SENATOR USIE RICHARDS (USVI): If we could have your attention please so we could proceed with the group reports. If we can have your attention, please. Representative Eric Johnson and Representative Dee Dawkins-Haigler, if you all could come to the podium to my left so you could give a quick report. This is team one. Thank you. Representative Johnson from Texas.

REPRESENTATIVE ERIC JOHNSON (TX): Thank you very much, Mr. Chairman. Okay, so the first decision we had to make was between the open marketplace approach which is exemplified by the Utah model as we learned this morning and the active purchaser approach which is exemplified by the Massachusetts model. And we had a lot of discussion about this. It went way over the time we were supposed to. A lot of good points were made. We had at least one person who was very adamant about the open marketplace being the approach, Representative Camper wanted to explore that more, so I think we need more information about the open marketplace approach. And I think the main idea there is giving an opportunity to some of the smaller players in the insurance market to come into the market who might be able to cater more to the needs of African-American patients and whatnot. So that was one of the positive points of the open marketplace.

But ultimately, hold on, we decided as a group ultimately that the active purchaser model is probably the best way to ensure quality providers are in the system and to kind of tailor the smorgasbord of coverage and services that are going to be offered to the patients and that is something that the Maryland and Illinois delegations-- is that they have Democratic leadership there-- have kind of already gone down the path of and that's what we decided that we would do in an ideal world is to go with the active purchaser approach.

The second decision we had to make was between whether or not we'd offer the minimum benefits or the maximum benefits, the minimum benefits being the ten areas that the federal mandate says you have to cover. And then we came up with a whole bunch of things that we would actually do in addition to the minimum in an ideal world, and I can't really see them from here, but I think that adult oral and vision coverage is not part of the current federal list of things that has to be in your plan. Children are covered, I think, but adults are not. So we would do adult for oral and vision. We'd also do mental health issues, treatment for seniors to deal with depression and things like that for seniors. We'd look at alternative therapies like chiropractic and homeopathic and podiatry. We'd cover those types of things if we could.

And obviously but the first thing at the top of our list that we wrote is the fiscal reality versus what we'd like to do. We're mindful that, you know, obviously these things to go above and beyond the

federal requirements requires you to make a commitment on the state's part to spend more money on this. So this would actually cost the state, whatever state you're from, it will cost you more money to do these things out of your state's pocket. But these are the things that we'd like to do. And the last thing was substance abuse programs are obviously very important. So that was kind of the ultimate decision we made was to go with the maximum coverage if we could, but Representative…

SENATOR USIE RICHARDS: Okay, we will have President-elect Representative Joe Armstrong.

REPRESENTATIVE JOE ARMSTRONG (TN): We had a great team effort and our discussion was based on open or restrictive market. I think we actually were in opposition of the first group for the fact that we felt that in an open market, it gave more companies an opportunity to come in and compete for the business. What it did was also when you look at those smaller companies and when you look at insurance market, it's a business, you know. And so in order to get minority businesses participating, you've got to have it on the level that they can afford to come in and compete.

So we wanted the market to be open. We looked at the history behind black insurance companies. In 1980, we had over 38 black insurance companies in this country, now we only have three. So you know, the market has tightened up. So this opens the market. And then our experience in Tennessee, when we opened up our TennCare, we took our Medicaid population, the entire Medicaid population in Tennessee and put them in managed care. We, out of the 12 companies competing, you had two -- no, I'm sorry, three African-American insurance companies manage care. Two were state-wide, one was regional in Memphis. And so it allowed those companies to go. And it was the largest transfer of state public dollars to private industry in the history of the State of Tennessee about $3 billion. It can only be achieved by open market. And if it had been a closed market, it would have just been Blue Cross, United, Cigna, the normal big guys, you know.

And so, we chose open market because this is not only about providing healthcare, but insurance is business. Okay, and then we went -- the next was we went to the minimum coverage. The reason we picked the minimum coverage is because if we do the basic coverage and then allow those companies that are competing in the open market to come in, in order for them to get consumers, they have got to offer something in addition to the basic coverage. One example is one company in Tennessee offered the basic services, the ten basic services, but they offered an insurance policy to people that -- a life insurance policy. And so they got a lot of customers that chose their plan because a lot of people were -- didn't even have a basic burial policy. And then you could target it toward the different regions, you know, from one end of the state, one population might have one type of

difficulties. Representative Fox (MA) mentioned about violence as a health issue in certain parts of her particular district that if you had a company that offered some coverage, additional coverage and education and strategies toward curbing violence, that that might be essential benefit.

