U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

AGENCY FOR HEALTHCARE QUALITY AND RESEARCH
(AHRQ)

CITIZENS' HEALTH CARE WORKING GROUP

MEETING

THURSDAY,
MAY 12, 2005

The meeting was held at 8:30 a.m. in the Cherry Blossom Room of the Crystal City Hampton Inn, 2000 Jefferson Davis Highway, Arlington, Virginia, Randall L. Johnson, Chair, presiding.

PRESENT:

RANDALL L. JOHNSON, Chair
CATHERINE G. McLAUGHLIN, Vice Chair
FRANK J. BAUMEISTER, Jr., Member
DOROTHY A. BAZOS, Member
MONTYE S. CONLAN, Member
RICHARD G. FRANK, Member
JOSEPH T. HANSEN, Member
THERESE A. HUGHES, Member
BRENT C. JAMES, Member
PATRICIA A. MARYLAND, Member
MICHAEL J. O'GRADY, for Secretary Michael O. Leavitt, Member
ROSARIO PEREZ, Member
AARON SHIRLEY, Member
DEBORAH R. STEHR, Member
CHRISTINE L. WRIGHT, Member

ALSO PRESENT:

LINDA T. BILHEIMER, Robert Wood Johnson Foundation
DEBORAH CHOLLET, Mathematica Policy Research
JON COMOLA, Wye River Group on Health Care
MARCIA L. COMSTOCK, Wye River Group on Health Care
PAUL FRONSTIN, Employee Benefit Research Institute
MATT SALO, National Governors Association
KENNETH L. SPERLING, CIGNA HealthCare
TERRY STOLLER, Medimetrix
ANTHONY R. TERSIGNI, Ascension Health

STAFF PRESENT:

LARRY T. PATTON, Designated Federal Official
KEN COHEN
ANDREW ROCK
CAROLINE TAPLIN

AGENDA PAGE

P-R-O-C-E-E-D-I-N-G-S

8:34 a.m.

CHAIR JOHNSON: Good morning, everybody. We'd like to welcome you back. And today, last night someone was asking, well where is Brent James? It's kind of like "Where's Waldo?" And we found him. And he has shown up.

VICE CHAIR McLAUGHLIN: He's not the voice from above?

CHAIR JOHNSON: Not the voice from above or -- we're delighted you're here.

DR. JAMES: I'm delighted to be here.

CHAIR JOHNSON: Okay. And this morning we're going to talk about the private health care system. And we have with us Deborah Chollet and Paul Fronstin.

You have their bios and Deborah is going to be talking to us principally about the small employer market. And Paul is going to be talking to us about the large employer market and the products that are out there and the regulations that impact us.

I see that Paul's material is on the screen. So does that mean that you have flipped a

coin and that you are going to go first, Paul?

MR. FRONSTIN: We went by the agenda.

CHAIR JOHNSON: Okay. Why don't we do that? A minor detail, right? Okay.

MS. CHOLLET: Then we flipped a coin.

MR. FRONSTIN: Yes, we flipped a coin. Deborah lost.

CHAIR JOHNSON: Well, what we've been experiencing is a time, and I think we've discussed this with you, where we ask you to do a brief presentation. And to provide a foundation of information regarding the employer based system. And maybe 15 minutes each, or 20 minutes each, and then the rest of the time for questions. And we'll go to about 9:45, okay?

MR. FRONSTIN: Okay. Thank you. And I'll try to stay within my time as best I can. That's probably the biggest challenge this morning, given the topic I was asked to address.

And please excuse my cough. For those of you I've shaken hands with, I'm not contagious. We are experiencing the worst allergy season in Washington in seven years. I heard on the radio on

the way in this morning that the pollen count on April 20th was the highest it's been in seven years. And it's certainly taking its toll on a number of us here.

What I'm going to do is walk you through a number of facts about the employment based market. I'm going to spend more time focusing on the medium and large size market. And then Deborah is going to focus more time on the small market.

Although a number of my slides have data on both and it's very difficult to just present one market without comparing it to the other market.

It's important to keep in mind that the employment based market, employment based health insurance is the most common form of health insurance in the United States.

Out of a population of about a little over 250,000,000 Americans under age 65, and I'm not including the Medicare population in here because they get Medicare, almost 160,000,000 people get coverage through an employer; either their own employer or their spouse's employer or parent's employer or some other relationship.

Only about 17,000,000 buy insurance on

their own, directly from an insurance company. We've got about 43,000,000 people covered by public programs. This is mainly Medicaid and CHIP. There are also Medicare people in here. And that leaves about 45,000,000 people uninsured. These data are for 2003. It's the most recent data we have.

When you look at the employment based market and where workers are, those who get health insurance from this market, you see that about half are in firms with 500 or more employees. Okay? And that's just the private sector.

If you factor in the public sector, which is mostly large, not always but mostly large, you have another 17 percent that get coverage through what would be considered the large group.

So the large group really accounts for half to two thirds of the market. And then you've got this group, this private 100 - 499, kind of a mid-sized market.

I guess HIPAA, which I'll talk about in a moment, defined the small group market as 50 or less. With a number of the surveys we've looked at, we don't have good cuts at 50. We have cuts at 100.

Which is why the data is presented this way.

But it looks like the mid-sized market is at least 12 percent, and maybe a little bit more. And there are really no hard rules as to where the small group market begins or ends; where the mid-size market begins and ends. It's rough estimates; 50 to 100, 200 to maybe 500.

Workers are generally satisfied with their health benefits. Just over half liked the mix of benefits and wages. But if they would want anything to change, they would want more health benefits. And they are willing to give up some wages to do so. About 27 percent report that. Eleven percent of workers report that they would prefer less health benefits and would rather have some more pay instead.

I'm going cover some things that I think many of you are aware of. One of the challenges with this group is that you come from many different backgrounds with different levels of knowledge. And so bear with me as I go through some of these things that you may be aware of. Although it's often helpful to review and to make a few points.

There are a number of different ways in

which people are covered by health insurance; different types of health plans. There are the traditional fee-for- service or indemnity plans, which basically let's you go to any doctor you want and reimburses you a certain percentage of the charges.

There are HMOs which essentially own the facilities. Often times the doctors are employed on a salary basis. It's usually a limited provider network and very low or no cost-sharing to the beneficiary.

Point-of-service (POS) plans, which I'm sure you've heard something about, are essentially HMOs that give you the option to go outside the network. And if you do, you pay more money for that benefit.

Preferred provider organizations (PPOs)are panels of providers who individually contract with insurers or employers. They're usually both in network and out of network benefits. So you have that choice. It's similar to fee-for-service in many respects in the way that providers are reimbursed. They're usually reimbursed on a fee-for-service basis. Often times, it's discounted.

One of the issues with presenting this

slide and these four choices is that these plans are starting to look alike. There's a lot of convergence. It's very difficult to tell the difference these days between a PPO and a point-of-service plan.

I have the option of both. And, aside from some limited cost sharing differences, they're essentially the same plan.

And even HMOs have eased their restrictions on various rules and regulations regarding referrals to specialists so that you can now self-refer and often times go outside the network.

The last point, consumer-driven health plans; it's a new type of health plan. I'll give you some more information about that at the end of my presentation.

Enrollment in these various types of plans doesn't vary that much by firm size. The left hand column is a firm-size broken down into, you know, here defining the small group market as 3 to 199, and then your mid- sized 200 to 1000, and then 1000 and above.

Very few people remaining on traditional fee-for- service health plans. I don't even like to use the word "traditional" any more. Even though we

often do. Because, for many people, they've never been on one of these plans. It's not traditional for them at all.

We've got somewhere between 22 and 28 percent of the market in HMOs. The majority of the market is in the preferred provider organization; over half of the insured population, regardless of what firm size you are looking at, and the remainder between 10 and 20 percent in a point-of-service plan.

How are these plans regulated? All health benefits in the workplace, it doesn't matter what size firm you are employed with, every private sector firm is subject to ERISA.

ERISA is the federal law that governs all benefits in the workplace. It sets forth standards on reporting and information disclosure; claim appeal procedures, remedies for wrongfully denied benefits, and fiduciary standards.

I'm not going to go into great detail about any of these. Though we could spend quite a bit of time on them.

ERISA is the law that preempts state laws related to benefits. It's the reason why there is

such difficulty when it comes to states trying to mandate that employers provide benefits for all their employees.

Right now, the only state that does that is Hawaii. There have been a number of attempts in states to do so. California passed a law, I guess it was two years ago now, and the law never took effect for various reasons.

It never got to the point where it was tested at the federal level as to whether or not it was in violation of ERISA. But it may well have been found to be violating ERISA.

ERISA does grant the states specific rights that allow them to regulate the business of insurance. And it's important to understand that the business of insurance is often different than the business of providing health benefits to workers.

And the reason why it's different is because of the choices that employer have when it comes to offering a benefit.

An employer can decide to become its own insurance company. Okay? Large employers often do so. They assume the risk of paying claims. They pay

claims out of their own pocket. They're known as being self- insured plans.

And those plans, since they're not actually going out and buying insurance from an insurance company, they're not paying premiums to an insurance company, those plans are not subject to state insurance laws. Okay? They're only subject to ERISA. Okay?

Often times, those plans will use an insurer to administer the plan. So, if you ask someone what plan they're on, they may tell you they're on Aetna or CIGNA or a Blue Cross plan.

But that doesn't mean that the employer is buying insurance for those workers and paying a premium to those health plans. They're usually just paying a fee to those health plans to administer the plan for the employer; to push the paper work, and also to use the network discounts that that insurance company has in place with providers.

You're essentially, when you're self-insured, it's like rending a PPO plan from an insurance company.

The opposite is a fully insured plan.

That's where an employer goes to an insurance company; pays the insurance company a premium, and the insurance company assumes the risk for insuring workers.

And that's where states come in. Because states are allowed to regulate insurance companies. So if a state sets a mandate and requires an insurer to cover a certain benefit, it's because it's requiring the insurer to provide that benefit.

And, as a result, the employer that's buying insurance from that insurance company is required to buy that benefit. Okay. Does that make sense to everybody? Does it not make sense? Okay.

There are various ways in which states can regulate health insurance. They can mandate benefits. There are premium taxes. And there are other ways in which they can regulate benefits.

When you look at the percentage of workers covered by self-insured versus fully insured plans, and I have date here for two years by firms size, you see that, in the small group market, very few workers are covered by self-funded plans. About 10 percent in 2004.

Do you have a question?

MR. FRANK: Yes. Could you spend one minute before you move on and just tell us what is known from the perspective of an employer, how did they choose about whether to go fully insured or self-insured or something in between?

MR. FRONSTIN: Okay. I'll oversimplify my answer. I think it all boils down to cost. If it's cheaper to self insure, an employer's going to self insure. And there are a lot of other things to consider. But, essentially, an employer that self insures is typically large, as you see from this chart. Because they can spread the risk over lots of employees.

EBRI is a small employer. There are less people working in EBRI than there are in this room. We would never self insure. One large claim would cost us a lot of money. We wouldn't be able to spread that over all of our employees.

So it really boils down to cost and the risk that employers are willing to take. Because you could see, as firm size increases, the percentage of employees covered by self insured plans increases as

well. There's a degree to which employers are willing to take a risk in this mid-sized market.

And there also some considerations. How uniform do you want your benefits to be if you are a large employer? Do you want every employee in the U.S., if you operate in 40 or 50 different states, do you want them to all have the same benefits?

If you do, it makes sense to self-insure. Because then you don't have to comply with state mandates and you can design a benefit package. You could design one benefit package instead of designing 50 benefits packages, which is also costly because you're contracting with insurance companies in 50 different states.

And what often happens is, an employee who moves from state A to state B will have to change benefits just because they moved. Even though that person is working for the same employer. Okay?

So you can see from this chart the percentage of workers covered by I say partially or fully self insured plans. And we use the term "partially" because oftentimes employers will buy insurance for the self-insured plan. So, if claims

reach a certain level, then they'll have insurance to protect themselves.

It's not health insurance that they're buying. It's reinsurance.

MR. O'GRADY: Paul, just one second of clarification. When you were talking before about this dynamic of as a firm gets larger and that it's the employer cost, would it also be fair to say that employers at some firm size, it's a waste of money to pay an insurance company to hold risk. Whereas, in the example you gave of EBRI where you're actually paying some extra amount on a premium for the insurance company to hold your rise, versus the risk once you're up to 5000-10000 employees, you're in effect paying for nothing?

MR. FRONSTIN: It gets pretty close to that. But there are other reasons. It depends upon market conditions. There may be a consolidation going on in the market. Insurers may be dropping premiums to gain market shares. And, in certain situations, it may make more sense to buy an insurance product.

The question I get most often is how many employers self insure. That's not a question you

could answer. Because often times you will find large employers that offer a national self insured product, but also offer local HMOs as a supplement or as another choice for their employees.

So they're actually doing both. And it depends upon what kind of choices they want to provide. Often times it depends upon the market condition, the labor market conditions.

You know, if there's very low unemployment and you're trying to provide rich benefits, you may provide more benefits in one area of the country than the other area. And that may mean offering some HMOs in addition to your self insured product. Okay?

But you can't really answer how many employers self insure, because they often times offer both a fully insured plan and a self insured plan. I think it's better to look at the percentage of workers that are covered by these plans.

MR. FRANK: How important is state premium taxes?

MR. FRONSTIN: To the decision as to whether an employer self insures?

MR. FRANK: Yes.

MR. FRONSTIN: I think they're a consideration. I don't think that's the only thing they look at. But if the margin, you know, if they're looking at the cost, that plays into it.

Okay. Besides ERISA, the other federal law that you need to be aware of is HIPAA, the Health Insurance Portability and Accountability Act of 1996, which, in a nutshell, created national standards regarding portability and access to care, the way pre-existing conditions are addresses in health plans, for people that change health plans, discrimination based on health status disclosure of information, electronic transmission of health information, and privacy issues. And this was also the law that originally created medical savings accounts.

Other federal mandates other than those two bills and these four bills, there isn't that much federal legislation that oversees health insurance in the workplace.

There's COBRA, which provides for continuation of coverage. There's Newborn and Mothers' Health Protection Act, the Mental Health Parity Act (MHPA), as well as the post-mastectomy

surgery mandate.

That's pretty much it, when it comes to regulating benefits at the federal level. ERISA is the major piece of legislation you need to be aware of and HIPAA is the other major piece of legislation you need to be aware of.

In terms of the cost of providing these benefits, if you look at annual premiums, you know, I'm often told small employers spend more than large employers for health benefits.

And when you look at what they spend for employee only coverage, you see that that's true, although not by a whole lot, with small businesses spending an average of about $3700 -- a little over $3700, and the large businesses a little under $3700.

The reverse is true when you look at family coverage. You can't really just look at premiums to say that small businesses spend more than large businesses. Because often times large businesses are providing much more comprehensive benefits than small businesses.

So you'll find that, for family premiums, this $300 difference at the large firm level, where

large firms are spending more on a family than a small firm is. You just can't make this comparison by looking at premiums because they're offering different benefits.

And once you control for the benefits package, typically you'll find that large businesses spend more. And even though large businesses that self insure do not have to comply with state mandates, usually they do, because they're already providing such comprehensive benefits.

MR. HANSEN: Paul, did you factor in or is there any difference in the part of the premium that the employee might pay? Is there a difference between the big and the small?

MR. FRONSTIN: This is not the percentage of the premium. This is the total cost. This is the total dollars. I think I had that slide. Question? Yes?

VICE CHAIR McLAUGHLIN: Paul, I know that about a decade ago GAO estimated that controlling for the content of the plan, which is what you were just referring to, that small businesses, on average, pay ten to forty percent more on their premium for the

same package.

MR. FRONSTIN: Right. For the same plan.

VICE CHAIR McLAUGHLIN: Does EBRI have any evidence that ten years later it's less than that, more than that, same?

MR. FRONSTIN: No. No. We haven't looked at it.

VICE CHAIR McLAUGHLIN: So you would guess that it's still ten to forty percent?

MR. FRONSTIN: It's still ten to forty percent. Right. Right. And let me answer his question about percent of premiums.

When you look at what percent of the premium, putting aside cost sharing when you need health care services, when you look at what percent of the premium workers pay by firm size, typically small business pays more; at least in terms of payroll deduction.

And that's because at the small group level, insurers are allowed to set minimum participation requirements.

EBRI used to have a minimum participation requirement. If we didn't have 97 percent of our

employees covered, our insurer could drop us. As a result, we don't charge any premium for employee only coverage. We want everyone to have insurance.

Large firms typically don't do that. And the small firms typically don't offer a choice. So you're offering one plan and everyone's on it. Whereas, in the large group, you're offering a choice of plans and the premium will vary depending upon which plan you choose. Okay?

Are you keeping track of how often I'm talking versus the questions, so I'm not cut off?

CHAIR JOHNSON: No.

VICE CHAIR McLAUGHLIN: Well, the other thing is that, you know, I just realized some of this is probably going to be covered by Deborah when she talks about small group and individual. So, we should probably hold off on questions about the small group.

MR. FRONSTIN: Okay. Okay. In terms of offer rates, it's well known that just about every large employer offers health insurance to at least some employees; not necessarily all employees. Whereas, when you look at the small group market, it's only about 63 percent, and it's fallen since 2002.

Coverage rates are much higher in the large group market. Close to 70 percent, and it's been consistently close to 70 percent since 2004, whereas in the small group market it's been declining. It was close to 60 percent in 2000 and now it's down to 50 percent. That's the percentage of workers covered by health benefits, really through their own employer.

And the one thing that this doesn't take into account is that workers have a choice. You know, often times you can get insurance through a working spouse. And these numbers would be higher if we took that into account.

The percentage of employers providing a choice of plans. You can see that there's, in the small group market, not much choice. 86 percent of employers only provide one choice. 86 percent.

EBRI is the exception. EBRI is in the yellow here because, even though we only have 12 employees, we do provide a choice of plans.

And as the firm size grows, you can see that choice of plans grows as well. Whereas, you get to the jumbo employers with 5000 or more employees,

and 72 percent are offering three or more plans.

But keep in mind, what is three or more plans? Often times, if it's an insured arrangement, it's a choice between an HMO, a PPO, and a point of service plan that are all offered by the same insurance company.

So it's choice of something. But I view it as residual choice, because the employer has already made the choice as to what to offer. And it's not necessarily a choice. There's not much competition when it comes to the choice, if different insurers are not being used to provide the various choices.

Deductibles, you could see how deductibles vary by firm size. You know, we were talking just a minute ago about premiums varying by firm size. Here you could see that large businesses typically have lower deductibles, whether it's for in network or out of network benefits, than small businesses.

So once you are looking at the premium, you see the premium differences, one of the reasons why those premiums may be close is because small businesses are not spending much more than large

businesses, on average. Because they are shifting more cost onto employees in the form of higher deductibles.

And we find the same thing with various hospital cost sharing. Where the hospital deductible is higher in small businesses, on average. The hospital co- insurance is a little bit higher and I already mentioned that the deductible is higher. The first line is the co-pay as well.

There are other ways employers are trying to save money. It's not just about cost shifting. And I think it's important to keep in mind what employers are doing. They're trying to provide incentives to employees to use care efficiently.

One example of that is prescription drugs. How many people here have a three-tiered drug plan? How many people don't know? I mean, there's a lot that haven't raised their hands. Okay.

Essentially, what employers are doing is trying to provide incentives for people to use the least costly prescription drug. So there are incentives to use generic drugs by charging you less for that drug. There are incentives to use mail order

pharmacies.

Typically, if you get your drugs through the mail, you can get a three-month supply for only two co- payments. So you save money. The plan saves money as well.

And when you look at in 2003 only six percent of plans of large employers didn't have some type of incentive to use a generic or mail order pharmacy. And it's down significantly from where it was in `98 when it was 2002.

Another area where employers are really just starting to explore with incentives is hospital care. They're creating tiered hospital networks. Tiered drug benefits is one form of tiering benefits. You have different co-payments, depending upon what drug you choose and where you buy your drug.

Most people are used to tiered provider benefits, otherwise known as in network versus out of network benefits, where if you stay in network, you pay one fee. If you go out of network, you pay something much higher.

Now employers are turning their attention to hospital benefits. And tiering those benefits. So

what they're doing is they're grouping hospitals into different tiers, trying to group those tiers based upon cost and quality. And they're setting different cost sharing rules, depending upon which hospital you choose or at which tier you choose to receive hospital services from.

So, if you choose hospital A, it may only cost you $100 a day. It may be a $200 deductible. Whereas, if you choose hospital B, which is more expensive and provides lower quality services, it may be $1000 deductible and there may be 20 percent co-insurance on top of that.

Employers are trying to make distinctions between different types of providers to steer people to the most efficient lowest cost provider. They're not taking away choices. They don't want to take away choices. They're just making certain choices more expensive and certain choices less expensive.

DR. JAMES: In that regard, I have a somewhat detailed question. Usually the argument for including more hospitals and more physicians within a particular panel or plan is choice; the people have greater choice.

One of the things that we discovered some years ago though is that when we expanded the primary care network above about 400 physicians, that adding additional physicians did not increase patient's perceptions of choice. Okay?

Have you ever investigated that or do you have any knowledge about that? This concept about choice I don't think has been carefully examined. And what does choice mean in this circumstance?

MR. FRONSTIN: Yes. I haven't examined it that closely. I'm not surprised by that finding. Just thinking about the Washington area and you look at the 400 pages of providers; some of those providers are an hour and a half away from where I live.

So it doesn't really matter that it's 5000 providers or 2000 providers. I want to know what providers I have access to that are convenient, that are high quality.

And I think people are more focused on the types of providers that they have access to; the relationships that they have with their primary care physician.

And we're just not at the point yet where

we have great data on quality of providers. I think that's really what people want to have in order to make good decisions. Mike?

MR. O'GRADY: I just had a conversation a few years ago with one of the chief actuaries from one of the major insurers who was in FEHBP and he said that their target was 50 percent of the providers in an area.

And being a federal employee, I had been in different plans. And I certainly know I moved out of the plan that had one pediatrician in all of Montgomery County. That was a motivating factor for me to change.

And I thought that sort of worked well. But it was kind of a rough kind of cut. They just had this notion that, in terms of when you're talking about consumers and you're talking about allowing them enough choice, that they stand a reasonable probability of finding their own doc on the in network list, that they were shooting roughly in their negotiations over price and everything else to add 50 percent of the providers.

But I also faced the thing you're talking

about with the hospital. And to tell you the truth, you know, when we knew we were going to have another baby and they basically said you could go to this hospital and pay a $250 deductible or go to this other one and pay nothing, you know, if the Ob-gyn didn't have, you know, kind of rights in both hospitals, it would have been a harder decision.

But I went to the one that didn't cost me $250 extra. And you could see why. When I got there, the delivery rooms, there was, you know, they were maybe 60 percent capacity at tops. So they were clearly offering BlueCross BlueShield a break on their per diem or whatever.

I didn't have a problem with it because it looked like BlueCross BlueShield would share in the savings with me.

MR. FRONSTIN: Yes. And the one thing we don't know is how large these differences in cost sharing need to be to get people to really think about the provider that they're choosing or the treatment option that they're choosing.

You know, I would argue that we started out with these three tier co-payments in prescription

drugs and the differences in the tiers were never large enough to steer people to the generics. And now we're starting to see the gap between the generic co-pay and the brand name co-pay start to grow.

I've also tried to talk employers into giving away generic drugs for free. If you want an incentive for people to try it, don't charge a co-pay for it.

And they're hesitant to give anything away for free, but they're think about well maybe we'll do this for three months free to give people an incentive to try it and find out if it's medically equivalent.

And if it isn't, we're not taking away the other options. They can go back to the brand name drug at the co-pay that we've been charging for a year or two, whatever it is.

MS. CHOLLET: Could I add a comment about choice, real quickly? Your comment made me think of this. You know the deductible and the incentives to get you to one provider versus another. But not only do you not know quality; mind you, for $250 you sold yourself out for quality which you couldn't appraise, right?

But consumers typically do not know quality. So it's not different and it's not clear how they would know and what information they would be able to assimilate.

But you also don't know about balanced billing. And that has become a huge issue. Not necessarily so much in hospitals, but definitely in outpatient care.

So you don't know price either. You only know one component of price, which is your deductible and your co-pay. But you don't know what your co-pay is going to be paid on. And you don't know where you are bare because the reimbursable limit on the plan is less than the provider wants to charge.

So it's really a crap shoot, by and large, outside of a tightly managed care system where you know you have no balanced billing and you know the rules walking in.

But for the kinds of plans that we are edging back toward, the less managed BlueCross BlueShield model plan, those retain all of the difficulties that those plans always had before the "managed care revolution." And that is, the not

knowing quality and not knowing price.

MR. O'GRADY: But the example I was thinking of was an in network situation. I mean, I knew what the cost sharing was to go to the in network provider which didn't have the $250 deductible. And that was sort of my entire exposure.

Now that's quite true and what Paul said about the idea of choice between different drug types, of course, the other, I mean I think the actuaries would point you to say pay the generic price. And if people want to buy more, that's up to them.

Now that would generate some pretty harsh co-pays, I think. At the same time, at least for those consumers who would like to do it, to be able to chose between the four or five major hospitals in the Washington D.C. area. I didn't think I was sacrificing quality.

I certainly know the difference between Georgetown and Sibley and Suburban. And that wasn't hard.

MS. CHOLLET: Even those two hospitals rarely rank, when you actually see the quality measures, they rarely rank equally. I mean, it's

surprising the level of variation in quality indicators in hospitals that are standing side-by-side, essentially.

CHAIR JOHNSON: We will see more information on quality ratings and efficiency ratings and initiatives to move forward in this area, with some of our hearings not only this couple days, but in the future for hearings that we have scheduled.

But your point is right on and it's a significant challenge for us.

MR. FRONSTIN: A question here?

MS. BAZOS: I know we're going to hear about quality in general in the big picture. But specifically, for plans, if they're going to a tiered system around hospitals, who is evaluating the quality for those hospitals? And is it treatment specific?

MR. FRONSTIN: It is and it isn't. It's really at the early stages. We have groups like Leapfrog, the Disclosure Project, some employers that are collecting data. You know, GE is a good example that is able to collect data, some states that collect data. I know New York has a big data collection.

There's a lot of different efforts out

there that are trying to collect data and disseminate it in a usable form. But we're at the very early stages.

MS. BAZOS: But then the onus of actually ranking hospitals in a region is on the employer once he gathers the information? Is that how it's sort of playing out?

MR. FRONSTIN: The employers are, I think, taking a lead in this area. But I wouldn't say the onus to collect the data is on the employer. I think they're using insurers to collect the data. They're using other third parties to collect that and provide them something meaningful.

CHAIR JOHNSON: Paul, I'm going to ask that we proceed and you complete your presentation and then Deborah talk, so we have questions available for Deborah, as well.

MR. FRONSTIN: Yes. I only have a few more slides. I mentioned before, I was going to talk a little bit about consumer driven health plans.

There are two plans I want to give you a brief introduction to. One is known as the health reimbursement arrangement (HRA).

These plans have been around since 2001. I'd say that was really the first time we started seeing these plans. Although I always come across an employer when I'm making a presentation someplace that says we've been doing this since 1974.

But essentially they've been around since 2001. What they are are high deductible plans. They're typically high deductible plans that also allow or give employees access to monies in an account to help them with the deductible.

So you could think about it as -- the example I use is a plan for employee only coverage that has a $2000 deductible. And the employer will put $1000 into this HRA, health reimbursement arrangement.

So, essentially, you could think about it as $1000 in first dollar coverage. And then $1000 deductible gap. Okay? So once you've run out of money in the account, then your deductible kicks in.

And then, once you've reached your deductible, that $2000 between the first $1000 an employer is spending and then you're spending, comprehensive insurance kicks in.

And that comprehensive insurance could be anything. It could be 80/20 co-insurance. It could be co- payments. It could be no out of pocket payments at that point. Okay.

This is a very flexible plan design. Employers could set the deductible at any level it wants to. It could set the contribution to the health reimbursement arrangement at any level it wants to. It could allow money that's not used in a given year to roll over to the next year if it wants to. It doesn't have to. It could set constraints on how much can build up on that account if it wants to. It doesn't have to. It could also allow employees to have access to that money after they leave their job, for qualified medical expenses.

Okay. But the employer doesn't have to do that. It's a very flexible plan design and I'm only giving you some real highlights of these plans.

One thing to keep in mind, the money that goes into the account can only be funded from an employer. Employees cannot put money in an HRA. And typically, these are self-funded arrangements where employers don't put money in the HRA, they're

basically just creating an account that exists on paper.

So if I had the account, if my employer says I have $1000 in this account, really what it means is my employer's going to cover my first $1000 in expenses. Okay? They're not necessarily setting aside money in an account for me.

And employers could also let you use the money in the account for any qualified medical expense whatsoever. I've seen one plan that will let you take the money in the account and go out and buy other insurance. Some plans do that.

You could use it for things that are not covered by the plan, such as dental care or vision care. And what happens in those cases is you're spending the money on medical expenses, but it's not counted against your deductible.

So you may have a $2000 deductible, $1000 in the account. You may spend $200 on a pair of eye glasses. Your deductible is still $2000. You just now have less money in the account to apply or to help you until you reach your deductible.

The other type of account based plan,

which you may have heard about, are health savings accounts. I heard you were talking about MMA yesterday. The Medical Bill is what authorized health savings accounts.

And essentially, the way they work is, and this is a very unique account. It's the only thing out there that allows a person to put money in an account on a tax free basis. It allows you to build up that money on a tax free basis. And, if you pull that money out for a qualified medical expense, it's tax free. IRAs don't work that way. 401K plans don't work that way.

The only way you could make a contribution on a tax free basis is if you have a high deductible plan. So you must have at least a $1000 deductible for employee only coverage, and at least a $2000 deductible for family coverage.

There is no maximum deductible with these plans, but there is a maximum out of pocket of $5100 for employee only and $10200 for family coverage.

Contributions are tax free, but they're limited. You can put in the maximum of your deductible or $2650 this year. So, if you have a

$1000 deductible, that's all you can put into the plan. All you can put into the account.

If you have a $3000 deductible, the most you can put in, in a self only plan, is $2650. Okay. Distributions from the account are always tax free for qualified medical expenses, whether or not you have a high deductible plan. You do not need to have a high deductible plan to take money out of the account to pay for medical expenses.

So you could have one of these plans for five years, build up a couple thousand dollars in an account balance, change health plans, and still have access to the money in the account to pay your out of pocked medical expenses.

One exception to the contribution limits is that there are catch-up contributions. Once you're 55, you can put in more than the minimum. By 2009, you will be able to put in as much as an extra thousand dollars a year.

And the last slide is that there's a lot of interest in these plans. A survey that was done about a year ago found that 73 percent of large businesses were likely to offer an HSA based plan by

January 1 of next year.

Whether or not we're going to see 73 percent of large employers do this is still to be seen. But the reason why they weren't planning on doing it for 2005 was because by the time the guidance came out last year, it was just too late to put in a plan for this year.

I know of one employer that put in a plan for this year and was very happy when it got 1/10 of one percent take-up. Because they rushed to get it available to their employees and they did absolutely no education whatsoever to push the plan.

VICE CHAIR McLAUGHLIN: I have just one clarification question. Who determines what is an allowable medical expense?

MR. FRONSTIN: Allowable medical expenses are defined by Section 213(d) of the Internal Revenue Code. And it's just about anything except cosmetic surgery, except in certain cases.

VICE CHAIR McLAUGHLIN: So there's no variation by employer? That's not an employer's call?

MR. FRONSTIN: Employers can put restrictions on what's allowable in an HRA. An

employer could say, even though by IRS or Treasury definition an HRA can be used for any qualified medical expense, we're not going to let you use it for X, Y, and Z. An employer could do that. It's the employer's money.

In an HSA, employers have to be much more careful about it. They probably shouldn't put any restrictions on it because that's going to make the plan more complicated for the employer to provide.

MR. O'GRADY: Paul, should the way we think about allowable medical expense be the IRS definition, when you think about those things? I mean, hopefully not to many of us have seven percent or whatever of our income going to health. But it strikes me that there are some over-the-counter drugs, and there were some other things in there that were allowable that you do not normally think of as being so.

MR. FRONSTIN: Yes. There are some new rules regarding what's allowable which is, if you have a flexible spending account, which is a different kind of account I didn't talk about, you can get reimbursed on a pre-tax basis for over-the-counter drugs.

You could go out and buy a big bottle of

Motrin. For years, you've always been able to get reimbursed for not just eye wear, but anything related to contact lenses.

So there are some items that are non-prescription based that would be covered by these plans.

MR. O'GRADY: And I think the last figures I saw from the Health Plan Trade Organization was a million HSAs had been sold as of March. They put out a press release a little while ago.

MR. FRONSTIN: That's right.

CHAIR JOHNSON: Deborah, you've been very kind and patient. We'll now hear from you. Thank you, Paul for your presentation. We will hear more over the next two days about HSAs and HRAs and some of the trends that employers -- practices employers are putting in to help increase their quality and efficiency.

MR. CHOLLET: Okay. This is a technology challenge. I'm just checking on how it all works here.

I'm going to cover quickly some of the points Paul covered. I'm using a slightly different

data base. I went to the Medical Expenditure Panel Survey Insurance Component, called MEPS--IC, simply because it did break down firms into 50 or less and more than 50.

And that turns out to be a meaningful distinction in terms of sizes. Because much legislation is written around that, firms of under 50 have a different set of consideration than firms of over 50.

That's not to say that firms of 51 don't have the same problems that firms of 50 have. Hence, many states are becoming increasingly concerned about what's going on in that 50 - 100 bracket.

In Paul's data, you'll notice the 25 - 100 has a very different pattern than the less than 25 and it probably has to do with the group that is 51 to 100 being in a very different position than the groups of under 50.

