

Covering the Uninsured:

Costs, Benefits, and Policy Alternatives for New England

New England Public Policy Center
December 5, 2006
Conference Report 06-1



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Acknowledgements

This report would not have been possible without the outstanding comments and suggestions I received on earlier drafts. I thank Lynn Browne, Carrie Conaway, Phil Primack, Alicia Sasser, Katherine Swartz, and Robert Tannenwald for their support and insight.

—MPN



Covering the Uninsured:

Costs, Benefits, and Policy Alternatives for New England

by Matthew Peter Nagowski

Executive summary

On December 5, 2006, the New England Public Policy Center at the Federal Reserve Bank of Boston convened a policy symposium, “Covering the Uninsured: Costs, Benefits, and Policy Alternatives for New England.” As a growing number of Americans find themselves without health insurance, New England states are exploring innovative policies aimed at extending coverage. But the high cost of expanding coverage raises difficult questions about how best to improve access while preserving individual choice and maintaining quality of care.

The conference, which brought together a select group of stakeholders from all six New England states as well as representatives from national organizations, featured lively discussion and debate about the merits of various policy alternatives and funding mechanisms. Differing viewpoints among policymakers, insurers, doctors, hospital administrators, employers, public health advocates, and health policy researchers provided a frank and productive dialogue throughout the day. This report is a synthesis of the conference’s major themes.

Conference highlights include:

- The ranks of America’s uninsured have increased steadily over the past quarter century. In 2005, nearly 47 million Americans were uninsured, representing close to one-sixth of the nation’s population. The uninsured suffer from high levels of economic insecurity and poor health outcomes, placing large costs on the U.S. economy.
- As expanding health insurance coverage has been a low priority policy issue in Washington in recent years, states—especially in New England—are leading the nation, engaging in creative policies to expand coverage. But challenges remain for policymakers to actually implement reform measures.
- Expansions in state coverage require additional public funding. States are finding funds in such disparate resources as uncompensated care pools, tobacco settlements, and employer fees. Many reform plans are funded on the belief that coverage expansion will realize overall cost savings since hospitals will no longer have to incur large costs for bad debt and charity care, and that premiums will be lowered as currently uninsured, young, healthy, and low-cost individuals diversify the risk pool.

- Success in extending coverage depends upon making health plans affordable enough so that individuals and families can obtain coverage without undue financial burden. To ensure participation, state administrators must become successful marketers, targeting often hard-to-reach uninsured populations through effective channels of communication to convince them of the benefits from coverage.
- Key issues in establishing affordable and desirable health care coverage are the arrangement of the health insurance plans' benefits, premiums, deductibles, co-insurance rates, and the extent of the provider networks. The interaction of these plan characteristics and cost structures affects the affordability and desirability—and therefore success—of any attempt to expand health care coverage.
- Conference attendees expressed concern over whether true reform and coverage expansions are possible without curtailing the pace of health care spending. One key way policymakers hope to constrain costs is by more effectively managing expensive chronic care patients. Furthermore, coverage expansions will allow newly insured individuals to receive routine medical care, reducing their reliance on expensive emergency room visits.
- Policymakers must be mindful of market trends that can affect the implementation of reforms. The advent of retail clinics, for example, may erode traditional point-of-contact arrangements between primary care providers and insurers. Similarly, innovative health information technologies may affect the structure of provider and insurer networks.
- Participants agreed on three broad prerequisites necessary for states to adopt policies that extend coverage: money, political will, and a culture of trust. Clear incentives must exist for any reform to go forward, and all stakeholders must support and implement policies by acting in good faith with each other.

AN INTRODUCTION

BROAD, SECULAR TRENDS IN THE UNITED STATES ECONOMY CONTINUE TO UNRAVEL THE POST-WORLD WAR II RELATIONSHIP BETWEEN EMPLOYER AND EMPLOYEE, WHEREBY WORKERS OBTAIN GROUP HEALTH INSURANCE THROUGH THEIR EMPLOYERS.

The result has been an increasing number of uninsured Americans. Health care reform—including expanding coverage to the uninsured—is one of the major challenges facing American families and the economy.

Although President Bush recently proposed a change in tax laws affecting health insurance in his 2007 State of the Union address, health insurance coverage has been a low-priority policy issue in Washington in recent years. Consequently, states have been grappling with the challenge of covering the uninsured. As Joe Quinn, Wal-Mart Stores' Director of State HealthCare Policy said, "The real healthcare dialogue in this country is being driven by CEOs and governors. The most innovative and aggressive programs in recent years have come from the private sector and individual states." Business and political leaders are responding to public pressures to ensure access to health care. New England states are leading the nation, engaging in creative policies to expand coverage, and conference participants were eager to discuss the issues affecting their respective states.

Despite significant progress toward agreement on what might expand coverage, many difficult challenges remain for policymakers to actually implement reform measures. These include obtaining funding for coverage expansions, establishing affordable and desirable health care plans that ensure participation, and balancing the levels of personal choice and risk that the health care system can sustain. Moreover, these challenges come amid concerns

over large increases in health care spending and the changing ways in which health care is provided.

