



## STATE AND NATIONAL HEALTH CARE REFORM: Lessons Learned from State Efforts

As national reform is discussed during the upcoming year, current state reform efforts can provide some guidance about the process and policies of reform. Federal health policymakers can learn from the experience of states that have pursued innovations in both coverage expansions and delivery and payment systems reforms. Since state efforts have dominated the reform agenda recently, in part, because there has been little to no federal action, there is a wealth of experience and lessons that can inform the national discussion regarding health reform. Other states can also learn from the efforts of those who have been pioneers in the area of health reform.

**Comprehensive Reform is Possible: Massachusetts Sets the Standard with a Public-Private Approach** When Massachusetts passed its health reforms in 2006, the policy environment changed in a fundamental way: Massachusetts demonstrated not only that comprehensive reform is possible but that it can be accomplished in a bipartisan manner. Throughout 2008, policymakers watched uninsurance rates fall as various aspects of Massachusetts' reform became effective (see page 30 of *State of the States 2009* report for a full description of the progress of Massachusetts health reforms). Massachusetts succeeded by using a mixed public-private approach, representing a compromise between those who support a single payer plan and those who advocate for an entirely private model. This general

strategy was resoundingly accepted and incorporated by all the states that developed or proposed serious plans for reform, including California, Colorado, Maine, New Jersey, Oregon, Pennsylvania, Vermont, and others. All aimed for practical solutions that build on the current system.

### **Compromise and Consensus Building**

As health reformers seek to learn from the experience of states, it quickly becomes apparent that there are fundamental differences in the political possibilities in some states compared to others. While there is growing consensus around the policy of coverage expansion, there are still huge hurdles to surmount in working out the politics of reform, both in statehouses and among the interested stakeholder groups. Specific reforms may be stymied or suddenly become possible based on the personalities and influence of particular groups in a given state. With that caveat, there are several "lessons learned" related to building political support among stakeholders that can be observed across states.

- **Leadership is essential.** Leadership in both the executive and legislative branches is critical for reforms to be enacted. If there is no strong political leadership behind a reform effort, it will likely founder as it encounters the inevitable vested interests that would prefer the status quo.
- **Be inclusive.** An inclusive consensus-building process is transparent and gives stakeholders real input. While it may not

be possible to gain the support of all the interested groups, a process that gives the relevant groups real influence and a seat at the table can prove helpful for gathering needed support.

- **Build relationships early.** It is important to start building trust and relationships with stakeholders early. Once a reform proposal begins to move, it may move quickly and there may not be time to build the alliances that could help support reform. Early relationship building also contributes to a sense that reform is inevitable and participation is better than exclusion.
- **Find supporters wherever possible.** If it is difficult to get important stakeholder groups to support proposed reforms, it may be possible to convince key leaders who represent those groups. For example, if support from the statewide business organization is difficult to obtain, it may be possible to find support in a local chapter or a key business leader.
- **Get supporters on the record.** Initial support for reform can fade through a long negotiating process. In addition, key allies may not deliver the needed political and financial assistance to gather support for reform. Gathering supporters early and getting commitments for the ways they plan to help is critical.

- **Keep your eyes on the prize—Part I.** While legislators or groups may have significant concerns about specific pieces of reform legislation, it is important to not lose sight of the bigger picture in order to maintain strong overall support for reform. Reform efforts can easily fail in the face of strong opposition if support is lackluster or begins to wane.
- **Keep your eyes on the prize—Part II.** The perfect should not be the enemy of the good. There are states in which a moderate, bi-partisan reform proposal was unable to pass due to opposition from the right and the left. Particularly for those who strongly support universal coverage, it may be worth supporting a plan that is not the preferred option in order to achieve a shared goal of expanding coverage.

