

**Briefing: NCSL 2004 Annual Conference:  
Insuring the Uninsured  
July 22, 2004**

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**REPRESENTATIVE REBECCA D. LOCKHART:** Welcome. Welcome to the state of Utah and to this session. My name is Representative Becky Lockhart. I represent District 64 here in Utah, which is about 45 minutes south of Salt Lake City, a little town called Provo and the northern part of Springville. I hope you enjoyed lunch. I understand that it went just a little bit late. Let me tell you a little bit about myself and why I find this topic very interesting.

I graduated University with a Bachelor's Degree in nursing and spent seven years in women's health and then decided on a career change and that was to be a politician. But because of that background, I spent all of my time in the legislature dealing with health care and health related issues and this has always been a hot topic. And that is, insuring the uninsured. We always have those who are uninsured.

At the beginning of my service in the legislature, we had lots of money here in this state, most states did and so what we were mostly talking about was expanding programs and working on ways to insure those uninsured and then came the economic down turn and the last few years we've had reductions in programs and increases actually in the numbers of the uninsured. Albeit at a slow rate here in Utah, but I'm sure across the nation you're facing those same things.

The topic of insuring the uninsured is of great

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interest to all of us, and especially to me as this is the arena I work.

We have some great speakers here today. First I want to mention that NCSL has a publication called State Options for Expanding Health Care Access. There aren't enough for everyone who's here, so in lieu of passing those out, there is this form on the back table if you'd like a copy of that. It is free to legislatures and legislative staff. If you'd like to fill that out and leave it with someone here who is from NCSL.

I'm very excited about our speakers today. The first speaker is Mr. Don Moulds. Don Moulds is Director of the California State Senate Office of Research. Previously he was Principle Consultant to Senator John Burton, President Pro Tem of the California Senate. As Principle Consultant, Mr. Moulds specialized in health care and insurance and workers compensation. He also serves as Chief Consultant to the Workers Compensation Conference committee and was a Fellow in the Senate Judiciary Committee. Please join me in welcoming Mr. Moulds.

[Applause]

**DONALD MOULDS:** Thanks for having me.

Wanted to begin by talking a little bit about the state of the uninsured problem in California. Some various options that were considered in the state last year and I'm going to talk about FD2 or the Health Insurance Act of 2003 or now

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Proposition 72, which is on the state ballot, all the same thing.

The state of uninsured in California is that there are roughly 7 million uninsured persons in California. Those 7 million are people who are uninsured at some point during the course of the year. 4.5 million of those individuals are uninsured for the course of an entire year. And 80% of those 4.5 million people are working people. I know that all the states in our nation have difficulties with the uninsured. California, because we have so many people, our numbers are a little bit higher than everybody else's. It's been a problem that California has grappled with for a long time. It's interesting to go back and look at analyses of various attempts to deal with the problem because the problem really hasn't changed that much over the course of time in California. It's been ongoing, it's gotten a little bit worse and a little bit better and then a little bit worse again. But it's something that's been with us for a long time now.

California started to get serious again about the uninsured a few years ago with the introduction of various bills and then last year in particular, with the introduction of four different bills and I want to outline those and talk about the different proposals.

The first was a tax credit proposal that was put on the table by Republican Keith Richman in the assembly that proposed

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tax credit for the purchase of health insurance for individuals.

The second was a single payer proposal put on the table, it was SB921, by a Senator from West Los Angeles, Sheila Kuehl. It was proposed to take all of the different health delivery systems and merge into one single state system, including worker's compensation.

The third was an individual mandate that was actually brought, it was a [inaudible] Cohen Bill. Assembly member Cohen was in the assembly. An individual mandate that proposed requiring individuals in the state of California to have health insurance and then offering subsidies for individuals who couldn't afford to carry health insurance.

We have mandatory auto insurance in California as many states do and it was modeled after that, but it was a sliding scale and there was a state contribution that was financed by sales tax and then there was an employer contribution and then employee contribution, of course, because it was an individual mandate based on ability to pay.

And then the fourth proposal was the pay or play proposal that became SB2 that then became the health insurance act of 2003.

Of the four proposals, SB2 was the only one that actually made it to the Governor's desk and got signed. The other three had certain limitations. I think Democratically

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controlled legislature was skeptical of tax credits mostly because of research done on tax credits which suggest that they're not as effective as other things and also candidly because of state budget deficit.

And then the single payer and individual mandate both faced two-thirds vote because they involved various taxes and the need for state funding and so we were left with SB2. SB2 does the following.

In 2006, would require employers with over 200 workers to do one of two things. Either provide health insurance to workers and their families or pay a fee to a government board that would provide coverage for those workers and their families.

By 2007, Bill would require employers between 50 and 199 workers to provide health insurance for the workers only. Employers between 20 and 49 workers would have the same obligations as those between 50 and 199, but only if we have passed a subsequent tax credit to help them with the cost of providing health insurance.

As the law stands now, it would apply to employers who employ more than 50 persons. It would also require that workers work at least 100 hours a month, which is a little bit more than 24 hours a week. And they would have to work for three months before they would be eligible for coverage. It would require the employer to pay at least 80% of the cost of

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the premiums associated with health insurance. So workers could be asked to contribute as much as 20% of the costs of the premiums unless they make less than 200% of the federal poverty level, in which case, their contribution would be capped at 5% of their wages.

The other thing that SB2 did. Created a state purchasing pool that would be used to purchase health insurance for employers that opted to pay the fee in lieu of providing coverage. The idea is that they will pool resources and vie competitively in the private health insurance market so that employers who, for whatever reason, don't want to go out and purchase on their own, have a place to go. The other hope, of course, is that they will be able to buy in large quantities, get a good price and that it will have an evening effect on the health insurance market.

The product that SB2 requires eligible employers to provide is the product that is the minimum under what's our health and safety code, which regulates HMOs, basically hospital care, basic preventative services, acute care, plus prescription drugs. Wide open on what prescription drug coverage constitutes, but would require some form of prescription drug coverage or a PPO regulated by the Department of Insurance in California. Unless, to make it a little more complicated, a union and an employer get together and decide, for whatever reason, that there is a health insurance plan that

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better fits the needs of an employer and employees, in which case they can arrange for some sort of alternative minimum health insurance.

