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## **National Congress on the Un and Underinsured – Day 3 Part V: State and Local Health Reform December 12, 2007**

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**ALAN WEIL, J.D., M.P.P.:** Good morning. We have a nice opportunity here to discuss state reform in maybe a little more detail, a little bit more of the nitty gritty. And I was going to introduce the subject, but had a suspicion that Diane Rowland's comments would essentially be the same as mine and indeed that suspicion played out. I don't think I need to tell you that there's tremendous interest in health care reform at the state level. There's a lot of activity. There's probably at this point a little bit more talk than there is action, but there's enough action that it's worth talking about and that's what we're going to do this morning. I also think it's noteworthy that despite the checkboxes that you saw that show the polarization among the presidential candidates among Democrats and Republicans that although I would not want to minimize the contentious nature of this issue at the state level, there really is much more of a common center in the state level discussions. There is a consensus that no state is seriously, at least among those that Diane noted on the map, no state is seriously considering options that are at either end of the extreme on the political spectrum either to the left or to the right, that all those states that are moving forward are discussing some combination of public program expansions and subsidies for private coverage with building on the base of the

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system that we have and not fundamentally transforming it. And indeed that is the experience that we are working from.

So given that this is coming towards the end of a lengthy conference, the first thing that I'll suggest is that none of us have slides so we don't need the room dark. And the second thing I'll do is I'll introduce the folks who are joining us on the panel. If you saw the program we were going to have a fourth panelist, Carmen Odom who is now President of the Milbank Fund, but was a cabinet official in North Carolina. She is not as you can tell joining us, but we will, even better [laughter]. Ask and you shall receive. So we have joining us, furthest from me is Richard Figueroa, health care advisor in Governor Arnold Schwarzenegger's office in California, former official in the insurance department. Someone I've actually had the pleasure of working with all three of the folks sitting up here with me today. We will begin with comments up to the minute on the status of California. We'll then turn to Jon Kingsdale who is the, if the camera can come one closer to me, Jon Kingsdale is the Director of the Massachusetts Commonwealth Connector Authority. He is basically responsible for, with his board, the major implementation tasks that Massachusetts is confronting. He was previously the Senior Vice President for Policy Development at Tufts Health Plan. And between the two is Ray Scheppach, long time Executive Director of the National Governors Association and economist, former Deputy Director of

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the Congressional Budget Office, to give a broader state perspective.

So I'm going to start by asking Richard, you got off the plane, bring us the news from discussion in California as they are happening at this very moment.

**RICHARD FIGUEROA:** Thank you Alan. So I was a little, couple seconds late. I was making sure the kids got to school with the three hour time difference. Anyways I'm Richard Figueroa. Everybody calls me Fig. I'm a health care advisor in the Governor's Office in California. Alan asked if it might be good to kind of give a little update on what's happening out our way. As most of you know we ended our legislative session in August with no resolution in terms of the Governor's broad comprehensive health care plan that he had inaugurated back in January. So he called a special session. And the special session kind started kind of end of August, early September and it's kind of continued to the present with no real resolution yet. We're facing a deadline because whenever the legislature agree to, the Governor still believes we're really going to get there, has to go on the ballot next November. And the reason it has to go on the ballot versus simply kind of passing the legislature and being signed into law by the Governor is because it's very likely there'll be little to no Republican votes to pass the health care plan. And because it contains financing it requires a two-thirds vote in California. We're

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one of like three states that requires a two-thirds vote for it to pass fiscal measures. So in order to pass something that has some money in it, given that you're not going to have Republican votes to do that it's going to be very hard to get two-thirds and so instead we have to go to the ballot next November. To go to the ballot next November you kind of have to backtrack in terms of how long it takes to collect signatures and validate the signatures and produce ballot pamphlet materials, et cetera. So you're looking at a situation where it pretty much has to get done some time this month, maybe even early January if you can really push to put on the ballot. And so legislation the Governor had been working throughout the fall and now early winter on trying to get it done.

They've agreed on a lot of elements like prevention and wellness elements. They're kind of low hanging fruit; not a whole lot of disagreement about what to do in that area. Even things like medical loss ratios for insurance companies, a structure for a guarantee issue of individual coverage or GI as it's known. They're pretty close on transparency. A number of issues like E-Prescribing and incorporation of additional information technologies into the health care system in California.

But there are some major issues outstanding. And they include affordability. You know, how broad and how deep should

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the subsidies be. To whom should they be extended and what kind of exemptions, if any, should be incorporated into the new structure. Should it be kind of like what Massachusetts did where you have this kind of affordability schedule plus hardship exemption? Should it be some other combination? Who's to do it? What would it look like? How much direction should it be getting? That's a major issue. Also the structure of a purchasing pool. We expect to have a Medicaid expansion but using the DRA or Deficit Reduction Act flexibility. We intend to through kind of a purchasing cooperative where people would be paying co-payments and premiums and try to be a lesser benefit package than traditional Medicaid would be. And who has access to that? How many other people can purchase, how many other people have access to that pool in some kind of subsidized or unsubsidized manner. That's kind of a major issue. Is it going to be a negotiating pool versus a connector like they've done in Massachusetts?

The dollars remain a sticking issue. When we proposed it in January there was like a \$14 billion package. It's probably north of that now because it's part of kind of the negotiation process. We've provided more subsidies and deeper subsidies to folks than we had expected in January. So we're looking for additional dollars. Whether that comes from employers is a controversial issue given how tentative many

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employers are about participating in kind of a reform package, particularly those that don't offer coverage. So you have employer groups going, "Well, I don't think we should be the major focus of additional dollars here." The Governor has to justify that we instead look to things like leasing the lottery. The legislature said, "Well, we don't like that idea so much. Maybe we should increase tobacco taxes?" One of the things that is hard about what we're doing is it's a very different political calculation you make when you're just going to pass something by the legislature and have it signed by the Governor than when something has to actually go to the vote of the people. And when it has to go to the vote of the people you have to be pretty careful about the kind of things you include and don't include because of some of the vested interests behind some of the things that you may include or might not include. And again it's a very different going to a vote of the people than passing something by the legislature and having it signed by the Governor.

Being documented is a big issue. That represents about 20 percent of the uninsured in California. And you just heard the previous speaker talk about how it's become one of the fault lines in the larger presidential campaign. It's a fault line in California as well, and so whether or not there'll be public subsidies for the undocumented or some other mechanism, particularly for very low income undocumented who in a world of

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an individual mandate, how would they meet it without some kind of subsidy? And again, when you try to put a public subsidy for the undocumented on the ballot, it's going to be a pretty controversial, pretty contentious sort of thing. So there's some calculations that kind of go into that.

Basically the way it's working right now, and I'll finish, kind of we have to move on, is the Governor is kind of doing shuttle diplomacy between employer organizations and provider organizations and himself. Our democratic leadership is doing lots of shuttle diplomacy between themselves and labor, organized labor, particularly SCIU and AFL-CIO about kind of where they are on these kind of things. And the Governor and legislative leadership meet and try to figure out what's the best way to kind of bridge some of the gaps between labor and management, which is where a lot of this is kind of coming down to.

One other thing I'll mention is that yesterday, it's been kind of in the local papers in California, we are facing a pretty large fiscal crisis in California. Our deficit between the current year and next year looks to be about \$10 billion maybe even substantially north of that. So that's something we have to overcome and luckily our health care reform package is all off budget. It's funded by - you talk about the large prevalence of Federal funding in a lot of these funding schemes. It's also true in California in provider fees,

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employer dollars, employee dollars, et cetera, some county dollars that we currently give to counties for the uninsured; we would kind of pull back for the purpose as well. But still it's going to be challenging for us to sell to the California population. A large expansion of the State's role in covering individuals when we have this large budget deficit, even though it's off budget, but all the same we have this large budget deficit looming at the same time. So we certainly have a fiscal challenge that we didn't quite expect in January that's kind of loomed up large and that we're going to have to deal with in the context as well.