What I've done in most of my slides, however, is show you the very smallest case, the less than 50, the more than 50, and then the very largest case, over 1000. And it gives you an idea of the distribution. But the middle two bars are the ones

that, for regulatory purposes, turn out to be very important.

First of all, I want to make a point that most firms are small, but most workers don't work in small firms. Okay?

There is a real discrepancy between the firm-size distribution of employers and the firm-size distribution of workers, and it gives you a sense of why you have this dissonance. Historically, most small employers have had problems with health insurance, and most firms are in that size category, but most workers are not. Most workers are in those very large firms to the right. Almost half are in firms of over 1000 and 72 percent are in firm sizes of 50 or over. That is typically not the turf of small group reforms and regulation.

As Paul mentioned, small firms are less likely to offer coverage. But in fact, if you're in a small firm that offers coverage, you are about as likely to be eligible for coverage in that firm as if you were in a firm of over 1000.

The vast swath of firms between 10 and 1,000 tends to have a lower proportion of workers

eligible, when they are offered coverage. And the reason is what Paul mentioned; the smallest employers are in the insured market, and the insurers require threshold participation.

If you're coming in with a group of 10, maybe even 20 or 25, and you don't deliver the entire group, you pay a higher premium for that because the insurer is wary of adverse selection. They don't want to be competing against another plan type that might that might draw more favorable selection. They want you to deliver the whole group.

The mark-up if you don't deliver the whole group can be significant. And regardless of whether you deliver a whole group, the markup for delivering just fewer employees can be significant.

In many states, there is a big difference in premium for delivering 10 employees, regardless of whether you're giving them choice, and delivering 17 employees. I've heard companies say that because I was able to bring all 17 employees to the table, my total cost for coverage is the same as when I brought 10 to the table. That was the size of the mark-up. The challenge is, of course, is bringing all 17 to the

table.

You'll see that there's a big drop off between offer and eligibility, and eligibility and enrollment in larger firms. About 81 percent of those who are offered are eligible. And about 82 percent of those who are eligible take up. Take-up looks very similar to that in firms of 50 or more. And I'll explain why in a minute.

Small group employees constitute a relatively small proportion of the market, in part because few employees are employed in the small groups. Groups over 50 are 80 percent of the market. Groups of under 50 are about 20 percent of the market, including groups of one in states where self-employed individuals are in the group market.

So most insurers are selling to groups of over 50 and most of their business is groups of over 50. This problematic portion of the market is small: if you add up the self-employed workers and groups of under 25, you are looking at half uninsured workers.

By the way, that's true of the change in uninsured workers between 2000 and 2003. Half of those are also in groups of under 25. But groups of

under 25 represent almost the entirety of the new growth in employment between 2000 and 2003.

If you were to standardize the package of benefits, which is very hard to do with available data, the premiums that small employers pay are higher. They are higher for a number of reasons.

First is that there are higher administrative costs in small groups. Small groups tend to have higher employee turnovers so there's higher enrollment and disenrollment activity. Small groups have higher rates of firm failure; the whole firm goes out of business and everybody leaves the health plan. They represent a higher cost simply to get the business in the door. You're knocking on more doors to get the small employer business. For all of these reasons the administrative cost of these plans is high.

There is also a greater risk of adverse selection. Sometimes somebody is sick in the group. I've talked to insurers who say that when they have looked at the highest cost member of a small-group plan, the person has the same last name as the owner of the company. They may go out and get insurance to

cover somebody that they know in their company; small companies tend to be very personal enterprises.

With the greater risk of adverse selection, insurers tend to carry somewhat higher reserves against small businesses, but they also make money on these businesses. They're not loss leaders for insurers.

In part, the reason that they're able to make money on them is that there's a low opportunity to self-insure in small groups. Paul showed you the very low rate of self-insurance though even that low rate of self-insurance is problematic.

There is a lot of economic sway that you can bring to bear when you say my alternative is to self-insure. You can simply leave the table if you're not getting a price you want. Small employers don't have the option of leaving the table. And if they do leave, they're probably ill advised to do so. So they stay in the insurance market and the number of insurers that they're bargaining with is increasingly small.

In Maryland, for example, there are essentially only three insurers in the entire state.

They have bought each other up in great numbers over the last few years. If you look at parent companies, you're looking at about three insurers in the state. And that's not unusual in many states.

All of this comes down to the fact that benefits as a percent of the premium, what we call the loss ratio, is relative low. In large firms, we're looking at upwards of 90 percent. In small firms, loss ratios are typically in the range of 60 - 75 percent.

So small employers are not getting as good a bargain in many ways. They end up paying about the same overall premium, as Paul mentioned. But what they're doing is basically buying a lower benefit for the same premium.

To maximize group size and to bring as many employees to the table as they can, and Paul mentioned this, they offer one plan, no choice. And they typically offer a restricted provider plan—not the cheapest plan, the exclusive provider oprion, in part because they know their employees and their employees have providers. Again, it's a very personal business. Nor do they offer the most expensive plan,

which is unrestricted and tends to be prohibitively costly for these companies.

The key, I think, to the small group dilemma, the small employer dilemma, is that in order to bring as many employees to the table, they typically pay a larger percentage of premium. Paul mentioned this as well. And they especially pay a larger percent of premium for single coverage.

This chart, I think, speaks volumes in terms of how small employers perceive their options in the market. Almost 80 percent of employees in the very smallest group pay nothing for their health insurance coverage, if they're offered it. There's a low likelihood of offer. But, if they're offered it, 80 percent are not contributing for single coverage. And about 40 percent of them are not contributing for family coverage. You see that, in groups of over 1000, that is distinctly not the case.

So, in order to get that threshold size, and therefore a reasonable offer of coverage for the owner of the company and for the key employees of the company, the employer has to offer a policy with very

low contributions for the employee. The upshot is that small employers pay higher premiums and their contributions to premiums in particular are much higher--about 25 percent higher than the largest companies. All of this boils down to a more expensive plan for a very small company. Almost no matter what they do.

There are, as Paul mentioned, some key regulations in addition to ERISA. I didn't even really focus on ERISA-- the Employee Retirement Income Security Act. It's principally a piece of pension legislation. But it has this enveloping piece that covers all employee benefit plans. And so, therefore, as Paul mentioned, if you're self-insured, you can basically walk away from state regulation and state taxation.

But, in addition to ERISA, there are some other pieces of legislation that are important. COBRA, the Consolidated Omnibus Budget Reconciliation Act, allows employees to continue coverage after they leave a company under most circumstances of exit, including family changes like divorce or death of a worker. The family members who were covered can

continue coverage under the employer plan.

Smaller firms were exempted from COBRA, but some states have not exempted smaller firms. They've required continuation in smaller firms in order to allow people to stay out of the individual market, which I'll get to in a minute, and in benefits even as good as the small group market.

They have enacted what we call mini-COBRA laws, which can apply COBRA continuation provisions to groups as small as three. That has been an issue in the sense that the way COBRA is set up, employees or their dependents have about two months to elect continuation retroactively. So continuation is almost perfectly adversely selected among people who expect short breaks in employment and short breaks in coverage. I can say after I'm admitted to the hospital, that I really wanted that coverage and then can pick it up.

So COBRA tends to be very expensive for employers, even though the individual who elects it, by law, pays as much as 102 percent of the average plan cost. But those who elect COBRA can be very expensive members of the plan and their real cost can be considerably more

than 102 percent.

The smallest firms are exempted from Title VII of the Civil Rights Act, which requires firms to offer maternity coverage on the same basis that they offer coverage for any illness. Groups of under 25 are exempt, and so we find one of the way that groups of under 25 will pare their benefit back to get a lower premium is to omit maternity coverage.

This turns out to be a big issue in states. For example, Washington State offered maternity coverage in the Washington Basic Health Plan and found out quickly that they were about the only source of coverage, other than larger firms, which are regulated by federal law, and Medicaid. The program had to make some adjustments quickly to deal with adverse selection.

So the smallest firms are not exempt from HIPAA, and in fact, HIPAA did a lot in the small group market. We'll get to whether one believes that's good or bad in a minute. But HIPAA addressed some of the most egregious issues related to insurer issues in the small group market and essentially brought all states up to the standard of what most states already had

done.

HIPAA didn't change things for most states; it basically ratified what most states had already done. But some states had not, and it was a hard reach for them. Some states still haven't done it; California still hasn't done it, so it is ostensibly still under enforcement by CMS.

First, HIPAA required guaranteed issue in the small group market. That is, if a small group approaches an insurer and applies for coverage, the insurer has to sell it coverage. It cannot say, you have a sick person in your group, so we're not going to sell you coverage. Or, you have this sick person in your plan so we'll sell you coverage for everyone else but Joe, but we're not going to cover Joe. They can no longer do that. HIPAA prohibits it.

HIPAA also required guaranteed renewal, but there were only maybe two states that didn't already have guaranteed renewal. That means that the insurance company can't say, Joe got sick last year, so we're going to drop your coverage. Insurance companies were doing that, which is why the states stepped in to require a guaranteed renewal. HIPAA

brought all states up to that standard.

HIPAA also put in place portability. When I change jobs, if I've met my pre-existing condition exclusions -- I've waited six months for coverage of my diabetes, because that's what I came into my first plan with -- I cannot have that six month waiting period restarted because I change jobs and go to another employer plan. So that was helpful.

HIPAA also allows me into the individual market if I have a period of qualifying coverage. It allows me into the individual market guaranteed issue, but the coverage can be expensive.

On the states' side, the states have done a number of things that HIPAA didn't do. One thing some states have done is address pricing. HIPAA stayed away from pricing issues. Under HIPAA, if I go into the small group market, I'm guaranteed issue, but I can be charged anything. I can be charged a price that is so high, it will just discourage me and I will go away, or look for other coverage.

Some states said that insurers can't do that. They cannot rate on health status, or rate up a group that has a sick member at all or as much as they

might want. Many states have said that insurers can't rate on health status at all; that's called community rating. They may rate on other factors, like age or industry, on a number of characteristics, but not on health status.

Many states have put in place mandated benefits. Some of those are reasonable; some of them perhaps are not. The one mandated benefit that is universal across all states is coverage of newborns. Insurers were saying that children who were born with congenital problems had a pre-existing condition that wasn't covered at the point of birth. That's prohibited in all states, although we see occasionally -- this happened in Indiana a few years ago -- we see an effort to repeal even that provision. But it is the one mandated benefit that's universal across all states.

Some states have put in place strong mental health parity. Maine and Vermont come to mind. Both states require insurers to cover mental health on the same basis as they cover all other conditions. California has a kind of limited mental health parity provision in place: California has a list of diagnoses

which must be covered on the same basis as other conditions, but if you're not on the list, then your insurance company can cover you differently.

And, as Paul mentioned, there is one state, Hawaii, that has mandated coverage. That provision was grandfathered into ERISA. Hawaii enacted that provision in I think in `72 or `73, and ERISA was enacted in `74. So they still do require employers to offer coverage in Hawaii.

This is, I think, one of the most important questions that you may have to address. The reality of whether all of these kinds of regulations intended to make the small group market fairer have raised the alternative problem of making coverage more expensive and therefore discouraging employer offer of coverage in the small group market.

We have a fairly large body of research evidence on this question. Although I have to caveat this by saying all of these researchers, myself included, have looked at the same data base for answers, so it's not surprising we come up with the same results. We're all looking at the current population survey (CPS), and it tends to tell us all

the same thing, although we use many different ways of measuring variables and different statistical techniques.

But it appears across the largest part of this literature that guaranteed issue, in particular, reduced the coverage in the small group market. We presume that's because it raised prices in the small group market. We only have the pre-HIPAA, post-HIPAA experience in most states, and then we have some selected states that had guaranteed issue before HIPAA was enacted. But it appears that there's maybe a one and a half percent difference in coverage in the small group market related to guaranteed issue. Conversely, and this is consistent with the rest of that story, that if we look at workers that we think are high risk, they were more likely to be covered in guaranteed-issue states than in states that did not have guaranteed issue before HIPAA.

We have very mixed results on other regulations, and I think that it's notable that the second and third large bullets are the territory of state regulation -- this is non-federal regulation we're looking at.

We haven't found any significant effect on community rating -- that is, provisions that prohibit rating on health status. And, with mandated benefits, we don't see that large employers do not have those benefits but small employers are stuck with them. Instead, we find larger employers offer these benefits voluntarily. So it doesn't appear that, in general, the mandate forces a lot of change. Conversely, many states have authorized the sale of "bare bones" plans to small groups, which strip out mandated benefits, but employers aren't particularly interested in them. Typically, they don't sell well when they're offered.

I'm going to move on quickly to the individual market. This discussion is going to be brief, which probably fits the number of people who are in this market. Individuals are about seven percent of the market, nationally. But in some agricultural states, they’re as many as 15 percent of the market. For example, in the upper mid-west, there is more individual coverage than in other states.

But, in general, it's a small market and it's a relatively old market, compared to the group market. About a third of the people in this market are in the

oldest age category, 45 - 64. And that turns out to be an important little piece of information to stick in the corner of your mind when you consider the other issues related to the individual market.

Underwriting is aggressive in this market. Some states have prohibited underwriting on health status, but most states have not. Most states allow rating on health status.

Applicants can be denied coverage entirely in the individual market. You can have what is wrong with you permanently excluded. And it can be great swaths of what is wrong with you. For example, your entire circulatory system can be not covered by the health insurance plan that is offered to you. Your brain may be excluded from coverage, obviously a big exclusion. Policies that tailor coverage to exclude specific conditions are called “sub-standard” and they can be extraordinarily sub-standard in some circumstances.

Also, you can be rated up for what is wrong with you. That is, you can be offered a "sub-standard” rate, which means you pay 20 to 30 percent more because you have some condition or

illness. Sometimes the condition that triggers denial or a rate-up can be major: there is no state in which an HIV-positive applicant will ever be given coverage unless coverage is guaranteed issue. And sometimes it can be negligible: If you come in with the level of allergies that Paul has this morning, you might be denied coverage or you would be rated up. (So stay with your group plan, Paul. You might go out in January looking for something.)

Individual coverage is expensive. The premiums are high for all of the reasons small group premiums are high, but in spades. It's a very expensive market. Insurers presume adverse selection. And, while the loss ratio is low on small-group products, it's still lower on individual products. Benefits as a percent of premium can be 50 to 70 percent.

Many states have set target loss ratios; some have set floors. But they can be extraordinarily low. In Arkansas, for example, the target loss ratio -- i.e., the one they really discourage insurers from falling below -- is 40 percent. So that as much as 60 percent of the premium goes toward everything but

benefits.

In general the individual market is unstable. It's just really not a pleasant place to be for either the insured or the insurers, as it turns out. When group coverage grows, this market shrinks rapidly.

We saw evidence of this during the economic expansion. It produced a small expansion of group coverage by the late `90s, and the individual market shrank precipitously. Enrollment plunged, and the exit was not balanced. That is, the people who were left in the individual market were the older policyholders.

The young people moved into group coverage and the individual market became older still.

The reason the oldness of this market is important is that a significant proportion of individuals in this market are paying the very highest rates. Individual policies are always, or almost always, age rated. So, a large portion of this market is in the highest rate class, a situation that contributes to the instability of this market.

The market also has many small insurers in

it. While Blue Cross and Blue Shield plans hold most of this market, there are many very small insurers that make a lot of noise about this market. I sometimes liken them to mice that roar.

If you regulate them, they protest loudly. Frankly, the small insurers are really trying to make a go of it in this market, and you can't blame them for their positions. But there's a reason that this market hasn't been cleaned up in most states, and a lot of it has to do with the balance of insurers in the market.

HIPAA solved some problems in the small group market, but it solved very few in the individual market. Most of the problems in the individual market remain. It is, I repeat, not a pleasant place to be.

There is guaranteed renewal in the individual market, although in some states some insurers may re-underwrite at renewal. That is, you can't be dropped from coverage, but if you got sick during the year, you can have your coverage rated up. We don't believe it's common, but it sometimes happens.

There is no guaranteed issue in this

market, unless the state requires it. In nearly all states, I can be denied unless I am HIPAA-eligible, and then I will be rated up. The difference in the D.C. market between a HIPAA-eligible person and a not-HIPAA-eligible person is three to one. You can go on the carefirst.com website and check out what you would be charged; it will give you a good idea of what would happen. There is a little check box there, I'm HIPAA, I'm not HIPAA; you can see what the difference is.

In addition, there's no individual-to-individual portability. If I try to move from an individual plan to another individual plan, I can be denied. Just three states have guaranteed issue: New York, New Jersey, and Maine.

Most states have put in place high-risk pools, but high risk pools have their own set of problems. They tend to be very expensive -- about two and a half times market rates, sometimes more. Remember that a significant proportion of people in the individual market are older; they're already paying very high rates. So if you're going to pay two and a half times the rate you would get in the market for standard coverage, you're paying a lot.

There can be waiting periods on high-risk pool coverage that are really problematic. The high-risk pool in Texas came to my attention yesterday: in Texas, if I don't accept COBRA coverage, I can not join the high risk pool until the COBRA coverage I could have purchased expires. That is, since I could have 12 months of continuation on COBRA, I cannot get into the high-risk pool for 12 months after leaving my group plan. In addition, after I join the high-risk pool, I have a six-month waiting period for anything that is wrong with me. So, for example, I have cancer but I didn't realize it until three months after I left my employer. I did buy a gap policy in the individual market, but my gap policy expires after three months. And because I came up with the cancer diagnosis, the gap insurer, which is not covered under guaranteed renewal regulation, decides not to renew my policy. I can't get into the individual market. I can't get back into COBRA.

MR. FRANK: Is this the lowest?

MS. CHOLLET: Well, it turns out to be. It turns out to be a very small pool of sick people.

So I go to the high-risk pool in Texas and

I'm told I could have elected COBRA, so I cannot enroll for twelve months. And even so, when I enroll, I will wait another six months before chemo will be covered.

This is actually the story of a real person. This particular person has literally no options other than, as a sick person, to try to get a job with coverage. That is their single option. I went around and around with an insurance agent yesterday morning about this, and there's no other option for this guy.

So that's how this market works. It's very hard for most people to anticipate all of these rules and how they will affect them. People who feel that they are healthy and do something like buy a gap policy, they don't realize how much risk they have put themselves in.

So with all of these provisions -- the cost, the fact that whatever's wrong with you won't be covered for a period of six months and sometimes 12 months -- it's not surprising there's low enrollment in high-risk pools.

And, because there's low enrollment,

there's very little impact on the market. The high risk pools are intended to take the highest risks out of the individual market and bring down prices in the individual market. But they're not doing that because they're not big enough. In Minnesota, it really is big enough, and there are a few other states, like Nebraska, where we see some impact of the high-risk pool on prices in the market. But, typically, they just really don't do much.

There are no affordability protections in HIPAA. Again prices were not addressed. Some states have tried to deal with affordability for individuals with health problems by putting in place rate bands in the individual market. Several prohibit health rating. Some allow insurers to rate on age, but the highest rates can't be more than twice the lowest rating – that is, the youngest may be charged half of what the oldest person is charged.

Some have composite rate bands that allow insurers to rate on any number of things, but at the end of the day, the rates can't be more than two-to-one or three-to-one for individuals in the market.

Only one state -- New York State -- has

pure community rating. In New York, you're charged the same rate regardless of your age. The only thing that makes a difference is where you live in the state and how many people in the family you're covering. But that is the only state that has pure community rating of all products.

This last slide lists some ideas to improve the market. I think I won't take up your time to go through these, but I wanted you to see them and have them in your materials.

MR. FRANK: Could you at least go down them and tick off which problems they address. I mean, for example, the refundable tax rate. That seems to be aimed at stability. Right? By bringing more people in?

MS. CHOLLET: It's really affordability and stability, but mostly affordability.

MR. FRANK: Okay.

MS. CHOLLET: And the uninsured. The issue with refundable tax credits is two-fold. Number 1, it has to be a fair amount for most people to get in, and this is a very expensive market.

MR. FRANK: Right.

MS. CHOLLET: And the other is that it would require a significant change in state regulations. It makes no sense, for example, to have a refundable tax credit that you can spend if you don't have guaranteed issue and you can't get a policy.

MR. FRANK: But it wouldn't deal with adverse selection?

MS. CHOLLET: It would not deal with adverse selection directly. But if more people were in the market, presumably it would deal with it indirectly.

MR. FRANK: Maybe. But they still compete to avoid the bad ones? Right?

MS. CHOLLET: Yes.

MR. FRANK: Right. So if you have multiple plans, you still have a problem.

MS. CHOLLET: Yes. But you can regulate your way into a more stable market. For example, New York State is made-to-order for a refundable tax credit. And there are other states that have very clear rules; guaranteed issues, rate bands on age, and no rate variation on any other factor. It would be

very easy to drop a refundable tax credit into a state like that. But, for most states, it would be a challenge.

There could be federal funding to make high-risk pools affordable. In the last several years, there have been federal funds available -- not big money – to help states to cover only the administrative expense of high-risk pools. But that funding was zeroed out in the President's 2006 budget, and it's not clear whether it will be reinstated.

There are a number of states that have in place reinsurance products and two or three that actually subsidize those reinsurance products for individuals or for small groups. They are of increasing interest. New York State has the biggest of those.

CHAIR JOHNSON: A question for Paul and Deborah both. Senator Wyden, who together with Senator Hatch, of course has helped and been the stimulus to create the legislation calling for the Working Group. He has expressed concern that, in his mind, about 30 percent of money goes toward administration.

I think for the small group market, Deborah, you indicated statistics that indicate that. Now you said only about 20 percent of the employees are in that.

Let me ask both of you -- by the way, Richard, in response to a question you raised earlier, in my experience is the reason most large employers are in self-funded plans. It's not only the cost that Paul indicated, but it's a chance to design their benefits without state mandates, and have all of those different regulations applying to them. Especially nationwide employers.

As a result of that, our administration has, at least through 2000, was about eight percent; eight to ten percent, in that range. And that included programs for educating pregnant women about maternity care, helping people with chronic illnesses and so forth.

And our experience with HMOs has been someplace between eight and 20 percent, was the administration costs for them. We were not self-funding them though, Richard, and so it's different-- Question would be, if we had some

mechanism to have uniform rules nationwide, to what extent would that reduce the administration costs and help us achieve some of the goals that we have?

MS. CHOLLET: What kind of rules do you have in mind?

CHAIR JOHNSON: Well, you've talked about state mandates and there are other administrative -- you, both of you have looked at some legislation that causes differences. And I'm just wondering if having uniform rules like ERISA rules nationwide or some other uniform rules would be helpful.

MS. CHOLLET: I think it would have a surprisingly small effect. And the reason is that Blue Cross – Blue Shield plans which are organized at the state level are the dominant carrier in almost every market. So the to the extent you're in the insured market, the carriers have accommodated those differences in rules. They’re not necessarily a cost to the carrier.

The costs in the small group market relate to the fact that there are so many moving parts that you don't see in a large employer group. Employers move a lot in this market; they shop. Something like

58 percent of small employers under 25 questioned in the Kaiser Family Foundation Survey said they had shopped for insurance in the last year.

Small employers will change insurance move companies readily, and that entails dis-enrollment, re-enrollment, and marketing costs in the small group market that just don't occur in the large group market. So you would retain all of those costs, and I am not convinced that you would see a lot of saving from uniformity.

CHAIR JOHNSON: Paul?

MR. COMSTOCK: I agree with what Deborah said. And I guess I would just add that I think we're moving to more administrative costs. So to the degree that we do see savings, it would be offset by things like trying to provide collect data on information on quality, the education programs.

And we may see some savings, but we're not going to be able to sustain it, given other things that are on the horizon that are just going to take its place.

It may result in a better care experience and maybe down the road more efficiencies. But we're

not talking big swings at the margin, really.

CHAIR JOHNSON: We are about 15 minutes overtime, but maybe we have two or three questions that we can take, and then we'll take a break.

MR. HANSEN: Paul, just one of your slides, I didn't quite understand it. Slide 16, your average annual deductible employee only by firm size, and I guess I'm trying to figure out what the trend is there and I don't know if you could just walk me through it real quickly.

MR. COMSTOCK: Yes. This is just the 2004, so what it's showing by firm size is, for example, on the left hand side, the PPO in-network. It's showing that for the smallest firms, those with 3-199 employees, the average annual deductible on employee coverage is just over $400. Whereas for someone who's in a firm with between 200 and 1000 employees, the average annual deductible is going be, you know, it looks like it's about $250. And then it goes down from there for firms with 1000 or more.

So that's the first part there. And then it shows how those deductibles vary by firm size if you go out of the network in a PPO. It shows you what

the deductibles are if you're in a point of service plan. And there you see they're very low for the large firms, but very high for the smallest firms. And then how those deductibles are even higher in a point of service plan, if you go outside the network.

MR. HANSEN: Thank you.

MS. MARYLAND: I'm actually asking a question for clarification so that I can get a better handle on the size of the problem. And it's directed to Deborah Chollet.

You indicated to me that small employers with less than 50 FTEs represent 20 percent of all the major employers -- all employers. And that one half of the working uninsured come from this group. Is that a true statement?

MS. CHOLLET: Yes.

MS. MARYLAND: Okay. And that's pretty significant.

MS. CHOLLET: Under 25. One half comes from groups under 25.

MS. MARYLAND: Wow. That's significant to me. And I heard you say it quickly and I wasn't sure if it was correct or not.

And you also indicated this is the fastest growing group in terms of employers, represented by these small employers. The fastest growing employment.

MS. CHOLLET: Employment. Right. Literally, all the net employment gains between 2000 and 2003 were in groups of under 25. in larger groups, there were employment gains and losses, but they offset each other.

MS. MARYLAND: So this is an area that we really need to focus on if we want to get a handle on how to reduce the number of working uninsured?

MS. CHOLLET: Yes.

MS. MARYLAND: Okay. Thank you.

MR. COMSTOCK: Yes. But I think one thing to keep in mind is that you're seeing job creation in this group. But the group becomes large as it creates jobs. Not every small firm that creates job stays a small firm.

MS. PEREZ: Okay. That's true too. That's helpful. Thank you.

MS. CHOLLET: But also, as an aside, one of the most problematic issues for the states, and I think for policy in general, is that about 20 percent

of uninsured workers work in the very largest firms. That's an issue of workers not being eligible or having no employer contribution to coverage. The problem is one of low-wage workers. The firm size is a problem too, and it is an important cut. But low-wage workers, no matter where they work, are very likely to be uninsured.

CHAIR JOHNSON: First Montye and then Mike.

MS. CONLAN: Deborah, you talked about high-risk pools. What about general insurance pools for -- that, I'm thinking, because I live in Florida. We have insurance companies that pulled out of hurricane coverage. So the state set up a general insurance pool. What about something like that for small employers and individuals?

MS. CHOLLET: There is one state trying to do that: Maine. The challenge there is that general insurance pools, in order to be different from purchasing coops, (and I can come back to those in a minute), require subsidies. Engineering subsidies to the low-wage workers in those small firms to get higher participation with ongoing employer participation requires some effort. And you have to

figure out where the subsidy funds are going to come from.

The alternative is a simple purchasing arrangement that the state may organize or not. In California, for example, the purchasing cooperative was started by the state and then, by law, turned over to a private-sector group after three years.

Employer participation in unsubsidized purchasing coops tends to be relatively low, and most employers come in from another insured arrangement. So they are helping, but they're small and they don't tend to have -- they have never been proven to have -- a price advantage. They're not cheaper.

MS. CONLAN: So you wouldn't recommend encouraging this kind of movement towards insurance pools?

MS. CHOLLET: I would recommend it if it is a very comprehensive approach. If it's just a purchasing cooperative, it's probably not going to solve the problem. It will help some people because there's non-zero membership; some people are going into it, so it must be a better deal for them. But it hasn't solved the problem anywhere that it's been put

in place.

If it's a bigger arrangement, something like what Maine has tried in their Dirigo Health Program, where they are brining in the small groups and subsidizing their low-wage workers, hoping to expand it to larger groups over time and also trying to fold in the individual market so that it's not this little ragged edge where no one is well served. If it were a more comprehensive approach, then I would say it's a very interesting possibility.

MR. O'GRADY: To get back to the last slide on ideas to improve, because much of this story is not particularly uplifting. It's sort of a negative tone to it. So I would like to spend a little bit of time on ideas to fix it.

And it is true that, in terms of Montye's point, there is four billion dollars in the President's budget to set up a -- but it is the administrative. It's not to subsidize the premium. But to allow states to be able to set up and get the administration of a, whatever you want to call it, a general purchasing or a non high risk, it is a notion.

And it is with some of these things that

there are very serious price barriers in terms of the size of the premium.

But when we look at the experience of things like IRAs and 401Ks, when you're talking about using tax credits and using tax advantage, there is also a certain difficulty that people his when those first came in of just knowing how to navigate that market.

And so, if there was this notion if the state actually had the infrastructure, if employers, even if they weren't contributing for whatever, could handle the deductions out of your pay, that that would at least set up a more fertile environment for this to be able to move forward.

But I guess, in terms of just thinking about these things, whether it's tax credits or high risk pools, or more moderate risk pools, or state reinsurance mechanisms, you seem somewhat pessimistic about those.

Do you have other things that you think would work better that wouldn't -- I mean you talked a heave subsidization. I assume we now start moving off of four billion and start moving to 40 or 100 billion?

I mean we're talking fairly serious investments and I don't, you know, after just spending 400 or 530 or whatever you think the drug bill cost, it's hard to see where that kind of a dollar amount would come from.

Do you have other things that might be within the current purview of the federal budget?

MS. CHOLLET: I think the conundrum is low-wage workers. And a very expensive product. If you do the arithmetic, a family of three at $40,000 is pushing above ten percent of gross income to buy health insurance. I think that is the fundamental problem.

The product is expensive and the people who are suffering are the people who can't afford that expensive product. Now, we can reduce the price of the product in a number of ways. Certainly, administrative cost efficiencies would be important and finding ways to bring down administrative costs.

When Maine set up their pool, they negotiated with the largest insurer in the state, Anthem Blue Cross - Blue Shield. They told Anthem that an acceptable bid would have a nine percent

administrative cost, and that's what they got.

But it takes that kind of a big buyer to call those shots. And the Maine program has authority to go self- insured. It took the ability of the state to walk away even from that one big insurer to get that concession. You really have to play hardball in a big way to make this work. You can drive down administrative costs, but you can't do it, I think, with small initiatives.

I still think the low-wage workers require subsidies and I think giving them a lesser insurance product -- something that has much higher cost sharing in it -- probably isn't going to either solve people's problems or actually save you much money. Most people don't spend through their deductibles, even when their deductibles are $500. Most people are healthy. So you're simply passing cost sharing onto people who have some serious health problems. I think the issue is very difficult: I don't think there are small fixes, and I think money is required.

MR. FRANK: I'm going to move back to Paul for a minute. You sort of took us through the various types of cost containment and quality improvement

strategies that are being used; tiered benefits, tiered formularies, and the like, quality reporting.

Yesterday we heard about some of the issues in Medicare in terms of expanding Medicare Advantage, improve quality programs there. Every one of these leads to higher administrative costs.

On one hand you might say, God, isn't this horrible? We have all these horrible administrative costs. But we're not happy with what we're getting and all our fixes drive up the administrative costs.

And one might look at this as saying actually, in a lot of places, we don't spend enough on administrative costs. And I'd just like to get actually both of your views on this.

MR. COMSTOCK: Yes. That's an interesting observation. And I think, because Randy asked me the question before about administrative costs, I think one of the other things that we're sort of not considering is the administrative costs of more individual responsibility and what that's going to do to the system in terms of uncompensated care, as people have higher deductibles; in terms of adjudicating claims, because people do have

deductibles.

And figuring out what the right reimbursement is; when you get paid. I've heard insurance companies telling their members don't pay the doctor when you go to the doctor. Wait for us to settle the claim before you pay, because you don't know how much it's going to be until we settle it. Doctor may charge $200, but if we're only reimbursing him $100, that's all that will come out of our account and you'll need to go back and try and get that money back from the doctor if you overpaid.

So I think we're adding in a whole layer and we need to be really careful, because it's going to effect affordability. Ultimately, it's going to drive up administrative costs.

CHAIR JOHNSON: Deborah, would you like to comment on that? On Richard's question?

MS. CHOLLET: I have basically the same response. The only other thing, though, is the complexity of the system for patients is just becoming enormous. I think individual responsibility, personal responsibility is, of course, important. But I don't see financial incentives, in many cases, helping

tremendously if we, the consumers, don't know price before we walk in to get care. If we don't know quality, even after we've left. And we have no way of controlling some of the issues in our environment.

For example, I had a conversation with a plan that covers police and fire fighters, and they want to put in a high-deductible product. And you think, well, how many of their health problems are controllable? What does that do for their incentives? I'm not getting what incentives you want them to pay attention to. Fewer donuts maybe; I don't know. It's a cost shift.

So, we not only have increased the administrative costs in ways we haven't begun to measure, but we've created a system that is so complex for patients that it's, I think, counterproductive.

CHAIR JOHNSON: Let me thank you on behalf of our whole group for your comments. I think the interest that you've generated is reflected by the fact that we've gone well into our break. And we'll take a 20 minute break in just a second. But, Deborah, I'd just like to comment on your very last statement.

And that is, as we move into some of our other hearings and hear from other folks, we will be hearing from folks who are involved with providing information to patients, both on efficiency and quality. In the start-up phases of that, to be sure, but that might help get at some of the questions and comments that you have.

Again, thank you very much. We'll reconvene at 10:30, if we can.

(Whereupon, at 10:11 a.m. a recess to 10:32 a.m.)

CHAIR JOHNSON: Well, we'd like to welcome you back to our session. And, again, thank you for your active participation as a Working Group. Thank you for your active participation in the first session this morning.

