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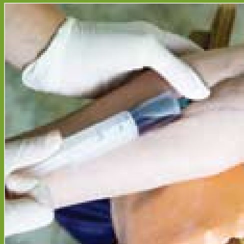
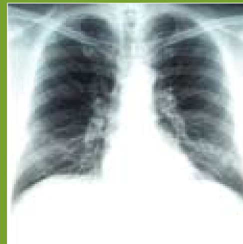
Access to Universal Health Care:

New Jersey, the Nation, and the Globe

POLICY RESEARCH INSTITUTE
FOR THE REGION

RICHARD F. KEEVEY, DIRECTOR

DALE SATTIN, ASSISTANT DIRECTOR

THOMAS HALE, EDITOR

PRINCETON UNIVERSITY
WOODROW WILSON SCHOOL
of Public & International Affairs

This Executive Summary of the proceedings offers an overview of the symposium. A complete report on the conference will be published at a later date.

Access to Universal Health Care:

New Jersey, the Nation, and the Globe

September 12, 2008

Richard F. Keevey, Director

Dale Sattin, Assistant Director

Thomas Hale, Editor

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The Policy Research Institute for the Region was established by Princeton University and the Woodrow Wilson School of Public and International Affairs to bring the resources of the University community to bear on solving the increasingly interdependent public policy challenges facing New Jersey, metropolitan New York, and southeastern Pennsylvania.

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Woodrow Wilson School of Public
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Princeton University
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Princeton, N.J. 08544

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Preface

Universal health care has been a topic of heated debate and controversy since the Clintons' unsuccessful plan to revamp the U.S. health care system. In 1993, President Clinton addressed the nation saying, "Millions of Americans are just a pink slip away from losing their health insurance, and one serious illness away from losing all their savings" and announced the formation of a Health Care Reform Task Force to be headed by Hillary Clinton. By 1994, the resulting litigation over closed-door meetings, protests from both Republicans and Democrats, counter-proposals, and the famous Harry and Louise ads paid for by the Health Insurance Association of America ensured that the proposed universal health care plan would not be passed.

In 2008, the climate in the country has changed considerably. The rising numbers of uninsured Americans; the fear of losing one's job and employer-provided health care benefits along with it; the escalating costs of co-payments and deductibles; all have led people to believe that the system is broken and that an effective national health care policy must be formulated and implemented.

As employers are finding it necessary to raise employees' premiums and deductibles, reduce coverage, or even eliminate health benefits, individuals who try to buy health insurance on their own find it even more difficult as premiums for individuals are unaffordable for many; and insurance companies "cherry-pick" whom they will cover, excluding applicants who are already sick or who have pre-existing or chronic medical conditions.

There are many suggestions of ways to go about expanding and improving health care in the United States, while also addressing the ever-increasing burden of escalating costs. There is growing support for a national system of universal health care modeled on the Massachusetts program, a system mandated under Republican governor Mitt Romney, which provides universal coverage through mandates, subsidies, and alternative risk pools.

Another suggestion is to implement a voucher system, establishing state or regional insurance exchanges that would pool small groups and individuals so that the premiums could be kept down. The voucher system would require insurance providers

to accept everyone, but would offset the higher costs to the companies by paying them more money for high risk enrollees.

It is not just the cost of insurance coverage that has risen precipitously, but health care costs in the United States are also increasing at twice the rate of inflation. Current health care costs are 17% of the GDP. By 2025, the CBO estimates that percentage to increase to 25%, reaching 49% by 2082.

Policy Research Institute for the Region director Richard Keevey noted that "Universal health care touches one of the deepest nerves that runs through public policy on the state, national, and international arena… Over 15% of Americans had no public or private health insurance in 2007, totaling close to 46 million people."

A recent GAO report addressed the challenges to state and local governments arising from the increased cost of health care, and recommended that the federal government establish a supplemental assistance program through the Medicaid system to help states during times of economic downturn.

Some of the suggested recommendations for keeping health care costs down include the use of electronic records, evidence-based health care systems, similar to that of the United Kingdom, and increased emphasis on preventive medicine.

It is evident that there are many problems and many differing opinions on how to deal with the issue of health care, but one point of agreement is that this is a policy issue of vital importance to the nation and the region that will be a top priority for the new Obama administration.

On September 12, 2008, The Policy Research Institute for the Region (PRIOR) and Princeton's Department of Molecular Biology cosponsored the forum, "Access to Universal Health Care: New Jersey, the Nation and the Globe," bringing together experts from the region and the nation to discuss this pressing issue.

The forum was divided into four sessions- the first session focused on universal health care in New Jersey and featured New Jersey Senator Joseph Vitale, the Chair of the Health, Human Services and Senior Citizens Committee, Heather Howard, Commissioner of the New Jersey Department of Health and Senior Services, and

Christine Stearns, the Vice President for Health and Legal Affairs, New Jersey Business and Industry Association.

Session two's discussants addressed the topic of world-wide universal health care and included Uwe Reinhardt, James Madison Professor of Political Economy at the Woodrow Wilson School, Princeton University, Maggie Mahar, Fellow at the Century Foundation, and Ezekiel Emmanuel, Chair of the Department of Bioethics at the National Institutes of Health.

The luncheon keynote address was delivered by Len Nichols, Director of the Health Policy Program at the New America Foundation.