But I certainly thought when we were preparing for this I'd be able to come here and say, "Fantastic," as the Governor says so often [laughter] in terms of where we are. And the Governor, in his genes he's a very optimistic sort of individual, so he really thinks we're going to get there. But the time, the clock is ticking but we keep plugging away and keep narrowing and narrowing the gap. So I think in the next two to three weeks at the latest it's either going to be go or no go. But again, we're working hard and we hope to get it done.

**ALAN WEIL, J.D., M.P.P:** So if I went to Las Vegas and next to the big board on who's going to win the Super Bowl I saw the odds makers for, not whether or not it will pass the ballot initiative a year from now, but just whether there will

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be a bill that the Governor will sign, what would I see up on the screen?

**RICHARD FIGUEROA:** Well we keep saying we're fourth and inches, but we everyday we're on a different part of the field is the problem, Alan [laughter] to use a football analogy. I think the Governor would say it's 100 percent the legislature might put it a little less than that, but not -

**ALAN WEIL, J.D., M.P.P:** The Governor really thinks he's going to get it done.

**RICHARD FIGUEROA:** And he keeps pushing and pushing until he gets stuff done.

**ALAN WEIL, J.D., M.P.P:** Good. So speaking of getting it done in Massachusetts, Jon Kingsdale is responsible for getting it done. We've had reference, obviously, to the Massachusetts experience. Why don't you give a very brief overview of the structure, though I think it's probably familiar to many people here, but your sense of whether, of what you're currently confronting as challenges and how things are going in Massachusetts.

**JON KINGSDALE, PH.D:** I'd be happy to. First of all I just want to continue the analogy to tell Fig that we are definitely rooting for you, for the West Coast team. If we can get the most innovative state, that would be ours, and the largest state, that would be theirs, [laughter] and East and West coast to enact close to universal health insurance, why

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it's virtually a national movement and maybe we can shame the Federal government into doing something as well.

I'll give you a little bit of overview and update. And I really need to take a little time because I've only been here, I got an hour of last night's session and an hour this morning, and have already heard so many mischaracterizations of Massachusetts and so much discussion of Massachusetts that I'm really grateful for the sponsors of this conference to allow me now what is it, the 117<sup>th</sup> day of the conference, ten thousand, nine hundred and forth-seventh session? And we really should give you all an award. I mean with this kind of pluck and determination you're going to get national health insurance one way or another. You're going to outlast, out wait everybody else. So let me do a little overview and some corrections and just very specifically, Diane Rowland is absolutely right. Federal money is totally essential to what we're doing and critical in California. I think it will be to any state efforts. And we're particularly well practiced in Massachusetts at finding Federal money.

David Himmelstein was very entertaining. God if he and Michael Moore ever team up what a movie they could make. But I just have to - for those of you who kind of took what he had to say as gospel, maybe a couple of facts on Massachusetts might help. I was surprised that he described, he actually quantified exactly the penalty at \$2000 dollars. It actually

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hasn't been determined yet. He is wrong on fine ups. I thought it was interesting that he was shredding the for profit sector, but boy it sounded to me like a for profit HMO talking about, gosh, shredding the safety net hospitals. It's all about the money. This is our largest economic sector. He's right, it's about money and the nonprofits as well as the for profits scabble like dogs over every penny. The Dukakis bill of course didn't have much impact because it was overturned two years later. And I do thank David for pointing out that politicians in the United States tend to overstate their accomplishments. That was a revelation to me. [Laughter] And I'm sure you all learned something totally new from that as well. And just one fine point, the Prudential Tower and the Hancock Tower, they were both sold by those companies 10 to 15 years ago. In fact both companies got out of health insurance 10 to 15 years ago for whatever relevance that might have.

Okay, so Massachusetts. Here we have kind of a shared responsibility approach. It's filling in around the existing system which is always messy. So we have individuals mandated to purchase insurance if they can afford it. Actually to be accurate, adults not children mandated. Clearly that's a big burden on them. We have significant taxpayer subsidies for lower income. That is up to \$31,000 a year for a single person, \$62,000 a year for a family of four. That would be 300 percent of FPL for those of you who carry the numbers around in

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your head if they don't have access to Medicare or Medicaid or employer sponsored insurance. So clearly a big taxpayer pick up there. Employers are required to do a fair share contribution, lots of arguments about whether that fair share is really fair. They are also required to do a tax dodge for their employees. That is when the employees have to pay for it themselves to run it through payroll deduction pre-tax. In Massachusetts the average marginal tax rate is 41 percent so that's a 41 percent Federal and State subsidy for people who have to buy insurance themselves. And that's a really clever way to address one of the elements of cost. There's substantial insurance market reform, very threatening frankly to the insurance companies, and very, very successful. I want to describe it in a minute. And then of course this being politics, there's an increase in the Medicaid rates under so-called pay-for-performance. That would be to those safety net providers and to physicians to increase what they're getting from Medicaid. Because if there's one thing that government does really well for sure it's hold down payment rates. We're pretty good at that. Okay.

So how's it going? I would say it's going reasonably well by which I mean as well as one might possibly expect doing something as difficult and challenging and controversial as this is. It is interesting that Massachusetts and instructive did pass universal health insurance once before and then de-

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legislated it. That's how controversial this stuff is. Not in the rest of the world, but in the United States. We have, since beginning to implement health reform in July of 2006, signed up we estimate over 300,000 uninsured are newly insured. That's our estimate for January 1, and 100,000 of those we estimate projecting forward on existing data will be in commercial, private, totally government unsubsidized insurance. And a substantial chunk of the other 200,000 plus will be in partially subsidized, the rest in fully subsidized Medicaid or Commonwealth care. We're about I'd say halfway through implementing this law. It took literally three years of private, public debate, discussion, lobbying, et cetera to enact health reform in Massachusetts in April 2006. We're about 18 months into implementing it and I think it's a three year implementation time table, just as it was a three year enactment time table.

We've been able to find the uninsured. And this is a real contrast with a sort of Canadians or some other system where you're just born into health insurance. We have to actually go out and find the uninsured and there's a whole bunch of them who don't want to be insured to be perfectly blunt. I mean the typical image is somebody who's poor and can't afford it and they're certainly a big part of the problem. There are a whole other bunch of people who can afford it and they get it. This whole thing's a scam. It's to

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subsidize doctors and hospitals and insurance companies and drug companies, et cetera, et cetera, and they don't want no part of it. And then a lot of the uninsured aren't reading the New York Times and listening avidly to PBS or NPR, and so they're hard to find. And one of the reasons we've succeeded in Massachusetts in finding 300,000 plus and we're going to continue, is that we've got a very, very broad sort of civic campaign. So we've got the Red Sox and we've got CBS and Comcast and the T, and Bank America and the Greater Boston Interfaith Organization, 70 churches and synagogues and mosques, and health care for all and the business community, all out trying to support what we're doing. Get the message out. And in the course of doing that we actually find a lot of people who are signing up for WIC and fuel assistance and other programs that they're also eligible for that they didn't know about.

I was just talking to somebody out in Greenfield in the Connecticut Valley. On Saturday we're doing an enrollment event, and they've got a 27 percent uptick in their WIC and fuel assistance sign ups this year because of the outreach we're doing around health insurance. But the point is it's not, you're not born into it and so you actually have a positive step. This is not like going down to you local car dealer and seeing how fast you can get that new baby up to 60. There's nothing fun about buying insurance. The uninsured are

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typically anxious about it to tell you the truth, and so it's a real sales job. And that's my business; I sell health insurance. That's my mission and frankly given our revenue and all, that's my margin.