While having an open and inclusive consensus-building process has been important in several states, it is possible to overstate its role and importance in health reform. There are examples of reform proposals conceived by a few key individuals in leadership (Maryland 2007) and also of failed state efforts where significant resources were invested in promoting compromise between stakeholder groups (New Mexico 2008). Comprehensive reforms have failed and succeeded for a variety of reasons. Consensus-building is no magic bullet, but key stakeholder opposition to proposed legislation never helps either.

States that have established a consensus-building process around comprehensive health reform have done so for several reasons. These include:

- Government leaders are seeking input and assistance putting a plan together. A given governor or legislative leader may make increased access to health coverage a priority, but needs time and help putting a final plan together.

- A stakeholder process may be a way to educate key interest groups and government officials on the issues related to health reform. Informed leaders will make better decisions than those without much exposure to the issues.
- If a leader has made health coverage a priority but does not have the political ability to pass reform immediately, a stakeholder process may be a way of sustaining interest in the topic until the political situation is more favorable.
- Implementation is notoriously difficult and key stakeholders will be needed during the implementation stage to ensure that any reform proposal is ultimately successful. A collaborative process builds support that will be needed when the program inevitably encounters obstacles later in the process.

**Financing** Finding sufficient and sustainable funding for comprehensive reform has been a challenge for every state. The same will be true for the federal government. States have taken several different approaches that may be instructive.

**Provider Taxes:** A number of states have had provider taxes in place for some time. For example, 43 states have some kind of provider tax, and 30 states taxed more than one category of providers.<sup>1</sup> A majority of these taxes were used to increase provider reimbursement levels, but a few states also used them to expand health coverage. Minnesota, for example, established a tax on health care providers in 1992 that has proved to be a reliable source of funding for their coverage efforts. This assessment on providers is broad-based, as opposed to a premium tax, in that it taxes everyone who uses health care, including those who are self-insured. Funds collected through this mechanism have risen with health care inflation, a key consideration as health care inflation has continuously outpaced general inflation.

During the California reform effort, the final bill included a provider tax on hospital services, but not on physician services. Hospitals agreed to this assessment because they found that—in general—hospitals would recoup the cost of the tax through reductions in uncompensated care. (Physicians, who are not required to serve the uninsured in the same way that hospitals are, would see uneven benefits from expanded coverage based on the number of uninsured patients they see.) In this way, a hospital provider tax is a useful mechanism for the state to recoup some of the savings to the health system that will result from reform.

**Redirect Money Currently in the System:**

Peter Orzag, when he was director of the Congressional Budget Office, stated that, “a variety of credible evidence suggests that health care contains the largest inefficiencies in our economy. As much as \$700 billion a year in health care services are delivered in the United States that do not improve health outcomes.”<sup>2</sup> For this reason, it would seem attractive to attempt to fund coverage expansions by redirecting money in the current system. The problem with this approach is that funding for coverage expansions is needed immediately, while the savings garnered through delivery system reform can often only be realized in the longer term. In addition, it is difficult to quantify these savings and then funnel them back into paying for coverage.

Maine attempted to fund their coverage subsidy through a Savings Offset Payment (SOP), which was designed to capture and redistribute savings in the health care system resulting from multiple reform initiatives under the Dirigo Health Reform Act. These included limits on annual capital investments and savings to providers from reduced uncompensated care. While it was enacted with more than two-thirds support in 2003, in practice the SOP proved to be politically controversial—especially regarding the methodology by which cost savings are

calculated—resulting in a court challenge in 2007. Although Maine’s Supreme Court upheld the SOP, nearly all parties have agreed for some time that a new funding source was needed to ensure the continued viability of the Dirigo reforms.<sup>3</sup>

States that have pursued efforts aimed at lowering the growth of health care spending over time have had some success. Minnesota Governor Tim Pawlenty set a goal in 2007 of reducing health care costs by 20 percent (from projected spending based on current rates of growth) by 2011. This emphasis on cost containment can be seen in Minnesota’s 2008 health reform law. The law contains a provision that requires the measurement and assessment of the cost savings effectiveness of the reforms. If certain cost containment targets are met, the repayment of a transfer of funds from Minnesota’s provider tax fund to its general fund is triggered.