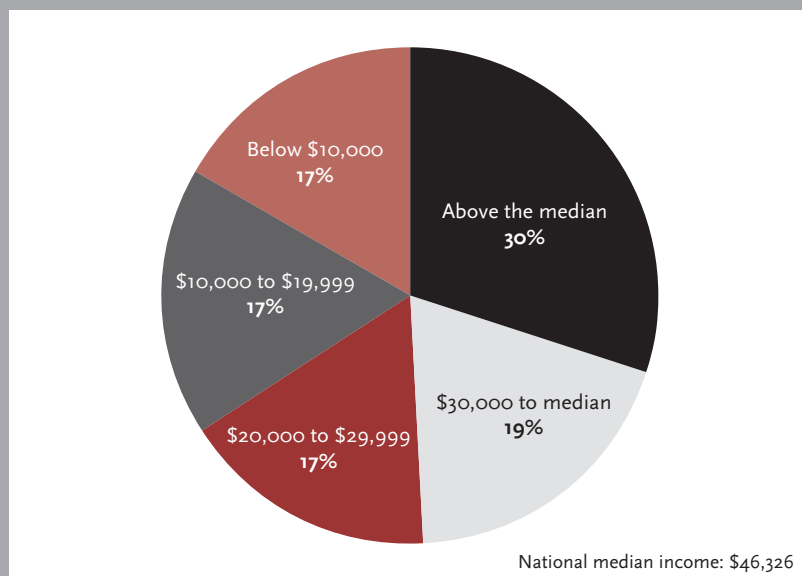
Paying for the expansion in coverage

Paying the full cost for health insurance is not within the budget of most uninsured families, including many middle-income households. Therefore, if coverage is to be expanded to uninsured residents, states will either need to expand entitlement programs, such as Medicaid or State Children's Health Insurance Programs (SCHIP), or they will need to subsidize insurance premiums in the private market. Either way, any expansion in coverage will likely require additional public funding.

Lack of health insurance is not just a problem for the poor

IN 2005, 30 PERCENT OF THE UNINSURED NATIONWIDE LIVED IN HOUSEHOLDS EARNING GREATER THAN THE MEDIAN HOUSEHOLD INCOME.

Distribution of uninsured by household income, 2005



Note: Limited to individuals under the age of 65.
Source: Current Population Survey

Over the long term, any sort of fiscal stress will affect a state's ability to expand coverage.

In New England, several states have turned to one-time sources of revenue to initially fund coverage expansions. For example, Maine, Massachusetts, and Vermont have redistributed federal funding obtained through Medicaid waivers to expand eligibility and coverage to certain segments of the population. Maine, Rhode Island, and Vermont have used their tobacco settlement allocations to seed partial funding.

A problem with one-time sources of revenue is that when they run out, states may need additional money to sustain expansions in coverage. With this in mind, Rhode Island has created a trust out of its tobacco settlement to fund in perpetuity a program to reduce the health insurance premiums for small businesses. Other states have implemented or are exploring excise taxes on tobacco to fund coverage expansions.

One New England state—Massachusetts—is using a unique source of revenue to fund its coverage expansion, gradually tapping its \$693 million uncompensated care pool. Massachusetts' pool—the only one of its kind in the nation—is funded by assessments levied on hospitals and insurers. The money in the pool was previously used to reimburse hospitals and health care clinics for services that were provided to uninsured individuals. In redirecting these funds from care to insurance coverage, it is unclear how much revenue individual hospitals and clinics may lose and whether they will be able to continue to provide care in the face of such losses. “This issue,” said Nancy Turnbull, President of the Blue Cross Blue Shield of Massachusetts Foundation, “is so touchy that nobody wants to directly answer questions about it.”

Many reform plans are funded upon the belief that coverage expansion will induce more cost savings because hospitals will no longer have to incur large costs for bad debt and charity care and more of the uninsured will receive routine medical care, which will reduce their reliance on expensive emergency room visits. Combined with a diversi-

fication of the insurance risk pools through the addition of relatively young and healthy uninsured populations, states are hoping that these savings will curb the growth of private insurance premiums and allow for future coverage expansions.

However, states will encounter significant fiscal difficulty if such cost savings fail to materialize. In Maine, the DirigoChoice plan was designed to be partially funded by an assessment on the amount of cost savings the insurer saw as a result of providers reducing their fees in response to less charity care and bad debt. But disagreement over the size of the cost savings and the subsequent size of the assessment ultimately ended up in court. Currently, Maine is searching for new sources of funding for its fledgling plan.

Employers are another source of potential revenue for states. Health care legislation passed in Massachusetts and Vermont in early 2006 requires annual fees of \$295 and \$365 per full-time employee, respectively, to be paid by employers that do not offer health benefits to their employees, subject to some exemptions. But these assessments are not large enough to cover the complete cost of expanding coverage to employees who are not offered insurance, especially as the cost of health insurance continues to rise. The current political climate makes the possibility of higher taxes to pay for coverage unlikely.