The final session focused on universal health care in the nation and the Massachusetts experience. Panelists included Nancy Turnball, Associate Dean for Education Policy at Harvard's School of Public Health, Brian Rosman, Director of Research, Health Care for All, and Merrill Matthews, Jr., Director of the Council for Affordable Health Insurance.

The conference on universal health care presented various points of view, brought many questions to the fore, and provided a venue for academics, practitioners, and community members to discuss a topic that is of paramount importance to all of us.

The following executive summary and agenda of the proceedings offer an overview of the symposium- a complete report on the conference will be published at a later date.

Special thanks are offered to Thomas Hale for his work on this publication.

Sincerely,

Richard F. Keevey, Director

Access to Universal Health Care:

New Jersey, the Nation, and the Globe

September 12, 2008

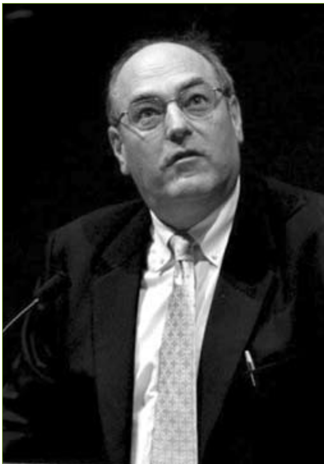
Executive Summary

In the United States today 47 million individuals lack health insurance. Some 1.3 million of them live in New Jersey. The United States is the only wealthy country in the world that does not provide universal access to health care, and yet it spends far more per capita than any other country—nearly one dollar in every six—on the health care system. The American system is the least fair and least efficient in the developed world.

In recent years New Jersey has made some progress on this crisis by making insurance available to all children in the state. Other states have also engaged in reforms; Massachusetts, for example, has created a universal access system for all citizens. At the same time, reform seems increasingly likely at the federal level following the election of Barak Obama.

It is thus an important, even heady time to discuss universal health care, the topic of a forum convened on September 12, 2008 by the Policy Research Institute for the Region at the Woodrow Wilson School, Princeton University. The event, co-sponsored by the Princeton department of molecular biology, gathered together local and national policy experts and practitioners from government, the private sector, advocacy groups, and academia. The resulting discussion was incredibly rich, and is summarized in this document.

The forum consisted of four sessions. First, representatives from New Jersey discussed recent health care reforms in the state and prospects for expanding coverage further in the future. Senator Joseph Vitale, the principal legislative architect of New Jersey's reforms, and Commissioner Heather Howard, who directs implementation of the program, provided first-hand accounts of the issues at stake and the challenges ahead. Ms. Christine Stearns of the New Jersey Business and Industry Association complimented these views with a private sector perspective. Although agreeing in theory with the importance of universal healthcare, Ms. Stearns voiced the concerns of the business community about rising costs and their ability to afford to provide coverage for employees.



Princeton University's Dr. Daniel Notterman stated, "We believe that universal health care is the great unfinished business of our generation."

The second session turned to the global level, asking how other countries provided universal access to health care and what New Jersey and the United States might learn from them. Professor Uwe Reinhardt of Princeton provided an overview of different national healthcare systems while Dr. Maggie Mahar of the Century Foundation focused on the issue of comparative effectiveness standards. Dr. Ezekiel Emanuel of the National Institutes of Health laid out a range of options for reform in the United States informed by comparison with other countries.

Over lunch, Dr. Len Nichols of the New America Foundation gave a detailed overview of the current state of the health care debate in Washington, and speculated how it would change under a new administration (still undetermined when he spoke). Although the Democrats and Republicans approach the issue from different perspectives, there is growing acknowledgment that people cannot afford health care and that some type of government universal plan is a necessity. Nichols stated that in 2006, 17% of the median family income was spent on health care premiums and that employers are pressuring Congress to do something about their rising costs.

The last session of the day discussed the Massachusetts plan, a potential model for New Jersey in some detail. Dr. Nancy Turnbull of the Harvard School of Public Health gave an overview of the program, while Mr. Brian Rosman of the advocacy group Health Care for All gave a number of lessons that had been learned in the political process of brining universal health care to Massachusetts. Finally, Dr. Merrill Matthews, the self-described cynic in the group, spoke to the obstacles states faced in implementing systems like Massachusetts' and voiced "time will tell" skepticism about the success of the Massachusetts and similar state plans.

At the beginning of the forum, Dr. Daniel Notterman of the Princeton molecular biology department stated, "This conversation is an essential one, and our fervent hope is that this conference will move even further the discussion on how to achieve a sound and thorough basis for paying for and for receiving care." No one left the forum unaware of the massive challenges universal health entails. Participants throughout the day noted that considerations of cost, financial sustainability, the division of power and responsibility between the state and federal levels, and the sheer complexity of the American health care system make any attempt at reform staggeringly difficult. All the more impressive then, are the experiences of New Jersey and Massachusetts, where expansion of coverage has been possible. Moreover, it is all the more vital that those experiences, as well as those of other nations, be carefully understood and analyzed. As Dr. Notterman told the audience, "We believe that universal health care is the great unfinished business of our generation."

Session I:
Universal Health Care in New Jersey

Joseph Vitale

Senator and Chairman, Health, Human Services and Senior Citizens Committee, New Jersey State Senate

The discussion began, appropriately, with New Jersey Senator Joseph Vitale of the 19th Legislative District. As Deputy Majority Leader and Chairman of the Health, Human Services, and Senior Citizens Committee, Senator Vitale has been at the forefront of health care reform in New Jersey, drafting and sponsoring the KidCare and FamilyCare programs.

