

Health Care Reform and American Federalism: The Next Inter-Governmental Partnership

*by Michael Sparer, J.D., Ph.D.
with responses from state health policymakers*

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State Coverage Initiatives



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With the election of President Barack Obama, the issue of health reform returned to the national agenda. President Obama has made comprehensive reform a high priority, emphasizing the need to get reform enacted during his first year in office. Congress has been tasked with developing the details. The goals include providing coverage to the uninsured, financing that coverage with some combination of new tax revenues and effective cost containment measures, and more generally slowing the rising cost of the nation's health care bill. It is, of course, too soon to predict the outcome. While there is a window of opportunity for reform, there are also significant obstacles, including uncertainty over how to pay for access expansions and partisan disagreement over a proposal that the uninsured (and perhaps those with private insurance as well) be offered the option of enrolling in a new publicly-administered health insurance plan.

Perhaps due to the speed of the current debate, however, federal policymakers have largely ignored two issues critical to the implementation of any new legislation: first, how will new federal rules fit with the nation's complicated and entrenched set of inter-governmental health care partnerships; and second, how will those rules accommodate the extraordinary inter-state (and intra-state) variation in every aspect of the nation's health care system? This issue brief addresses these issues. It begins with a review of the evolution of the nation's inter-governmental health care partnership, followed by a discussion of how proposed federal reforms to expand Medicaid, to create a health insurance exchange, and to restructure the health care delivery system might impact that partnership. The brief concludes by encouraging policymakers to establish a task force, work-group, or some similar institutional mechanism that would focus on the federalism and implementation implications of both proposed and enacted reforms.

States and the Inter-Governmental Health Care Partnership

States play a key role in every aspect of the current health care system. Both Medicaid and the Children's Health Insurance Program (CHIP), for example, delegate to the states broad authority to set eligibility criteria, develop benefit packages, and determine reimbursement rates. Equally important, states pay anywhere from 23-50 percent of the cost of these programs, more than \$150 billion annually. States also regulate much of the nation's private insurance industry and they fund and administer public employee health insurance programs. States operate medical education systems, license health care providers, supervise the quality of care delivered by those providers, and establish medical malpractice systems. States own and operate hospitals for the mentally ill and developmentally disabled, operate worker-compensation systems, and have broad powers to establish and implement public health programs.

Importantly, however, states perform nearly every one of these tasks as part of an inter-governmental partnership with both federal and local officials. The federal government, for example, sets broad rules that constrain state discretion in both the Medicaid and CHIP programs. The federal Employee Retirement and Income Security Act (ERISA) limits state discretion to regulate firms that self-insure. ERISA also precludes many consumers from using the state courts as a forum to challenge insurance decisions to deny medical coverage. The Health Insurance Portability and Accountability Act (HIPAA) imposes various regulations on the private health insurance industry. Meanwhile, the nation's 3,000 local health departments are the linchpin of the public health system; locally-owned public hospitals are a key part of the medical safety net, local officials often determine Medicaid eligibility, and some local governments even contribute to the cost of such programs.

The Variation Variable

States exercise their discretion within the nation's inter-governmental health care partnership in extraordinarily different ways. For example, no two Medicaid programs have the same eligibility rules, benefit packages, or reimbursement policies. State Medicaid officials are also experimenting with a vast range of care management initiatives, pay-for-performance programs, and efforts to encourage greater use of home- and community-based services. Similarly, while every state has enacted some initiatives to aid their uninsured residents, these initiatives vary widely in scope and impact. In Massachusetts, for example, state policymakers in 2006 enacted several policies (including a Medicaid expansion for children, subsidies for adults, a new insurance exchange, and an individual mandate) as part of an effort to reach universal insurance coverage. Other states (including Maine and Vermont) have also enacted comprehensive programs aimed at dramatically reducing the number of uninsured residents. Most states, however, have settled for far more incremental (and varied) efforts to expand their Medicaid and CHIP programs and to make health insurance more accessible and more affordable in the small group and individual markets.

What explains this variation? There is a large body of literature that offers explanatory theories. First are theories that look at internal state characteristics. For example, states have very different fiscal resources and it can be argued that wealthier states have more generous social welfare programs. States also have different political cultures, socio-economic demographics (including rates of uninsured), interest group politics, institutional capacities, constitutional requirements, and bureaucratic politics. Complicating matters even further, local communities vary significantly in the composition of their medical workforce, the practice patterns of those health care providers, and the cost of health care services and health insurance premiums. Medicare spends far more money on beneficiaries in Dallas, for example, than it does on

State Response by Scott Leitz, Assistant Commissioner, Department of Health, Minnesota

Dr. Sparer's paper accurately describes the complex interrelationships between the state and federal governments and the need to consider these interdependencies during the debate on health reform. As a leader on health reform, Minnesota starts from an enviable spot. We have one of the nation's lowest uninsurance rates, a relatively healthy population, and a largely non-profit and collaborative care delivery structure that has resulted in high quality outcomes at relatively low cost. Nonetheless, like many states, we face rising costs, uneven quality, and an increasing burden of preventable chronic disease associated with unhealthy lifestyles.

