortfall in revenue that we see in FY09 and managing costs over the long term. I want to thank everyone who has participated in our conversations and acknowledging that we need to continue with the shared responsibility among consumers, providers, insurers and employers if health care reform is going to continue to succeed.

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The ideas that you presented to us and that we have analyzed are not the only good ones out there and we would be happy to hear about other ideas than the ones that I put on the table. But I ask you to come forward now.

To address the FY09 estimated deficit we must act now. We have learned more about access to employer sponsored insurance. We know that employers have contributed to the increase of the number of insured by enrolling about 85,000 more employees in health insurance. However, we also know from a report we issued last week that we have a significant number of employed individuals who are enrolled in COMCARE and we need to think about whether or not we should do an assessment on employers for those employees higher income care because this is one of the biggest drivers of our deficit at this point. The Commonwealth would need to participate in that assessment because we have employees on COMCARE as well.

We also have heard a lot about whether or not the fair share contribution is fair and it is something that we are willing to look at and have analyzed what it would mean to change the 33-percent contribution or 25-percent participation rate to 33-percent and 25-percent. Again the Commonwealth would need to address how it participates if we change that rule.

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We also face uncertainty about the enrollment in COMCARE. We believe it would be prudent for the state to establish a fund to set aside that would be there to address unexpected enrollment in COMCARE. And in order to do that we should consider new assessments that would be temporary, on insurers and others.

Finally, we asked hospitals who have seen an increase in their Mass health rates since 2005 to consider now looking at where we stand in terms of those rates and how they deal with our Medicaid MCO plans. To think about the achievements we have made at increasing hospital rates where we are not under reimbursing hospitals as much as we were before and to look at this going forward in a new way.

We put these ideas on the table understanding that consumers and the taxpayers have already stepped up to the plate to increase their responsibility in making this work. In the long run, however, we know that health care costs must be contained if we are going to sustain health care reform. Many of you know that I have emphasized the focus on wellness and health as a means of containing costs. This long-term vision is something that we all hold and that we all can agree upon. However, how to get there is something that we have not established thus far. We need to pay for patients that are coordinated care, not for things. To fall back on a

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Clintonesque, and that is Bill not Hilary, comment let us remember. It is the patients stupid. It is not things that we should be paying for. It is the health of individuals that we should be promoting.

The goals and recommendations that have come out of the Health Care Quality and Cost Council support this approach to containing costs through the Healthy Massachusetts Compact that we announced in December. We have supported this approach and we are proud that we are one of the states chosen to participate in the State Quality Institute. Our first site visit is this afternoon and everybody that is at that meeting is in this room. So we know we will all get there on time.

We have examining ways that we can, therefore, promote this type of transformation of payment policies. We are considering a new policy so that the Commonwealth does not pay for readmissions to the hospital. We know that these are costly and they represent a lapse in the type of care that we all must strive for. They represent a lack of coordination, problems with transitions from one clinical setting to another or to the community and the lack of appropriate follow-up for chronic conditions. Massachusetts ranks in the lowest core tiles for these types of readmissions, and in order to contain costs we must decrease them. We are beginning a pilot project where we will be reporting to individual hospitals their

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readmission rates. We will give them some time to look at these rates and analyze how they can decrease them, and then we will consider a policy where we will not pay for readmissions. We understand, however, that we must promote primary care on the other end of the spectrum and we also are looking at payment policies that will support the medical home and primary care. We can do this within our public payer programs and we invite private payers to join us in this initiative.

These are things that we can do immediately and that will have an immediate impact on cost containment. We look at this as an opportunity. We want to ensure the financial stability of health care reform and we must use this as an occasion to implement some creative and innovative cost management strategies. We welcome your comments and continued support to do this in the spirit of shared responsibility. [Applause]

LIZ WALKER: Thank you Secretary Bigby. Reverend Hurmon Hamilton, Jr. is a true community activist. He is the Senior Pastor of Roxbury Presbyterian Church U.S.A. since 1994 and a founding leader of the Greater Boston Interfaith Organization, GBIO, serving as the organization's president since 2004. The GBIO has more than 50,000 members with 65 congregations from both Christian and Jewish faith communities across the state. Under Reverend Hamilton's leadership it has

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played a critical role in making health reform a reality. Reverend Hamilton, the opening question for you, now that Health Reform has passed, what is the GBIO looking ahead to and how do we keep advocates engaged.

REVEREND HURMON HAMILTON, JR.: Thank you very much, Reverend Walker. Let me just add GBIO is now composed of both Christians, Jews and Muslims members, and we are very proud of that. [Applause]

Jarrett Barrios called me the other day, and interesting enough, he said to me he was calling all of the panelists, but he had a unique word for me. He said now you have five minutes and they are not preacher five minutes. So I am going to try to stay faithful non-preacher five minutes. And he said he had a preacher moderating just in case I try to take liberties.

Let me begin by saying I am just elated to be here this morning with all of my colleagues here on the table and those of you out there who helped to make health care reform a reality here in the Commonwealth. It is non-debatable health care reform to date is a success in Massachusetts. When you talk about health care reform, you talk about it in kind of broad numbers today as we looked at the presentation. We talked about 340,000 people. But for me it is extremely personal.

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There are a number of stories of individuals in my very congregation who has benefited in a lifesaving way from health care reform. Those of you that saw the presentation earlier saw a young man by the name of Keith Rudolph. If you were with us last week you heard him share his own testimony. How he was without health care for over 14 years in this state and during that period of time had a mild stroke. Had to be rushed to the emergency room, and after being taken care of, did not have the means to get follow-up care and was using home remedies to try to take care of himself in the midst of a mild stroke. Today he has health care.

All of you have heard me tell the story of Deacon Laverne Barnes, one of the deacons in my church who went 15 years without health care. Part of that time was in Arkansas and she moved from Arkansas and came to Massachusetts, still did not have health care, working. And we got her into COMCARE as a result of the reform. And she found out through going to a doctor to get checked for a sinus infection that she had a mass that was almost life threatening, rushed into surgery, came out of surgery. And when I went in to see her the day after her surgery, barely could talk, she turned to me and she said thank you. She was not saying thank you for a pastoral visit. She was saying thank you for fighting for health care reform.

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These are just a few of the stories. Leroy Lawrence, for example, another one of my members and Jonna Williams, tell the story of how for 15, 16 years they were without health care reform. The only way they got to see a doctor was to go to the emergency room. Leroy tells the story about how he had a horrific asthma attack, almost took him out of here. And he went to emergency, they took care of him and a few days later he got an exorbitant bill that also almost took him out of here. Today, they have health care and most importantly they say, they tell this story, that when they would go to the emergency room, oftentimes they felt as though they were being treated as invisible. They felt as though they were less than human. But today they have health care and they are being treated with the status that they deserve.

One out of eleven members, one out of every eleven members in my church, is affected by COMCARE. And one of out of every seven members is affected is affected if you add Mass Health. So for me, it is personal and in the words of Laverne Barnes to providers and insurers and employers and the community advocacy, community and the administration, etcetera, legislature, in her words I say to you, thank you not only for reform, but for saving people's lives.

Now where do we go from here? This is a significant question. First, I should point out that I know that before

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the legislature even as we speak there is this notion around outreach and enrollment grants. I want to point out that the people that I named, and the list goes on in my church and all across the Commonwealth that makes up this 340,000 number that we are celebrating today, had to be enrolled. Everybody say enrolled.

AUDIENCE: Enrolled.

REVEREND HURMON HAMILTON, JR.: That is pretty good. Try it again. Say enrolled.

AUDIENCE: Enrolled.

