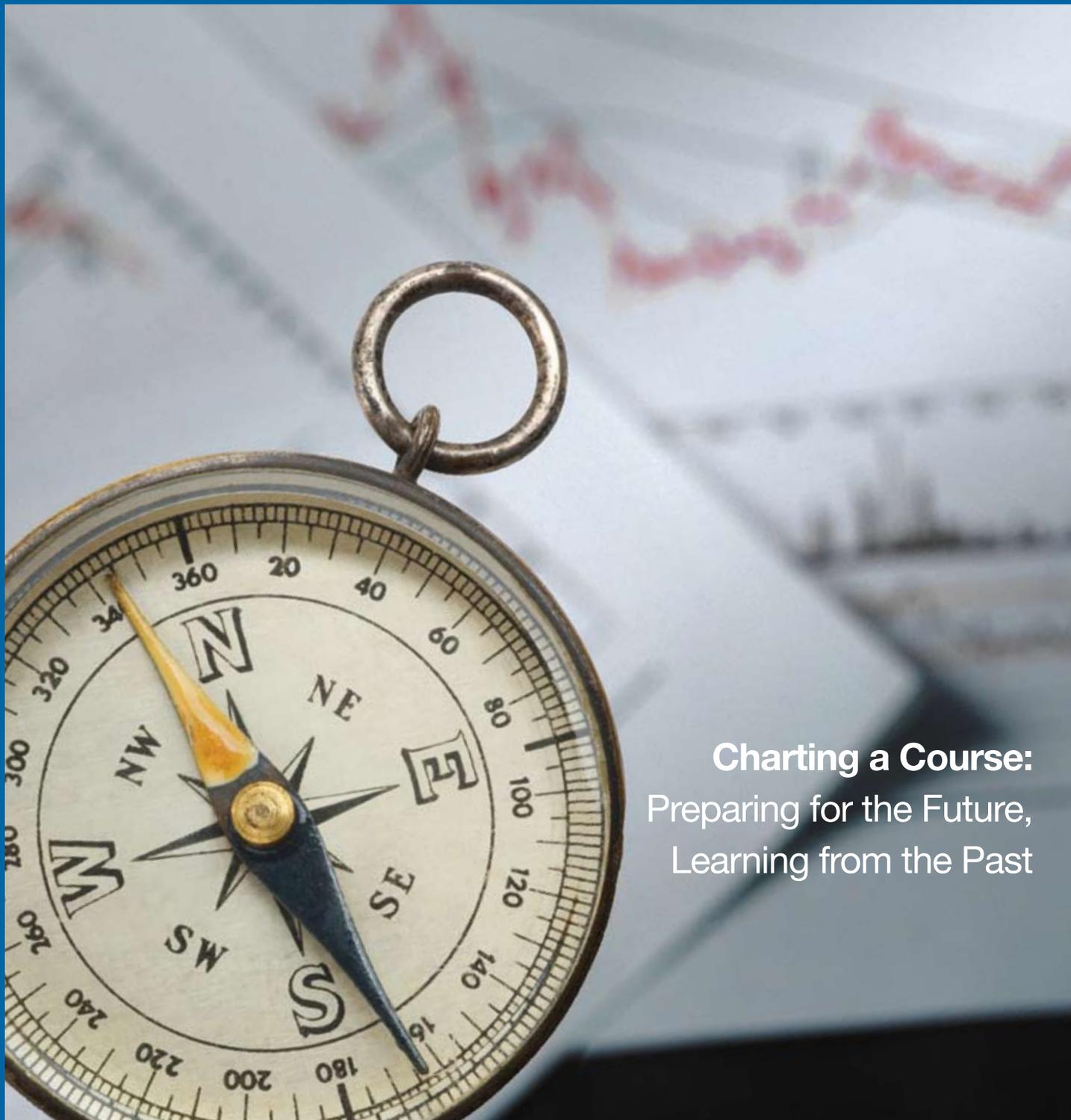




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STATE OF THE STATES

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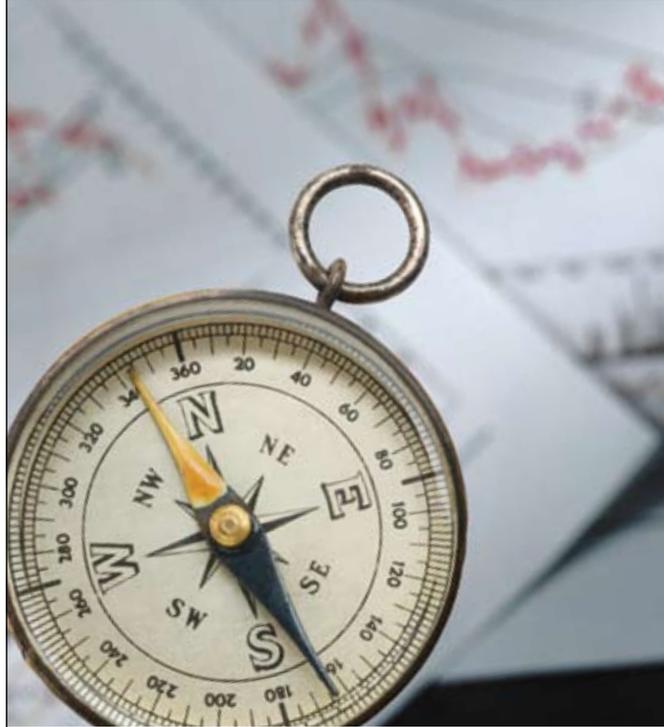


Charting a Course:
Preparing for the Future,
Learning from the Past



AcademyHealth

STATE OF THE STATES



About SCI

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. For more information about SCI, please visit our Web site www.statecoverage.org.

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Executive Summary

CHARTING A COURSE: PREPARING FOR THE FUTURE, LEARNING FROM THE PAST

This year's *State of the States* will review the full range of state activity on health reform during 2008 while also looking to the future, particularly in light of the expected impact of the economic downturn and the possibility of federal action. This is a time of both challenge and possibility for policymakers, and the nation. The experience of states can inform the ongoing discussion.

With the election of Barack Obama to the Presidency, Congressional leaders have begun to set ambitious goals for the 111th Congress, including comprehensive coverage and systemic reforms to promote quality care and cost containment. For this reason, this year's report not only analyzes the experience of states in the past year, but also explores the relationship between states and the federal government.

The states will be watching reform efforts at the national level, first for their possible immediate impacts (for example, a short-term boost in the federal Medicaid matching rate to address the states' budget shortfalls) and then to see how broader federal reform may impact their particular states. Particularly in light of severe budget deficits, some states may choose not to act in 2009 in the hopes that federal coverage expansions and other reforms will be forthcoming.

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 reform efforts

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.

As the discussion continues in 2009, some critical questions will need to be resolved:

- How can the states and the federal government best work together in the context of national reform?
- How can the federal government provide leadership that empowers the states to be effective partners?
- Which tasks are best undertaken at which level of government?

Given the large variation between states in coverage rates, health care delivery system models, insurance market structures, income levels, and a variety of other aspects, federal reform will certainly impact states differently. How can states and the federal government work together to reduce undesirable variation while still allowing for creativity and innovation at the state and local levels?

