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Harvard Medical School Public Forum: Insuring the Uninsured: Does Massachusetts Have the Right Model? 17 May 2007

Lisa Lehmann

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Lisa Lehmann:

Good afternoon, my name is Lisa Lehmann, and I have the privilege of being your moderator this afternoon for our program on the Massachusetts healthcare legislation, in which we hope to critically examine this law. I want to begin by thanking Nir Eyal, Dan Brock, and Allan Brandt who were helpful in planning this event. Christine Moreira and Laura Horn provided fantastic administrative support without which this program would not have occurred.

Providing healthcare to all Americans is one of the most significant ethical and domestic policy challenges facing our country today. In the United States, 46.6 million individuals are uninsured, and in Massachusetts an estimated 536,000 individuals do not have insurance coverage.[1] Despite the pervasive dissatisfaction with healthcare in the United States, no consensus has emerged on how to reform the system.

Should reform be comprehensive or incremental? Should priority be given to reforming the financing system or to improving the organization and delivery of healthcare? Is the solution to develop individual mandates with subsidies, a single-payer system, or universal vouchers? These are some of the questions that we will consider this afternoon. In April 2006, Massachusetts enacted landmark legislation designed to achieve comprehensive healthcare reform. By July 2007, almost all Massachusetts residents will be legally required to have health insurance or face a fine. The Massachusetts plan has encouraged a national debate about how to address the problem of the uninsured. More than 20 states are now engaged in serious policy efforts to design their own healthcare reform initiatives. This forum will explore key details of the proposed legislation, to better understand if the Massachusetts legislation will be a successful and sustainable model that can solve our ailing healthcare system.

We have three wonderful panelists this afternoon. Our first speaker will be Dr. Katherine Swartz. Professor Swartz is Professor of Health Economics and Policy in the Department of Health Policy and Manage-

ment at the Harvard School of Public Health. Her research interests focus on the population without health insurance and efforts to increase access to healthcare coverage, reasons for and ways to control episodes of care that involve extremely high expenditures, and how we might pay for expanded health insurance coverage. She recently completed a book entitled *Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do*.[2] She was also a member of the Massachusetts Commission to Study the Effects of Merging Small Group and Individual Health Insurance Markets in Massachusetts. This was a commission that was required by the Massachusetts legislation that we're talking about this afternoon.

Our second speaker will be Dr. Michael Chin. Dr. Chin is a family physician who has worked in primary care at a community health center in Boston. The majority of his patients did not have health insurance, and it was this experience that motivated him to become involved in health policy surrounding the uninsured. In 2006, he joined the Commonwealth Health Insurance Connector as a senior policy analyst. Today he will share with us some of the key details of the law.

Dr. Marcia Angell is a senior lecturer in the Department of Social Medicine at Harvard Medical School. She is trained in both internal medicine and anatomic pathology. She joined the editorial staff at the *New England Journal of Medicine* in 1979, became executive editor of the journal in 1988, and was editor-in-chief from 1999 to 2000. Dr. Angell writes frequently in professional journals and the popular media on a wide range of topics, particularly medical ethics, health policy, the nature of medical evidence, the interface of medicine and law, and care at the end of life. She has been a vocal critic of the Massachusetts healthcare reform legislation with her opinions appearing in the pages of the *Boston Globe*. Please join me in welcoming our panelists. Professor Swartz will be our first speaker. *[Applause]*

Katherine Swartz:

Thank you very much, Lisa, for those kind introductory remarks. I am going to talk about changes in who lacks health insurance and why, and I'm going to focus more on national numbers rather than specific numbers for Massachusetts, in part because most of my data come from the country and not from the state of Massachusetts, but also I think the problems that this state is facing are common among all 50 states. And what I want most of all is for you to see that what's happened in Massachusetts is in a context of new pressures that are building on private health insurance.

To begin with, let me just talk about who lacks health insurance in the country. As Lisa said, we're facing a situation right now where basically one in six of non-elderly Americans do not have health insurance. And although the Census Bureau released some revisions to the estimate of 46.6 million uninsured (they had a computer error) and the new estimate is closer to 45 million, my reaction to the revision is that either way the number is huge — and really the point to focus on is that one in six non-elderly Americans do not have health insurance of any type.

The second point about the uninsured to note is the increase in the number between 2004 and 2005 — 1.3 million more people were uninsured. Almost all of those people lost access to employer-sponsored coverage, and that's important in the story that I'm going to be talking about here.

The third point I want you to remember is that 30 percent of the uninsured had middle-class incomes. I am defining "middle-class" somewhat arbitrarily as anyone with an income above the median household income. In 2005, the median household income was about $46,300 — so anyone with a family income above $46,300 would be in the middle-class by my definition. I know that I'm not taking account of the number of people who live in a person's family with this simple definition. But by using households (rather than families), I am encompassing single individuals and people who live in multifamily structures of households. I have found that in general if we talk about incomes relative to the poverty level, most of the public doesn't understand what we're talking about. But they can relate their own income to this somewhat arbitrary threshold of middle-class income of $46,300.

So the point I'm going to talk about is that not only do 30 percent of the uninsured have middle-class incomes, but also the issue of being uninsured has become a growing problem for the middle-class. One

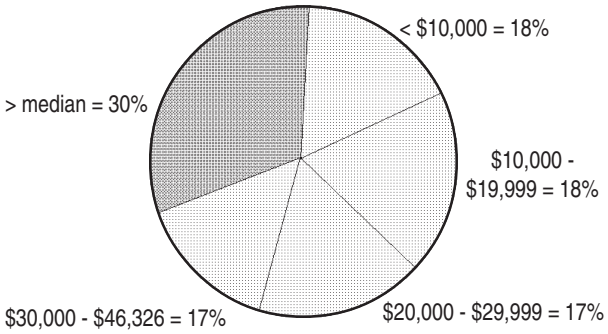
question I would like you to have in the back of your minds is: how can it be that someone who is a middle-class person does not have health insurance? What's going on here?

The last point I want you to remember about the uninsured is that almost three in five are young adults. They are between the ages of 19 and 44 years of age. This is a big shift over the last 25 years, and I'm going to talk more about this in the next couple of minutes in my brief overview.

The first pie chart [figure 1] illustrates the incomes of the uninsured and shows the point that 30 percent of the uninsured have incomes above the median household income threshold of $46,300. Clearly, however, most of the uninsured have very low incomes. They are people who cannot work or who are paid very low hourly wages and/or cannot work more than part time. For a variety of reasons, they have low incomes. Among the people who earn between $30,000 and $46,000 are some single individuals, maybe recent college graduates who, you know, clearly are middle-class. They may be earning $40,000 as new teachers of first grade, for example. Thus, even though I am saying that 30 percent of the uninsured are middle-class, there are clearly some people, especially if they live in single-person households, in the income range between $30,000 and $46,000 who also could be called middle-class. This point will come up again shortly.

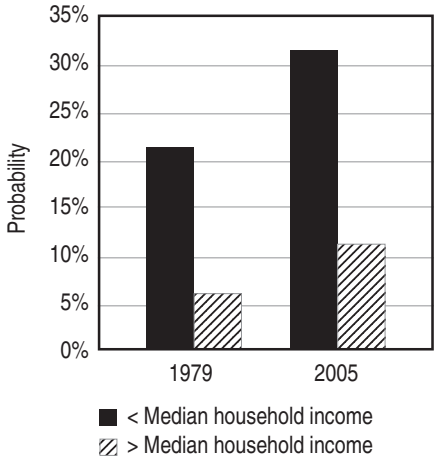
The second figure [figure 2] shows what's changed between 1979 and 2005 in terms of the simple probability of being uninsured. This figure is just for adults who are between the ages of 23 and 64; I have taken out college-age children on the grounds that there are lots of things going on with them, and people who are 65 and older are almost all covered by Medicare. What we see is that in 2005, a third of all adults whose incomes were not middle-class were uninsured. That fact should be shocking by itself. But the second point of the figure relates to the adults with middle-class incomes — in 1979, 6 percent were uninsured, and I've been looking at the uninsured numbers using the CPS [Current Population Survey][3] data starting with 1979. The percentage of adults who were middle-class without health insurance stayed at about 6 percent all the way through the 1980s and pretty much through the early part of the 1990s. But then around 1995, the percentage started climbing. And for the last five or six years, it's been climbing very rapidly, so that now, as you can see from the figure, 11 percent of middle-class adults are not insured. Part of the story I'm going to tell you is about why this fraction has increased so much, but the fact that one in nine middle-class adults is now uninsured is part of what has caught the attention, finally, of a lot of politicians. It is why there is

Figure 1. Income of Uninsured, 2005



Source: Katherine Swartz's analysis of March 2006 Current Population Survey (*http://www.census. gov/cps/)*; median household income in 2005 was $46,326.