REVEREND HURMON HAMILTON, JR.: Thank you. They had to be enrolled and not only did they have to be enrolled, but every year they have to be re-enrolled. Everybody say re-enrolled.

AUDIENCE: Re-enrolled.

REVEREND HURMON HAMILTON, JR.: Alright and so if we are going to make sure that they stay re-enrolled, which has a direct effect on the cost of health care, I want to urge the legislators who are paying very close attention to this to make sure that this is funded fully and completely. [Applause]

Finally, let me say a word about where we need to go. Obviously, there are three legs that Health Care Reform Part 1 was built on and Health Care Reform Part 2 will also be built on. First, there is the contribution and the support of the

government, both the administration and legislative support has been outstanding and they have stepped up to the plate in the name of the next level of shared sacrifice and responsibility to ensure that the dollars are there to keep this moving forward even in a time of recession or in deficit spending. They certainly we appreciate.

Secondly, the individuals all over the Commonwealth have stepped forward and they have been enrolled. A recent report came out, I think you have it in your packets, DR Report that said that the impact of the mandate is most minimal. We are very excited and impressed by the folks who stepped forward and did their fair share and enrolled this first year out. And we are very excited about that. So they are doing what they need to do. Consumers and taxpayers have agreed to pay higher premiums and co-pays. They are doing what they need to do. Employers, 70-percent in the Commonwealth are doing what they need to do. They are providing credible insurance to their employees. And we are excited and we appreciate that.

But the report that came out a few days ago that Secretary Bigby alluded to, certainly is one of great concern and reminds us that there is great work to be done. And I would simply say it like this. That if Wal-Mart, which was number one on the report, can make millions of dollars out of the Commonwealth economy, and its employees the sizable number

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of them can be kept healthy by state government, then we need to be able to say to Wal-Mart, you cannot be permitted to come and freeload in Massachusetts. It might work in Arkansas, it might work in California, but not in Massachusetts. [Applause]

And the other 1,400 folks who are on that list, and there is about 84 new firms that is on that list, we are sure that in this atmosphere of shared responsibility and shared sacrifice that you are willing to step forward. I appreciate the state recognizing it was number three on the list, not doing so I think out of political necessity but also out of just the reality of doing the right thing, have said we are going to step forward and look at the structural changes that we need to make to make sure that we are not on that list. And I would suspect that employers all over this Commonwealth will follow their lead and their example. In the meantime, I hope that the state does raise the threshold of the employer fair share threshold to ensure that we all are well motivated. Now I am sure I got a few amens on that one in here.

Finally, let me say for the last finally, let me say as relates to cost controls, GBIO and our partners, we stand very strong on this cost control thing. And we think that it is extremely important that we do our part to make sure for example, that the structural impediments that prevent providers and insurers from doing the right thing around cost control,

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those kinds of impediments are removed. And we still have got a few problems to solve like what do we do for those individuals who are offered insurance by their employers but they cannot afford and they are still not eligible for COMCARE. We have got to find a way to solve that. I am convinced in the spirit of shared responsibility and shared sacrifice, just like we got Part 1 done, we will get Part 2 done. Thank you.

[Applause]

LIZ WALKER: Thank you Reverend. As Executive Vice President of Health Care Services for Blue Cross Blue Shield for Massachusetts, Andrew Dreyfus is responsible for the company's Health and Wellness performance measurement and improvement and Provider Contracting and Services divisions. He is also leading the development of a new collaborative initiative to improve the quality and safety of healthcare in Massachusetts. Andrew served as the first President of the Foundation during his tenure. The Foundation awarded nearly $17 million in grants to community organizations and launched a series of policy initiatives including the Road Map to Coverage featured at earlier Foundation summits, which helped to contribute to the state's landmark 2006 Health Care Reform Law. Andrew, my question to you, tell us about Blue Cross Blue Shield's plans in the field of health reform and the role of those health plans in this next phase.

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ANDREW DREYFUS: Thank you, Liz. Blue Cross, as Liz said, was intimately involved in the development of the Health Care Reform Law and remains firmly committed to its success. As Secretary Bigby and Senate President Murray and Nancy Turnbull said, the long-term success of health care reform depends on our ability to tackle what Reverend Hamilton just referred to as Health Care Reform 2. I would actually take a step further and reframe the question because the cost and affordability problems that are facing health care in Massachusetts are not simply a problem of sustainability of health care reform. It is a problem of sustainability of our health care system as we know it; our mixed, public, private and employer sponsored system. If we cannot solve our affordability problem, we will not be able to sustain our entire health care system as we know it.

So we have to ask ourselves the question, what can we do to slow the growth and costs in Massachusetts, and more broadly in health care? We have spent several years looking at this question carefully in Blue Cross and we have come up with what we believe is the most promising route. And in some ways it is one which we think is most acceptable to the public, and that is the best way to slow the rate of growth and costs is by making care better. Quality as we think of it equals affordability. And I think the architects of the Health Care

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Reform Law knew this either implicitly or explicitly because they created a Quality and Cost Council. You notice they did not create a Quality Council and separately a Cost Council. They created a Quality and Cost Council because those two problems are linked. And I am pleased that Secretary Bigby both understands this problem and chairs that important body.

So Blue Cross, we spent some time thinking how can we simultaneously advance quality and promote more affordable coverage? And we thought that the most fundamental thing that we had to change was we had to change the way that we pay for health care. And we have asked national experts, local experts. I have not found a single health care expert who will tell me that we can change and slow the growth of costs without changing the way we pay for care. And Senate President Murray said it exactly right. We have to move from a system that pays for volume to one that pays for value. We have to move from paying just for activity to one that pays for outcomes and quality. And we have heard a lot of references today to primary care to the medical home. We cannot have a medical home just in isolation in the system. We need it within a reform system.

So Blue Cross, we have developed a new way of paying for care. It takes the old system, which rewards activity and volume, instead develops a system which rewards outcomes. This

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system combines what we call a global payment, a fixed payment per member per year with substantial quality incentives that allow physicians and hospitals to earn up to 10-percent above what they are earning today if they perform well on quality. It is a five year contract to take away out of these annual fights and negotiations between health plans and physicians. It responds to Reverend Hamilton's call for providers, for physicians and hospitals and nurses and health plans to work together in collaboration, not as adversaries, but as partners. It is designed to encourage integration because we know that fragmentation in care both puts patients at risks and is one of the greatest frustrations that families encounter in our health care system. It promotes the management of chronic disease that Secretary Bigby has championed because until we reward the kind of care that people with chronic illness needs, we are not going to have better management of chronic illness and better prevention.

I am pleased to announce that two brave physician practices in Massachusetts have signed bridge agreements with us, with Blue Cross Blue Shield, to begin to implement these Alternative Quality Contracts. And we call them Alternative Contracts because we are not forcing this on anyone. It is an option; it is an alternative. But Atrias Health, the parent of Harvard Vanguard and other physician practices, the largest

independent physician practice in Massachusetts, has signed this contract with Blue Cross. The physicians associated with Arbour Hospital has signed this contract. They are willing to agree to hold the rate of the increase of costs to something not at 11 or 12 or 13-percent that we see in so many contracts today, but something more closely resembling overall inflation. They are willing to be measured, not on some black box measures that Blue Cross holds, but on a transparent set of measures that have been supported and that nationally by the most important national organizations.