Minnesota's reform approach recognizes that coverage is important, but must be addressed in combination with containing health costs, improving the quality and value of care, and improving the health of our population. Our approach focuses on transforming our health care system to make it sustainable and to produce better value.

Our reforms are focused on three core principles: investing in public health to promote healthy behaviors and prevent avoidable chronic disease; restructuring the payment system to better align provider incentives and improve value; and creating efficiency through better use of information technology. All of these areas provide potential for state and federal partnership.

One such example is our recently launched Statewide Health Improvement Program (SHIP), which aims to reduce the percentage of Minnesotans who are obese or overweight and to reduce tobacco use. We modeled SHIP on Centers for Disease Control (CDC) funded pilot programs that demonstrated effectiveness in four Minnesota communities. Our statewide SHIP program awarded \$47 million in grants to Minnesota communities for 2010 and 2011 to help prevent the chronic disease that results from unhealthy behaviors. Our partnership with CDC enabled us to test out a model and to learn from best practices around the country so we could put state funding into an initiative that had been proven to work.

We also see potential for state and federal partnership in our payment reforms. Minnesota's 2008 reforms represent a first step toward the fundamental payment reform needed to create a system that rewards providers for keeping people healthy, instead of only paying to treat the sick. These reforms promote transparency and payment reform through standardized public reporting of quality, care coordination payments to health care homes, development of tools to compare providers on overall cost and quality of care, and bundled payments for "baskets" of care. Taken together these reforms encourage health care providers to find innovative

ways to deliver higher-quality, lower-cost health care and to encourage consumers to choose high-quality, low-cost providers. As we look to the future application of these payment reforms and market transparency tools, we see a prime opportunity for federal and state partnership. For example, requiring Medicare to participate in regional or state payment innovations like ours would allow states to truly align incentives across the market to drive system change.

Finally, we have worked to improve the administrative efficiency of our delivery system. We've mandated that all health care providers have electronic health records by 2015, and that all payers and providers use e-prescribing by 2011. We are also the first state to require all health care providers and payers to exchange administrative transactions electronically, which provides more than \$60 million in annual savings. These initiatives have positioned us well to help the federal government achieve its desired outcomes from the HITECH Act and also provide a model for federal reform.

As Congress and the President look to finalize national health reform, it will be important to recognize the interconnectedness between states and the federal government. Minnesota's reforms provide an example of successful federal/state models to advance reform's goals.

beneficiaries in Minneapolis, an outcome that seemingly has little to do with Medicare reimbursement rules and much to do with variation in the organizational structure and practice patterns of local health care providers.

The external policy environment also influences states in fundamentally different ways. ERISA, for example, has a more significant impact on state efforts to regulate the large group market in states with large numbers of self-insured firms than it does in more rural states with lots of farms and small businesses. Similarly,

the federal rule requiring state Medicaid programs to cover children in families with income below 100 percent of the federal poverty level had a different impact in states that were required to expand eligibility (and spending) to meet the mandate than it did in those states that already provided such coverage.

Some Historical Perspective

State policy variation within the context of a complicated inter-governmental partnership is neither a new nor an unexpected trend. To the contrary, this

is a longstanding and important part of the American fabric. The story begins in the 18th century with the conflicting views among the founding fathers on the relationship between the different levels of government. There were those, like Alexander Hamilton, who believed that we needed a powerful federal government, fueled by a dominant executive branch. Thomas Jefferson, in contrast, argued that the Hamiltonian vision would lead to monarchy, and that we needed instead a more decentralized and democratic republic in which the federal government focused on foreign affairs while domestic policy was set by the state and local

State Response by Deborah Bachrach, Medicaid Director, New York

New York is among the states that have moved out ahead of federal health reform, investing its own dollars in expanding Medicaid eligibility in an effort to provide comprehensive affordable coverage for growing numbers of uninsured. Cognizant of Medicaid's central role in the health care system, Governor David A. Paterson has initiated critical reforms intended to ensure that eligible New Yorkers are able to get and keep coverage and that Medicaid buys cost-effective, quality care. The federal government is New York's partner in Medicaid reform, paying approximately half of all Medicaid costs and setting the overarching program rules.

Of immediate concern for New York is whether federal health care reform will treat all state partners equitably, providing comparable financial support to states that chose to provide limited access to public health insurance and states, like New York, that have expanded coverage. For example, the House bill provides states with ongoing and enhanced federal funding for Medicaid coverage of single adults with incomes up to 133 percent of the Federal Poverty Level (FPL). The same federal funding is available regardless of a state's current Medicaid eligibility level. In contrast, the Senate bill provides states with time-limited enhanced federal

funding, but only to the extent that the state does not currently cover single adults with incomes up to 133 percent FPL. The Senate approach penalizes states, like New York, that in years past have invested scarce state resources to expand access to health coverage. It perversely rewards states that have previously chosen not to cover single adults at any income level. Under the Senate approach, only those states that have wholly failed to provide health coverage for single adults will receive full federal funding for this group. The issue of federal funding is not simply one of equity among states. With New York projecting multi-billion dollar budget deficits, the availability of federal funding will determine the extent to which New York will be able to maintain a quality health care system.