So maybe some lessons learned if and when California gets ready to do it about how to find their six million uninsured. I can't believe - it's going to be huge. I mentioned non-group reform. So successful sign ups. Non-group reform is one of the unheralded but most important, and I get excited because I'm a technician, successes of Massachusetts. If you're going to mandate people to have health insurance while most people get it through their employer, you have to have a functioning way, market for them to buy it on their own. The non-group market is typically dysfunctional by which I mean there's the California model where you can get it cheap but if you get a pimple they take it away from you or double the price of your policy, medical underwriting and so forth. Or Massachusetts pre-reform guaranteed issue, guaranteed renewal, but then the insurers price it only to the sick because everybody else can get it when they need it. Only the sick buy it.

So the typical uninsured Massachusettsian [misspelled?] was a male, that's important. Fifty-seven percent of the uninsured are male and they do think by and large insurance is for sissies. I'm not kidding. I mean we've done the focus

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groups. This is really a marketing outreach effort. They get that something could fall on them, well on their buddy not on them, but they do not believe in chronic illness. That's what women get. I'm serious. They do not believe this is going to happen to them. This is the young and the middle age paunchy invincibles. [Laughter] Anyway, so a typical uninsured individual would be a 37-year-old Bostonian could buy health insurance on April 1, 2007, was \$335 a month. Now think about this, 37 years old. These are on average healthy people, \$335 a month, \$5m000 deductible, no drug coverage, okay, not a good value. Not anything close to what you get with group insurance which might be seen as a market standard of a functioning market. So we did a whole bunch of things and as a result on July 1, 2007, after implementing reform, we offered - Oh, and there were three products available to this guy and you had to call the insurance company and wait 20 minutes to get somebody because they didn't want to sell it to you because even at those prices they're going to lose money on it. So July 1 you had a choice of 42 different options displayed, just call us up or get on our website, and that same 37-year-old Bostonian could pay \$184 which is a lot, about 55 percent of \$335 for a policy that has a \$2,000 deductible, a lot, but 40 percent of a \$5,000 deductible. Full drug coverage, full ER and office visit coverage before the deductible, so literally half the price and twice the benefits. That's a good thing.

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Public support is absolutely key. The democratic legislature went along with Governor Dukakis' presidential ambitions and did the universal health insurance thing against the business community wishes. They then undid it. We got zero out of it basically very little. This passed with all 40 Senators voting for it, all but two Representatives voting for it, and of course they're all Democrats virtually, a Republican Governor and a Republican administration in Washington supporting it. You don't want to refinance the 16 percent of our GNP. Sixteen percent of our GNP on a one to 49 vote. You just don't want to do it. I mean I could not do my job if that's the way it had worked out in Massachusetts. But the legislature in its wisdom did create a great framework and then they bucked to my connector organization, our board, which is fully representative of the full political spectrum in Massachusetts. All the way from the Senate to the far left. [Laughter] They did buck to us the sort of second tier tear 'em apart kind of issues like, what is the minimum insurance package people have to have and what do you mean by affordability and those kind of things. And while we were doing those controversial issues support for reform went from 61 to 20 percent of likely voters, 20 percent opposed in September of '06, to 67 percent in favor 16 percent opposed in June of 2007. Four to one. That is so important. Our board which is representative of the political spectrum in

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Massachusetts has voted unanimously on all those major contentious issues including business, the actuaries, the economists. We have over 90 percent awareness. Even a majority of employers in a November-released Kaiser poll support reform, so I say it's going reasonably well but there are huge bumps ahead of us. And maybe I should stop and we can talk about bumps if you want to.

**ALAN WEIL, J.D., M.P.P.:** It's good to stop before you get to the bump. Ray from where you sit, you are surrounded at the front of the room by states that are moving or trying very hard to move on this issue, but you represent Governors of all 50 States. What's your sense of whether or not States in general are up to the task of moving this issue forward? Or are you sitting amongst outliers here or is this the movement that's about to sweep the country?

**RAYMOND SCHEPPACH, PH.D.:** Well personally I think the movement will continue and it's interesting. I think when Clinton was elected last time there was a lot of state action that virtually stopped and the pendulum swung to Washington. I don't think there's as much hope out there now so I think it's going to be very different. My sense is that incremental changes will continue in the states, irrespective of what happens here. I would however say that I think that the financial underpinning is going to get a lot weaker. Basically fiscally we had a good run really from the 2002 downturn.

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We've had revenue growth at the state level in the high single to low double digit. Over this period of time states have built balances up 10, 11, 12 percent so it's been a good time, but this sub-prime thing is beginning to hit states now. Sales tax revenues particularly are down because when people upscale to bigger houses they tend to buy new furniture and curtains and rugs and so on, plus people have been pulling a half a trillion dollars out of their home equity every year for the last four or five years and spending half of it which is essentially gone. So we're already seeing the housing bubble and I'd probably prefer to be in Massachusetts as to California going forward on that issue because it's really hitting four states particularly hard: California, Nevada, Arizona, Florida. But it's also impact in places like Ohio and Michigan in combination with the auto industry. So the real issue here is whether we fall into a recession or not. And economists are saying 40 percent odds. Well being an economist, that translates with me into about 75 to 80 percent odds [laughter] because nobody wants to say we're going to have a recession.

To say there's any good news; however, there is some offsetting value of dollars down quite a bit which is helping some farm states, some other manufacturing states. The price of oil is up. That squeezes some states but it creates severance tax revenues for some others, so we're seeing more differential this time. That although I think we're going to

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continue down in terms of revenue growth in the aggregate, some of the states are actually going to end up a little bit better off. But I think in terms of moving forward again it's primarily the New England states, states along the Canadian border that have the high coverage rates now. California I think is somewhat unique given their undocumented problem and the real size of their uninsured to sort of get from here to there.

**ALAN WEIL, J.D., M.P.P:** So let me take it back to California and ask, Jon says you don't want to restructure a seventh of the economy 51, 49, and Fig you said there are no Republican votes for the reform, are you setting yourselves up even if you can get it through this stage for failure down the way as the tough decision have to be made? Or is California more able to pull things off on that kind of slender margin than Massachusetts?

**RICHARD FIGUEROA:** Hopefully yes. There are a few things that we've tried to do I think which will hopefully kind of get us through this. One is, and Jon kind of referenced it a little bit, the nature or the level of support for health care reform in Massachusetts. It's probably about 70 percent or so in California? Even though some of the elected officials on the left would rather be single payer and some of the elected officials on the right would rather you just use market-based kinds of things, there's a very large middle of

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moderate Republicans and we have a very large Independent group in California like 20 percent of our electorate, and the Dems. So between the Democrats and the Independents that's already about two-thirds of the electorate or more in California. So he's working from a pretty good base of folks that want to get something done. We had about, I don't know about 1,000 pre-meetings before the Governor ever put out his proposal and for other states that are looking to do this it's one of the things you really want to do is touch base very broadly with the widest possible community of groups both left and right, and kind of incorporate different elements of what they want in there which is kind of what we did because it certainly helps us later on.

We've been trying to put together a pretty sizeable coalition of the willing which includes provider groups who for the first time in 30 years would see a pretty sizeable increase in their Medicaid rate both in the hospital and the physician side. All the major insurers except for one are willing to do more than they have been willing to before in the individual market for example the big steps being WellPoint, to some extent because at the end of the road they see large amount of covered individuals which they would also serve. And again because the volume of people is so large in California who we'd be covering, there's a big group of dollars and people associated with that with all these new insureds. A lot of the

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business groups are pretty moderate in their view to provide full coverage of folks and see some difference between the way they compete and the way others compete when they don't offer coverage. So you have certain elements of the business community that are willing to go along with this.

Labor generally wants more folks covered, but they have different polls on them that maybe other organizations, given that they have to negotiate for rates and there's different groups within labor that have different views on this stuff, but again you have to bring labor along. And then consumer groups who in the end are going to be much of your public face going down the road. And trying to explain to the public why this is a good thing you want trusted names and trusted groups out there. You probably need some element of bipartisanship and the Governor gets teased a lot about bipartisanship meaning him as a sole Republican Governor and the Democratic legislature. And so he gets teased a bunch about that but I do think you need some element of bipartisanship to be successful in this. And then you probably need to have built into this kind of a continued open process to reach consensus on key elements.