The other provision in SB2 is insurance market regulation. In California right now we have a small employer purchasing pool with regulations and rate bans and guarantee issue for employers between 2 and 50. We basically extended that up to employers up to 200 with slightly large rate bans. Rate bans I believe for the 2 to 50 are 10% rate bans. They would be 15% rate bans for 50 to 199. And then no rate bans for the over 200. There is a fear that when you get over 200 people move into self-insurance and the rate bans we're seeing has a mechanism that would incur that kind of thing.

So that's the general outline of the Bill and I can field questions if you have questions about the Bill in particular.

But a couple of reasons why we opted to do this in particular. One is that the legislature regarded as fundamentally irrational to have that many uninsured people in California. Why? Because you end up providing services for them eventually. Rather than providing services on front end in terms of preventative care, you end up providing services on the back end in emergency rooms and you have conditions that manageable. Diabetes for example, hypertension for example, that turn into very serious conditions that are very expensive

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to treat. Diabetic comas for example. Strokes for example. And that's bad for workers and bad for Californians and, of course, it's much more expensive. It's a proactive way of reducing the costs and the pressures on our safety net and it's good for California.

It also was a way of leveling the playing field. There's a lot of debate, as you health care folks know, about various ways of going about this. The reason that we opted to expand upon employer based coverages, it was seen as the most practical way of going about insuring the uninsured in California. This Bill would pick up between a million and a million and a half of those 4.5 million uninsured people in California. And it would do it by building on an existing system rather than blowing up an existing system and starting all over and people, as you all know, get very nervous when you tinker in major ways with their health insurance, so this was seen as a less invasive way of going about it.

There's a perverse incentive that exists right now and it's a growing problem in California and probably in some of your states too, and that's this. That employers right now provide health insurance, compete with employers who don't. And right now we exist in a system where you have, by and large, most people receiving their health insurance from their employers. And yet those employers who are providing are competing with employers who aren't providing to put the same

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product on the shelf for the same price or for a better price. And when you have added costs of health insurance, you can't do that. What we've seen in California, as you've seen in the rest of the nation, is the gradual erosion of this way of providing health insurance. With no backup.

We use some statistics from the University of California, Berkley that suggested that the average employer, who provides health insurance, a family benefit, provides health insurance for 1.1 dependent in addition to the worker, who is being picked up. This could drop that number to something closer to .7. So it levels the playing field. It makes it a more reasonable cost for employers who are already doing the right thing and providing health insurance. And for that reason, is necessary if we're going to sustain employer based health coverage.

At that I will cease and happy to answer questions.

[Applause]

**REPRESENTATIVE REBECCA D. LOCKHART:** Thank you. I neglected to mention that we'll take questions at the end of all three of the presentations.

Our second speaker is Representative Benjamin Dudley of Maine. Representative Dudley is a member of the Appropriations Committee and past member of the Committees on Banking and Insurance and Health and Human Services. Last year he was appointed to the Select Committee on Health Care Reform. A

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Committee of Jurisdiction for the Dirigo Health Bill. Representative Dudley is currently on sabbatical from his work in the health policy arena in order to campaign for speaker of the Main House. Representative Dudley.

[Applause]

**REPRESENTATIVE BENJAMIN DUDLEY:** Thank you Rebecca. Good afternoon everybody.

When you walked into this room this afternoon and sat down, you immediately became very lucky people. Without knowing it, you became extremely lucky. That's because I was about to launch my inaugural PowerPoint presentation here today and after careful review, I decided to scrap it completely. So you've all been spared of becoming guinea pigs.

Has anybody here heard of Dirigo Health? Great. And does anybody here know what Dirigo means or even how to pronounce it, we've had one test already. All right.

Dirigo is the state motto in Maine and it means "I lead" or "I direct". But I think we're more comfortable with I lead these days.

It passed about a year ago at the close of our 2003 session with two-third majority. Extreme bipartisan support. It was a unanimous Bill. Unanimous Committee report out of the Joint Select Committee. What's important to recognize about Dirigo Health is that it's not just health insurance. Much of what you read about it and what people are talking about,

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certainly in Maine, is the health insurance product that's going to emerge as a result of Dirigo Health. But what Dirigo Health really is, is a comprehensive review and ultimately reform of the health care system in Maine. With focus on controlling costs, improving quality and providing access to the 13% of Maine people who currently are uninsured.

It's useful perhaps to set the stage a little bit about the nature of health care in the State of Maine. I'm sure many of you will find some of these numbers familiar for your own states as well. Speaking about health care and the Maine economy.

The increasing costs of health care are a significant burden on Maine's economy. CMS estimated that the total health care spending in Maine in 1998 was about \$5 billion, which was 16.5% of the gross state product. Using national rates of growth from CMS, the Governor's office estimates that spending in 2004 will be \$7.7 billion, which is 17.9% of gross state product. Representing a tremendous increase in health care costs at a time when state revenues and the economy as a whole is struggling.

There is a particular burden on what we consider the engine of Maine's economy. Small business. Small business represents vast majority of all businesses in Maine and about 50% of employment in the State of Maine. In the five years from 1996 to 2001, small businesses in Maine, those employing

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50 or fewer employees saw an average increase in health insurance premiums of 58% over that five year period. 58%. Not only does that represent huge increases for them in the cost of doing business and the cost of attracting a good work force, but it's also an unpredictable cost. You don't know, year to year, how much it's going to increase by and it disrupts your business operations for that reason as well.

Health care spending, and therefore, premiums has increase faster than income in Maine, which results in health care becoming increasingly unaffordable. Family supports have less to spend on other needs and business as we were just discussing, are less available to invest in business development.

So it's useful at this point to tell everybody about what the cost drivers are. This will also be familiar to you. In Maine the major cost drivers in health care spending fit in several categories, but the first thing, inappropriate utilization of services, excess capacity and other inefficiencies in the delivery of services. Total spending is the function the cost per unit and the number of units consumed.

It's interesting to point out that there are 39 hospitals in the State of Maine. 39 hospitals serving the population of about a million and a quarter. The geography of main is such that the rest of New England could theoretically

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fit inside the State of Maine. It's a large state geographically speaking relative to the other New England states. A very small population. So it's a very rural state. So we have a number of hospitals spread out over a fast area so that we can serve this rural population.

I'd like to add that yes Maine could fit the rest of New England within its borders and actually in the months like July and August, it seems like everybody's actually there.