So I think while we are strong supporters of the law that Senator Murray has introduced and passed in the Senate and that will be taken up in the House, we do not need a new law today to get to work now to make care safer, to make care more affordable. What we need are creative, imaginative and willing physicians and hospitals and for that matter other payers like Medicaid and like Medicare who are willing to pay for value to work together for value and to ensure by doing so that this Health Care Reform Law that we have worked so hard on will be sustained. Thank you. [Applause]

LIZ WALKER: Thank you, Andrew. Lynn Nicholas joined the Massachusetts Hospital Association as President and CEO in August 2007, bringing more than 30 years of hospital and association experience from New Jersey to Louisiana to

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Washington D.C. As CEO Lynn is responsible for leading advocacy, education and other services for the Mass Health Association's 90 hospital and health system members. And Lynn, the question you can start out thinking about is the MHA represents a cross-section of large and small health systems. How is the MHA playing a role in health system change and what will hospitals need to do next?

LYNN NICHOLAS: Thank you, Liz. Well, first of all it is an understatement to say how excited I am to be in Massachusetts at this critical juncture in health care history. And the 90 plus hospitals, 92 hospitals, that I represent today are very proud of where we are today. They feel a great deal of ownership for the progress to date and a great deal of responsibility going forward to make sure that it sticks. So we are truly committed.

They also know all too well that they escalating trends in health care costs are not sustainable. And in many, many ways, and I will only mention a few, are trying to address that. First, they are focusing on the variation in health care, which results in errors and less efficient care. And through the MHA we are planning a statewide diabetes initiative to deal with just one aspect of chronic disease to show that working together we can truly make a difference on one of society's great challenges.

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They are also implementing or planning to implement whether large or small health information technologies, like computerized physician order entry or electronic health records because those will enable more quality and effective care. And in the long run not the short run, drive down costs.

They are also willingly and increasingly transparent about the quality of care and outcomes because we have learned first hand that that process of transparency acts as a catalyst which fosters learning and that fosters more rapid improvement. They are also implementing better ways of delivering care through technology and also through use of new care models that utilize a very diverse and committed multi-disciplinary workforce.

But hospitals need your help. They need the states help to make these efforts fruitful. Here is a key and very timely example. They cannot be constrained by state government through dictation of how to staff and manage care. Informed flexibility and innovation are key ingredients in customized and excellent care. Rigid standards should not be barriers to thoughtful management. We need help in that regard now, specifically from the Senate.

On the other hand, hospitals should be and are accountable to the public for care and those care outcomes. And transparency through public reporting is no longer

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controversial. In fact, it is becoming an ingredient of competitive advantage for hospitals. I would say that clinical outcomes more than price should dictate which providers patients choose. It is said that culture trumps strategy every time. When it comes to health care, quality trumps costs because in the long run the highest quality providers and caregivers will provide the best value. It will not necessarily always be the lowest cost provider. But even in the quest to provide greater value, better quality at a lower cost, hospitals need your help. In order to focus on improving the systems of care and improving the quality, they need a reprieve. They need a reprieve from the ever increasing levels of bureaucracy and administrative overhead spawned by the well-intentioned actions of others.

Let me give you an example. Most of you in this room fit into this category. Employers and health plans, through your excessive customization of plans, there are tens of thousands of plans and plan offerings in Massachusetts that hospitals and physicians have to deal with. This has accumulative impact requiring hospitals to engage more and more business office staff and less and less doctors and nurses who can focus on improving care instead of focus on improving the revenue cycle. That is why the Senate's President's bill is so important. Within three years hopefully we will have

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standardized billing and coding, and that is a very important first step, and I have a whole list of other issues that I think through collaboration, which is the type of collaboration that led to that bill, we can deal with.

So not only in the business office do we need help in terms of administrative overhead, but we also need a more strategic approach to quality reporting and a simplification of what we are doing in that arena so that we can focus on the results and not just the reporting.

I would say, however, with all these things that we are already doing and many more, that these will only impact and whittle away at the cost trajectory in minor ways. We need to do something much more profound to make a difference. Now is the time for the leaders in Massachusetts to convene in a collaborative partnership just like the one that spawned health care coverage reform. But this time, we need to have discussions about payment reform. Until we make what we pay for the priority, we cannot dramatically change the landscape we know today. We will whittle the rough edges but we will be disappointed in the expectations. The current focus, the dialogue now in Massachusetts, is too much on who we pay. The underlying problem is what we pay for. None of us would be here today if we had a never ending stream of revenue. So we have to direct the revenue that we do have and that will come our

way in the future in a more rational way that is fair, predictable and sustainable.

Two last examples, you have heard them before today. Chronic disease is the 10-percent that drives 90-percent of health care expense. Primary care is the best anecdote for the high cost tertiary fixes that are at the end of the road for ill treated chronic disease. Bottom line, access to primary care, which can best deal with chronic disease, is not reimbursed adequately to be the driver it needs to become. So our hospitals are ready, they are willing to engage in the type of strategic collective discussion that spawned coverage reform and made us a model for the country. There is no reason why Massachusetts cannot be an incubator for the nation regarding payment reform as well. Let us talk. Thank you. [Applause]

LIZ WALKER: Thank you Lynn. Anne Gauthier is Senior Policy Director for the Commonwealth Fund's Commission on a high performance health system based at Academy Health in Washington D.C. Anne oversees all commission activities as well as the state's Innovation Program, which aims to improve state and national health system performance by supporting, stimulating and spreading integrated state level strategies for expanding access to care and promoting high quality efficient care. Anne, Massachusetts has become a model for other states to emulate in health reform. Tell us what you are doing with

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the Commonwealth Fund and what you see as a trend as we move forward with health reform.

ANNE GAUTHIER: Thank you, Liz. It is truly an honor and a privilege to be sitting up here and looking at the leaders in this state and to be celebrating the second anniversary of Massachusetts groundbreaking Health Reform. I was not introduced as a baseball mom, but I am. I am delighted to be the cleanup hitter here in a state where you have already hit a number of homeruns and yet you have got the bases loaded again ready for the next step.

I have been asked to place Massachusetts' reform in the context of broader national reform. And in addition to being a funder who supported the Urban Institute's evaluation of the reform, I am approaching this as my role with the Commonwealth Fund's commission on a higher performance health system and our work over the past three years, which I think will resonate with you given the comments that the leaders have already made today. Throughout this presentation, which will be brief, I will be referring to some slides in your handouts, so I would suggest that you might like to pull them out at this point.

Deeply troubled by the rising numbers of uninsured and the failure to achieve value for resources invested in health care, the Commonwealth Fund Board of Directors established our commission in 2005, chaired by Dr. Jim Mongan, the President

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and CEO of Partners HealthCare here in Boston, and including 18 additional leaders and experts including Cleve Killingsworth of Blue Cross Blue Shield of Massachusetts. The commission has been given the charge of promoting a high performing health system that provides all Americans and especially those who are most vulnerable with affordable access to high quality, safe care while maximizing efficiency in its delivery and administration.

The commission's first report, a national scorecard called Why Not the Best, released almost two years ago in September of 2006 and to be updated next month found that the U.S. overall scored just 66 out of a possible 100 on 37 indicators of healthy system performance. Where 100 represents not the ideal, but what has been achieved somewhere for some groups of patients.

How does Massachusetts compare to the rest of the U.S.? In 2007 the commission released its first state scorecard on health system performance, which assessed state variation across key dimensions of healthy systems performance, access, quality, avoidable hospital use and costs, equity and healthy lives. The findings document tremendous unwarranted variation across both states and regions and the potential for substantial improvement if all states achieve the levels achieved by the top states. The leading states consistently

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outperformed the lagging states but all states have room to improve.