The analysis in this report explores these challenging issues. It also provides the necessary context for readers as they learn about state-level innovations and reforms. Perhaps the two most significant themes that emerge from a review of 2008 state-level health reforms are: 1) the impact of the recent economic downturn; and 2) the emerging trend among states to address cost and quality together with access as they consider comprehensive reforms.

Surveying the Landscape. This section analyzes trends in health care cost and coverage. It notes that while employer coverage rates have held relatively steady in the last few years, declines will be inevitable as the current recession takes hold. While many people will lose their employer-sponsored coverage as the unemployment rate climbs, more will become eligible for state Medicaid programs. This will further pressure already burdened state budgets. By December 2008, at least 41 states and the District of Columbia were reporting mid-year budget gaps, amounting to an estimated \$43 billion shortfall.¹ Forecasters predict that these budget gaps will only worsen as states struggle with declining revenues.²

State Coverage Strategies. While election year politics slowed the rate of state reforms relative to 2007, significant progress was accomplished in several states. Massachusetts and Vermont continued implementation of their comprehensive reforms, with Massachusetts reporting that 97.4 percent of its residents are now insured and Vermont launching two of three coordinated community pilots under its Blueprint for Health.

Minnesota, Iowa, and New Jersey all passed significant health reform legislation in 2008. Minnesota's legislation was broad in scope and included major provisions that address improved health care coverage and affordability, payment reform and price/quality transparency, chronic care management, administrative efficiency, and public health.³ Iowa lawmakers expanded children's coverage to 300 percent of the Federal Poverty Level (FPL), called for a medical homes program and several other quality and transparency initiatives, and set up a task force to develop a plan to provide comprehensive coverage to all Iowans in five years. New Jersey also expanded health coverage for kids and passed a mandate that all kids be covered; they also expanded health coverage for parents up to 200 percent FPL.

Several other states attempted major health reforms—most notably California and New Mexico. While their ambitious goals were not achieved in 2008, they advanced the

health care discussion in their states. Finally, a handful of states used 2008 as a consensus-building year, putting together comprehensive plans for health care reform in the coming years. These states include Arkansas, Connecticut, Ohio, Oregon, and Utah. While the economic picture in each of those states has darkened considerably during recent months, there are still hopes of enacting at least some of the recommendations being proposed.

State Children's Health Insurance Program. Ten states passed legislation in 2008 to expand children's health coverage, either through increased eligibility levels or stepped up enrollment efforts. The failure of federal lawmakers to pass a reauthorization of the State Children's Health Insurance Program (SCHIP) in late 2007 and the impact of a restrictive federal directive limiting the use of federal funds to expand coverage above 250 percent FPL had a dampening effect on SCHIP expansions.

State Reform Efforts Target Small Businesses. Because of declining coverage rates in the small business market and the difficulty of finding affordable small business coverage, many states have developed interventions to bolster the small business market. These include providing premium subsidies, offering reinsurance programs, restructuring benefit plans, providing tax cuts and credits, or some combination of these approaches.

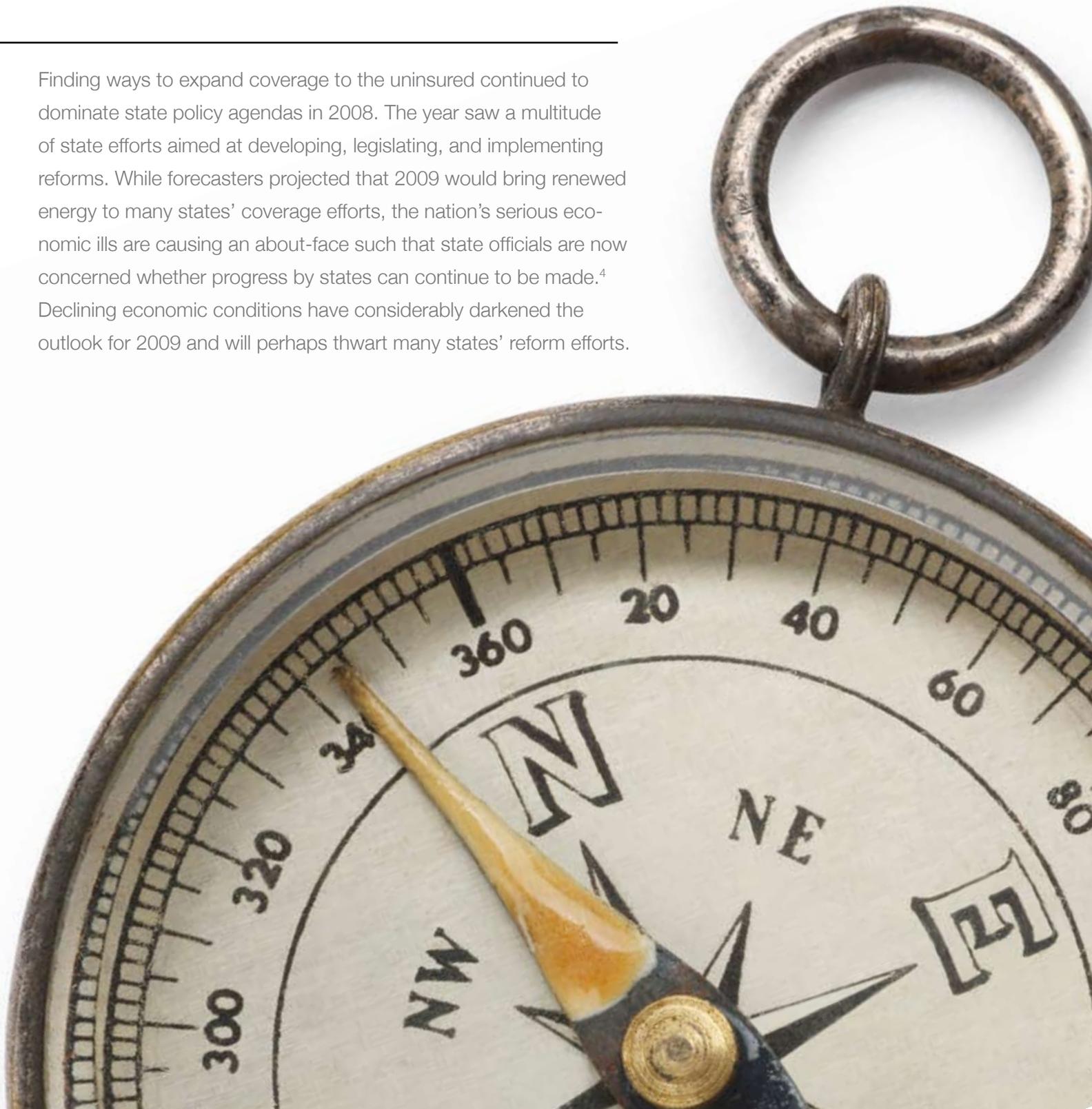
Cost Containment and Quality Improvement. The U.S. health care system has seen dramatically rising costs in recent years. These increases have impacted the budgets of individuals, employers, states, and the federal government. The quality of care, unfortunately, is not improving at a commensurate rate; indeed, high spending does not correlate with high quality. There is a growing consensus that payers—including states—are not getting good value for their health care dollar.