I'd like to request that, especially since we have three speakers to join us now that we allow you speakers to go through what you'd like to say. But we're going to ask you to hold to no more than 15 minutes for your presentation. And that will allow -- we've got lots of questions and you sensed some of that if you've been with us for part of the morning.

And sometimes it's hard to hold back those questions. But we'd like to give you your time, but we'd like to hold you to your time as well, 15 minutes each so that we can have questions from all of us.

Matt and Linda and Terry, welcome, especially. We're not going to reference your background and so forth individually. But let me just say this. When the hearing subcommittee was looking at who we might bring here, your names surfaced to the top and there was a lot of enthusiasm about inviting each of you. So, we're glad that you're here and we look forward to your information.

And, Linda, since you're first on our agenda, if you would go first and then maybe Matt and then Terry if you follow, that would be good. Okay.

MS. BILHEIMER: Thank you, Randy and Catherine. And good morning everybody. And thank you very much for inviting me to come to talk to you today.

When I was invited, I was asked to talk about what states are doing to expand coverage. So I asked whether you want a 5,000 ft. discussion or a 30,000 ft. discussion and I was told 15,000. So,

this is my best effort at a 15,000 ft. discussion.

And you will notice that I have actually changed the title of the presentation. Rather than focusing only on state strategies to expand coverage, recognizing the environment in which states are now operatingwe really have to think about state strategies to expand or maintain healthcare coverage.

What I want to do first today is to give you a sense of the variation in the nature of the uninsured problem among the states. States are very different. And if you don't get anything else from my presentation, that is the take-home message that I want you to grasp.

I'd like to talk briefly--and I'll make it very briefly because Deborah covered this in some length--about the strategies that states have used that have affected private health insurance coverage. I will tell you a little bit about their strategies with regard to public programs, what the impact of the current fiscal constraints are and then look to see where it looks like states are going in the future.

In terms of the variation among the states: What this slide shows you is how much the

states vary in the nature of the uninsured problems that they face.

This chart shows you data on the five states with the highest rate of uninsured in 2003 and the five states with the lowest rates of uninsured (as shown in the white bar across the top of the chart).. So, you can see on the left-hand side, Minnesota with nine percent of its under-65 population uninsured compared to Texas with 28 percent.

The key point to note here is that it is not differences in the share of the of the population that is in public programs that is driving differences in uninsured rates. Rather, it is the difference in the proportion of the population with private insurance coverage, which primarily means an employer sponsored coverage.

(I have included the non-group market under private as well, but it accounts for a a small fraction of total private coverage .)

What is driving this is differences in the employer base of insurance in the states. So, if you look at New Mexico for example, 52 percent of the under 65 population is enrolled in private insurance

coverage compared with 80 percent in Minnesota, which is a huge gap to have to make up.

You will also notice that the five lowest states in terms of private coverage are all in the South and West and the five states with the highest rates of private insurance are in the Northeast and the Midwest.

And if you look at the purple bars in the middle of the chart, you will see that, in fact, the states with the highest uninsured rates cover more of their population in public programs than do the states with the lowest uninsured rates.

Minnesota, for example, is covering 11 percent of its under-65 population in public programs compared with New Mexico, which is covering 23 percent in public programs and still has 25 percent of its population uninsured.

A different way of considering this issue is to look at the proportion of the population that is below the poverty level in these same states. And you will see that not only is the revenue base likely to be much lower in the states with high uninsured rates, but initiatives to expand public coverage to low-

income populations are going to have quite different impact. Suppose you had a program that was going to expand public coverage to everyone below the poverty level. The impact and fiscal consequences in states with high uninsured rates would be much greater than for the states with low uninsured rates, because the have such a high percentage of their population below poverty.

So, what have states done to expand availability and affordability of private coverage? As Deborah pointed out, in the 1990s we saw many efforts by states to reform their individual and small group markets through underwriting and rating reforms.

In general, as Deborah indicated, these initiatives had little impact on overall coverage rates,and the individual market reforms may actually have reduced coverage levels in states with the most comprehensive reforms, although high-risk people were more like to obtain coverage.

We've talked about exemptions from mandated benefits. Again, there is little indication of a large impact on coverage there. And several states in the 1990s combined efforts at group

purchasing arrangements with these market reforms which, as you heard, tended to have a small impact in terms of enrollment and resulted in problems of adverse selection.

We also saw more state efforts at re-insurance that weren't taken up much. We saw and continued to see high risk pools being developed. And also tax incentives to expand coverage, again, which didn't gain much traction.

One of the issues for states has been that state-only tax incentives don't provide a big enough incentive to make a major difference in coverage. An interesting question is whether state tax incentives combined with Federal tax incentives, which are now being discussed, would have a bigger impact.

But it's worth keeping these ideas in mind as we look at where states are now going, which I'll discuss at the end of this presentation, because some of these ideas are being thought about again and revamped, even though they didn't have much impact in the 1990s. People are now saying: What can we learn from the 1990s experience to help us shore up these markets in a more effective way?

Turning now to public coverage, as you are well aware, we have seen tremendous expansions of public coverage, particularly since the latter part of the 1990s with a strong emphasis on low-income children. Most states now cover children at least up to 200 percent of the Federal poverty level.

So, the large majority of children across the country who are in families with income below 200 percent of the poverty level are now eligible for public coverage.

We have also seen some expansions for low-income parents, plus other adults in some states, but it's important to realize that income eligibility is very much lower for adults and parents, where such coverage exists.

This slide has data only for parents, but it shows you the income-eligibility levels for parents, both working and non-working. (Some states make a big distinction in terms of the income eligibility standard, depending upon whether a parent is working or not.)

Only 20 states cover parents above a 100 percent of the poverty level. And we see a

significant number of states that have coverage levels below 50 percent of the poverty level, with 18 states covering non-working parents at 35 percent of the poverty level or lower. In some of those states, it's considerably less than 35 percent.

To give you a reality check on what that means: The poverty level right now is somewhat over $19,000 for a family of four. So, 35 percent of the poverty level is less than $7,000 a year for a family of four. So, we have 18 states right now that are covering non-working parents at that income level or lower.

For adults without children, the income-eligibility levels tend to be lower still, if the state covers adults without children at all.

The other thing that states have done--often in partnership with the private sector (including my Foundation) is to develop more effective strategies to enroll eligible people in public programs. With most children below 200 percent of the poverty level now eligible for public programs, how do we get them enrolled, given that we're dealing with populations now who may be unfamiliar with public

programs or the welfare system?

We have had a variety of state initiatives to expand outreach through schools, health fairs, etc, and the Robert Wood Johnson Foundation has also done a lot of work in this area. We've also seen efforts to simplify the enrollment and re-enrollment processes for Medicaid and SCHIP, as well as efforts to make coverage more seamless so that children, in particular, can move easily between Medicaid and the SCHIP program as their income changes, without having to drop out and re-enroll or being told that they've come in through the "wrong door". Some states have now adopted "no wrong door" policies. You go in and apply for public coverage and they work out what you are eligible for.

States have also made efforts to simplify the enrollment process. I won't go through all the ways in detail, because I expect you are familiar with many of them. They focus on getting rid of interview requirements, dropping asset test requirements, making people eligible to stay enrolled for longer periods of time so they don't have to renew every two and three months, and dropping some of the verification

requirements that families find hard to meet.

These were the efforts that states have been working on to expand coverage and get more people enrolled. But then we had to face the implications of the economic turndown for these public coverage programs.

It's important to realize that states face a double whammy here because not only do they face slower revenue growth during and immediately following a recession, but Medicaid is a counter- cyclical program. So, when the economy goes down, states' revenues decline and the demand for Medicaid services goes way up.

This chart shows enrollment from 1997 through 2003 in Medicaid. It is not the usual numbers you are familiar with, which show how many people were ever enrolled during the year. These are the estimates of the number that were estimated at a particular point in time. But you can see that between 1999 and 2003, enrollment increased by about a third in Medicaid nationwide. And that increase seems to be continuing.

This slide shows you what happened to

different groups who were eligible for public coverage during this time period. Between 2000 and 2003, there were significant drops in employer-sponsored coverage for children, parents, and other adults as well.

The interesting story here is how effective Medicaid and SCHIP were in protecting children. You can see that there was a very large increase in Medicaid and SCHIP coverage of children during this period and a much smaller increase in Medicaid coverage of parents and other adults.

Indeed, the uninsured rate among children actually fell during this recessionary period, while the uninsured rate of parents and other adults rose significantly.

So, how big a burden is Medicaid on the states really? (I'm sure that Matt will come chiming in on this one as soon as he gets the chance!)

This chart shows you Medicaid's share of state general fund spending. What you will often hear is that Medicaid is now a bigger share of states' budgets than K-12 education. While that statement is generally true, the critical word is budget, and the important point to understand is that the budget

includes all the Federal dollars as well. Many states receive large amounts of Federal dollars to support their Medicaid programs,and they're also using various forms of financing schemes that are included in that budget number as well. So, you get a somewhat different picture if you look at state general fund spending. Nonetheless, you can see that Medicaid is indeed a significant share of state general fund spending, exceeding 20 percent of state general fund spending in some states.

I know that tomorrow you are discussing cost containment, but I think you cannot talk about efforts to expand or maintain coverage without dealing with the cost realities that states are facing, because these two issues are so integrally related. The strategies that states are adopting are increasingly tied to their fiscal realities as they are now having to address questions that were less dominant when the economy was booming.

The types of questions they're asking are: How do we maintain the coverage that we have? And how can we stop the erosion of employer sponsored coverage that we're seeing happening, given the fiscal

constraints under which we're operating?

Some states are focusing primarily on how to curb their Medicaid and SCHIP costs, and some of their initiatives will have significant effects on public coverage and hence on overall coverage in the states.

Some states are scaling back eligibility, I expect most people have heard about the very large eligibility cutbacks in Missouri and Tennessee, where people will lose public coverage and are unlikely to pick up private coverage. But Missouri and Tennessee are by no means alone; other states are making significant cuts in their eligibility criteria for Medicaid.

To avoid having to cut eligibility, some states are cutting benefits or provider payments. Some are doing both or all three. Some are looking for ways to increase premiums and cost-sharing requirements which are, again, likely to reduce coverage in those states. We know, based on all the research that we have, that low income families when faced with even a small premium are likely to drop coverage. So, even relatively small premiums are

likely to have a large impact on public coverage.

Some states though are looking at ways to rethink the equation and ask: Are there ways that we can expand coverage for a significantly reduced benefit package? Can we adopt the philosophy that something is better than nothing, if we can't afford to provide very rich Medicaid benefits to a large low income population? Is it better to reduce benefits for some current public enrollees and use those savings to provide more limited benefits to a larger population? It's a complex question that is likely to be raised in your hearings around the country.

The state that led the way with this was Utah, but we now have several other states that are adopting similar models.

We also have states --

CHAIR JOHNSON: Linda, can we ask you to maybe wrap up your section in about two to three minutes?

MS. BILHEIMER: Yes.

CHAIR JOHNSON: And then we'll move on.

MS. BILHEIMER: Yes, absolutely.

We also have states that are looking for

ways to use Medicaid to expand coverage for workers. We have other states that are adopting more dramatic approaches and I won't go into all of these. I will just talk briefly about Florida and South Carolina that are looking for ways to convert their public coverage programs into more consumer-driven programs with the equivalent of savings accounts or a lump sum payment that people can use to make choices in private markets. And I'm sure Matt will pick up on that.

And we also have states, such as Maine and Massachusetts, that are looking for more wholesale restructuring of their healthcare systems involving both the private and the public sectors. And, again, we can talk about that.

So, just briefly. We have had grants from the Federal Government through the Health Resources and Services Administration to allow states to think about what their coverage problems are, and how they might expand coverage in the future.

When they surveyed their populations, many states learned the key importance of employer-sponsored coverage, and the fact that the majority of their uninsured were workers or in working families.

And we now have a handful of states that have received pilot planning grants actually to try to implement some of the ideas that they developed under their state planning grants.

What you will see here in this slide is that these strategies nearly all focus on employer-sponsored strategies. Of the nine states that have received pilot planning grants, only one is not focusing on how to expand employer sponsored covered in some way. Some are developing so-called three-share models that involve the community, the individual, and the employer in paying for coverage for-low-income workers. States are also bringing back some of the tools that didn't appear to work very well in the 1990s, but might under a revamped system.

Finally, there is growing state interest in ways to avoid the ongoing erosion of employer-sponsored coverage. This is a really interesting slide because it shows you some of the ideas that states have that have been dormant for awhile and are now re-emerging.

This slide shows state legislation that was introduced this year. We have 10 states that have

introduced some form of employer mandate, but we also have states that are looking for more subtle ways to bring employers into providing coverage or stopping them from dropping it.

In some cases, the legislation would declare an employer ineligible for state contracts or business tax breaks unless they covered their workers. And legislators in many states have introduced bills to authorize publication of the names of employers whose workers are enrolled in public programs.

And with this, I think I will just turn it over to Matt. As you know, the governors are thinking about ways to expand coverage in the future and how to address their Medicaid problems. They're looking at different ways to restructure the Medicaid program to slow the growth of people who are becoming Medicaid eligible, with strategies that focus on tax credits and bringing employers into the market again, as well as how to address their long-term care costs.

CHAIR JOHNSON: Linda. Thank you for your comments and I know that one of the challenges that the three of you have is you've got a wealth of information and knowledge and these issues are so

important and how do I consolidate that into a short time.

But we'll take questions, Linda, and Terry and Matt when you all are done. So, we'll spend a good deal of our time on that.

DR. BAUMEISTER: I just don't see a need to hurry so much. I think that -- I'm here from Portland and I'm taking four days out of my practice to do this and to learn from these people who are experts in the field. And I see no need to hurry them along so much, because they are encyclopedic in their knowledge and I am somewhat neophyte to some of this information. And when you put pressure on them, it puts pressure on me. I start listening faster. And I find this very enlightening and I think we ought to get all the juice out of them we can.

I don't know if anybody else feels that way.

CHAIR JOHNSON: We all agree, Frank. We do want to get as much information as we can.

MR. SALO: We're here for the full two hours.

MS. BILHEIMER: Yes. We're here to answer

questions.

MR. SALO: What we don't say in presentations, we'll get in the Q&A. It's a sunk cost. Okay.

Okay. Good morning. And thanks for having me here. It's certainly a pleasure.

And as Linda and I were discussing before the panel started, I am sort of notoriously a contrarian by nature but, unfortunately, I can't really find much in what Linda said to disagree with, because I think she's absolutely right on a lot of what the pressures are on the public and private systems and a lot of the motivations that states have and the actual tools that states are looking at to try to address this.

And I'm even delighted to see that she's done my presentation for me with her last slide. And maybe we can put that back up later, but if not, it's okay.

I want to talk a little bit about since clearly our focus is going to be on, you know, public sector attempts to address the issue of healthcare coverage. You can't talk about that without talking

about Medicaid. And so I want to talk a little bit about Medicaid without going into too much detail and about how the governors view it and then a little bit about sort of where we're going. And, I believe, Linda was referring to a bootlegged copy of what we were hoping was a confidential internal discussion document, despite all the efforts of Robert Pear at The New York Times to make it a public debate.

But, we do not actually have a proposal yet. We may never have one. We have been working on one for probably about the past six months and I'd be happy to talk about the things that at least are being circulated.

So, having said that, with respect to Medicaid, I can't stress enough how large and how important and how honestly frightening it is for a lot of governors when they really start to bear down and look at what the Medicaid program is and what its become.

The Medicaid program, according to Kaiser's estimates will cover 53 million people in 2005. And the Congressional Budget Office I've seen estimates that say it will cover as many as 58 million

by the end of the year. And that we will spend at estimate $330 billion in 2005 alone on this program.

And as Linda pointed out, it is a significant source of state general revenues and, you know, we're the ones who like to say it's the -- you know, we're the ones who like to add in the Federal funding so that we get to the point that says, Medicaid is now the largest item in state budgets, because if you add in the Federal funds, which in Medicaid in some states are significant, Medicaid is now in terms of dollars spent, is larger than K-12 education and is growing at a rate that is much faster. And that terrifies people.

That terrifies people in state government who know that one of the bed rocks -- one of the foundations of state government is to prepare the workforce of the future. And if you have to sacrifice education, whether it's K-12 or high ed in order to pay for healthcare. I'm not saying the healthcare is not important, but sacrificing education funding is not the way to go to prepare the workforce in the future.

So, consequently Medicaid reform very high

on the agenda of the governors as it has been every year for as long as I've been doing this which is more than a decade.

It is important to keep in mind, I think again as Linda had mentioned, that Medicaid and SCHIP have done enormously important work in terms of -- already having done enormous work solving or keeping the number of the uninsured less than what they would have been otherwise.

And if you look over the past five years. Linda looked over the past four. I'll look over the past five. A period of time where the state economies and the state finances were in abysmal shape. States were in the worst fiscal situation since World War II and for the first time in recorded memory, we had years in which state revenues were actually declining.

If you look over that period of time, the Medicaid case load grew 40 percent. Forty percent over a five-year period which represents about 15 million people, largely not as a result of states' expanding coverage.

But, you know, I guess there are two things. One as Linda mentioned, sort of the

counter-cyclical nature of Medicaid. As the economy goes down, people lose their jobs. People lose their healthcare. They come on to Medicaid. And that's how it's supposed to work. In an ideal world, that's how it would work.

And then in theory, as the economy picks back up, people get jobs. People get healthcare. They come off of Medicaid. We're not seeing that. And the reason I think that we're not seeing that is that there are more forces at work here than just the counter-cyclical nature of the economy.

The economy has come back. The Federal economy is doing quite well. The state economy is doing much better. People are working again. Job growth is up. Employer-sponsored healthcare is not. As people are getting jobs, they are getting jobs in the service industry. The service industry traditionally doesn't provide health insurance. They are getting jobs in small businesses who are increasingly finding it very difficult to afford healthcare. And they're getting jobs in the traditional manufacturing market. You know, the big three. The automotive industries in Michigan who in

order to remain competitive globally, are finding it increasingly difficult to afford the healthcare costs of retirees and of workers and of their dependents.

You know, the heads of the manufacturer will say, $1,500. They have to build $1,500 into the cost of every car that rolls off the lines to pay for healthcare. And if they're competing with Toyota and BMW who don't have to do that, that puts them at a distinctive disadvantage.

So, there are large problems facing the Medicaid program. And, you know, I'll acknowledge that the 15 million people that have come on to the program over the past five years, are predominately women and children. And, you know, from a demographic standpoint, these are not terribly expensive people. You know, the average annual cost of paying for women and kids, $1,500, $2,000, $2,500 a year. So, it's not like we're talking about a year of nursing home coverage for a senior at $60,000 or $70,000. And I don't care how cheap they are, 15 million of them are not free. And the ability of the Medicaid program to continue to finance an ever-increasing portion of those folks is rapidly going south.

So, do we think Medicaid needs reform? You bet we do. And we think there are a lot of ideas that could bring down costs without really sacrificing access to care and quality of care.

But we're looking at the Medicaid program in a much more expansion comprehensive way because it's become increasingly clear to us that the problems of Medicaid, the reason why we're spending $330 billion a year is not because there is something wrong with Medicaid. It's not because it's an inefficiently administered program. It's not because there's a lot of waste, fraud and abuse.

The reasons why Medicaid costs so much basically boil down to about three finite issues. And these are the issues that I think really need to be addressed if we're going to solve Medicaid's problem. And by and large, all three of these problems ultimately have nothing to do with Medicaid itself.

First of all, Medicaid costs a lot of money because healthcare is expensive. And we can kind of shake our head and say, yes. That's right. But medical inflation has been going up more than

twice the rate of regular inflation for as long as I can remember. It is vastly exceeding wages and the ability of state or Federal governments or the employers to finance it.

We spend a lot of money on healthcare in this country. We spend more than any other country in total and we spend more per person. And I'm not convinced that we're getting a good return on our value.

You know, how does the United States compare with other industrialized nations on health outcomes? Certainly, not number one. We're probably in the realm of 25, 26 in that realm. We waste a lot of money on healthcare.

We have the most sophisticated advanced medical technology. Our healthcare infrastructure, our healthcare information technology has not kept up. Healthcare is probably the only field in modern America where information technology is so far behind the advances in research and in delivery.

We need to get to things like electronic health records to prevent misuse and overuse and consistent overuse of healthcare services. We need to

look at e- prescribing because I think that we in this country have very little idea about what the interactions of drugs actually are and what the benefits of drugs really are. And, you know, I think there is a lot of bad healthcare going on at there.

We need to look very seriously at patient safety, at medical errors, at quality, transparency of quality information. These are not easy things by any means. But they have to be done. And, you know, we're happy to try to lead the way. I know that Secretary Leavitt has talked a lot about the Federal Government trying to take the national lead on healthcare information technology. I think that's a great discussion to start having. If the Feds can't, we're happy to do it. We're happy to do it in partnership. But it's got to be done.

And that's going to save money not just for Medicaid, but for Medicare and the private sector and everybody else. So, that's one.

Number two we kind of alluded already, which is the erosion of the employer sponsored market. Employers just aren't offering coverage for their workers or their dependents as much as they used to.

And some people will sort of get into a chicken or egg kind of fight over -- well, people are dropping it because the public sector is there to pick it up and they know that it's safe and it's okay.

And so some people argue, oh, the only reason the public sector is there is because the private sector isn't covering it. And we can have that fight forever. But the fact of the matter is, the private market, employer sponsored market, is eroding. And we need to do something about that.

Does that involve individual healthcare tax credit? Employer tax credits? I don't know, but I think it's worth exploring. You know, does it involve trying to use as much leverage as we can? Maybe states would be able to look at all of the levers that the state has. Medicaid program, the SCHIP program, state employee plans. Bring them together in some sort of alliance where you could bring in small businesses. You could partner with larger businesses. And increase your leverage to be able to offer different packages at lower cost for everybody and maybe find ways to keep people on private sponsored health insurance.

And the problems with having 53 or 58 million people on Medicaid. Yes. It's a great benefit, but one of the main reasons why Medicaid is 330 billion and not 500 billion a year is that we don't pay providers very well at all. We chronically under fund every provider in the system. And trust me, I hear from all of them. And they wonder why they're being picked on. And they're not. We're under funding all of them, which is a problem if you're covering 20 million people. It's a very serious problem is your covering 53 million people. And if you're going to cover 75 million people, I can guarantee you it's unsustainable because the networks will just dissolve. And your Medicaid eligibility card will be a hunting license.

Yes. In theory, you have coverage. Good luck going and finding it.

Again, are any of these things easy or cheap? I don't think so. But they've got to be done and they're not Medicaid's fault.

And the third big thing is, I think the most important. And this is the conversation that very few people are actually having. And that's the

extent to which we do not have any kind of rational thought- threw policy on long-term care in this country.

Most people in this country if you ask them, if you need long-term care when you get older or you get sick or get hurt, you know, what's going to happen? And they're going say, oh. Medicare will be there for me. And we know that's just not true.

And, you know, again we can sort of quibble the numbers because a lot of the long-term care expenditures in this country are hard to track because it's unpaid, it's informal, it's family care. It's hard to really quantify that. But the dollars that we can quantify show that Medicaid is the single largest payer of long-term care services in this country.

The Medicaid program ends up covering two thirds of every nursing home -- two thirds of all nursing home residents in this country. And that's not a safety net. Medicaid has become the de facto long-term care insurance or long-term care services program in this country. And we have done it not by action, but by inaction. And we can't continue to pay

for that.

The demographics on the aging of the population are pretty clear. And the costs of long term care which are now $60,000, $70,000 per year in a nursing home are pretty clear. We have got to find a better answer.

And I could sit here and say, oh. You know, Medicare starting covering drugs. Maybe Medicare should start covering long-term care. Well, that's not going to happen, you know. And I can't sit here and say, well. Everyone should just have long-term care insurance, because while I think that would be a good idea, the market just isn't there.

So, we've got to do a lot of very difficult lifting on this both from the big picture macro policy level. We have to have a national dialogue on this. And this is more important than Social Security. This is going to bankrupt the system real soon. So, we got to find ways to encourage people to finance their long- term care needs in a way other than just backing into Medicaid, either when they get sick or when they get impoverished or whether they're impoverishing

themselves on paper inappropriately.

So, those, I think, are the three big problems that are facing healthcare and are facing Medicaid. And we are going to try to get those addressed. It is not something that the governors can do on their own. We're going to need the Federal Government for help. And we're going to need the entire healthcare industry to help because just as Tennessee and Missouri are, I think, -- Linda is right, not alone. They may be on the front end. They may be the bellwether of this, but they're not alone. You know, Medicaid is not alone in this. And as Medicaid goes, if Medicaid goes, so does the rest of the healthcare system.

And I don't now if that's inflammatory rhetoric, but I think it's very much true. And we have to get real serious about what some of these cost-drivers are.

Having said that, you know, as Linda points out. There are things within Medicaid that we do think can be changed and can help drive some of these program changes.

Medicaid is very much a one size fits all

program. If you qualify for Medicaid, and you're, you know, you're one of those adults, one of those parents in a family of four who is making $7,000 a year. Or whether you qualify for Medicaid in a more generous state. Say Massachusetts or something where you're getting covered at 150, 200 percent of the poverty level. You have the same benefits package.

There is no real way for the system to say. As you make more money, as you're higher up on the income scale, as we continue to get into the working poor, there's no real way to structure benefits differently.

The cost-sharing rules in Medicaid were written in 1982 and haven't been updated. Currently there are populations who cannot be charged cost-sharing at all. There are services for which cost-sharing cannot be charged. You can't charge more than $3 for any service. And ultimately, even if you do charge it, you can't enforce it. If the person doesn't have or won't pay the $3 for their drugs, you can't deny them the service. That doesn't make sense.

And I appreciate Linda's point about, you know, if you charge premiums to very low income

people, maybe they walk away from the program. That's a concern, but I think you have to work through it. Because I just don't now that, you know, in 2005, does it make sense in the healthcare system to have a benefit for whom it is truly free? That there is no personal responsibility. There is no incentive for people to pay what they can. And I would say no.

So, again. These are things we're looking at. Obviously, Congress needs to enact any of them. Some of them maybe are more controversial than others. But, we're going to try to fight the good fight in that and I'm sure I've exceeded my 15 minutes. But happy to answer questions afterwards.

CHAIR JOHNSON: Terry, can you go next, and then we'll have questions.

MS. STOLLER: Actually, I was going to say that what Matt and Linda described regarding states having different levels of coverage was perhaps a little more emblematic of the challenges that communities face. The reality is that the Federal Government and the states create structures that cover some folks and don't cover other folks. Communities have a very difficult time sometimes trying to

understand what those different coverage thresholds mean in their community. Many of the organizations serving the uninsured really struggle day to day to meet the needs of the uninsured in their community.

What I'd like to cover today is one of the national funder initiatives focused on trying to find community-based solutions to the uninsured to improve coverage and access.

I'd like to provide some context (which I think actually has been described here this morning for the national funders' investment), talk a little bit about Communities in Charge (so that you understand the subtle nuances of this particular national funded initiative), our findings, some important considerations and some replicable strategies and strategies to avoid at the community level.

I think that Linda and Matt and the other speakers talked a little about the economic context of the last five, six, seven years.

Communities in Charge, which is funded by the Johnson Foundation, Community Voices, which is funded by the Kellogg Foundation and the HRSA, Health

Communities Access Program, formerly called the Community Access Program were all created in the late `90s, early 2000. And, again, created in an environment where there were state and Federal surpluses and it was clear that there was not going to be anymore Federal or state action to broaden coverage.

And so the question is, in an environment where you had motivated communities, (that is, where there were real faces for the uninsured: they are the taxi drivers; they are the people that clean up after meetings, who work in gift shops in hospitals, who work in hotels and at other similar service-related jobs. They had real faces that providers who were treating them or who were wandering around the system trying to get the care that they need; they're real faces), and also providers (who are experiencing some real pressures; Matt alluded to some of the pressure around Medicaid growth in numbers of folks being covered; but on the other hand, real constraints around the payments that were being made to providers) there were also some examples of communities that stepped up to the plate (actually I know that several

of you live in communities here; I know that you live in Halifax County in Florida. Is that right?)

MS. CONLAN: Volusia.

MS. STOLLER: Volusia. I'm sorry. That's what I meant to say. But Halifax Hospital there actually has a program that's funded through tax financed district that covers the uninsured.

So, you have communities like Hillsborough County another community in Florida that decided that they would rethink healthcare financing by raising a half cent sales tax and reorganizing the system of care. And now cover about 30,000 low income folks in that community who are not eligible for Medicaid. (And these are people under 100 percent of the Federal poverty level.)

Again, Milwaukee, Marian County, which is where Indianapolis is, and Wayne County, Michigan, are other examples of programs.

So, again, all of this environmental context raises the question. Could communities create and finance new coverage and delivery systems?

So, let me just give you a very -- two-second overview of Communities in Charge. You can

read this, but the bottom line is that the Robert Johnson Foundation created Communities in Charge to really challenge communities to design and implement new or expand existing community-based systems for financing and delivering care, offering a full spectrum of services. So, it wasn't enough to just offer primary care. Communities had to integrate the other services that would be required to really give someone all the needed care that they would require for a certain condition.

The expectations were that these would be community- wide initiatives. That is, involve not just the "usual suspects" of the safety net providers, but include private providers, employers and advocates working together as a community to help define a uniform system.

Also, the result would be a systemic change. That is, not the same old, same old, but a new way of doing things. That the programs would serve a large number of uninsured persons. That is, tens of thousands, not a couple hundred or a couple thousand. And, again, they were roughly modeled on Hillsborough Healthcare in Florida which had a

financing change. And, again, the idea here was not solely to have communities raise taxes as a means to support new coverage but to find other solutions to support new coverage and again restructure the delivery system.

There were important attributes to this program. One is that it was directed towards large communities. That is, communities that have a minimum population threshold of 250,000. The idea there is that most large communities don't have challenge of providers -- actually, the paucity of providers that you find in rural areas. Those existing providers in large communities may not serve everybody, but the fact is that you had a base of actually enough providers and acute care facilities so that the initial focus of community efforts was on coverage and emphasis on a systematic process for design and implementation, and the main thrust here was that these four-year initiatives, really now about a five years, programs needed to be sustained within the community and not just five-year demos that evaporated when the funding disappeared -- the foundation funding disappeared. Again, emphasis on active coalitions,

champions, invested leaders and having enough providers. And you'll have a map in your packet that describes the funded sites. Those in red are the ones that continued onto phase two.

The 12 communities that ended Communities in Charge developed three different approaches to addressing the problem of the uninsured. Four developed public private coverage and I know later you're going to talk about some private coverage initiatives this afternoon. Communities in Charge really was a public/private effort in everyone of our communities.

Let me just give you an example of a public/private coverage model.

In Alameda County, which is where Oakland is in California, the project developed a couple of coverage products. One was a program called Alliance Family Care that used some sales tax revenue from a state sales cigarette sales tax, foundation funding and donations from existing providers to fund coverage for families and children who are not eligible for the state's SCHIP program.

They also created another program that

leveraged state and Federal dollars to cover low-wage, in-home health service workers. Again, the structure for that coverage program was created by the state.

On the public/private voluntary model side, we had several communities that created more voluntary programs. Some of you may be familiar with a program in western North Carolina called Project Access or the Buncombe County Model, which is a voluntary program in a rural region.

We had one of our communities try to replicate that model in an urban environment. We had others that involved similar collaboration among providers using Disproportionate Share money which is Medicaid money matched by the state and Federal Government, where a portion of it, in the State of Georgia, for example, is set aside for primary care services and that was used to pay for prescription drugs. Currently there are no funds available to pay for prescription drugs for the uninsured.

We had four communities that developed what we call "other public/private models" (I know Ascension actually is a partner in a couple of these).. Austin is one community that not only

developed some voluntary models in the provider community (where one of the hospitals agreed to provide care for about somewhere between 2,000 and 5,000 people; within the system eligibility for the program was determined from a financial perspective and then enrolled persons had access to care within the system). They also did a little Project Access program through their medical society,.and the City of Austin itself actually expanded coverage within its Medical Assistance Program.

Austin also had some other initiatives. One is a shared clinical record that currently includes 360,000 unduplicated individuals who use the safety net in a three-county region in central Texas around Austin. They have over 1.4 million encounter records and I think a couple hundred thousand dollar prescription orders. They have accomplished other projects as well.

So, what were the findings? Well, Linda really set this one up for me: Location matters. If you can imagine the difference in 50 states. Think about the communities within those 50 states. Different Medicaid thresholds. Different structures

for Medicaid disproportionate share distributions within the states and within the communities.

Some of our communities had no disproportionate share funds. In others, those funds were targeted to only a couple of hospitals. So, again, where you are matters.

Additionally, some states mandate local responsibility for indigent care. In fact, some of the most innovative community-based programs have come from those states that mandate local responsibility for medically indigent individuals: Florida, for example, Michigan, California and there are a few others. (Not very many, but a few.) Those states have affected the kinds of infrastructure that's been built to help communities access state and federal funding. And then the riches. That is, not only just how rich a state is (Linda covered that), but also the distribution of revenue within the state.

And, again, not every community has the "right stuff". You'll see a little bit later (and I'll skim over that), that this is really, really hard work. Our communities were exceptional communities. You really can't accomplish this work without these

elements.

In the interest of time, I won't go through them, but I do want to emphasize the last one: real resources. Communities, even to run a program for chronically ill, uninsured persons, need real resources. We have a program in Louisville (which is a merged county, now city, Metro Louisville now); it costs them $1.5 million to coordinate care for the 2,500 chronically ill, uninsured enrolled individuals in that community. (2,500 people is all they've got enrolled in that program.) So these kinds of resources are really required to even do the smallest little bits of things that some of our communities have done.

It is pretty obvious that the healthcare system is really not a system for the uninsured. There are too many gaps: Specialty care. There's no disproportionate share dollars for physicians and with pressures on physician practices, particularly with the consolidation of the physician market, there's less room for individual physicians to donated care.