As you can see by slide six, compared to the country, Massachusetts is a clear leader ranking eighth overall, second in access, third in quality, we will get back to avoidable hospital use and cost, you are an expensive state, twentieth in healthy lives, first in equity. A key finding of our scorecard is that leaders in this state have recognized that access and quality are highly correlated and for a picture of this see slide seven. Massachusetts ranks 35th though, in avoidable hospital use and costs. Failure to deliver the right care, manage disease and coordinate care well has implications for costs as well as quality. Indeed avoidable hospital use is another aspect of quality and one that Massachusetts might well focus on. Furthermore, high cost care is not necessarily associated with high quality care or alternatively, it is very possible to deliver high quality care that is lower in cost.

While many forces shape our health, including the environment, work place, poverty and migration, these indicators in our scorecard are also sensitive to health care and public health policies and thus provide a baseline from which states can measure the impact of improving healthy system performance. So the question for Massachusetts is whether it

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can improve its performance on these indicators by further improvement in the health care system.

Let me make a few comments on what Massachusetts reform has accomplished and why it matters. We believe that these next two years, which encompass presidential and congressional campaigns and the agenda setting first year of a new administration, present a rare and critically important opportunity to build on efforts like Massachusetts to achieve real health system change. Last fall the commission released a report entitled An Ambitious Agenda for the Next President that laid out five key strategies, which taken together could lead to a truly high performance health system.

The first and most important strategy is affordable coverage for all Americans with financing a shared responsibility of federal and state governments, employers and individuals. The Commonwealth Fund and the commission are proponents of Massachusetts' approach to expending affordable health coverage to all residents through mixed public, private financing and the insurance connector.

As you can see on slide nine, my colleagues recently published an article in Health Affairs that outlines how to achieve this nationally, a plan we call the Building Blocks of Automatic and Affordable Coverage for All. Universal coverage is absolutely essential for a high performance health system

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and is associated with more effective and efficient care. While Massachusetts has been a formidable leader in the crucial domain of health insurance, universal coverage must be pursued simultaneously with comprehensive reform in the delivery system to control costs and improve quality and value. Universal coverage should not be held hostage until we have a more efficient health care delivery system. But we need to start now to initiate the reforms necessary to achieve both high performance and real value in health care. So looking forward, Massachusetts should be and seems to be thinking about how it can push the envelope on other components of a high performance health system. And we have heard several leaders today say they are ready.

The commission's second strategy involves aligning financial incentives with the goal of enhancing value in health care and specifically advocates fundamental payment reform, you have heard that from others here, that would reward physicians and other providers for achieving both quality and efficiency targets, and move us away from the current reliance on fee for service payment toward incentives for quality, bundled payments for episodes of care or global rates for patient care and that emphasizes value and values primary care.

The third strategy calls for reducing the fragmentation of care at the local level by pulling together physicians and

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hospitals into more organized networks of providers, which can yield important benefits for caregivers as well as accountability for delivering accessible continuous care over time.

The fourth strategy calls for attaining improved quality and efficiency by linking provider networks through electronic information systems, which will help improve transitions and continuity of care and the ability to provide more focus care for patients with chronic diseases. It also includes public reporting on measures of quality and costs as well as access and equity and an emphasis on wellness.

And the fifth strategy calls for establishing an accountable national leadership including a national process for fostering public and private collaboration and setting national goals and coherent policies.

There is a place for state action in all of these strategies, including participation in the national process. What is heartening is that Massachusetts has the resources and the will to lead the way in some exciting areas. I would like to commend our report Bending the Curve on slides 10 and 11, which was released in December and demonstrates that by doing a bundle of these strategies listed on the slide, we can actually cover everyone and save $1.6 trillion, I got the letter wrong, it is $1.6 trillion over 10 years. We are currently working to

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evaluate some of these options on a state level. And you have heard that we are also sponsoring a State Quality Improvement Institute with Academy Health and are delighted that Massachusetts is among the states working with us to improve its quality indicators. And we are looking forward to our site visit with the state team, which includes public and private leaders, this afternoon. More information is on slide 12. On slide 13 I list some specific strategies that are aligned with the commission's ambitious agenda. Some of them you have thought about and others are for your consideration in the future.

Coming back to Massachusetts' place in the national agenda, I would like to not that nationally the public is ready for health care reform. Recent polling data shows that large majorities of the public regardless of political affiliation or income level say that health care reform will be very important in their decisions, very important or somewhat important. And the public also favors maintaining the current employer based health insurance system that is over 80-percent.

I have provided a summary for you of the candidates plans on slide 14, but has been noted, the democratic candidate's plans aim for universal coverage building on the existing employer based system and promoting shared responsibility for financing similar to the construction of

Massachusetts reforms. They also include provisions for delivery system reforms. Presumed candidate McCain's plan does not attempt to achieve universal coverage. It seeks to expand the individual market rather than build on the current employer model.

There is a window of opportunity following the 2008 elections, but there is not a sweeping mandate for a particular type of national reform. Given the differences between the democratic and republican proposals and the difficulty of taking sweeping action in congress, state action continues to be very important.

Just a few more words in conclusion. We are really excited about what Massachusetts has done and is doing. We understand that during the negotiations on health care reform, everyone did not get their first choice. But there was agreement that movement towards a higher performance system was preferred to the status quo. We understand that all states are not like Massachusetts. They do not have the resources or the political will to make substantial changes to their health system. While we commend states like Massachusetts for taking responsibility for its residents' health and serving as a model of what can be achieved, 50 individual state actions are not the ultimate solution. To get to universal coverage nationally we need federal money and above all a federal commitment to

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transforming the U.S. health care system into one that helps everyone to the extent possible lead long, healthy and productive lives.

The key message of the commission's work and the Massachusetts experience from my perspective is that we as a nation are not helpless in meeting the challenge to reform our health system. Our commission has demonstrated that we have great room to improve, to achieve higher value for the amount we spend on health care. But there are solutions and we must work towards them collaboratively. We look forward to working with you. [Applause]

LIZ WALKER: Thank you. We are still accepting questions, so you can hold up your card and our staff will pick up your questions. And before we get to the questions that you have already passed forward to me, I am going to ask one that all the panelists can tackle. We all know that health reform is working. Everyone is excited about what is ahead, but as we have all heard from all the different directions and we already know, this is costly. In your opinion, in order to continue to make health reform work, what is the number one, and you have all touched on this in kind of broad terms, but what is the number next concrete step that Massachusetts should take? Secretary Bigby, we will start with you.

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SEC. JUDY ANN BIGBY: As I said, I think that the most fundamental thing that we can do is change the way we think about how we pay for health care. We are too focused on paying for individual services or procedures. When I think about the progress that we have made and the way that we manage people with chronic diseases, for example, 25-years ago when I started practicing medicine, we had very little to offer people with diabetes who were still monitoring whether they were controlled by having them dip their urine and bring in sheets showing 1+, 2+, 3+. We now have medicines that prevent kidney failure. We know what to do to prevent stroke and heart attack. We have tests that tightly monitor whether their sugars are controlled.

Yet, the way we pay primary care and other physicians to take care of these patients and our expectations for what we should be achieving has not changed in 25 years. We need to reform the way we think about this and focus more on the patient and the outcomes and the things that we can do that are not high tech and do not add as much value to this system. But focus on the interactions between people and their physicians or other providers and really transform the way we pay for this.

REVEREND HURMON HAMILTON, JR.: I am going to answer this question not so much as the President of GBIO but as just Reverend Hurmon Hamilton, Rox, Pres. I think the number one

thing from my perspective as a consumer advocate that we need to do in terms of cost control is beat back this ballot initiative to eliminate the income tax in the state of Massachusetts. I think that is what we need to do. [Applause]

I was talking to some administrative officials to find out exactly how much that would cost and they said to me in the first year, that if that should pass, $12 billion would be removed from the state coffers. Let us all say that. Say 12, I cannot hear you, 12.