With federal funding comes federal rules that rightly seek to ensure that state Medicaid programs are administered consistent with federal law. This plays out through line-by-line reviews of 50 state Medicaid plans, state plan amendments (SPAs) and waiver requests. Important reforms can easily be delayed months or even years as states defend changes to eligibility rules, reimbursement methodologies or program requirements. For example, in an effort to reduce the churning of eligible New Yorkers on and

off of Medicaid coverage, in 2007, the New York legislature authorized 12-month continuous eligibility for adults, augmenting the existing authority for children so as to promote continuity of coverage for families. Two years later, federal approval is still pending for this important state initiative, as it is for requested reforms to the state's outdated reimbursement methodology. And, these are just two examples of the dozens of pending state plan amendments that form the underpinning of New York's efforts to expand coverage, improve quality and control costs.

With state administrative budgets declining and the imperative to reform the health care system growing, it is essential that the federal-state partnership that operates Medicaid focus less on line-by-line reviews of state plan amendments and more on state accountability and outcomes. We need to scrutinize state coverage rates and quality metrics; and analyze state Medicaid payment policies to determine whether they align with Medicare policies and help to reduce unnecessary readmissions and promote integrated delivery models. And, we must recognize and address the challenges Medicaid and Medicare face with respect to dual eligible beneficiaries who are among the most medically complicated and costly for both programs.

governments. James Madison articulated yet a third approach under which excessive and arbitrary government activity (at all levels) would be limited by checks and balances and divided political power.

Rather than resolving these differences, the United States Constitution provides support for each view, leaving to each generation the task of engaging in an ongoing federalism debate. Prior to the 1930s, the Jeffersonian view dominated and it was considered wrong (perhaps even unconstitutional) for the federal government to set or administer economic

or social welfare policies. President Franklin Roosevelt then engineered the creation of the New Deal welfare state, in which the federal government (sometimes alone and sometimes in partnership with the states) became the key driver of both economic and social welfare policy. The inter-governmental partnership has continued to grow ever since. During the 1940s, for example, the federal Hill-Burton Program provided funds to state and local communities to expand the nation's hospital stock. During the 1960s, the federal government not only enacted Medicare and Medicaid, but it also funded numerous local health care initiatives (such as community health centers) as part

of President Lyndon Johnson's effort to create a "Great Society." Even during the 1970s, while President Richard Nixon spoke forcefully of the need for a "new federalism" that would devolve power back to the states, he also signed into law a host of new federal health care programs (such as the Health Maintenance Organization Act of 1973 and the National Health Service Corps) which dramatically increased the federal role. Put simply, over the last 75 years, the nation's economic and social welfare agenda has grown exponentially, almost always however with a mix of federal and state dollars, and a combination of federal, state, and local administration.

Good and Bad Variation

The merits (and demerits) of state discretion and interstate variation are too often oversimplified and poorly understood. Liberals generally tend to prefer federal health care leadership, arguing that some basic level of access to care ought to be a right of citizenship and not subject to the vagaries of local political culture and politics. Liberals also suggest that the health care crisis is a national problem that requires national solutions, and that even the best state-based initiatives are generally financed largely with federal (Medicaid) dollars. The longstanding counter-argument is that in a large and heterogeneous society, state discretion and variation might enable policy to more accurately reflect local needs. Local control is also arguably more democratic, more accountable, and (according to some) more innovative. Finally, local control presumably enables the states to serve as “policy laboratories,” trying and testing new ideas before enactment and implementation on a national scale. Of course, the lessons learned in the health policy laboratory often depend on the analyst. The reforms enacted in Massachusetts in 2006 seem, for example, to be a model that some national policymakers hope to follow. Others argue that the Massachusetts model illustrates why comprehensive coverage expansions without equally comprehensive cost-containment measures are problematic.

Despite the rhetorical and philosophical arguments, however, nearly all would agree there are times when centralization (and thus federal leadership) is needed and that there are times when variation (and thus state and local leadership) is more appropriate. For example, the home care delivery system in New York City should look very different from its counterpart in rural Idaho. Similarly local health departments need flexibility to assess and then respond to community-based needs. Local needs do differ. At the same time, however, there is little justification for certain forms of interstate variation. Why should a low-income resident of California receive Medicaid coverage while an Alabama

resident with the same income is uninsured? Why should a hospital in Pennsylvania receive far lower reimbursement than a similarly situated facility in New Jersey?

The task (and the challenge) is to develop policies that minimize inappropriate interstate variation and maximize useful variation. Otherwise put, the policy challenge is to figure out who should do what within the increasingly complicated inter-governmental partnership.