Getting down to where the costs are. Hospitals, of course, are the single largest are of health care spending, counting for over a third of all health care spending. And within hospitals, we're talking about inpatient costs. Maine has the sixth highest cost per adjusted discharge in the U.S. in 2002, just under \$7,000 per discharge. This is 19% higher than the national average, 45% higher than the northeast regional average. Inpatient utilization and outpatient utilization are very high in the State of Main. Outpatient costs are, while in recent years had been below regional averages, have just started to increase far beyond what is happening within the region and nationally.

Physician and other professional services are the second largest area of health care spending, accounting for about a quarter of all health care spending in Maine. At this point we don't have a good sense of within that structure, where the costs are and where efficiencies might be found. But

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within Dirigo Health there is a plan for collecting this data and making better use of data collection. Of course not to be ignored are high rates of uninsurance.

Don was speaking about this and the costs that the people without insurance pose to the system as a whole. Whether not receiving preventive treatment when they're getting diagnosed very late in an illness into greater costs of treatment, ultimately.

Maine [Inaudible] first in New England and the percentage of citizens without insurance approximately 13%. The uninsured tend to be more costly, as we were just discussing the health care system because they're likely to receive less preventive care, diagnosed late in their illness.

Maine hospitals and physicians we estimate spend about \$275 million a year in bad debt and charity care. Costs that are shifted to other premium payers then would pay the claims off in inflated charges.

Who are the uninsured in Maine? 80% of the uninsured in Maine work for small business. 73% of the uninsured in Maine are below 300% of the federal poverty level.

This brings us to a discussion of costly chronic conditions. Don was speaking of this as well. The four leading causes of death in Maine are cardiovascular disease, heart disease and stroke, diabetes, chronic lease disease and cancer. They account for approximately 70% of Maine's deaths

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each year. The burden of morbidity and mortality associated with these conditions totaled almost \$2½ billion in Maine in 1999. I know that number might sound small to some of you, but that's almost 50% of our bi-annual budget.

These chronic conditions can often be prevented by changing personal behaviors such as tobacco use, physical activity and eating habits, among others.

Pharmaceutical costs are also, like we all know, a major cost driver. Prescription drugs are the third largest single category of health care costs in Maine. The rate at which those costs have been growing is significantly faster than all the other categories of expenditure. And I think that's probably typical throughout the country.

Maine has been a national leader in an aggressive state of initiative designed to make drugs more affordable for residents through programs like the Maine RX Program. But [inaudible] in St. Louis in a couple weeks and we can talk about that in more detail.

What is Dirigo Health and what is the answer that it proposes to controlling costs and improving access and improving quality? As represented before, the cost of health care is not driven solely by economic factors. Timely access to appropriate levels of care and quality of care provided are significant factors in Maine's high health care costs.

Accordingly, efforts to contain health care costs must

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address issues of quality and access. The specific approaches that we took under Dirigo are as follows. There are a number of them.

The cornerstone of them is health insurance products. The Dirigo Health Plan. Which focuses on, among other things, capturing and reducing bad debt and charity care. Taking those dollars that Don was talking about, that we spend on the back end and getting them to the front end, getting them to early treatment and preventive programs.

Dirigo Health aims to reproduce the burden of uncompensated care and providers and therefore, all premium payers, by expanding access to coverage for the uninsured and underinsured. This will be achieved through the implementation of the Dirigo Health Plan through more affordable, private health insurance products.

The Dirigo Health Plan is fundamentally a market based approach to health reform. It contracts the state contracts or the Dirigo Health Agency contracts with a private health insurer already doing business in the State of Maine to provide a new plan in the market place, marketed to individuals, small employers, and sole proprietors with a five year plan of expanding access to all the uninsured Maine. Capturing all the uninsured within this plan. Perhaps down the line, as the program achieves its goals, expanding marketability to larger groups as well.

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It's paid for through employer premium payments, employee matching payments, a tax on insurers, which is a result of the recovery bad debt and charity care. The theory being if we're giving health insurance products to people and they're getting the early treatment, they're not going to need those costs on the back end. So the extent that we achieve savings in bad debt and charity care, we're going to apply those savings to a tax on insurance companies. Which will receive a pass through of those savings from the provider community. We'll take those savings and tax the health insurers to recover through savings and bring them into the Dirigo Health Plan, into the State General Fund, as a matter of fact, to help fund other initiatives like a modest expansion of the state's Medicaid program.

Those people who are enrolled in the Dirigo Health Plan will see affordable product, particularly those folks under 300% of the federal poverty level. They'll receive discounts on a sliding scale basis that can be quite significant. Discounts to their share of the premium payment. People who work for a small employer who are also Medicaid eligible will be enrolled through their employer plan and the employer plan would wrap around Medicaid coverage using the Medicaid program as a way to deliver health care and savings to Dirigo Health Plan to people who are Medicaid eligible who are also working.

Dirigo Health also focuses on preventive treatment and

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wellness with first dollar coverage for preventive care and wellness programs. It does have significant deductibles for other treatment, but when considering that most of the people enrolled in the program are going to be uninsured anyway, we've been able to justify that. But they are still much smaller than what we're seeing people are buying on the open market anyway with high deductible plans just to have some catastrophic coverage.

Again, it's a five year plan for universal coverage. That's the Dirigo health product in a nutshell. I know that's a lot to take in, in such a short period of time.

We also create. This is the second significant piece of the Dirigo Health Plan. The bi-annual State Health Plan. The State Health Plan purpose is to strategically improve the allocation and coordination of our health care resources to help Maine become the healthiest state in the United States. The State Health Plan will articulate health system improvement and goals and measures to meet those goals. Including enhanced criteria for the Certificate of Need Program, which I will discuss in a moment. An inventory of health care providers and resources. Development with public purchasers of a pay for performance reimbursement system to providers, to give providers an incentive. We're going to initiate payment standardization as well.

That's a quick overview of the State Health Plan. But

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basically trying to get an assessment of what our health system is right now and creating goals and trying to create some rationale perspective on how to develop access to health care and how to manage the state health spending in an efficient way.

We're going to strengthen our Certificate of Need Program. It strengthens existing CON Program by establishing more robust criteria as advanced through the State Health Plan. Additionally, due to an increase of outpatient services provided at non-hospital institutions, CON review has been expanded to include physician offices and ambulatory surgical units. Units outside of hospitals that are springing up, probably in part due to the fact that they're not currently subject to CON review. CON approval is what they required for capital expenditures of more than \$2.4 million. New technology investments of more than \$1.2 million and the offering of new services totally more than \$110,000.