There are too many silos and the existing financing structures are a barrier to system change.

That is, I talked a little bit about disproportionate share. If a hospital that receives disproportionate share tried to create a structure where it may pay for prescription drugs or for specialty care services, and it keeps people out of the hospital (thus potentially lowering the hospital's indigent care costs), the hospital's disproportionate payments will go down. So, it's this downward spiral: making a more efficient structure for care only reduces the payments the hospital uses to make care more efficient.

And if you'd like, I have a wonderful example from one of communities of how this system is really a non- system, even for people who have jobs, who are really adamant and interested in trying to control their disease states so that they can make things work. And I have a wonderful example from another one of our communities that really illustrates this.

And perhaps this is one of the most important points and findings from Communities in Charge. That is that Hillsborough was an anomaly. Communities can't fix this coverage problem on their own. They don't have the financial resources to make

it work.

Yes, if states and the Federal Government can say, we'll each put in a buck with a buck from you and to make three bucks instead of one buck. Yes. There are examples of that working. But, again, what was described as the financial problems in the states, financial problems of the Federal Government, it's even worse at the local level. Particularly, for urban communities where income and other economic components are just heading even more downward.

All of that said, there are communities with the right stuff that can do things. They can leverage funds. They can broker public/private partnerships. And do some of the other things that are here. They can build infrastructure that improves the efficiencies within the delivery systems. And I can talk about some of those if you'd like later.

I went through some of these before, about how difficult this work is. I think the second bullet about Big P and Little p politics makes this very, very, very difficult work for communities and, again, leadership is everything.

There are replicable strategies that came

out of our program. Health policy forums were a strategy used by one of our communities Jacksonville, Florida. This process really helps communities come to that awareness and assess whether they have what it takes (the right stuff) to go forward.

Several of our communities implemented common eligibility screening tools which again make sure that as many people that are eligible and are signed up for public programs, particularly Medicaid and SCHIP. These tools also create efficiencies so that lower-level hires can actually do the screening in a much more systematic and universal way. Shared clinical records: (again, we had some communities that tried to do electronic medical records and if you'll remember that Big P, Little P, of politics sabotaged many of those efforts); but we do have this wonderful example in Austin of a shared clinical record that not only provides real, on an individual basis, improved abilities to track how individuals are accessing the system and what care is provided so there is less duplication. For example, you can call somebody up and say, gee, Mrs. So and So was in your emergency room and had this test done. Can you tell

me what the results were so that I don't have to repeat it here?

Likewise, at a macro level, in Austin they were able to tell (within two or three weeks) what happened when the State of Texas eliminated some of its Medicaid benefits for mental health services and the impact the elimination of these benefits had on the primary care delivery system, (which was many more visits on the medical side and the severity of the diagnoses significantly increased).

I described the state/Federal partnership coverage programs that are successful. We do have communities with the right stuff that were able to coordinate gap filling. That is that they were able to pool among all the hospitals set amounts of resources so that there's a more systematic way for communities to provide access to diagnostic tests, hospital services, specialty care, particularly mental health services. In Alameda County, they're actually pulling in the silos around housing and the justice system. So, again, those services are available.

I want to reiterate two things to avoid. And I think Linda described one of these and you heard

from Deborah Chollet earlier about the second bullet. But let me first describe what I mean by emergency room diversion programs.

These are programs that have been tried in several communities through the HCAP program and through Communities in Charge and through some of the other funded programs. These programs involved recruiting individuals who are seen in the emergency room for more primary care level services and saying, if you sign this form, we will contact you and try to facilitate your access to a community health center or some more appropriate place where you can get services.

And unfortunately what our programs have found, and also some of the other funded programs, is that without significant incentives, and what I mean by incentives is more or expedited access to specialty care, assistance—real assistance—with prescription drug coverage or getting medications and access to an outreach worker to help people understand where these services are. You can't change these health seeking behaviors, and most importantly, you can't do it without real access to primary care and specialty

care.

Many of the clinics, because they are strapped for cash, community health centers in communities operate 9 to 5. Even those that have evening hours, or drop-in hours are just over-taxed. But just like hospitals, those community health centers can't continue to take everybody and still keep open their doors, because they have to have a black bottom line in order to open the doors the next day. These clinics need to be able to have enough paying patients (and that could be Medicaid or other insurance--usually it's Medicaid) in order to make their bottom line work.

In terms of small business strategies, I had the, I guess, good fortune 15, almost 20 years ago to work on some pre-HIPAA, state-level small business expansion projects. (I didn't have gray hair then.) These strategies didn't work really effectively then and don’t now: three of our communities pursued small business strategies in order to expand coverage for low income, low wage workers and had exactly the same experience. That is that they have now created another barrier to coverage, which is having the small

employer put up the money. (I guess I call it this the "math myth": the numbers say. Oh, gosh, we should do small business expansion strategies. There's lot of people who work in small businesses and most of them are uninsured. And there's very few relatively small business have coverage. Seems like a pretty big no-brainer.

But the reality is that the costs of coverage as Deborah described are just too high for low-wage workers to have this be a good solution. The projects offered coverage at the price points that small employers stated was acceptable. Our project in New York City had a premium of $117 a month for single coverage, which was one third the price of any comparable product. They signed up 100 people from 25 firms.

And all the data on the extensive outreach that they had, but a very able chamber down there could not fix this problem for low-wage workers.

So, I'll get off my soap box now.

And if you want more information, I put our website communitiesincharge.org. We have a manual on there that's a "how-to" for communities thinking

about community-based strategies.

And the second reference is an Issue Brief that we developed with another Robert Johnson Foundation program called State Coverage Initiatives that really talks about state and local collaboration. I don't now if you included that in the bibliography for --

MS. TAPLAN: I sent it out to everyone in advance of the meeting.

MS. STOLLER: Good. Thank you.

I'm sorry if I ran over.

CHAIR JOHNSON: Okay. Thank you very much all three of you again for your presentation and we'll open up for questions at this point.

VICE CHAIR McLAUGHLIN: Linda, and what Terry said fit into this.

One of the main reasons why this Working Group was asked to hold hearings was to feed into our report that we're going to be putting out later this year to the American people. And so we are eager to find things about state and local initiatives, which was one of the assignments that we were given.

One of our goals, of course, is to

communicate to the American public some of these issues in a very reader-friendly way. So, I loved your chart with the five high states, the five low states, because that's exactly the kind of picture, I think, that people are going to be able to grasp and get the idea.

So, I was sort of disappointed when you didn't do that for us on the state budget thing.

Is it possible to do that? Medicaid's fiscal burden, because you showed about, you know, New Mexico, having a very high percent on Medicaid relative to Minnesota, for example. And then Texas and Florida actually have a small percent on Medicaid. And I was wondering how much of this is poor state, rich state? So, what you could get to if you looked at your, you know, the share of state/Federal -- I mean, state general funds, is there anyway? Are there data that we could get --

MS. BILHEIMER: Yes.

VICE CHAIR McLAUGHLIN: -- that would be able to tie the high/low and see?

MS. BILHEIMER: Yes. I could get that for you.

It starts becoming very complicated. Because if you look at the way the state spending information is laid out by the National Association of State Budget Officers, you find they break out major categories of spending, such as education and Medicaid, by the major sources of funds such as the general fund, Federal spending, and other state spending.

And in Medicaid, other state spending that is a very mixed bag, because it includes all of the various funding mechanisms that states have employed through intergovernmental transfers, disproportionate share payments and so on. It's hard to tell what that bucket represents.

All I have here is the general revenues. I can get that information for you and show it to you state by state and --

VICE CHAIR McLAUGHLIN: Right. But I was just curious, I mean. You have four states that are, you know, the 25 percent and, you know, 4 states that are 20/25.

Do you have any idea just off the top of your head who those four are that are over 25 percent?

And then maybe there's 9 that are less than 10 percent. But is there any matching with the earlier chart you gave us?

MS. BILHEIMER: It tends to be the case but I cannot pull up individual states.

VICE CHAIR McLAUGHLIN: Why not?

MS. BILHEIMER: I should have brought that table with me. But it tends to be the case that the states with -- we're talking about the state budget issues here.

VICE CHAIR McLAUGHLIN: Right.

MS. BILHEIMER: I was mixing up your questions, and thinking about the parent coverage issues.

I'm not going to answer that without going back to the data, but I will get the data for you. --

VICE CHAIR McLAUGHLIN: That would be great.

MS. BILHEIMER: Okay.

VICE CHAIR McLAUGHLIN: Thanks, Linda.

MS. CONLAN: I want to thank all three of you for teaching me so much and triggering so many questions in my mind. And I'm learning far more about

economics than I ever thought I would on this Working Group.

But I guess I'm starting to understand. I have bits and pieces because, of course, I go to Tallahassee and advocate for the medically needy program in particular and Medicaid. And every year our state legislature tries to balance the budget on our backs, we feel. And I know that the state has attempted to shift costs to the counties and to the hospitals and there was an uproar. But I guess I'm learning now that this is even more complicated than I thought because I also know that Florida's economy is based in large part on tourism.

Tourism involves a lot of service jobs. Low-paying service jobs.

I was heartened to hear in our recent legislative session, one of our legislators singled out and shamed Wal-Mart for what they labeled as corporate welfare for the number of Wal-Mart employees that are also Medicaid beneficiaries.

And I know a lot of this is beyond the scope of this group, but in terms of the governors certainly isn't. Are we just picking out Medicaid as

an easy target or do the states, particularly Florida, need to look at ways to diversify the economy or make large employers accountable and see the whole picture instead of just focusing on us. And then also in terms of our group, should we in some way help to empower Medicaid beneficiaries? Do we need a national Medicaid beneficiary association to be coming to Washington to approach the President and say. These are our problems and this is what we need. And so you're considering the governors and consider this.

So, anyway. I'm just throwing these things out.

MR. SALO: I guess I'll take that.

Those are all very good questions.

I would say a couple of things. States have to balance their budgets every year. We are unlike the Federal Government in that sense. At the end of the day the budget has to get balanced. And if you don't have the revenues to match the expenditures, something has got to give.

And in this political climate at the state level, at the county level, at the Federal level, there is for the most part no interest in raising

taxes, especially raising taxes in order to fund, you know, public programs.

I would definitely not walk away from this thinking that Medicaid is an easy target. Or that Medicaid is being singled out. Or that any particular group within Medicaid is being focused on.

Medicaid tends to be the last item you go to cut in the budget for many reasons. One of which for every dollar you have to cut from the state budget Medicaid, you're giving up a dollar or two dollars or three dollars or four dollars from the Federal Government.

MS. CONLAN: Right. And what about the business activity that is generated?

MR. SALO: It's an economic development issue.

MS. CONLAN: Right.

MR. SALO: But, nonetheless, at some point you have to say, enough is enough. You know, if Medicaid starts off at 10 percent of your budget, in five years it's 20 percent. In five years it's 40 percent. Just because you're bringing Federal money in doesn't mean that's sustainable.

And there are very real questions about, you know, the role of Government versus the role of employers versus the role of families and the individual.

Medicaid is really the last thing that gets cut. If you look at the growth of Medicaid from the state perspective over the past five years. You know, look at the growth of Medicaid. I don't have a chart. I'm sure someone's got a chart. The growth of Medicaid compared to the growth in state revenues and the growth in state high ed. Higher ed is being cut and Medicaid's largely remaining untouched.

So, I would, you know, it's not an easy target. It's probably the hardest target. And, I guess, I can't really comment on diversifying the state economies. That's way beyond the scope of my job.

But I would say that you do have beneficiary associations. And you've got your Families USA. Your Child Welfare League of America. And you've got Center on Budget and Policy Priorities. There are organizations in this city whose focus it is to look out for beneficiaries and they have a very

loud voice. The extent to which they get heard as much as say the governors or as much as say AARP or as much as the Chamber of Commerce. I don't know. But there are voices.

DR. SHIRLEY: A comment for Terry on your ER diversion bottom line issue.

You might be interested to know that our last past legislative session did authorize the division of Medicaid as they can document savings to Medicaid from the ER diversions to share those savings with the clinics that adopt extended hours. So, that might relieve some of the bottom line issue related to that.

DR. BAUMEISTER: Would you just make a comment about the role of prescription drug costs and the Medicaid budget?

MR. SALO: I'd be happy to.

Linda point out as Linda was summarizing what the governors were thinking. She neglected to include the numerous thoughts we have on prescription drugs because technically it's not really relevant to expansion of coverage in health access.

But, I guess it's indirectly -- yes.

We're looking at it. We agree very much with the statements that the President has made which pretty much flatly is, we think Medicaid pays too much for prescription drugs. How we get from where we are where we're paying a lot of money -- too much, to where we should be, paying less, paying the right amount? How we get from here to there is a difficult question.

There are a lot of different moving pieces in this. There are -- you know, we have issues about, you know -- we -- states are often working blind when it comes to purchasing prescriptions drugs. What we pay the pharmacists and ultimately the manufacturers is not necessarily relevant to what they actually cost. And because pricing information is proprietary, we don't know.

We are very concerned that there are sort of gaining of the system by pharmacists and pharmacies. Sort of manipulating what we call the spread in order to maximize their profits.

We're concerned that the manufacturers aren't giving the proper level of rebates on the drugs that we're getting. We're concerned that the Medicaid

program which is the largest purchaser of drugs in this country cannot operate closed formularies.

The Medicaid program which has every day to choose between whether or not we're covering medically needy populations, which is an option. Whether or not we're covering basic primary healthcare for pregnant women, at various levels of the population, which at some point are options. Medicaid does not have the option of saying no. We're not going to cover Viagra. No. We're not going to cover Nexium because we think it costs too much and doesn't really do anything.

We can't operate a closed formulary. Medicaid law says that you can do a preferred drug list. You can do prior authorization, but at the end of the day, if the doctor says my patient's got to have the Nexium or the Viagra, the Medicaid program has to cover it. That's a problem.

And then, you know, they kind of -- there are also issues around trying to encourage generic utilization, trying to encourage proper utilization. You can't do it in Medicaid through a tiered co-pay like what happens in the private sector because you

can't charge more than $3 for anything. And even if you do charge the $3, you can't enforce it.

So, there are a lot of moving parts in the Medicaid drug program that need looking at.

CHAIR JOHNSON: Joe and then Richard.

MR. HANSEN: You made the statement and I think you answered part of what I was going to ask. That we spend more on healthcare in total dollar and also on a per capita basis. And that is the first time I've heard that or seen that.

Also that if you look on a macro level, that our quality or our results are not where they should be, if we're the highest spender. And I'm talking about infant mortality or length of life and things like that.

So, that suggests to me that there are some real inefficiencies in this situation or somebody is getting too much money and is not spending it wisely. Just talk in pretty general terms about the prescriptions.

Do you want to expand on that in any other areas of your thoughts?

MR. SALO: I'm going to expand a little,

but not a whole lot. This is not something, you know, like I say, we don't have all the answers. We don't have all the answers. But, you know, we've talked about electronic health records. That's got to be a piece of the puzzle. Because, yes. Somebody goes into the ER, gets a bunch of very expensive lab tests and goes across the, you know, across the city two weeks later to a different place. They have no record -- they do all those tests again.

If you have an electronic medical record, that can track all of that, you can reduce overuse. You know, e-prescribing, we kind of got into. There's a lot of efficiencies to be had there I think.

Even if you remove the issue of doctors -- pharmacists not being able to read the doctor's scribbled handwriting. I think we practice a lot of defensive medicine in this country. And a fair amount of that is probably driven by fear of lawsuit or, you know, fear of things like that.

I think we probably, and this is not something that our organization has gotten into, but I think it's something we need to look at. We spend an enormous amount of money on a person's last six months

of life. You know, is that necessarily money well spent? We don't know enough about quality. We don't know. You can't comparison shop on, you know, the quality of doctors, on hospitals, on nursing homes. Medicare is getting there. But I think we have a long way to go both there and, you know, and the rest of the system is so far behind that.

And groups like Leapfrog are really making a lot of progress in there.

But, you know, how many people die in this country as a result of preventable medical errors? It's like 80,000, 90,000. There's a lot of things I think that when we're doing that we could be doing better and more efficiently. And I'm sure there are a lot more experts on this than me.

But, Linda?

MS. BILHEIMER: Just a comment on that.

I think what you are seeing at the same time that you are seeing efforts to think about how to expand access and coverage, increasingly those are also being tied to quality improvement initiatives. Just as there is enormous variation around the country in access and coverage, there is an enormous

variation in practice patterns. And as we get a better understanding of standards for different types of care and as we produce quality measures, one of the things that both the Federal and state governments and the private sector are looking to do is how we design our coverage initiatives to provide appropriate incentives for meeting certain standards of care.

And I think the debate going forward is not going to be a coverage debate or an access debate. But it is going to be a debate that is going to link coverage and access and payment with incentives for healthcare quality.

And I think we're just in the early states of those debates. We've got some interesting experimental models, both at the Federal level and at -- in the private sector. And I think it also bears saying though that some of the quality improvement initiatives will cost money rather than save money. They will produce a better outcomes, particularly for people with chronic illness. But they may not produce the types of savings that people are necessarily hoping would come out of them, though they may produce better care.

CHAIR JOHNSON: We'll be talking more about the initiatives that you all have been just referencing in future hearings. And that's going to be -- we appreciate you kind of leading us into that, Richard.

MR. FRANK: I've always been impressed by the National Governors Association's website, list of publications, taking on sort of problem solving. I was a little disappointed you didn't share much of that with us.

So, I was hoping that maybe you could send us some of your position papers, because I know you don't have enough time to go into a lot of the specifics and I think that would be sort of really useful.

On the Medicaid drug side, I actually think it's not as bleak as you set out. First of all, Medicaid for the most part has the highest generic prescribing rates of any payer in the world, including Europe. So, it ain't that bad.

Third of all, the preferred drug lists are actually quite effective and have been used in ways that are very much akin to the way that private

employers use three-tier formularies to steer demand and to get rebates and supplemental rebates, which I actually think give you information about what prices are.

Also, states are litigating left and right on the mark-ups and on the rebate issues and they actually get access to a lot of data through the litigation and through those investigations. So, I actually think that we have a series of activities that actually make me optimistic on the drug front.

And, you know, the peer project sector model doesn't seem like the obvious way to do it for people who are making $7,000 a year to make them, you know, pay a big chunk of their cancer drugs.

MS. BILHEIMER: If I could follow up on the drug question.

One of the issues that doesn't get enough attention is the population that Medicaid covers that has high drug usage, which has been a growing issue in recent years with the expansion of the disabled population to include significant numbers of seriously mentally ill people and also people with AIDS.

The development of psychotropic drugs has

made a huge difference in the lives of severely mentally ill people and has brought many more of them into the Medicaid program. Similarly, AIDS/HIV drugs have clearly had a life changing effect for people with AIDS and have brought many more of them into Medicaid who might not otherwise have enrolled.

So, Medicaid has seen rquite a transformation of its disabled population in the past 10 to 15 years. People tend to think of the disabled as those with severe physical disabilities. And what we're now seeing is a much broader disabled population entering the program, which has to be taken into account when thinking about prescription drug expenses in the program.

MS. CONLAN: I had a question for Terry.

I guess I didn't realize. I know that I pay a fee on my property taxes each year for the Halifax taxing district. And there's another taxing district on the west side of the county for the hospital over there.

But, I guess, you're telling me that this is something unusual or maybe even unique. And I know that Halifax is a public hospital and I as well as any

other person can go there and receive services. So, I just thought maybe you could explain to me a little more about that whole issue.

MS. STOLLER: Well, the way that it works is that, you're right.

One. There are several elements. The first is that Florida is one of the states that requires or mandates that local government be responsible for the care of medically indigent people that reside in their community. And several communities within Florida, as you know, have public hospitals and to support those public hospitals, they have created health financing districts. And it's those funds that go to support the public hospital and also to-- and the public hospital is not just the acute care institution, but it's the broader level of services. It's the clinic, and the coordination it pays for other things.

And what Volusia and particularly the Halifax region has figured out that it's to their benefit to pay for a continuum of care of services rather than number to treat folks who show up in the emergency room to be treated.

And, for example, in Hillsborough County when they created their coverage program, they ended up saving some inordinate amount of money on their required coverage of services, because they had put it into a managed care framework where there were authorizations required and better coordination of care.

And they also "capitate" providers. Capitation means they give a fixed amount of money to provide all the services. And in Volusia -- sorry, in Hillsborough what they did was just give the fixed amount of money to county-contracted delivery systems in four sections of the county and the providers there have to live within that amount of money. If people needed more services, they just had to absorb the additional cost. They just provided a more aligned incentive to do a better job of getting people what they need.

And that was really part of what the folks in Hillsborough discovered that led to the creation of the program. It was that, "gosh, there were people showing up who needed to have their leg amputated because they didn't get an ingrown toenail taken care

of or they had no place to go to primary care." And, in fact, when they began to coordinate care in a way that gave people real access to primary care, low and behold, there was a difference in what they were asked to pay for.

And actually there are folks, I can tell you, in Halifax that can talk to you about the cost benefit of that particular program and the investments. You know, if folks have coverage, and these are mostly working folks who earn something more than what they - - their income is slightly above Medicaid.

I think as you know, Medicaid floor is like 35 percent of the Federal poverty level or 33 percent, some really low level. So, these are not people who are particularly wealthy, but the fact of being able to spend their money not on being bankrupted by the healthcare system and other places and businesses in town has been a positive business investment for that region.

I don't now if that helps.

MS. CONLAN: And I just wanted to mention also.

I think it must have been in the reading materials that we were sent and maybe it came from your organization.

When we talked about initiatives last time, I was tempted to bring this up, but not knowing the full story, I didn't.

We're very proud in Volusia County to have created the Healthy Kids Program. And I think reference was made to a county program that was then expanded and became a model for the country and I suspect that's Healthy Kids.

It's a very successful initiative. It's now expanded to Healthy Families and I just want to get the word out that there are good things happening on the county level. Creative ideas and this taxing district and I've gone to Halifax many times at different parts of my long career as being uninsured, under insured and a Medicaid beneficiary to take advantage of those things that my property taxes are paying for as well.

MS. STOLLER: I actually was lucky enough to work on the design of the Healthy Kids Program more than 10 plus years ago. And I think it's important to

understand that in Volusia County it was really a Medicaid demonstration program so that when it initially started, it was when we had the HCFA, which was the Health Care Financing Administration and it was intended to examine streamlined eligibility and outreach to enroll kids in coverage. And it's been highly successful now and insures something like 300,000 kids in the State of Florida and it is part of the state's SCHIP program for school-based kids.

But when the HCFA demonstration ended, Florida created this state/local partnership where local counties (and Volusia County was actually one of the counties that really stepped up to provide some funding) ended up funding up to a max of about 20 percent of the program and the other 80 percent was picked up by the state at the time.

And obviously with the expansion and creation of the Federal SCHIP program, the share in Volusia went down to a certain level. So, in Florida counties are responsible for some portion of the payments of the SCHIP program.

And I think it's just important to mention from the county perspective, getting back to

your question, Catherine, about the financing for Medicaid, that New York State requires its counties pay 25 percent of the non-Federal portion of the Medicaid program which is causing counties there to just scream bloody murder in terms of this huge burden. As Medicaid goes up, it's the local property taxes that are having to fund that.

And different states require a different level of local government contribution towards Medicaid. In Florida there is not only for the SCHIP program but also for Medicaid's and long-term costs and some things who part of the state. So, I think that's just one of these many variables of who pays for what.

MS. BAZOS: My question is for Matt and I thin kit's very naive, but I want to ask it anyway.

Medicaid serves special populations and what you're thinking about as you go forward is to look at pharmaceutical costs, electronic medical records and enhancing access and capacity.

Is there ever any thought and this goes to Terry's comment about the silos. And I'm thinking about the silos within the Federal and state

governments in the broader sense.

Is there ever any thought from states to partner with VA systems, which have excellent medical records? They're known for their low cost and quality pharmaceutical program and they are also a system that serves special populations and, if I understand them correctly now have extra capacity.

MR. SALO: I can't speak to the extra capacity of VA. I don't know. But I think you're absolutely right in that, you know, Medicaid does cover a lot of special needs populations. And within Medicaid there are a lot of very different silos of special needs populations. And, in fact, it's very difficult and we didn't really touch on this. It's very difficult to talk about the Medicaid population because there isn't one.

There are many, many different one. Medicaid serves very, very fundamentally different roles in each state. You know, I call Medicaid sort of the Frankenstein of the healthcare system, because Medicaid has sort of grown over the years to take on bits and pieces of all of the other failures of the rest of the healthcare system.

Seniors don't have a drug benefit. That's okay. Medicaid will cover it. You know, people who are working have very expensive healthcare costs when their insurance runs out. Medicaid will cover that. Low income seniors can't afford their Medicaid premiums. Medicaid will cover that.

Too many uninsured people. Too many uninsured kids. Medicaid will cover that. And you can just go down the line. Foster care kids, etcetera.

Very, very. Medicaid is the largest payer for mental health services in this country. Medicaid is the large payer of HIV/AIDS services. Pays for 90 percent of the HIV/AIDS services for kids in this country. It's enormous. It's huge. It's very different populations.

The vast majority, sort of the face of Medicaid is often sort of the welfare face, because that's what it's traditionally been. And that's who most of the people are. Most of the people in Medicaid are relatively healthy, relatively healthy. Pregnant women, kids, family members for whom Medicaid sort of serves as an insurance program. But 70

percent of the cost is for the elderly and people with disabilities -- physical, behavioral, mental, emotion, etcetera.

And those are very, very different populations with very different needs.

Absolutely, we need to partner with VA, partner with Medicare, partner with -- we need to partner with everybody. We need seamless systems.

One of the reasons that the VA is able to get such low-cost drugs, is that there are special provisions in the law that essentially say, the VA can go out and essentially negotiate in theory the cheapest drugs prices in the country for a volume that size. Medicaid can't do that. Medicaid is prohibited from partnering with VA in that respect.

But, yes. And I want to stress that when we are talking about Medicaid reform, talking about cost- sharing, talking about restriction of various drugs, we're not looking at that in terms of people with very special health needs for whom -- you know, I don't think it's appropriate, you know, to charge somebody who is very disabled without a whole lot of money, a lot of money -- you know, a lot of co-pays.

That's not really where we're going.

Yet, Medicaid reform has to take into consideration the very different populations and the very different needs that those populations have. And I think Linda's slide even kind of alluded to that a little bit. You know, you actually probably need more access, more coordination of care for some of those populations.

So, that's kind of a rambling answer. I'm not sure if that answered your question.

MS. BAZOS: It did in part.

MR. SALO: Can you focus me to help me answer it a little better?

MS. BAZOS: Maybe we can talk after. We're running short of time.

MR. SALO: Okay.

CHAIR JOHNSON: Mike and then Monty and then my question will be, if I might, is what didn't you have a chance to say because of our time limits that you think we still need to hear? And we'll start with you on that Linda and then go across all three of you.

But first Mike and then Monty.

Mr. O'GRADY: There are a couple of things that I'd like to focus on.

You know, in a number of these presentations we've heard sort of the down sides and the bleak things. And so I'd like to think about kind of solutions and what you do. And there's a number here that can understand met somewhat reticent to go into much detail about this. But there's some interesting ideas here.

I thought Linda also had an interesting one about the employers.

One perspective I'd like to put on the table a little different is because part of my responsibilities in my current job go beyond healthcare. I also have a fair amount on the analysis and evaluation of welfare to work, some of these other programs. And so when we think about -- if the most fertile area and not that any of these are necessarily great solutions, but I'm sort of taken by Linda's point of, gee. Couldn't you work with the employers? Is there something -- with all the difficulties that Terry pointed.

The one thing to keep in mind and

certainly will not try to defend Wal-Mart. Is that we've gone through over the last five or six years, an amazing welfare to work program. And we have been strongly encouraging employers to hire people who are Medicaid recipients and other people coming off the rolls.

Now, what that work now almost ten years into it, has shown that maybe 10 percent of those folks were able to get jobs that actually had health insurance. But this is, you know, this is a population that had been on welfare and they are starting to get jobs and they are starting to move back into the economy. And the last time we had this with this most recent downturn, instead of going back on welfare, a significant percentage of them use their unemployment benefits rather than going back on. So, this is sort of a process that we're talking about that goes beyond healthcare.

So, to a certain degree when we think about employers and what we'd like to do and not do, you know, we are not in an employer mandate country. And, therefore, and I don't -- and we'd like employers to do certain things. But I'd like to think of it

within the realty of what are the options that you could do? How could you be innovative to think about getting them to play more? And that's why some of the things that were touched down in Linda's slide of Matt's thinking. You know, and his idea of how do you get some of that employer in the mix?

If you think that because of the population and because of kind of employers, these are not guys who are going to step up and say, sure. I'm going to contribute $3,000 per person per year.

But, you know, how do you get them in? And that's why I was sort of -- Linda's points about kind of three way kind of financing and some of these other things.

But I would just hesitate on some of this stuff about employers. It would be hypocritical for me as a Fed because we've been giving them very strong incentives and very strong sort of nudges in the direction of hiring more and more of these people.

So, you know, we think it's a good thing. But I am concerned. I saw the State of Wisconsin got -- when we were talking about Wisconsin the other day. They got -- they got kind of real bad rep, I thought,

in the paper awhile ago, you know. Wisconsin Welfare to Work Program, you know, most people only get low-paying jobs.

I'm sorry, I don't now what the reporter thought. They were going to become brain surgeons when they came off welfare. You know, having jobs, getting into the labor force, getting into that sort of stuff. This is a big improvement in that whole other social policy area.

The fact that we're only up to 10 percent. We actually have enough of a labor force and it's the kind of job that they are getting health benefits. It's not going down, you know.

Would we prefer it be 50 percent? Sure. But it's growing and it's another very important policy area.

MS. STOLLER: I can actually provide an example from one of our communities again of an innovation. It's not tested yet, and it doesn't involve small employers. But it involves large employers in our Jacksonville project. And I can't name the employer that stepped up to the plate, but it's a new, very large employer that has agreed to

provide coverage for about 250 low-wage workers who are ineligible for company's regular coverage plan. And I pressed this. I thought, well, okay, fine. This is an employer's way of just, you know, not covering all its employees. But, in fact, the company has a very generous benefit plan for those employees that work full time. (The cashiers and others that really are employed in this particular company.) And the employer has agreed to step up to pay $50 a month, "Contribute" is what they call it, $50 a month toward a benefit package that includes primary care, specialty care, some generic medications. And the hospitals in the region have come together to say, look. We provide free care for a lot of these folks anyway. Our contribution will be, we'll give hospital services (at one of the Ascension hospitals in this particular region).

And so they're going to put together a benefit package. It's not a fancy benefit package. It was constructed to be sensitive to the realities of low- wage workers and what they can put on the table. It's a little too early to tell whether it's going to work. But the funding for this, (it's a demonstration

that is initially going to target about 1,600 folks) is funded by local tax dollars. About two and a half million. Another three plus million from the hospitals. And less folks think that this is just charges that the hospitals are going to contribute. They actually are valuing the hospital services at a percentage of the Medicare payment level. (And it's not above 100 percentage.)

So, there's a way of leveling the playing field among all of the providers in the community including for profit institutions. So, it's an example of inviting the corporate community in. And they actually have some interest as well from some other large employers in the service industry. And we'll see what happens.

I mean, the problem is that, you know, they haven't had enough time to really cultivate those relationships with the large employers. But through their health forums process, the project really engaged the political leadership in Jacksonville. The mayor and city council members and some select members of the business community and now they're trying to cultivate it along. It's not the big answer but,

again, it's a beginning -- you know, I think Peter Cunningham who may be coming here to speak with you. I don't know if he talked about his "Culture of Coverage", which I think is more a market or really a private sector approach to having all the employers step up to offer coverage within a community.

But, you know, I think the fiscal reality for most employers is that they can't afford, you know, $1,500 bucks on every car price for employer health coverage.

MS. BILHEIMER: Regarding some of the interesting ideas that are out there-- I guess this comes back to Randy saying what would we have talked about that if we had a little bit more time. It addresses some of your questions too, Mike, I think.

Several Interesting ideas are emerging or under discussion, particularly at the state level. Policymakers realize that private sector reforms in the 1990s didn't not pan out.

We may be stabilized some of the insurance markets a little bit. We did not expand coverage. We were not successful with group purchasing arrangements. We were not successful with

re-insurance. But now we're talking about trying to get or keep private insurers in the game and asking how to do so.

Some states are looking at these ideas again and asking: Are there ways that we can make this work better?

A key question is how to get a critical mass in the insurance pool for small businesses, so that you're not dealing with a purchasing pool consisting entirely of small employers moving in and out, which produces great volatility.

A second issue is whether you can define an affordable benefit package. (You're going to hear a lot of debate around the country about affordable benefit packages.) The terms that we heard at the end of the 1980s — such as minimum benefits and essential benefits — are now reentering the policy debate, along with the question: if you define an essential benefit package, is it necessarily more affordable than a more comprehensive benefit?

Some interesting models being proposed that build on these ideas. New Mexico, for example, has a waiver that they haven't implemented yet. But

it's got some interesting ideas that involve, establishing a big insurance pool, providing subsidies to employees who obtain coverage through this pool, establishing a benefit package that is only purchasable through this pool.

And if you as an employer agree to participate in the pool, you get the advantage of this benefit package that is offered only through the pool and you can get a significant discount on it.

If you look at what the governors were talking about in their winter meeting, what they saw potentially on the table were Federal dollars for tax subsidies and for establishing purchasing cooperatives. And their response was: Maybe we can marry these ideas. Maybe we states can establish purchasing cooperatives and channel tax credits through them, with some state tax credits on top. Again, the idea is to create a critical mass, channeling the subsidies through that single organization.