Businesses may respond by encouraging eligible employees and their dependents to enroll in Medicaid and SCHIP. Commenting during the second panel discussion at the conference, Trish Riley, Director of the Governor's Office for Health Policy and Finance in Maine, wondered whether increased coordination between large employers and the state would address this contentious issue. For example, it might be more efficient if coverage for low-wage and part-time workers were administered through a Medicaid program, with partial funding from employers.

As long as health care spending decelerates and state revenue collections remain strong, state fiscal conditions for coverage expansions remain on steady ground. But over the long term, any sort of fiscal stress will affect a state's implementation of reform and expansion of coverage, especially as aging Baby Boomers place additional pressure on the health care system. Moreover, a significant amount of funding for state coverage

Who are the uninsured?

Katherine Swartz, Professor of Health Economics and Policy at Harvard University's School of Public Health, gave a keynote presentation on the growing ranks of the uninsured. Her remarks were based in part on her book, REINSURING HEALTH: WHY MORE MIDDLE-CLASS PEOPLE ARE UNINSURED AND WHAT GOVERNMENT CAN DO, published by the Russell Sage Foundation in June 2006.

Over the past quarter century, the ranks of America's uninsured have increased steadily. In 2005, nearly 47 million Americans were uninsured, representing close to one-sixth of the nation's population. However, it is not the country's elderly or most needy that lack health insurance. The federal entitlement programs of Medicare and Medicaid cover these members of society; it is working households that have experienced the most erosion in health care coverage.

While individuals with less than a college education continue to comprise the majority of the uninsured, erosion in coverage also has occurred among the well-educated and higher-income segments of the population. Swartz's presentation highlighted that over the past 25 years, the rate of being uninsured among these groups nearly doubled; currently, 30 percent of all uninsured individuals come from households earning more than the median household income.

Swartz attributed much of this change to the continuing decline in the provision of employer-provided health insurance, which was precipitated by the decline in manufacturing employment that began in the early 1980s. The decline in well-paying manufacturing jobs—which often came with union-backed benefits—was followed by a transition to a service-based economy, in which many more workers encountered smaller firms, increased job insecurity, and fewer benefits. Since then, employers have been increasingly concerned over the growing costs of health insurance and are leaving behind their traditional role of providing health benefits to workers.

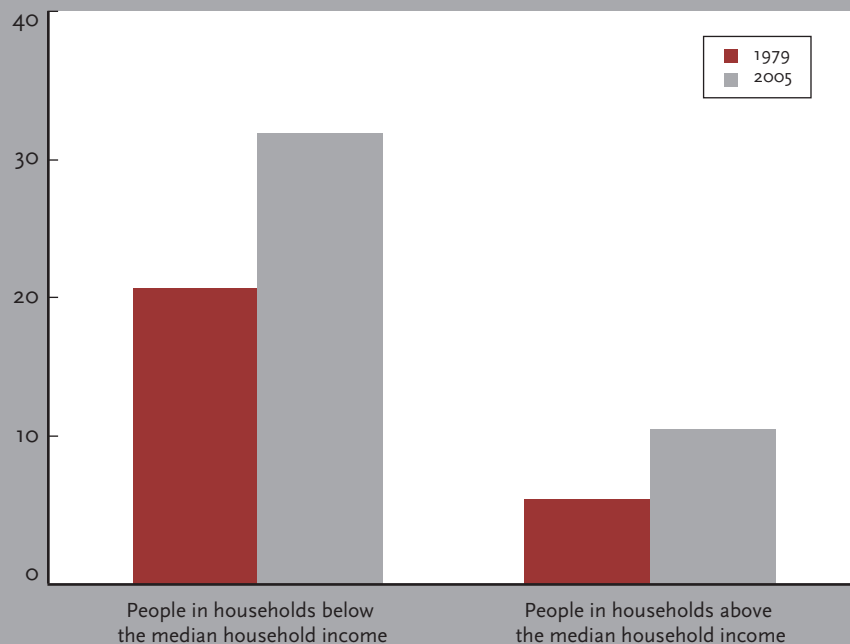
Swartz also documented the systemic change in the nature of the employer-employee relationship that has occurred over the last decade. She found that an increasing fraction of workers are self-employed or working as contractual or temporary workers and, more likely than not, lacking pensions and health benefits. These alternative work arrangements are particularly common among the nation's younger workers.

Some commentators allege that the uninsured go without coverage because they voluntarily choose to remain uninsured, believing that they are healthy, don't need coverage, and have other demands on their limited incomes (such as college or auto loans). Regardless of why the uninsured forego coverage, research shows that they suffer from negative health outcomes. A 2004 Institute of Medicine report found that the uninsured are twice as likely to be hospitalized for avoidable complications and have a 25 percent higher age-specific mortality rate than the insured, even after adjusting for their underlying health and demographic characteristics. Moreover, the report noted that the uninsured are far more likely to postpone or go without care and are especially unlikely to receive the crucial preventive care that can improve health outcomes while controlling costs.