This really managed through the Capital Investment Fund, which is an imaginary pool of money that the state is creating, saying, we will not invest beyond this level. This is how much we're going to invest in new technology spending in this year. The budget focusing on what the third year operating cost would be for that new equipment that is brought on line after CON approval.

We created a commission to study Maine's hospitals.

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The Commission consisting of nine members representing providers, insurers, consumers and business, is conducting a comprehensive analysis of hospital costs, roles of hospitals, hospital reimbursement, capital and technology needs and this Commission will report its findings in November of this. A significant portion of the report will make recommendations to policy makers for achieving improvements to our hospital system. 39 hospitals serving such a small population. The goal, trying to find efficiencies and perhaps changing missions of hospitals, but at the same time, with a priority on preserving rural access. As you can well imagine, this is going to be a very politically consensus piece of Dirigo Health, but one is vital given that hospitals are the number one cost driver for health care in Maine.

We're focusing on enhanced public purchasing. We created a public purchasers steering group, which brings together the largest public purchasers in the state to determine ways to determine public purchasing and health care. Public purchases bear the cost of the majority of health care spending the State of Maine, yet there is a very low level of integration and efficiency within the public purchaser community and the public purchaser steering group seeks to find ways that these groups can work together to find cost savings and efficiencies.

We've instituted voluntary cost controls, which have

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been successful to date. Dirigo Health asks hospitals, physicians and other providers, as well as insurers, to limit operating margins to 3% during this transitional period until Dirigo Health gets off the ground. Which by the way, the product is scheduled to be offered on the market come October of this year.

Hospitals were also asked to limit cost [inaudible] to 3½%. Approximately all hospitals have agreed to try to meet these targets, as has half the major insurers in the State of Maine.

We also institute a new rate regulation in the small group market for health insurance. For the first time, insurers providing small group coverage are required to submit premium rate increases to Bureau of Insurance for approval if the loss ratio is projected at less than 78%. We're finding ways to increase regulation and make sure that savings that are achieved in the system are actually brought home to savings for premium payers.

Accountability for all insurers. All health insurers doing business in Maine will be required to comport with standardizing annual reporting requirements. These requirements will include prescribed definitions of items, including administrative costs and medical costs so as to allow easy comparisons of loss ratios and profit across lines of business and across insurers.

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We're also engaging in price posting. Providers are required to make available upon request, your charges for the most common inpatient and outpatient procedures, enabling consumers, businesses and other payers to compare provider costs.

There's also another effort which I haven't mentioned so far. It's called the Maine Quality Forum. Which is designed at finding out what's happening in Maine when it comes to best practices and making sure the provider community is well aware of what best practices are for a given illness. And also making sure the consumers have the information they need to compare the quality of providers, as well as, the cost of providers for the quality that they deliver.

I think I'll close my remarks there and I look forward to any discussion that follows. Thank you all.

[Applause]

**REPRESENTATIVE REBECCA D. LOCKHART:** Finally we'll be pleased to hear from Scott Leitz. Mr. Leitz is Director of the Health Economics Program at the Minnesota Department of Health, where he also serves as a state health economist. As the primary health policy development and analysis unit in Minnesota's Executive Branch, the Health Economics Program serves the legislature, stake holders, consumers and other interest groups. Mr. Leitz.

[Applause]

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**SCOTT LEITZ:** Representative Dudley mentioned that he was going to spare you his PowerPoint. I will do you no such favor. I'm a government economist. I use PowerPoint. I know no other way. You'll have to bear with me.

Good afternoon, I'm pleased to be here. I'm going to talk a little bit about Minnesota and some of the things that are going on in our state right now, some of the past reform efforts that Minnesota has undertaken and what our current status of things are, what our past project extensions have been and maybe a little bit about a high risk pool that's operating in [inaudible]. Talk a little bit about that and some of the neat characteristics of it and how it might help stabilize the private health insurance market and then I'm going to close with some upcoming challenges that Minnesota has and I think they echo many of the challenges other states have as well.

If we look at where Minnesotans get their health insurance coverage, thinking back to Don Mould's 7 million uninsured in California. We have 5.4% of our population in Minnesota that is uninsured, which are 270,000 people. So by in sheer size of the challenge, it's not nearly as large as it is in the State of California or even in Representative Dudley's Maine where the uninsurance rate is closer to 13%. But as I'm going to show you a little bit later on, the challenge is still there, even with the state of a relatively

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lower insurance rate like Minnesota because there's racial [inaudible] groups that are increasingly a large portion of Minnesota's population that have much, much higher rates than what we seen with our traditional white or Caucasian population in the state.

Minnesota does benefit from having a relatively strong private health insurance market. We have about the same share of the population, that gray area, that's enrolled in public health insurance program, but a higher percentage of our population enrolled in private health insurance coverage relative to uninsured. If you look nationally, it's true that there's a strong correlation between states with strong private health insurance markets and low uninsured rates, so that's certainly echoed in the statistics we see for Minnesota.

Although our rate for coverage is relatively low and we have a relatively strong type of health insurance market, we have seen, since 1999, look at the blue area, which is private coverage, a decline in private coverage even in our state where it has sufficiently been rather strong, relatively stable uninsured rates, that black strip. But an increase in public health insurance coverage and of course, over that time period, 1999 to 2002 is created when we saw budget deficits, slow economy. We saw rapidly rising health insurance premiums in our state just as you all did in your states as well. And certainly probably some movement from private coverage, where

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premiums become increasingly unaffordable for people into public coverage.

In fact, Minnesota, like most states, has trouble with the issue of rising health care costs growth. The red line indicates the health care costs growth in the private market in Minnesota and, of course, has outstripped all the other indicators, whether it be income, overall inflation or worker's wages over that time period of 1999 to 2003 and is outstripped by a substantial amount, even if employers were able to continue to contribute the same amount towards their employee's health insurance coverage, that increase in costs growing faster than workers' wages simply means more workers' wages going to have to go for health insurance coverage, is going to squeeze down unaffordability.

We have seen enrollment in the small employer health insurance products, which as Representative Dudley and Don Moulds mentioned, is where most of the uninsured reside. We have seen declines in people enrolling in small employer health insurance coverage and that's like a function of the rising health care costs as well as the rising premiums that they're facing their rising employees' share of coverage.