All of that said, the fact remains that insurance is still going to be expensive and as several people have pointed out, even with a

three-share type of process, you are still asking a significant share to come from the employer--even if it's only 30 or 40 percent. For many employers, that still seems prohibitive even if it's a relatively smaller premium.

So, I think the jury is out, but some of these ideas that are re-emerging need to be watched and tracked closely to see if some states can pull off this type of strategy.

In terms of the cost, it's worth realizing that right now the average nationwide premium for a family policy in an employee-sponsored plan is now close to the minimum wage.

If you're going for a PPO, it's actually about the same. The average nationwide premium for a PPO is the same as the minimum wage.

Well think about that from an employer's perspective. If you think that you are paying the workers for their productivity and the minimum wage reflects the productivity of that workers, you are essentially -- if you are paying the whole premium for a family policy -- having to double the worker's productivity to make that worthwhile to you as an

employer.

Again, so coming back to the economics here. That is a reality which I think we don't fully grasp. And that issue about how we can provide the subsidies to employers and employees to make it affordable, even with all these arrangements, is the challenge.

CHAIR JOHNSON: Montye first and then Joe will have our last question.

MS. CONLAN: I guess I wanted to come back to Matt without this Medicaid advocacy, because it's so obviously so important to me.

For several years I've been going to Tallahassee and sometimes out. Recently, I went to Jacksonville to testify before the House and the Senate. And I often, you know, I talked yesterday about the pained faces of the legislators as we tell our story.

But then I also along with many other advocates tried to offer some consumer friendly cost-saving measures as a reform. You know, as an intermediate step.

I don't find that the legislators take

those recommendations to heart and implement them. And this year I went to Jacksonville and testified before a joint subcommittee. I actually told them about this Working Group. And I suggested we have something like that on the state level in Florida.

We have smart people in Florida. We have economists. We have physicians and nurses and all of that. And why couldn't we, you know, have that kind of participation?

Well, within -- and saw them actually nodding their heads and smiling. And so I thought. Wow. You know, maybe they listened to me.

Within two days, they had recommended that we have these new pilot programs for the HMOs in Jacksonville, Duval and Miami-Dade County. So, I'm wondering and many of these recommendations I don't think up. They are recommended by Families USA or Florida Legal Services. So, they are good, legitimate recommendations that smart people have come up with.

And I'm wondering why the states and the governors aren't considering some of those cost-saving reforms.

MR. SALO: Like what?

MS. CONLAN: Well, like what?

Well, for example, this year I told them about how I take -- how I need more prescription drugs now than I did when I first started because I have a progressive disease. And it ultimately gets down to simple management.

So, at this time, I'm taking about six prescription drugs a month. Well, the pharmacy charges $10 for a dispensing fee for each and every one of those drugs every month.

If I could be re-certified maybe for three or six months at a time, I could help the state -- or the state could save money on those pharmacy dispensing fees.

Okay, so it's small potatoes for me, but multiply that times all of the other medically needy beneficiaries and it adds up. That's just one of them.

And there were others I just can't think of off the top of my head. But I'm just wondering and Catherine pointed out the other day that this group is not really to appeal to the legislators as much as to appeal to the public.

And then I was thinking about AIDS patients and when did they really get heard. Didn't they start a group called Act Out or something?

DR. BAUMEISTER: ACT UP.

MS. CONLAN: Yes. So, getting back to we need a national Medicaid beneficiary's association to ACT UP or something and rally the general citizenry of the country. I guess I just don't understand why small steps aren't taken and that's makes me feel that you're you because you're now representing the governors and all of that, balancing the budget on my back when I'm saying. I understand the problem. I want to work with you. I want, you know, to offer these things.

MR. SALO: I guess I'm not sure how to respond. I can't speak on behalf of every state legislature, but I do think that they take cost-saving ideas pretty seriously.

The caveat is always if you are saving money in the Medicaid budget, you're saving it from somewhere. Who is going to be impacted? Are you saving money by paying pharmacists less? It may not sound like a problem to the consumer, but I guarantee

you that's a problem with the pharmacists. And they are probably much -- they are much more organized and politically powerful.

MS. CONLAN: That's why I'm talking about organizing the Medicaid beneficiaries. But that's what I was talking about and part of the awareness, part of the legal services in particular, they talk about the business activity that is generated by Medicaid. So, that's what you're coming back to. And it is not only bringing money into the state from the Federal Government, but then generating business activity as well.

CHAIR JOHNSON: Thank you for your comment, Montye.

Joe, last comment/question.

MR. HANSEN: Yes. I was just a little bit startled, Linda, by your last comment. And as we talk about cost and everything and you, at least in my mind, you linked productivity with minimum wage. And I don't see the connection at all. And if we're going to start measuring how we're going to tack the cost of healthcare based on the minimum wage, that's a road I'm not going to go down.

MS. BILHEIMER: No. I wasn't suggesting that.

I wanted to illustrate just the magnitude of the total cost of a premium relative to what many workers are currently making. I mean, for many workers who are currently uninsured, if their employer was to pick up the full premium for a family policy, it would essentially double their compensation. And that is something which is a difficult issue to address when looking at a large -- a very large pool of low-wage workers in the country.

MR. HANSEN: But it also opens up then the question of the profits of the company and everything else, which is something --

MS. BILHEIMER: Oh, yes. Yes.

MR. HANSEN: -- we're not going to -- I hope we're not going to get into.

MS. BILHEIMER: No. Absolutely. Absolutely.

MR. HANSEN: You and I can get into that, Randy.

MS. BILHEIMER: No. I wasn't passing judgment on that. I was just using it to illustrate

the relative size of the premium.

CHAIR JOHNSON: Well, thank you, panel, for your excellent contribution. I suspect we could go on for awhile. And we'd have diverse opinions from our group and maybe from you all. But it's been very helpful. And so we thank you very much.

We'll take a 60-minute break for lunch if that's okay, consistent with what we decided yesterday. So, that would mean we'll reconvene at 1:40.

(Whereupon, the meeting was adjourned at 12:38 p.m. to 1:46 p.m.)

A-F-T-E-R-N-O-O-N S-E-S-S-I-O-N

1:46 p.m.

CHAIR JOHNSON: Well, good afternoon, everybody. Hope you had a good lunch and ready to go for eight more hours and then we'll be done for the day.

This afternoon we are privileged to have

Ken Sperling and Anthony Tersigni here to share some of their thoughts and experiences on private sector initiatives to expand coverage.

Ken and Tony, we have in our manual your bios and so we're not going to introduce you by repeating the material that's on your bio. But we've had positive comments regarding your background, Tony, and the experiences that you've incurred or you've been going through and some of your initiatives.

And by way of background, in addition to what you see on the bio for Ken, Ken is a person who has served the HR Policy Association as a consultant before he joined CIGNA in an attempt of the human resources executives nationwide of large companies to expand coverage. And so Ken will not be speaking as much from his perspective as a CIGNA person, but from his prior life and then share some of his experiences with CIGNA I suspect along the way.

So, what we've been doing is going just as it is on our agenda, which means, Ken, that we'd like to ask you to go first, if that works.

MR. SPERLING: Thank you, Mr. Chairman. It is a pleasure to be here. Thank you for inviting

me. I've been at CIGNA for a whole month, but I did spend 17 years with Hewitt Associates, a health care consulting firm, and for the last two have been working on an initiative which has resulted in what's called National Health Access, which will be rolling out this fall. So, on behalf of the HR Policy Association, I'd just like to go through essentially what that initiative is, how it was formed, what our challenges were and I look forward to a lively dialogue following some very brief comments.

So first, what is the HR Policy Association? The HR Policy Association represents the senior HR leadership, the chief human resources officers of about 240 of the Fortune 500 companies. So these companies represent about 15 percent of the U.S. labor force. These folks have not traditionally dabbled in and through this organization in health care primarily because their membership is really a cross section of American industry and includes companies like HCA and Tenet, and some insurance companies, and some PBMs and some people who are very vested in the health care industry.

So how do you do anything in health care

with that kind of cross section of membership without, you know, offending your membership? But it kind of came to a head in 2003 when the surveys that they traditionally take of their membership identified health care as the number one issue among chief human resources officers across the country unanimously. And it was decided that unless the private sector tries to get involved in effecting systemic change in health care in this country, we were headed for a federally or state- controlled health care system. And that necessarily isn't a bad thing, but these chief human resources officers wanted to try to give the private system at least one more chance.

So they identified the uninsured as really the principal focus of the HR Policy Association's health care agenda. Now why the uninsured? Well that, more than anything else, was believed to be the tipping point toward a federal or state-controlled solution and the uninsured have a direct, as well as an indirect, cost to employers. Uninsured Americans are less productive than their insured counterparts. They spend less time at work. They still get health care, but they don't get enough of it and they don't

get the right type of health care. And I'm not going to go into all of the issues because I know you've covered a lot of this ground already.

But from an employer standpoint as well, when an uninsured American receives health care, that health care is paid for somehow. It goes into the bad debt of hospitals. It goes into the bad debt of physicians. It results in higher rates of reimbursement to pay for that uncompensated care and eventually trickles down into higher premium rates for employers. So there is a recognition that we as insured Americans are paying for our uninsured counterparts anyway and it was decided to try to effect systemic change from an organization that does have volume and scale, and interest.

So the organization formed three coalitions as well as established a public policy direction. Randy MacDonald from IBM chaired the subgroup that looked at this called the Health Care Policy Roundtable, Tim Hughes from Cox chaired the Public Policy Directions and then there were three human resources executives that chaired three coalitions focusing on kind of non- traditional

coalition initiatives. Most health care coalitions are what I would call commodity buy, which means you get a large group of people together and you try to squeeze a point or two of discounts for administrative fees by buying in scale. That wasn't the goal here. The goal here was to try to use volume to effect system change, to address the issue of the uninsured and promote provider transparency, hospital and doctor transparency in the areas of quality and efficiency. And the initiative we're going to focus on today is what's called the Affordable Health Care Solutions Coalition which really looked at the issue of the uninsured in depth.

These companies were the charter coalition members. These 60 companies or so were the ones that stepped forward and said, "We'd like to explore the feasibility of doing something on a combined basis." And they wanted to focus on the working uninsured. Their employees and those employees dependents who did not have access to a traditional employer-sponsored health care program. So these include part-time employees, independent contractors, pre-Medicare age retirees who didn't have access to employer-subsidized

coverage and across these 60 companies it was about 1.3 million employees representing about 3 million lives.

The concept of the coalition, the Affordable Health Care Coalition was to address the issue or the working uninsured by aggregating large groups of employees with a very diverse risk. So not just part-time employees, but part-time employees who may earn $13,000 or $14,000 a year, with independent contractors, you know, software engineers who may be earning $75,000 or $100,000 a year, with temporary employees and create a large enough group with a diverse enough risk that to the insure marketplace it was an attractive risk to take. They also sought to create a more viable kind of individual health care market through the employer channel so an individual could access affordable price pointed coverage options. And then through their volume and scale promote the dissemination of more data on provider quality and provider efficiency. So this was full-time, part-time, temps without coverage, contract workers, independent agents, consultants and pre-65 or pre-Medicare age retirees.

These employers got together and set up some goals. Those goals were, number one, they wanted this to be fully insured. So this is true insurance. Because the employers weren't interested in suffering any risk from bad experience or, frankly, reaping any rewards from good experience. This was an insurance contract between the insurance company and the individual. There was not a required direct employer subsidy. So this was going to be an employee-pay-all type of approach. These employers had made the decision about which groups of employees they were going to subsidize. This was not going to require a direct employer subsidy.

Very important point. We wanted this to be guaranteed issue. So no medical questions and no medical underwriting. We wanted a national solution. Did not want to bring this up in one state or one market place at a time and we wanted a range of options and price points that were significantly better than the current individual health insurance market, including comprehensive major medical insurance. Because right now those uninsured individuals who don't have access to their employer-

sponsored coverage were looking to the individual health insurance marketplace and in a lot of cases it was either too expensive or they were getting turned down because of health conditions and we wanted to find a solution to that. And again, we wanted to promote provider cost and quality transparency.

So this is what we built and the program is called National Health Access. Essentially it offers six levels of coverage. And anybody who is eligible for this program through their employer can access any one of these six levels of coverage.

So starting at the bottom. Level I is a discount card. Fairly simple. It offers 30 to 40 percent discounts on medical services, pharmacy, dental, hearing and vision services. It's not insurance coverage; it's a discount card. But where the retail marketplace would offer a discount card for maybe $20 or $30 a month, this is going to be priced at less than $4 a month to access.

Now all of these are kind of building blocks, so each one builds upon the next. So Level II has all the benefits of Level I plus, it's called the wellness benefit, and these are for folks who just

want access to some office visits, some preventive care and some pharmacy benefits. So office visits are paid at 80 percent up to a $350 annual max. Pharmacy benefits reimburse $20 a prescription up to five prescriptions a year. Preventive care covers 100 percent of preventive care testing up to $100. Dental, there's two exams a year and vision care there's one exam a year. And this is priced at about $45 a month.

Level III is a scheduled outpatient benefit. It has everything that was included in Level II plus it has benefits for outpatient surgery up to $3,000. It has physician services for outpatient surgery up to $300, lab services up to $300, and this is priced -- in the levels of III and above have prices that differ by geography and by age and by gender. But for, let's say a male, age 28, living in Phoenix, this would be priced at about $75 a month.

In Level IV we get into even higher levels of benefit which includes everything that came before it plus inpatient benefits, so inpatient hospital benefits of $800 a day up to 30 days, plus emergency room benefits and some expanded limits on the

outpatient side.

Levels V and VI are major medical coverages. So these coverages, the $2,000 deductible and the $1,100 deductible are traditional major medical programs. So for instance, the Level V is a $2,000 deductible. It has 70 percent co-insurance, so the plan pays 70 percent after the deductible. There is an out-of- pocket limit and the out-of-pocket expense is $5,000 a year. It has $1 million lifetime maximum and pharmacy benefits are provided at 70 percent coverage for generics and 60 percent coverages for brand. And health savings accounts are also available under these two options. And the rates vary fairly widely by geography and age and gender.

So we came up with this design and went out to the insurance markets to say, "Can we put this together," given our goals of national coverage and guaranteed issue and all of those things and fully insured models and things that we wanted. We had to make some compromises because there was no insurance company who was willing to step forward and give us everything that we wanted.

We chose UnitedHealthcare as our health

insurance partner with the first four levels; the discount card, the scheduled benefits. But even UnitedHealthcare was not willing to give us guaranteed issue major medical coverage in all 50 states, not right out of the box. So we got 15 states of our choosing with UnitedHealthcare. We got Humana to step forward and have 16 states of major medical coverage and then CIGNA stepped forward and offered their group model, or staff model HMO in Arizona, in Phoenix.

So for these 32 states we're able to cover 87 percent of those 3 million people. So we were able to cover the majority of the population. So we have 50- state access with those Levels I through IV and we have 32 states of access with Levels V and VI, covering about 87 percent of the population.

There are just a couple of challenges and these are important because I think it highlights some of the things that we were up against. And the first one is the largest one, and that's one of risk. Is that how do you build a model that offers guaranteed issue, no medical underwriting, major medical coverage with $1 million of coverage and keep it affordable and protect the insurance company from, you know,

catastrophic losses? Because in order for this model to work, it's got to work for everybody. It's got to work for the consumer; has to be affordable, has to work for the employer; the employer can't be a risk, and it has to work for the insurance company; the insurance company can't suffer catastrophic losses or the insurance markets will pull away from it.

So how do you then control that and the risk issue, the potential adverse selection issue was a mess and that kind of led us to the compromise that we had to make on the major medical coverage to have a bit of a fragmented state- by-state solution. But we were able to give guaranteed issued coverage across all 50 states for the lower levels of coverage.

We couldn't cover franchisees or small employers. Franchisees are not employees, so the laws wouldn't let us cover them. And small employers, we ran into state-regulated small group rating problems for employers of less than 50 employees, so we couldn't bring small employers into this model either. The insurance markets wanted this to look like one group.

They didn't want a million individuals

coming at this in different ways. So we needed to build a front end infrastructure that would essentially make this look like one big homogenous group coming into the insurance markets. So we had to build a front end infrastructure where we could transfer eligibility, where we could handle enrollment, where billing could be handled to the individual on a monthly basis, where there were call centers that people could call to ask questions on a bilingual basis. So we had to build all that front end infrastructure in order for this to be appealing to the insurance markets, because it looked like one big group and not a million individuals.

And the last challenge was a real lack of consensus in the United States on what hospital and doctor quality meant. We do not yet have consensus on how to measure quality, a quality doctor or a quality hospital. What is that? And where does the data come from, and how does it get reported, and how does it get aggregated and scored? So we came up with a model of how to measure efficiency and effectiveness and our insurance partners in this initiative signed off on it and we're going to move forward with it, but it would

have been a lot easier if there was a national standard for measuring provider quality on a hospital and a doctor side.

So it was not without its challenges, but we built the best we could build. Initially; it's going to get better over time, and it is currently about to be kind of the -- the outreach to the eligible individuals will be happening over the next 60 days and this will go live in the fall of 2005. We have three-year commitments from the participating employers, as well as the insurance partners, so this is not a one-year deal. People who are participating in this are participating for the long term.

And that's kind of where I'll stop. I know there are going to be questions, but I know you ran late and I'm going to try to keep us on track. Thank you.

CHAIR JOHNSON: Okay. Tony, could we go with you and then we'll take questions following that? Unless, Mike, you have a question you really want to ask right now.

MR. O'GRADY: No, I don't.

CHAIR JOHNSON: Okay.

MR. TERSIGNI: Thank you, Mr. Chairman and Working Group members. I'm pleased to be here this afternoon. I'm Tony Tersigni and I represent Ascension Health. Ascension Health is a Catholic health system and the largest not-for-profit health system in the United States, operating in 20 states and the District of Columbia.

Our facilities, which we call health ministries, range from large complex urban hospital to community health clinics in challenged rural areas, yet the common thread among all of our ministries is their particular commitment to serving all people, particularly those who are poor and vulnerable.

Ascension believes that we have both an opportunity and an obligation to create environments that offer safe, high quality health care for all who need it. Out of this obligation was born, in 2002, our Call to Action. Specifically, Ascension Health's Call to Action is a pledge we are making to deliver "Health Care That Works, Health Care That is Safe and Health Care That Leaves No One Behind."

As part of our promise to leave no one behind, Ascension Health is committed to achieve 100

percent access to care in every community we serve and to transforming health care leadership by promoting a new model of public/private partnership.

This slide represents our principles related to the provision of health care that leaves no one behind as approved by our Board of Trustees.

Mr. Chairman, as you are aware, last week was Cover the Uninsured Week and for the third consecutive year all of Ascension Health's acute care hospitals participated in activities and events in support of expanding coverage to all Americans. Throughout the year all of our health ministries have committed to undertaking screening and enrollment activities to help identify Government or private insurance programs for which our patients are eligible. Our commitment to expanding coverage to the 45 million Americans lacking health insurance in addition to our related efforts as the invisible safety net expanding access to care for those individuals and the millions more who are underinsured is at the heart of all that we do.

Today, I will be outlining Ascension Health's key strategies toward improving access to

care and coverage and I will introduce you to our virtual Access Institute. It is important for me to speak to you today not just because Ascension Health serves as a significant provider of care, but also because we are a large employer. Our organization views the issue of health care reform through the eyes of our 106,000 employees across this country. As such, we have committed internally to such innovations as a socially-just living wage and wellness programs for all of our employees. Additionally, as part of our system's health insurance program and as a matter of justice, our lower-level employees pay less in out-of- pocket health care costs than our higher-paid employees do. I mention these things because I think it is important for all to understand that my thoughts and concerns about coverage issues also stem from Ascension Health's role as one of the largest employers in each of the communities we serve.

The Citizens Health Care Working Group faces significant challenges in leading a national discussion about the scope and type of transformational action that will be required to address the crisis of the uninsured. All indications

point to ongoing annual double-digit increases in health care costs and we know that with those rising costs are likely to be further erosions in both private and public sources of insurance coverage. Some people will say that we can continue to muddle through, that our patchwork of safety net public and private hospitals and clinics can ensure that the poor and underinsured and uninsured obtain the care that they need. However, America's safety net providers are already straining to meet the needs of the millions of uninsured and underinsured who show up in our emergency rooms with problems that could have been prevented or moderated with more timely and appropriate preventive and primary care services.

In this regard, I am especially pleased that you have as one of the members of your group Dr. Patricia Maryland, President of Ascension Health's St. Vincent Hospitals and Health Services in Indianapolis. Dr. Maryland's work with Ascension Health combined with her 25 years of experience in the health care field makes her ideally suited to represent the broader hospital community on the Citizens Health Care Working Group and to play a constructive role in

fulfilling the work group's Congressional mandate.

Today I've been asked to represent the hospital community at this hearing. As such, I think it is important for me to note that hospitals can and do play an important role in helping our patients obtain insurance coverage. Individually and collectively hospitals are committed to helping people we serve sign up for public insurance programs for which they are eligible. I also should point out that over the last few years the American Hospital Association, AHA, and the Catholic Health Association, CHA, have worked together to develop a proposal designed to achieve universal coverage of children through a combination of Medicaid and State Children's Health Insurance Program expansions, premium subsidies for both public and private coverage, tax credits, and enabling uninsured small employers and individuals to buy into public employee health benefit programs.

Ascension Health supports the proposal because it includes the key building blocks for a practical phased-in approach to achieving significant reductions in the number of uninsured. This is evidenced by the fact that many of the elements are

found in Congressional proposals sponsored by both Republicans and Democrats. In addition, the CHA's new "Covering A Nation initiative" focuses on transforming the health care delivery system to respond to the growing and serious health care problems of the uninsured and underinsured. Both the AHA and CHA are committed to finding workable solutions and will continue to endorse efforts to build support for such solutions in Congress.

In many ways, the idea of expanding coverage and the notion of improving access are two sides of the same coin. Access without coverage is problematic at best, and coverage without access is of no use to anyone. I wish to share with you Ascension Health's ideas in particular about increasing access to care and in an interrelated way about ensuring coverage for care. I'm excited about our efforts because I believe the work we are undertaking in this area will truly be transformational.

How do we improve access to coverage? Briefly, here's our road map. Our work centers on Ascension Health's virtual Access Institute. The Access Institute is not a place; rather, it is a

conceptual framework that includes the key strategies that will get us to 100 percent access.

The four strategies are, first, a national legislative leader. Ascension Health supports the passage of a series of laws to expand access for patients served by private sector safety net providers. Second, we will catalyze a new public/private model of access leadership. To date 12 communities with Ascension Health Ministries as local partners have begun to implement our five-step model to 100 percent access. In doing so, health outcomes in those communities are measurably improving. Third, we will continue to serve as a voice of the voiceless helping to change public perceptions to more strongly support the imperative nature of health reform. And finally, Ascension Health will serve as a national public policy partner, doing our part to achieve transformation and reform in the broader health care field and therefore providing access and coverage for all.

I would like to speak in more detail about our five- step model I just referenced and its emphasis on public/private partnership.

In our 100 percent access work to date we have identified five key benchmarks that must be achieved for systemic change to take place on the local level. We call these benchmarks Ascension Health's five steps to 100 percent access. They include, step one, that local providers partner as a coalition to establish a formal organizational infrastructure. This includes the development of shared information systems that allow all the providers within the collaboratives to see complete patient health records. This infrastructure creation usually requires some catalyst funding, which may come from a variety of sources. I direct your attention to this slide which displays the present problem quite well. This slide is actually from Austin, Texas. Now you can see the patient highlighted wound up visiting two emergency rooms on the same day and neither facility knew about the other visit. Austin's local collaborative of providers now can identify when things like this are happening and can work to make them an uncommon occurrence as they steer patients to a medical home that offers quicker and more reliable diagnoses and that results in less unnecessary use of

expensive health care options like the emergency room.

Step two, that important gaps in the existing safety net services be filled, especially in areas of dental and mental health, as well as outpatient prescription drugs.

Number three, that a care model is developed and implemented for the community's uninsured population that emphasizes coordinated services throughout the continuum of care.

Number four, that private physicians in the community are recruited to volunteer to provide medical homes and specialty care for uninsured patients.

And finally number five, that sustainable funding be achieved to pay for the collaborative's ongoing efforts. In the absence of federal support, this may take the form of state or local funding like a health care district or may come from an investment from the business community. Across our health system, our ministry is working with other public and private providers in their communities to replicate this five-step model. And as they do so, they are expanding access and getting people covered.

My written testimony contains a handful of examples of the good work we are seeing to date in New Orleans, in Austin, Texas, in Tucson, Arizona and even in less-populated areas like Tawas City, Michigan and rural parts of Central Indiana. We know we not only need to get people enrolled in insurance programs, but just as importantly we need to take steps to improve their care model so we will see positive health outcomes.

That is the approach we as a nation should be taking to help improve access and coverage. This is not simply about giving someone an insurance card, which, while absolutely critical, is not enough. We believe that more is required and Ascension Health is taking a leadership role in this area.

You see on this slide a map of our 12 access model sites. To help many of these local collaboratives start up their operations, Ascension Health provided $7 million in matching funds on top of federal grant money obtained by the local coalitions. I know Dr. Maryland has shared with the Working Group the good work going on in Indiana. In Austin, the coalition has developed an insurance eligibility tool.

I think the Working Group should know about this. We call it the Medicaider program. The Medicaider program is an online real-time tool for determining an individual's eligibility for Medicaid, SSI, SCHIP and local charitable assistance programs that are offered by local hospitals and clinics. Participating providers use this tool to quickly determine whether an uninsured patient is eligible for one of these programs. In Austin, over 200 people now employ the Medicaider tool across 45 sites associated with 18 health care organizations. Once the individual's eligibility for Medicaid, for instance, is established, the software provides the enrollment forms thus helping to expedite the enrollment process. It could also be used to determine an individual's eligibility for free or discounted drugs offered by pharmaceutical manufacturers' patient assistance programs. At a time when eligibility requirements for Texas Medicaid and SCHIP are becoming increasingly more restrictive, Medicaider has resulted in over 3,000 people becoming newly insured through Medicaid, SCHIP or local programs. That is the kind of tangible success we are witnessing as a public/private

partnership takes on the problems of the uninsured in our communities.

Mr. Chairman, I'm grateful for this opportunity to address the Citizens Health Care Working Group about the issue of expanding health care coverage. I am convinced that our country can transform health care and improve access by working together in partnership to meet the needs of our brothers and sisters throughout these United States. We must wait no longer. The time for bold action is now. Thank you.

CHAIR JOHNSON: Thank you very much. Go ahead, Mike, if you'd like to start with your questions.

MR. O'GRADY: I just had a couple of questions for Ken in terms of just how this program would actually work. I mean, it did seem fairly ambitious in terms of -- especially when I saw, you know, kind of your demographics picking up the pre-Medicare retirees, which we know people really struggle with and I was kind of curious how that went.

In terms of, you gave us some ball parks for kind of what it would actually cost. Now, you

certainly said that it varied depending on age and part of the country and things, but once you got up to that top, that Level VI, can you just give kind of a typical, knowing that there would be variation by region and demographics, on what the major medical with the $1,100 deductible HSA was going to be?

MR. SPERLING: Sure, absolutely.

MR. O'GRADY: Or just ball park. I mean, it doesn't have to --

MR. SPERLING: No, I actually wrote that down, had it right next to me and, you know, I didn't take it over with -- but the Level VI for -- there we go. Thank you very much. Level V, which is the $2,000 deductible.

MR. O'GRADY: Yes.

MR. SPERLING: For a female, age 38, in Chicago --

MR. O'GRADY: Yes.

MR. SPERLING: -- was $336.

MR. O'GRADY: Okay.

MR. SPERLING: Level VI for that same female, age 38, in Chicago was about $395 a month. Now in the other example is Phoenix. The male, age

28, in Phoenix for that Level VI is $71. Now, what's the difference? Well, part of it is the cost of Phoenix versus Chicago.

MR. O'GRADY: Right.

MR. SPERLING: But the other difference is the cost of maternity.

MR. O'GRADY: Maternity.

MR. SPERLING: Which in the individual marketplace is usually carved out of individual policies. And if you want to buy it, it typically adds about $250 a month to your individual policy, if you can get it.

MR. O'GRADY: Yes.

MR. SPERLING: So, I mean, our model was trying to provide -- when we say "comprehensive major medical," we mean comprehensive major medical, including maternity benefits.

MR. O'GRADY: Now, and this was in terms for an employ who took it, you said that there wasn't an employer contribution?

MR. SPERLING: Correct.

MR. O'GRADY: Okay. So the employer provides the infrastructure for it? Is that the way

to think of it?

MR. SPERLING: The employer provides the promotion.

MR. O'GRADY: Yes.

MR. SPERLING:

Communication. Provides eligibility reporting into the front end.

MR. O'GRADY: Right.

MR. SPERLING: Payroll deduction, if they can, and not employers can. But if they can, that's fine. And that's it.

MR. O'GRADY: Got it. And then in terms of I was a little confused in terms of the one slide talked about the number of people actually, you know, total covered, but it sounded like this hadn't totally rolled out yet.

MR. SPERLING: No, it's rolling it. It will be effective in the fall of 2005.

MR. O'GRADY: Okay.

MR. SPERLING: The communication of this to eligible individuals will start within the next 60 days.

MR. O'GRADY: I see.

MR. SPERLING: But we have firm insurance contracts, the infrastructure is being built, this will go live this fall.

MR. O'GRADY: I see. So the notion on the slide that talks about eligible versus covered is --

MR. SPERLING: Right.

MR. O'GRADY: -- that more the idea of who actually hits the categories of this across these different states. So that difference would be the -- like you talked about 15 states that didn't belly up, however you want to think of that --

MR. SPERLING: Right.

MR. O'GRADY: -- that didn't participate? And why were some states -- I mean, I was trying to look through those states and sort of -- is that, you know, high reg states or --

MR. SPERLING: No, really --

MR. O'GRADY: I mean, in Maryland I know we --

MR. SPERLING: It wasn't that much of an issue of regs.

MR. O'GRADY: Yes?

MR. SPERLING: It was an issue of risk.

It was an issue of no insurance company willing to step forward and say, "I will go at-risk from day one" --

MR. O'GRADY: yes.

MR. SPERLING: -- "for guaranteed issue insured major medical coverage in all 50 states." So that's why we had to kind of parse it out. So, UnitedHealthcare told us, "We'll go forward with 15 states you choose, but we'll take 15 states initially. We may in fact expand it if the experience that comes in is favorable over time, but for right now on the -- we'll go 50 states for the lower levels of coverage, 15 states for the top two levels, the major medical."

So, then we turned to Humana, who is not a national health plan; they're a regional, and got 16-state commitment from Humana and then CIGNA ponied up for -- where they have an incredibly cost-efficient staff model HMO with Phoenix. So that's how we've kind of patchworked together this 32-state solution and we were able to by picking and choosing where these employers had eligible populations. Even though we only have 32 states out of 50, we're able to cover 87 percent of the eligibles.

Mr. O'GRADY: Well, that also struck me, that kind of a lot of the states that weren't covered were little states, little population states. So again, that how do you bundle --

MR. SPERLING: We were able to kind of pick and choose our states, yes.

MR. O'GRADY: And just one last question then on that. In terms of, you did build this whole kind of front end, this whole infrastructure. A number of our discussions earlier today and yesterday were about kind of the different loads we see administratively and what's going on there. Do you have a feel for kind of cost per life or what percentage of the total that you think -- because to a certain degree you're performing some of those costs.

MR. SPERLING: Right.

MR. O'GRADY: We see large employers take care of and we don't not necessarily see them show up in a retention rate on an insurance premium.

MR. SPERLING: Right. On average, the administrative load that is in these numbers is around $10 per employee per month.

MR. O'GRADY: Per month? So about $100 --

well --

MR. SPERLING: About $100 a year.

MR. O'GRADY: Okay.

MR. SPERLING: But it's scaled. So for instance on the discount card, it's about five cents.

MR. O'GRADY: Yes. Sure.

MR. SPERLING: And on the major medical coverage, it's a little bit more. Frankly, we think the majority of the enrollment is going to be in the scheduled benefits, in the wellness benefit, the outpatient benefit, the outpatient and inpatient benefits, because those are price pointed at a place where it's going to be most attractive to folks.

MR. O'GRADY: Got it. Thank you.

VICE CHAIR McLAUGHLIN: I had some more clarification questions. You said in the one slide that the focus was the uninsured population and large corporations. Definitional, what's large? Is there a cut off on number of employees?

MR. SPERLING: There's no firm cut off, but traditionally the members of the HR Policy Association are large companies, typically with more than 5,000 employees.

VICE CHAIR McLAUGHLIN: So then the only people for whom this product is going to be available are employees of these 240-member companies?

MR. SPERLING: The 60.

VICE CHAIR McLAUGHLIN: Oh, just the 60?

MR. SPERLING: Those 60 companies that have kind of put --

VICE CHAIR McLAUGHLIN: Okay. I just --

MR. SPERLING: -- stepped forward and said, "We're interested in doing this."

VICE CHAIR McLAUGHLIN: Got it. Okay.

MR. SPERLING: Now, some of those companies, there's no surprise that they would be interested in this kind of an initiative. You've got companies like, you know, Circuit City and Hilton Hotels and organizations in the retail space or the hospitality space that have lots of part-time employees where this initiative can really serve.

VICE CHAIR McLAUGHLIN: Right.

MR. SPERLING: You've got other employers like a Honeywell or an Alcoa who don't necessarily have a lot of part-timers or independent contractors, but just believe it's the right thing to do.

VICE CHAIR McLAUGHLIN: Well, I mean, that's getting my other clarification question, because maybe everybody got it, but I missed that. So it's only going to be marketed to these 60 initial charter members, right, okay? And it's only going to be offered to currently uninsured employees of those 60 companies?