The probability of being uninsured has increased significantly

FOR INDIVIDUALS IN HOUSEHOLDS ABOVE THE MEDIAN HOUSEHOLD INCOME, THE LIKELIHOOD OF BEING UNINSURED HAS NEARLY DOUBLED OVER THE PAST QUARTER CENTURY.

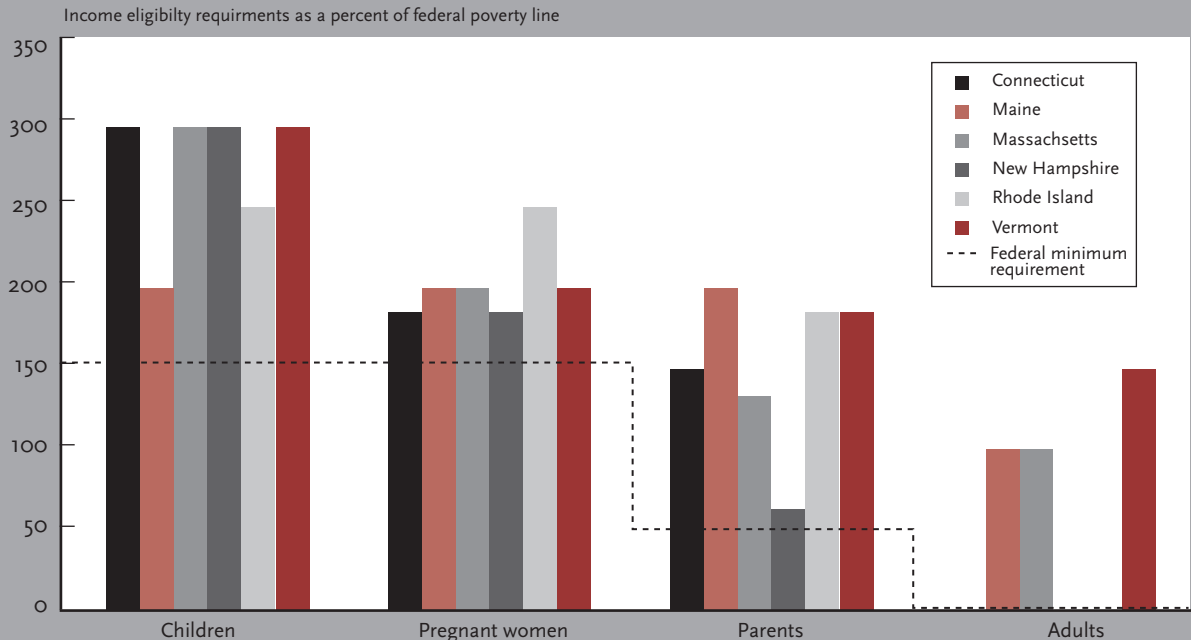
Percent of people aged 22-65 without health insurance, 1979 and 2005



Source: Current Population Survey

New England provides relatively generous health coverage for low-income individuals

MANY NEW ENGLAND STATES HAVE EXTENDED COVERAGE FOR LOW-INCOME INDIVIDUALS BEYOND FEDERAL MINIMUMS.



Source: Academy Health, 2005. Supplemented with information from state sources through December 2006.

expansions is coming from the federal government via Medicaid waivers, leaving them sensitive to the stability of federal policies and funding.

Establishing affordability and ensuring participation

Once funding for coverage expansions is secured, states still need to ensure that uninsured individuals and families actually enroll in health plans and obtain coverage. Crucial to the success of coverage expansions is enrolling the young and healthy portions of the uninsured population. Young and healthy policy holders who were previously uninsured help maintain lower average risk levels in the volatile small group and individual insurance markets and thus help keep premiums low.

Conference attendees agreed that the key ingredients of establishing affordability and ensuring participation are controlling the costs of plans and marketing them effectively. However, this has proven to be a daunting goal. In the case of Maine's DirigoChoice program, first-year participation was not as high as initially anticipated due to a number of challenges surrounding the program's implementation, including establishing its benefit structures and plan costs as well as marketing it to potential participants.

Massachusetts policymakers have adopted an individual mandate as a policy tool to ensure participation. Individuals face tax penalties if they do not purchase health insurance through either the private market or one of the means-tested health insurance plans offered by the Commonwealth Health Insurance Connector. Uninsured Massachusetts residents will face the loss of their personal tax exemptions for tax year 2007; beginning in the 2008 tax year, penalties will increase up to 50 percent of the premium individuals would have paid if they had purchased health insurance. However, because the cost of the penalty will be less than the actual cost of obtaining coverage, some individuals may accept the penalty rather than pay for coverage.

Achieving high participation rates requires structuring the available options so that they are affordable enough to make it realistic for individuals and families to be able to enroll in the plans without undue financial burden. This means that states may need to subsidize the purchase of health insurance plans farther up the income ladder than previously considered. Subsidies to people with incomes even as high as 300 percent of the federal poverty line may not be enough to allow for health plans to be truly affordable for uninsured families.

It remains to be seen whether the uninsured will find value in the new options being offered.