Health Reform in 2009

The current health reform debate has focused on two issues: cost and coverage. To different degrees and with different priorities, reformers hope to provide health insurance to the nearly 50 million Americans who are currently uninsured, to finance that coverage with some combination of new tax revenues and effective cost containment measures, and to more generally slow the rising cost of the nation’s health care bill.

The coverage expansion proposals can be divided into three broad categories. First are proposals to expand publicly-funded insurance coverage, ranging from the incremental (expand Medicaid or SCHIP or Medicare coverage) to the more ambitious (create a new public health insurance program for the uninsured, which might also be available as an option to those with private coverage). Second are efforts to use the federal government’s regulatory authority to mandate expanded coverage, either via an employer mandate (a requirement that employers either provide full-time employees with affordable coverage or pay into a public health insurance fund) or an individual mandate. Third are initiatives that seek to make private health insurance more available and more affordable to the uninsured. The most common ideas in this category are to create a new “health insurance exchange” that would serve as a purchasing pool for the uninsured, to provide tax credits, or to encourage the growth of high-deductible and thereby low-cost private insurance policies.

First, any reforms enacted by Congress and signed into law by the President will be implemented in the nation’s complicated and entrenched set of inter-governmental health care partnerships. Second, any reforms enacted by the national government should take into account the enormous inter-state (and intra-state) variation in the nation’s health care system. Third, there is very little public discussion of either of these two issues.

The financing and cost-containment strategies also can be divided into three general groupings. First are proposals to raise new revenue through new taxes. There is increased attention, for example, to the idea of treating at least some of the health insurance premiums paid by employers as taxable income to the employee. Second are initiatives that would cut the amount that government pays Medicare Advantage health plans or Medicare and Medicaid health care providers. Third are a host of more general efforts to restructure the health delivery system, often by imposing pay-for-performance methodologies that would presumably encourage both lower costs and more value-based purchasing. These more general proposals are often linked with efforts to encourage greater use of health information technology, greater reliance on comparative effectiveness studies, and expanded adoption of various care management strategies.

There is no way to predict which coverage expansions will be enacted or how such expansions will be financed. It is too soon to say whether this will be another sad tale of disappointment and failure, an inspiring story of comprehensive reform, or something

in the middle. But there are three facts that are exceedingly clear. First, any reforms enacted by Congress and signed into law by the President will be implemented in the nation's complicated and entrenched set of inter-governmental health care partnerships. Second, any reforms enacted by the national government should take into account the enormous inter-state (and intra-state) variation in the nation's health care system. Third, there is very little public discussion of either of these two issues.

This is not to suggest that members of Congress will not look out for their own constituents. There is little doubt, for example, that the legislators in high-cost states are less likely to support proposals to cap the tax exclusion now given to employee health insurance premiums than are their counterparts in low-cost states. Similarly, the National Governors Association and other organizations representing state interests continue to press for local autonomy (fueled by federal funding). Nonetheless, there is surprisingly little discussion about which level of government should do what in a reformed health care system. Nor is there enough discussion of how different proposals might have different impacts in different states. To illustrate these points, consider the federalism implications of three aspects of proposed health reforms: a Medicaid expansion; a new health insurance exchange; and an ambitious care management initiative.

Federalism and Finance: The Proposed Medicaid Expansion

Medicaid, enacted by Congress in 1965, provides government-funded health insurance to nearly sixty-five million low-wage Americans. It is the core of the nation's health insurance safety net. It is likely to be an important component of any comprehensive health reform initiative. It is also one of the nation's most complicated and controversial inter-governmental partnerships. For starters, Medicaid is not a single national program but it is instead a collection of state-administered

programs that receive federal funding (between 50-77 percent of total costs) so long as the programs follow some basic federal rules. Between 1965 and the mid-1980s, federal Medicaid law contained relatively few detailed requirements, delegating instead broad decision-making authority to the states. States used this discretion to develop extraordinarily diverse programs, with very different eligibility standards, quite distinct benefit packages, and fundamentally different approaches to provider reimbursement.

Beginning in the mid-1980s, however, the federal government significantly increased its control over state Medicaid programs. The most obvious example was a host of federal rules requiring states to dramatically expand eligibility standards, especially for pregnant women and children, but there also were new federal rules governing benefits and reimbursement as well. One consequence of the new rules was a dramatic expansion in enrollees and expenditures. More generally, however, the programs' inter-governmental partnership soon became far more controversial and contentious. Several states began efforts to use provider taxes and other more complicated fiscal strategies to shift costs to the federal treasury, prompting federal officials to complain that states were trying to game the system to leverage federal dollars. This inter-governmental battle continues today. Meanwhile, states also complained that federal officials were inhibiting innovative delivery system reforms by denying, delaying or micro-managing state requests for waivers from general federal rules. These battles also continue today.