The state is working toward that goal with several initiatives:

- Administrative simplification, which requires all payers and providers to conduct routine administrative transactions electronically by the end of 2009 and requires payers to use a single statewide implementation guide for claims interpretation;
- Requiring electronic prescribing for all prescriptions by 2011 and electronic health records (EHRs) by 2015 for all providers;
- Standardized statewide quality measurement of all providers and a transparent ranking of state health care providers based on cost and quality of care, using a newly established all-payer database;
- Transformation of the payment system in the state through a statewide quality incentive payment system and payment for baskets of care; and

- Public health initiatives and funding to reduce the disease burden in the state over time, with a particular focus on those diseases linked to obesity and tobacco use.

One source of current spending that is being tapped by states is safety net spending. While few states have a large, well-funded uncompensated care pool like Massachusetts, most do have some disproportionate share hospital (DSH) funding that can be redirected into coverage expansion. In California’s plan, they sought to recoup funds that were being spent by counties on indigent care. States and the federal government should use caution in tapping safety net funding, however. Safety net providers—especially those providing care in underserved areas—may need transitional funding as they make the shift from caring for those without insurance to the newly insured. In addition, extra resources may still be needed to maintain services for hard-to-serve populations. Finally, no coverage expansion is likely to reach everyone, so consideration must be given to continuing to provide health care for residual populations who may remain uninsured.

**Sin taxes:** Finally, many states have used tobacco taxes to fund their coverage expansions. This has proven to be a popular funding source with state legislatures because it promises to also achieve the public health goal of reducing smoking, especially among younger smokers. The concern about this funding source is that revenues are likely to decline over time while health care spending is likely to grow. States have also considered taxing soda, wine, and beer. Other unhealthy foods—like candy or snacks—could be next. But such taxes are not without their critics. In both Oregon and Maine, these so-called “sin” taxes failed in public ballot initiatives—Oregon failed to pass a tobacco tax to fund their children’s health program and Maine’s beverage tax was repealed when put to a public vote.

**Shared Responsibility:** The Massachusetts reform is the most notable example of a state that explicitly aimed to have each group that would benefit from the reform contribute to funding it. Individuals are required to purchase insurance if they can afford it. Businesses are assessed a fee if they do not offer insurance to their employees. Government also pays a portion. Of course, Massachusetts is also an exception in that the state already had significant funds available in the form of their uncompensated care pool.

A potential downside of this approach is that “shared responsibility” also may mean “shared pain.” It may result in more opponents to a reform proposal than advocates, particularly if the necessary financial resources being spread to various stakeholders are large. California and New Mexico also used the language of “shared responsibility” as a principle to guide their ultimately unsuccessful efforts to fund comprehensive reform.

**Sustained Effort** Many states are learning that health reform takes sustained effort over several years. This has played out in several ways:

- Massachusetts did not pass comprehensive health reform until its third attempt. Both incremental and failed attempts at health reform can be seen as laying the groundwork for future efforts. Either can be a good educational process for both government and stakeholder groups. They can also build momentum and support for future efforts.
- States like New Jersey, Iowa, and Wisconsin are taking a phased approach, also referred to as sequential reform—or incremental reforms with a “vision.” Policymakers are developing multi-year plans, enacting building block reforms and planning to pass additional reforms in subsequent years.

- Many states—like Oregon, Colorado, and New Mexico—have developed a stakeholder process for putting together a reform proposal over time. In Oregon this process was set in place by the legislature, and was led by multiple working groups. In New Mexico, Governor Richardson led a three-year process of gathering input and putting together a plan.

Sustained effort is also needed once legislation has passed. States have learned that reform proposals can succeed or fail in the implementation process. Programs must have simple, understandable rules. Outreach and education are crucial. Government officials must continue to work with stakeholder groups to ensure the programs meet their needs and do not have negative unintended consequences. Plus, strong evaluation mechanisms must be put into place at the outset. Evaluations allow policy makers to adapt the program as needed as it moves forward.