We're kind of going down the same path that Massachusetts did about punting about what the minimum coverage would be, punting what affordability exemptions would be, even punting some of the quality and cost containment stuff to an

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advisory committee or some organized group that would have public hearings. I think all those things have led to there being still a pretty good reservoir of good will and good faith bargaining about how to get to a place. Again you are going to have to do some things differently if you go to a public plebiscite basically about up or down this thing than you would if it was just the legislature passing it. But again I think the steps we've taken to be as inclusive as possible and for lack of a better term kind of punting on some of these other issues that might be really, really delicate or might create rain or black clouds on the horizon in terms of initially, I think in the end as soon as we're able to pass this it will lead to a very positive conclusion in November.

**ALAN WEIL, J.D., M.P.P:** So part of your response is basically don't just look at the votes in the legislature as a measure of bipartisanship or breadth of support. There are lots of other ways to do that and particularly depending when you take a state with the political history that California does and the way the districts have been designed, that the legislative composition may not be a great reflection. I do want to note that I too, when I read the Massachusetts statute initially used the term punt as the way to characterize these tough decisions, but over time have come to really appreciate that it was not a punt in the sense of we can't deal with this someone else better, but a notion that there are issues that

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the system needs to be more responsive than the legislative process can be. And that if you fix things in statute and it doesn't look quite right you're waiting a long time and you've got to fight all these battles over and over again to repair them and there's an opportunity in an administrative process to move things along more quickly. I worry though whether or not in a ballot initiative that people understand that the same way they would a legislative process.

Jon, I'm going to let you off the hooks on the bumps in the road because I want to sort of do one last round of questions and see what folks out here want to bring up. You mentioned of course, and it always comes up in these discussions, the role of Federal money, the expiring Medicaid waiver that sort of forced the states hand in thinking about a new plan, but what other interactions do you have or does the state's plan have with the Federal government? What are you getting in terms of Federal support in addition to just dollars through the waiver? What barriers do you run up against that you feel come from the Federal government or are you pretty much doing this and they're just, they are on the side?

**JON KINGSDALE, PH.D:** I actually think you got it right at the end of the question. We have one condition, I believe, in the, two conditions in the specific to our program in the Federal and the Medicaid waiver. One is we adhere to actuarially sound rate and bid process and so forth for the

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Federally-subsidized plans and the second is that those plans try to get license, some of them are not actually licensed commercial insurers. We're trying to work that out now. But other than that we have a pretty free hand except that we are - and I know some of the folks from the Feds are here so, I think, let me put it this way. I think I haven't seen a lot of negative interference. I think it's a great relationship with all the folks at CMS who I adore. [Laughter]

**ALAN WEIL, J.D., M.P.P:** That goes without saying.

**JON KINGSDALE, PH.D:** No, but seriously I think that they've been very supportive and fairly hands off but obviously very interested in following us and looking for information. I do want to comment if I might on your prior statement about the legislature. And I'll illustrate it with something I hear over and over and over again. Don't bring this legislation back to us. It's brutal. And it is not flexible. I mean there may be health reform two in another couple of years and there are some technical amendments that go along, but by contrast it's an incredible policy solvent for our board to be able to say, "You know what? We have to make a decision. We think we're setting affordability standards right but let's revisit it every year and we'll have more information next year." If you do that in a legislature it's like every year gear up for lobbying and get all your money and get all of your political support geared up because you have another go at the legislature. And the

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difference between that and the way we operate is really an important element of flexibility.

**ALAN WEIL, J.D., M.P.P:** Well, and you shifted the free enrollment threshold from 100 percent of poverty to 150 percent of poverty, something that could have taken years in a legislative process. Maybe we would get a different answer to the Federal question if we were talking to the Medicaid agency, but I think it is interesting to note that it is possible in your state with a relatively positive relationship with the Federal government to view this as largely you're doing what you need to do and aside from the money which is not a small issue. Your fate is largely in your hands.

**JON KINGSDALE, PH.D:** I would add that, and it is again David Himmelstein was incorrect, we have to reapply every few years for the Medicaid waiver. So we're now in the process of doing that and that will be another major check point with the Feds.

**ALAN WEIL, J.D., M.P.P:** And Ray, when you think about the governors' policies with respect to Medicaid and coverage, money does always come up first, but what else are the governors' looking for in a relationship with the Federal government to try to keep this issue moving forward?

**RAYMOND SCHEPPACH, PH.D.:** Well I think there's a number of things of what I would call kind of the infrastructure. We're still lagging in health IT in terms of

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the standards that are necessary. What you find is an inability to move forward. I think that beginning to move more on the E-Prescription, but the other components of it, and I think that in the long run because I think it would produce a very good data base and probably so-called evidence-based medicine quite a bit if we move on that. So I think that's important. I think quality standards are important. Personally I think much more price cost transparency that the Federal government could state would be a plus. So all of those and then I think the other piece is funding. You know I was actually hoping that there would be a political compromise this time which would have been an expansion of SCHIP coupled with tax credits for families where states, a lot of states would enough money on the table to sort of move forward. Unfortunately it didn't happen now so you're not going to see a lot more coverage. I don't think any states are going to monitor and things, but I would hope that every time the Federal government has stepped up to the plate previously my attitude is that they want to do too much. And the way I really see it is Federal government provide the infrastructure and the funding, let states go and implement it, recognizing the fact that they're going to have to come back again where you're actually going to have to necessitate uniformity in a number of areas and do that as a third step. Unfortunately I

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think they're going to want to do it on the front end which means it will probably fail.

**ALAN WEIL, J.D., M.P.P:** Well on that encouraging note let's open up to the audience and the keepers of the microphone can span out.

**CHERYL MATTHIAS:** Good morning. Cheryl Matthias with AARP. I just can't help but take a moment to commend the two states that are up here and I would add Vermont to that list. We at AARP have decided very intentionally to work on state health care reform, and for the reasons that have been expressed up here. Somebody has to roll up their sleeves. Somebody has to slog through the issues. Somebody has to figure out where the problems are and how to resolve them. And these will show evidence of what works and what doesn't work in different states and everything that's accomplished here, many of those things are things people thought couldn't be accomplished. I mean the discussion about how the premiums in Massachusetts magically, with a lot of rolling up sleeves and hard work went down. I mean whether we're going to get to an agreement in California and even though we're going to have to deal with the initiative next year, these are really, really important movements and you see results that you don't expect. And that's I think something that, you know there's a lot of talk over the last couple days at this meeting and some of it very altruistic and impassioned, but the bottom line is you

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make progress when people roll their sleeves up and start just slogging through all the boring issues.

**ALAN WEIL, J.D., M.P.P:** Thank you for that comment. I would just say two things. One, please add Maine to your list of states that you want to congratulate for rolling up their sleeves. And the other is there's a tremendous amount of thought and action and energy on this issue and a lot of states that are not quite as far as these. And that should be acknowledged because that's actually even a lot less fun to do this when you don't have a law in place or you aren't sure you're going to get anything done than after you have it. But I appreciate that comment.

**KEN TERRY:** Yes, Ken Terry from "Medical Economics" magazine and I wanted to know what Massachusetts is going to do about the \$150 million shortfall it already has in funding the subsidies for its universal insurance? And also what plan do you have for the increasing cost of health care in the future? Is the guy who's got a \$2000 deductible plan now going to have a \$3,000 deductible plan?