Figure 2. Probability of Being Uninsured by Middle-Class Income for Adults, 1979 and 2005



Source: Katherine Swartz's analysis of March 2006 Current Population Survey (*http://www.census. gov/cps/)*; for this figure, adults are defined as persons who are 23 to 64 years of age.

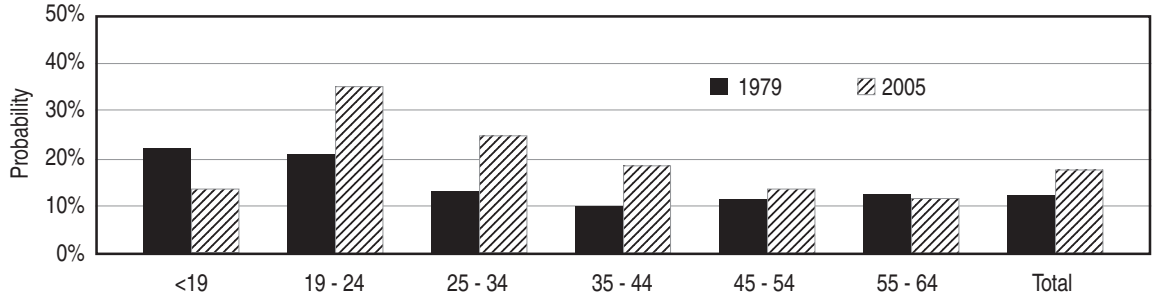
political pressure to do something to increase access to health insurance for people who don't have health insurance.

Before I get to why being uninsured is increasingly a middle-class problem, let me quickly describe two other points about what has changed over the past 25 years in the characteristics of the uninsured. As the next figure about the simple probabilities of being uninsured by age shows [figure 3], we can all pat ourselves on the back for what's changed for children. The decline in the simple probability of being uninsured is a clear reflection of what's happened with the Medicaid eligibility expansions in the late 1980s and then the State Children's Health Insurance Program. People who are 19 to 24 years of age have always included a large fraction without health insurance. Some of this has to do with dynamics of very young adults taking jobs for a while and then going off and traveling or returning to school, or just first job problems in general. But what I want to focus on are 25 to 34 year olds and 35 to 44 year olds. We have had a sharp increase in the simple probability of being uninsured for those two age cohorts, so that 26 percent of 25 to 34 year olds are now uninsured and 19.5 percent of 35 to 44 year olds are uninsured — that is stunning. I worry about them if they get diagnosed with cancer, for example, or are in a car accident, which are the two biggest problems for people in these younger age cohorts, and also for women having children. But it is also not good for us as a society to have younger, generally healthier, people not in the risk pool of people covered by health insurance. So this is a problem not just for the individuals who don't have health insurance but for the rest of us. Particularly if you're a baby boomer, you want these people back in those insured risk pools.

The last figure [figure 4] has to do with how the simple probabilities of being uninsured have changed since 1979 for people who we can describe in terms of their educational achievements. I don't want to dwell on people who have not finished high school, because we've had big demographic changes over the last 25 years. But if you look at people who are high school graduates and those who have some college (which generally means the people have been to a community college and obtained some type of associate of arts degree; and note that community colleges are where most of the technical education in the United States is now occurring), there has been an increase in the simple probability of being uninsured in spite of people getting increased skills, especially technical skills. This is a worry. But then we also see that people who have college or post-graduate educations have had an increase in the simple likelihood of not having health insurance.

So the question is: Why? What's going on here? What should we as a society be worried about here? In answering these questions, the first thing I want to tell you is that between 1981 and 1984 this country suffered a severe recession — one that many of you I'm sure remember. We had an enormous decline in the number of manufacturing jobs as a result. The number slowly came back, but it never returned to the same level that we had in 1979. The percentage of all non-farm jobs that are in manufacturing has declined since 1979 from 22 percent to just under 10 percent. You may say to yourself, "Well, 22 percent is not so large. Who cares?" But I am a labor economist, and I can tell you that in the postwar era, manufacturing set the tone

Figure 3. Probability of Being Uninsured by Age, 1979 and 2005



Source: Katherine Swartz's analysis of March 2006 Current Population Survey (*http://www.census. gov/cps/).*

in this country for what one should expect from a good job — and a good job included employer-sponsored health insurance. The fact that the fraction of jobs that are in manufacturing has fallen to one in 10 means that that tone is missing from the discourse.

This decline in manufacturing jobs affected not only the people who lost the jobs — it also affected their children. If you think back to the education figure I showed you [figure 4], there were people who grew up in middle-class households and expected to be able to get well-paid jobs in manufacturing with just a high school education. After all, their parents had good blue-collar jobs in manufacturing, and they thought they would just go right into the steel mills, the automobile manufacturing, the durable goods kinds of manufacturing — and also be able to have good jobs with health insurance without going to college. But in fact, those jobs disappeared from the landscape here in the United States starting in the mid-1980s. The question is, where did all those younger people go? By the early 1990s, unemployment rates were declining, so clearly these younger people were finding employment. Where they found jobs was the service sector of the economy. The key fact to know about the service sector is that smaller firms (that is, with 50 or fewer employees) dominate the service sector. And importantly, smaller firms are far less likely to offer health insurance as part of the total compensation that they give their employees.

Starting at the end of World War II, we had a decline in the proportion of workers working in small firms. The decline continued through the 1950s, the 1960s, and the 1970s and bottomed out basically at the end of the 1970s, when around 37 percent of workers in the private sector were employed in small establishments. This fraction started climbing back up again, and by 2005, it was at 44 percent of all workers in the private sector. This, too, is an important part of the explanation that I'm telling.

The third change in the last 25 years that has affected who has health insurance is a change that started around 1996 to 1997, so essentially only 10 years ago. There has been a change in the employer-employee relationship, so that we now have more people working as self-employed people or on a contractual basis, or through contract houses or temp agencies. Many more people are not technically "employees" where they work. This change in the employer-employee relationship is particularly affecting skilled, highly educated people in occupations like software engineers, hardware engineers, any kind of information technology, jobs related to broadcasting, writers, editors, people who are film editors, and so on.

For example, if you have a job in broadcasting and you do not work in one of the largest six cities in the United States, you are more likely to be a self-employed contractor than an employee of a broadcast studio or network station.

Teachers in community colleges and adjunct teachers in universities are frequently hired on a contract basis. Contract houses are virtually the same as temp agencies, although contract houses focus on placing professional people. Such people are being placed in companies that do not want to hire them as traditional employees. And the reason is that the companies would like not to pay the costs of health insurance and pensions.

This shift to hiring workers through contracts so they are not technically employees started with the accounting changes in 1993 to 1994 that required firms to show the expected future retiree pension and health benefit costs as liabilities on their financial statements. Today, we're talking about probably close to 9 percent or 10 percent of the working population, particularly people 25 to 44, who do not have the choice anymore of being an employee. Instead, they are hired on a contract basis, many of them earning relatively high incomes — and they are not getting health insurance as a fringe benefit.

It is important to note that between 1980 and 2005, after accounting for inflation, the cost of healthcare per capita has almost tripled. That provides a very strong incentive for employers to be looking to hire people on a temporary basis or a contract basis.

The changes in the uninsured over the past 25 years and the reasons for those changes have two outcomes worth noting. First, the growth in the number of middle-class people who lack health insurance, particularly the increased fraction of middle-class younger adults who are uninsured, is putting a lot of pressure on policy makers across the country. I don't know how many of you went to "meet-and-greet" events with candidates for Congress or state offices last fall, but I was impressed listening to people pressing

candidates about health insurance and mentioning that they had grown children, or nephews, nieces, or neighbors' children, without health insurance.

The second outcome is that employers — both large and small — very much want to limit their healthcare costs. The recent sale of Chrysler to the private investment firm Cerberus is not an accident; it very much has to do with the healthcare costs as well as pension obligations of Chrysler. Small employers, too, are nervous about health insurance obligations. I don't know how many of you know people who have started small companies over the last 10 years, but I have yet to be in a conversation with somebody who has started a small company who offers health insurance to employees. Instead, the conversation usually is about how the person is running a "virtual" company where the person brings people in to help with a contract that he or she obtained. The person running the company does not hire employees *per se;* the workers are often known as 1099 employees because they are hired as consultants or associates for specific projects.

The increase in such practices and the increase in the probability of a middle-class person not obtaining employer-sponsored health insurance have led to the growth in support we are seeing across the country for public programs that will support private insurance markets and expand access to those markets. I just want to go through some of the problems here in Massachusetts with the individual insurance market (which will be merged with the small group market on 1 July 2007) so you can see the setting in which Massachusetts was operating. If you try to buy individual (sometimes called "non-group") insurance, you are talking about paying very high premiums relative to what you would pay as an employee of Harvard University — that is, your share of the total premium that Harvard pays.