Senator Vitale laid the challenge before the audience in no uncertain terms. New Jersey has some 1.3-1.4 million uninsured people who fall into three basic groups: 300,000 undocumented workers and their families, 640,000 individuals who are not eligible for state or federal programs, and over 300,000 individuals who are eligible for Medicaid or SCHIP but are not yet enrolled. The Senator was emphatic that "the overall mission of our plan is to have an individual mandate in New Jersey that everyone must have health insurance." The question, of course, is how to get there.

Senator Vitale outlined a two-phase plan. Phase one, begun two years ago, focuses on children and families. The mandate signed into law this summer requires every child in New Jersey to have coverage. This program was accompanied by an expansion of the SCHIP program to allow parents living at twice the poverty line—about $42,000—to enroll as well. While this income limit, the highest in the nation, has been criticized by the federal

In his commentary, Senator Joseph Vitale was emphatic that "the overall mission of our plan is to have an individual mandate in New Jersey that everyone must have health insurance."

government, Senator Vitale argued it was justified because "it's expensive to be poor in New Jersey."

The second phase Senator Vitale envisions—providing care to the over 600,000 individuals not currently eligible for federal or state programs—remains very much a work in progress. Compared to phase one, phase two will be "extraordinarily more complicated… not just politically, but in terms of the financing," Senator Vitale noted, considering the state's dire fiscal position and the economy's gloomy outlook. Much will depend on whether or not reform proceeds in Washington, and what that reform looks like. Still, Senator Vitale thought New Jersey's accomplishments to date boded well for the state's ability to tackle the issue in the future. "You know," he told the audience, "we're the little state that could."

Heather Howard

Commissioner, New Jersey Department of Health and Senior Services

Heather Howard, the head of the state Department of Health and Senior Services, turned from the legislative to the executive side of the New Jersey experience. Howard

Commissioner of New Jersey Health and Senior Services Heather Howard noted that once people have medical insurance, they have a medical home, meaning they have access to preventative care.

praised the state's "very progressive leadership," for creating what she termed a "strong" plan. Indeed, she noted that the plan was so strong the state had had to defend it from the Bush administration, which considered its benefits overly generous.

Commissioner Howard described the New Jersey programs in detail, starting, again, with children and families. Thanks to the recent changes, Howard asserted that "any family, regardless of their income, can buy into the state program at an affordable rate. That's $137 a month, which is a lot cheaper than what insurance would be out on the individual market." The laws and programs for universal health care for children are now in place.

But having the right laws and programs is only half the battle, according to the Commissioner: "Now our job is to make sure they sign up for it." Implementation, in other words, is just as important, a theme that reappeared throughout the conference.

Commissioner Howard then spoke more generally about why universal health care, for both children and adults, is so important. First she noted that families without health care often rely on emergency rooms for what should be routine care, at great expense to hospitals and to the detriment of other people in need of emergency services.

Perhaps even more importantly, Howard noted that "once people have health insurance, they have a medical home, which means they get access to preventive care." Because preventive care is both more effective and less costly than treating problems after they develop, universal health care offers significant benefits. One of the Commissioner's statistics was particularly revealing: 96% of women who have health insurance see a doctor in the first 3 months of their pregnancy. Only 73% of women go see a health care provider in the first trimester if they don't have health insurance.

Commissioner Howard concluded by discussing challenges to future health care reform in New Jersey. First, she stated that New Jersey is actively looking at "some version of an individual mandate"—i.e. a universal requirement that New Jersey residents purchase health care—along the lines of the Massachusetts program, though she noted that "the devil is in the details." Second, she raised the issue of the 300,000 undocumented residents in New Jersey, a major and complicated challenge to coverage in the state. Last, she argued that in order for universal health care in New Jersey to be effective it must be both financially and politically sustainable.

Christine Stearns

Vice President for Health and Legal Affairs, New Jersey Business and Industry Association

Speaking directly to the issue of financial and political sustainability, Christine Stearns of the

Christine Stearns of the New Jersey Business and Industry Association argued that greater focus on cost containment would be important for the business community if and when New Jersey moves forward with universal coverage.

New Jersey Business and Industry Association then brought a private sector perspective to the discussion. Though she agreed emphatically with the previous speakers on the desirability of universal health care and its benefits, she informed the audience that there were "some doubts in the business community" over the cost of health care reform.

Echoing Commissioner Howard's claim that the "devil is in the details," Ms. Stearns asked, "How are we going to try to achieve [universal health care]? How are we going to ensure that we get more people covered at a reasonable cost? How much will it cost? Who's going to pay?" Though Ms. Stearns stated she was "long on questions and sort of short on solutions," she argued that greater focus on cost containment would be important for the business community if and when New Jersey moves forward with universal coverage.

Discussion

The wide-ranging discussion following the presentations focused on details of the broad themes the speakers raised. One set of questions concerned potential changes to the regulation of the health care insurance market. Uwe Reinhardt bluntly declared regulations that prevent companies from creating different plans for high-risk and low-risk individuals (e.g. older and younger people) "stupid." The problem, Professor Reinhardt argued, was that so-called "community-rating" programs attract and retain only high-risk individuals, limiting their effectiveness. Ms. Stearns agreed, though Senator Vitale noted that eliminating some distinctions, such as those between men and women, could lead to unfairness.