**JON KINGSDALE, PH.D:** Sure. Well I want to correct the way you characterized the \$150 million. And it could be more than \$150 million. So listen, because this is going to require more than a sound bite. We had somewhere between 372,000 and 600,000 uninsured. I told you they're not always fully plugged in to every outlet in our society. Some are 20 year old kids

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trying to decide if they're going to stay in Massachusetts next month, you know, blah, blah, blah. So we had an estimate based on official state survey data which was at the low end of that range and we had a budget projection based on enrollment. We're doing a great job. We're enrolling more people than we expected, partly because we've got a tremendous outreach campaign, and probably partly because we used too low an estimate of the size of the problem, the number of uninsured. So we have a budget appropriation that was based on those estimates. That budget appropriation will go up through a supplemental appropriation if it turns out we need more money. That's the value of having virtually unanimous support for a really important initiative. Because you succeed you don't get punched in the face because you're helping more people. Our cost per individual is actually slightly below budget. So for all intents and purposes we're right on budget there and great news: we're insuring more people than we thought we would at this point in the three year roll out. So yeah, if it turns out, and we're still trying to figure it out, it's a couple more months, did we peak earlier and it's going to flatten out? Probably not, it's still possible. Is it going to end up year end more people than we anticipated? Likely, if it does there'll be more appropriations for that which is shared 50/50 with the state and the Feds.

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Your second question was about cost trends. So that's one of the big barriers. That's one of the big bumps in the road coming. What are you going to do about that double digit inflation that we seem to have annually in the cost of health care? And we've been very aggressive in messaging to the health plans about trying to get that rate of increase down. I want to be sure you all understand that rate of increase down. Nobody in their right mind actually talks about actually reduction in the cost of care. But we're sort of in a dialogue here in Massachusetts that's unique. We actually have all the parties who contribute to that problem, and it's by no means just those health insurance companies. In fact to return to David's theme, all of ours are nonprofit. That doesn't let them off the hook, but they're all nonprofit. But 86 to 88 percent of their premium dollars go right out the door to hospitals and physicians and drug companies et cetera, and frankly our drug trend is way down. It's down to about five percent. It's basically inpatient and hospital-based outpatient care that's driving the cost increases in Massachusetts. Those folks are very supportive of reform. Some are very nervous about their safety net dollars, but they're basically supportive. And they're now talking to each other about, how do we sustain this thing? Because when I go around the state and say this is not sustainable if we continue with double digit inflation, they all nod yes. They get it.

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So this is a whole new dialogue. You know we have cost control in the United States as follows. Every year we throw a couple million more people on the uninsured rolls. And in a recession we throw five million on the uninsured roll, you know even more on the uninsured rolls. And that's our form of cost containment. That's literally what happens. Small business in particular and individuals say, "I just can't take 20 percent rate increases. I'm doing away with insurance or I'm not offering it." So what we're doing in Massachusetts is we're getting everybody into the tent, we're going to fold down the flaps. Throwing people on uninsurance would be admitting defeat, and we're going to say now let's have a serious dialogue about the two things we can do. Pay a little bit more and moderate the rate at which it increases. And you know David Himmelstein is right about a lot of things. This is about people's take home money. This is about how much we in the health care sector get. We get for example four times more per inpatient acute care day than the average of the ten a week OECD countries. We get more than three times as much per hospital acute care stay as the average in the OECD. And it's not those 381 billers [misspelled?] that are a part of it. You walk around a European hospital and it's amazing how shabbily the CEOs are dressed. [Laughter] It's about people's income. That's a very, very difficult conversation to have here in the

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United States. We're going to have that conversation in Massachusetts. [Applause]

**ANN COHEN:** Hi my name is Ann Cohen [misspelled?], and I'm a discipline and palsy consultant and actually my question is regarding the safety net. We heard a little earlier that it's been an issue in Massachusetts, shifting DISH [misspelled?] funds from public hospitals. Can you address that? And for which I'm sorry, I know in California this is a political questions, but I know it was a big controversy when we looked at expanding Medicaid managed care around the impact on public hospitals. Can you address how the hospitals are reacting right now regarding health without the reform? And for the Governors Association what recommendations would you make to the Feds regarding restructuring DISH [misspelled?] in the future as we look to expand programs for the uninsured?

**JON KINGSDALE, PH.D:** I think there's a rule of only two, so I'm going to yield to you. Only two questions per questioner, is that right?

**RICHARD FIGUEROA:** Do you want me to go first or what?

**RAYMOND SCHEPPACH, PH.D.:** Go ahead, I didn't get that.

**RICHARD FIGUEROA:** Just real quickly, the Governor has a strong kind of safety net. One of the things that the safety net, and particularly public hospitals has been concerned about is below 100 percent population, the childless adults very low income, homeless male, et cetera, are they going to be kind of

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moved into a managed care setting which is the predominant means by which our Medicaid beneficiaries receive coverage? What they have suggested instead is that basically individuals that are below 100 percent of the Federal poverty level be under their sole purview. They'd basically in a kind of a county based system where basically they wouldn't have access to anything other than a network that the county itself would put together. So basically the county would control dollar for that individual, for those individuals, so that's kind of what we've been talking about with public hospitals with our county hospital system. Obviously the labor organizations are very interested in that as well because that's kind of their bread and butter I some areas is serving as the major labor component of the public safety net system. So that's one of the issues we've been working out. I think the Governor in general would like to have folks irregardless of where they are in the income spectrum, have wide access to a wide variety of organizations and networks and health plans and county-based systems, but at the same time we have to deal with the reality of the politics in California and elsewhere. So we are in active discussions with the public safety net hospitals about giving them exclusive purview of at least the group that is directly under 100 percent of the poverty level which is kind of the group they serve right now, albeit on a charity care or non-subsidized basis.

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**RAYMOND SCHEPPACH, PH.D.:** I'll just say quickly, the last 10 or 15 years there's been a number of proposals to change this. We basically have supported through keeping it the way DISH is. When the administration came out with this proposal we did not support it, but we did not oppose it because there may be some individual governors who may be interested in it. Although we went through and looked at a quick calculation of the number of uninsured in states with high DISH and it seemed to us the proposal probably wouldn't help more than about three states.

**JON KINGSDALE, PH.D.:** Yeah, and I'll talk with you afterwards, okay?

**ALAN WEIL, J.D., M.P.P.:** Room for one more quick question? We can actually all take a breath before Jacob comes up and . . . Well there is one. It's under the lights so I couldn't see, but we'll make this the last question.

**BETH MCCARTHY:** Hi, it's Beth McCarthy of Families U.S.A. We're at a conference on underinsured and so Richard this question's directed to you. You've done a lot of great things with this proposal. It's got private market reform, public program expansions as we talked about, but there's very few protections for people who are underinsured and will be required to acquire coverage under the individual mandate. Can you talk about why the Governor's been resistant to include protections for consumers?

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**RIGHARD FIGUEROA:** I'm not exactly sure, you mean by protections, like affordability protection? Okay. One of the things the Governor has been very adamant about is trying to get everybody under the same tent. And the way that he's tried to do that is through the individual mandate. That's such a lynchpin because from that kind of flows what we believe is the major cost containment feature of our proposal which is getting rid of the hidden tax. And people call it different things, but it's basically the tax that all the people that do have coverage pay on behalf of those who don't have coverage whether it's two percent or 10 percent or 20 percent or 30 percent, it's really there. So he has been very reluctant to really do any affordability exemption whatsoever. What he has been doing instead is trying to figure out how broad and how high the subsidies can go to get everybody kind of in the tent. So it's been a kind of a key feature for him. It's obviously an issue of contention currently and will continue to be until we reach some kind of resolution. But it really comes from a place of trying to reduce the hidden tax which has been kind of a major key element to keep the business community on board because they know they're bearing the brunt of that. It's been such a key constituency that's been a major element. He also really, and he comes from I don't know because he comes from Austria and they're kind of born into care really finds it difficult to accept that insurers can deny people based on previous medical

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conditions. That's very difficult for him to accept and so he'd like to get the guarantee issue and he knows the best way to do that is to do an individual mandate, have everybody in because then the insurers are willing to play as well. And we have some relative degree of acceptability in the population that if everybody's in there hopefully you'll have a good risk mix and so then you won't have large spikes or increases over time. So it's driven by a number of different factors. In the end we may be doing something on the affordability side, but it's really driven by trying to get everybody in the tent and trying to reduce the hidden tax, and his interest in doing guaranteed issue which requires a real good mix risk in the population.