AUDIENCE: 12

REVEREND HURMON HAMILTON, JR.: Billion.

AUDIENCE: Billion.

REVEREND HURMON HAMILTON, JR.: Dollars.

AUDIENCE: Dollars.

REVEREND HURMON HAMILTON, JR.: Alright, I think the budget is somewhere around 28, $27 billion. So almost half of the state budget would be cut. That is just the first year. We go up the second year. That would decimate health care reform in the Commonwealth; decimate it. And so we need to defeat this and not just defeat it slightly, we need to resoundingly defeat this notion of rolling back income. And then we need to have a mature healthy conversation about taxes in Massachusetts. [Applause]

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ANDREW DREYFUS: Well, as I said in my earlier comments and as Judy said, I think payment reform is first. But what I would say is right behind that and as a piece of it is that we need to empower patients in a different way in our health care system because we have not really touched on that today. And that you know we talk a lot about what physicians can do and what health plans can do, but we need to talk a little bit more about what individual patients can do partly to keep themselves healthy, but also to be armed with the kind of information and questions that they need to get the right care. Because we know that actually when you ask patients about their own preferences, they often choose the style of care that Judy has been talking about. They want good primary care. They do not want to be shuttled off to specialists to have surgery that they may not need to have. And so let us bring patients into the health care equation in a way that we have never had in the past. Let us actually have a movement in Massachusetts like we have had a movement against tobacco, like we have had a movement around seatbelts, like we have had a movement in civil rights. Let us have a movement around patients. And Howard Coe who is sitting right here and others are leading a new partnership health care excellence at Massachusetts that is beginning to create just that kind of movement.

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LYNN NICHOLAS: Yes, I am next. Obviously from the hospital perspective you heard me make a loud plea for payment reform. But there is a critical ingredient that we have to do before we do the type of payment reform that would really make a difference and we have put the baby step, the first step in the water, the first foot in the water, made the first baby step, whatever it is. And that is to invest in health information technologies and things like an electronic health record. Because the truth of the matter is that you cannot do significant payment reform. We cannot do episodic bundled care. We cannot do capitated agreements unless you absolutely can manage your business clinically through the entire continuum of care through every single handoff from a non-acute care provider to an acute care provider to a nursing home from the physician's office.

You know I am going to use a Big Dig analogy. I love the Big Dig. I did not have to live through it. I saw Boston before the Big Dig and I am here after the Big Dig. And the beauty of the city and the seamless way traffic flows now, there was a lot of underpinning of that that had to happen first and it was very daunting. It was messy and it was expensive. But if it was not tackled and if it was not done, we could not have the city that we have today. That is the same analogy in terms of investing in this.

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So yes, true, the Mount Auburns of the world, the partners of the world, the academic medical centers, some of the large systems can do the kind of reform that we are talking about because they have already made that investment. But the vast majority of community hospitals in Massachusetts are not there yet. And until we incentivize that, promote it and all help with the shared responsibility of putting that infrastructure in place, I do not think that we can really make the gains that we are looking for either in quality or in reducing the cost of health care.

ANNE GAUTHIER: And I love the cleanup hitter position here. I think that your question is a wonderful question. What is the next one thing? I am going to reply and say it is not one thing. It is the series of thing that each of the panelists here has said. It is a cohesive strategy and they fit nicely into our commission's five major strategies here. It is the state taking the leadership and bringing together the public and private players here to focus on the three or four major things that we have laid out and getting them done. And that is the only way that it is going to be possible. Health care is not as simple as one thing or we would be there.

LIZ WALKER: Thank you. We have many questions from our audience. I am going to start right off. This is for Mr. Dreyfus and Ms. Nicholas. Quality of care depends on access to

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care. This person, I was in one hospital several extra days waiting for an interpreter. The interpreter at the hospital did not match my needs. How are you addressing access for people with disabilities so that they have a quality of care?

LYNN NICHOLAS: Well, as I understand it and again I am relatively new. I have been here about 9 months. There has been a great deal of progress in Massachusetts on the interpreter issue and in making that available. But the truth of the matter is, that takes money. It is a priority but I have been in hospitals where 17 languages are spoken and so you need the capacity to have someone 24/7 to be able to address that issue. So as we think about quality of care, it is not just clinical results. It is issues like that and I think that payment needs to foster that and incentivize it and value that and we will get there. But I do know it is a priority and I know the hospitals struggle mightily with that issue. Maybe we just need to figure out a better mousetrap than trying to do it the way we are doing it now.

ANDREW DREYFUS: I would just add that and I think no one has surprisingly mentioned the word, but you know we still have persistent disparities in care and outcomes [applause] in our state and part of this quality agenda and our affordability agenda has to be to eliminate disparities at every level of the system, inpatient, outpatient, in the clinic. We know there

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are places, especially in our community health centers, that have long experience in this arena. We need to translate this experience to the larger health care system. I think it has to be part of our agenda. And we have to pay for it. [Applause]

LIZ WALKER: This is a question that any panelist can address. What more can be done to expand the use of advanced practice nurses such as nurse practitioners and nurse midwives, given the shortage of primary care physicians and OBGYNs?

SEC. JUDY ANN BIGBY: I will take a stab at that. We actually are fortunate that we have some policies in the state that do not preclude nurse practitioners and nurse midwives from practicing. There are things that we could do to promote them being more independent that I think would serve the Commonwealth well and would address the issue of primary care and access to that level of services. I think that we also need to make sure that when we talk about payment reform and paying for primary care, that our policies support that group of individuals as providers as well.

ANDREW DREYFUS: I would just say we increasingly recognize that health care is a team sport, not an individual sport and nurses and physical therapists and other members have to be part of the care team, especially when managing chronic illness.

LIZ WALKER: Here is a question for Anne. We talked a little bit about, you said nationally the public is ready for health care reform. What other states are learning from the Massachusetts model? Is there anything that we can learn from other states?

ANNE GAUTHIER: Absolutely as even this leading state, as you have recognized, has room to improve. Let us stay in your own region and look to Vermont, for example. I realize that is a smaller state with a different delivery system but Vermont has developed an exemplary blueprint for chronic care and is looking at how one gets a better organized system, provides support to some of the small physician practices to provide the range of services that are needed to truly have a patient centered medical home. It has got the public and private payers aligned in implementing this print and they are starting some pilots that look to improve care and control costs. So that is one concrete example.

LIZ WALKER: Secretary Bigby, is the administration examining ways to control rising costs of prescription drugs, such as combined purchasing across all state programs or utilizing the state's non-profit pharmacy benefit manager for our own state purchasing?

SEC. JUDY ANN BIGBY: I bet I can guess who asked that question. We are looking at these issues. We actually know

that from some of the past policies that were implemented that prescription drug costs in Massachusetts are increasing at one of the lowest rates around the country. Whereas in the past they represented a significant part of the increasing costs, represent much less of that cost. There are strategies related to the purchasing of these drugs that we have looked at for all of our public programs and we have some mixed results in terms of who it benefits and whether or not it saves us money. But it is one of the things that we are looking at again in order to identify other opportunities for cost savings. But the idea that it impacts all of our entities equally is probably not true.

LIZ WALKER: Reverend Hamilton, of course your membership was instrumental in passing health reform. You are continuing to work hard to make sure it stays affordable. How do you keep your membership excited about issues like cost control, quality improvement and health system changes? I mean how can you keep that up?