## A Sense of Urgency Creates

**Opportunity** One of the major reasons Massachusetts was ultimately able to pass their health reforms was the threat of losing significant federal funds that were—at the time—being directed to care for the uninsured. The federal government told state officials that they needed to convert their Medicaid safety net funds into an insurance model or risk losing federal financing for care of those individuals. Reform was viewed as inevitable, so all the relevant stakeholders had an incentive to stay at the table to improve the bill rather than try to defeat it.

Reformers in other states have wondered how to create a similar sense of urgency in their own states and whether reform is possible without a perceived crisis. It remains an open question whether spiraling health care costs and the current economic crisis will create this sense of urgency among state and federal leaders. In any case, states have learned that it is difficult to build and sustain support among affected stakeholders without a sense of urgency or

inevitability, because there are so many who are heavily invested in the status quo.

**Individual Mandate** The individual mandate included in the Massachusetts reform has generated significant interest nationally, yet the idea of making insurance compulsory is a complex one. If the aim is to achieve near-universal coverage, state experience so far has demonstrated that a voluntary system is not sufficient. Nevertheless, an individual requirement to buy insurance raises serious political, administrative, and policy questions.

From a policy perspective, those pursuing an individual mandate must consider: a) how to make the policy affordable to those who are being required to buy it; b) the richness of the package of benefits that people are required to purchase; and c) how to enforce the requirement. In general, researchers have found that “the effectiveness of a mandate depends critically on the cost of compliance, the penalties for noncompliance, and the timely enforcement of compliance.”<sup>4</sup>

While the policy challenges are significant, the benefits are substantial. They include:

- **Distribution of Risk.** An individual mandate requires everyone to be part of the risk pool, which prevents people from waiting until they get sick to buy coverage. It more broadly spreads risk and allows the premiums of healthy people to support the costs of those in need of medical services; this is the very purpose of insurance. It also enables the government to require insurers to sell policies to everyone, regardless of health risk.
- **Fairness.** Because a mandate brings everyone into the system, it reduces the amount of uncompensated care that health care providers must offer. The cost of these uninsured patients currently is passed on to other health care purchasers. Therefore, a mandate would reduce cost shifting from the uninsured to the insured.

- **“System-ness.”** A mandate reduces the current fragmentation of care, with uninsured patients currently seeking care from emergency rooms and other safety net providers. In theory, if everyone had insurance, they could maintain a continuous source of care with consistent preventive and primary care, which would improve their overall health and reduce long-term costs to the overall system.

## Benefit Design and Affordability

The Massachusetts Connector Board was forced to grapple with both affordability standards and benefit design in the context of the Commonwealth’s individual mandate. Massachusetts based their affordability standard on income, premiums, age, and geographic location. They then set minimum creditable coverage standards to ensure that individuals have adequate coverage.<sup>5</sup>

Many advocates have argued that an affordability standard should include out-of-pocket costs like deductibles, coinsurance levels, and co-payments. There is considerable debate about the appropriate levels for the cost of these variables but, in general, there is agreement that levels of both premium and out-of-pocket costs should be related to income and the ability to afford those costs.

States have grappled with benefit design in their Medicaid and SCHIP programs and also as they have regulated their private insurance markets. States have had to address the question of benefit design in state-based programs that offer subsidies for private or public/private plans offered in the individual and small group markets. There is significant variation on the approach states are taking. Some states are actively pursuing policies that promote a high level of choice between plans while other states have focused on ensuring that their residents are purchasing meaningful coverage. A majority of states have begun



to look at ways to ensure that insurance policies promote wellness by removing barriers to preventive care and chronic care management services.