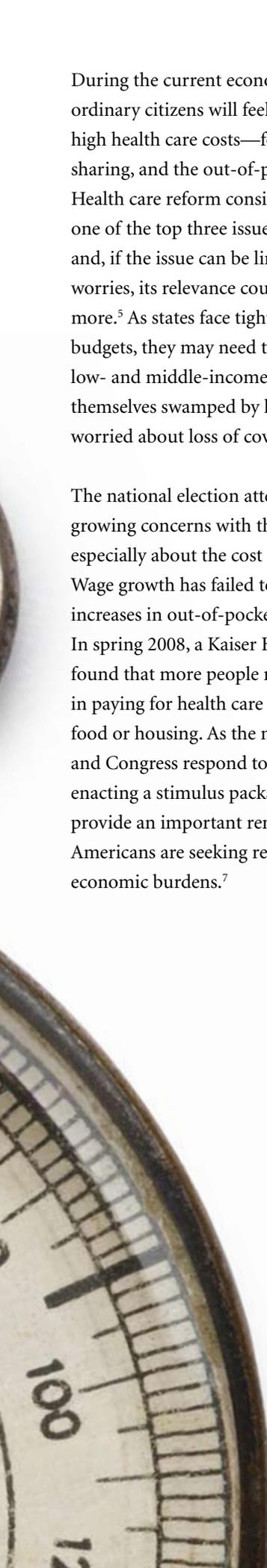
States have undertaken a series of strategies to improve value by containing costs and improving quality. These include: 1) investing in primary care through medical homes and care coordination; 2) wellness initiatives; 3) efforts to promote patient safety and prevent medical errors; 4) price and quality transparency initiatives; 5) health information technology and exchange; and 6) efforts to reduce preventable hospital readmissions.

Looking Forward. The immediate future in health care policy is uncertain. While many states have laid the groundwork for significant reform in the last few years, budget shortfalls and the potential for federal reform are likely to dampen state efforts. Nevertheless, the coming year will put the spotlight on health reform as federal lawmakers consider the issue and more businesses and individuals feel the pinch caused by the economic downturn. It remains to be seen whether the national discussion around health reform excites or dampens state efforts and what role states might play in a changing federal system.

SURVEYING THE LANDSCAPE

Finding ways to expand coverage to the uninsured continued to dominate state policy agendas in 2008. The year saw a multitude of state efforts aimed at developing, legislating, and implementing reforms. While forecasters projected that 2009 would bring renewed energy to many states' coverage efforts, the nation's serious economic ills are causing an about-face such that state officials are now concerned whether progress by states can continue to be made.⁴ Declining economic conditions have considerably darkened the outlook for 2009 and will perhaps thwart many states' reform efforts.





During the current economic downturn, ordinary citizens will feel the crunch of high health care costs—for premiums, cost sharing, and the out-of-pocket cost of care. Health care reform consistently polled as one of the top three issues for voters in 2008, and, if the issue can be linked to economic worries, its relevance could increase even more.⁵ As states face tightly constrained budgets, they may need to respond to low- and middle-income voters who find themselves swamped by health care bills and worried about loss of coverage.

The national election attested to voters' growing concerns with the economy and especially about the cost of health care. Wage growth has failed to keep pace with increases in out-of-pocket health care costs.⁶ In spring 2008, a Kaiser Health tracking poll found that more people reported difficulty in paying for health care than paying for food or housing. As the new president and Congress respond to calls for relief by enacting a stimulus package, the poll data provide an important reminder that many Americans are seeking relief from a range of economic burdens.⁷

This section uses various data sources to explore the current landscape. Despite some variation in data across sources, the overall trend is consistent. Moreover, given that data sources typically lag current conditions by a year, the numbers (particularly the national rates of uninsurance) paint a rosier picture than the reality faced by many states. This section looks behind the numbers to project the potential impact of the nation's altered economy on states—their budgets, public programs, and efforts to expand coverage to the uninsured.

UNINSURED DECLINE IN 2007

For the first time since 2004, the number of uninsured declined, dropping from 47 million in 2006 to 45.7 million in 2007.⁸ Several factors contributed to the decrease. First, the rate of employer coverage remained relatively stable between 2006 and 2007 (although there were modest declines), most likely because of the continuation into 2007 of the economic improvements experienced between 2004 and 2006, a period in which real median income increased as the poverty rate dropped.⁹ Second, public coverage expanded between 2006 and 2007. Health insurance reform implemented in Massachusetts during 2007 also significantly contributed to the decline in the number of uninsured nationally.¹⁰

But the decline in the uninsured masks a sobering reality: an estimated 50 million people were uninsured for some time during 2007. And nearly two-thirds of adults—116 million people—were uninsured for part of the year, were underinsured, experienced problems paying their medical bills, or deferred needed health care because of its cost.¹¹

Furthermore, given the economic downturn, the 2007 decline in the number of uninsured may prove to be a minor aberration in an otherwise upward trajectory that has prevailed since 2000. The U.S. unemployment rate reached a 16-year high of 7.2 percent in December 2008,¹² an increase that will almost certainly lead to a drop in employer-sponsored coverage and an increase in the number of uninsured. In fact, forecasters predict that the number of uninsured will jump by at least 2 million in 2008, and might go even higher given the unemployment outlook in late 2008.¹³

STATE FISCAL CONDITIONS DARKEN

After several years of fiscal stability, states are navigating a bleak economic landscape. Undoubtedly, declining state revenues will severely undermine future spending and coverage plans. As the impact of the nation's worst financial crisis since the Great Depression ripples through state economies, many states are already experiencing difficulties. The collapse of the housing market and growing cost of energy have taken a toll on state revenues, creating budget gaps and the urgency for short-term borrowing.

States routinely borrow to meet short-term spending obligations, particularly given calendar fluctuations in incoming revenues; accordingly, lenders typically count on states to repay their loans.¹⁴ In fall 2008, however, a slump in the credit markets caused lenders to restrict access to loans, causing many businesses and states to worry about their ability to borrow short-term cash. California and Massachusetts were the first states to raise the alarm that a credit freeze might jeopardize their short-term borrowing needs. Like others, these two states may need to turn to the federal government as a lender of last resort.

UNINSURED IN AMERICA: THE FACTS

Figure 1 **Average Annual Firm and Worker Contribution to Premiums and Total Premiums for Covered Workers for Single and Family Coverage, All Plans, 2008**



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2008

Number and Percent of Uninsured Decreases¹⁵

- The total number of uninsured decreased in 2007 to 45.7 million from 47 million in 2006. The percentage of uninsured also decreased from 15.8 percent to 15.3 percent.
- This is only the fourth time since 1994 that an increase in health insurance coverage among the non-elderly population has been recorded.
- Despite this increase, the percent of people covered by private health insurance decreased from 67.9 percent in 2006 to 67.5 percent in 2007.
- Rates of uninsurance continue to differ significantly across the country. On a regional level, the Midwest and Northeast had the lowest rates of uninsurance (11.4 percent for each), followed by the West (16.9 percent), and the South (18.4 percent). States with the lowest uninsurance rates include Hawaii (8.3 percent), Massachusetts (8.3 percent), and Minnesota (8.5 percent), while states with the highest rates of uninsurance rates include Texas (24.4 percent), New Mexico (21.9 percent), and Florida (20.5 percent).
- Nine states had statistically significant increases in uninsurance: Kansas, Kentucky, Louisiana, Nebraska, New Jersey, New Mexico, New York, North Carolina, and Texas.
- Five states showed statistically significant decreases in uninsurance: Connecticut, Indiana, Massachusetts, West Virginia, and Wisconsin, as did the District of Columbia. Massachusetts alone accounted for 22 percent of the decline in nonelderly uninsured.¹⁶

Employer Offer Rates Level Off in 2008 after Long Decline¹⁷

- In 2008, 63 percent of employers offered health benefits to their employees, although this is not statistically different from the 60 percent of employers who offered coverage in 2007. This is down from 69 percent in 2000.
- Employer-sponsored coverage varies dramatically by firm size. Nearly all (99 percent) of large firms with 200 or more employees offered coverage, but only 49 percent of firms with three to nine employees did so.
- Firm size is not the only factor that affects whether an employer offers coverage. Firms with no union workers as well as those with a higher proportion of lower-wage workers (defined as a firm where more than 35 percent of workers earn less than \$22,000 annually) are less likely to offer coverage.