REVEREND HURMON HAMILTON, JR.: I think we have to keep them actually involved in the debate, in the discussion in practical ways. GBIO is blessed with a part of a larger ACT coalition, which is a wide gathering of not only consumer groups and faith groups, but providers as well. And we are insistent that we will stay inside of that dialogue and help

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facilitate and foster some of those dialogues in some creative ways that continue to bring the people who are most impacted by this reform, the real people who we have talked about today, the people you heard me name into the center of this discussion.

LIZ WALKER: This is a question for Andrew. How will this charge change premium rates for members? Does that make any sense?

ANDREW DREYFUS: No.

LIZ WALKER: It did not make sense to me either.

ANDREW DREYFUS: You mean how will the payment change we are promoting change premiums for members. Well, you know today our medical costs trends at Blue Cross are growing at about 11-percent per year. That is about half the additional price or cost we pay for care and about half the increase in the user severity of care. And so premiums for our both individual and group accounts are growing at about that level. Some of them so-called buy down benefits. We designed the benefits to get single digit premium increases, but they are still too expensive today and growing too fast.

Under our alternative contracts, rates should grow at about half the rate they are growing today. So rather than growing at 11 or 12-percent, we would like to see those come down to 5, 6 or 7-percent, something more approximating overall

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inflation in our society. So individual and group premium purchasers should see a direct benefit. We also believe they will see perhaps or more importantly better care.

LIZ WALKER: I think this is a question to all of you or whoever wants to tackle it. How can we control the medical arms race? How can we deal with the provider monopolies and the prices that result?

LYNN NICHOLAS: I guess I have to start with that one. So the answer to the medical arms race is because we pay our hospitals and our providers to have a medical arms race. The amount of technology that we have is needed in terms of the high end tertiary care. But the fact of the matter is that that end of the health care business is a lot more lucrative than the other end of the health care business that does not need as much of those very valuable tools. And so we really need to look carefully at when is enough. Yes, there is obsolescence; there are new technologies. But you know there is a lot of research out there that shows that the incremental things that we do on the high end do not make much difference in terms of population health at all. It is all the things that we do not do that we know how to do that we do not invest in and that we do not do. And so the payment system and the delivery system really is one that has evolved to meet the

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incentives that are in place. And the incentives absolutely incentivize the medical arms race.

Until we change that fundamental underlying principle, doctors, hospitals and physicians will never stop investing heavily in that because that is what makes their bottom line and that is what in many respects people want and ask for. So it needs to be a careful discussion. I am not saying it is all bad and I am not saying you can cut it off, you cannot. But you do need to titrate it a little more carefully towards the other end over time and I think it will become more balanced. And bottom line we need more balance.

SEC. JUDY ANN BIGBY: I would just like to add to that. I have actually been in conversations with providers where this issue has come up and was told explicitly well as long as you pay for these things, we will continue to make sure that they are consumed and that they help us meet our margin. I have actually had providers say well if we manage our diabetics better or asthmatics better and they are not admitted to the hospital, that affects our bottom line. And what are you going to do to pay us for that? So one of the things that we need to achieve is to change provider and patient behavior over what is important in terms of really maintaining health. And while we can have conversations about it philosophically, I think that

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payment reform is the way to get people to change their behavior.

LIZ WALKER: This is for Lynn, Andrew and Secretary Bigby. How can we align payers and providers, case management and disease management programs?

SEC. JUDY ANN BIGBY: I think that there is a lot that we can do about this. And Lynn and Andrew and I have actually had conversations about how to see this work. Through Healthy Massachusetts we have invited people to the table to talk about aligning performance measurements around disease management so that different payers are not asking providers to measure in different ways the type of quality and value based outcomes that we are talking about and would love to see more emphasis on. I think it takes an explicit agreement to collaborate on what is important, how we measure it and what our ultimate goals are. And I believe that we have a good foundation to continue to work on that conversation.

ANDREW DREYFUS: Amen.

LYNN NICHOLAS: And I might just add, we just held a very successful charrette, so if you do not know what that word means you can go look it up on Wikipedia, but it is a very fancy summit, where we reached out and had very distinguished panelists, including Secretary Bigby, Commissioner Orbach here and others. Nancy Turnbull moderated it. We got input on what

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are the 10 best ideas that hospitals can do to change the face of diabetes in Massachusetts. Virtually every one of those ideas required a collaborative process with health plans and with payers of all sorts.

And so as we sort through that and at our board meeting next week, we are going to kind of hone that down to a doable list and get started. And I think there is great opportunity for collaboration. I spoke with my colleague, Mary Lou Bicey, who is here today. She heads up the Health Plan Association and we know the medical directors of all the health plans are interested in this issue. So I think that you will see some real inroads. It will take time and we have to pick the right goals. But I think we can be very successful.

LIZ WALKER: This is for all of the panelists. What are your views on single payer systems and those that argue that without a single payer system we are swimming against the tide?

ANDREW DREYFUS: Well, you know it is interesting when you look at other countries' experiences, you know there are countries like Canada with single payer plans, there are countries like in the Netherlands and Switzerland that have consumer driven plans or countries like Germany with multiple payer plans. And what is common to all these plans is not a single payer but it is that they set a budget for health care

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and then they live within the budget. And that is the way they have been able to slow the rate of growth of costs. And you can do that also with public and private delivery systems, private in Canada, public in Great Britain.

So what we have to do as a health care community is figure out how are we going to slow the rate of growth and costs and how are we going to agree to live within a budget? And I think in this country we want physicians and patients and other caregivers controlling budget. And that is I think the goals of the kind of payment reform we have been talking about. Even if tomorrow we clicked our fingers and had a single payer system in this country, we would still have to figure out a way to get out of our kind of volume based system and move to a value based system.

So single payer is a solution to the financing of health care. We have to have a solution to the payment of health care.

LYNN NICHOLAS: I will take a crack at this and this is a disclaimer that this is not an official position of the Massachusetts Hospital Association at all. But it is something that I have thought about throughout my career. I think the term single payer is a misnomer. But I do think there is room for the concept of single payment because why should a CABG or why should an angioplasty or why should a primary care visit or

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an arthroscopic procedure, why should the payment for that vary so dramatically? I think there is room for multiple payers. The government in terms of Medicare, Medicaid through Mass Health, you know the state through the connector products, the employers through the health plans, those can all be payers.

What I would like to see is more rationalization, though, of the payment itself so that there is less variation and that the standard of care and quality becomes more equal across providers, at least for the common things that are done. And then providers should compete not on payment, but on service, excellence and quality. And those should be the distinguishing characteristics. And so it is not easy to get there, but I think in the other industrialized nations of the world that have more of these attributes than we do, they have more common payment methodologies. They have few payers, many fewer payers. But it is not in any case or virtually any case a single payer. I do not think that can ever work, personally. And this is not an official position that we have debated yet.

REVEREND HURMON HAMILTON, JR.: Let me just say that perhaps at some point the single payer strategy may be reasonable to debate. But I think one of the great strengths of what we are doing here and is being thought about nationwide is this notion of shared responsibility. And I think that to say that we all have got to do this together, the employers,

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the government, the individuals that we all have a role to play both in delivering health care, managing costs and making sure that everybody is covered. I would hope that we would run with that as far as we could go. It seems to me that that is something that is very fundamental to who we are as a nation and who we imagine ourselves being going forward.

LIZ WALKER: This is our last question and this is for Judy Ann Bigby and the rest of the panel. Should the state consider broad-based taxes as a way to fund health reform going forward? Is an expanded coverage a societal obligation?