**ALAN WEIL, J.D., M.P.P:** So let me just close by echoing something Ray said earlier. When President Clinton proposed health reform it really took the wind out of the sails of state efforts because I think there was such a sense that it was going to happen. Maybe this time there was a little more skepticism and the states are a little bit earlier on the upslope of reform, so please continue to watch these states and others as they take on these issues. And please join me in thanking our panelists this morning. [Applause]

**PETER GRANT:** And thanks to Alan for his moderation. And thanks to you for staying here for this kind of war of attrition of 170 speakers, and thanks to Jacob Hacker who's so

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generously come to end this. I'm a little disappointed we didn't get him here earlier because he's one of just a number of superb speakers who's joined the faculty. Jacob is a professor of political science and a resident fellow at the Institute for Social and Policy Studies at Yale. He's a fellow at the New American Foundation. His most recent book, which he will be signing following his presentation out front, is "The Great Risk Shift: The Assault on American Jobs, Families, Health Care and Retirement and How You Can Fight Back." He's written a number of other books as well. One of which is "The Right To Know: The Genesis of President Clinton's Plan For Health Security." Jacob.

**JACOB HACKER, PH.D.:** Well thank you so much for having me. Let me just pull my presentation up. There it is. Great. I'm delighted to be here. I want to thank Peter for that introduction and Vivian Mayer [misspelled?] for arranging my visit. It's certainly, as this conference has shown, a time of great ferment on these issues and I think the relevant question with which to end this conference is should be expect that serious action is going to happen particularly at the national level? I have some trepidation about answering this question because I stand between you and the exit to this conference. [Laughter] I'm very pleased that you've had the endurance to stay on and I hope I can keep this relatively light. Given the subject I'm afraid there may be a little bit of departure from

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that, but I've also had a bit of a taste of the experience to hardy audiences who are staring at the exit.

I was on a book tour this year for my book, "The Great Risk Shift" which as Peter mentioned I'll be signing after this and a book tour is an experience that most academic authors don't usually get to have. And there's a reason why most academic author don't get to have such an experience as I learned on the road. I was preceding at most of my stops Barack Obama who would attract adoring crowds, throngs, people literally crying trying to get a hold of him and his book. Thousands of his books as it turned out. And in fact I went and did an event at which Barack Obama had been the speaker the week before and "Lemony Snicket" was coming the next week, so I kind of felt like I fit right in. And I had some really wonderful experiences. One of them was I went to my hometown of Portland. I went to Howe's [misspelled?] book store. We had a nice audience. People were into the book. My parent threw a few softball questions out from the audience and it was great all around. It was sort of what I would envision a book tour for a modestly famous author would be like. Then I had a somewhat less sunny experience, no pun intended. I went up to Seattle and I went to a place called the Town Hall Forum. Now the Tall Hall Forum is this Seattle institution where they host events for authors and musicians and the like. And as I got there, there was a huge crowd milling outside. It was pretty

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exciting and I was starting to feel a little nervous. I had not expected a massive audience. In fact I could hear the crowd coming inside the auditorium, this sort of pent-up excitement and demand and there were people outside, maybe 200 people outside just waiting to get in. So I just kind of pushed through the crowd expecting at any moment people going, "It's Jacob Hacker," and then, you know, maybe screaming like in a Beatles movie. But in any case I got to the door and to the right of the entrance there was a little sign which I had to peer over to read. And it said, "If you're here for Professor Hacker's talk he'll be in the basement." [Laughter] So in fact it was not me whom the adoring crowds were waiting to hear from, it was this man, Ed Viesturs. Ed Viesturs, for those of you who don't know, has climbed all the major peaks in the world without supplemental oxygen. And although I told the 12 assembled people downstairs that I've written all my books without supplemental oxygen, needless to say that was not particularly exciting.

And indeed, I don't think the exploits of academics don't really get people that excited. I'm reminded of one of the first evaluation I got as a new assistant professor and it started quite promisingly. It said, "Professor Hacker, if I had just 15 minutes to live I'd want to spend it in your class because then that way it would seem like an hour." [Laughter] So needless to say we're not the most exciting lot.

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So what I want to do is speak for about 20 minutes, a little bit less now, and take some questions and I'll try to make it seem like 15 or 20 minutes, and I like this picture which I've been using sort of when I talk about my book because it of course expresses very vividly the idea of risk. And the risks that I've been talking about in my book tour and giving talks about my book is increasing economic risks that families are facing as more and more of the responsibilities that were once borne by government and employers, particularly in health care, has shifted onto the fragile finances of American middle class families. But there's another kind of risk we can talk about and that is political risk because in a way Ed Viesturs has it good compared with American health reformers. They are in a sense scaling the Mount Everest of American domestic policy challenges and they may well find themselves over a crevasse much deeper with much less in the way of support. You know the failure of health care reform in the United States is about as American as apple pie. It's been roughly 100 years of 15 year intervals between defeat. In the progressive era health care reform campaigns went down in flames at the State level, roughly in the late 1910's. FDR briefly entered the fray in the 1930's and backed down because of the opposition of the AMA. When he backed down Harry Truman later picked up the charge and of course promptly ran headlong into the concerted opposition of conservatives and doctors. And his defeat in the

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late 1940's was probably the sort of necessary condition for the one big victory of reformers in the 1960's with Medicare in 1965. Because of course the Medicare strategy was born out of that defeat, and I'll overturn this analogy in a moment. And as a consolation I guess for Truman's defeat, he was the first enrollee in Medicare Part B, so maybe President Clinton should start looking forward to something.

But of course after Medicare passed there was a widespread sense that this would be the stepping stone to universal health insurance, and all those efforts ran aground in the late 1970's until 15 years later almost to a year, the Clinton health plan was born and died. So we're looking right now on the 15 year cycle at a major national debate about health care next year. And the question we should be asking is should we expect anything to be different than it was the last six or seven times around? Is there any reason to think the present moment is sufficiently more auspicious? And I think more useful to you, is there anything we can take away from this dismal history of past defeats and particularly the failure of the Clinton health plan, about what might make the prospects for change better today than in the past?

Now I have one big point. And it's taken me a little while to get to it, and it is that although we are all for the most part health policy wonks, we read health affairs, we love to talk about the billions that will be saved doing this and

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the fine-tuning of mandates and the like, the bottom line is that health care reform is about politics. If real estate is about location, location, location, health care reform is about politics, politics, and politics. And the failure of the Clinton health plan is a vivid reminder of that. Now of course the Clinton health reformers were scarcely ignorant of politics. In fact they had an intricate political strategy that was embodied in the very proposal they put forward, but this strategy placed policy development ahead of coalition building. It placed bridging elite disagreement over what the best model was ahead of real political compromise and building a broad movement for change. And of course the plan itself was a bright bull's-eye on the Clinton white house during an era of increasingly parlimentarized [misspelled?] partisan conflict for which the White House seemed grossly ill prepared. So while the architects believed they were building a bridge to compromise, they actually ended up burning the bridges behind them.

So the question is can it be different this time, and I believe strongly that it can if we learn some of the right lessons from the past. And here it's helpful to go back to the mottos that were taped on the war room wall when President Clinton was running for office. They were the economy stupid. If you remember it was, "It's the economy stupid." Don't forget health care and "Change versus more of the same." So

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with apologies to James Carville, here's what I see as the three big mottos for the health reform war room, "The politics, stupid," "Don't forget fear," and "Change politics versus more of the same." So what do I mean by that? Well first the politics stupid. This is the point I've already made but it is crucial. Health care reform is ultimately a problem of building political support for dramatic change in a governing system that's designed to prevent it and indeed, as I'll note in a moment, has become in some ways more hostile to large-scale change than ever.