The reason for this is that there are much higher risks in the individual markets due to the potential for "adverse selection." Adverse selection occurs when purchasing health insurance is a voluntary decision, and the people who know something bad about their medical history or their own current health problems are more likely to purchase health insurance than people who think or know they are healthy. The insurance companies know that this occurs, and if you or I were running an insurance company, we would be very worried about the potential for adverse selection, too. The concern about adverse selection in the individual market causes insurers to include a risk premium in their premiums — this risk premium is payment for having to bear the risk that the insurer might have a run of people with extremely high healthcare costs, which is different from what you would expect from a normal draw of enrollees from the general population. Adverse selection concerns also are present in the small group markets, where small firms have to buy health insurance. Small firms face higher per capita premiums than large employers, but lower per capita premiums than individuals in the individual markets generally are quoted.

Because the premiums in the individual market are higher than in the group markets, various politicians have proposed providing tax subsidies as a way of helping lower income people buy individual health insurance. I think this will exacerbate the risk of adverse selection because it just gives money to lower income people, and the first in line applying for coverage will be people who know that they have a medical problem. More to the point, these proposals do not confront the adverse risk selection problem that insurers are facing, so insurers will just keep premiums high and collect the subsidies.

Another fact to understand about the individual markets is that they are pretty confusing. There are generally many choices with different premiums and different cost-sharing options. Particularly for younger adults who are contemplating the higher premiums and the confusing choices, the situation is very much like what it is for those of us in our fifties or sixties who are thinking about whether to buy long-term care insurance. We look at the complicated choices and say, "Tomorrow, I'll deal with it tomorrow." So one reason we see more of the 25 to 34 year olds and 35 to 44 year olds without health insurance is that basically they look at the choices in the individual market and say, "The premiums are high, and I'm not likely to be sick. It's confusing." — and they stay out of the market.

So how did policy makers in Massachusetts respond to this? First, they said one way to deal with the adverse risk selection problem is to require almost everybody to enroll in a health insurance plan, and the state would subsidize coverage for those with low incomes. That will go part of the way toward reducing the potential risk of adverse selection. This move is now being talked about rather easily in at least another 16 or

17 other states that are working on expanding access to health insurance. The conversation now is about state efforts to expand health insurance, and this implies that everyone is part of a social compact, and as part of that compact individuals have the responsibility to buy health insurance. That is a totally different conversation than we were having just 18 months ago. So requiring everyone who can afford to buy insurance to do so is the first thing that Massachusetts did.

Second, Massachusetts dealt with the concern about adverse selection in the individual market by merging the small group and individual insurance markets into just one market. We will no longer distinguish between people purchasing coverage as an employee through a small firm or as an individual. The merger of the two markets will pool the risks of individuals who do not have employer-sponsored health insurance with the employees of small firms. I was a member of the commission to study the likely effects of merging the two markets, and we estimated that the premiums for people purchasing coverage through small firms might go up between 1 percent and 1.5 percent, but the premiums for individuals would come down by about 15 percent. This gives you some sense of how much the risk of adverse selection should decline with the merged pooling of the two markets; individuals will see substantially lower premiums.

A couple of other observations about what Massachusetts did. There is a strong sense of joint ownership of the uninsured problem: employers, healthcare providers, the state — and by "the state" I mean all of us as taxpayers, whether we are companies or individuals — should help pay for health insurance for everybody. And importantly, if we find that some things aren't working, we will fix those things. This sense of joint ownership extends not just to what was done already, but into the future as well. I think that is an enormous accomplishment of people in this state who worked on developing the legislation and then the past year's worth of work to implement the plan. Nancy Turnbull, who is sitting in the audience, deserves enormous credit for getting people to work together on this.

A second observation is that the Connector [Commonwealth Health Insurance Connector, discussed in more detail below] has done yeoman's work in defining the terms of the basic benefits package and the cost sharing that will be required of individuals, as well as defining what is affordable coverage. In the past year, the emphasis has been on expanding access to health insurance and getting everybody on the same boat or under the same tent. What comes next is trying to slow healthcare spending, because if we do not do that, the plan is going to come unglued. Other states also are saying they are going to expand health insurance access first and not be deterred by the problem of rising spending — and that it is easier to deal with the rising healthcare costs if everybody is under the same tent.

My third observation is about the Connector's clearinghouse role. The clearinghouse role allows people to enroll in a health insurance plan and then take their coverage with them if they change employers or are between jobs or become self-employed. That is a tremendous accomplishment. It reduces the dynamics of insurance coverage for many individuals, and it reduces the costs to insurers of having to dis-enroll and enroll people who otherwise would have spells without coverage.

The Connector's clearinghouse role also means that we have standardized policies, making it easier for people to compare the different health plans. In addition, employers, primarily small employers, can basically designate the Connector as their employer-group health benefits plan. This is a very important point that has been missed by a lot of the media coverage. Designating the Connector as the employer-group health benefits plan means that the amount the employer contributes to the premiums can be treated as pre-tax dollars. This is what happens here at Harvard University, when Harvard contributes money toward the premium costs of its employees. The fact that the employer contribution is not treated as taxable income is good for the employers, because they do not pay Social Security and Medicare payroll taxes on the contribution. It also is very good for employees, because they do not pay the payroll taxes and the marginal income tax on the employer contribution. Thus, small employers that previously have not contributed to their employees' health insurance costs can now obtain the same advantages as large employers by designating the Connector as their employer-group health benefits plan. This is very much like what goes on in New York City with a program called HealthPass, which enables small employers to offer their employees choices in health plans. The small employer does not have to choose one health plan for all of its employees; HealthPass allows the

employees to have a choice of about 24 different plans, and the employer simply pays the premium money to HealthPass. This is a significant part of the Massachusetts plan.

The questions that the Connector has wrestled with over the last 10 months are the same questions that other states are now confronting. Two questions in particular are at the center of these discussions: How should costs be shared between individuals and employers? And as a percent of income, what is an affordable amount that people should be required to pay? (We can repeat this question for companies as well.) The second question relates to who may receive subsidies and what the upper income ceiling will be for who is eligible for subsidies.

A large number of European countries are dealing with these very same questions. I will be happy to talk further about this in the question-and-answer period. But three countries in particular — Switzerland, the Netherlands, and Germany — provide interesting lessons for us. They are three of the four European countries with the highest percentage of GDP [gross domestic product] that is spent on healthcare.

So to sum up, I have tried to set the stage here for thinking about what is happening in Massachusetts. As a country, we are facing much larger pressures now to expand access to health insurance and in particular to think about people whose incomes are high enough to afford coverage, but who do not have access to employer-sponsored health insurance. We are working through this joint public/private ownership of the problem in a way that I've never seen in the 25 years that I've been studying the uninsured. This public/private joint-ownership-of-the-problem approach that the states are taking is very important — for one thing, it allows us to work through the implementation problems at the state level and learn what works well and what does not work before we try any of these ideas on a national scale.

Ultimately, of course, the problem of the uninsured is a national issue. We in Massachusetts are lucky. We had money to throw at this problem, for two years anyway. We had a relatively low proportion of the population without health insurance. That's not the case in states like Alabama, Mississippi, and Louisiana, where efforts to achieve universal coverage will not be viable without fairly large income redistributions toward those states. But we are a country, and the uninsured younger adults are a problem for all of us. Massachusetts has been a wonderful beacon in all of this, and it is clear that other states are picking up on the lessons from the Massachusetts plan as they literally cut-and-paste portions of the Massachusetts legislation into their own legislative proposals. That is a high complement to Massachusetts policy makers. *[Applause]*

Michael Chin:

Thanks for having me. My background is clinical, as a family physician, and I don't profess to be an expert like our other panelists are. So I'm going to mostly stick to the facts, and try to set the foundation for this discussion by describing what is the law that was passed in April of 2006 and what has happened in the last year because of the law.

So the topic that we're discussing is: Does Massachusetts have the right model? I'm going to give an overview of the goals of the reform law, and I think of the goals as being threefold: Number one is to increase access to health insurance. Or in other words, to decrease the number of people who are uninsured in Massachusetts. Number two is to address the rising costs of healthcare in Massachusetts, and number three is to improve the quality of healthcare in Massachusetts. So the law is not just creating one program to insure some lower income individuals in Massachusetts. As you can see, the law tries to address all three problems. It's a very broad and a very ambitious law. We're going to try to zip through it in 15 minutes, so fasten your seat belts.

First, let me address the issue of *access.* There are many different ways that the reform law tried to increase access to health insurance. The first one is a program called Commonwealth Care, which is a program available to qualified individuals with a household income that is between 0 and 300 percent of the federal poverty level. It's subsidized so that the premiums individuals pay are between $0 and approximately $110 per month. It began in October 2006 and has already enrolled approximately 70,000 people. That's a lot of people; 70,000 people who probably wouldn't have insurance now currently do have insurance through this one program. Individuals in Commonwealth Care are enrolled in one of the private nonprofit Medicaid

managed-care organizations, which includes Boston Medical Center HealthNet, Network Health, Fallon Community Health Plan, and Neighborhood Health Plan.