The ongoing inter-governmental tension over Medicaid policy is, however, only one feature of its current incarnation. Two other features are also worth noting. First, despite the federal mandates and the more complicated inter-governmental partnership, state Medicaid eligibility standards still vary quite significantly, especially with respect to coverage of adults. Second, there is similar variation in state delivery system, quality, and payment initiatives. For example, most states encourage or require beneficiaries to be part of a managed care initiative, but some rely on

commercial insurers, others on non-profit health plans, and still others act as the plan themselves. There is also interstate variation in cost-containment strategies, programs for the chronically ill, and value-based purchasing.

Perhaps surprisingly, Medicaid has received relatively little attention in the current health reform debate. To be sure, the Democrats in Congress have generally proposed additional coverage mandates, prompting the nation's governors to complain that states cannot afford their share of such an expansion. Of course the states' ability to afford their share of a mandatory expansion will vary depending on the state's current eligibility criteria, the condition of its budget, and the percentage of the expansion that is funded just with federal dollars. Moreover, federal Medicaid expansions could impact other state initiatives (such as CHIP eligibility, or other state programs to aid the uninsured) as well as ongoing state managed care initiatives (whether the current provider networks have the capacity to accommodate the expansion population). Finally, federal officials ought to consider how Medicaid can provide a model for reform. Consider, for example, the debate over the proposed public plan option. State Medicaid managed care programs illustrate how such an option might work in practice, whether the public plan contracts with private insurers (as do some state programs) or if it, instead, is the state itself that contracts with health care providers (as in state primary care case management programs).

Federalism and Regulation: The Proposed Health Insurance Exchange

The health reform proposals now before Congress generally contain a host of new rules to govern the nation's private health insurance industry. For example, new federal legislation could well require private insurers to offer coverage to all applicants regardless of health status. Such legislation also could limit the ability of private insurers to charge higher premiums to the sick, and it might

State Response by Christopher F. Koller, Health Insurance Commissioner, Rhode Island

Defining the respective roles of state and federal governments in health reform begs the resolution of a fundamental conflict in the debate: are we constructing a personal insurance system—with the goal of minimizing personal bankruptcies—or a medical care financing system—with the goal of assuring the provision of some basic level of medical care to all? U.S. policy appears desperately to want it both ways—bestowing entitlements for medical care to the elderly, the disabled and low-income families while demanding private insurance to fund routine maintenance and minor repairs. In the absence of a federal resolution to this conflict, state policymakers and regulators address it locally, incompletely and with—as Sparer notes—great variation.

State regulators have historically enforced on health insurers a set of rules developed for all lines of insurance, focusing on consumer protection and financial solvency. Recognizing the health insurance was “different” from other lines, some states in the 1990s enacted statutes responding to public concerns regarding managed care (statutes now largely marginalized by market shifts to PPOs). These were grafted on to existing insurance departments (as in Massachusetts), placed in public health agencies, or given their own home (California). In subsequent evolutions some states have attempted to give regulators broader authority over the affordability of commercial health insurance than other lines of insurance (Rhode Island) or the market for health insurance (Massachusetts’ Connector Authority).

As has been much documented, even greater variation exists in how small group

and individual commercial health insurance underwriting is overseen. States permit rating based on myriad combinations of age, gender, geography, pre-existing conditions, benefit exclusions and smoking status, and allow rating variances for the same product anywhere from 200 percent to many multiples.

How will the federal and state governments reframe their sometimes-awkward partnership with the passage of any health reform? Much rides on whether and how such federal laws address the “bankruptcy protection” vs. “medical care financing” conflict noted above.

Federal reforms with an individual mandate and a corresponding employer requirement, a subsidy for low income people, and a more structured health insurance market that standardizes underwriting rules point toward a view of health insurance markedly different from other lines of insurance and closer to the medical care financing perspective. The resulting state/federal partnership should recognize that creating greater distinctions between the oversight of the medical care financing markets and the oversight of other insurance markets.

In such a world the federal government would be the standard setter and the financier. Federal policymakers would define the “floor” above which states could add their own requirements in areas such as underwriting rules, minimum benefit levels, affordability standards, and subsidy levels. The federal government would provide the base subsidies themselves and spur quality improvement and cost control through Medicare payment reform, information

technology standards, and clinical practice standards. The federal government’s role in defining standards for clinical quality should draw from its role in defining highway and airline safety.

Since medical care is delivered locally, by locally-based providers, market oversight should reflect that. The states, as Sparer notes, would facilitate the reorganization of delivery systems—including the hard work of coordinating provider payments—to improve quality and lower costs. Our experience in Rhode Island is that this is possible but requires significant collaboration and state leadership, and is markedly more difficult if Medicare and ERISA plans do not come to the table.

Besides Sparer’s other state role of administering insurance programs for low wage workers (and non workers), states could also elect to oversee the markets (at least for small groups and individuals) for medical care financing products—including product standards, transparency and consumer protection—and be the enforcers of federal standards on players in the market. States have consistently proven capable of this but it conflicts with the political and cultural ascendancy—at least until the recent recession—of increased nationalization of financial markets and their oversight.