SEC. JUDY ANN BIGBY: I think that, I am not really sure what the true meaning of that question is. I think that one of the things that we have heard this morning loud and clear is that the way that health care reform in Massachusetts is working. We have also heard a lot about the expense and cost of it and I think what I take away from the comments of many people in this room and from what we can learn about what we have done is that we really have a lot of money on the table for health care right now, and that there are ways that we can use those funds to make sure that everybody does have access, that everybody is getting the right care. And so talking about different taxes or new taxes as a way to ensure that we have this reform succeeding going forward, we could talk about that but I think we have a system that everybody agreed upon right

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now. We have enough money in the system and I think our challenge is how do we make sure that we are providing the right care in the right place at the right time for everyone in the state with the funds that we already have.

REVEREND HURMON HAMILTON, JR.: Let me just add I do think that in a broader way, beyond health care as I said earlier, that there ought to be a sensible dialogue that is not divided between conservative and liberals and maintaining my liberal position and my conservative. There ought to be a real sensible dialogue in this state going forward about taxes. But I think the key to this health care reform is the fact that 70-percent of the employers is providing a credible, affordable health care. We can get that number even higher within the context of shared responsibility. That is what is really unique. That is the real model that I think we offer for the nation to learn from. And so I would not argue for broad-based taxes as a way of solving the tough questions around cost control. I think we have to bear down and do the hard work around that and not break this model that we currently have. But reasonable conversation in a broader way at some point ought to happen.

LYNN NICHOLAS: I would just add quickly that in many respects we have a broad-based tax already. The funding for health care comes from many, many sources both overt and

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covert. And so all of us in this room are paying whether through funded mandates, unfunded mandates, through a portion of our payroll, we are all paying for this now. I would agree entirely with the Secretary that we need to better utilize the funding that we do have and do all the things that we have talked about all morning first. And then at the end of the day if we have gotten 95-percent there and we cannot get that last 5-percent for some reason, you know then we have that discussion. But we are a long way away from doing that and I would rather focus on the challenges that we have already agreed and the priorities that seems to be a great deal of consensus around here today.

LIZ WALKER: That wraps up the panel discussion and I want to thank all the panelists who joined us today. And as you find your seats, we will give you a big round of applause. [Applause]

And I would now like to introduce, turn the program over or back over to Phil Johnston, who is going to introduce our next guest. [Applause]

PHILIP JOHNSTON: Thank you, Liz. Let us give Liz Walker a hand. Is she not the best? [Applause]

Well, it is good to be here and it has been quite a morning. We are now into the afternoon and we are going to have a few words before you have a box lunch. I am sorry we do

not have lobster or that sort of thing. But thank you all for coming for the summit that now is I think a regular part of the lives the people in health care here in the Commonwealth.

It is my pleasure to say a few words about two of my favorite people. First, is Ted Kennedy and the second is Deval Patrick, who is our distinguished Governor. And I want you to know this is the third time that Deval has been here, and the first time as a candidate, a little known candidate in those days. He sat in the back there, just listened quietly and absorbed quite a lot and I think he has told me over the past couple of years that that had a big impact on his thinking.

Well, I want to talk just for a few minutes about family and about Teddy because we all love Teddy and I know that he would have been here and you should know that on the day that he had his seizure on the Cape, two weeks ago last Saturday, he was planning to tape a message to this summit. And as you know he has never missed one of them. He has either been here by film or in person. And we all are well aware I think of the role that he has played over the years in health care.

And as we gather together in this building and we are all like family because I look around the room we have all worked together, right, wearing different hats over the decades. I hate to say that now, but it has been decades. The

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one permanent presence that we have had during all of those years as we have fought for the things we all care about in this room has been Ted Kennedy. And when we think about his brothers, and it is important to think about his brothers as we gather together in this building, think about President Kennedy and the commitments that he had going back a half century now. When you think about the Cuban Missile Crisis and for me who I cut my teeth on the Civil Rights Movement in the '60s, the speech he gave on civil rights on June of 1963 ended the scandal of silence on the part of the federal government that had lasted a century about how we treated African Americans in this country.

Then you think about Bobby, whose 40th anniversary of his passing we will observe on Friday. You think about his life and what he accomplished in civil rights with Cesar Chavez with the farm workers, his opposition to the war in Vietnam during his years in the United States Senate. And you think about the past 45 years, 45 years, with Ted Kennedy, the youngest brother, as a member of the United States Senate. And think of what he has accomplished. And you think about those three brothers and add the sisters because Jean and Eunice and Pat were similarly extraordinary human beings. It is really something that has had an enormous impact on all of our lives. But they fought for values, Jack Kennedy and Bobby Kennedy,

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fought for particular values. And I think Ted Kennedy picked up, as he said after Robert Kennedy died, he picked up the flag and carried it on and he has during the 40 years since Robert Kennedy's death.

What are those values? The values are pretty simple. They are represented here in this building, but they are represented in the lives of all of the members of the Kennedy family and all of us who have been inspired by them and influenced by them. Economic justice for every man, woman and child in this country and around the world. Social justice for every man, woman and child in this country and around the world. And racial justice for every man, woman and child in this country and around the world. It is pretty simple. That is what Kennedy has been about. We all know that, those of us who have worked with him and almost everybody in this room has worked closely with him over the years, and so many tens of thousands of people in this state and across the country.

And I can tell you that it is no surprise to anybody in this room as involved as he has been over the 45 years in so many important issues, civil rights and criminal justice and education, the number one issue that has been his principle concern since he entered the Senate in 1963 has been the notion that every man, woman and child in our country ought to have access to high quality affordable health care. And he has

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worked for that since the day he got in there and we all know the Speaker, the Senate President, the Governor, everybody who participated in the enactment of Chapter 58 is well aware of the role he played in doing that.

Yes, all those players and every single person in this room played a key role in making it happen. And people like John Kingsdale and Judy Ann Bigby and Leslie Kirwan and other heroes and heroines in state government are helping to implement it. But we all are aware that it would not have happened had it not been for Ted Kennedy, right? [Applause]

So he has a challenge now and when I think of Ted, and I say this as the Chairman of the Robert F. Kennedy memorial, we are going to be commemorating the 40th anniversary of Robert Kennedy's passing on Friday. And I think of what Ted said about Bobby in that eloquent speech eulogy that he gave at St. Patrick's Cathedral in 1968. And what he said about Bobby could be said and should be said about Ted, that he is a good and decent man who saw wrong and tried to right it, saw suffering and tried to heal it, saw war and tried to stop it. Does that not summarize Teddy as well as Bob Kennedy? [Applause]

So he is down in Durham, North Carolina fighting the fight. He is going to overcome it and he is going to work with the next President of the United States who will be, I just

want to emphasize this, there will be a new President of the United States and we will inaugurate the next President on January 20th of next year, and Ted Kennedy is going to be leading the fight to do nationally what we have done here in Massachusetts. So let us send him a round of applause in absentia. Send it down to Durham, North Carolina to Ted Kennedy. [Applause]

Now I talked about two of my favorite people. That is one. The other one is Deval Patrick and he has had a briefer but similarly impactful effect on our Commonwealth and on this issue. And as I told you, he cared so much about it and was one of his principle issues during his campaign that he talked to all of us endlessly about it, that he came and participated in this process that the Foundation had initiated several years ago. Through Judy Ann Bigby and through Leslie Kirwan and through Tom Deaner and John Orbach and others in his administration led by Deval. This is an administration that has cared deeply about Ted Kennedy's view that every man, woman and child in our society ought to have access to high quality affordable health care. For that, Governor Patrick we are very, very grateful. Please welcome Governor of the Commonwealth Deval Patrick. [Applause]

GOV. DEVAL PATRICK (D): Thank you. Thank you everybody. Phil, thank you not just for the very warm

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introduction and the constant reminder that I have been here over and over again, but for the much deserved tribute to Ted Kennedy. I share the concern, the pride in his record and the confidence given who he is and how he is that he will pull through this. So to a speedy recovery to Ted Kennedy.