That's kind of where we're at with regards to costs and coverage in Minnesota. We're going to talk a little bit about some reform initiatives that were undertaken in the past and sort of where we're at right now with things.

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In terms of health reform in Minnesota, we passed a series of major system wide reforms in the early 1990's. These reforms were intended to address cost, quality and access, were intended to be broad and inclusive of the entire system, so you weren't just dealing with access, you weren't just dealing with cost, but you were simultaneously attempting to deal with all of the issues.

Sample reforms that were passed. You see many of the things that probably echo what Representative Dudley in Dirigo Maine is doing. Top one being Minnesota care subsidized health insurance program, which I'll talk about in a little bit more detail today. I'm not going to go into all of these, but just to show you there was a whole host of things that were passed during that time period. Certainly after 1994, what we saw was that premium growth began to sort of decline nationally as well as in Minnesota. A lot of the pressure for reform was just as they are driven now, was driven at the time by increasing costs and businesses angst about the increasing costs that they were dealing with their health insurance premiums.

After '94 some of that pressure sort of came off because of the [inaudible] premiums. What we saw was a lot of the provisions that were passed in this broad sweeping reform initiative in the early '90s were either repealed or never fully implemented. There are some pieces that remain.

The one I want to focus on primarily is the Minnesota

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Subsidized Health Insurance Program. We had that effective in implementing risk adjustment for public health insurance programs. We do still have a capital expenditure reporting law which is similar to what Maine has passed with regards to their capital investment and technology examination.

I'll touch briefly on the final, which is our provider tax funding mechanism for the Minnesota Care Subsidized Health Insurance Program and talk a little bit about some evidence that we have recently had on the effectiveness of Minnesota care or a subsidized health insurance program expansion on reducing and compensated care.

Minnesota Care is also for shorthand called the Subsidized Health Insurance Program, was implemented in 1992 as part of that larger health reform initiative that Minnesota undertook. We were the first state to do a really broad based health insurance coverage expansion for people who had incomes which were too low or didn't qualify for employer sponsored coverage, but earn too much to be eligible for Medicaid program.

There was a focus on families and kids on Minnesota Care and it was financed much the way many of the SCHIP programs are financed now. Through a sliding fee scale with subsidized coverage through paper, starting at relatively low amounts for people with low incomes per dollars per month, going up to about 8% of income at the top end.

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Target population for Minnesota Health Care was primarily the working poor. Families without access to employer coverage, but with income too high for Medicaid program. And really two types of eligibility categories. Families with children who were eligible up to 275% of the federal poverty line and adults without kids who were eligible up to 175%.

As I mentioned Minnesota Care served some degree as a model for what was subsequently passed under the State Children's Health Insurance Program. And as such, we also had certain barriers that were built in to prevent the substitution of the Minnesota Care Program, this subsidized program, using state dollars for substitution into private coverage. And you can see some of the barriers that were put in place to prevent that. The primary one being the need to be uninsured for at least 12 months. And again, most states that have implemented an SCHIP Program subsequently have some barriers in place to prevent that sort of erosion from occurring.

Enrollment in the program went up relatively rapidly over the course of its first decade. Peaked out in 2003 at about 150,000 Minnesotans. Put that in context, that's about, we have a state population of about 5 million, so it's certainly less than 2% of the population, so it's an overall sort of coverage piece. It's not a huge portion of the population. Nevertheless, it plays an important role for

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certain populations as I'll talk about. We did have a small decline in 2004. I'll touch on why that is in a second as well.

The program seems to be getting its target population; about half the enrollees are children. The remaining, about a third of the population enrolled in Minnesota Care are parents. The adults without kids portion, that black piece, have been growing over the course of the past five years. Likely because health insurance premiums in the market place have been growing fairly rapidly in the individual market and people are likely moving into Minnesota Care as an affordable option.

90% of the enrollment in Minnesota Care is below 200% of the federal poverty line. Two-thirds is below 150%. So again, income wise, it's hitting its target populations. So while the population enrolled in the program isn't a massive population, it is certainly serving as an axis point for low income populations.

I want to talk just for a second on funding mechanisms for the Minnesota Care Program. When the program originally started it was a state only program financed by a 2% tax on the revenues of health care providers, broadly defined hospitals, physicians and so on. We did receive an 1115 waiver in 1996, which allowed for federal financial participation, which pays for about a third of the program costs, it matches the costs of kids and parents below 175% of poverty in the program.

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The general concept behind the provider [inaudible], which is not unlike the concept behind the HMO tax in Maine, is that as you have more people insured, they should have less uncompensated care. They have now a source of third party payment and you should see uncompensated care decline. That was actually rigorously looked at in the December 2003 issue of the Medical Fair Research and Review [inaudible] professor at the University of Minnesota, published a study that looked at the extension of Minnesota care compared at the levels of uncompensated care at hospitals. Found that the levels of reduction in uncompensated care in Minnesota actually seeded the amount of provider tax that was paid into cover the programs. As a trade off, a pretty good trade off by and large. It did actually work as theory would suggest which economists occasionally like when it actually works out that way.

Minnesota, like all other states, has been dealing with a budget deficit. Health insurance programs certainly are those areas where there is a lot of money, so we have made some changes in the past couple of years with regards to these things. I'm going to skip by these two slides here because they get a little complicated and go to this one where I have failed to label the top.

Pretend on the left hand side, on the left hand set of bars it says, Children 2 to 18 and on the right hand side

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pretend it says pregnant women. What happened during our 2003 legislative session as a result of the fairly large budget deficit is that we reduced Medicaid eligibility for children ages 2 to 18 from 170% of poverty down to 150% of poverty. They still remain eligible for the Minnesota Care Program, although they will have to [inaudible] premiums to be on that program. For pregnant women we reduced eligibility from 275% of the federal poverty line to 200% of poverty. Again, those women would remain eligible for the Minnesota Care Program, which has benefits which are equivalent to Medicaid benefits, but people between 201% and 275% of poverty would have to pay premiums to be on that program.

Spend a couple of minutes talking about our high risk pool in Minnesota. Minnesota has the nation's largest high risk pool and I'll talk for a few minutes about what that is and some of the challenges that are head for it.