Senator Vitale then expanded on the individual market for health care—those who buy health care insurance directly from insurance companies instead of through their employers. He noted that of the 80,000 individuals who obtain health care this way, the 20,000 who buy policies that cover only basic and essential care are the only sector of the market that is growing. Overall, the market is in a "death spiral," the Senator argued, making it impossible to diffuse risk efficiently: "It's a little bit like having 60,000 18 year-olds driving Ferraris and expecting to have low auto insurance rates."

A second group of questions focused on implementation. Some audience members asked how expanding coverage will improve health care if New Jersey lacks sufficient doctors and hospitals, particularly in some subfields, to treat the number of patients. Compounding this issue is the very low reimbursement rate New Jersey has for Medicare and Medicaid, meaning doctors are often unwilling to treat many patients using these programs. Commissioner Howard responded that the new programs will feature higher reimbursement rates, hopefully giving sufficient incentives to doctors to make the plans useful. She also argued that recent hospital closings were part of a plan to match

the overall provision of resources more closely to demand by shifting capacity to where it was most needed.

Also related to implementation was the issue of cost. Several audience members asked how the state planned to control expenses while moving forward with reform, and what the role of business would be. Commissioner Howard noted the “catch-22” of health care reform is that while focusing only on costs could hamstring efforts at reform, without sufficient attention to finances reform would be impossible. Senator Vitale stressed the long-term view of cost containment, noting that preventive medicine takes a long time. “Those are generational changes. Those are cultural changes,” he said.

Ms. Stearns noted that even though it might make sense, from a purely cost-benefit perspective, for businesses to encourage employees to engage in more preventive care and to give them the health insurance to do so, many businesses cannot take that route. Small companies in particular “don’t have a lot of leverage, and they don’t really know what the answer is.” Part of the problem is “the way insurance is regulated and what we require to pay, and it’s a matter of then figuring out… how…we try to allow for more creative incentives in compensation for physicians” that emphasize early treatment.

The idea of capping the amount of treatment for some patients, particularly those close to the end of life, was also raised. Commissioner Howard stated that end-of life care needs to be reformed in New Jersey through expansion of hospice and possibly other means, noting New Jersey spends a very high amount on a patient’s last six months of life compared to other states. Senator Vitale said that the issue had not been discussed in government, and argued that everyone should be entitled to the fullest medical care possible.

Session II: Universal Health Care Worldwide

Uwe Reinhardt, Ph.D.

James Madison Professor of Political Economy, Princeton University

Professor Reinhardt placed the United States health care system in a global context, where it does not compare particularly favorably: "You take any randomly selected group of health policy analysts who spent their life doing this… no one in his wildest dreams would ever build a health system based on an employer-based system such that when you lose your job, you lose your health insurance." While the United States spends significantly more on health care than the rest of the world, we get less actual care, and we have close to 50 million uninsured citizens.

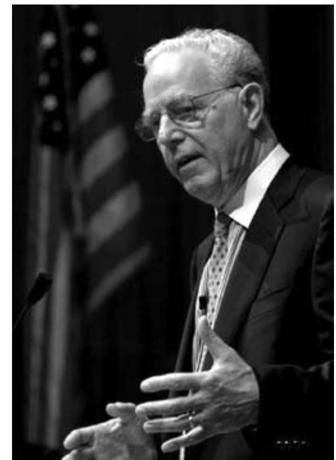
The overriding problem, according to Professor Reinhardt, is that U.S. health policy "is formulated incrementally, without the overall guide of a coherent, agreed-upon set of social goals, nor any explicit agreement on the distributive ethic the U.S. health system is to observe." The result is a piecemeal system that ranges from "socialized medicine" (e.g. the government-run hospitals in the Veterans Affairs system) to individual out-of-pocket payments for medical services to private health care providers, and everything in between.

The first priority, therefore, should be to decide what the goal of the health care system is. In most countries it is universal coverage based on the underlying principle of social solidarity. No such consensus has been reached in the United States, Professor Reinhardt believes, and it will be difficult to move to universal health care without it.

Professor Reinhardt then turned to different possible institutional arrangements for national health care systems. Health care systems must perform a number of functions, he argued, including

1. Financing Health Care (taxes, premiums)
2. Through Risk Pooling (insurance), protecting individuals from the financial cost of illness
3. Producing and Delivering Health Care
4. Purchasing of Health Care (by patients or insurers on behalf of patients)
5. Assuring adequate current and future supplies of health care resources (esp. workforce)
6. Stewardship and Governance (regulation and oversight of the system)

Countries must decide who should perform each of these functions: patients, private commercial entities, non-profits, quasi-governmental bodies, governmental bodies, etc.



Professer Uwe Reinhardt observed that U.S. health policy "is formulated incrementally, without the overall guide of a coherent, agreed-upon set of social goals, nor any explicit agreement on the distributive ethic the U.S. health system is to observe," resulting in a piecemeal system that ranges from "socialized medicine" to individual out-of-pocket payments for medical services to private health care providers, and everything in between.

Different countries assign these functions to a wide range of different actors, and examples of all of the above combinations can be found in different countries' health care systems. U.S. reform efforts, Professor Reinhardt argued, should look at what system has performed best vis-à-vis a certain goal, such as universal coverage, and strive to emulate its arrangements. Without committing to specific reform proposals, Professor Reinhardt advanced the proposition that universal coverage could be best served if the finance and insurance functions are met by government—either through public provision or rigorous regulation—and the delivery functions by private companies or non-profits.