Thank you Jarrett and all of the members of the Foundation for organizing this and everyone for coming together today. I know there are many elected officials here or who have been here in the course of the day. All of the special people I acknowledge you each one and all of the members of the administration who are here. Thank you for your partnership and your leadership and your coaching of me.

I think you spent a good deal of time today and with good reason celebrating the extraordinary accomplishments of two years in this grand experiment with health care reform. And there is a lot to celebrate. Indeed health care reform is one of the first issues that I am asked about by other governors when I meet them or by policy makers and leaders in Washington. And I am proud of the story we have to tell.

We have a great deal about which to be proud. Because of you some 340,000 adults and children who were uninsured a little bit more than a year ago are insured today. In one short year we have cut in half the number of working aged adults without insurance, with the greatest progress among poor

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people. The proportion of Hispanics reporting having a health provider jumped from 70-percent in 2006 to 81-percent in 2007. And while employers in other states are dropping coverage for their employees, companies here are holding strong, as you know, with nearly three-quarters to offering health insurance to their employees.

And as more Massachusetts residents have insurance, fewer are using the Uncompensated Care Pool. This is helping to drive down the costs of the Uncompensated Care Pool by some $240 million so far, a trend that is helping us to pay some of the costs of enrolling additional people in health insurance. More people have access to regular checkups and to dental visits. Simple checkups that can keep families and children well and provide an early warning for more serious and costly illnesses. And fewer people fear that a medical emergency will lead to a financial one. That is all good news.

I heard about a woman recently who had been going to the emergency room time after time after time to have her chronic sore throat treated. Through health care reform she was able to get insurance, see a primary care physician who diagnosed that chronic sore throat as throat cancer. And she is now on the path to recovery. There are hundreds of stories just like this one. And I mentioned this one as a very simple

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reminder that health care reform is not an abstract benefit. It is a real one.

Each and every one of you here can be proud of the remarkable success that health care reform has brought and each and every one of you deserves thanks. I want to thank Speaker DiMasi, Senate President Travaglini and Governor Romney for working together to craft the legislation in the first place, and to Senate President Murray for continuing her stewardship of the program's development. I thank all the providers and insurers and businesses who understood the benefit to all of us when each individual has access to insurance. My thanks to all of the members of the ACT Coalition and Health Care For All, GBIO and others who kept the justice and common decency of universal accessible and affordable health care at the forefront. And my thanks to the members of my team who have taken the lead in implementing health care reform, Secretary Leslie Kirwan, Secretary Judy Ann Bigby, John Kingsdale, where are you John? You are supposed to be here. There is John and the members of the Connective Board and staff who have charted a course through uncharted waters and done so with prudence, creativity and sensitivity.

Health care reform happened because this broad coalition shared the responsibility for inventing it. And I am here to tell you that you must now share responsibility for

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sustaining it. Health care reform, as we all know, is unfinished business. The challenges we face to fully achieve and sustain its promise are almost as significant as those you faced in creating it in the first place. Health care reform as already cost more than originally budgeted in this fiscal year. As you all know, we expect that it will cost more than earlier estimates for next fiscal year. These cost increases are playing out against the backdrop of state budget already straining under the burden of more worthy claims than there are resources, where health services already occupy 50-percent of the pie. They are also playing out in an environment of national economic unease where a downturn can mean even greater enrollment with even fewer resources to pay for it. We have to reckon with that. And when I say we I do not mean we in state government alone. I mean you and me. We have to reckon with that because we invented it and we share responsibility for it.

Although the scale is different, budget planners at the state level are asking themselves the same questions families at kitchen tables are asking themselves, and small businesses are asking themselves. How do we cope with escalating costs? We need to confront the challenges of paying for health care reform and controlling costs with the same focus, commitment and sense of shared responsibility that you all brought to the table in enacting health care reform in the first place.

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Now happily that process has already begun. We have had many helpful conversations over the past few months with leaders of the coalition that brought us this groundbreaking initiative. I want to thank them all for their input, their initiative, their candor and their creativity. As a result, taxpayers and consumers have already started to take on greater responsibility for paying for reform and controlling costs. Secretary Bigby and Senate President Murray spoke earlier today, I know, about a number of other ideas through which other parts of the community can contribute to sustaining health care reform. Every one of these ideas must be on the table. And we must act because the cost of inaction is too high. If we fail to act and health reform fails, consider the human community and financial cost of increasing the rate of uninsurance by 50-percent. Consider the human community and financial cost of an increase of just 5-percent in the number of people who do not seek preventive care. Consider the human community and financial cost of a working woman who goes to an emergency room time after time because her sore throat is really undiagnosed throat cancer and who never learns otherwise.

Our course is not an easy one and there are hard choices, but that is the nature of change. And change is worth the work. It is worth the sweat and the tedium. It is worth

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it to that woman who is getting treated for her cancer. For someone else, some other woman able to get a regular mammogram when she could not before. Or for the man who is able to afford his blood pressure medication. Or to the child who falls behind in school because of a chronic toothache unable to get a regular dentist visit. It is worth it to all of us who recognize that we are one community in Massachusetts and that we are all in this together. We have come a very, very long way.

We all see the benefits of this experience both in real terms and in abstract ones. And though I have not been here all day, I am guessing there has been an awful lot of our congratulating each other for the extraordinary progress we have made and well deserved. But there are challenges that lie ahead and I am asking you to join with us with the same spirit and the same commitment and the same creativity that you brought to inventing this wonderful reform to assure that it lasts and it is here for the benefit of people and generations to come. Thank you and I look forward to working closely with all of you. [Applause]

JARRETT BARRIOS: Well, we have come to the end of our journey, or at least this chapter in our journey. I want to say thank you to each of you who have taken the time. I want to say thank you to our wonderful speakers today and I am

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hoping you might join me in a round of quick applause for them. [Applause] Won't you join me also in thanking our wonderful MCs Larry Tye and Liz Walker for their great support? [Applause] For our board of directors, for all of our supporters, to all of you who have worked on health reform and making a success thus far.

I want to ask you for one more round of thank yous. This was not an easy day to plan. Many, many people working at our Foundation have worked hard. They often get forgotten in this and I for one would like to just ask quickly if you would join me as I read their names, just hold off your applause, I want to thank the many, many hardworking souls over at the Landmark Center who made this a success. Valerie, please stand up, Valerie Bassett, Michael McCormack in the back who does our Leadership Institute, Phil Gonzalez who directs grant making, Elizabeth Cruz who is soon to leave us to become a nurse, Carla Guzman in the back who does grant making, Sasha Mungle and Gayle Johnson who helped make our office work, please stand Gayle. Jeannie Christiano, Miriam Messinger, Susan Ryan Volmar, thank you all very much, Angie McCoy, thank you very much. You have done a wonderful, wonderful job. [Applause]

And one last person you saw earlier, the person who runs the Mass Medicaid Policy Institute, our partner in crime, Anya Rader Wallack. Thank you very much. [Applause]

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We have a wonderful and affordable bag lunch for you out in the hallway. But before you take that, I am reminded by our fabulous event planner that you have in your folders a yellow sheet. If you fill out this yellow sheet, your input on how we did today will be considered for next year's third anniversary for health reform. Thank you all very, very much. [Applause]

[END RECORDING]

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