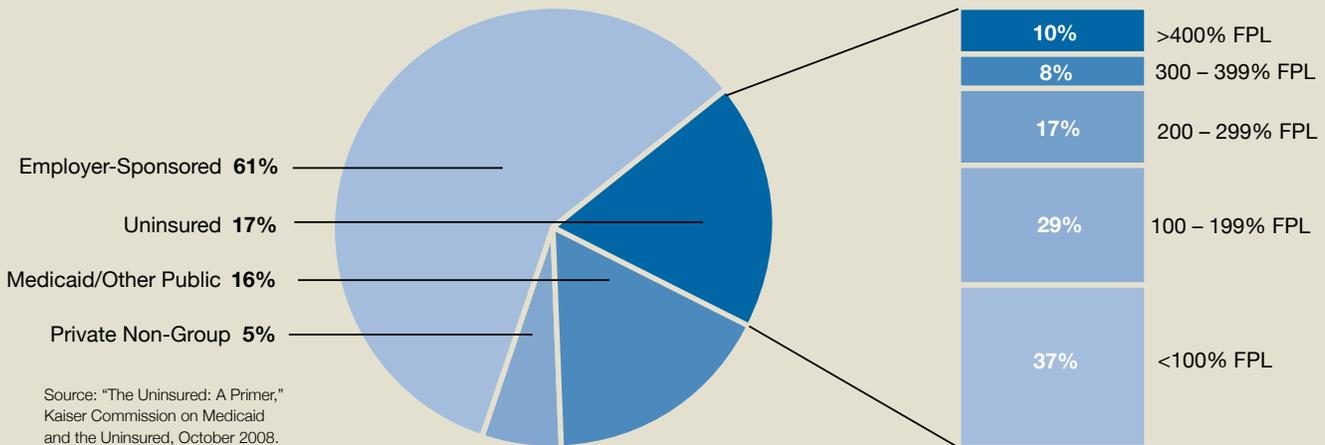
Rise in Public Program Enrollment

- More people were covered by Medicaid in 2007. The percentage of people covered by Medicaid increased to 13.2 percent from 12.9 percent in 2006.¹⁸
- Much of the increase in health insurance coverage can be attributed to an increase in the number of people covered by government programs. The number of people enrolled in these programs increased from 27 percent in 2006 to 27.8 percent in 2007.

Health Insurance Premiums Go Up, Move Toward High Deductible Health Plans¹⁹

- Since 1999, health premiums have increased a staggering 119 percent. That is more than three times the rate of increase in employee wages (34 percent), and is more than four times the rate of increase in inflation (29 percent) over the same period of time.
- Health insurance premiums continued to increase in 2008, rising 5 percent in 2008. The average annual premium for single coverage in 2008 was \$4,704 and the average annual premium for family coverage was \$12,680.
- Workers with both single and family coverage paid for a significant share of their premiums. Single coverage workers paid more than 15 percent and family coverage workers paid more than 26 percent of their health insurance premiums. There was significant variation within this group, with more than one-fifth of single coverage workers and 47 percent of family coverage workers paying more than 25 percent of their premium.
- While the rise in health insurance premiums was relatively modest, more employers are turning to health plans with high deductibles and fewer benefits to keep premiums down. The percentage of workers enrolled in high-deductible insurance plans (defined as having a deductible of \$1,000 or more) jumped from 12 percent in 2007 to 18 percent in 2008. Among firms with 3 to 199 employees, the rate more than doubled from 16 percent to 35 percent.

Figure 2 **The Nonelderly Uninsured As a Share of the Population and by Poverty Levels, 2007**



- Increasingly, these high-deductible plans are being coupled with a health savings account, where an employee (and employer, if so inclined) can set aside a portion of their income on a pretax basis and then use that to cover qualified medical expenses. In 2008, 13 percent of employers offered plans with a savings option. While this does not differ statistically from the 10 percent that offered last year, it is significantly greater than the 7 percent of employers that offered them in 2006.

with 6.6 percent of individuals in families with annual incomes of \$75,000 or more.

Uninsurance varies considerably by industry. Those employed in blue-collar jobs such as agriculture, forestry, fishing, mining, and construction industries constitute a significant share of the uninsured (36.5 percent).

In 2007, minority groups were more likely to be uninsured than whites. While 12.7 percent of whites were uninsured in 2007, 33.5 percent of

Hispanics, 20.9 percent of African Americans, and 17.7 percent of other ethnicities (primarily Asians) were uninsured.

Country of birth also impacts insurance coverage with 33.2 percent of foreign-born individuals being uninsured as opposed to only 12.7 percent of native-born individuals.²¹

Young adults continue to have the highest uninsured rates; those aged 18-24 and 25-34 have uninsured rates at 28.1 percent and 25.7 percent, respectively.²²