We do know for an example, if you look at any given health insurance pool, one thing that is fundamental about the concept of insurance is that health care spending is highly concentrated. 1% of the population spends 27% of our health care resources, 5%/55% and so on and so there is a strong incentive for insurers to attempt to avoid that 1% and that 5% and enroll that 50% of the population that spends only 3% of our resources. One way that other states have used to try to stabilize pools is through the risk of high risk pools ... some

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of these high risks off of the private market and put them in a larger pool where risk can be more broadly spread.

Overall high risk pools provide insurance and risk spreading functions for people who are generally medically uninsurable. So people who are outside a group and need coverage in the individual market that have high health needs. They provide insurance. They are generally subsidized, because what happens, people with those high health needs needed to pay their entire cost of their care, it would simply be unaffordable. So by definition these are people with high health needs. Premiums are generally capped in high risk pools, usually at 125% of 150% of the average premiums in the market place. And then generally speaking, states provide some supplemental funding to make up the differences between premiums paid and the claims losses, often times through assessments high insurance carriers in the market.

Conceptually, because of that skewed distribution of spending, if you're able to pool those people with higher health needs and provide some subsidy for them to get into the insurance market, you should be able to pool some of that higher risk out of the private market and stabilizing some of that risk for people who are still enrolled in the private market. It also provides a nice means of access for persons who otherwise would not be covered.

Now this isn't going to get rid of your uninsurance

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problem. High risk pools generally are very small. Minnesota has the nation's largest out of about 30,000 people. Most states run in the single thousands. What the establishment of high risk pools does do is to hopefully stabilize the rest of the market for those people who are still in the individual market.

[Inaudible] Minnesota's high risk pool. This comprehensive health association or MSHA is our high risk pool. It's the nation's largest. Relatively high enrollments in the early 1990's declined throughout the decade and then started to climb again in 2000, as illustrated by this chart. Enrollment in MSHA is pretty [inaudible] of the economy. When you see the economy being relatively not as strong, you see enrollment tend to go up as health insurance premiums rise, you see enrollments tend to go up and so forth. So it tends to follow the same sort of cycle that health insurance premiums do.

Finance by enrollee premiums and an assessment by health insurance companies. Premiums are capped at 125% of the individual market in Minnesota. Currently we're operating at 112% of the market, and that's that premium paid by enrollees comes to about half of the program's cost and insurance assessment on carriers operating in the fully insured market in Minnesota, cover the other remaining half of the market. Minnesota has also periodically kicked in some additional funding to help to ease the burden of assessment on the health

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insurance companies.

Not surprisingly, enrollment is concentrated among middle age and near elderly. People with higher health needs in general and enrollment tends to be concentrated in those areas. The incomes of people in the MSHA program tend to be somewhere between what it is for all Minnesotans and what it is for uninsured Minnesotans. So, about a third of the enrollees in MSHA have incomes below 200% of poverty, compared to about a fifth of all Minnesotans and about half of the uninsured. Their incomes are somewhere in the middle of those two broad groups.

Similarly, and not surprisingly, people enrolled in MSHA have care persons that are very similar to people in the individual market. About half of the people enrolled in MSHA are self-employed individuals. Those would be those naturally looking for coverage outside a group so they become natural candidates to be in a high risk pool if they happen to have high health needs.

Some of the ongoing policy issues in regards to MSHA and for most state high risk pools are the shrinking assessment base. There's trends for self-funding of health insurance benefits which pulls premium dollars out of the fully insured market, which is the only portion that states can assess do to ERISA and in Minnesota we see that self-insured portion of the population, that yellow line, has been growing compared to the

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fully portion of the market which has been declining. Secondly as growth and enrollment continues to go up in the MSHA program, funding the program simply continues to be a challenge.

I'm going to close real briefly by talking about a couple of the challenges that we have upcoming on the issue of access. Again as I mentioned, Minnesota is fortunate in the sense that we have a relatively low uninsurance rate, about 5.4% of our population and if you measure it by the standard national surveys, it's either the lowest or among the two or three lowest rates in the nation.

What we do know from some recent work that we have been doing in the state is that while the overall rate is low, we do have disparities in coverage, just as practically every other state and we know nationally these are the figures. Our white population, while the overall rate is 5.4%, white population in Minnesota is 4.6% of uninsured. You see that the black, American Indian, Hispanic populations range between 15% and 17% of their populations being uninsured in Minnesota. And those are some of the most rapidly growing populations in our state as referenced by this chart. They are going to be growing at rates much more rapidly than our white population. So that's going to be becoming an increasing challenge in our state, how to deal with the access issue for populations that will be growing more rapidly and having higher rates in other

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populations. Certainly, even though we have standard coverage for low income populations, those below 200% of poverty, still have uninsurance rates that are much, much higher than higher income populations. Again, due to access to employer sponsored coverage, those rates tend to be driven. Also, when we look around the State of Minnesota, there are 87 counties in Minnesota of darker colors being higher in insurance rates, lighter colors being lower in insurance rates; you could see a lot of geographic disparities in access to coverage. Certainly in rural areas of the state, that seems to be a challenge.

I'll close with the contact information slide. I'd be happy to answer any questions about this or other things that are going on in Minnesota and thank you for your attention.

[Applause]

**REPRESENTATIVE REBECCA D. LOCKHART:** Thank you to all of our speakers. We now have an opportunity for folks in the audience to ask any questions they might have. I ask you to state your name and your state.

**CHARLES SCOTT:** Charles Scott, Wyoming Senate. Question on the California program.

How do you deal with the ERISA exemption employers? How does that play into it?

**DONALD MOULDS:** That's a good question and actually I omitted the very last part of my talk and want to talk about, it will just take 30 seconds. Three challenges that are facing

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the law.

The first is the referendum that I mentioned in passing at the very beginning of the talk. In California when a bill becomes a law, it can be referendized [ph?] somewhere to an initiative if you collect enough signatures. So it's stayed at the moment and it has been put on the November ballot.

The second is actually a state constitutional challenge. In California, you need a two-thirds vote; I think I mentioned this very briefly also, in order to pass a tax, but the majority of the vote in order to pass a fee. There is a complicated distinction there. To call something a fee there has to be a nexus between the money being collected and what it goes for. If there's not, then it's a tax. So there's potential litigation there.

And then the third thing is ERISA. This is structured a fee that you get around by providing health insurance rather than employer mandate provide health insurance. And we worked with, among other people, Patricia Butler, who does a lot of work on ERISA nationally. Actually has a really nice paper on the California Health Care Foundation website on the ERISA issue and Health Insurance Act of 2003.