So that's one way that the law has addressed trying to increase insurance in Massachusetts. The second one is Commonwealth Choice. Unlike Commonwealth Care, which is subsidized, Commonwealth Choice is not subsidized. Premiums in Commonwealth Care are usually higher than the $0 to $110 per month. The Commonwealth Choice program began open enrollment this month, and we'll talk a little bit more about it later.

The next piece is young adult plans. These are health insurance plans that you can enroll in only if you're aged 19 to 26. We've just heard from Katherine Swartz that the young adults are a big percentage of the people who are uninsured in Massachusetts, and these young adult plans are targeting this problem. Previously these young adult plans were not available in Massachusetts, but today you can enroll with coverage beginning in July. The benefits may not be as comprehensive as some of the other plans, but as a result the price has been able to be lowered. And because the price has been lowered, it is more affordable and more accessible for young adults.

The name "The Connector" is short for the Commonwealth Health Insurance Connector, and that's the agency where I've been working, and it's the agency that among other things has been charged with implementing these two programs, Commonwealth Care and Commonwealth Choice.

Next are MassHealth expansions. Most of you know that MassHealth is the Medicaid program in Massachusetts. The law did call for expansions to MassHealth, and since the passing of the law, over 40,000 people were enrolled in MassHealth who were not previously insured.

I'm going to skip over discussing the "individual mandate." You've probably all heard about this, and we just heard about it from Katherine. Beginning 1 July, most individuals in Massachusetts aged 18 and above are required to have health insurance. This requirement is going to start in a month and a half, and that will likely increase the number of people who are compelled to buy insurance, and thereby help to decrease the number of uninsured.

There's a whole set of new employer responsibilities that were brought about by the law, including the Free Rider Surcharge, Fair Share Assessment, and new requirements of employers to have Section 125 plans. These are examples of some of the new employer responsibilities that are aimed at increasing the number of people who have access to employer-sponsored health insurance.

And then there are a couple of other things that are affecting insurers, and these may be referred to as market reforms. We just heard a lot about them from Katherine, including the merger of the small-group and non-group markets. The law also expanded dependent coverage, which is another example of a market reform, and we can talk about this more if we have time later.

I want to echo what Katherine has said about healthcare reform really being a shared responsibility. As you can see, this is not just the government making a program. There are new responsibilities for the government, there are definite responsibilities for individuals, and there are new responsibilities for employers and for insurers. The problem of being without health insurance is a huge one nationally and in Massachusetts, and it's going to take all of us together to help fix that problem.

So we have just talked about access. As I mentioned, the law goes further and tries to address not just access, but also *cost* and *quality.* There are several ways that the law tries to address cost containment and rising costs in healthcare. I'm just going to mention one of them to stay under 15 minutes. We know that the average age of the uninsured in Massachusetts is about 37 years old. That's pretty young. Before the healthcare reform law, if that person on their own — not through an employer, but on their own — tried to get insurance, it would cost them over $300 per month. Today you can call the Connector or you can call up a carrier, and this 37-year-old person who lives in Boston can get coverage for as low as $184 per month. That's a big difference. And then if you consider some of the tax deductions that Katherine mentioned, then the cost can be even lower as a result of saving on taxes. So that's one example of how costs are trying to be contained.

So we've discussed access, and we've just mentioned costs. Let's briefly move to *quality.* The law tries to address the issue of quality in a couple of ways. The first is with the definition of "minimum creditable coverage." The law has charged the board of the Connector with defining what is minimum creditable coverage. Minimal creditable coverage is the criteria that any health plan in Massachusetts must meet in order to fulfill the individual mandate. That's a mouthful. So let me try to give an example: prescription drugs. The Connector board is currently deciding if minimum creditable coverage includes drug prescription coverage. If the board decides "yes," minimum creditable coverage should include drug prescription coverage, then an individual could buy a product that does not have drug coverage, but that individual may be considered not to have met the individual mandate, and might therefore face associated penalties. In other words, there are strong financial incentives to buy a plan that meets this minimum creditable coverage. There are strong financial incentives not just to buy health insurance, but also to buy creditable, quality health insurance.

So that's one way the law tries to address quality. I'll mention another: since August of 2006, the law called for and assembled a Health Care Quality and Cost Council. They meet about once every month, and their goal is not to address access, but instead to focus on how do we improve quality and how do we contain costs in Massachusetts.

Another way the law addresses quality is through increasing Medicaid reimbursement rates, and to introduce pay-for-performance measures in Medicaid.

An additional method for improving quality is through the formation of a Health Disparities Council that is charged with addressing the disparities in health among different racial or ethnic groups. This council has not yet been assembled, but one of its goals may be to try to improve the quality of care that ethnic groups are receiving in the state.

So we have talked about how the law attempts to improve access, cost, and quality. There are also several other aspects of the law, including what's going to happen to the "free care pool" in Massachusetts. There are lots of other parts of the law that we can get to if people have questions.

The moderator also has asked me to give a quick assessment and a one-year update. It's now been a little over a year since the law was passed. There clearly has been some early successes: about 70,000 people are enrolled in Commonwealth Care. Over 40,000 additional people have been enrolled in MassHealth. So within just a year, over a third of previously uninsured people in Massachusetts are now insured. That's pretty impressive to achieve in under a year. And there's also much more to come. Commonwealth Care is continuing to grow. Commonwealth Choice just started this month. The individual mandate and most of the new employer responsibilities have not yet gone into effect. So it's going to be some time before we get an idea of the full impact and effectiveness of the reform law.

Are all these steps going in the right direction? It's a great question to ask, and I think some people are going to argue that even though you have early successes, in the long term, this law is not going to be the solution. I think some people — for example, if you're a proponent of a single-payer system — might say that the reform law is not a step in the right direction. And I think that's a great and healthy debate to have, especially when, like Katherine said, Massachusetts is very different than other states that have much higher rates of individuals without insurance. But I would say that many people both inside Massachusetts and outside of Massachusetts are looking at what has happened in just under a year in Massachusetts, and they are saying, "Hey, that's pretty impressive." And that's part of why we are seeing so many other states looking at the Massachusetts model and asking themselves, "What parts of the Massachusetts model can we adopt? What parts would work here in our state? What parts would not work here in our state?"

Finally, if you want to learn more, there's a new website (*www.MAhealthconnector.org*) that was launched a few weeks ago that has a lot more information. For example, if you want to find out how much insurance costs for your young adult son who's graduating this month, you can find out at this website. There is also a lot of general information about healthcare reform in Massachusetts that you can find on the website.

Are there challenges ahead? There definitely are challenges ahead, so if there's time during this forum, we can talk about what are the challenges that we foresee coming over the next year, and over the next couple of years. So I look forward to an interesting debate. *[Applause]*

Lisa Soleymani Lehmann, "Harvard Medical School Public Forum: Insuring the Uninsured:Does Massachusetts Have the Right Model? 17 May 2007," *The Journal of Clinical Ethics* 18, no. 3 (Fall 2007): 270-93.

Marcia Angell:

Massachusetts is certainly to be congratulated on seeking to extend healthcare to nearly everyone in the state. Every decent society should ensure healthcare, just as they do education, clean water, and police and fire protection. So it's a laudable goal, and it's certainly one that I share. But unfortunately, I'm afraid the Massachusetts plan will fail in the long run and probably the short run, too. I won't get into the fine points of the plan today because the problems are not at that level, but rather at the level of the plan's overall conception. So what are those problems? Well, I see five major ones.

Number one. The plan's success depends primarily on requiring individuals to buy their own health insurance in the private market — a highly regressive policy that forces the near-poor to pay a much higher percentage of their income on healthcare than their more affluent neighbors. Older, sicker patients will also pay more. The state pays the premiums for those beneath the poverty level and partially subsidizes them for those up to 300 percent of the poverty level. But above that (about $30,000 a year for an individual), people are on their own.

I checked the Connector's website and found that the least expensive plan for a 57 year old had a premium of about $4,000 a year, a $2,000 deductible, and substantial co-pays and co-insurance (35 percent co-insurance for hospitalization) up to a maximum of $5,000 a year. So as I calculate it, our hypothetical 57 year old with a $30,000 annual income could pay as much as $11,000 out-of-pocket, or over a third of his income. An individual mandate of this sort has never been attempted, and I believe it's unlikely to succeed. I call this the "Squeeze Blood from a Turnip Plan." In 2008, those who haven't purchased insurance will be fined half the premium of the lowest priced plan. I doubt the state will have the stomach to enforce that. I hope it doesn't.

Two. Health insurance is not the same thing as healthcare — not by a long shot. In the Commonwealth Choice plans on the Connector website, there's a clear trade-off between premiums, on the one hand, and deductibles and other out-of-pocket costs, on the other. The plans with the lowest premiums have the highest deductibles and other costs, but those who select the cheapest plans are likely to be precisely those least able to afford high out-of-pocket costs. So they could end up with health insurance that they are reluctant or unable to actually use. Furthermore, the cheapest plans are also the least comprehensive. For example, they don't cover prescription drugs, which constitute a growing fraction of health costs. So even when people do seek healthcare, they may find the particular care they need is not covered by their stripped-down policy.