Who are the Non-Elderly Uninsured?²⁰

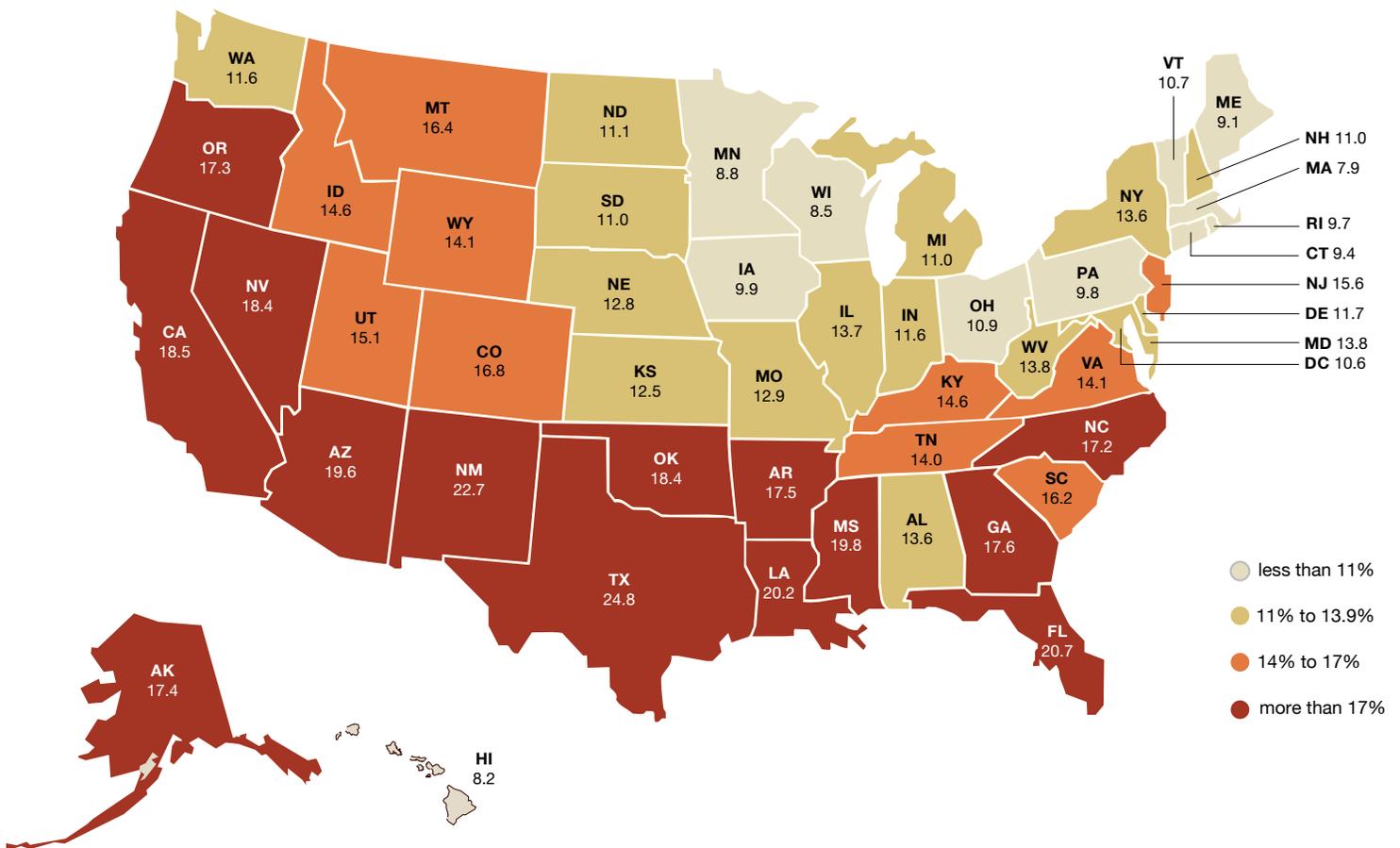
Although the number and percentage of uninsured dropped in 2007, there continues to be marked economic and social disparity within the non-elderly uninsured population.

A majority of the uninsured are members of families with a family head who works during the year (almost 83 percent). Only 17.4 percent of the uninsured are members of the families where the family head did not work at any point during the year.

Those with low incomes represent a disproportionate share of the uninsured. Nearly one-third (32.5 percent) of the uninsured in 2007 live in families with incomes below \$20,000. More than 35 percent of individuals in families making less than \$10,000 were uninsured as compared



Figure 3 Percentage of People Without Health Insurance by State, 2006-2007 Average



Source: DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica Smith, U.S. Census Bureau, Current Population Reports, P60-235, Income, Poverty, and Health Insurance Coverage in the United States: 2007. U.S. Government Printing Office, Washington, DC, 2008.

Even before the financial crisis, many states were facing budget deficits that forced them to raise taxes, cut spending, or both. In fact, in early 2008, 29 states had already confronted budget shortfalls totaling \$48 billion as they prepared their fiscal year (FY) 2009 budgets, which typically begin on July 1.²³ By December 2008, new mid-year budget gaps emerged, leading to budget gaps in at least 41 states and the District of Columbia, amounting to an estimated \$43 billion shortfall totaling 8.8 percent of state budgets.²⁴ The projected gaps for fiscal year 2010 total 16.8 percent, based on states that are already reporting projections. Forecasters predict that these budget gaps will only worsen as states struggle with declining revenues.²⁵

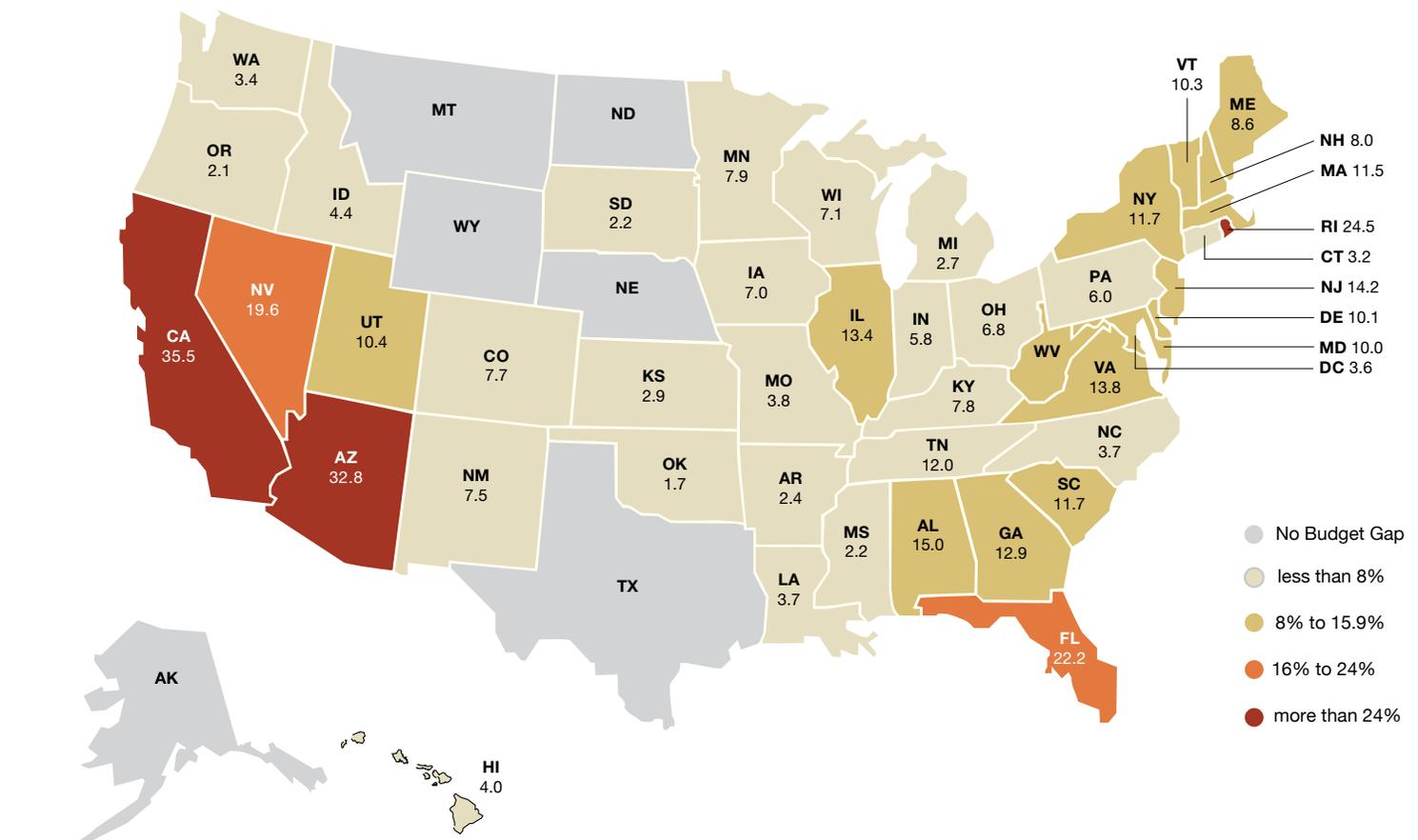
By law, most states must balance their budgets. When the economy sours, states cannot run deficits and must close budget gaps by cutting expenditures, raising tax revenues, or drawing from rainy day funds or reserves. For many states, the worst financial crisis in recent times will mean layoffs and program cuts. Virginia is one such example. Faced with a \$2.5 billion shortfall for its two-year budget, Virginia is laying off 570 state workers, leaving vacant an additional 800 unfilled positions, and instituting a hiring freeze. The state also plans to close several older correctional facilities and will reduce the budgets of higher education institutions by 5 or 7 percent. These cuts, however, address

only a portion of the state's budget gap, necessitating further spending reductions.²⁶