So we said put the minimum in, we'll have a competition with the companies to answer those additional benefits in order to draw people in. So we were open and minimum.

DELEGATE SHIRLEY NATHAN-PULLIAM (MD): Yes, and I just wanted to say that I know in our state of Maryland, we choose a state basic plan. And in the state basic plan, of the ten essential benefits that we chose, we, of course you know that before 2014, it will be closed off. You cannot add any more to it because it's more costly for you to expand it beyond that period of time. So a lot of states have different things that they in fact do.

REPRESENTATIVE GEORGE FLAGGS (MS): Let me make this point too now. No, these are -- Joe, am I right?

SENATOR USIE RICHARDS: And before you go, Representative Flaggs, your group has just two more minutes left.

REPRESENTATIVE GEORGE FLAGGS: No, I want just you understand it, this is a policy and we're talking about the working poor now, we're talking about the working poor and I'm telling you, based on what Dr. Wright was saying, you need to understand is now, you're not going to have as big as a market as you think that's going to qualify it here because you got to be able to afford it. So be careful. Do not take your emphasis off of the state expanding Medicaid. Your constituents, the poorest people in your district, need Medicaid expansion. That's where the money is. That's where the money. Because in order to get them in this market, you've got to be working and you've got to be able to afford it, this insurance.

This insurance is targeting working poor people. Now, the folks that you really represent, I'm telling you, need the expansion and Medicaid because it pays 100% the first three years to these states and then after the first three years, it pays 90%. You can't beat it.

DELEGATE SHIRLEY NATHAN-PULLIAM: And keep in mind that by 2014, the state plan, it says it right here, that the coverage will have to cover all ten essential benefit plans for the -- on the Medicaid by 2014.

SENATOR USIE RICHARDS: Thank you very much, group two. We're going to have Dr. Wright give a quick response to the presentations of both groups one and two, and then we're going to break for lunch right

out the door and make a right. And someone will say a prayer over the meal. It looks like the president over the Indiana Legislature Black Caucus will bless our meal before we leave. Go ahead, Dr. Wright.

DR. ERIC WRIGHT: Well, I heard a lot of very good ideas. You also are grappling with all the very technical issues involved here, and I would just leave you with one important thought, and that is you all may not be the right people to make this decision, okay. Now I'm saying that because one of the really important observations about this healthcare problem is that it is in a huge system. And every decision you make has ripple consequences, which is why some of the people in my world recommend actually taking it out of the political sphere. The best role I think legislators, presidents, congress could do is to lay out some priorities but then create an apolitical body to actually do the long-term management.

The most important structure that a lot of things are happening, a lot of -- across the nation, but Massachusetts had a very interesting observation which nobody had seemed to pay attention, and that is they created something called the cost and quality committee. And one of the reasons that this is such an important-- I call it the stealth-- committee because in fact what it is is staffed by a bunch of folks who have the technical expertise and the representation of the constituencies in the healthcare system to really think through and do the math on how to balance these different economic interests.

It is true that having a more open market may give people more opportunities, but it also comes at some costs. The question is about how to make decisions about cost that balances. And so it's not an easy decision, it's also not something that should be made simply based on the rhetoric you hear. You want to have data driving decisions. And one of the things businesses learned over the years is that to do constant quality improvement over the long haul, you need a bunch of people who are actually doing the analysis and feeding that information back.

So it should be in a didactic or very much a symbiotic relationship between the legislature, the executive branch, and I would argue, a healthcare board of some sort that does the math, reports back is accountable and transparent, but then also helps us make informed data-driven decision-making. And that's really hard to do within our legislative process and that's not a criticism of the process; it's just the reality of the process. I mean, you need PhDs in health economics, and I'm not one. I'm not advocating a job for me. But trust me, there are a lot of technical issues here that are far beyond any of our ability to sort through. And you need to have people who have the resources and the time to be able to think this through and monitor the change over time, because each year, there will be opportunities to make adjustments. And we have to build the system now that can learn from itself over the next several

decades as we go through this huge transformation of the U.S. healthcare system. So that's my final analysis.

SENATOR USIE RICHARDS: Thank you, Dr. Wright.