Now it's easy to criticize Clinton and his allies for some of the moves they made, you know, the plan was too complex, they moved too slowly, they failed to build a coalition until fairly late in the game, they focused heavily on an in-house policy that ended up mobilizing conservatives who were bent on taking down not just the plan but the Clinton White House. But I think we should recognize or ask why did people who are so smart, and they clearly were smart, get the politics so wrong? And to me the answer really is ultimately a fixation on policy analysis over political thinking. Indeed if you think about it, the unwieldy moniker that was the health plan, managed competition within a budget, kind of says it all. It says that the plan's real goal was to bridge the elite divide over competing reform visions. Visions that all shared the underlying commitment and assumptions about the need for

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and value of technically minded policy analysis. Because in policy analytic terms the Clinton health plan was really a tour de force. It envisioned the comprehensive restructuring of the entire vast architecture of America's medical industrial complex.

Let's go down the list. Existing employer-based health plans? Well clearly these were inadequate and destructive of the delicate incentives that the plan envisioned, so basically the Clinton administration figured that only the largest of employers would be allowed to provide coverage directly. There wasn't a platform for incentivized consumer choice. Well, let's build it in the form of so-called health alliances and the plans will come. And the plans themselves? Well HMOs and other technically managed health plans were the wave of the future they reasoned, and therefore they should be the centerpiece of the reform however much fear or dislocation that might provoke. You know, Medicare's architect, Wilbur Cohen once said that health reform was one percent inspiration and 99 percent implementation. If you look at the choices the Clinton reformers made, it was about 99 percent inspiration and not much thinking about the political and the institutional realities that they were to eventually face.

There's a quote that I think sums this up quite wonderfully. And it's from the task force papers that were released in response to the lawsuit against the Clinton White

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House. It's from Walter Zelman, and I don't mean to pick on him, but this was what he wrote in March of 1993. So while the Clinton task force was undertaking its work. Now what's really notable here is you see is the sense in which the plan itself is the political breakthrough. And in that sense I think we have to have a sharp break from the assumptions of the Clinton reformers in the sense that our goal is not, the goal of reformers should not be to resolve a lead-level disagreements over competing policy models. It should be to think about how to come up with a set of options that can really navigate the difficult political waters that reformers will inevitably face. And that's going to bring me to my two next points.

So the next point I said should be on the health reform war room is, "Don't forget fear," and this is often summed up as the Harry and Louise problem, but I think it's a deeper problem than that. In fact the Harry and Louise ads were, as I painfully show in my book, the road to nowhere. Not a particularly attack. They summed up a bunch of critiques of the plan that were very effective in shaping public views of it. So what are the fears we're talking about? Well fear number one is that good employment-based coverage will be destroyed. And fear number two is that government and in particular taxes will expand. And those are the fears that reformers have to worry about and they should be at the center of any thinking about what kind of reform plan to pursue and

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how to pursue it. After all, as I said, this is not the first we've had this debate. Again and again reformers have sought to bring the United States into the company of nations that make health insurance a right of citizenship rather than an element of employment, an entitlement of old age, and a grudgingly provided safety net for the poor. But again and again they have run headlong into a central reality that the United States' heavy reliance on employer-provided workplace health insurance means that many Americans see reform as providing less but paying more. Now I want to be clear that we've seen, and as we've learned over the last few days, a dramatic erosion in this employment-based system. One that is well-captured by the long-term decline in own employer coverage over the last 30 years, but it's still the case that Americans can be easily scared into thinking that their coverage will be destroyed, they'll be forced to pay more. Moreover it's easy when we start to talk about it to forget that financing reform is ultimately a matter of politics and taxes in particular. And taxes are politically challenging even under the best of circumstances.

So when the rhetoric heats up reformers are going to have to fight fear with fear. The fear of losing coverage against the fear of government, the fear of medical bankruptcy and debt against the fear of taxes, but they're also going to have to be able to fight fear with hope. With a clear, simple

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and unthreatening vision that builds on what exists and meets public concerns head on, a vision that may lack the intellectual satisfaction of a fine-tuned policy blueprint, but which provides the political satisfaction of actually having a chance of passage. Now I think there's some evidence the reformers have taken this message to heart, though simplicity and clarity still remain pretty elusive in the discussion. For example in announcing the reform plans in 2007 as we learned this morning, all the top tier democratic candidates were basically, let me just skip this one, all the top tier democratic candidates were basically adorst [misspelled?] at something very similar, which would include some kind of new insurance pool that would include a choice of public and private health plans but with an emphasis including a public insurance modeled after Medicare. This would include some kind of shared financing requirement with employers either being required to pay or play and finally these proposals would all have some either eventually or immediately have some kind of mandate. And the Obama plan of course only applies to kids, but even Obama has said that he would consider a mandate on individuals in the long term.

Now I think this approach lacks much in terms of conceptual and policy clarity or the inspiration that David Himmelstein provided us earlier today about the sort of large scale reforms we need, but it does have some pretty big

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political virtues. And I should say I guess in the interests of full disclosure that I've been peddling an idea largely along these lines for the last few years. For one thing it means that the vast majority of people who now have private health insurance coverage through their employer would continue to have it. Here is the estimate of the effect the proposal that I've put out, which basically has these three elements. Here's the current system which you know well. About 60 percent of non-elderly Americans have private employment-based coverage and about 20 percent, sadly, are uninsured with Medicaid and SCHIP picking up a substantial of the population as well. Now if my plan was implemented yesterday, thankfully the numbers would look more like this. And this proposal has a six percent payroll-based contribution. So employers either have to provide coverage or they pay six percent into the new health care for America plan as I call it. So there is some shuffling but the fact is that we're moving from a world in which 60 percent of non-elderly Americans have employment-based coverage to a world in which in which half do, which is not nearly as radical a change as moving toward a true Medicare for all system. At the same time you're also not having to raise nearly as much in the way of new tax financing to fund the system. The numbers are very preliminary here, but the net Federal costs of this plan are probably on the order of \$40 billion, which is remarkably low. And even if you came up with

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subsidies for low wage employers or small employers, you could do it for an amount that would be about what we spent on the Medicare Prescription Drug Benefit last year, which is \$50 billion.

And finally, and this is not to be underestimated and I think it's been missed a bit in the debate, this public insurance plan component of it, the fact that if you're in the health care for America pool or the public pool that people are talking about, you would be able to choose a Medicare-like plan, does create a politically possible of moving over time toward a greater role for public insurance for Medicare-like coverage, which I think is the right direction to move for a variety of reasons. So if employers continue to retreat from private coverage, if private costs continue to rise much faster than public spending then over time more and more Americans will come to be within the large public plan which I think is good. And it would happen without some of the massive disruptions that would be entailed by an overnight transformation to such a system.