MEDICAID ENROLLMENT, SPENDING SET TO SWELL

In FY 2008, state Medicaid rolls increased by 2.1 percent as states began experiencing the effects of a weakening economy. With a deteriorating economy, unemployment rises and people face the loss of both employment-based coverage and wages, making them more likely to be eligible for public programs such as Medicaid. As a result, Medicaid enrollment is expected to jump even higher (by 3.6 percent) in FY 2009.²⁷

Figure 4 **Size of FY 2009 Budget Gaps: Total Gap As Percent of FY 2009 General Fund**



Source: Center on Budget and Policy Priorities, State Budget Troubles Worsen. Table 3. <http://www.cbpp.org/9-8-08sfp.htm>
 Note: These numbers are based on the estimated revenue shortfall before the FY 2009 budget was adopted, plus the mid-year gap for FY 2009.

Total Medicaid spending increased by 5.3 percent in FY 2008; for FY 2009, state legislatures adopted Medicaid appropriations that are 5.8 percent higher than Medicaid expenditures in FY 2008.²⁸ Increases in Medicaid enrollment and spending combined with budget constraints raise the strong possibility of Medicaid program cuts as states try to manage growth in their public programs with fewer resources. In fact, two-thirds of Medicaid directors project Medicaid budget shortfalls, which could translate into decreased eligibility or provider payments or both.²⁹

A recent analysis found that a 1 percentage point uptick in the nation's unemployment rate would result in 1.1 million additional

uninsured and would increase Medicaid and State Children's Health Insurance Program (SCHIP) enrollment by 1 million adults and children, resulting in an additional \$1.4 billion in state Medicaid spending.³⁰ Given that the unemployment rate increased by 1.5 percentage points from June 2007 to August 2008, analysts expect to see an increase in Medicaid and SCHIP coverage of approximately 700,000 adults and 900,000 children, barring cuts in eligibility.³¹

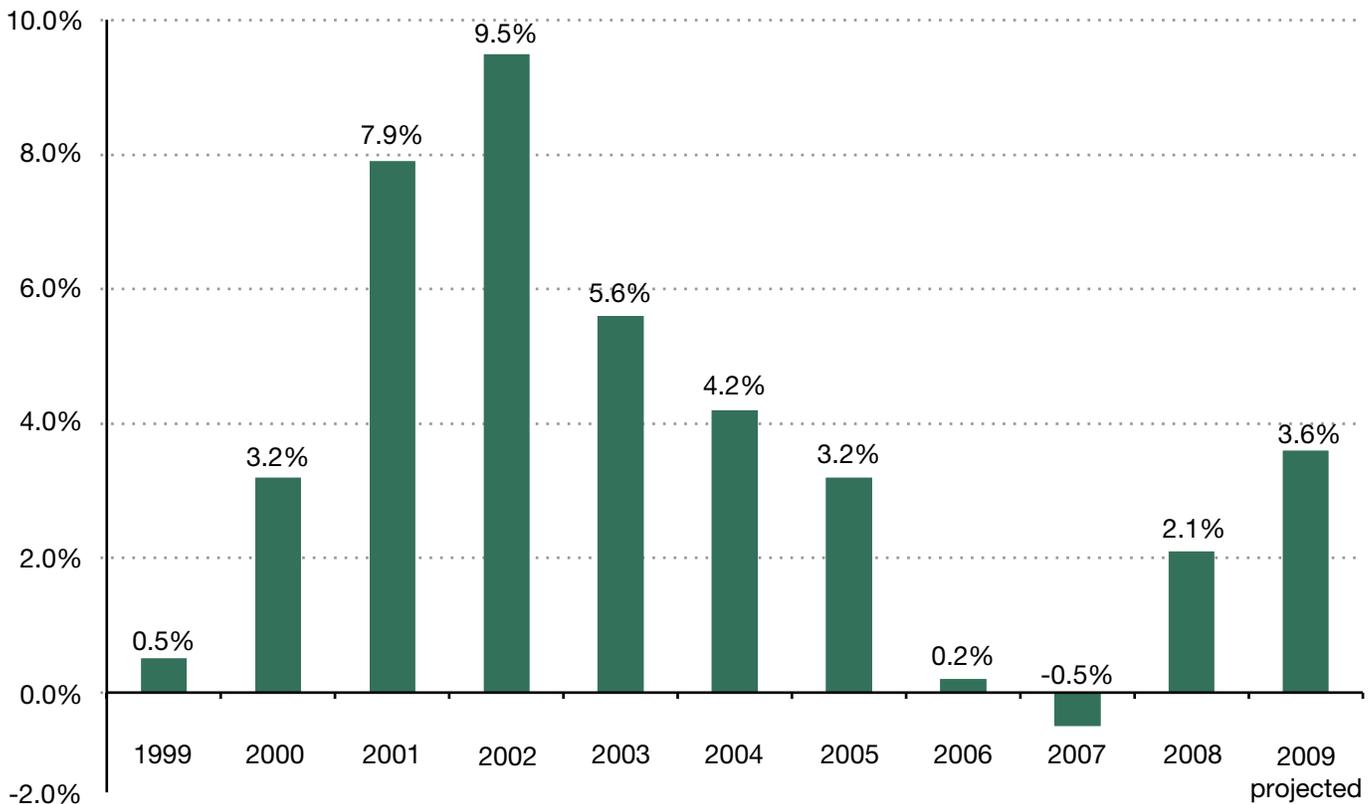
EMPLOYER COVERAGE CONTINUES ITS SLOW EROSION

Although there were some signs of a brief stability between 2006 and 2007, the number of people covered by employer-sponsored insurance continued to decline, falling to

59.3 percent in 2007, down from 59.7 percent in 2006.³² The decline continues a trend of decreasing employer-sponsored coverage that began in 2000. Furthermore, the percentage of employers offering health insurance coverage has fallen from 69 percent in 2000 to 63 percent today, a worrisome drop given that employer-sponsored coverage is the primary source of coverage for most people under age 65.³³ And, for small employers, the trend is more alarming; whereas 57 percent of firms with three to nine workers offered coverage in 2000, the figure has dropped to less than half today (49 percent).³⁴

Health insurance premiums continued their upward march in 2008, increasing by 5 percent from 2007 average premiums. The

Figure 5 **Percent Change in Medicaid Enrollment, FY 1999-2009**



Source: Headed for A Crunch: An Update on Medicaid Spending, Coverage, and Policy Heading Into an Economic Downturn, Kaiser Commission on Medicaid and the Uninsured, September 2008, <http://www.kff.org/medicaid/upload/7815ES.pdf>.