Three. The Massachusetts plan originally required all health insurance, even that provided by employers, to meet a minimum standard of coverage. But the Connector has backed away from that. Employers are supposed to pay a $295 per employee fine if they don't provide health benefits, but they are now considered to have met their obligation if they offer benefits to just 25 percent of their employees or contribute 33 percent of the premiums, no matter whether their employees accept the offer and no matter how skimpy the coverage. So the problem of underinsurance will remain widespread.

Four. No one seems to know where the money will come from to pay for the plan or whether there will be enough. Supposedly it will come mainly from the individual mandate (that is, the turnip), general state revenues (another turnip, given the current budget shortfall), a shift from the uncompensated care pool, and the paltry fine of $295 per employee on businesses that don't offer health insurance. But as one state legislator told the *Boston Globe* last year, "We don't know what it's really going to cost or where we're going to get the money. To some extent, you might call it a Hail Mary pass."[4] But let's assume we do scrape the money together. Then what? The major failing of this plan, the elephant in the living room, is that it contains no mechanism for slowing price inflation in healthcare. Yet health insurance premiums have been rising much faster than background inflation. The plan relies on market competition to hold down prices, but that's fanciful. It's certainly not doing that now. If prices don't continue to skyrocket, it will only be because benefits are cut. So even if we do find the money for this plan at the outset, it will quickly become too expensive, as well as increasingly inadequate.

Five. The bureaucracy to administer the plan will grow rapidly, as will the legal costs, and that will siphon off dollars that could be used, could better be used, for healthcare. Massachusetts already spends

about 40 percent of every healthcare dollar on overhead, according to a 2001 report to the legislature by the consulting firm LECG. The plan requires the state to determine whether insurance is affordable and meets minimum standards. But these judgments can be challenged. As Jon Kingsdale said earlier this year, "There's going to be a court challenge" to whatever the board decides.[5] In particular, those just over the 300 percent poverty level who have to buy their own insurance in the private market will object that they, and not the state, should be able to decide what they can and cannot afford. And the appeals and lawsuits will probably be endless.

So those are the major failings that I believe will cause the plan to implode. To recap. One, the individual mandate is harsh and inequitable and probably will be unenforceable. Two, private insurers will offer plans that are either unaffordable or inadequate. Three, the plan does not address the growing problem of underinsurance, particularly in employer-sponsored plans. Four, funding is unsure and that problem will only grow worse since there is no way to control price inflation. Five, the plan will require a large bureaucracy whose decisions will be subject to constant challenges.

Now, already, the plan is unraveling. About 60,000 people have been excused from the individual mandate because they can't afford it. That's over 10 percent of the uninsured, and there are currently no plans to cover them. The minimum standards for coverage have been relaxed. They no longer include prescription drugs, for example. Employers and workers who originally would have had to upgrade their current insurance no longer have to do so. The idea is that these compromises will be dealt with later — by January of 2009. House Speaker Salvatore DiMasi explained the delays this way: "We're moving to universal insurance and then toward insurance that has substantial benefits. That's the key," he told the *Boston Globe*.[6] It certainly is. But it's wildly optimistic to believe that after people have signed up for stripped-down coverage and costs have continued to climb, there will be the money and political will to add to the benefit package.

Massachusetts is not the first state to come up with a plan to provide near-universal health insurance to its citizens, although it is the first to rely on an individual mandate. Maine tried it in 2003, Minnesota and Tennessee in 1992, to name a few. And, of course, Massachusetts made an earlier attempt in 1988. All were greeted with great enthusiasm and fanfare in the media. You should have seen the *Washington Post* stories about the Maine plan. And all failed and died with scarcely a whimper. What they had in common, and the new Massachusetts plan also has this, is that they left our current dysfunctional system essentially intact and simply tried to expand it around the edges. But this system relies on employers and private insurers whose incentives are really to provide as little healthcare as possible. In fact, I suspect that most employers will soon follow the big three American auto makers and look for ways to get out of providing health benefits altogether.

Private insurers, for their part, try to avoid the old and the sick and attract the young and healthy, and they vary their prices and coverage accordingly. They also do everything possible to shift costs to other payers and back to patients themselves through high deductibles, co-payments, and claim denials. The overhead costs of all this risk rating and cost shifting are staggering. So when this inequitable and wasteful system is left essentially intact, any attempt to expand coverage inevitably increases costs, and I think will increase costs unbearably. And that is what will happen in Massachusetts.

The only workable solution is a single-payer system in which everyone is provided with whatever care they need regardless of age and medical condition — that is, a system similar to Medicare, which is a single-payer system embedded within our larger private system. There would no longer be a private insurance industry that adds little of value yet skims 10 percent to 15 percent of the healthcare dollar right off the top. Employers, too, would no longer be involved in healthcare.

The most progressive way to fund such a system would be through income taxes that would be more than offset for individuals by eliminating premiums and out-of-pocket expenses. Over the years there have been many independent analyses of the costs of converting to a single-payer system, either within a given state or nationally. They included studies in the early 1990s by the General Accounting Office, the Congressional Budget Office, and consulting firms, such as the Lewin Group, hired by state governments and, in Massachusetts, by the state medical society. Most found that a single-payer system would initially cost

roughly the same as the system it replaced, while providing universal coverage, and over time, it would be much cheaper.

Polls report that most people and most Massachusetts doctors, I might add, favor a single-payer system.[7] Even the *Boston Globe* called for a national single-payer system yesterday. In an editorial about the big three automakers' desire to transfer health costs to the auto workers union, it said, "It would make more sense for the federal government to oversee a national health system financed from taxes. The cost would be spread across the entire population, rather than borne by Chrysler or other companies that no longer enjoy the assured profitability of their best years."[8]

Nevertheless, the private insurance industry has managed to convince many people that a single-payer system is unrealistic. You hear that word over and over again: "Unrealistic." But what is truly unrealistic is anything else. My greatest concern about the Massachusetts plan is that when it unravels, people will draw the wrong lesson. They'll assume that universal care at a cost we can afford is simply impossible and give up on it. It's not impossible. It's just unlikely to be achievable while leaving our dysfunctional healthcare system in place. *[Applause]*

Lisa Lehmann:

I want to thank our panelists for sharing their insightful perspectives with us. In just a minute, we'll open it up to you, our audience, for conversation and questions. We have two microphones that will be at the bottom of the floor on each side of the auditorium, and if you could please come up to the microphone and tell us your name and ask a question, we'll have the panelists respond to it.

I'll take the prerogative of getting us started, if I may. Marcia, you've really given us a cogent argument for a single-payer system, and that's not the route that Massachusetts has gone. I'm wondering if Kathy and Michael might be able to comment on your perspective on a single-payer system. Is that the way we should be moving? Why didn't Massachusetts go that route? What might be some of the pitfalls of a single-payer system?

Katherine Swartz:

Okay. So I'm going to answer a slightly different question. I don't think it's possible to go to a single-payer system like *that.* Instead, I see what Massachusetts has done, and what a number of other states are considering, as being steps toward perhaps a single-payer system. There is a great reluctance in most of the United States to not do away with private health insurance. If the Massachusetts plan doesn't work after whatever else we end up doing to fix some of the problems that surely will come, I see this step as moving toward something that looks like a single-payer system.

I guess I also see it more as a change in the conversation about how we pay for health insurance; and in particular really addressing the question of how much of the cost of healthcare should be borne by individuals, how much should be borne by employers, and how do we treat children or people who are not gainfully employed. Do we say that the costs for such people are the responsibility of all of us? And I would certainly go in the direction that children, for example, are the responsibility of the government, the state. (I'm using the word "state" to indicate society.) We should be investing in children because they're the future of the country. Employers should also be helping to pay for children's healthcare because they are future workers.

All of this essentially looks like we are drawing money into some central clearinghouse and then paying for healthcare as people need it. There are a variety of ways of paying for the care, one of which is to go through insurance companies.

But I want to come back to what I started with — I do not think we can go to a single-payer system overnight or within one year. I think of this more as a decade-long discussion, and we are moving toward that. And I think the cost of Medicare will hasten this shift as well — we will end up being in one system that everybody is in. Whether this is something which people who are currently 65 and older get grandfathered into the current Medicare and the rest of us move into a different system, I don't know. But I think the conversation about how we pay for healthcare in the country is going to involve all ages and not just people under 65.

Michael Chin:

I'll make two quick comments. I agree with Katherine that if the legislature had decided to switch to a single-payer system, it would be hard for me to imagine insuring people as quickly as we've done as a result of the current law. As we said, over 70,000 people in Commonwealth Care and an additional 40,000 in MassHealth have become insured. So that's pretty impressive numbers in such a short amount of time, which would have been very hard to achieve if Massachusetts had tried to switch to a single-payer system.