The result—in theory—would be a set of local markets with more consistent clinical, consumer protection and market conduct standards than exist currently, and more attention to equity and fairness and less emphasis on product variation and capital formation than the markets for other types of insurance.

prohibit insurers from excluding pre-existing conditions from new coverage. Federal policymakers also are considering legislation that would create one or more “health insurance exchanges,” administrative entities that would facilitate a regulated health insurance marketplace.

These proposed federal forays into health insurance markets are a departure from

the nation’s longstanding approach to insurance regulation. Indeed, as the private insurance industry evolved during the 1950s and 1960s, it was the states that regulated their conduct, imposing capitalization and reserve requirements, limiting (in some states) predatory marketing practices, and in a handful of states regulating the reimbursement rates paid to hospitals. This regulatory regime

was consistent with state oversight of other insurance markets, including life, home, and automobile insurance.

In 1974, however, in an effort to respond to a crisis in the nation’s pension industry, the federal government unintentionally preempted state oversight of much of the private insurance industry. The goal of the federal Employee Retirement and Income

State Response by Craig Jones, Director of the Vermont Blueprint for Health

Since passing its 2006 landmark health reform legislation, Vermont has maintained an intensive commitment to comprehensive health reform that includes universal coverage, a novel delivery system built on a foundation of medical homes and community health teams, a focus on prevention across the continuum of public health and health care delivery, a statewide health information exchange, and a robust evaluation infrastructure to support ongoing improvement with quality and cost effectiveness as guiding principles. The essential ingredient has been bipartisan and visionary leadership provided by Governor James Douglas and the state General Assembly. From policy to implementation, Vermont's reforms are designed to provide access to high quality health care for all of its residents, and to improve control of health care costs.

Vermont has approached universal coverage through CHIP, expanded Medicaid eligibility, and work with commercial insurers to establish health plans that offer affordable coverage to residents who cannot afford private insurance. The most recent example is Catamount Health, a private-public partnership offering high quality coverage with income-adjusted subsidies through commercial insurers. At the same time that these coverage reforms have reduced the uninsured population from 9.8 percent in 2005 to 7.6 percent in 2008, the state has implemented a balanced set of delivery system and health information technology reforms to ensure that those coverage improvements can be sustained.

Guiding legislation calls for a highly coordinated statewide approach to health care wellness and disease prevention. Vermont's Blueprint for Health is leading this transformation with pilots in three communities that include patient centered medical homes supported by community health teams. At the core of this model is financial reform with all major insurers participating *except Medicare*. In addition to usual payment, primary care practices receive an enhanced payment based on the quality of care they provide. Insurers, including Medicaid, also share the cost for community health teams, which include members such as nurse coordinators, social workers, and behavioral health counselors who provide support and work closely with clinicians and patients at a local level. The teams also include a public health specialist dedicated to community assessments and implementation of targeted prevention programs.

The model is designed to be scalable and adaptable, from small independent practices to large hospital based practices, and from rural to urban settings. Financial sustainability depends on reducing avoidable acute care, and insurers shifting expenditures from contracted disease management to local community health teams. For both the community care teams and enhanced provider payment, the state is subsidizing Medicare's proportional funding to make the pilots whole. *However, long-term clinical success and financial sustainability depend on Medicare's full participation.*

Cost effective care depends on health information being available when and where it is needed. Vermont has committed to building a statewide health information exchange, expanding the use of electronic medical records (EMRs), and funding these initiatives with a Technology Fund (using a surcharge on paid medical claims). EMR use is steadily expanding through state-funded and independent initiatives. Increasingly, hospitals and practices are feeding data through the exchange to a common web-based clinical registry that can support patient care in practices without EMRs, along with the care coordination and population management activities of the community health teams.

Ongoing evaluation and quality improvement are integral to Vermont's reform efforts. Steadily, the information infrastructure is being developed so that routine analyses, reporting dashboards, and comparative benchmarks can provide transparency and guide a continuously evolving health care environment. Data sources such as the common clinical registry, public health registries, and supplemental evaluations using chart reviews and surveys are part of a multi-dimensional evaluation framework. A key element is a new multi-payer claims database that will enable true financial monitoring of reform efforts. *Again, Medicare's participation is the crucial missing component in this data repository.*

In sum, health care reform cannot be truly successful without a Medicare partnership with states.

Security Act (ERISA) was to impose federal standards on the nation's pension system, but the law has also preempted state regulation of firms and unions that establish self-insured health plans (even when they hire private insurers to administer their self-insured plans). ERISA also generally prohibits states from enacting employer mandates and it limits the rights of millions of consumers to sue their health plans for the wrongful denial of care. Largely as a result of ERISA, most

large firms in the United States self-insure, leaving the states to focus their regulatory efforts on the small-group and individual insurance markets.

During the mid-1990s, following the failure of the Clinton reform initiative, state officials enacted a host of incremental efforts designed to make health insurance more available and more affordable in the small group and individual markets.