increase was relatively modest compared to that of past years. Nonetheless, many workers face higher deductibles and out-of-pocket costs. A growing share of workers—now at 18 percent—have insurance policies with deductibles of at least \$1,000, a significant increase over last year’s 12 percent of workers with deductibles of the same level. But the increase is most noticeable among employees of small firms with 3 to 199 workers; more than one-third (35 percent) of these workers must pay at least \$1,000 out of pocket before their insurance starts to pay, up from 21 percent in 2007.³⁵

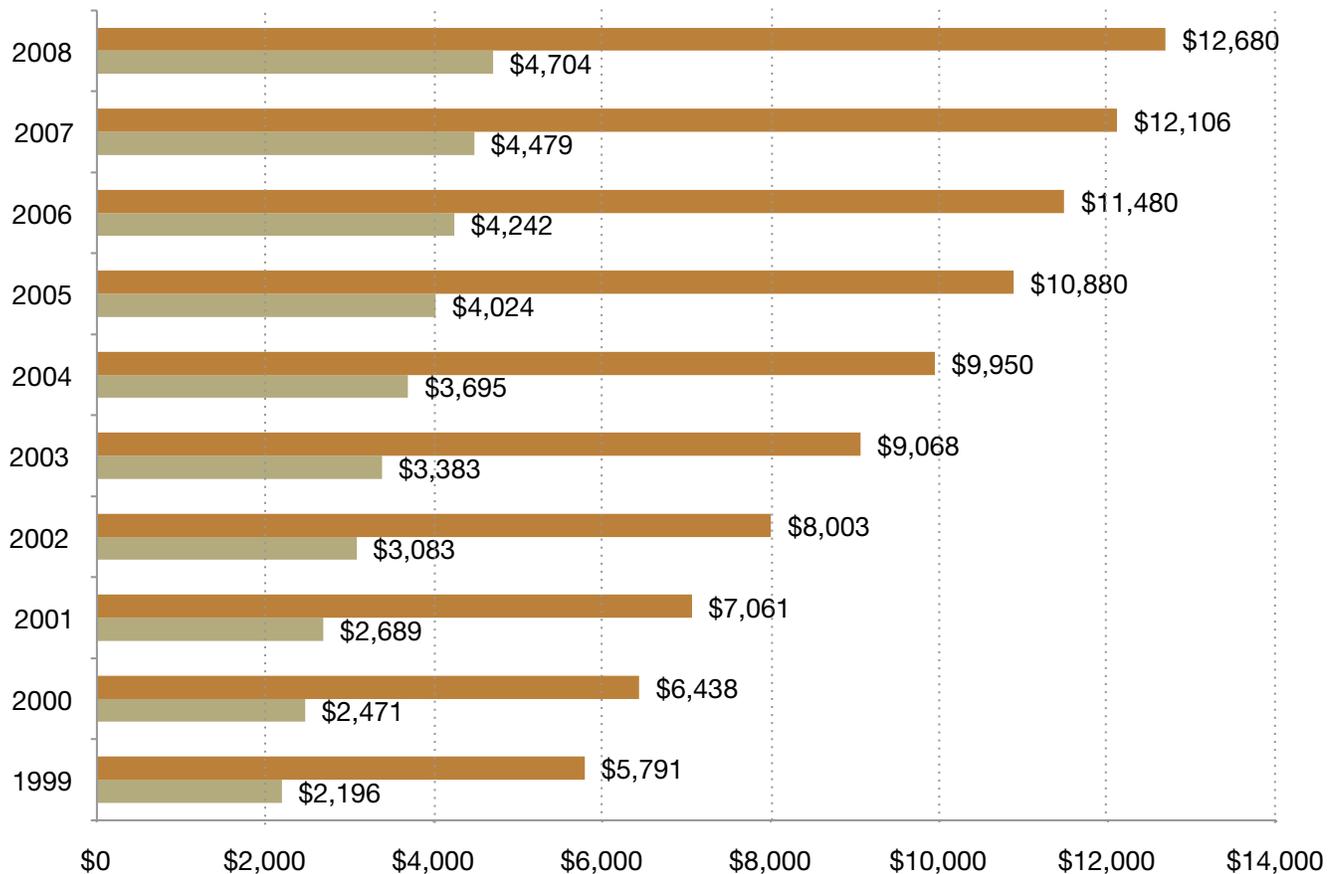
POLITICAL AND ECONOMIC CONDITIONS LIKELY TO IMPACT 2009 ACTIVITY

In 2008, state activities to provide coverage to the uninsured continued to make headlines, most notably the Massachusetts efforts to implement a near-universal health coverage program. Massachusetts was able to decrease by half the state’s number of uninsured in 2007, resulting in 300,000 fewer uninsured residents. In fact, the Massachusetts efforts to implement universal coverage accounted for more than 20 percent of the decline in the nation’s number of uninsured last year.³⁶

Almost half of states included coverage expansions for the uninsured in their proposed FY 2009 budgets, but those plans now appear to be in jeopardy. States may scale back these efforts or abandon them entirely as they struggle to close budget gaps and maintain current levels of coverage.³⁷ Furthermore, current economic conditions will increase pressure on states to contain costs. For many states, controlling costs may prove more difficult than expanding access.

Current economic conditions raise the specter of a recession more severe than the one in 2001, which had a long-lasting

Figure 6 **Average Annual Premiums For Single and Family Coverage, 1999-2008**



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2008

impact on states. Following that recession, unemployment hit a high of 6.3 percent, a figure this recession surpassed in the fall of 2008. Without the \$20 billion in temporary federal relief provided to states in 2003, the impact of the 2001 recession would have been even harsher. Even now, forecasters suggest that a similar federal intervention may be needed—sooner rather than later.³⁸