MR. SPERLING: Yes.

VICE CHAIR McLAUGHLIN: So if you have coverage through your spouse you're not eligible?

MR. SPERLING: No. If you don't have coverage through these employers, and by the way, this is not a closed group. Any other company that wants to participate in this initiative, can.

VICE CHAIR McLAUGHLIN: They could join?

MR. SPERLING: They can join.

VICE CHAIR McLAUGHLIN: Right. Okay.

MR. SPERLING: So this is the initial group that has stepped forward. If there are other companies that want to join, they are absolutely welcome to do so.

VICE CHAIR McLAUGHLIN: Right.

MR. SPERLING: If you do not have coverage

through your employer, you are eligible.

VICE CHAIR McLAUGHLIN: I'm just trying to build on what the group's already heard.

MR. SPERLING: Right.

VICE CHAIR McLAUGHLIN: And put what you've told us in the context of what we've heard of the uninsured. Okay?

MR. SPERLING: Yes.

VICE CHAIR McLAUGHLIN: That's all. So it's currently uninsured employees at the beginning of these 60 corporations?

MR. SPERLING: Yes.

VICE CHAIR McLAUGHLIN: Now are they uninsured because they're not eligible or are they uninsured because they don't take up and they are eligible? Does it matter?

MR. SPERLING: They're uninsured because they are not eligible.

VICE CHAIR McLAUGHLIN: Okay.

MR. SPERLING: We did not want to make this a replacement for employer-sponsored coverage.

VICE CHAIR McLAUGHLIN: Got it.

MR. SPERLING: And frankly, if anyone has

a choice between this kind of employee pay-all structure or a subsidized employer program, that subsidized employer program is likely going to be a lot more attractive than this. So we don't think that there is going to be those situations where if an employee has elected not to participate in their employer plan, that they're going to be attracted to this. Because even at a 50 or a 60 percent employer subsidy, that payroll contribution rate is going to be very attractive compared to this program. This is designed to offer access to affordable coverage to those people who are not eligible for an employer-sponsored program.

VICE CHAIR McLAUGHLIN: Okay. So I think we're all square now, because we heard the difference between people who don't take up, people who aren't eligible, people who have it from a spouse.

MR. SPERLING: Right.

VICE CHAIR McLAUGHLIN: So I just wanted to make sure we're all talking about the same group. I think have a better understanding. And so then my question is, for some of these people why do you think the adjective "affordable" is appropriate? If it's

$480 a month for one person, this 38-year-old female in Chicago, that's almost $5,000. And if you're talking about a 38-year-old female who's not eligible for her company's plan, it's probably because she's a part- timer, right? And part-timers earn part-time salary.

MR. SPERLING: She could be a part-timer, she could be an independent contractor, she could be a part- timer but she could be married to an individual who works for a small company or is a sole-proprietor who doesn't have group insurance coverage. And we recognize for the major medical coverage that may still be out of reach for a lot of people, but frankly the individual marketplace is too.

VICE CHAIR McLAUGHLIN: Right.

MR. SPERLING: And what we're trying to do by not just offering Levels V and VI, but offering the four levels underneath that is for people who may not necessarily need $1 million of insurance coverage or want $1 million of insurance coverage, access to plans that do not have that level of richness, but are priced at an affordable level. And at the very bottom of the pyramid a discount card which anybody can

afford, which can at least give them access to the kind of contracted discounts that health plans have with providers. So we understand it's not perfect, but there is just no way that we could accomplish comprehensive major medical coverage on a guaranteed issue basis for what anyone in the country would consider to be affordable.

VICE CHAIR McLAUGHLIN: No, I understand. I'm just trying to marry what we heard about from Peter Cunningham about who are the uninsured.

MR. SPERLING: Right.

VICE CHAIR McLAUGHLIN: And what their characteristics are with this and trying to figure out how good a fit. And you know that, you know, what's a realistic goal in terms of what percent of those uninsured people are going to be willing and able to take this up.

MR. SPERLING: Right. And that was a balancing act that we really struggled with and one of the ways to reduce the price point is to individually underwrite and throw out the worst risks. And frankly, we just didn't want to go there.

Now truth be told, the UnitedHealthcare

platform is a guaranteed issue platform. The Humana platform and the CIGNA platform are based on individual products. So there is medical underwriting. But for instance, in the Humana program what we were able to accomplish is a very wide underwriting gate. So for example, if you have a family history of heart disease but you don't have heart disease yourself, you purchase in the individual marketplace you're likely to either get turned down or to have an insurance rate which is higher than "standard." Under this model, you approach Humana, that gets issued standard coverage at standard rates. So we were able, through the scale and volume, accomplish a much wider underwriting gate in the 16 states than we had before. For the UnitedHealthcare program in the 15 states it is no medical underwriting at all.

MR. FRANK: This is for Dr. Tersigni. Thanks. I enjoyed your presentation. I thought it was very good.

Now, as I understand it, the way you're taking us sort of steps away from the insurance concept really and is -- I mean, setting aside the

outreach activities. So your notion of the special health districts and sort of creating essentially a network of access, if you will, sort of steps away from the insurance concept but really targets sort of some of the core populations that we heard about yesterday, the sort of low-income weakly-employed sometimes folks.

And so what I wanted to do is to sort of focus on the design of the special district. There are a number of states who use special districts to run their mental health systems. So for example, Ohio does it and I think Iowa does it to some extent. And would it work in the same way where you'd have levies on property taxes going to sort of an independent board which would then serve as the sort of financing authority for and the organizer of the network of access? And if that's true, how can we potentially avoid some of the low-income school district problems that we face in funding public education that way?

MR. TERSIGNI: I think what you've described is one model that I think we're experimenting with or trying to experiment with across the country. There are numerous models and in another

part of the country we're looking at a tax on cigarettes. So our whole approach is how do we try to find the best formula that will work for the most people as opposed to having a strict formula that may or may not work in a particular community, number one, and number two, may in fact be hurting that community, depending on how you view those.

MR. FRANK: But do I have the basic structure right?

MR. TERSIGNI: Yes. Yes.

MR. FRANK: You know, I agree. I think that's a very good response that the financing ought to be flexible.

MR. TERSIGNI: Right.

MR. FRANK: But that's the basic model, right?

MR. TERSIGNI: Correct.

MR. HANSEN: This is for Ken and maybe first a comment. On part-time, that's a dangerous definition because looking at your list it strikes me that there might be what are considered part-time workers that are really working full-time. They may be part-time at Circuit City and also be temporaries

at UPS. You know, I run into these type of people all the time that are working 50 or 60 hours a week, but it's two or three jobs. So I could see the appeal of something like this in those cases where it might be affordable, however that individual defines it.

But my question was, the premiums, you related them to age and I don't quite understand. And what would be the age, because one of the concepts is pre- Medicare retirees and you didn't have anybody in that example. So do you have any idea what a 58-year-old person would be paying?

MR. SPERLING: For the top level of coverage it's probably, depending on the area of the country, it could be in the $500 a month range. Now as you go down the ladder, the coverage gets substantially cheaper. But the important thing to recognize here is that for the 58 to 64-year-old person who is of reasonable health entering into the individual health insurance marketplace, the chance of that person getting coverage at any price is fairly low. So, I guess I'm going to default to the we-did-the-best-we- could answer.

MR. HANSEN: I was just curious. It

wasn't a criticism.

MR. SPERLING: Yes. And the reason that it's scaled by age is to make it attractive to the broad spread of risk. We want the 58-year-olds, but we also want the 22-year-olds and that's the way to keep this program affordable for everyone.

CHAIR JOHNSON: Mike?

MR. O'GRADY: I'm trying to get my hands around exactly how this works on the ground. And if you don't mind, I'll pick on Pat just so that we've got the local expert on hand.

This is a situation where basically you go out -- now that's trying to bring in people with rural underserved and that's -- certainly I think that there's a well-documented, that there's a big problem there, even when the have coverage. So it's this notion of -- and what you've put on is this outreach as well as an integration in terms of you've got, you as a faith-based organization and then with local public as well, first to make sure these guys -- anybody who is eligible for whatever public program, get them signed up and then figure out some way to kind of integrate what they might be getting either

community health center or something like that with the hospital based care. Is that --

MS. MARYLAND: Yes.

MR. TERSIGNI: Yes. For example, and I won't pick on Indiana, but in Detroit one of our ministries, St. John, is in a collaborative with the Detroit Medical Center, an academic medical center, Henry Ford Health System, a world-renowned health system, and the City of Detroit Health Department, and they have created that collaborative to do exactly what you've just suggested.

MR. O'GRADY: Are there any complications being a faith-based organization and in that kind of collaboration?

MR. TERSIGNI: Not really because those areas that obviously we stay away from because they are in violation of our ethical and religious directives, our other collaborative partners are able to provide those services, so all of the services are being provided in that community.

CHAIR JOHNSON: Can you share a little bit more of how your IT initiatives are assisting with your processes in your initiatives?

MR. TERSIGNI:

Yes, we're spending an awful lot of time, money, and energy on IT in terms of being able to coordinate care and one of the commitments of partners coming together in a particular community is they're going to commit to creating that IT infrastructure, and it's in dollars, as well as in man and woman power to do that. And again, in certain markets we're well advanced in that particular area and in other markets we're just getting there. So it ranges in terms of capability. But our intent is to make sure, as I indicated on that one slide, that regardless of what portal of entry the uninsured in a particular market go into, that we're all interconnected and we're sharing information across portals of entry. I don't know if that answered your question or not.

CHAIR JOHNSON: Go ahead.

VICE CHAIR McLAUGHLIN: Hi. We talked a little bit about this at lunch, and which is why I want to bring it up about the Austin, that it's my understanding that the medical records that you're talking about are not just kept from the different components of SETON Healthcare, but with the community

health centers as well.

MR. TERSIGNI: Correct.

VICE CHAIR McLAUGHLIN: And the public clinics.

MR. TERSIGNI: Correct.

VICE CHAIR McLAUGHLIN: And I think, you know, that kind of cooperation, giving the interest in community health centers as a source of care for our uninsured is interesting to our group. One of the charges we have and one of the reasons why we're having these hearings is to learn more about local initiatives and do you have an insight in how that happened? Because in Detroit, and for Michigan, I know Gail Warden tried very hard to get the Henry Ford Health Care System to collaborate with the public clinics and there's territory fights. And is there any suggestion of why you think it worked in Austin, lessons that could be learned?

MR. TERSIGNI: Well, let me tell you our approach. Our approach is, we need to be able to collaborate and compete in the same marketplaces. On certain issues we need to come together and collaborate. Caring for the uninsured is an area

where we bring all of the parties, and they may be competitors, together and say, "On this particular issue, we need everybody to participate, to collaborate, and be willing to share information." We've been pretty successful in all 12 of these markets. You know, some of these markets are more advanced than others, but we actually have, you know, fierce competition in some service lines in these markets but we have tremendous collaboration on this particular issue because we all recognize that these patients are going to end up in our emergency rooms and/or clinics and if we can't coordinate that care, those people are not being well served and what we're doing is we're exacerbating a problem of rising health care dollars.

VICE CHAIR McLAUGHLIN: One other piece, and this is sort of unfair information, but I was one of the evaluators of the program in Austin, so I know a little bit more about it than would be indicated just from this presentation today, but I know that one of the issues too was that the SETON Healthcare clinics and the community health clinics got differential payment for seeing patients because the

state Medicaid office would reimburse differently than the others. And so, they actually negotiated some arbitrage basically. So, you know, I think that was one way also they were trying to make both sides better off.

MR. TERSIGNI: Right. Right.

VICE CHAIR McLAUGHLIN: And I just throw that out, but I think that's another reason why this succeeded.

MR. TERSIGNI: Yes. And, you know, as you've pointed out, one model doesn't fit all and so we are actually experimenting in these 12 markets with variations on the theme of the five-step model. And we're learning.

CHAIR JOHNSON: I'd like to follow up on both of our comments and then get to you, Montye, if we could.

You're in several states and yet you've installed some information technology. To what extent are you paying attention to standards and interoperability initiatives that are being developed by David Brailer's office here in Washington and/or to what extent is a lack of movement forward with those

standards having an impact on what you're doing? And related, then how do you work interoperability across states and with other organizations? What are your expectations about that?

MR. TERSIGNI: Actually, at this point I can tell you that we haven't worked the interoperability across states yet. We actually have been confined, to date, in the local community. So that has made it a little easier. But at some point, depending on where the resolution of health care reform is, that issue needs to be addressed. We just haven't addressed that.

In terms of Dr. Brailer, we are in constant communication with his office in terms of looking at what's coming down and what do we need to do. We have created our own, our being Ascension Health, our own IT infrastructure and strategic direction for what we need to do as a health care organization and we're making sure that it's consistent with where the Federal Government ultimately wants to get to and as we're a little ahead in certain aspects of that, we're sharing that information with the Federal Government as well.

CHAIR JOHNSON: And the follow-up question would be, what we hear from so many, and it's both providers and some hospitals, is that they don't have the funds to install health information technology. Talk about that and potential return on investment that you've experienced.

MR. TERSIGNI: Well, that clearly is an issue, both -- well, inside and outside of our health system. Now, we have made, in our health system, we have made a major commitment saying that the IT has to be the enabling force for us to improve quality of care as we move forward. And so we're making the major investment and we've taken a position, since we have large, small and rural organizations, and some of them can't afford the IT infrastructure that we, from a corporate perspective, are saying, we want everyone to have. We are going to bring everybody up to the same level and we're just going to work it out. Now, the stand alone systems or stand alone hospitals are in a much more precarious position in that if they can't generate the cash for capital needs, you know, they have to really prioritize and that becomes an issue that we as a nation are going to have to help

resolve as we move forward.

CHAIR JOHNSON: Montye?

MS. CONLAN: I just wanted to thank you for describing what seems to be a model of excellence combined with a very compassionate mission. And I was wondering about the experience from the perspective of the patient. You show the slide of the person that presented themselves to two different emergency room on the same day. What would happen when that patient came to the second emergency room?

MR. TERSIGNI: In terms of care or in terms of treatment? If you could be just a little more specific.

MS. CONLAN: What would the experience be? Obviously if you've identified they've gone to the first emergency room, in an effort to save health care costs, you would want to prevent them from coming again, right?

MR. TERSIGNI: Well, our partners agree to, number one, treating whatever the episodic incidence is and then educating the patient, as they present themselves, in terms of helping them find a medical home. And so for that particular patient, for

example, the second emergency room would be committed to making sure that they identified a medical home for this individual and identified, for this individual, how to get the primary care, how to focus on getting the primary care, because oftentimes these patients just don't know where to go, or don't have transportation. And so, we take that on as an obligation of saying that's part of our commitment of coming together in this collaborative. Taking care of the medical problems first, but then educating, as well as finding a medical home, and that's where we work with private physicians in making sure that they're committed to accepting those patients as we direct them there.

MS. CONLAN: So when the patient presented themselves the second time and they were identified through your system, would they then be referred to a case manager that would be working with them, or I'm just wondering, you know, from the patient's perspective, "Here I am. I've come to your emergency room for the second time. What's my experience then?"

MR. TERSIGNI: In this particular case, in Austin, yes, a case manager would then take over the

relationship and direct the patient. Like I said, it differs in different models, but in this particular example, that's what would happen.

MR. O'GRADY: Yes, just a couple of clarifications on that, because in terms of the health information technology, I think the media has left, to a certain degree, the wrong information. You know, Dr. Brailer is the coordinator and that's very much the way the Feds are viewing this.

MR. TERSIGNI: Yes.

MR. O'GRADY: You know, there's not a health IT czar.

MR. TERSIGNI: Right.

MR. O'GRADY: This is a coordinator. And the Feds are trying to move into a position where they're not the 800-pound gorilla, or they're not just simply going their own way and good luck with the rest of the industry. So certainly the Feds are a major purchaser. They want a seat at the table. But it is that kind of consensus collaboration that Secretary Leavitt in terms of both the environmental policy and as the Governor of Utah is one of the best men in the field of how you bring together these diverse and sort

of come up with something that everybody can live with. So that's much more the way I would view the federal role in this, when you start thinking about, you know, Dr. Brailer's work and some of that sort of stuff.

The other thing I wanted to point out a little bit, and Dorothy brought it up a little bit about the VA, in our research on sort of both the business case for health information technology and who's ready to go and who's not, we found a somewhat counter-intuitive result. The VA clearly, you know, have done an awful lot, a, you know, industry leader in that sense. Community health centers, very sophisticated. You know, specialists downtown making the big bucks, not there at all and fairly discouraging results in some of it of, "Why not?" "Well, I'd have to use a keyboard." You know, that's not a real good answer to most Americans of why you're not moving forward in terms of what we see in terms of both return and investment, patient safety, improved quality, some of these things. So there's just this sort of reverse of what you might have expected, where you'll find a community health center with young docs

doing, you know, everything you'd want them to do and, you know, top guys in their field downtown looking at you like you're crazy.

CHAIR JOHNSON: All right. Dottie and then Aaron.

MS. BAZOS: Could you just clarify for me a little bit so that I understand this well enough? Among the local providers do you negotiate the shared burden of providing the care for the uninsured? Is that what you mean by providing a medical home? The providers accept a certain percent, or number, or whatever of -- there's no money involved in this, is there?

MR. TERSIGNI: Correct. Correct.

MS. BAZOS: It's just that the providers are deciding that --

MR. TERSIGNI: There's no money. Trust me.

MS. BAZOS: -- they would be seeing a certain proportion of folks who are uninsured anyway, sort of willy-nilly, ad hoc, so what this does is sort of manage their care by giving -- by assigning patients to a physician as their primary care

physician. Is that --

MR. TERSIGNI: Right. Yes, let me just clarify though.

MS. BAZOS: Okay.

MR. TERSIGNI: For the majority of the providers, other than the private practice physicians, there is no assignment of, "Well, you get three patients and I get three patients." It's the private physicians and the specialists that we actually talk to, "Dr. Jones, will you take 10 patients," and you know --

MS. BAZOS: Right. The patients who go outside of the FQHC or outside of the hospital?

MR. TERSIGNI: Correct. Correct. But the other providers take whatever comes in and then it ends up being that patient's medical home.

MS. BAZOS: Okay. All right. I just wanted to make sure I had that clear.

MR. TERSIGNI: I don't know if I clarified that for you.

MS. BAZOS: No, that is clear because in some communities what we see is some providers become sort of magnets for -- I mean, they call themselves

sort of Medicaid or uninsured magnets because they like working with these populations, some of them. So they've been trying to negotiate some kind of shared payment with FQHCs. But I just wanted to make sure I had your model down, so I understood.

MR. TERSIGNI: Yes.

DR. SHIRLEY: I think I may have been suffering from post-prandial hypoglycemia and I didn't realize that this was one patient. Is that right?

MR. TERSIGNI: The example, yes.

DR. SHIRLEY: And this person obviously is not shopping for access. I think this patient is probably shopping for something else, if I just had to -- yes. Yes. I just --

MR. TERSIGNI: And our hope is that this patient, now that he or she has a medical home, which would also deal with the education piece of what, I think you were referring to, of what the patient was shopping for.

DR. SHIRLEY: Well, I would think a medical home would have sensed something in this two-and-a-half month period in which this patient -- this patient was shopping around. Patient had access.

MR. TERSIGNI: Yes.

DR. SHIRLEY: Because undoubtedly the patient had an encounter every place they stopped. No financial barriers, no --

MR. TERSIGNI: Correct.

DR. SHIRLEY: -- no interpretation barriers, but the patient still -- and I think it's more this patient needs some special attention.

MR. TERSIGNI: Right. Correct.

CHAIR JOHNSON: Ken, in your presentation you indicated that you could not cover franchisees or small employers. Can you talk about some of the rationale for that?

MR. SPERLING: Sure. We originally wanted to extend this coverage out to franchisees and small employers, but the state insurance regulations kind of stood in our way. The way we had to structure this, in order to avoid medical underwriting, and let's maybe back up a step, we could have launched this on an individual platform or a group platform. The problem with launching this in the individual insurance platform is that once we developed a rate that would have been affordable according to what we

are trying to accomplish, in a lot of states that product, that rate has to be available to all comers. So then you get into the kind of the risk issues and the individual marketplace which is maybe an individual marketplace less than perfect.

So that led us down to the group contract, you know, the employer-specific contracts. Well, in a group contract, in order to have coverage, you have to have an employment relationship. And in a franchise relationship, there's not an employment relationship. It's a business relationship. So franchisees could not be covered because they don't meet the definition of an employee. So then we said, "Okay. What do we do about that? Well, maybe we can get the franchisee as a separate employer in here." Well, that works if your franchise has more than 50 employees. If your franchise has less than 50 employees, there's a other set of state small-group rating regulations which stands in the way of even putting this platform in place.

So we had to kind of work through a fairly complicated maze of state and insurance regulation in order to kind of bring this thing up in the first

place. And even now, we have a mix of individual and group contracts. The group contracts are ERISA plans, which means that in order to qualify as an ERISA plan the employer must promote it. And we have individual contracts, which in order to be an individual contract, the employer can't promote it. So in our communications around this program we have to walk a very fine line depending on where we are, what kind of contract we're dealing with. So it's a challenge we're going to overcome, but it was a challenge.

CHAIR JOHNSON: A follow-up to that would be that earlier today we talked about the challenges for the smaller employer and the individual employee purchasing coverage. I'd like to ask you a question similar to what I asked earlier today; and that is, to what extent do the different rules covering health care coverage state-by-state have an impact on what you're doing and to what extent would uniform rules nationwide be preferable or be helpful in providing coverage, as you're trying to do?

MR. SPERLING: Well, I'm not going to use the term "association health plan" because that comes with it an assumption of regulation that I don't think

we want to get into. But if there were a process where small employers could come into an insurance system that did not have as many built in costs of some of the state mandates that are out there, then that would help the affordability issue. Because one of the things that small employers really have to wrestle with is any insurance product that they might buy comes with state-mandated benefit baggage that creates costs right from the start. And I'm not arguing appropriateness of any one mandate, but just taken as a whole, they create a cost burden that prices some employers completely out of the system.

Second, is that small group coverage tends to be very volatile with insurance companies coming in and out of the marketplace and small employers suffering 30, 40, 50 percent rate increases from time to time based on the very volatile claims of a small population. So a small employer who could come into a purchasing pool or something more stable can eliminate some of the volatility. So we absolutely and fully support efforts to create large purchasing pools that would lend more stability to that small group population and a process where we could offer

scaled-down coverage or have more flexibility in coverage so that you could offer choices to those small employers at price points that would bring some of those small employers who are currently out of the market back in. But more importantly, keep those small employers who are offering coverage and are right on the cusp from jumping out.

MS. WRIGHT: It's probably a loaded question for either one of you, but I guess I'm just trying to get my arms around, and, Anthony, it may be directed more towards you because in your bio I see HCA there, what any of this, how all of this fits in or matters, or would affect programs for the non-profit hospitals, which we obviously came from, versus the profit hospitals versus your specialty hospitals that we --

MR. TERSIGNI: I'm not sure I understood the question though.

MS. WRIGHT: What is, I guess level the playing ground for all of them. You know, right now I can see the program that you're doing fitting in and getting out to those community centers. I don't see the for- profit hospitals or your specialty hospitals

willing or wanting to pick this up.

MR. TERSIGNI: I really can't speak to the for- profit or specialty side. I mean, I really should only, and can only, focus on what Ascension Health is doing and what the not-for-profit industry is doing. And again, we're committed to not only helping to promote health care reform, but making sure that we are taking care of the community that we serve. I mean, that is – we, as 501(c)(3) organizations, are community resources and we take that very seriously. And so as part of being a community resource, you know, if there is a profit, so to speak, at the end of the year, it goes back into plant equipment and programs in the community because we are a community resource. So I can only speak for our experience.

MR. SPERLING: I guess from our standpoint, even though this is a kind of an insurance model, we see the issue spanning the non-profit and the for-profits fairly equally. Because the bottom line is, when somebody walks into a hospital and receives care, whether it's a for-profit or a non-profit hospital, if it's uncompensated care, they

probably get about five cents on the dollar. From Medicaid, depending on who you want to listen to, maybe that number is 40 or 50 cents on the dollar. From Medicare, it's something less than the 100 percent, 100 cents on the dollar, they'd like to get. And essentially the difference is made up with commercial insurance contracts where they can kind of balance the books and kind of make everything work. But I don't think anybody would argue that there is immense shifting between the different payers or non-payers in the system.

So we can't just take a current private health care system, layer it on top of 45 million uninsureds and expect the costs are going to go down, or even stay the same. I think all the literature suggests that we will end up with an increase in costs. So we've got to reform the system systemically through driving greater efficiencies and greater qualities and whether that's through IT or whether it's through information, or whether it's through driving volume to higher quality providers, all those things are noble causes and should be pursued. But I think if we can lessen the burden of uncompensated

care, then that takes less pressure off of the rest of the payers to increase their rates to essentially balance the books. And that is a non-profit and for-profit issue alike.

MS. CONLAN: How are the volunteer physicians identified and recruited?

MR. TERSIGNI: Well, we actually ask the community collaboratives to identify those physicians and they do it in a number of ways. Some are employed physicians, some are private practice physicians. And so, you know, there are a number of ways that we enlist their support. Basically we appeal regardless what physician it is, whether employed or private, that, you know, it's part of being a member of the community and giving back to the community in some fashion. And so, we've been very fortunate. I can't think of, in any of our 12 sites, where we've had physicians turn us down.

MS. MARYLAND: And if I could add to that, Montye, in Indiana specifically, from our active medical staff, when they come on board as a part of receiving their credentialing process for their privileges, one of the -- you know, we're very clear

about our expectations and really sharing some of the burden, if you will. And if you can distribute it such that it doesn't become overwhelming to any one person or any one practice or PC, it seems to be very reasonable. And we've not had the problem, at least in Indiana, I can speak to that, of finding the specialists, to line up specialists that support our needs for our patients.

MS. CONLAN: So then would you say you have 100 percent compliance in terms of volunteering, or you said, you know, when they come on board you make clear your expectations and all the physicians agree?

MS. MARYLAND: Well no, of course they don't all agree initially, but believe me, when we work with them, because it's sort of a shared type of effort here. I mean, we're supporting the physicians in the growth of their practices and really helping them flourish also. And in return, to just become part of our ministry; and we call it a ministry intentionally, that this would be just an expectation asked of our physicians. And we have really, since I have been associated with my facility, I have not had

any and we've not felt any real issues, quite frankly.

MS. HUGHES: Therese Hughes. This is for Mr. Sperling. I wanted to just for clarification better understand the 1.3 million across the 60 companies. Is that all of the uninsured in the companies, or is that just the uninsured that you chose because of their ability and need in these categories?

MR. SPERLING: That 1.3 million across the 60 companies would represent the total employee population that did not have access to an employer-sponsored program. Now that doesn't mean they're uninsured. Some of them might have individual insurance. Many of them nay have insurance through their spouses.

MS. HUGHES: Okay.

MR. SPERLING: But these are people who are not for instance for, and I'll pick a company, IBM. These are people that IBM does not offer its employer-sponsored program to. So they would include part-time employees, they would include independent contractors.

MS. HUGHES: Right.

MR. SPERLING: It would include temporary employees. Although some of IBM's temporary employees have coverage available to them through the temporary agency.

MS. HUGHES: Right.

MR. SPERLING: So we are not assuming that 100 percent of the eligible population will enroll in this model. In fact, we're assuming that probably 10 to 15 percent will enroll in this model.

MS. HUGHES: I understand that. I guess I wanted to go one step further and ask you in particular, in Arizona will any of these employees be those employees that are brought in from out of the country who, you know, work for the different companies, but for whom federal regulation has said that you're not responsible for providing coverage under. And I wondered if any of them would be able to access this.

MR. SPERLING: That would be an employer-by- employer decision. If they are working for one of these employers and receiving a pay check and are on their HR systems and are not offered coverage through the employer-sponsored plan, they would certainly be

eligible for this model if the employer chooses to make them so.

MS. HUGHES: Okay.

MR. SPERLING: And we have not heard from any of these employers that they want to exclude any given group.

MS. HUGHES: Okay.

MR. SPERLING: Because there's no reason for an employer to want to exclude them.

MS. HUGHES: Thank you so much.

MR. FRANK: I'd like to sort of follow up on Christine's question. In a sense, the way you answered your question talked about sort of your own policies and the way you all do business. And you've certainly persuaded me that you guys are the good guys in your markets. But, when we think about extending this as a model, which is sort of the way we started, for other parts of the country where you actually may not be the main player and in an area, then I think the issues that Christine raises kind of become more salient, which is what happens if you have a mix of facilities or a mix of organizations and in a sense creating the sort of special health district and the

network creates a set of providers that are committed to doing this, but it winds up unburdening some of the other ones and actually implicitly winds up creating a potentially significant subsidy at taxpayer's expense, right, that might come off your property tax or the cigarette tax, or whatever. How would we kind of think about sort of patrolling that territory, or is there other legislation or, you know, how do you deal with that?

MR. TERSIGNI: From our perspective, we believe the model works regardless of whether there's a taxing district or not, whether it's for-profit or not-for-profit, because as Ken indicated, the uninsured are showing up on our doorsteps whether we're for- profit or not-for-profit clinics, hospitals, whatever. So we just believe that once you're committed to the five steps as a community, that it can in fact work.

MR. FRANK: Let me get concrete about it.

MR. TERSIGNI: Sure.

MR. FRANK: Okay. We have let's say a community health clinic, a non-profit hospital, a general hospital, non-profit general and another

non-profit general hospital with a psych unit and then a specialty psych hospital and the specialty psych hospital does a little bit of Medicaid, does a little bit of uncompensated care, but you know, it's not at the top of their list. It doesn't go well and let's say they're for-profit. Suddenly, you sort of put together a special district and you have a three-facility network, which is the two non-profits and the CHC, let's say. Suddenly there isn't quite the same burden of community responsibility on the psych hospital to do its part because there are these other things. Now that's fine from the point of view of the patients, you know, so that's a good thing and, you know, but it's also perhaps more costly and a subsidy to somebody else and not everybody's pulling their weight in the community effort here. And I'm just saying what do you do about that?

And that's sort of where you were going?

MS. WRIGHT: Yes. Thank you.

MR. FRANK: You got me thinking about that.

MR. TERSIGNI: I don't know that I have an answer for that because I can tell you that in the 12

sites we have we get everyone committed to play. So, I mean --

MR. FRANK: One answer is that's what you got to do.

MR. TERSIGNI: That has been our answer at least and again, to address to something that would happen like that, I really can't. I don't know the answer for that.

VICE CHAIR McLAUGHLIN: Richard, just one thing. The Sisters of Mercy, which is another Catholic hospital chain and one of them is right in Ann Arbor -- well, it's in Ypsilanti, but in Ann Arbor. They recognize that they operate in different markets and a little known secret we know because most of the CEO, most of the staff are graduates of our program, so we get a lot of inside skinny on them, they do a lot of cross-subsidization within the corporation so that hospitals that are members of the Sisters of Mercy in markets where they are carrying more than "fair share" and the market competition is such that they can't get everyone on board to share the burden are subsidized by hospitals who are in markets where they are the dominant player and they're

able to get people around. So I don't know if that is done in other hospital systems, but I do know that's what's done in the Sisters of Mercy to take account of this exact issue that different markets are going to have different structures.

MR. FRANK: Yes, the point I was getting at is it may be disturbing to the community and maybe hard to sort of keep a coalition together if somebody gains a windfall at the expense of --

VICE CHAIR McLAUGHLIN: Oh, I agree, but I think that's what Tony said, you make a commitment that this is what we have to do.

MR. FRANK: Right. She said you have to everybody, right.

VICE CHAIR McLAUGHLIN: This is our mission and then you make it work. And you don't sit around going, "Well, they're benefiting from what we're doing."

MR. FRANK: Yes.

VICE CHAIR McLAUGHLIN: You just say, "They're benefiting from what we're doing. Okay."

MR. FRANK: Yes. No, I --

VICE CHAIR McLAUGHLIN: But it takes an

institutional commitment.

MR. FRANK: Yes, but what I'm saying is that in the sense if this is to be a model, you need to figure out mechanisms to encourage everybody to come together and that's what I was trying to get at, you know, I think good will alone does not always win the day everywhere.

VICE CHAIR McLAUGHLIN: I mean, if you want to get down to specific and brass tacks, okay, my example is right where we're at where we have, you know, the Catholic hospital, not-for-profit, our own Lutheran facility or -- and that not-for-profit and MedCath came to town three years ago. You know, I don't see some of these programs that MedCath is going to step up to the plate to say, "I want this."

MS. MARYLAND: But in that particular situation MedCath, and I don't know if it's a cardiology heart hospital; if it is, I just assumed that it was, okay? Because we also have similar issues. There are physicians on the staff that may be an investor in that specialty hospital who also are on staff at other of your other non-profit hospitals and they will share, at least our experience in

Indianapolis is that they do do their fair share because we plead to -- what was the term that we used earlier, "shameful" --

UNIDENTIFIED SPEAKER: Right, the "shame game."

MS. MARYLAND: -- "shame game" here and it's clear that, you know, you want to be on the same page, particularly when you're part of -- and for us it's a ministry, a home that we're providing for these patients and care that we're providing for these patients.

MS. WRIGHT: They're sharing. They're sharing the non-insured, you know, and the physicians yes are on the other staffs, but I can tell you any town I think, reading some of the history of MedCath, has gotten very ugly politically where it was our major group of cardiologists at our hospital that was stripped from our hospital to go invest in MedCath.