Alicia Sasser, an economist with the New England Public Policy Center at the Federal Reserve Bank of Boston, noted that policy-makers also must be careful to design subsidies for coverage expansions so that there is minimal interference with the private insurance markets for health care. With significant subsidies in the individual or small-group markets, employees may choose to forego their employer-sponsored coverage, or employers may drop health benefits for their employees altogether.

Reformers also need to be mindful of the market in which they are working and tailor new health coverage products to the specific needs, interests, and profiles of consumers. For instance, Patricia Leddy, Chief of Staff for Rhode Island’s Department of Mental Health and Retardation, said one reason many eligible children under SCHIP remain uninsured is that the societal norm is to insure families as a unit, so some heads of households will not sign up their children for SCHIP unless

they can cover the entire family. Recognizing and responding to such behavioral concerns is essential to the successful implementation of any health policy reform.

In the end, coverage not only has to be affordable, but uninsured individuals and families must also become convinced that they will benefit by enrolling for coverage. State administrators need to become successful marketers and advertisers, targeting often hard-to-reach uninsured populations through effective channels of communication, to ensure program participation.

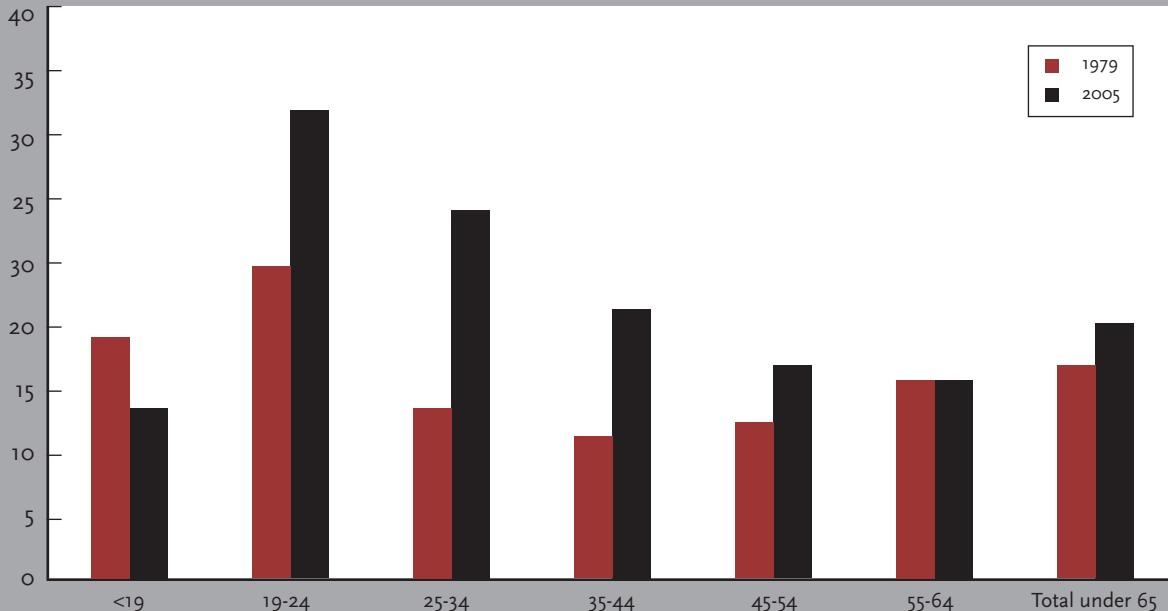
Managing the roles of choice, risk, and adequacy

A key issue in establishing affordable and desirable health care coverage is the arrangement of the health insurance plans’ benefits, premiums, deductibles, co-insurance rates, and provider networks. The interaction of these plan characteristics and cost structures affects the affordability and desirability—and therefore success—of any attempt to expand health care coverage. It also determines the amount of choice offered to individuals and the amount of risk that individuals may assume for their health benefits and coverage. Conference participants disagreed over the

The young are increasingly likely to be uninsured

ADDING YOUNGER, HEALTHIER PEOPLE TO THE INSURANCE SYSTEM WILL REDUCE THE LEVEL OF RISK IN THE POOL AND DISTRIBUTE COSTS AMONG MORE INDIVIDUALS.

Percent of people without health insurance by age, 1979 and 2005



Source: Current Population Survey

role that personal choice and responsibility should play in expanding health care coverage. Some noted the tendency of personal bankruptcies to occur under the weight of large health care bills and questioned how vulnerable individuals should be to extremely high deductibles or co-insurance rates. Others expressed concern over the level and quality of care that certain low-premium plans might afford beneficiaries.

In response to such concerns, Jon Kingsdale, Executive Director of the Massachusetts Commonwealth Health Insurance Connector, argued that in Massachusetts, the choices and risks that a person may assume in any expansion of health coverage will be within a highly regulated market. Strict statutory constraints are imposed on health insurers' pricing, and the state is placing a floor on what may be considered legitimate health insurance.