Professor Reinhardt believes that the sheer complexity and scale of the U.S. system, combined with a general adversity to drastic change, will make health care reform and progress toward universal coverage an incremental process in this country. In the future he argues "the U.S. will preserve roughly the same mosaic of different systems we already have and merely make marginal changes at the fringes of each system."

Maggie Mahar, Ph.D.

Health Care Fellow, The Century Foundation

Dr. Mahar compared how countries decide what kinds of drugs and other medical products should be covered by insurance. The United States, she and other speakers noted, spends an enormous amount on health care while receiving worse results. Part of the problem, she argues, is that the United States allows both public and private insurance to cover the cost of products that, while making huge profit for health care companies, do relatively little for patients.

Dr. Mahar began her talk with the story of the "Bespoke Knee," an artificial knee that is marketed as specially designed for women. Dr. Mahar argued that though this product was no different than any other artificial knee, its manufacturer, Zimmer, was able to sell it for twice as much because advertising persuaded female patients that this new knee was better for them.

Dr. Maggie Mahar compared how countries decide what kinds of drugs and other medical products should be covered by insurance. She noted that the U.S. spends an enormous amount on health care, while receiving worse results.

The problem, Dr. Mahar contends, is that the United States does not require companies to demonstrate that new medical products are better than existing alternatives. To be approved they need only demonstrate that they are better than a placebo—i.e. "better than nothing." Many other countries, including Britain, Australia, Norway, and Sweden, keep national registries of data on product performance. (In the U.S. the Mayo Clinic, the VA Administration and Kasier Permanente also keeps such records.) Companies must demonstrate that their product is as good or better than alternatives in order remain on the market. By adopting a similar form of comparative effectiveness regulation, the United States could cut costs by eliminating products like the Bespoke Knee, Dr. Mahar argued. Encouragingly, there is legislation to create such a Comparative Effectiveness Institute before Congress.

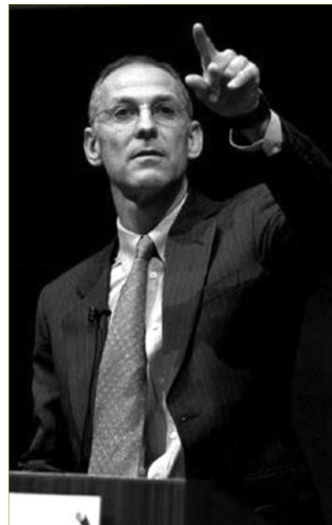
But even more helpful, according to Dr. Mahar, would be to compare the cost-effectiveness of various drugs, as the UK does. There companies must demonstrate that products can achieve equal or greater benefits for equal or less cost. This kind of testing helps a country get better value for its health care spending. Dr. Mahar believes that in order for the United States to extend health care to more of the population it will be essential to contain costs through this type of regulation. She closed her talk with a stark quote from David Mechanic's The Truth about Health Care: "At some point we as a nation will have to decide whether we wish to design our health care system primarily to satisfy those who profit from it or to protect the health and welfare of all Americans."

Ezekiel Emanuel, M.D., Ph.D.

Chair, Department of Bioethics, National Institutes of Health

Dr. Emanuel continued the discussion of cost. He noted that the only dimension in which the American health care system was number one globally was expense. The country spent some $2.1 trillion on health care in 2006, a number which is dangerously increasing every year. Indeed, Dr. Emanuel offered the audience a dire warning, "By 2050 if we don't do anything, the federal budget is just Medicare. Forget it. Education, defense, Social Security, environment, forget it."

So serious is the issue of rising costs, Dr. Emanuel believes, that it does not make sense to discuss the goal of universal health care until the issue of financial sustainability has been solved. He argues that "a 10% increase in health care cost drives down the number of people who have insurance in this country or coverage of any form by 0.55% of the total population, which is 1.5 million people." In other words, unless costs are contained the number of uninsured will continue to rise, making universal coverage increasingly difficult.



Dr. Emanuel offered the audience a dire warning on the rising cost of health care: "By 2050 if we don't do anything, the federal budget is just Medicare. Education, defense, Social Security, environment, forget it."

Echoing the comments of earlier speakers, Dr. Emanuel noted that some costs can be saved on the administration side, and, joining with Dr. Mahar, he argued that cost-ineffective procedures need to be disallowed.

Dr. Emanuel then contrasted different paths to reform. First, incremental reforms, such as digitizing medical records, expanding SCHIP to all children, or giving individuals tax credits to buy insurance, cannot resolve either the moral problem of incomplete coverage nor the fiscal problem of escalating costs. Second, mandate programs, like the Massachusetts plan, are unlikely to achieve 100% coverage, Dr. Emanuel argued, because there will always be a small group of non-compliers. Moreover, because health insurance is expensive, they also require the government to give out large subsidies to make insurance affordable. Long-term sustainability may be uncertain. Third, single-payer national health plans achieve universal coverage and reduce administrative costs by eliminating intermediating insurance companies. But Dr. Emanuel expressed

doubts that such a system would be feasible, and noted it would not necessarily reduce non-administrative costs.