A second comment is that the situation or the model that works in every state is going to be different, and in Massachusetts our rate of uninsured — around 6 percent of people in Massachusetts — is a lot lower than it is in other states. And also the percent of people who are already covered by employer-sponsored insurance is a lot higher than in other states. So, in that regard, maybe a single-payer system might make much more sense in states other than Massachusetts.

Lisa Lehmann:

Marcia, do you want to respond to those comments?

Marcia Angell:

Well, just briefly. What's standing in the way of moving to a single-payer system is the implacable opposition of the private health insurance industry and the pharmaceutical industry, which would have to face bulk purchasing by the state and price negotiations. So these industries are implacably opposed. In Massachusetts, the big hospitals were bought off by rate increases, and so they, too, have gotten behind the new plan. They all propagate the mythology that moving to a single-payer system would be terribly hard to do, that it would be very complicated. Well, there's nothing more complicated than this current plan. What you're seeing is "Harry and Louise"[9] all over again. We're told we just can't do the sensible thing.

Lisa Lehmann:

Thank you. Norm, do you have a question?

Norman Daniels:

Thank you, all of you, for very good presentations. My inclination is to agree with the criticisms that Marcia made of the plan. I just wanted to bring into perspective a couple of international and historical remarks, which maybe didn't appear in the 25-year time period that Katherine was talking about. If one goes back to 1993 and the Clinton effort at reform, the numbers of uninsured in the United States were roughly 33 million. So we've had over a 45 percent increase in the number of uninsured in just 15 years. At the same time, we've had deeper and deeper and more complicated entrenchment of the fragmentation of our health system and the entrepreneurial thrust to it with an ideology overlaid about competition. Competition is not going to solve these problems. Remember, Clinton had articulated at the beginning of that plan that single payer was out. So what we've seen in the aftermath of that is enormous growth, not only of the uninsured but the continuing rise of healthcare costs.

So I go back to a point that Marcia made in her remarks. It seems to me that we're stuck in a system that is spending 50 percent more than other developed countries per capita on healthcare, and it's doing it because of the very structure of the system that we have. Yet we were told by Clinton that you can't move away from that complexity in any direct or straightforward way, that it's politically impossible. I think if we are told that now, we are victims of obfuscation. It is not that complicated to expand Medicare or some other version of a single-payer system in this country.

What you really get are arguments about competition and a market ideology which pushes us in the direction of saying individual competition is necessary, but they do not turn us in the direction of what is done in other countries to establish a balance between monopoly and monopsony powers. That is what all other countries have been using to control their healthcare costs, at least in developed countries.

So my question, Katherine, really is why is it so complicated to move away from this system? I think it's not that complicated. I agree with Marcia, but I think that the real obstacles are political and the failure of

some clear leadership around this. It was a failure in my view within the Clinton administration, and each time we have to face this problem a decade or after a failed effort at reform, the problem is made worse by the magnification of the investments in entrepreneurial and fragmented healthcare.

Katherine Swartz:

I think that no one should mistake my answer to say that I do not want to go to some kind of single-payer system. But I don't think that for political reasons you're exactly right, that we can do this in any very short-term period of time. And the reason I believe that is I spend time every year in the West, and there is really intense opposition in the western states to the notion that we would move to a single-payer system tomorrow.

On the other hand, one reason I spent time trying to set the stage of what's going on in the U.S. with the uninsured is it is now clear to many people in states like Montana, Wyoming, South Dakota, North Dakota, Washington, Vermont, et cetera, that their children do not have health insurance. Their adult children don't have health insurance. Their grandchildren don't have health insurance. That is what is driving these state efforts to think about expanding access for self-employed people and employers that are very small, smaller than what are required of Massachusetts or Vermont to participate in these states' plans. The fact that there are so many people who work for these smaller firms or are self-employed who are worried about their access to health insurance, plus the fact that very large employers are saying they cannot afford to continue the obligations they have to the unions, means that there is growing support for public policies to help people buy private insurance on their own.

But I don't know that people really believe that we're going to get competition between insurance companies to keep the costs down. Insurance companies today do not bear risks. Marcia is absolutely right about that. Larger employers (any employer basically over 250 employees) self-insure. They do not buy insurance policies. They are paying insurance companies to be the third party administrator, so the insurance companies are not bearing risk. If you're talking about small employers below 250 employees down to say 50 employees, they're forced to buy policies, and those are the companies particularly that are now, if they're starting up or have already been offering health insurance to their employees, are back-pedaling away in terms of forcing their employees to pay more, just to keep the costs down. I really believe that over this next decade we are going to see an enormous shift in the conversation about who pays for health insurance, how much, what is it that we're buying — because the insurance companies do not want that risk.

The next question is what is it that the insurance companies are doing. Well, they're processing claims. It's just exactly what they do for Medicare on a contract. So we are moving toward a single-payer system with insurers processing claims. The question is, How do we get there — How do we get the country to move along? I'm clearly a Democrat, but Governor Mitt Romney did an enormous favor to this country by saying it is a requirement that people buy health insurance. That has changed this conversation into a discussion about being in a social compact.

Part of the social compact is an individual's responsibility as well. It's an eye-opener that we're now into that conversation. So do I think we're moving toward a single-payer system? Yes, I think we are. Do I think that there are problems Marcia has outlined about what's happening here in Massachusetts? I'm not in that boat. I think that we've done an enormous move forward, and now we can turn attention to trying to figure out how to slow down the growth in healthcare spending because we cannot afford it at the rate we're going.

So thinking of these as steps, and that we have achieved a joint ownership of this problem between employers, providers, and all of us as individuals — that's enormous. We should be very proud of that. I think that progress then opens the door for being able to resolve these issues that you've brought up, that Marcia has brought up, and that many of us have raised. But I don't want to repeat what we did in the Clinton era of everybody throwing arrows at the problem. I think it is much better to be constructive about how do we fix this problem, what do we do next, how do we get more money into this system, and so on. That's the conversation we need to be having.

Lisa Lehmann:

So, Kathy, you've articulated a position that is very positive with regard to the idea of shared responsi-

bility and the individual mandate. That is in stark contrast to the view that we heard from Marcia in which she suggested that an individual mandate is harsh, unenforceable, and not equitable. I want to ask Dan Brock, who is the head of the Division of Medical Ethics at Harvard Medical School, if he can comment on this idea of an individual mandate and shared responsibility. Is this mandate ethical? Is this ultimately a good thing?

Dan Brock:

In every other developed country there is some form of national health insurance that usually is paid for out of general tax revenues. Sometimes it comes through employers, but it's a shared financial responsibility. In Canada, in Great Britain — now that's a way of mandating that the community subsidize the overall costs of the healthcare system, and it allows us to do what used to be called "community rating," namely, in effect, the sick get subsidized by the well. Now, I have to think that is ethically justified, but I don't think the individual mandate is all that different from that other system that spreads the cost. What this is doing is spreading the cost by saying, "If you have incomes, it will be a subsidized premium that you'll pay." But instead of free riding and saying, "Well, I'm young and I'm healthy" — obviously, *I'm* not young, but many who are say — "I'm young and I'm healthy, and so I'll take my chances, and if I get really sick, I'll go to the emergency room, and I know the federal government requires me to be treated if I go to the ER." That's free riding, right. So this is a way of trying to insure that we avoid that free riding.

Now I want to ask one question, which is about the title of this forum: Does Massachusetts Have the Right Model? And one way to interpret that is, has it got it right in terms of a plan that other states can mimic to some degree? There are several facts that make it not too likely that this can be widely imitated by other states. We live, as we know, in the most liberal state in the country, and so there's more concern with dealing with this problem. As was pointed out in Kathy's presentation, we have a relatively low uninsurance rate in comparison with other states. As we know, it's nearly twice that overall in the country. And we live in a relatively wealthy state, in comparison with other states that have higher rates of uninsurance.

So I would think more conservative states with a much bigger problem in terms of numbers of uninsured and less wealthy states are going to have an awful — even assuming we can make it work in Massachusetts — are going to have an awful hard time following suit and making it work in Louisiana and Mississippi and Alabama and Arkansas and so forth and so on. So I wonder what some of you think about the potential in other states.

Katherine Swartz:

That's a great question. So it's true that California, for example, sent people here and people from here went there to talk. The governor's people basically did a cut-and-paste of parts of the legislation here, as well as the legislation in Vermont.

One key difference between the Massachusetts and Vermont legislation is that Vermont has a "blueprint for health" that talks about certain health problems or public health problems that are not the responsibility of a single employer or a single insurance company. The blueprint for health's initial issue is people who are overweight because Vermont has a large number of people who are overweight, like most other states, and type 2 diabetes is a big problem there.