Indeed, states can choose to regulate the market for health insurance to ensure that consumers may only obtain coverage deemed adequate by policymakers, limiting consumers' risk exposure. However, any such mandates are likely to result in increased insurance premiums. While health coverage expansions are attempting to address this issue by subsidizing premiums for more comprehensive policies to attract more low-risk

people, it remains to be seen whether the uninsured will find value in the new options being offered.

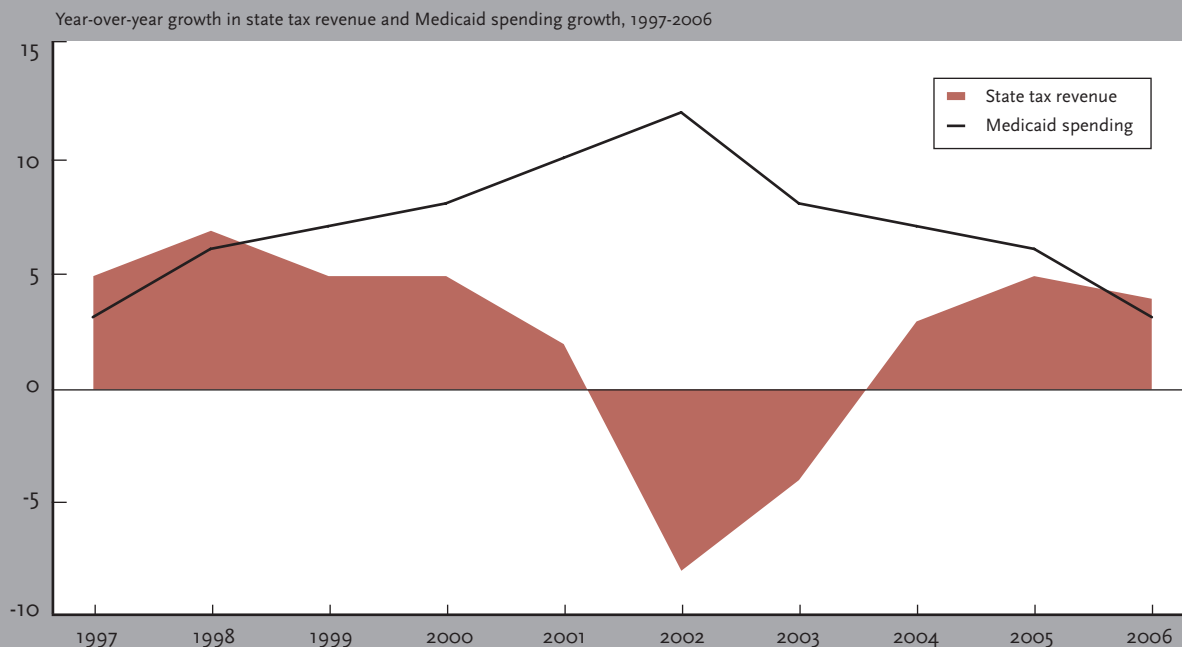
Taken together, there appears to be a large gap between what people desire in terms of health plan benefits and what they can afford or are willing to pay. Given the choice, a considerable number of individuals without coverage choose to be uninsured rather than enroll in high-deductible, low-premium options. As a result, some reformers and employers are increasingly turning to what is known as consumer-driven care, which links high-deductible plans to health savings accounts that allow consumers to save for medical expenses on a tax-free basis. Yet qualified plans with health savings accounts are currently a small portion of the market and it is questionable whether they are valuable to low-income families.

Insurers and employers must ensure that incentives are properly aligned to create a healthy, productive workforce that is able to obtain adequate preventive care. For instance, some new employer-sponsored plans offer low premiums and high deductibles complemented with front-end features such as wellness plans and a small number of pre-paid physician visits and partial prescription payments.

Still, some attendees expressed concern

Growth in health care spending is an ongoing challenge

IN FISCAL YEAR 2006, STATE TAX REVENUE GROWTH OUTPACED SPENDING ON MEDICAID FOR THE FIRST TIME IN EIGHT YEARS.



Source: Kaiser Commission on Medicaid and the Uninsured. "Results from a 50-State Medicaid Budget Survey, State Fiscal Years 2006 and 2007." October 2006.

over the wisdom of Massachusetts's mandate that all individuals purchase health insurance, questioning why policymakers couldn't trust individuals to make the best decisions for themselves. The response to this argument was that if health care coverage is going to be affordable to more of the uninsured, then individuals with low risks must be brought into the insurance system.

Can the pace of health care spending be slowed?

In the most recent round of health care policy initiatives, cost containment has taken a back seat as policymakers focus on expanding coverage. Amy Lishcko, Commissioner of Health Care Finance and Policy for Massachusetts, acknowledged that as Bay State legislators debated the state's reform, many difficult questions surrounding cost containment were left until after the legislation passed. This was done because the necessity of coverage expansion became paramount, leaving concerns regarding spending for more careful consideration by commissions with more time, information, and stakeholders present.

The bulk of health care spending is for a small fragment of the population who require extremely expensive care.