MR. O'GRADY: I guess I would share Richard's concern about free riders in any of this and the sort of incentives set up, but at the same time we do know, as you pointed out before, part of being a not-for- profit is a certain tax advantage that you

have for doing charitable care in the community. So I guess if, you know, I share Richard's, but at the same time I'm sure if there is a guy here from one of those for- profits who decided to opt out, they say, "Yes, and we pay more taxes and we do other things because we are a for-profit hospital." So it's a mixed bag, but it certainly seems that Tony's got the right -- if you can get all the actors to agree up front and you're sure they're not agreeing on paper and then not really doing it, that does seem the best way to move forward, before anybody really starts, you know, before it really gets off the ground.

CHAIR JOHNSON: You have another, Dottie?

MS. BAZOS: One quick question. I think I asked my question badly last time.

When you go to a community and you're going to share the risk or the burden of managing the care of the uninsured, what if the uninsured population is already going to one institution more than another? Do you actually move patients to another institution, or you share the money somehow? Because we're working on this in a community in New Hampshire and that's one of the questions. I mean,

patients already sort of chose their physicians where they're feed and their at a certain place and we have providers who have, you know, much more of a burden than others.

MR. TERSIGNI: To date we don't even talk about sharing money because presumably all of this care is free. What we're looking for is to coordinate the care across the continuum. So in none of these sites have we gotten into a discussion, at this point, of, "Well, I've got more indigent patients than you do and therefore you should take some." It just doesn't work that way. It's our way of saying we can help the community by getting them out of the emergency rooms and it's in everybody's best interest as a community citizen for us to do that and there is no sharing of money in our model at this point.

MS. BAZOS: So is the burden across the providers seen as similar? You haven't come to a community where one facility or provider is seeing most of the patients, most of the uninsured patients?

MR. TERSIGNI: I don't know the answer to that where one provider is seeing most of the uninsured patients. I just know that all of the

partners have their fair share of the burden and that's how we just accept our fair share of the burden. We don't count heads, if that's what you mean.

MS. BAZOS: Okay.

MR. TERSIGNI: I don't feel I'm answering your question and I apologize.

MS. BAZOS: No, you are.

MR. TERSIGNI: Okay.

CHAIR JOHNSON: We'll adjourn from the session just a second. But do either of you have additional comments that you would have liked to have made that we haven't asked you about, but you've thought of since your original presentation?

(No audible response.)

CHAIR JOHNSON: Okay. Good. Well, thank you very much. We appreciate two unique approaches in trying to extend coverage and we appreciate your being with us this afternoon. We will take a 15-minute break and then we'll reconvene and get into some of our business issues.

(Whereupon, at 3:18 p.m. a recess until 3:36 p.m.)

CHAIR JOHNSON: Well, welcome back.

We're going to go into Working Group business at this time. And we have several things on the agenda. Let me just touch base with you all on them.

The first thing we're going to do is we've invited John Comola and Marcia Comstock to join us and to share some of their thoughts on our Working Group, just as we asked AmericaSpeaks to do that yesterday. And they have agreed to do that, and so we'd like to welcome you.

In addition to that, what we're going to do so we have everybody's expectations up front, we're going to share with you the Hearing Committee's recommendations for the next series of hearings.

And then we're going to go into what we'll call Executive Session. And you may recall yesterday we had some comments on that. And when we do that, we're going to invite those who are familiar with working groups such as this to tell us what are the parameters, what can we do in working sessions and what is it best not to do, in fact not legal to do in working sessions. So we'll talk about that before we go into that. And in that time we'll talk about the

process and we'll talk about some of our committee structure for the future, and so forth.

So that's the agenda for the rest of the day.

MR. FRANK: Randy, are we going to do the minutes?

CHAIR JOHNSON: Yes, we will do the minutes. First, are there any comments or corrections to the minutes? Okay.

MS. HUGHES: In the minutes it says Therese Hughes from the Venice Free Clinic, and it's the Venice Family Clinic.

CHAIR JOHNSON: Okay.

MS. HUGHES: And I would like to have that identified properly.

But then in answer to a question that was raised yesterday, I would like to be in the future identified just as myself and not for entity, because I think it gives a look to the public that I really don't want to have perceived.

Thank you.

CHAIR JOHNSON: We had talked about, I think it was a suggestion of Larry Patton, a question

to the group whether or not we wanted to be disassociated with our business or education units, sponsoring organizations, whatever we call them. And we had somewhat of a sense that that might be what we'd like to do, just let's just affirm that for the record.

Is there anybody who would object to just listing our names?

MR. O'GRADY: I assume that I'm the exception to that, since I'm representing the Secretary.

CHAIR JOHNSON: Okay. Okay. That's fine.

MR. O'GRADY: We can do it that way.

CHAIR JOHNSON: Okay. Thank you.

Other comments regarding the summary. Now keep in mind there will be a full transcript that will be on the website. And so that will be available to others who view what we've been doing in our meeting.

But, go ahead.

MS. CONLAN: I just wanted to mention that before I had referred to the Heuga Center, not the Hugo Center. It's H-E-U-G-A.

And they are not a treatment center,

they're a disease management center, I guess you would call them.

CHAIR JOHNSON: Okay.

Yes, Richard?

DR. BAUMEISTER: (Off microphone).

CHAIR JOHNSON: Richard?

MR. FRANK: I have a suggestion for next time, more than this time. I felt that particularly other than where we had our list of issues, that there are a lot of comments that were made that were substantive, at least that I had from my notes that didn't show up here. I thought that both Senators Wyden and Hatch had some real substantive things to say and this focused more on their sort of processes kind of remarks. And I think that it doesn't need an elaborate treatment, but just enough so that it will remind us that those things were said.

CHAIR JOHNSON: Okay. Thank you. Okay.

Thank you very much.

I guess is the formal structure that we formally vote to approve these? What's recommended?

Okay. With the corrections that are suggested, may we entertain a motion to accept the

summary as provided?

MR. HANSEN: So moved.

DR.JAMES: Second.

CHAIR JOHNSON: Thank you. Any further discussion?

All in favor say "aye."

ALL: Aye.

CHAIR JOHNSON: Opposed. Thank you.

Okay. Thank you very much.

Jon Comola and Marcia Comstock are known to some of us, but they're not known as well to others. And so we've asked them to come and share a little bit about some of their experience and thoughts regarding opportunities for the Working Group. And, by the way, we have not asked them for a formal presentation at all, so they're not here to do a formal presentation although they could. That's not part of the agenda.

But if you would share some of your thoughts relatively informally of your observations and thought of opportunities and so forth, we'd appreciate that.

MS. COMSTOCK: Let me first say that Jon

and I very much appreciate the opportunity to sit in informally yesterday as "the public," because we're not here in any official capacity, to hear some of the comments that were offered to you, some of the thinking from experts around health care and to have a few minutes this afternoon to tell you a little bit about who we are, and the kind of work we have been doing for the last few years, why we're particularly interested and enthusiastic about your mission and your charge and then offer a few thoughts with regard to some things you might think about.

Wye River Group on Health Care is a nonpartisan and not for profit organization that fundamentally serves as a catalyst. We bring very diverse health care interests together in a neutral environment with a particular goal of building trust among those parties and beginning to try to identify some common interests in order to generate movement in a positive direction around health care.

We've been together working for about five years, and we are very different in terms of our style. We're very different in terms of our background.

Jon comes at these issues with experience in government relations, public affairs, communications and the insurance industry. And I come at it as a physician. I'm an internist and preventive medicine specialist who spent a great deal of my career as a corporate medical director in the employer sector and then had the opportunity to get into public policy working with the President of the U.S. Chamber of Commerce as his fellow.

I want to say a few things about what we feel are the tenets of our work that are somewhat different from many other organizations.

First of all, Jon and I have lots of opinions, but we don't advocate for positions; rather our job is to reflect the views and the opinions and the thinking of the folks that we work with. And this is always done in a multi-stakeholder fashion.

We believe very strongly in being inclusive. And when we say "inclusive," we're not talking about health care. We're talking about health and we're talking about communities.

Third, unlike many organizations that have excellent ideas and potential solutions and who try to

convince people that what they think is the best solution, our goal is to carefully define the problem from the perspective of different interests. And what we have found is that when you do that with almost any problem, the range of possible solutions tends to become less and you increase a lot of understanding amongst people who may have not thought they had as much in common as they in fact do.

And finally, the process is very methodically designed to create buy-in and ownership of the end result or the product.

With regard to the philosophy, we don't take ourselves seriously, but we take what we do very seriously.

At the national level we've worked for a number of years. We've been involved with thought leaders in a number of different sectors; organizations like Robert Wood Johnson, AHA and HRSA have worked with us around strategic planning and the development of action plans for various kinds of initiatives that they had underway.

Now, about three years ago we expanded our work at the community level, and we did this through a

project that we called "Communities Shaping a Vision for America's 21st Century Health and Healthcare." And I'm going to pass around the summary of the first phase of the project for you to look at. And I'd like to also make available through Randy and George the first chapter of this, which is the summary of values and principles for policy, not solutions from the public but from community leaders that we worked with that might just be of interest to you. And it's done in their own words, which I think you'll find quite creative.

This initiative had the active involvement of the Administration and the Democratic leadership, and the support of major trade and professional associations from across health care sectors as well as the business community and consumer groups.

We very methodically selected ten different communities using a variety of criteria including geography and size and regulatory environment, and competition and cost and quality indicators based upon Wennberg's work and others.

We went into these communities and we met one-on-one with 25 to 30 leaders; community leaders

and health care leaders. And we did this not only to gain an understanding of the marketplace and what was going on in the community, but to build trust, to get the leaders to see us as credible, neutral catalysts that wanted to bring their community together to talk about healthcare challenges and to see where there was agreement.

We returned several weeks later and we held what we called Health Care Leadership Round Tables. And in these meetings we focused on some issues that we were told that these leaders don't talk about very much, for example:

Do we have a social contract for healthcare in this country, and what would be the attributes of a well designed healthcare system if we started from scratch today, and; very importantly, how do we engage our citizens in helping us to solve healthcare problems?

And I want you to know we were told by these leaders, again not the public, that they didn't often have the luxury of having these kinds of conversations because they were so busy focused on day-to-day activities. It was an extraordinarily

exciting initiative that we continue to be involved in going into our third year.

I'm not going to go through what we learned there, but I will say just a couple of things:

(1) One of the first things that these community leaders told us is we have got to engage the public in discussions around what it is that we, as a society, really want from health care and how we can achieve that. They were absolutely adamant that that is a foundation for moving health care policy in the right direction.

They felt that there was a lack of trust in the health care system and, frankly, that the health care system had helped to create and foster that lack of trust. What you'll find in communities is that these leaders are going to support the kind of work that this group is doing with the public.

When we released this report in the fall of 2003 we knew about the Wyden-Hatch legislation and we invited Senator Wyden to come and to keynote the press conference, and he was gracious enough to do that. And at that time he asked us if we would try to help support the legislation by putting out notices to our

communities about its intent the importance of getting the public engaged.

So I'm going to stop at this particular point and Jon is going to talk about some of the ideas that we have. But it's just very important to emphasize this work was not the work you're doing. It was a very different kind of work, but what it does is very much lay a good foundation that gives you a sense of what some of these particular leaders are saying. And they absolutely will support the importance of the public engagement.

Jon?

MR. COMOLA: Thank you.

I want to reiterate how pleased Marcia and I are to be a part of the dialogue, yesterday and today as attendees and to have the opportunity to sit in and hear what was shared with you and hear your questions. Because it provides us with some real insights as to how you're looking at these issues and what's important in your thinking.

In whatever capacity we can be of assistance to you, whatever that may be, we welcome that opportunity.

I wanted to do a couple of things with you really around what might be distinguished as the difference between the economic structures and the sociological structures. A lot of what you've heard, absent maybe yesterday's dialogue coming from the organization “millions of voices”, has been really on the economic side of equation; how do we deal with these issues with regard to the uninsured, how do we deal with government programs providing services through Medicare and Medicaid and so on and so forth.

On the other side of the equation, and this certainly came through in our work in the communities, is the importance of the cultural elements. Not only elements related to health care disparities and things like that; they're really elements focused on how people interrelate with one another.

We were blessed yesterday to have a brief conversation with George talking about some of the work that he had done as an investigator and there are a lot of similarities in what he found to be success factors in addressing those cultural elements, in addressing those social elements in bringing people

together and advancing ideas.

You're charged principally, as we understand it, with gathering public opinion, and as Catherine and Aaron said yesterday so well, in also educating the public, which is critical to raising awareness.

The other thing that you're doing, and I'm assuming is the main driver for all of you being here, is you have a goal to improve the health care system. , You were briefed yesterday by the folks who know more about processes to gather information than anybody else in this nation. We're not here to tell you about how that operates. But what we do want to do is talk about how you bridge that information to ensure action. Because at the end of the day if we're going to achieve our goals, which we all share in terms of improving the health care system, we have to be able to take the information that was gathered and have an affinity built among those other institutions and structures that are powerful in effectuating change.

So whether we're talking about the industry from the hospital sector or insurance or

employers or government, those are all institutions that when the voices of America come to them and make these kinds of recommendations or present ideas are going to say "Well, did I have an opportunity to be a part of any of that conversation, and does it fit within my agenda." Or are you going to recommend something that runs headlong into what is doable for them from where they sit? And it's only part of the equation. And the reason I raise it is because I think there's a real opportunity to bridge those two concepts. The idea is capturing public opinion simultaneously with briefing and keeping up to date industry sectors that are critical to your end success.

And so I wanted to plant that seed in these few words that we had to share with you this morning more than anything else. And I think when I speak of industries, I'm thinking of the industry at the community level involving doctors, involving insurance company folks, involving business, involving public health, involving advocacy groups in those conversations so that they feel like they have a stake in the outcome of that dialogue.

These may be things you already know and you've already thought of, so forgive me if I'm just repeating what you're already sensitive to. But in our work it certainly has come home in spades that being able to set a neutral table, advance the ideas coming out of that table in a meaningful way means at the forefront inclusiveness.

And so we look forward to supporting your work. And I think I'll stop there and if we have any questions, we are happy to answer those.

You have in front of you a document that was drafted in February and it followed on the heels of some conversations we had with some GAO staff and AHRQ. Larry Patton was leading that conversation. It was a wonderful opportunity for us to simply reflect on some of the charge elements that you have before you, share some of our learnings, and talk about what are the kinds of things that you might think about as you move forward.

So with Larry's permission and the Chairman's permission we wanted to hand that out. I think you have it in front of you. And it's just food for thought. These are ideas, some I know have

already been touched on by other speakers, others I know have not. So I hope they're helpful to you.

Thank you.

CHAIR JOHNSON: Okay. Questions for Jon or Marcia?

MS. HUGHES: First of all, thank you for coming.

And then second of all, what I wanted to ask is you made the comment of bridging the information for access. And I wondered what exactly do you do to bridge the information of access of the information that you've accessed and how would that be handled?

MS. COMSTOCK: I'm not sure if I understood, so if you can --

MS. HUGHES: Do I need to make it clearer? You said that you would gather information and that -- maybe I misunderstand. But I felt that you have the neutral table, you have ideas that are developed and those ideas need to be advanced not just to the American public, but you're going to bridge this information within the structures of those who would be making changes. And I wondered what exactly does

that mean and what do you have that other agencies don't have?

MR. COMOLA: That's an excellent question, and I think it's really in the methodology.

If when you have a dialogue you are inclusive in the development in the research, in the execution of what it is that comes out of that dialogue, that you involve other sectors, including the folks who were around the table having that conversation, then you're more likely to get buy-in at the community level and nationally for whatever those recommendations. Envision if you will, a set of participants standing on the football field in play versus the ones in the stands.

Right now your process really is set up by legislation at arms length from those sectors that are going to have to make the changes that you're going to ask them to make. You've been set up to be the kinds of people who don't represent and aren't advocates of specific interests, per se. In other words the legislation read that those that are in the lobbying business can't serve on this committee. But yet we know at the end of the day in order to bring about

changes you're going to be looking for regulatory changes, administrative changes, changes that might require congressional action or state legislative action. So unless you think through and strategically set into motion at the front end of the project ways to involve those folks in a meaningful way, then you're not likely to have their support at the end of the day.

And I could reflect on other large legislative initiatives that failed, I think, in part because of missing that point, which is why we wanted to bring it up.

Does that help answer that question?

MS. HUGHES: Well, it explains the process very well, but I don't really understand how you're going to accomplish this. I guess I'm looking at how do I determine whether the project at the end of two years is a success or not. I might have a number of variables that I look at high priority and low priority for success. And I just wondered if my highest priority is that it enacts, let's say we come up with ten points that resound across the nation and they look workable, is what I'm understanding that

you're going to help us get access to leadership people who would make this work? I don't want to sound naive, but I just don't understand what it is and I just wanted to better understand that.

MS. COMSTOCK: I think what we're sort of thinking about is the fact that this group was set up deliberately to be going to the public, for the public's perception not the leaders' perceptions, is a good thing, because that has not yet been done. But at the same time ultimately health care is delivered by doctors and hospitals and so on.

All we're really suggesting is that it needs to be a simultaneous, not a sequential process. You don't want to do all of your information collection without at the same time kind of being cheerleaders along with the industry.

The materials that we're providing are basically saying to you we think that the industry will be supportive, but in order for them to be supportive, we don't want your process to close them out. So as we're going along, it's keeping them informed, involving them in the process.

In the document that we handed out, we had

some ideas that talked about developing alliances that are ongoing. They're not the ones whose opinions you're seeking initially, but you want to have them informed. They want to feel like they're going arm-and-arm with you, that they're supporting the gathering of public information and not helping to shape it as much as to understand what you're learning so that they can be informed, and not be blindsided afterwards. You know, that's when people resist things.

I think, actually, it was Wyden who made the comment at our press conference, he said what we're talking about here is turning the process on end. The way we've approached public policy for 60 years is to put smart people in Washington together and have them come up with a solution and then send it out to the American public. And we're talking about turning that on its ears and going to the citizens and asking them what is it that they really want.

As I recall the President of the American Cancer Society, John Seffrin, said it's a fundamental tenant of democracy that before you go making public policy, you ask people what it is that they want and

what's important and what the trade-offs are. That's all we're saying. We're saying while this is being done let's make sure that the trade and professional associations in D.C. and the physician executives and the hospital CEOs and the employers in the communities are also kept informed and are encouraged to belong to the process. The key is inclusivity. Does that make better sense?

MS. HUGHES: Yes.

MR. COMOLA: That's wonderful. I want to build in one little idea in terms of an operational concept that helps build one of those bridges.

Depending on how you shape this, you may want to use surveys or other tools to reach through to the constituencies of different organizations; the insured of an insurance company, however many people they have insured in a region, for example. You may want the company to send out a survey that you all have developed and then have them send it back to you or however it might work. Same thing with a doctor's office; things that people can fill out and send back in. The same thing with all the other sectors.

In other words, they can become agents to

help you achieve --

MS. COMSTOCK: Magnifiers.

MR. COMOLA: And magnifiers to help you to achieve what you want to do. And that gives them a sense of ownership in what you're trying to achieve.

MS. COMSTOCK: And the other thing is, you know one of the problems we perceive in health care is that the media frequently likes to tell horror stories. You know, it's not really exciting to tell good news stories that often. However when you go out into these communities and want to get attention for what you're doing in these conversations, you want to have the health care system also cheerleading and saying, "yes, this is the right thing to do. We want to have the public's opinion also." So it's another reason to make sure that you have as many allies for this as you possibly can and you want to be tamping down any potential resistance, even though it's going to be there eventually. It's less likely to be so if you're working as much as you can hand-in-hand from the get-go.

MS. HUGHES: Thank you so much.

CHAIR JOHNSON: Joe, did you have a

comment?

MS. COMSTOCK: It was a really good question.

MR. COMOLA: That's a good question.

MR. HANSEN: Yes, but it got answered.

MS. COMSTOCK: We just answered every question.

MR. HANSEN: Well, you made a statement at the very end that I'm finding a little bit curious. Because we don't know, quite frankly, where we're going to end up,

MS. COMSTOCK: Right.

MR. HANSEN: But you said we're going to meet resistance. And I'd like you to expound on that a little bit. On what issue and on what kind.

MR. COMOLA: The short answer is that any change meets with resistance.

MS. COMSTOCK: Yes. Yes. That's all we mean.

VICE CHAIR McLAUGHLIN: So we won't recommend change.

MS. COMSTOCK: Well the second best solution is always the status quo, and that's why

that's what we've got.

MR. COMOLA: That's right.

MS. COMSTOCK: Right?

MR. COMOLA: Right.

MS. COMSTOCK: No. No, we don't know. But people just naturally resist most change.

MR. COMOLA: Yes. Yes.

MS. COMSTOCK: Another quick thought. We had a meeting recently where we were looking at consumer engagement and everything from social marketing, talking to Procter & Gamble and Pepsico about how you make soap powder inspiring and all this other kind of stuff and how we get people engaged. And we had Dr. James Prochaska present. And many of you in health care know he is the father of the behavioral change model. And one of the people who participated said; "do we ever think about the fact that organizations need to go through the stages of change, too? We don't think about that very often." Everything is cultural. People are cultural, populations are cultural, organizations are cultural, doctors, hospitals, insurance and so on, employers, unions; all of them, they have cultures.

So, anyway, we just think that change is a process.

MR. COMOLA: And you all have some wonderful assets here, too. I mean, you have the Secretary's chief policy person here. The Secretary, obviously, is vested in making sure that this works.

MS. COMSTOCK: Absolutely.

MR. COMOLA: You have Democratic and Republican leadership that you can roll out if you're trying to get press attention or if you're trying to get some of these organizations to pony up and support you financially.

MS. COMSTOCK: Right. Right.

MR. COMOLA: Maybe you want to go to some of these groups and say we'd like for you to put some money into the kitty to help us achieve these goals.

You might say: Robert Wood Johnson, this is something you guys have been working on a long time. Kettering, this is something you guys have had a strong interest in.

There's lots of opportunities. And I guess thinking entrepreneurially is partly what we were trying to do in setting out the ideas in this paper.

VICE CHAIR McLAUGHLIN: One of the other things, though, that I thought where Joe was leading that we don't really know where we're going to be in two years in terms of our recommendations.

MS. COMSTOCK: Right.

VICE CHAIR McLAUGHLIN: I mean, it was made very clear to us when David Walker interviewed each one of us and made very clear to us by the Senators Wyatt and Hatch in our meeting last month that they didn't want people who already had a vision.

MS. COMSTOCK: That's right. That's true.

VICE CHAIR McLAUGHLIN: Who already had an idea of what we were going to recommend. The whole point of this is to engage in this dialogue with the public. And so we actually don't know --

MS. COMSTOCK: Right. We agree.

VICE CHAIR McLAUGHLIN: -- who our allies are going to be versus who is going to be really mad at us.

And you say the Johnson Foundation has been wanting to do this. What if two years from now we come back saying 45 million uninsured, not a problem. It's okay, actually.

MS. COMSTOCK: That's right. That's right.

VICE CHAIR McLAUGHLIN: The Foundation is not going to be our ally anymore.

MR. COMOLA: That's right.

VICE CHAIR McLAUGHLIN: Right? That's not what they've been trying to do.

MR. COMOLA: Right. Right.

VICE CHAIR McLAUGHLIN: And so that's the only thing, and in your response to Therese's question, I think normally when you have a product that you know you want to sell, ally development absolutely. Identify your allies.

I think the best we can do is something else you talked about was identify the stakeholders.

MS. COMSTOCK: Yes.

VICE CHAIR McLAUGHLIN: But we can't identify our allies yet.

MS. COMSTOCK: When we did this project, the green book that's going around lists in the front the financial sponsors and the supporting organizations, those whom we didn't solicit monies from. Many were consumer groups or groups who didn't have a lot of money but they helped us identify

participants. Well, you'll notice that there are organizations like the American Cancer Society and Blue Cross and Blue Shield and AAHP. At the very time that we got them to fund this project, they were arguing vociferously on the Hill about colon cancer screening, okay. The reason that they funded our project was because, as they said, at the end of the day it's the right to thing; to put aside our agendas and try to at least listen to leaders.

Again, I reemphasize, we are not suggesting that what we did is what your charge is. It was not. But you can understand then that the reason that they did it is it's better to be in the tent with the camel. And so rather than not be a part of it, they wanted to have their representative, their voices heard. So they were allies but they also told us -- particularly ACS, (all the sponsors and supporters and participants had the opportunity to edit drafts of the reports).

that at the end if they were terribly uncomfortable with the result, they wouldn't be able to put their name on it but they watched the process. And they said at the end of it we don't agree with

everything that it says here, but we agree that what you did had integrity. So they were allies but they hadn't necessarily bought into the final product because they couldn't control it and we didn't know what was going to come out. It's a good point.

MR. COMOLA: And I think to really highlight the point you're making, which is an excellent point, what we did here and what we can affirm to you guys right now is that the leaders of those institutions, the 350 some odd people we worked with, all recognize that they are faced with changes. It's no longer tenable to continue to do business the way that they have been doing business. They all told us that, almost without exception.

MS. COMSTOCK: Yes.

MR. COMOLA: So to that extent they were willing to play in this sandbox, so to speak, because they wanted to be a part of something they saw as constructive, not any different than what Ascension is doing in the communities right now.

MS. COMSTOCK: That's right.

MR. COMOLA: It's better to sign up for something that you feel good about even though you

know there is a risk to you.

MS. COMSTOCK: Right.

MR. COMOLA: But it's a risk where everybody else is in the same tent taking the risk.

MS. COMSTOCK: It's like the issue of the uninsured. I don't care whether you had somebody that was the most liberal voice at the table or the most conservative; everybody came to the conclusion that insuring access to health care for everybody in this country is both socially desirably and economically advantageous. I don't care whether you're altruistic or pragmatic, there's certain truths, there's certain things that people can come to agreement on wherever they're coming from.

But your point is really well taken.

CHAIR JOHNSON: Last question. Richard?

MS. COMSTOCK: Go ahead.

MR. FRANK: Let me see if I can sort of restate at least what I'm hearing and get your reactions to it.

MS. COMSTOCK: Okay.

MR. FRANK: We're not really charged with getting everybody to participate that you've talked

about.

MS. COMSTOCK: Right. No. No. That's exactly right. Okay.

MR. FRANK: Just let me finish. But I think what I heard you raising was saying to some extent the process has to respect all the people who have skin in the game, so to speak.

MS. COMSTOCK: Yes.

MR. FRANK: And that you can accomplish showing that respect and getting some useful input through having regular updating sessions with people, maybe suggestions about where to look, who to talk to, information sources you're overlooking. And is that sort of the type of agenda that you were suggesting?

MS. COMSTOCK: I think without question--

MR. COMOLA: Yes, that's absolutely a part of it.

MS. COMSTOCK: -- that's absolutely part of it. It's absolutely a part of it, yes.

MS. CONLAN: I guess I live in a very tiny little world. My world revolves around the local YMCA.

MS. COMSTOCK: Yes.

MS. CONLAN: And there was a press release about this Working Group. And, of course, I live in a tiny community so it was in the newspaper and, you know, it kind of made a big splash.

Anyway, to my amazement I have found all kinds of professionals that also come to the YMCA; pharmacists, insurance agents, nurses as well as patients and just general people who use services of the VA, or whatever. And they all have identified themselves to me and really were unanimous in two things. (1) they agree that there's a problem, a severe problem.

MS. COMSTOCK: Yes.

MS. CONLAN: And (2) they all asked me to keep them informed. They wanted to be part of the process by at least knowing about what was happening.

MR. COMOLA: Yes. Yes.

MS. CONLAN: And I said to them initially, well you know I want to know what's happening, too. But be assured that as soon as I know, I will share it for you.

MS. COMSTOCK: Yes.

MS. CONLAN: So anyway, on my little

microcosm there if we can take that as a model and then apply it in the specific to what you were saying in general, I think that you're right in that people want to be a part of the process and that they want to be kept informed. And the more that they're kept informed, they just feel that, I guess, you're not going to sneak anything up on them.

MS. COMSTOCK: That's right.

MS. CONLAN: And that you'll hit them with it at the last moment.

MS. COMSTOCK: That's right. Right. That's right.

MS. CONLAN: But then also they realize that some people have the ability and the time and the energy to devote themselves to it fully and then some people can just be participants by hearing about it.

MS. COMSTOCK: Yes. Yes.

MS. CONLAN: And so I just wanted to offer that.

MS. COMSTOCK: I agree.

CHAIR JOHNSON: Jon and Marcia, thank you very much for your time this afternoon. We appreciate your sharing your thoughts with us. And we'll look

forward to calling you.

MS. COMSTOCK: We will provide the chapter in there.

CHAIR JOHNSON: Okay.

MS. COMSTOCK: We can leave those two books for you to hand around.

CHAIR JOHNSON: Okay.

MS. COMSTOCK: But just the first chapter I think would be of interest to the group.

CHAIR JOHNSON: Thank you.

We'll switch topics. And what we would like to do next is talk about the next series of hearings that the Hearing Subcommittee has put together. And what I'd like to do is pass around to you some copies and materials that relate to that.

I'll just open the topic and then what I'd like to do is give others who have been participating an opportunity to comment on different areas where we're going to consider going.

The Field Hearing Subcommittee consists of the people that you can see on the list in the book, page 1. And then if you take a look at -- we've talked about some potential date of meeting. And then

what we've done is we've followed up on different dates and provided some potential topics for discussion.

This is to not be intended, our discussion this afternoon is not to say that all of this material is in concrete. Still have to work on finalizing the dates and part of that will be what you'll share with us this afternoon as well as some of the content in some of the hearings. However, based on what we have known so far these are the locations that we would like to share with you as recommendations and potential dates and then subject matter.

So one of those areas is Jackson, Mississippi. And, actually, though Aaron is not on our subcommittee, he issued an invitation to the Working Group to come to Jackson, Mississippi. And Aaron is just a second will ask you to share some of your thoughts on what we might cover there.

And, of course, you have some other locations that we're contemplating; Indianapolis, Boston, Salt Lake City and San Diego.

And what I'd like to do is ask Dottie to start the conversation, if you would, on Boston some

of the things that we might cover there. If we could do so with Pat talking about Indianapolis. Mike, if you'd talk about San Diego. And even though Brent wasn't with us, if you'd talk a little bit about what you see as potential opportunities for content in Salt Lake City. And just do so briefly, if you would. This is not to be a full summary of what we'd be doing, but just touching on it so you have a sense and then we can get some feedback.

MS. BAZOS: I think we discussed Boston and thought it would be a great place to have a hearing. One reason it is -- we were thinking about some of the speakers the Committee had mentioned they would like to hear from. One was Don Berwick, Jack Wenberg. We thought this would be a good place to think about quality.

We also thought Boston had some major teaching hospitals and inner city outreach programs. There we could also access other New England providers who are doing some really interesting work, including those from Maine, New Hampshire and Vermont. So we thought that would be a good hub and also provide us some access with some of the major persons who you

wanted to hear from.

Catherine?

VICE CHAIR McLAUGHLIN: Okay. No, I just wanted to add one thing that actually today when Linda was talking about New York and New Jersey that the fact like New York is the only state that had blah, blah, blah I was reminded that Kathy Swartz who is at Harvard who is the one evaluated the New Jersey program and also has evaluated New York ones. So I'm just saying that you guys should add her because given that we've heard about those two states today, I think it would be very helpful to have her come and share with us what she learned from those experiences.

MR. O'GRADY: You don't think we've already had way more Harvard representation on this than --

VICE CHAIR McLAUGHLIN: In kindness to my competitor, you can never have too much Harvard.

CHAIR JOHNSON: Richard, how much did you pay her for that?

VICE CHAIR McLAUGHLIN: He's buying the --

MR. O'GRADY: Can we have a vote on that one?

MR. FRANK: She came to it on her own.

CHAIR JOHNSON: Okay. Aaron, would you share some of your thoughts on Jackson? Will you turn your microphone on?

DR. SHIRLEY: I'm please that the Subcommittee is seriously considering accepting our invitation to come to Jackson, Mississippi.

I think, just to set the stage for what Mississippi is like in regards to what our mission is, what our charge is, you'll be coming to a state in which about one-fourth of its population is either on Medicaid or uninsured. About 765,000 individuals on Medicaid and about 325,000 is uninsured. So the problem of the uninsured is magnified considerably by the fact that unlike many of the other states across the country, a significant number of uninsured in Mississippi are unemployed. There are a great deal, maybe about 50 percent, might be employed. But it's about the other 50 percent would be unemployed.

Our Medicaid program is strictly limited to the mandatory federal requirements. So we don't have any frills. And we're struggling with it right now because I mentioned we have 765,000 as we speak,

come July 1st of this year we're going to lose about 130,000 of those because of the reduction in the appropriations by the state.

We have one academic institution that trains our physicians, and it's located in Jackson.

The site in which we envision you holding your hearings, the building, has Senator Thad Cochran's name attached to it. I don't know if that's appropriate to say here. But that would carry, I think, some significant meaning somewhere down the road.

I would attempt to, if possible if he's available, I know that he would be willing to be present and to welcome you if his schedule would allow.

I've thought about the types of people who we might want to hear from: One being the Director of the Division of Medicaid; one being the Dean and Vice Chancellor of the academic institution, the teaching hospital. And because Blue Cross administers the SCHIP program, I would think that they would be an interesting participant.

We have at least two faith-based groups,

one in which you mentioned Sisters of Mercy, there is a component there in Mississippi.

And there's another faith-based group that the major advocate for the immigrant and migrant population there in the state. We have a growing number of immigrants primarily migrant. And their plight is somewhat unique in that there are a few of those who may be eligible Medicaid/public assistance who are actually participating for a lot of obvious reasons.

I would think that some representation from the medical associations, the AMA components and the NMA component would have an interest in what we will be discussing.

And then, of course, the representatives of the city and county governments would have an interest because they are struggling also with the premium issue in the stats and municipal employee group.

We have a facility that could very well accommodate the group and whoever would participate in the hearing, plus the hearing.

There's one other significant point I

meant to make. I've forgotten. But I would think I would need some guidance from you as to what you feel the group would like to accomplish if it should come to Mississippi, given what I've told you, the environment.