Instead, Dr. Emanuel proposed a system of vouchers under which every individual would receive a coupon to obtain a standard benefits package—modeled on that for federal employees—from an insurance company. The companies would be paid a risk-adjusted premium to prevent selection. Dr. Emanuel's idea draws from the Israeli model, which he held up as an example from which to learn. In that system four competing health plans offer citizens a standardized package of benefits, determined by a central regulator. Individuals may then choose to supplement this basic coverage with other forms of insurance as they see fit.

Discussion

Two themes emerged in the discussion. First, some audience members were concerned about the role of private companies, questioning how much of health care spending becomes insurance companies' profits. Dr. Emanuel argued that profit was a minimal concern, and that we should be interested first and foremost in outcomes. Professor Reinhardt supported this view, noting that profits account for a small part of health care costs; in good years the typical insurance company makes a margin of only 5-6 percent. Dr. Mahar concurred, pointing out that insurance companies' profits depend largely on the bond markets—where they invest the money they earn in premiums—and so are not particularly relevant.

Dr. Mahar also addressed the issue of private advertising for medical products, which amounts to hundreds of millions of dollars per year. Dr. Mahar believed this was a significant waste of money, especially because it often aimed at products that were less than essential for health. She speculated that the next administration might impose new regulations on such advertising.

Second, the speakers were asked if health care reform in the U.S. could proceed on a state-by-state basis or if a national program was necessary. Professor Reinhardt argued that "Massachusetts has shown quite a bit is possible," though he noted that Massachusetts is a rich state with relatively few uninsured. New Jersey, which is also relatively wealthy, could do it as well, he argued, though he was much more pessimistic for states in the Sun Belt, which are less wealthy and have more uninsured.

Dr. Emanuel noted that state-level reform is difficult because states lack control over certain key pieces of the policy puzzle. For example, tax exemptions for employer-based coverage, regulation of employer-based coverage, and Medicare all depend entirely or in part on federal policy. "If you can't get your hands around that," Dr. Emanuel argued, "your ability to change what private insurers do is much more limited."

Session III: Luncheon Speaker

Len Nichols, Ph.D.

Director, Health Policy Program, New America Foundation

Over lunch Dr. Len Nichols of the New America Foundation spoke on the prospects for national health care reform from a Washington perspective. Dr. Nichols was involved in the failed Clinton health plan of the early 1990s. While he stated, "I'm not proud of every line in that 1500-page bill," he also claimed, "we learned a lot, we're back again, we're going to try again."

Dr. Nichols first reflected on why health care is such a pressing political issue now, in 2008, after over a decade of relative inaction. He cited two major reasons. First, as Dr. Emanuel had also stressed, the rising costs of health care are looming large in policymakers' minds. Dr. Nichols praised Peter Orszag, the director of the Congressional Budget Office, for convincing lawmakers in both parties that rising costs would be a major threat in coming years.

Second, Dr. Nichols argued that international competitive pressures have made American businesses, many of which pay for their workers' health insurance, demand reform from Washington. According to Dr. Nichols' figures American firms pay on average over 11 percent of their workers' health benefits, more than double what firms in Canada, Japan, or the UK pay.

This new attention to health care has resulted in some unusual alliances. Dr. Nichols noted that recently the heads of non-unionized Walmart and the Service Employees International Union, a fierce Walmart critic, shook hands and promised to work together on health care. If a new coalition for health care reform is forming it is coming none too soon. Dr. Nichols estimates that 18,000 Americans have died every year for lack of health care since the failure of the Clinton plan in 1994—a quarter of a million people in a decade and a half.

Dr. Len Nichols of the New America Foundation spoke on the prospects for national health care reform from a Washington perspective. He noted that now, in 2008, health care has become a pressing political issue for two reasons: the rising costs are looming large in policymakers minds, and that international competitive pressures have made U.S. businesses demand reform in order to help offset their own rising costs.

Dr. Nichols also noted shifting attitudes within both the Democratic and Republican parties that bode well for reform. "Democrats have discovered markets," he argued, while high-profile Republicans like Mitt Romney and Arnold Schwarzenegger have placed health care at the center of their agendas. "Bipartisan reform means that both parties have to see their core values reflected in the policy outcome," Dr. Nichols said. For Democrats, that "means you've got to cover everybody and you have to take particular care of the vulnerable," while for Republicans it means "you can't have bureaucrats and government dictating. You've got to have markets and real choice." While he believes a single-payer system is outside the realm of political feasibility—"forget about it"—Dr.

Nichols does think there is increasing convergence on what he calls "a new marketplace that works for everybody."

However, even these elements of an emerging consensus are no guarantee that reform will happen. Dr. Nichols next turned to a list of objections and challenges to expect in any national debate on health care. The first was, again, cost. It may be necessary to raise more revenue through taxes, Dr. Nichols suggested, though he was also encouraged by Dr. Mahar's comments on how much could be saved by moving to a more evidence-based system. "The opportunity cost is huge if we would just get our arms around it," he stated.

A second difficulty will be reforming the delivery of health care, where the mantra of the American Medical Association is, according to Dr. Nichols, "do what you want, but leave me alone." The truth, according to Dr. Nichols is that all providers are not equal, higher prices do not imply higher quality, and that health care delivery can be more evidence-based on scientific. Pushing reform in these areas will require a significant break with the status quo.