Many states required insurers to provide coverage to all applicants (guaranteed issue), required insurance renewal even if the policyholders medical condition worsened (guaranteed renewal), and limited insurers ability to deny coverage for conditions that began prior to the date of enrollment. Some states also encouraged or created purchasing alliances, permitted insurers to sell "bare bones" (and presumably less expensive)

State Response by Jason Helgerson, Medicaid Director, Wisconsin

Wisconsin launched an ambitious, long-term health care reform agenda in January 2006 with Governor Jim Doyle's announcement of his "Affordability Agenda" to ensure that all Wisconsin residents have access to affordable health care coverage. The policy solution to expanding coverage was creation of a single health care safety net—BadgerCare Plus. BadgerCare Plus is a comprehensive statewide program to ensure that 98 percent of Wisconsin residents have access to health insurance. It represents a classic example of the essential and critical partnership between a state and the federal government to provide coverage to more people.

The first phase was expansion of coverage to all children, implemented in 2008. BadgerCare Plus dramatically streamlined eligibility by merging family Medicaid, BadgerCare (the Children's Health Insurance Program), and Healthy Start—making the program easy to understand, enroll in, and administer. The program was rebranded as "health insurance for all children," thus significantly reducing the stigma often associated with public programs.

In 2009, BadgerCare Plus was expanded to cover low-income childless adults, the most chronically uninsured people in Wisconsin and those traditionally not covered

by Medicaid. They are individuals and married couples between the ages of 19 and 64 who are not pregnant, disabled, or qualified for any other Medicaid, Medicare, or CHIP program. Only a handful of states pursued federal waivers to allow expansions to cover childless adults.

The Centers for Medicare and Medicaid Services (CMS) approved Wisconsin's Title XIX Demonstration Waiver to expand BadgerCare Plus to include childless adults by allowing the state to finance the expansion using reconfigured Disproportionate Share Hospital (DSH) funds. Wisconsin is able to use the DSH money, typically used to cover emergency services for uninsured patients provided through hospitals, for primary and preventive care to previously uninsured childless adults through basic, cost-effective services known as the Core plan.

Under the waiver, Wisconsin has the flexibility to adjust the benefit package to control costs. A Clinical Advisory Committee on Health and Emerging Technology (CACHET) was formed to advise the state on how best to structure the health insurance benefit to meet the needs of the population as well as control costs. The CACHET consists of health care professionals from across Wisconsin and across health care disciplines.

BadgerCare Plus for childless adults is a data driven program with a focus on health outcomes. Childless adults are required, as a condition of enrollment, to complete a health needs assessment (HNA) so the state can help match them with health plans and providers that best meet their needs. The HNA also allows the state to gather baseline data on the health status of childless adults that will assist CACHET in making recommendations on covered services.

In all of these reforms, the state of Wisconsin has served as an effective partner to the federal government, making these state-federal programs more cost-effective and responsive to the needs of enrollees. Through administrative simplification and working with local community groups, the state has lowered the barriers that prevented people from obtaining needed health coverage.

Moving forward, the state of Wisconsin would like to see continued federal financial commitment to Medicaid unless an exchange plays a broader role in national health care reform. Wisconsin is excited that national health care reform is finally at the top of the federal policy agenda.

limited-benefit policies, created high risk pools, provided tax credits, and even prohibited insurers from relying on health status when setting premiums.

A sharp debate over the effectiveness of the state-based insurance reform initiatives persists, but states continue to tinker with these and similar insurance reforms. At the same time, however, federal officials in the late 1990s enacted their own modest version of insurance reform (in the Health Insurance Portability and Accountability Act of 1996 [HIPAA]) and today are considering enacting additional insurance reforms (including guaranteed issue, community rating, and a health insurance exchange) at the national level. It is entirely unclear, however, which level of government would administer such

policies. It is equally unclear how these policies would mesh with the existing (and varied) set of state regulations. Consider, for example, the proposed health insurance exchange. Would there be a single national exchange or multiple state-based exchanges? If there were a national exchange, who would administer it and how would it interact with the existing (and varied) set of state insurance regulations? If there were multiple state-based exchanges, would states need to create new administrative agencies (as in Massachusetts) or rely on their existing administrative infrastructure? Who would pay for and supervise either situation? More generally, how will the proposed set of federal insurance reforms impact the current inter-governmental regulatory regime?

Federalism and Health Care Delivery: The Proposed Focus on Care Management

The American health insurance system that emerged following World War II was predicated on two key assumptions: there should be a clear separation between the provider of care and the payer of care (to protect physician autonomy) and the physician should be paid a separate fee for every service provided. By the early 1970s, however, policy analysts were noting four fundamental problems with this arrangement: 1) fee-for-service medicine was inflationary; 2) unbridled physician autonomy led to substantial variation in

the practice of medicine; 3) there was little evidence that more expensive care was necessarily better care; and 4) there was little care coordination between most patients' health care providers. These factors soon contributed to the so-called managed care revolution, under which providers presumably would either be salaried or would receive capitation payments, physician gatekeepers would coordinate care, and health services researchers would develop practice guidelines and protocols that would standardize care and reduce inappropriate utilization.