So this somewhat runs against the grain of what I said up front about policy. I must admit I'm a policy wonk. So I want to end by saying that obviously finding a policy that will minimize public fears and get us where we want is only part of the battle, and indeed a small part of the battle. The bigger challenge is to build a coalition that can engage Americans

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constructively in this struggle while pressing leaders to act. And that I'm afraid means coming to grips with the transformed world of American politics that stymied the Clinton health plan. Because the battle over President Clinton's health plan really occurred on the transition on the fault line between two political worlds. The first world is the one that we still talk about in wistful terms, the world of bipartisan compromise, often behind closed doors. This world rested on the continuing of presence of moderates both Republican and Democratic who in the era of divided government usually held the cards in high stakes fights. It was premised on some degree of insulation of the legislative process from both special interest arm twisting and part strong arming. It was premised on a broadly competitive political environment. The myriad fierce campaign fights that ensured that, as House Speaker Tip O'Neill famously put it, "All politics is local." That world is gone and it's not going to be returning any time soon. Congressional moderates are a vanishing breed. Campaign money and corporate lobbying hold greatly increased sway. Parties, leaders, and Congress wield vastly more power than they did a generation ago, and even with the shift of Congress to the Democrats, competitive congressional contests sadly remain few and far between. The result is much greater party cohesion and polarization, but without the consistent electoral discipline that insures us to that competition, those polarized

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parties respond to the interest of the middle of the road Americans. No one summed up the motto of this new world better than Texas Republican, Dick Armey, who helped bring down the Clinton health plan. "The first rule of politics," he said, "is never offend your base." We've gone from all politics is local to never offend your base. Now we generally tend to see this as a kind of equal opportunity problem; Democrats are going to the left, Republicans are going to the right. This is just false. In some of my previous work I've shown that almost all of the increase in polarization is driven by the move of the Republicans to the right. I'll let you ponder this slide and try to figure out how in the heck political scientists measure the conservatism or the liberalism of a member of Congress, but the point is that much of the increase in polarization is due to the move of the Republican Party to the right. The typical Senate republican, for example is about twice as conservative as he or she was a generation ago. And there has not been nearly as big of a move on the liberal side of the aisle. In fact, you don't need this figure to know this. Look at the campaign proposals. While all of the democratic candidates, leading democratic candidates have talked about what's required to get to near universal coverage, none of the leading Republican candidates have been willing to endorse any of the difficult or politically challenging steps that would be required to move in that direction.

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I'm sort of reminded of a cartoon from the early 1990's when the Clinton health debate, when Republicans said, "Can you believe how complicated the Clinton health plan is?" And then they said, "Well, here's something that's a little easier to understand." So if we go back to 1993, '94, and I'm going to end in just a moment, but the Clinton health policy team seemed utterly flummoxed by these two worlds it found itself caught between. It was torn between the old politics and the new. It embraced a cause cheered by the democratic left and then it adopted a proposal that alienated much of it. It packed its proposal with special favors for organized labor and then it campaigned against organized labor to pass NAFTA. It expected liberal committee chairs to play their game even as they made clear that the lodestar of their effort was the congressional moderate like Jim Cooper. So behind this back and forth darting I think was a sort of assumption that at some point, somehow, the old bipartisan politics would kick in and they would force some kind of backroom deal as they had on tax reform in '86 or on Social Security in 1983. That didn't happen and it's not going to happen this time. This time the fight is going to take place on the scorched earth of partisan warfare and that means that we're going to have to adopt strategies that reflect new political realities. In my view that means a much stronger clarity about ends but much greater willingness to compromise on means. A much greater attention

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to coalition building from the very beginning, well before a sympathetic President enters office, and yes, hard thinking about procedural reforms that could reduce minority obstruction, including the threat of a Senate filibuster. Which is I think the major barrier within Congress to change now that it's become the all-purpose tool of partisan obstruction. It will also require some serious efforts to bring on board committed reformers who support a universal medical plan, to provide them with the guarantees and arguments that they need to embrace and less inspiring but also a more politically palatable approach.

Now as we've learned there are promising signs. But the great unanswered question is whether a public disillusioned about politics can be brought to kindle some kind of faith in their leaders to dress this issue. I don't believe Americans have given up on politics yet. They say that they believe in government action on this issue. They say they want it to be a top priority and similar sentiments helped bring health reform to the top of the political agenda in the early 1990's. The question is whether we can learn from the early 1990's to address that issue today. After all, when Johnson sat next to Truman in 1965 he was really saying that for all his skill and charm it was the bruises borne by Truman and those before him that set the stage and set the strategies for the successful legislative drive that produced Medicare. Perhaps with

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strategic planning informed by history with an ambition tempered by realism and with a health dose of humility and good old fashioned luck we will be able to look back one day on our own recent history of defeat and the demise of the Clinton health plan above all not as irretrievably lost opportunities, but instead as painful missteps on the difficult yet necessary journey towards universal health insurance in the United States. Thank you. [Applause]

So in the very limited time I have remaining I'd love to take questions, but I also will be happy to answer questions as you eagerly line up to buy my book. [Laughter]

In the front row here. This reminds me a bit of in school when everyone wants to go home at the end of the day and they're all praying please, don't ask a question. [Laughter] So I'm sorry.

**JIM HIGHLAND:** Hi, I'm Jim Highland. I'm a health economist based in Portland, Maine. You said that the current political environment is never offend your base. Yet you also said that people are going to have to get to meaningful reform, they're going to have to focus on ends and not means. And it seems like the means issues are those very ones that offend the base on both sides and I think as I've listened to the speakers the last few days, and particularly the presidential candidate forum, the Democrats seem to have their head in the sand a little bit about cost growth needing to be addressed, about it

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being a real issue that gets in the way of reform and the fact that the tax code is a real contributor to that. That the fact that everybody in this room has a tax subsidy for their health insurance and the employment-based coverage costs have grown so much because we're all getting it on a tax-free basis. And it's no wonder that that cost engine won't stop as long as that tax subsidy is there. We all buy more of something if we're not paying tax on it than if we are paying tax on it. And that graph that you had of employment-based coverage going down is correlated completely inversely with the level of premium going up. And I think the Democrats ideologically don't seem to want to address that problem. On the other hand on the Republican side, the fact that markets don't really work, individual insurance markets don't really work and that you have to get everybody into the system if you're going to be able to manage the kinds of inefficient dynamics that we're already paying for to a significant degree via the cost shifting and the tax benefits that we give to the nonprofit providers and safety net providers, other ways in which we're already paying for care. It seems to me, how are the two parties going to address those ideological problems and get to a compromise given the political environment you've described?

**JACOB HACKER, PH.D:** Well as I said I think it's going to be a very difficult challenge and so I should clarify that most of my discussion was really about thinking about how those

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who are committed to universal coverage, which at the moment does not include a substantial portion of the Republican Party, would come to some agreement on a strategy for getting there and put aside some of the long-term disagreements among themselves about means which is going to lead, as you say, to some very substantial disagreements about means between conservatives and liberals. And I should be clear. There are certainly quite a few Republicans, I know some of them well, who believe strongly that you have to have, say a mandate on individuals to get coverage to get there. So let me say two quick things. One is that I'm not agnostic about means by any means. I believe very strongly that there are some ways to do it that work well and some ways to do it that don't. But I think that there's a tendency and this is what we saw with the Clinton reform initiative and we're seeing with the mandate wars between Barack Obama and Senator Clinton and Edwards right now. There's a tendency to elevate technical litmus tests above the underlying or overarching issues that need to be addressed. And the problems are two-fold of such technical disputes. One is that they're incomprehensible to most voters. Second of all they inevitably focus on the areas of disagreement conflict that are often where the most threatening aspects of the reform plans come out. And to me that's a really bad way to build broader support for action.

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The last thing I'd say is you mentioned cost grows. And I agree with you. I don't think Democrats are talking about it. I don't know if it's an unwillingness to talk about it on policy grounds, in fact I think most democrats believe that expanding coverage and in particular creating a public insurance option that can compete on a level playing field with private plans will control costs substantially over time. I think that there's a fear that politically talking about cost control will lead to the same kinds of dynamics that they saw in the early 1990's. I think that's true to a point. I think that where the point is is that if you look at why Americans are worried about health reform, it's cost. It really dominates their consideration. And second of all any plan that's going to involve requiring people to get coverage is really going to have to reassure people that you can control the costs of coverage over time. So we need to talk about it not so much in terms of cost growth or overall national cost, but in terms of making coverage affordable for middle class Americans.

Any other questions or should we all exit? And that wasn't a leading question. [Laughter]

[Applause]

**JACOB HACKER, PH.D:** Thank you, Peter. My pleasure.

**PETER GRANT:** Have a safe trip home. Thanks a lot.

[Applause]

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