So a similar blueprint for health initiative is in the California proposal of Governor Arnold Schwarzenegger. But then there are differences where, for example, California is trying to finance its plan, not with a nominal $295 per employer that does not offer health insurance, but instead a 4 percent tax on payroll of employers that do not provide health insurance. The 4 percent tax on payroll may be an opening gambit that the legislature in California will negotiate over — I don't know.

The other states that I have been in discussion with have focused much more on their small group and individual insurance markets. What intrigues these states is, first of all, Massachusetts' decision to merge the small group and individual insurance markets — something that as I said earlier has been under the radar of most people's attention. But the second issue that these states are interested in is what I've been proposing as

one part of a package that states might consider: reinsurance. Illinois and Montana, for example, are very seriously talking about reinsurance. Michigan is as well. New York State has reinsurance already in a program for low-income people and is thinking about expanding that. So all of these are different pieces —

Bud Relman:

Would you explain what you mean by "reinsurance"?

Katherine Swartz:

Yes. I've been proposing a reinsurance program whereby a government program would take responsibility for most of the costs of people who, in any given year, have extremely high medical expenses. So if you think about the medical expenditure distribution in the United States, you all know that 10 percent of the population is responsible for 70 percent of medical spending. But the top 1 percent of that distribution is responsible for about 28 percent of all medical spending. To be in the top 1 percent of the expenditure distribution last year, you would have had to have medical spending above $50,000 for the year. This goes back to what I was saying earlier, that the insurance companies in the individual market, as well as the small group market, tack on what I call a "risk premium," because they are very worried about people who might have these extremely high costs. So if a reinsurance program would pay for, let's say, 90 percent of all costs of people who are in that top 1 percent, the reinsurance program would pay 90 percent of the expenses above $50,000. And importantly, the reinsurance program doesn't just drop the premiums by the 28 percent of all spending; it drops it more than that, because insurers no longer have an incentive to include the risk premium in the premium to compensate for the possible adverse selection. Premiums really come down.

In the case of Healthy New York, which is a program for low-income people and is the only program in the country right now that uses this kind of reinsurance, the premium costs are less than half of the premiums in the standard individual market in New York State. The package of benefits is somewhat leaner compared to the standard market, but the insurers are the same managed-care plans and the physicians are the same. So this indicates to me that there is a risk premium in the individual (and small group) market.

What we want is for premiums in the individual and small group markets to come down sharply enough that younger, healthier uninsured people will start buying insurance. If more younger and healthy people come into these markets, it will stabilize the markets, and the premiums will stay lower. Massachusetts chose to merge the small group and individual markets to reduce individual premiums and stabilize the market, but government-sponsored reinsurance is on the back burner in the legislation. I think that people are looking at this as a way of bringing in these younger, healthier people and getting them to buy health insurance.

I want to make one more point before Bud comes in on this. Marcia's right to worry about the people who are older and whose incomes are just above the ceiling for getting subsidies. For an individual, the income eligibility ceiling for a subsidy is three times the poverty level. The poverty level for an individual is $10,000. So when she was saying $30,000, it's because that would be 300 percent of the poverty level for a single individual. But for a family of four, the poverty level is $20,000, and therefore $60,000 of income is the point at which a person would not be eligible for the subsidies. Michael might want to talk more about this — but the Connector was caught by how much money the state had available for subsidies.

The Connector expanded the income ceiling for eligibility for subsidies as much as they could and then worked backward in terms of figuring out what is a minimum credible insurance policy. I also want to make the point that if you lived in Wyoming, were self-employed, had a family of four, and your income was around $30,000 to $35,000, the kind of health insurance policy that you could get in would cost you about $700 or $800 per month for a family policy. You would be facing at least a deductible of $5,000, more likely $10,000 now. And the policy would not cover any well-baby care, any immunizations, or any well-adult care.

What is being offered here through the Connector is far better than what you would be facing in most other states if you had to buy individual coverage. And I think that point needs to be brought back into this discussion. Again, it's part of what the state is trying to accomplish, trying to move forward. Do I think that

the state is going to try and put more money in for subsidies in the future if it can? Yes. Do I think it's going to add more options about covering prescription drug coverage? Yes. Think of this as the baby was just born, and the baby hasn't walked yet. I don't want to throw that baby out with the bath water. I think it's more important to think of this as progress toward getting universal health insurance coverage, and, most likely, single-payer coverage in this decade because we cannot sustain what's going on right now. It's going to have to involve a different conversation about how we pay for health insurance and what it is we're paying for.

Lisa Lehmann:

Marcia, do you want to comment on that?

Marcia Angell:

Yes. I'm very uncomfortable with the rhetoric of shared responsibility in this context. Shared responsibility, as Dan Brock pointed out, is what you do when you pay your income taxes, and everybody is in a universal system. You're sharing responsibility in proportion to your ability to pay. What this plan does is to hit the poor and the near-poor much harder than wealthy people. Those with the least disposable income have to pay a higher percentage of their income. So this is not something, Kathy, that I would celebrate ethically. It's hardly a virtue of the plan that it is hardest on the most vulnerable. As for the baby, there's an expression in medical school that when you're learning how to do a procedure, such as a lumbar puncture, you "watch one, do one, teach one." We haven't even "done one" yet, and we're already presuming to teach other states how to provide universal care. I want to see what happens to this baby. Maybe it's stillborn, but let's just see what happens.

Lisa Lehmann:

Bud, do you have a question?

Bud Relman:

I have an observation and then a question. First the observation: I think too much attention has been given in this discussion, and in the Massachusetts plan, to getting everyone covered with health insurance, and not enough attention to the central problem, which is cost. It is the ever-rising cost of healthcare that is making insurance unaffordable by so many. We need to solve the problem of rising costs before we can expect to have universal coverage.

And now the question for the panel: Do they think it makes more sense to attack the healthcare problem as a whole, rather than simply try to achieve single-payer insurance reform? Shouldn't we be looking at how to reform the delivery system at the same time, in order to make it more efficient and affordable?

Lisa Lehmann:

Thanks very much for that excellent observation and question. Before I ask Michael to respond to the question, I want to elaborate on it a little bit. Michael, you suggested in your presentation that, in fact, this legislation is trying to address cost. But the example that you gave for that was the way in which the premiums that people have to pay are decreased. But the reality is that a decrease in premiums is associated with a decrease in benefits, and that's really not what we mean when we talk about controlling costs. Bud's comments are really on that point. When we're talking about controlling costs, we're talking about the escalating costs of high technology healthcare, especially the tremendous costs that we give to the elderly at the very end of life, and the question is, What does this plan do to control rising healthcare costs? What is Massachusetts going to do to control costs? And can we move forward without really dealing with the high cost of healthcare itself, not just by reducing the premiums associated with these health plans?

Michael Chin:

I completely agree with what a lot of people have been saying. You can insure everyone — whether it is in the current system that Massachusetts has or even in a single-payer system — and costs are still going to

be a problem. So I agree completely that cost is really something we need to pay attention to. And the legislature — these are really smart, intelligent people, and that's why they made a bill that wasn't only about access. It was also a bill that tried to address quality and cost. I think access gets talked about a lot more because it's very visible, and people can attach numbers to it. But people are trying to address quality and cost as well.

For example, this is what the Health Care Quality and Cost Council is trying to address, and in some ways I think their job is even harder than what the Connector is charged with, because trying to stop the national and international rise in healthcare cost is very, very difficult. The Council is talking about ways to do that, whether it is by trying to lower the number of hospital-acquired infections, or trying to increase the amount of people who are prescribing through electronic means, so that we decrease medical errors. These are things they are looking into that will hopefully increase quality and decrease costs. But it's very hard, if not harder, than getting people access to insurance.

Lisa Lehmann:

Okay, great, Rashi, do you have a question?

Rashi Fein:

I agree with Kathy but . . . It would be wonderful to have a conversation, I think that's what you called it, over the next decade. But if we're going to have a conversation, it would seem to me that it is incumbent on those who do favor a single payer not to retreat from that conversation by saying they favor single payer, but it's not practical. Because that's been the history going back to Bill Clinton, who spoke to the governors and said a Canadian-like system is much better but. . . . He didn't say "but it's impractical," because he didn't want to confess that he couldn't accomplish it. So he used a different word. It would seem to me that the problem with the Massachusetts program, if you like a single payer, is that it heads in the wrong direction and does not contribute to the discussion that we ought to be having.

It would be, I think, very difficult to have a single payer tomorrow, but to say that's the problem is akin to setting up a straw man. I don't think that anybody in favor of a single payer feels that you could, in a practical sense, suddenly redirect all the funds that come today from employers to health insurance companies without being engaged in a tremendously difficult war over what goes to wages, what goes to taxes, et cetera. But it would seem to me that if one is in favor of single payer, that one ought to head in that direction by stating this is where we want to end up and here are five steps that take us there. Cover all children on a single payer. Two years from now cover all people 18 to 30 on a single payer. Two years later 30 to 40, 45, or work down, but work in a way where people can see the end goal of a system that is not inherently different from what is being phased in.