Dr. Nichols concluded by laying out the current range of reform ideas, from the Conyers plan for a universal single-payer system to the McCain plan for individual health insurance tax credits. These thoughts were necessarily speculative, coming before the November 2008 presidential election, but he did make some predictions. Given an Obama victory, Dr. Nichols thinks we will see a move toward digitization of medical records, the expansion of SCHIP, and the creation of a national comparative effectiveness institute. He also expects a substantial expansion of coverage, and thinks Senator Ted Kennedy will continue to play the lead role in Congress, though there are likely to be tensions between the House and Senate. Reforms will likely begin being phased-in in 2010.

Discussion

The question period turned to linkages between the federal and state levels. One audience member asked what New Jersey should do given the likelihood of national changes. Dr. Nichols replied that marking out the state's goals, as Senator Vitale had done, was important so that New Jersey would be in a position to get what it needed out of national reform.

Another audience member was curious what lessons could be learned from earlier attempts by Hawaii and Minnesota to provide universal coverage, noting that discussion of these experiences was largely absent from the current debate. Dr. Nichols agreed that, though none achieved universal coverage, there were valuable lessons to learn from them, chiefly that each was ultimately limited by their rising expenses.

Session IV: Universal Health Care in the Nation– The Massachusetts Experience and Other Statewide Efforts

Nancy Turnbull

Associate Dean for Educational Policy, Harvard School of Public Health

Ms. Turnbull began her comments in a spirit of "great humility." The Massachusetts reforms have expanded coverage significantly in that state, she argued, but are not necessarily replicable or appropriate for other states. Furthermore, Massachusetts has not found solutions to the intractable problems of rising costs or availability of primary care, so the audience should not see her presentation as a list of silver bullets. The long-term viability of the program is "still very much in question." However, Ms. Turnbull and her colleagues "feel very proud of the progress" made in the state, and think it provides interesting lessons to others.

Ms. Turnbull then explained the Massachusetts system in some detail. First, the state improved the availability of subsidized health insurance by expanding the state Medicaid program, extending the eligibility guidelines for children and putting people back on the rolls who had been removed during a fiscal crisis several years ago.

Second, Massachusetts created a new health insurance program called Commonwealth Care, which is available to adults living up to three times above the poverty line ($31, 000 for an individual or $60,000 for a family of four) who are not eligible for Medicaid or for employer-sponsored health insurance.

Third, the state changed the rules governing the private health insurance market by combining the individual market, where people buy their own insurance from private providers, with the small group market. As in New Jersey, the individual market in Massachusetts had become very expensive. However, it was determined that combining the 50,000 strong individual market with the 800,000 people in the small group market would bring premiums down 25 percent for individuals while not affecting the rates paid by the small groups.

Fourth, and most radical, Massachusetts required citizens over 18 years of age to buy health insurance, the crux of the plan. This mandate program is implemented through the tax system; Massachusetts citizens filing tax

returns must check a box stating whether or not they have health insurance. Those that do not will be fined a penalty of $219 initially, but potentially growing as large as $900.

Fifth, Massachusetts increased the payment rates it offers doctors for Medicaid. This step was necessary, Ms. Turnbull argued, to get widespread provider agreement for the reforms.

Two issues were particularly contentious as the program was being negotiated and implemented. First was the debate over whether or not minimum coverage should include prescription drugs, which was ultimately decided affirmatively. The second issue, how much people forced to buy health insurance should be expected to pay, was also hotly debated.

While it is still early to fully assess the Massachusetts plan, the preliminary results are encouraging. As of March 2008 there are 439,000 newly insured people in Massachusetts, bringing the rate of uninsured to around five percent for adults and three percent for children, the lowest in the country. About 60 percent of these newly insured individuals came through public programs, while the number of employers offering coverage has remained steady.

Ms. Turnbull concluded her talk by noting that the Massachusetts program has remained popular through the early stages of implementation, and comes out of a very deliberate political choice: "we wanted to do coverage first." Though she agreed with other speakers that coverage and costs were "inextricably linked," the Massachusetts plan clearly emphasized the former over the latter.

Merrill Matthews, Jr., Ph.D.

Executive Director, Council for Affordable Health Insurance, Washington DC

Dr. Matthews introduced himself as "the designated dark cloud here who's going to rain on the parade." His comments stressed the limitations that states like Massachusetts or New Jersey face when attempting to improve health care for their residents.

First, building on Dr. Emanuel's comments, Matthews noted that federal programs and laws like Medicare and the Employment Retirement Income Securities Act limit the scope of states to act. Second, Dr. Matthews noted that "there's a graveyard filled with states that tried to pass some kind of plan… and eventually found that it died." Proponents of universal coverage tend to oversell their plans without sufficient attention to the costs, he argued, and thus fail to build programs that last. Third, Dr. Matthews warned that it often takes time for the flaws of a program to become apparent, and that the Massachusetts program is probably too young to judge. As special interests become involved and rising costs force the state to consider cost-cutting measures focused on providers or elsewhere, cracks in the coalition supporting the plan will emerge.

None of this means that states are unable to do anything, Dr. Matthews argued, just that health care reform is incredibly difficult. "I would encourage you as a state," he said, to "understand that people are economic beings. We do make rational economic decisions." This requires state governments to make citizens "value-conscious" shoppers for health care.

Brian Rosman

Director of Research, Health Care for All

Mr. Rosman laid out a list of specific political lessons from the Massachusetts experience. First, he argued that the process of passing the bill affects the implementation. In Massachusetts there was a lot of discussion and consensus-building between different sides throughout the legislative process. In one much publicized event, Democratic Senator Ted Kennedy stood with Republican Governor Mitt Romney as Romney signed the health reform bill into law. This bipartisanship facilitated implementation.