But we are what we've called from time to time, the ERISA gray area on this bill and now state law. Never sure quite what to call it these days. And it's over this question of whether because we are requiring that they pay a fee, which

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is within the boundaries; it will be considered a fee rather than a mandate. We think it is, we're hopeful in this challenge, we don't know.

What to do with self-insured employers is a difficult question. In the bill right now, what it says is that self-insured employers are required to meet the same standards as the insured. So they don't actually have to go out and purchase health insurance, but they get out from the fee by providing it. Now that is, of all the things in the bill, the most ERISA vulnerable provision in the bill. The bill is also severable, there is there a possibility that that part of the bill will be thrown out and the rest of the bill will be upheld, in this case, we're vulnerable to the potential of having employer's self-insured to get around the provisions of the bill.

A lot unknown and it will depend in large part upon what happens in November and then what happens in the courts after that.

**KATHY MANDERINO:** Good afternoon, Kathy Manderino representative from Pennsylvania. You may have partially answered the first part of my question to California, but let me ask it a little bit differently, because either I'm not getting it or there's still another piece that I need information on. And then my second part really, I know it would apply to California and Maine; I don't know that it

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applies to Minnesota. I'm really looking at those that are dealing with a product.

One of the things that you said that confused me about your California plan, you mentioned it in the context of minimum state health policy or code or something that defines a level of, I couldn't, and that also included some prescription drug coverage, so I didn't know what you were saying is, we have minimum coverages that if you are insuring people under a state insurance leaving ERISA out, this is the minimum you have and that's the product we went with.

**DONALD MOULDS:** If you're going to be exempted from the fee, yes, you have to provide a certain basic minimum benefit package.

**KATHY MANDERINO:** Was that an existing package? For example, right now before this program came in, if you were insuring your folks in a state health insurance product in California, it had to meet these minimum requirements that are the base you started with.

**DONALD MOULDS:** It's not actually a specific package, what it is there are rules that constitute health insurance for the purposes of the health and safety code. Now, there are certain things that if you, for example, if you failed to provide maternity care or if it was a dental only policy or if, actually maternity care is tricky because I believe in the insurance code there are existing insurance policies that don't

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provide maternity care, but not so in the, we're regulated by two different entities, which makes it enormously complicated PPOs by the Department of Insurance and then HMOs by the Department of Managed Health Care.

Some policies are allowable under the Department of Insurance in PPOs that aren't allowing under [inaudible] which are the Managed Health Care Department.

So they're very broad parameters. You have to provide catastrophic care coverage and things like that. But it's not a specific policy. There are a lot of things that fall under the rule book of what is allowable under Department of Managed Health Care.

It's also a work in progress because they review products on a case by case basis. There are challenges and presumably changes when you change administrations. Very high deductible policies under the previous administration, they were looking at some and the thought was they weren't going to be accepted under the new administration, maybe that would be different, we just don't know.

**KATHY MANDERINO:** And then the broader question for Maine and I guess it applies to the other states, to Minnesota a little bit. To the extent that you are creating or created a state product, a new product, any insight, suggestions or comments with regard to barriers you had to overcome from the private insurance market? Thank you.

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**REPRESENTATIVE BENJAMIN DUDLEY:** Well the first barrier for us, the market is very consolidated. There are three insurers and one is really the major player, Anthem Blue Cross Blue Shield. The trick was to make sure that we had a RFP that they would bid on. That's currently under negotiation. So hopefully by October we'll have an agreement and a product that we can offer. That's been the biggest hurdle overall.

The way we protected ourselves in that regard was to say that if nobody bids, the State Department of Human Services can structure its own insurance product, which creates a whole other set of problems of course, for the state to develop the expertise to design a health insurance product like that. We've been spared; it appears, by at least giving that one bid from the market.

**SCOTT LEITZ:** The Minnesota Care Product was not a new product; it was simply a Medicaid product. Objections of the industry were mitigated by fact that all of the Minnesota Care was delivered from the beginning entirely through HMO products and by and large the rates were such that they actually made money on the product. There really weren't a lot of concerns raised.

**HANK WELCH:** Hello there, my name is Hank Welch; I'm from Salt Lake County. I have a supply side and a demand side question for you.

Supply side, if we could muster the political will to

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set aside the incoming entitlement needs of doctors and hospitals, couldn't we rapidly take care of providing a network of primary preventative care by the rapid expansion of the non-physician health care providers, physician's assistance, family nurse practitioners and others, there are several studies that suggest that even do a better of providing primary care because they take the time with the patient and have more effective communication in human relation skills. So that's the supply side. All of these are good, but it seems to be without some basic supply side restructuring in the delivery of health care you are just tinkering in the long run.

On the demand side, there is an explosion of health care needs of the largest growing H cohort, 80 and above and we boomer people, with our sense of entitlement, are going to expect these younger generations to provide us with an ample supply of pensions and medical care and there's really no managing medical care, aiding and beyond as the chronic conditions multiply. You put me on a ventilator for five years and I'm going to have cataracts and dementia and on and on and on and isn't that going to be our ultimate challenge in the years ahead? To confront those cascading and actually capping the health care availability, saying this is how much we will spend on people over 80 or 85 and we can't afford anymore than that.

**REPRESENTATIVE REBECCA D. LOCKHART:** Have you

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approached the issue of the aging population?

**DONALD MOULDS:** California's demographics are different than a lot of other states. We're certainly facing that problem, but not in the same way that other states are. We have a younger population. I'm not saying it's not a problem, it obviously is.

To answer the first question. In terms of squeezing those additional savings out of the system in California depends on which part of California you're talking about. Managed Care is permeated most at California Health Care and actually our costs are lower in California than they are in a lot of other states. But there's a rural California where that's not the case, there's a suburban California where health care is inexpensive and then there's an urban California, which is mixed, depending on which part of urban California you're talking about. Some health care costs are much higher than the rest of the state.

In California, as I think is in a lot of other parts of the nation, you do see a nurse practitioner or a physician's assistant as the first person when you go in for basic care. But in certain parts of rural California, hospital costs are extremely, extremely high in part because of monopolies by hospitals and because there is one in the area and so on and so forth.