Advocates for expanding coverage believe it will lower the average cost of care. Adding healthier people to the insurance system will reduce the level of risk in the pool and distribute costs among more individuals. In addition, spending may decrease if care is more efficiently provided through primary care providers rather than emergency rooms. However, many conference attendees worried whether true reform and coverage expansions are possible without curtailing the pace of health care spending.

M. Beatrice Grause, President and Chief Executive Officer of the Vermont Association of Hospitals and Health Systems, echoed this sentiment, asserting that every stakeholder at the table needs to take a second look at the challenges and barriers to containing costs and collectively find common ground upon which spending can be constrained across the system.

One area of further reform is to address cost-shifting, whereby states, employers or individuals end up paying for the cost of caring for others through higher provider payments, insurance premiums, or Medicaid loads. Cost-shifting distorts the amount that needs to be spent on health care by different payers in the system and makes it difficult to assess the true costs of care. Similarly, if provider care were more efficiently managed so that patients got the very best and appropriate treatment, payers in the system would be less saddled by overly expensive or unnecessary procedures or prescriptions.

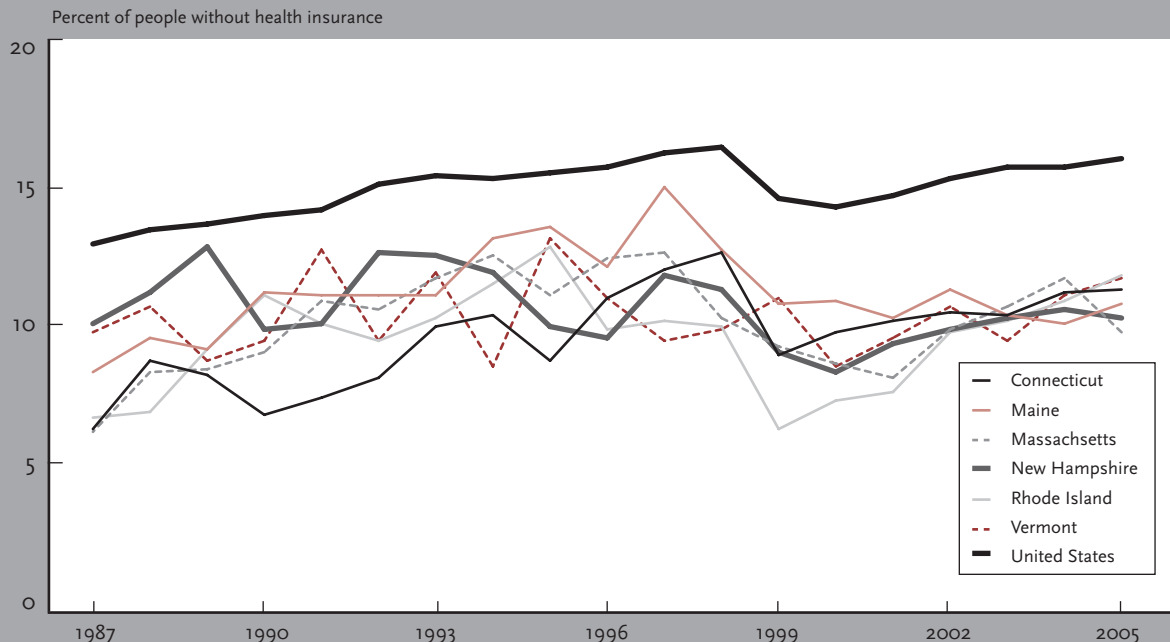
Because the bulk of health care spending is for the small fragment of the population requiring extremely expensive care, some of whom have chronic conditions, better management of their care would help curtail spending. Policymakers are responding by attempting to establish guidelines for chronic disease management and to ensure that patients receive the right care at the right time. In Vermont, the Blueprint for Health aims to get providers and insurers to cooperate and find innovative solutions to care while providing the support needed to help doctors and patients effectively manage chronic disease. And the Maine Quality Forum, a component of Dirigo Health, was conceived as a mechanism to monitor the quality of care and to ensure that best practices are adopted across the health care system.

One solution to the risk of costs due to extremely expensive patients was offered by Katherine Swartz, Professor of Health Economics and Policy at Harvard University's School of Public Health. She proposed government-sponsored reinsurance pools for the individual and small-group insurance markets that would allow the government to take over most medical expenses for the small number of people who require extremely expensive care in any given year. Such an arrangement might allow for significantly reduced premiums within those markets, as insurers would no longer be responsible for bearing the financial risks of having to pay for high-cost patients.

Some conference participants were skeptical of incremental solutions to controlling spending. The wide disparities in health care costs across different geographic areas of the country, combined with the large differential between how much the United States spends on health care compared to other

New England is better-insured than the nation

HOWEVER, THE RATE OF UNINSURANCE IN NEW ENGLAND HAS BEEN INCREASING SINCE 2000.