Second, providing an affordability exemption to the mandate was key to assuaging people's concerns that they would be forced to spend a lot of money. Indeed, some 62,000 people in Massachusetts have been excused out of mandatory health insurance on affordability grounds.

Third, the issue of under-insurance is just as important as lacking insurance altogether, which is why it is so important for the state to set standards about what an acceptable minimum of health insurance entails.

Fourth, Mr. Rosman reiterated that there is no easy solution to the funding issue. While Massachusetts is spending less in direct payments to providers, these savings are not enough to pay for the new program. The reality of health care reform is that it is costly, and this cannot be wished away.

Last, Mr. Rosman stressed the ongoing nature of the reforms. Since approving the main laws in April 2006, the legislature has passed three adjustment bills. Constant monitoring and tweaking are necessary to create an effective system. Ms. Turnbull later echoed this point in the discussion section, noting that "We're discovering new things all the time. We get some of them right and some of them wrong, and then we realize we have to address something else." Flexibility is thus key.

Mr. Rosman concluded by mentioning two things that Massachusetts did not do with its health care reforms, but that other states ought to consider. First, he argued that dental coverage, which Mr. Rosman believes is an essential part of overall health, should be included. Second, states should more actively address disparities in access to health care between racial and ethnic groups. Last, Mr. Rosman urged New Jersey to not wait indefinitely for Washington to act, but to move ahead on its own with universal coverage: "just go ahead and take that leap."

Discussion

The discussion period returned to many of the themes that had been raised throughout the day. One question asked whether employers who do not provide insurance to their workers are penalized. Ms. Turnbull explained that businesses who do not choose to provide health insurance are penalized a fee of $300 per worker per year, which she termed a "symbolic" charge.

Dr. Matthews was asked to further elaborate on his ideas for reforming health care. He said he was generally in favor of the McCain tax credit proposal, and said the fundamental issue was whether or not you think the health care market works. If you do, more choice and options are better; if not, more regulation is necessary.

Appendix A

Conference Agenda

Access to Universal Health Care:

New Jersey, The Nation & the Globe

September 12, 2008

Sponsored by the Policy Research Institute for the Region at the Woodrow Wilson School of Public and International Affairs, Princeton University

Universal health care touches one of the deepest nerves running through public policy on state, national and international levels. In recent years, New Jersey has staged significant activity in this area, sparked by an engaged citizenry and proactive advocates in the various administrations, the legislature and the private sector. In addition, the 2008 presidential election has shined a spotlight on America's inadequacies regarding the provision of health care, which has sparked increased consideration of models from around the world. This Forum will assemble individuals at the forefront of promoting and implementing universal health care in the state—as well as experts with knowledge of national and global practices.

Welcome and Opening Remarks

Richard F. Keevey, Director, Policy Research Institute for the Region, Woodrow Wilson School, Princeton University

Daniel A. Notterman, M.D., M.A., Department of Molecular Biology, Princeton University

Universal Health Care in New Jersey

Honorable Senator Joseph Vitale, Senator and Chairman, Health, Human Services and Senior Citizens Committee, New Jersey State Senate

Honorable Heather Howard, Commissioner, New Jersey Department of Health and Senior Services

Christine Stearns, Vice President for Health and Legal Affairs, New Jersey Business and Industry Association

Universal Health Care Worldwide

Uwe Reinhardt, Ph.D., James Madison Professor of Political Economy, Princeton University

Maggie Mahar, Ph.D., Fellow, The Century Foundation

Ezekiel Emanuel, M.D., Ph.D., Chair, Department of Bioethics, National Institutes of Health

Luncheon Speaker

Len Nichols, Ph.D., Director, Health Policy Program, New America Foundation

Universal Health Care in the Nation–The Massachusetts Experience and Other Statewide Efforts

Nancy Turnball, Ph.D., Associate Dean for Educational Policy, Harvard School of Public Health

Merrill Matthews, Jr., Ph.D., Director, Council for Affordable Health Insurance, Washington DC

Brian Rosman, Director of Research, Health Care for All

Closing Remarks

Richard F. Keevey, Director, Policy Research Institute for the Region, Woodrow Wilson School, Princeton University

Daniel A. Notterman, M.D., M.A., Department of Molecular Biology, Princeton University

Commentary sponsored by the Policy Research Institute for the Region at the Woodrow Wilson School of Public and International Affairs at Princeton University.

The Policy Research Institute for the Region was established by Princeton University and the Woodrow Wilson School of Public and International Affairs to bring the resources of the University community to bear on solving the increasingly interdependent public policy challenges facing New Jersey, metropolitan New York, and southeastern Pennsylvania.

With a full-time staff augmented by project coordinators and guided by faculty associates and an advisory board, the institute reflects and understanding that the issues facing our region cut across not only state and municipal borders, but also across a range of traditional academic disciplines. Our mission is to bring together the University's greatest resources—its faculty and students, its research expertise, and commitment to public service—to find solutions across boundaries that improve the quality of civic life in our dynamic, multi-state region.

POLICY RESEARCH INSTITUTE FOR THE REGION

Corwin Hall, Princeton University
Princeton, NJ 08544
(609) 258-9065
http://region.princeton.edu