**REPRESENTATIVE BENJAMIN DUDLEY:** I'll take a stab at

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that too. I think you raise an interesting point on the first one. The supply side. I've been part of discussion when talking specifically about medical health services and dental services getting away from physicians and dentists and getting to dental hygienists and LC, PCs and the like. Particularly in a rural state like me where there are places in Maine where you don't have a dentist. Just about the entire state, except for Portland, our largest city, you don't have any pediatric dental services available. So it's not been part of the reform discussion, but it certainly would be discussed further. I would say that perhaps it hasn't been part of the discussion is we did offer a big enough political problem with the reform we were discussing and I think trying to do that as well would have alienated us completely from the point of physician community. I imagine it was a political decision not to go further there.

On the other side of your question, Maine seniors are a dramatically increasing portion of our population. I think frankly there's probably more or less a hope that since this is more of Medicare problem, that the federal government is going to be the one forced to confront the issue. We certainly, don't have the resources nor the political will to cap services for seniors.

**HARVEY MORGAN:** Harvey Morgan from Virginia. I'm concerned with California. I've been reading this over and I

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missed a portion of your remarks, but the estimates are anywhere from \$1.3 to \$11.3 billion, depending on the group is estimating.

**DONALD MOULDS:** We think closer to the 1.3. That's not including the savings that we talked about.

**HARVEY MORGAN:** That's today? When it goes into effect? I'm concerned, if I were an employer, how would I know how much it's going to cost me per employee. I don't see anything in the literature that gives an idea as to how much it's going to cost, that's the first question. Secondly, you're only dealing with employees; you're not dealing with people who are retired beyond that. Some of them are dependent on Medicare.

**DONALD MOULDS:** That's right; we're not dealing with retired workers. This is a proposal that takes a big step towards picking up some of the uninsured, but it doesn't solve the whole problem. In terms of cost, it depends on the employer. First of all, 95% of employers over 50, in California, provide some health insurance already. For a lot of them, they're providing what we're talking about here and for those employers, they're providing full family benefits and they're picking up the spouse or the children of the employer who isn't providing insurance. For some employers, the cost of providing health insurance is actually going to go down, we think. For employers who aren't providing health insurance, yes, there are new costs that are associated with it, but what

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we think we're doing here, is we are lowering the cost of insurance overall. Because when you take that big of a chunk of the uninsured out of the system, you decrease the emergency room costs and all these others things, you bring that down. We think also we're bringing in more federal dollars into California in doing this and part of because of the way we structured the pool in the draw down of MediCAL and health families, which is our SCHIP program figure. But yes, there are employers who will assume new costs and any time that you have employer based coverage, that's something that happens. But if you have a system where most of them are providing it already, then leveling the playing field in this way is something that we just think is fundamentally fair.

**HARVEY MORGAN:** I think my big concern is that, at least in Virginia, many of the employers that do not provide coverage, are small employers. But even the larger ones are, as time goes on, diminishing their coverage or requiring lower insurance or whatever. My concern is that you may force businesses that are marginal out of business and then there won't be any employers to provide this stuff to the employees. That's a concern that I have with this kind of program.

**DONALD MOULDS:** And that's always going to be a reasonable concern and I don't want to diminish the significant cost that this could present to an employer who doesn't provide any coverage, but remember that our figures, are as I said,

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closer to the \$1.3 billion, we think it's probably going to be between \$1.3 and \$2 billion in new employer costs. Not including the savings, which we think are easily a billion dollars in the reduction and unreimbursed costs. And then additional federal draw downs, we actually think that this is financially not hugely, hugely expensive. The figures that you see, the \$11 billion figures, we're profoundly skeptical of them. I don't want to go into great detail and arguing—

**HARVEY MORGAN:** If I were an employer, you couldn't tell me how much it's going to cost?

**DONALD MOULDS:** I can tell you how much on average health insurance costs in California. It's about \$2,700 for an individual and about \$6,800 for full family benefits. That's something that you can write off completely. So if you're making a profit, half of that is, or you can rollover, so, half of that you get back in tax savings.

**REPRESENTATIVE REBECCA D. LOCKHART:** Thank you. We have time for one more question.

**EILEEN CODY:** Eileen Cody from Washington State. Curious to both California and Maine. In California, since you're facing the referendum, I know you have big opposition and what businesses supported and who's financing the referendum is part of the question. And then for Maine, you had the Chamber if my understanding it was a bipartisan; the Chamber was supported, so you had much more business support.

<sup>1</sup> kaisernetwork.org makes every effort to ensure the accuracy of written transcripts, but due to the nature of transcribing recorded material and the deadlines involved, they may contain errors or incomplete content. We apologize for any inaccuracies.

How did you do it? That's the other part of the question.

**DONALD MOULDS:** I don't want to talk too much about the referendum because it's a political campaign and I'm talking about SB2 and it's history, but it's supported by most of the large employer organizations. We had a number of employers who are providing health insurance come to us when we were crafting the bill and we were hopeful that we would get more support I the end than we actually did. There is association politics that I also won't bore you with that make individual coming out and supporting a proposal like this tricky, is an understatement. It's large business, organizations like the Chamber, manufacturers.

**REPRESENTATIVE BENJAMIN DUDLEY:** For us, the way we got the Chamber off [inaudible] was to engage them right out of the gate. Our governor was newly elected and one of his first things to do is to appoint these groups called Health Action Team and he cast a very broad net, including folks from the State Chamber and other non-Chamber affiliated small businesses. Folks from the state employees union, hospitals, physicians, other providers, insurers community, as well as advocates for the uninsured and legislatures as well, while casting as broad a net as possible to engage into the conversation before the bill was written, before the big public fight happened. So there was a certain degree of buy in and I would say a level of excitement with the leader of the state

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Chamber of potentially delivering on a lower cost health insurance product for their members. That said through the negotiations of it, it was very difficult and the Chamber certainly flexed its muscle and chief concessions, particularly when it comes to concerns they had about the tax on insurers and their concern of how that tax could be passed down and higher premiums, both within those folks who were buying the Dirigo Health Product, but outside of that, people who won't buy the Dirigo Health Product, like large group plan purchasers, they're concerns that the cost of Dirigo would be passed on to them.

So, heavy structured when it would protect business from those [inaudible].

**REPRESENTATIVE REBECCA D. LOCKHART:** Thank you. On behalf of NCSL I want to thank our speakers for their presentations and all the information they have presented. Also thank all of you for your attendance and interest in this issue and enjoy the rest of your day and the rest of your stay here in Salt Lake City. Thank you.

[Applause]

[END RECORDING]