Source: U.S. Census Bureau, Current Population Survey, Historical Insurance Tables.

countries—with no significant difference in terms of health outcomes—suggest that significant cost savings will not be achieved until the administration and provision of health care, including the adoption and use of new technology, is more effectively managed and streamlined. Tess Stack Kuenning, Executive Director of the Bi-State Primary Care Association, said that she would look forward to “much larger change in terms of the payer system,” due to the hundreds of payers with whom the system currently must deal.

Reform amid a changing landscape

Because the market for health care is always changing, policymakers need to be mindful of trends that can influence the trajectory of reforms. For instance, an increasing shortage of primary care physicians may result in limited access to services, despite expansions in coverage—a concern that especially reverberates in rural areas and as the Baby Boomers age. As retail clinics become increasingly popular providers of basic care, an individual’s primary interaction with the health system may be limited to walk-in visits with a nurse practitioner. The adoption of low prescription prices offered by large retailers, such as Wal-Mart, is another development that policymakers should watch. These mar-

ket changes, among others, can significantly affect the framework for expanding coverage in the future, especially if they erode the demand for health insurance among certain segments of the population or weaken the traditional point-of-contact arrangement between primary care providers and insurers.

The role that personal responsibility should play in remaining healthy is also becoming a significant issue. Policymakers and insurers are increasingly adopting incentives for people to try to stay in good health, paying people to join fitness clubs or to have a yearly physical. Similarly, health care plans may start penalizing individuals for maintaining poor health habits. Of course, these types of developments will lead to ethical issues as researchers uncover more predispositions to certain behavioral outcomes or health conditions. Nonetheless, a growing view sees the causes of many health conditions as public health issues that states should take the lead in addressing. For example, Vermont’s recent health care legislation created a Blueprint for Health to address chronic disease among state residents. Public smoking bans across the country and New York City’s recent ban on trans fats epitomize this development.

A final change on the horizon for health care reform is the implementation of infor-

mation technology, which will allow for the seamless transfer of medical records for patients, providers, and insurers across geographic regions. A planned health information exchange among Maine, Vermont, New Hampshire, and Massachusetts hopefully will lead to significant cost savings in terms of administrative and back-office work.

Dr. James Mongan, President and Chief Executive Officer of Partners HealthCare, predicted that the future will bring large, regionally based networks of providers and insurers that will be able to curtail costs

Transparency from stakeholders will allow for the proper evaluation of policy reforms.

through economies of scale, effective use of health care information technology, and managed care. Already, large health care systems, such as the Veterans Administration and Kaiser Permanente, are leading the way in this area, documenting cost savings and better health outcomes in the process.

Moving forward

Alan Weil, Executive Director of the National Academy of State Health Policy, stressed the daunting challenges facing health care reform and that “there are at least as many steps backwards as forwards. You just hope that you get enough forward in a row that it feels like you’re actually getting somewhere.” Recent reforms across New England are experiments, and policymakers are keeping their expectations of success intentionally low, although they would like to be pleasantly surprised.

As reform is implemented and inevitable problems arise, transparency from all stakeholders involved will allow for a proper evaluation of the workings of the system. Robust data collection and research on enrollment, participation, and health outcome trends will be critical to conceive and implement further reforms, whether at the state or the national level.

Several items of consensus surrounding the passing of health care reform legislation emerged during the course of the day. Most attendees agreed with John McDonough, Ex-

ecutive Director of Massachusetts’s Health Care for All, that states require three key factors to extend coverage to the uninsured: money, political will, and a culture of trust.

Given the current system, *more money* is needed to achieve the desired expansions in coverage. Funds are being shifted or more money is being sought to cover segments of the uninsured population. Even with these up-front costs, though, policymakers hope that coverage expansions will lead to health care cost curtailment in the long run.

For states that have enacted legislation, policymakers found the *political will* to prioritize the issues of coverage and access to care. In order for meaningful change to be achieved and for reform to be sustainable, all stakeholders—including employers, insurers, providers, and public officials—must negotiate policy options in good faith to address the problem of the uninsured. Often, health care advocates are able to inspire the political will necessary to achieve reform.

One reason why health care reform is so complicated is the multitude of payers and interests in the health care system. Costs in one part of the system amount to revenues—and jobs—in other parts of the system. Given conflicting interests across stakeholders, a *culture of trust* must exist across all parties if reform is to progress. As Erin Hoeflinger, President of Anthem Blue Cross Blue Shield Maine, stressed, no single player in the system is the sole culprit for the challenges the system faces, and reform must not be a “witch hunt” among competing interests if it is to succeed.

The U.S. health care system comprises a dynamic and diverse nexus of stakeholders that are constantly looking to improve health care outcomes for patients. Indeed, through its life-saving advancements in medical technology and care-giving, which stretch the length of healthy lives, it is an innovative engine of economic growth. But as with so many issues of public policy, the health care system presents reformers with complex tradeoffs. For any successful reform to go forward, necessary incentives must exist for change to occur, and all stakeholders must support and implement policies by acting in good faith with each other. Leadership demonstrated by the New England states will undoubtedly help to inform future health care reform across the country. ■

Speakers and moderators

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Erin Hoeflinger

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Jon Kingsdale

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Tess Stack Kuenning

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