By the mid-1990s, however, the managed care industry was in retreat, as physicians complained about reductions in autonomy and income and consumers complained about restrictive provider networks and wrongfully denied care. In response, the industry minimized some of its more unpopular practices (such as requiring written referrals for in-network care) and focused instead on profiling the practice patterns of their providers. Insurers also tried to develop new payment methodologies that would encourage higher quality care (so-called "pay-for-performance" or "value-based purchasing" initiatives) and to develop new care management protocols.

At the same time, federal and state officials also began encouraging value-based purchasing as well as care management initiatives. Medicare, for example, has implemented pilot pay-for-performance programs for both hospitals and physicians and is now planning to expand their scope. Similarly, nearly every state Medicaid program has developed a range of care management initiatives, which include efforts to focus on particular chronic illnesses ("disease management"), programs that focus on the relatively few high-cost patients that have several chronic conditions ("care management"), and more expansive efforts to provide a so-called "medical home" to all beneficiaries.

These efforts to restructure the health care delivery system are critical components of any health care reform agenda. Indeed policymakers are seeking to develop financial incentives and organizational strategies that will encourage the health care system writ large to look more like some of the high-quality and relatively low-cost systems (such as the Mayo Clinic) that are viewed as models to be emulated.

Two caveats, however, should accompany such initiatives. First, national efforts to restructure health care delivery systems cannot simply or easily be imposed on local health care markets. Indeed, this is an arena in which state and local officials may be better equipped to work with community-based providers and payers to organize and encourage such initiatives. Second, state-based leadership in this arena might be particularly appropriate since some variation in local delivery is not only inevitable, it is perfectly appropriate. The structure of a "medical home" in rural Arizona will and should look very different from such an organizational approach in urban New York.

Conclusion

President Obama and Congress are working to enact legislation that will make dramatic changes in the nation's health care system. The goals include providing coverage to the uninsured, financing that coverage with some combination of new tax revenues and effective cost containment measures, and more generally slowing the rising cost of the nation's health care bill. While the outcome of the legislative process is unclear, any new federal programs will need to fit with the nation's complicated and entrenched set of inter-governmental partnerships, and will need to accommodate the inter-state (and intra-state) variation in every aspect of the nation's health care system. This will not be an easy task, as illustrated by the case studies highlighted in this issue brief. Medicaid is a collection of fifty diverse state-administered

programs that cannot easily accommodate new national mandates. The proposed health insurance exchange will have a dramatic impact on state's longstanding responsibilities to regulate the private insurance industry. Efforts to restructure the health care delivery system must both accommodate and acknowledge the diversity in local health care marketplaces.

The hard and complicated task is to develop a new and better inter-governmental health care partnership that at times provides centralized (and thus federal) leadership and at other times allows for local diversity and inter-state variation (and thus state and local leadership). But there is no magic formula. At best there are general principles that might guide the effort. For example, the federal government likely needs to determine how the system will be financed and it ought to provide general rules governing the behavior of health insurers. Meanwhile, state and local governments are likely best able to work in local health care markets to reorganize health delivery systems. States might also be best suited to administer insurance programs for low-wage workers. These, of course, are just some of the possibilities. What should be avoided, however, is the enactment of a host of new policies that dramatically but inadvertently change the health care inter-governmental partnership. Instead, any changes to the inter-governmental partnership should be carefully considered and designed to produce better policy outcomes.

So how should policymakers proceed? One option would be to establish a task force, work-group, or some similar institutional mechanism, comprised of federal, state and local officials, which would focus on the federalism and implementation implications of both proposed and enacted reforms. This new entity could collect data on inter-state variation, consider whether and when such variation is appropriate, and propose policies that are responsive to such findings. Put simply, such an

institutional mechanism could be a first step to acknowledging and accommodating the critically important federalism and implementation implications of any health care reform. But even if policymakers do not create a new inter-governmental institutional entity, they should more carefully and more explicitly consider the inter-governmental implications of any proposed reform. As illustrated in this issue brief, health reform will be administered by a complicated inter-governmental partnership, and it will be implemented in a nation in which health care systems vary significantly between and within states. Acknowledging and responding to these variables is a critical component of a successful health reform agenda.

About the Author

Michael Sparer, J.D., Ph.D. is Professor and Chair in the Department of Health Policy and Management at the Mailman School of Public Health, Columbia University. Dr. Sparer studies and writes about the politics of health care. Much of his work focuses on the politics of public insurance programs, including Medicaid and Medicare, and ways in which inter-governmental relations influences health policy. He is the author of “Medicaid and the Limits of State Health Reform,” as well as numerous articles and book chapters, and he is the editor of the *Journal of Health Politics, Policy and Law*. Previously, Dr. Sparer spent seven years as a litigator for the New York City Law Department, specializing in inter-governmental social welfare litigation.

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