### The Relationship Between Reducing Costs, Improving Quality and Expanding Coverage

While Massachusetts has charted a path on health coverage reform, Minnesota has set the standard on cost containment through collaborative efforts by public and private health care purchasers and by passing major legislation in 2008 that will reform payment policies, promote health (medical) homes, emphasize prevention and public health, and lead to even greater cost and quality transparency.<sup>6</sup> Of course, Minnesota has also been a quiet leader in the area of expanding coverage, boasting the lowest uninsurance rate in the nation after Massachusetts.

While many coverage advocates are concerned that taking on cost containment, systems improvement, and coverage expansion at the same time will make

comprehensive reform politically impossible, the recent trend in states is to address these issues together. This may be particularly important in the near future given the economic downturn and the growing concern of Americans related to rising health care costs. Cost concerns are an impetus for reform, but cost-cutting initiatives (especially those with short-term savings) are likely to raise opposition from some provider groups. Opposition from affected stakeholders increases when the amount of money in the system is decreasing under certain cost containment strategies rather than when it is increasing as it might under a coverage expansion program.<sup>7</sup>

### CONCLUSION

While there are clear differences in both the policy and political environments at the state and federal levels, there is much that federal leaders can learn from states as they turn their attention to national health reform. Federal policymakers are encouraged to consult with state leaders as they consider national health reform. State policymakers' in-depth

knowledge of the politics of reform, the policy implications, and the role that states could play in a reformed system could be an invaluable resource.

### ENDNOTES

- 1 Wicks, E. "Can a Sales Tax on Medical Services Help Fund State Coverage Expansions?" State Coverage Initiatives Issue Brief, AcademyHealth, July 2008. <http://statecoverage.org/node/161>.
- 2 Address delivered to the annual meeting of the Retirement Research Consortium, August 7, 2008. Accessed October 10, 2008. [http://crr.bc.edu/events/2008\\_conference\\_agenda\\_and\\_papers.html](http://crr.bc.edu/events/2008_conference_agenda_and_papers.html).
- 3 Lipson, D.J. et al. "Leading the Way? Maine's Initial Experience in Expanding Coverage Through Dirigo Health Reforms," The Commonwealth Fund, December, 2007.
- 4 Glied, S. et al. "Consider It Done? The Likely Efficacy of Mandates for Health Insurance," *Health Affairs*, Vol. 26, No. 6, 2007, pp. 1612.
- 5 Complete information about Massachusetts affordability standards and benefit design requirements can be found on the Web site for the Connector Board at [www.mahealthconnector.org/portal/site/connector](http://www.mahealthconnector.org/portal/site/connector).
- 6 For a full description of the Minnesota reforms, see page 35 of the 2009 *State of the States* or visit [www.statecoverage.org/node/1296](http://www.statecoverage.org/node/1296).
- 7 "Intersection of Policy and Politics in State Coverage Expansion Campaigns," presentation by Walter Zelman, AcademyHealth Annual Research Meeting. [www.academyhealth.org/interestgroups/shrp/2008.htm](http://www.academyhealth.org/interestgroups/shrp/2008.htm).

### About State Coverage Initiatives

The State Coverage Initiatives (SCI) program provides timely, experience-based information and assistance to state leaders in order to help them move health care reform forward at the state level. SCI offers an integrated array of policy and technical assistance services and products to help state leaders with coverage expansion efforts as well as with broader health care reform. Our team of policy experts tailors its approach to meeting state decision makers' needs within the context of each state's unique fiscal and political environment. SCI is a national program of the Robert Wood Johnson Foundation administered by AcademyHealth.

The SCI strategy focuses on three key elements to build the policy making and technical capacity of the states:

- Supports a community of state officials that can learn from each other, share best practices, test new initiatives and encourage action.
- Provides unbiased information that brings strong research and analysis to the issues states are confronting.
- Offers responsive policy and technical assistance to improve state policymakers' ability to make informed policy decisions.

**For more information, please visit [www.statecoverage.org](http://www.statecoverage.org)**

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