CHAIR JOHNSON: Okay. Well, thank you. And it would be our expectation that both our staff and the Hearing Subcommittee would work with you to work out some of those details, if that would be okay with you?

DR. SHIRLEY: Sure. Of course.

CHAIR JOHNSON: Okay. Pat, do you want to talk about Indianapolis?

MS. MARYLAND: In Indianapolis, one of the major areas of focus would be that of rural health care, specifically looking at access and similar to what we talked about today and what Tony Tersigni talked about today.

I'd like to offer to press Christine from Sioux Falls, South Dakota if you might want to do something jointly with me. Perhaps in even bringing one of your demonstration programs and a couple of your constituents from Sioux Falls, South Dakota to

Indiana, that maybe we can share also some of what you're doing there and how you're addressing your issues in terms of access with your rural counties. I don't know if there's any interest from that perspective. But I don't know if we want to use this as a site where we can do some sharing, if you will, of best practices across the country. Okay. It's a possibility.

The other major area of focus, and we talked a little bit about this today, is health information technology. And I really wanted to share some of the unique things that we're doing in that area. Not just Ascension Health, I'm talking about the state of Indiana.

We have a new Governor Mitch Daniels, who used to be head of our OMB, who is really quite a change agent, it's probably the best way of putting it, and has been extremely aggressive in terms of how he has restructured his whole state administration. And his whole emphasis as a former executive from Lily is very much into better use of technology, tracking of information and really a huge emphasis on patient safety. And I know that he would like to attend the

regional hearing, and my problem will be the date. And I want to talk about that in a little bit in just a few moments.

And so the Governor Mitch Daniels is interested in participating. The Mayor, of course. The leadership headquarters for both Lily and WellPoint are located in Indianapolis and both of the executive CEOs from these organization would like an opportunity. And I'd like to talk to the group about your thoughts about that and from a payer perspective. And if you feel that that's something that's appropriate. So I'd like some discussion on that. But that's a possibility.

Of course, our Indiana Health and Hospital Association leadership is interested in attending.

I am thinking about bringing some best practices from across the country into Indiana as we talk about information technology, as we talk about patient safety to also hear from other areas within the country, although the region is in Indiana. I just don't want to focus on Indiana and I wanted to maybe open it up for some further discussions and your thoughts about it.

So those are sort of the kind of key areas we'd like to discuss.

The availability of a lot of the individuals that I talked about, the July 18th date is not going to work for quite a few of these individuals because of the summer vacations. Right after Labor Day would work best.

I know that there are two regional meetings scheduled, I believe, in July. Yes. And wanted to have your opinion about maybe something right after Labor Day, a couple of days after Labor Day is a possibility.

MS. WRIGHT: You know, South Dakota would love to participate, but after Labor Day is not going to work. From anywhere into July through October we're running into JCAHO with our health system.

MS. MARYLAND: Okay.

MS. WRIGHT: So more than likely it's going to be September/October.

CHAIR JOHNSON: Okay. Maybe we can come back and talk about it.

Brent, could you talk about Salt Lake City?

DR. JAMES: Although it's a relatively new idea to me, I believe that Jack Wenberg will probably be out at Jackson Hole at that point of the year. And so Jack might want to come down, and you may want to grab Eliot Fisher if you want to get that involved in the Boston side.

MS. BAZOS: Right. We had originally talked about having Jack in Boston. I think after talking to him, we knew he would be Wyoming. We thought maybe he might like to join you in Utah.

We're talking about having David Wenberg come because he's on the ground with some innovative and creative work. And have him come to Boston.

DR. JAMES: It would be great, although I have to say -- well, interestingly if you wanted to get Jack to talk about variation in care, geographic variation, David's real strong suit at the moment is shared decision making which is a very good topic. To get David to talk about preference sensitive care and shared decision making.

MS. BAZOS: Right. And have Jack talk about variation in Utah.

DR. JAMES: Yes. Yes. That might be a

good idea.

A third member of that team that's very, very effective is Eliot Fisher if for some reason we can't get the other two or for a shared decision making is Al Mulley from Mass General.

MS. BAZOS: Yes. And I talked to Eliot last week and he said he would love to fill in if either David or Jack couldn't.

DR. JAMES: Okay. That would be great.

Other things that I had on my list, though, a fairly long list where we could consider some things and it would just be a matter of putting it together.

Two things that are happening in Utah at the moment that might be of particular interest, our new Governor Huntsman replaced Mike Leavitt has put together a statewide discussion about health care reform. It might be possible to tie into that.

David Sundwall, originally from this town just returned home to the mountains is our new head of the Department of Health. And I think David would like to play a role in that. I think it would be very, very effective. Probably, haven't asked him,

but I'd be willing to bet.

MS. TAPLIN: I've spoken with him and he said he would do anything he could to help us.

DR. JAMES: Yes, I imagine so.

We also have just launched the Utah State Legislature major discussion a two year study section on health care reform and health care system functions. And I think that could tie in quite nicely as well if we could somehow link that piece in. They plan to bring in a long list of national experts to talk about some of these topics in a fairly significantly funded study over two years.

Other areas where we could probably supply so me good background information, while Regenstrief will talk about electronic medical records, I think we have a -- there, too.

We have one of the four grants in the country from AHRQ establishing a RHIO, a regional health information organization and which I believe has now transmitted the first official data in the country. Regenstrief, of course, has a different model that we'll see in Indianapolis.

MS. MARYLAND: We'll see that in Indiana.

DR. JAMES: Very heavy involvement in patient safety, heavy involvement in cost of waste. Estimates in American health care is at least 40 percent waste when we're speaking about money, and that might be a fun thing to discuss.

And the other things that you list, too, are quite interesting in terms of particular disease management, effective disease management that really does work.

So I think we could put together a really good day. The only question would be does it need to be three days?

CHAIR JOHNSON: Okay. And here, again, what we would do is we would look for your input to both the Subcommittee as well as to the staff. And the staff would handle some of the logistics to make life a little bit easier.

DR. JAMES: Randy, I think there's no question that we could arrange very good space. Especially with a little bit of notice that we could arrange a very good turnout. With all the other people already interested in this topic and discussing it, I think in some sense predigested it'd move us a

little faster down the road. And the only real issue will be negotiating what topics we try to cover.

CHAIR JOHNSON: Great. Okay. Thank you.

Mike has been serving with us as well, and some thoughts on San Diego.

MR. O'GRADY: Well, one of the things that I thought was attractive about San Diego is that some of the things that we've tried to talk of, you know, when you think about what we can do here versus what we can do outside in different parts of the country; one of the issues certainly has to do with what I would think of as immigrant health. And much of that is at least 50 percent of our immigrants tend to be Hispanic, and Mexico is certainly the largest sending country on that. So there's a number of different things there that I was thinking in terms.

If we wanted to go to an area where we had a critical mass of other people we would want to talk to as well as was sort of a border area that had done some of this work, it seemed that San Diego had had some advantageous to us.

It certainly has a big border economy. There are some of the experiments that have been done

there having to do with offering coverages especially to small employers. And some of the dynamics they've had there of people who go back over border to get their care and therefore are passed on coverage offers.

There's a number of different people to try and counterbalance the heavy Harvard, East Coast influence that goes on here. I was thinking of Kroenick is at San Diego. Buchmueller who does an awful lot on kind of the price sensitivity of premiums and what makes people take up and move from plan to plan is at UC Irvine.

It seemed we were also close enough to a large metro area where there'd be a number of different people that we would not be asking them to come across the country to talk to us. And it would also, as I say, particularly on the idea of some of the uninsured problems that have to do specifically with immigrants, it just seemed a spot that had a critical mass of a number of different people that we might want to talk to.

CHAIR JOHNSON: Catherine?

MS. PEREZ: I just had question about

maybe some of the organizations to come and speak on the Hispanic health issue. And I don't know if we'd be willing to extend out to an advocacy group, something like the National Council of La Raza who certainly has affiliates out throughout the southwest, but especially in California they are the largest advocacy group for Hispanics and they have a lot of health initiative programs that they roll out. So I didn't know if this would be the time to bring in a group like that to discuss some of the issues or there'd be another opportunity. Because I think they would have a lot to offer, too.

CHAIR JOHNSON: Okay. Let's keep that in mind.

And by the way, we have reached the last of the locations that the Subcommittee is recommending. But we talked about many locations. And there are other places we all would like to go to, and we talked about going to. And what we are trying to do here is look at diversity of geographies, different types of populations in addition to different topics and where people might be able to bring discussion on an initiatives and issues and so forth.

So, before we open up for questions I'd like to ask Catherine if she has further comments, since she's been on the Committee as well. And then I'll just have one or two, and then we'll open it up for questions.

VICE CHAIR McLAUGHLIN: I just want to make one sort of global comment, Rosie, that reflects on what you said and what Randy just said. We talked about a lot of communities. Pat and I both were rooting for Austin. And, you know, I was rooting for Milwaukee to get an old fashioned union town and Detroit to get the inner city. And Miami. I mean, we came up with a lot of good ideas.

And what I had to keep reminding the group as the person who is trying to shepherd the report that the point of the hearings was to give us the information we need for the report. But after that, we are expected to go a lot of places. Not as a group, but to have community meetings in a lot of places. And so it may be that so me of the places that we were brainstorming about -- I was asking the staff, start writing these places down. Because it may be that those are the kinds of places where we have to make

sure we do some kind of community meeting there. So, for example, in Texas have you be the Working Group representative at a meeting with that organization or whatever. And then maybe have me go to Detroit or Pat go to Detroit or I'd go to Milwaukee, or something so that those of us -- or Joe in Milwaukee. Those of us with special interests and knowledge about a group that we want to hear from in response to our report to engage the dialogue, we need to start thinking about that.

So a lot of the ideas that are being bubbled up, it's not that they're not going to get used. It's just that they may be used for the community meetings rather than the hearings. So keep those ideas coming.

CHAIR JOHNSON: The other comment I would like to share, and it touches on a subject that Pat would like to raise with us, and that is the target date based on the legislation for the initial report that we are to have completed is August 26th. And so we are attempting to have as much of our hearings content completed by that date as possible.

Now, that doesn't mean that we won't be

working on the report following that and we'll be talking more about how we get that out into the population and so forth. But that's one of the things that has guided some of our discussion, at least, but we'll open that up for comments as well.

So, I think, Richard you were first with your wanting to talk and then Mike. And then we'll go from there.

MR. FRANK: I guess I mean I almost actually don't care about location. So my question is actually more philosophical, which is a lot of what I heard described about particular sites sounded like we were trying to reduce the air fares for national experts, which I don't think is the point, right? Right? Because we identified all of these super stars as well; he's going to be in Jackson, he lives in Vermont. This one lives in -- he's Kroenick. You know, even though he didn't got to Harvard, he's still a smart guy. But I didn't go to Harvard.

DR. JAMES: I wanted you to know that while Jack currently is at Darthmouth, he did spend those five years at Harvard.

MR. FRANK: Well, actually, he's a Hopkins

graduate.

DR. JAMES: Yes, he is.

MR. FRANK: Which is where I come from. But anyway -- what I was getting at here before I decided to have fun with Mike, was that it seems to me that each of these places probably has a unique character. And maybe the point isn't to sort of save money on air fares for experts who might come here easily to talk to us, but rather to try to figure out what's unique in the character of these places and emphasize that. So that's one point.

VICE CHAIR McLAUGHLIN: I just want to say that that's precisely what the Subcommittee did where we said okay, we need a border town, we should have a town with some major teaching hospitals --

MR. FRANK: I'm just telling you it didn't sound like that.

VICE CHAIR McLAUGHLIN: I understand. But I want you to know that that was a lot of our two hour deliberation last week. We have to have criteria.

MR. FRANK: Right. And so if I'm missing that, I apologize. But the descriptions didn't sound that way.

The second thing is that I think, almost the last day and a half, there have been repeatedly issues raised about special populations. Long term care, mentally ill, HIV, women, low income women who are living alone who are elderly; all of those have come up and we touched them nowhere in any of these hearings except for now the measure. I think that we ought to use these hearings to touch on different populations and different experts who deal with those. You know, who has an innovative program for HIV? Who has border programs? Who has issue for the homeless, mentally ill, etcetera? And incorporate those perhaps to touch on unique aspects. Because I think we've now got the fundamentals down and these things are bubbling up, and I think we ought to make sure they're integrated.

CHAIR JOHNSON: Thank you. Okay. Mike and then Therese.

MR. O'GRADY: I wanted to bring up a topic that's struck me a couple of times, especially with AmericaSpeaks yesterday and the Wye River guys today. I've been involved, and it's just sort of a little bit of a warning but it hits on the idea of talking to

different groups. And I just thought I'd put in a big plug for balance.

You know, I've been at various things where I go out and do a town hall meeting and it just happens that half the audience is either providers or the patients of providers who just happen to have a payment issue that is currently bubbling up. You know, it's just a coincidence.

So you know there's a notion here as we go out to these different places should we talk to groups like this? Sure we should. But we should make sure that we don't only talk to La Raza. We should make sure that as we think about who the right people to talk to, it's not just experts. Richard's right, they've got a grant or something that will pay their tickets to come here. But as we go out and we think about who these communities are and what they are, balance will be real important.

And so when I was hearing the different things of what these different -- you know, either AmericaSpeaks or Wye River, part of that was if those groups can help us to make sure we're hearing from all the parties we have heard from rather than just the

one with the best lobbyists, that's going to be very important.

So I guess just as we think about planning overall balance. And there's a self-interest. If we expect the results of this Working Group to be taken seriously, we're going to have to show that we've done that due diligence to have a very balanced approach.

VICE CHAIR McLAUGHLIN: Just remember the difference between input into the report versus input from the public to form our recommendations, and AmericanSpeaks and Wye, they were talking about getting feedback and keeping stakeholders informed as we form our recommendations, which is different than the hearings which are just to inform -- I mean, we have a list of topics we're supposed to cover in the hearings, all of which are geared towards informing the report which is not recommendations. The report is just where the dollars come from, where the dollars go, local initiatives, etcetera.

So I think that you're absolutely right that when we start thinking about the community meetings and the website and the dissemination, and all that stuff we have to keep all this in mind. And

we have to think about long term care residents, and we have to think of senior citizens, and we have to think about people who don't have a computer, etcetera, etcetera.

So absolutely. One of us at the table has to remind us of this every time. I agree.

MR. O'GRADY: Yes. I think just even in terms of the report. As we heard today with things like the individual market and small groups, you can have different groups of very smart people look at the exact same circumstances and the exact same data and come away with a different message from them. Is this a challenge or is this just a lost cause or how do you approach this.

So I think that even with the report it's just important if we want the strongest currency we've got coming out of this, whether it's report or a final, however you want to think about it, I just would keep harping on the idea of balance, that we listen to different people represent different ideas and that we come forward with that. And it's sort of documented that we really did talk to those guys and we talked to those guys and we read the study from

these guys and we read the study from those guys. That's all. Just balance.

CHAIR JOHNSON: Therese?

MS. HUGHES: First of all, Richard gave a number of my ideas that I had been thinking about. But I want to say with deference to the Assistant Secretary as well as to the Committee --

MR. FRANK: And what is your title?

MR. O'GRADY: I'm in trouble now.

MS. HUGHES: You're not. I'm sorry. I know you're not the Assistant Secretary. I apologize to Mike. He is. Yes, you are.

Well, what was this about the title then?

MR. FRANK: Well, he insisted on having it in the report. So you took him on it.

VICE CHAIR McLAUGHLIN: Don't call him Mike, call him the Assistant Secretary.

MR. FRANK: Okay.

VICE CHAIR McLAUGHLIN: He's blushing.

MR. O'GRADY: I'm just wondering if people don't turn down their microphones, it'll be called the Assistant Secretary, Assistant Secretary.

MS. HUGHES: Okay. Now, where was I.

Assistant Secretary. Yes.

I recognize that this meeting in San Diego is about the report. And I wanted just to say that I, too, was aware that comments were made about individuals who have money and who are able to fly. We really should not, in my opinion, make it convenient for them because there's populations of people where projects exist that don't have the money to fly to the places. And while San Diego is a border town and it does have some very good initiatives that are going on there, people pass through San Diego. The majority of people come into Los Angeles. And in terms of migrant workers, the largest accumulation of migrant workers moves from San Diego to Los Angeles up north and back to what's within Los Angeles.

And I understand different things, but I guess I'm concerned that some of the communities that have programs like Ultimed for long term care, they're the largest provider in the state of California for long term care. And it's an FQHC. And they bring specific problems that address the issue of what is the largest use of Medicaid dollars, from what I've heard to date. And their looking -- I know they would

make the effort, but FQHC aren't really wealthy organizations. And the trip from Los Angeles to San Diego if you fly, is over $300. And I just want to speak for those who don't have a voice.

HIV/AIDS patients programs that work, they don't have excess money to bring their product down to San Diego. They could be in California, which certainly invites the openness to be in the state, but it really is not centrally located.

And then also the Asian community there is an Asian community in San Diego. But the Asian community is one of the larger growing communities of uninsured along -- I mean, everybody recognizes the Hispanic community is, but the Asian community is a growing one.

And then the homeless communities. Well, the largest homeless communities aren't in San Diego, even though it nicer weather than Los Angeles and I'm sure the people up and down the coast would rather ship them to San Diego, but that's not how it works.

And so I just w ant to say that maybe it's not a concern in other states, but certainly with the size of California that is a concern. So that's one

thing.

The second thing is is that if you go with San Diego for the hearing, I think it's naive to think that people from provider communities and other places aren't going to show up. Because this word will get out in California. I mean, this word will get out and everybody that can be there will be there. So I would like to counter that with the invitation for a town hall meeting to be in Los Angeles and one that could offer voice to agencies that are at the northern end of the state that have nothing that don't have the ability to come to the southern end of the state as well as at the southern end that have an easier that have may or may not have an easier time to come to the --

VICE CHAIR McLAUGHLIN: But I thought you were advocating to have the hearing in Los Angeles rather than San Diego?

MS. HUGHES: Well, I am because I am. But I also -- I am advocating for that. But I recognize that for this event San Diego -- I don't know. I just want to say that I think that, unfortunately, there's such a large state there that I don't want to preclude

that having one thing in this state, unfortunately, is going to be sufficient to provide enough eventually for our report. So if you use San Diego and you go with it now, fine. I just want to open the door to having a town hall meeting in Los Angeles so that people from the north and the south that have an easier access instead of coming all the way down could be present.

CHAIR JOHNSON: Okay. Comments further?

Let me invite Pat's comment on whatever.

MS. MARYLAND: Okay. I was just going to add the other question is how do you feel about trying to coordinate with our regional hearings, our Group meetings? In other words, so that we are at least being cost efficient with not only money, but also time. So, for example, our June meetings that's scheduled, I think we have our actual committee is scheduled when and our regional hearing is June 8th. Can we not if the members of this Committee are required to go to each of these regional hearings, can't we coordinate the two together so we can share the time? Do you understand what I'm trying to get to? So maybe instead of a one day type of trip, maybe

a two day where we would actually --

CHAIR JOHNSON: We actually have tried to do that. And we had scheduled before this was now printed, we had scheduled two days of hearings in Boston for July 21st and 22nd. But as we got some more of your blackout calendars in, we had more people who weren't able to meet on June 21st and 22nd. And for everybody's benefit, the dates that we've selected here are selected principally because they're the dates when most of you are available, though on almost every date that I can recall at least two of you are not able to make it.

So, you're busy people and we recognize that. We're just trying to do our best to schedule around your circumstances. But Pat's comment would certainly be appropriate.

MS. MARYLAND: Especially with the San Diego trip. The San Diego --

VICE CHAIR McLAUGHLIN: That's both in San Diego.

MS. MARYLAND: And the Working Group meeting would be in San Diego, too?

VICE CHAIR McLAUGHLIN: Yes.

MS. MARYLAND: Okay. Then it's fine.

VICE CHAIR McLAUGHLIN: That was the only date where there was, in fact, a two day window where only two people were missing.

MS. MARYLAND: Okay.

VICE CHAIR McLAUGHLIN: And so that was in fact why the decision was made to put the Working Group meeting in San Diego the day before or the day after the hearings.

CHAIR JOHNSON: Okay. Well, first our intent was to say these are projected dates that we'd like to suggest based on available schedules of everybody. And as you've sent in blackout calendars, Ken in particular has been keeping the blackout calendars, and these are the dates when we would have the least number of absentees based on the blackout calendars you've sent to us.

MS. WRIGHT: Randy, I'm confused. Because we just heard that these are the dates are available, and you've scheduled this date of Indianapolis. I also heard that we want all this information before August 28th. And then I hear Patricia saying that the people we want there are not going to be available

until after Labor Day. So I think then a secondary choice or another site needs to be picked, or something else that we get the work done that we want to get done in order to issue a somewhat or very intelligent report and have that information and not be missing any geographic piece.

CHAIR JOHNSON: Okay. And what's happening is this has been an ongoing changing kind of thing. In fact, the night before we came we got some more blackout dates. And then when we got here, Pat shared with us well this is not a good date from the perspective of at least one or two of invitees.

So, we'd like to open up the dates to you. But what we're just saying to you is the dates before we heard from Pat, these were the dates that were most available to most of us. Okay.

So do you want to talk more about -- I guess that one of the questions that we should be dealing with, two biggest questions that I understand is Therese's suggestion for a potential change in venue for the hearing in California and then potential dates. Do we try to do something after the 26th of August?

Are you cool with staying in San Diego?

MS. HUGHES: Yes, I'm cool with staying in San Diego. Yes. And the reason why I was thinking is as Pat had recommended, Chris coming with her, maybe we can pull in people from Arizona and Nevada. I really think we ought to be in Texas. I think Texas addresses a lot of the problems and they have the largest uninsured population. But, yes.

CHAIR JOHNSON: Okay. Thank you.

Okay. Aaron?

DR. SHIRLEY: I just thought of what I forgot, an element that I forgot. The facility, the proposed meeting site is a site that serves a significant number of uninsured and uninsured from all over the state. And based on Mike's comment, what I need from the group is knowing that, some suggestion as to how to take advantage of the fact that you're in a site that serves supposed to come long distances for care because they're uninsured. It's not that the care is not available in their home sites. It's that it's not available to them because they're uninsured.

CHAIR JOHNSON: Would you be open to working with the Working Group regarding that?

DR. SHIRLEY: Sure.

CHAIR JOHNSON: Okay. Thank you.

DR. SHIRLEY: Yes.

CHAIR JOHNSON: Okay. Well, other comments other than let's say this July 18th date that we need to resolve? Go ahead.

MS. MARYLAND: I'll guess I'll ask Katherine the question of the report, the draft. You know we're really talking about creating a draft by the 26th of August, whether or not a week later having additional information to add to the report is going to create a problem?

VICE CHAIR McLAUGHLIN: I don't think so. I mean, originally in fact we thought we might be able to cover all of the mandated topics and get what we needed for the first draft with only three hearings. And so to now, you know, put five before it I think we could move them. And I say that in part, I mean Randy and I have had a recent discussion about this deadline. And I think we want to honor the statute to the degree we can, but we also need time to get feedback from everybody on the Working Group. We need time to translate into Spanish, at least, if not also

Mandarin or Cantonese. We need time to have it checked by somebody. And I was thinking 6th literacy, but yesterday we heard 3rd grade literacy was what was recommended to us.

And so really the public version of the report can't possibly be by the end of August, the final report.

MS. MARYLAND: Yes.

VICE CHAIR McLAUGHLIN: So that means there's going to be at least a month or so of getting the rest of that work done, which means we can certainly making amendments to reflect having a meeting, one of the hearing after Labor Day. I just don't see that as a problem.

And particularly if we do honor the statute and cover the topics. Because you know a lot of the topics can be covered in two or three sites. We don't have to have all the sites to cover all the topics. It's just that having this variety, and we did look at, Richard, sort of we have a lot of different criteria that we need to bring to bear and three cites just wasn't going to do it for us. And that's one of the main reasons why -- and of course

mental health, Boston, Richard Frank, that's one of the reasons we picked Boston was because we want to do something on mental health.

For those of you who don't know, I mean Richard Frank is one of the leading experts in the world, really, on mental health and mental health issues. So we should take advantage of that expertise.

So I think that we certainly kept all of that in mind when we picked it. But, as I said, we thought about Milwaukee, Detroit, Austin. There were several of us, Rosie, who wanted the Texas connection. Miami was suggested. I mean, we really -- we thought of a variety of places. And, you know, at the end of the conversation we sort of thought well this set of five probably is pretty good. But, you know, if someone wants to argue for dropping one and replacing with a different one, I think that I don't speak for the Subcommittee but I as a member of the Subcommittee would welcome that kind of input. This was, as Randy posted, these were our recommendations. This has not been decided, these are just our recommendations.

CHAIR JOHNSON: Go ahead.

MS. BAZOS: I'd like to just propose, and this may be totally undoable, but perhaps a process. This is a question to the group. We spent a lot of time on the phone at hearings advocating for one side over the other. And, actually, I hadn't read the final because I left a day early. So I was -- I'm thinking that perhaps because the group is made up of people who are so invested in the decisions that are made, a process that we might want to consider as we go forward is we have staff and other people on the phone. Is it possible or would it be helpful to summarize some of our phone meetings for input from the larger group as we go forward. I mean I know today's meeting, Randy, you said give a very short summary of Boston. So I just gave like the two second summary of Boston, you know, because we wanted to talk about quality. But we talked about Boston for hours. And we talked about each site for hours. And I don't want Richard to think that this was a willy-nilly process or anyone else. And I just wonder if people need more input.

I mean, I just wonder if people need to have input into the process earlier.

MR. FRANK: No, I actually want no input almost. But all I'm saying is that that -- in fact, as I started off my remarks before, I don't care what the location is. For me it's much more important that we make sure that we're drilling down into the issues that have been raised in a way that's unique to each location. And any location that you're going to pick is going to have those opportunities.

And so I'm not going to get my foot into trying to make those judgments because I think you guys have done a fine job. And every location is going to be bad for some reason and every location is going to be good for a different set of reasons. All I'm saying is that I would like to see the subject matter kind of reflect the location and also not emphasize so much things that we can learn most easily here.

VICE CHAIR McLAUGHLIN: Right.

MS. PEREZ: Well, I just want to say, you know, that makes perfect sense. You know, I don't care where it is either. Certainly if you look hard enough you're going to find immigrants in just about every state across because they're following the farm. I

mean, we're going to do that. But I think that was very key about there were some serious issues raised over the last day and a half, two days about long term care. And I think we need to set up a trend that those were kind of emerging issues that we need to be concerned about and tie them in. And it's these sites have organizations and experts that are tackling these issues, I'd like to hear from them. And I think the community meetings will address what seems to be all these other things that we're kind of picking on.

VICE CHAIR McLAUGHLIN: Right.

CHAIR JOHNSON: Okay. One last comment and then I'd like to summarize if I could.

MR. O'GRADY: I think that one of the things in terms of when we thought about the different things of why you pick one, you know on the San Diego versus Austin, my thoughts were San Diego is right on the border. So from what I heard of the other research that's been done about why do we see like higher rates among Hispanics even after you've taken into account Immigration status and whatnot, some of those questions come up about people going back crossing the border and whatnot. But I guess I wouldn't want to

get too fussy about it one way or the other, especially if we found that of the people we thought we'd want to talk to in one city, that they're not available on the dates. I mean, to a certain degree I wouldn't mind if the staff had a little time to kind of track availability of certain things.

And so if it turns out that then -- and especially if our California delegation is not -- you know, I'm for Maryland. I'm not pushing for California. I thought this was a good site because of the people on the ground. And, honestly, I did not think that picking San Diego was putting an undue burden on people in Los Angeles to drive. And I don't know how many times we'll get back to California. I don't know that it's realistic to think we'll be going more than once or twice to any particular state, even the most popular state in the state in the country. So I don't know about that.

But if it turns out that the people we thought or the programs that we thought we wanted to see in a place like San Diego, nobody's going to be there, you know I don't want to push too hard for San Diego. Then if the folks in Austin are there, I don't

think the people in Austin -- and correct me, the Texas delegation can straighten me out on this -- I don't think the people in Austin going -- that that seems a much longer travel to actually get back across the border to get care. And I can see so me folks --

MS. PEREZ: Yes. It's just such a desperate situation that they do. But, again, I have to just kind of tag on to what you said. I think that these issues are so important and the work of this group is so important. I know certainly the people that have tried to contact me, you know, about this, they just want to be helpful. They're just like tell us what you need, we will be there even if it doesn't come to Texas, or wherever, if it's in Louisiana, we'll cross the border to go over there and provide the information. They're just like I think --

VICE CHAIR McLAUGHLIN: A different border

MS. PEREZ: Yes, a different border. I just think that if there is an interest from a person or an organization, I think they're going to make the sacrifice just because of the importance of what we're trying to get accomplished. So I don't know that they're not going to show. They're going to show.

CHAIR JOHNSON: Okay. If we can proceed.

One of the things that I've heard --

MR. ROCK: I just had a question.

CHAIR JOHNSON: Yes.

MR. ROCK: You've got these set up as one day events and I know it's part of the issue of availability of people's time. As a technical matter, will that be sufficient from what the kind of descriptions you know of your individuals states that one day will be able to allow you to do it since basically we're talking two or three panels. You know, we had anywhere from three people yesterday to half a dozen -- not eight or nine a day. Is that going to be a constraint that you'll find workable when we actually start setting it up or not?

CHAIR JOHNSON: Well, it could well be a constraint. And the availability of our Working Group is also going to a constraint because once we go apart from these days that we've got scheduled, we have up to four people who wouldn't be able to attend. And it seems that we want to have everybody attend who can. But that might be something that we're going to have to give some consideration to and work out the details

on that. So it's a good point.

I've heard a recommendation that we change the date and some consensus that we change the date for Indianapolis to some date after September 1st that we could work out together. That's one recommendation. Are you comfortable with that change from this Committee recommendations? Is there anyone who would have a concern about that?

VICE CHAIR McLAUGHLIN: We don't know what day in September, but --

CHAIR JOHNSON: We'll try to work on the date where most of you, again, are available. Okay.

So I don't hear anything against that, so we'll try to do that.

Are there any other recommended changes from what you have here, not in terms of content. Because we've made some notes on we need to deal with some of the content issues and the balance issues. But other of the, let's say, the fundamentals of what you've hard?

One of the things we've heard is that you'd like to see information earlier. So we'll try to provide more information and earlier.

Go ahead.

MR. HANSEN: That was exactly it. As the Committee or whoever, the Executive Director whenever he gets and makes those dates, because my schedule fills up. I could almost give you a new schedule new week. And so we need it back as quickly-- you know, all the way into next year, if you can pick dates that far in advance.

CHAIR JOHNSON: Thank you.

Mike?

MR. O'GRADY: Just real quickly on that I thought Rosie had a very good point there. But I think we're okay, coincidentally.

It seems to me Indiana has some of the more innovative things going on in long term care that we've seen. They have a Partnership Program which Matt Salo brought up and some of these other things.

So I think as long as we think about who we want to talk to when we get there, it could be very productive.

CHAIR JOHNSON: Okay.

Yes, go ahead.

MS. STEHR: I'm fine with these dates I'm

thrilled that we're doing this in Jackson, Mississippi and particularly at a site where the uninsured are being treated. It'll be a good reality check for everybody in this room that does not have health insurance.

CHAIR JOHNSON: Other recommendations, recommended changes? I see Ken is probably bringing his blackout calendar here.

MR. COHEN: There are three dates that are good in September.

CHAIR JOHNSON: Ken's talking about three dates that he's seen is good in September.

MR. COHEN: Compared to all the others.

CHAIR JOHNSON: Okay. The two dates that are available are 21st and 22nd and potentially the 23rd of September. And in those dates we have two people -- at least two people who can't attend each of those dates. September 21st, 22nd and 23rd which is a Wednesday, Thursday and a Friday.

MR. COHEN: You're available.

CHAIR JOHNSON: Two of you will --

VICE CHAIR McLAUGHLIN: Right. You are available those dates, that's what he's saying.

MS. WRIGHT: I'm saying I don't know. I'm saying I don't know yet because of JCAHO coming September/October.

CHAIR JOHNSON: Okay. So those would be target dates. We'll investigate, right, to see if our colleagues can make that.

MS. MARYLAND: You know, they said after Labor Day. So I'm going to plan on hopefully the majority of Senators, Lugar and Evan Bayh I would like to try to participate.

CHAIR JOHNSON: Okay. Any other recommended changes on the fundamentals, not the details but the fundamentals of what we presented? Comment?

Okay. Well, we will continue to work as a Hearing Subcommittee and staff to flush this out and get more details to you. And that's one of the things we've heard about not only the hearings information, but information regarding plans and schedules and that kind of content for the agendas and so forth Okay.

Okay. Then what I'd like to do is ask -- we had scheduled the possibility of at 4:30 getting into an Executive Session. And the idea was to talk

about process. So as a process question and what we were contemplating doing was hearing a little bit from Larry regarding parameters of Executive Session. But before we proceed let me ask you as a group is this the time that you'd like to do that or tomorrow we have a half hour scheduled at the end of the day. What are your wishes regarding going into an Executive Session at this time?

VICE CHAIR McLAUGHLIN: I say now.

MS. WRIGHT: I say now.

CHAIR JOHNSON: Okay.

MR. O'GRADY: I have an appointment, but I don't know that you need me here for the Executive Session.

CHAIR JOHNSON: It would be helpful. But, obviously, you'll have to do what you'll have to do.

VICE CHAIR McLAUGHLIN: Mr. Assistant Secretary.

CHAIR JOHNSON: Mr. Assistant Secretary.

Okay. Larry, can you just give us a brief summary of what we can do and can't do.

You can adjourn now.

(Whereupon, at 5:14 p.m. the meeting was

adjourned.)

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