The Massachusetts plan doesn't contribute to movement toward a single payer, neither does it enlighten us for purposes of that discussion. Indeed, I think it does something that is harmful. It continues to say, in effect, the employment linkage is not broken, it's the way we've had it, and it's the way we ought to continue it. And I think the problem with linking insurance to employer, not only is it problematic in how do you get all employers, but it is the antithesis, I think, of the kind of competition we ought to have between employers. It is not that Chrysler or Ford or General Motors have been more lavish in their health insurance benefits than Toyota or Honda, it is that Toyota and Honda have younger employees with lower healthcare costs, no retirees, thus again lower health costs, and they're located in Arkansas and places which are not as expensive medically as Michigan and Ohio.

So it would seem to me that we're heading in the wrong direction. Does that mean that we have done evil? No, there are 60,000 people who have insurance, and that's an improvement. Have we contributed to the dialogue, discussion, conversation that would bring us closer to a single-payer system more like Medicare? I don't think so. I think, in that sense, we've set things back.

Katherine Swartz:

I'd like to respond to that. The Netherlands has essentially a single-payer system. There are contribu-

tions from individuals and from employers, different taxes, however you want to think of it. Children are the responsibility of the state, and then they have about 25 or 26 different insurance plans. But the rates at which providers are paid are set by the national health board, and similar things happen in other countries as well. I think the way to think about what's happened here in Massachusetts is that the Connector is allowing people who work for small employers to break away from the idea that only the employers are responsible or the organizing force for health insurance. HealthPass New York is really the model for this — the employer pays into the Connector which is gathering up premium money from many employers, which is just like what happens in the Netherlands. Then the employees can choose whichever health plan they want. This step has been missed by most people thinking about what's going on here in Massachusetts.

I think employers want to get out of being in the business of paying for health insurance as fast as they possibly can. This is going on across the country, not just Massachusetts. That's why this conversation is really accelerating about what share of health insurance costs do we want employers to pay. I don't think we want employers to get off the hook on this. They are benefiting from having very healthy employees and having healthy children who will become healthy employees. They have a role here, too. So, in that sense, we are moving toward a universal payer.

In answer to Bud's question, I think that we cannot be controlling healthcare costs without having what looks like Medicare setting reimbursement rates and saying everybody's in this tent together. What's really driving our healthcare expenditures are, as Lisa said, the high cost, high-tech procedures, and diagnostic tests, like radiological scans. Why are we paying radiologists so much more than we are paying primary care physicians?

Having that kind of conversation along with discussions about how we will pay for healthcare is what we are moving toward, and I think we will do it within this decade. I also think employers want out of paying for health insurance, and therefore the rest of us have a responsibility to set the structure of that conversation and not let the employers get out of paying a share of the costs for health insurance in this country.

Julie Silverhart:

I'm Julie. I'm originally from New Mexico and came to Massachusetts for my medical training. Currently I am doing a geriatric fellowship and am the coordinator of Massachusetts Physicians for a National Health Program. I realized sitting here that I've never tried to understand how a liberal-minded person, especially a bright group like you who are health policy specialists, could miss the boat on why single payer is our country's only viable option. I understand why a chief executive office of an HMO [healthcare maintenance organization] supports our current for-profit health insurance system since he/she has much to gain with respect to his/her paycheck. Similarly, it makes sense that Blue Cross/Blue Shield shareholders must be ecstatic about our Massachusetts health reform bill because Massachusetts HMOs will get "subsidized" a significant sum of money by having this mandate on the poor and near-poor people. That is, our state will force individuals to buy inferior quality health insurance, those individuals who can't afford that premium might get some government assistance, and the HMOs make out like bandits because they have a captive pool of insurance buyers getting government assistance to further fill HMO purses.

I also don't understand how you can say it would be so difficult, complicated, and impractical to switch over to a single-payer system, when what we have right now is both incredibly complicated and completely inadequate. Our current healthcare system commits countless injustices to Americans and is wasting money that we don't have. Many of us here are physicians and have seen people who are not able to get the care they need because they don't have insurance. It is wrong to force these people to spend their already meager incomes on health insurance that we know will have high deductibles and be lacking in many areas.

I disagree with Katherine Swartz's earlier comment that because this reform, our "baby," is better than what Wyoming offers its residents, we should therefore be pleased with ourselves. I agree with Dr. Marcia Angel, that you're not saying much when your claim to fame is being "better than awful."

As I stand here with my two-month-old infant, I remember the preparations I made for his arrival. I worked hard to do things right for him and give him the best possible beginning in life. I wouldn't have been

happy to just offer him a bit better than "awful." If we have the ability to do something to switch, to make a change, then why don't we put our energy into the right place and move forward united for a single-payer system? Research has shown that the majority of doctors and the majority of the American population want a single-payer system. So when there's popular support, when we know that it would save money and provide care for everyone, I'd like to understand why you're putting your efforts into this reform that takes us further from single payer, as it just digs a deeper hole of debt for individuals, our state, and a bigger purse for HMOs?

Katherine Swartz:

Me?

Julie Silverhart:

Both of you. Why aren't you for single payer? Was there some shift that changed you from single payer?

Katherine Swartz:

I think you missed part of where I am. I was very careful to say that I'm not saying I do not want a single-payer system. I'm saying, "Think of this as a strategy game," and we have a game plan that will take us out over another decade. The goal is to think through how we are going to achieve universal coverage. I want greater access to healthcare. As for what is going on in Massachusetts, people are getting subsidies to purchase policies — that's the first thing.

Second, the deductibles are much higher than I think most people on the Connector board expected to have when they started working out the details of the Massachusetts plan. But the deductibles exempt three visits to a physician per year, so the Connector is clearly saying they want to make sure that people will come in for preventive care. And if you get sick, three visits total per year ought to cover at least one sick visit. After three visits, you have to pay the deductible. I may be wrong on this, but I believe that maternity care is totally taken care of under this. So don't get caught by thinking that the deductibles are terribly onerous.

The third point I want to make about this is that the Connector is being very careful about affordability issues and who will not be able to afford policies sold in the state. For people whose incomes are just above where the subsidies go away, the Connector is making exceptions. They are agreeing that the policies are not affordable for some of these people.

What do I expect will happen this next year? The Connector will increase the subsidy level, and they will make arrangements for these people to get some other kind of coverage. So it's not so white and black — this is very nuanced.

I was not on the Connector board, and I don't mean to defend everything they have done. But I think you have to see what they have done as an enormous effort to try to be fair to all sorts of people and that, although there are problems, the Connector and others are going to attack those problems one by one.

And meanwhile, we really need to be paying attention to the fact that more and more employers in the United States want to limit what they are paying for employer-sponsored health insurance. We ought to be thinking about what we want employers to contribute for our healthcare. They are going to benefit from a healthy population and work force. I sound like a broken record here — but I think this is the bigger issue that is overtaking us without our realizing it.

Lisa Lehmann:

Thank you. Please join me in thanking our panelists for a very lively and engaging conversation. *[Applause]*

NOTES

1. "Income, Poverty, and HealthInsurance Coverage in the United States: 2005, Table 8," *http://www.census.gov/hhes/www/hlthins/hlin05.html.*

2. K. Swartz, *Reinsuring Health: Why More Middle-Class People Are Uninsured and What Government Can Do* (N.Y.: Russell Sage Foundation Press, 2006).

3. Current Population Survey is a joint effort of the U.S. Bureau of Labor Statistics and the U.S. Census Bureau, *http://www.census. gov/cps/.*

4. Quotation is presented as a statement by an unnamed legislator to *Boston Globe* reporter Joan Vennochi in M. Angell, "Healthcare plan needs dose of common sense" (editorial), *Boston Globe,* 17 April 2006, *http://www.boston.com/news/globe/editorial _opinion/oped/articles/2006/04/17/healthcare _plan_needs_dose_of_common_sense/.*

5. Commonwealth Health Insurance Connector board director Jon Kingsdale, quoted in A. Dembner, "Sticker shock for state care plan: Average premium of $380 outlined," *Boston Globe,* 20 January 2007, *http://www.boston.com/news/local/articles/2007/01/20/sticker_shock_for_state_care_plan/.*

6. A. Debner, "State may give insured more time to upgrade," *Boston Globe,* 16 March 2007, *http://www.boston.com/news/local/articles/2007/03/16/state_may_give_ insured_more_time_to_upgrade/.*

7. D. McCormick et al., "Single Payer National Health Insurance Physician's Views," *Archives of Internal Medicine* 164 (2004): 300-4.

8. "Creative Destruction at Chrysler" (editorial), *Boston Globe,* 16 May 2007, *http://www.boston.com/business/articles/2007/05/16/creative_destruction_at_chrysler/.*

9. "Harry and Louise" is the name given to a television commercial that was paid for by a health insurance industry lobbying group in opposition to the Clinton proposed healthcare plan. It featuring a middle-class couple portrayed by actors Harry Johnson and Louise Claire Clark.