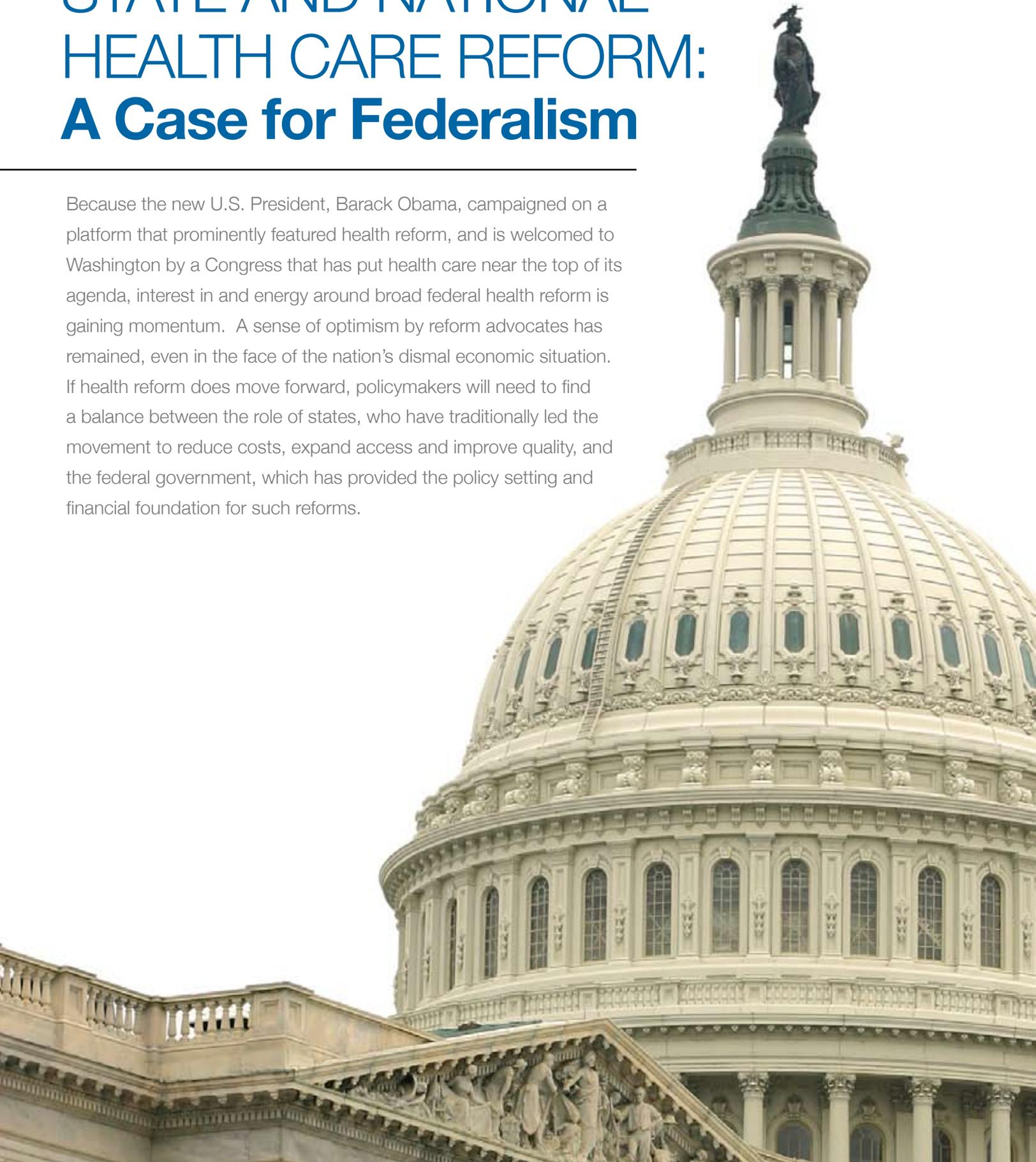
Health care reform was a major issue in the national election. President Obama campaigned on the promise of a universal coverage plan that builds

on the current system of private and public insurance. Some features of his proposed plan resemble the Massachusetts comprehensive reform plan. He has proposed that all employers, except small employers, either offer health insurance to their workers or contribute to the cost of coverage. His campaign proposal called for a National Health Insurance Exchange that would allow individuals without coverage to purchase a plan similar to that offered to federal workers. President Obama’s proposal also called for expanded eligibility under Medicaid and SCHIP.³⁹

To what extent the dramatically altered economic outlook will affect the President’s health care reform plans remains to be seen. He has signaled his intent to move quickly to repair the economy, starting with an economic stimulus package. At the same time, he has indicated that health care reform tops his agenda alongside clean energy, education, and tax relief for the middle class. Ambitious health care reform proposals may wait until after Congress addresses a stimulus package, although increased funding for SCHIP and other smaller agenda items with bipartisan support may see early action.⁴⁰

STATE AND NATIONAL HEALTH CARE REFORM: **A Case for Federalism**

Because the new U.S. President, Barack Obama, campaigned on a platform that prominently featured health reform, and is welcomed to Washington by a Congress that has put health care near the top of its agenda, interest in and energy around broad federal health reform is gaining momentum. A sense of optimism by reform advocates has remained, even in the face of the nation's dismal economic situation. If health reform does move forward, policymakers will need to find a balance between the role of states, who have traditionally led the movement to reduce costs, expand access and improve quality, and the federal government, which has provided the policy setting and financial foundation for such reforms.



Within our structure of federalism and given the complexity of the health care system, it is imperative to build upon the respective strengths of both state and federal governance to fashion health reform solutions with the greatest potential for success.⁴¹ This section looks at the strengths of states and the federal government, and outlines a potential framework for merging the two, informed by a growing body of research based on state reform efforts.

IMPLEMENTATION, SYSTEM REDESIGN, AND OTHER STATE STRENGTHS

In recent years, a lack of national consensus about how to address the growing number of uninsured people has prompted work at the state level to enact incremental, substantial, and comprehensive coverage reforms as well as other initiatives that address cost and quality. These states could not wait; due to the immediacy of constituent concerns—of individuals, employers, and other stakeholders in the health care system—state governors and legislatures felt compelled to act. Results were mixed. States have experienced both important successes and enlightening failures that can help inform a national plan and help frame the best structure for any new federal-state partnership.

States play a critical role in advancing coverage expansions and other health reforms by testing new ideas, both politically and practically. Because health care delivery is largely local, states are closer to the action when it comes to implementing some of the delivery and payment systems changes that are needed to truly transform the health care system. This proximity and flexibility in system redesign is a key strength for states. In addition, states have first-hand knowledge of their local landscape and relationships with the stakeholders that will be necessary to change the system. Much of the work related to implementing insurance reforms, delivery system redesign, and public health strategies traditionally have been led by states.

On the other hand, there are numerous limitations for states in these areas as well, including some structural and financial constraints that keep certain potential levers out of their reach. In these areas, the federal government offers key advantages.

FINANCING, CONTINUITY, AND OTHER FEDERAL STRENGTHS

While many states are attempting to move ahead with reform, they are not all equal in their capacity to address these large and complex problems. Significant variation exists across states in terms of resources, capacity, demographics, number of uninsured, insurance market structures, public programs, state funds available to invest in reform, employment base, political priorities, and a host of other relevant factors that must be considered if health reform is to succeed. For example, state uninsured rates vary from just under 8 percent to almost 25 percent and, generally, where those rates are the highest, the states have the least resources in terms of a tax base or population income levels to support funding for needed coverage expansions. So while

some states have moved forward and will continue to try to expand or maintain coverage rates, there are a large number of states that need significant federal support.

It is extremely difficult, if not impossible, to construct an effective and efficient national health system one state at a time.⁴² Importantly, as currently evidenced by the varying levels of public program eligibility, investments in public health, and quality measures, a state-by-state approach without sufficient national standards and support leads to inequity in the overall system.⁴³ Many states will not achieve universal coverage without a national framework and federal funding. This is a key argument for some federal reforms. Differences in the way that state and federal governments are able to address budgetary issues also suggest advantages to federal leadership on reform:

- **Counter-cyclical Budgeting:** The federal government is able to maintain spending levels during times of recession because they are not constitutionally mandated to balance their budget every year. Almost all states have annual or biennial budgets that must balance, which makes coverage expansions more challenging for states as they may not be able to afford to maintain benefit and eligibility levels during economic downturns.
- **Multi-year Budgets:** Because the federal government does multi-year budgets, they have the capacity to score savings in the Medicare and Medicaid program that will be realized in future years. This makes it easier for federal policymakers to find resources for program expansions from cost-saving approaches because the savings from these programs are often realized several years in the future.

- **Revenue Raising Capacity:** In addition, the federal government has the capacity to raise revenues in a broader fashion. In a hypothetical example, if \$100 billion was needed to cover all of the uninsured nationally, each state would have to increase their taxes by more than 13 percent. The federal government, on its tax base, would only need to increase taxes by about 4 percent to raise the same funds.⁴⁴ This example demonstrates the important difference in the scope of revenue-raising capacity at the two levels of government.

A FEDERAL-STATE PARTNERSHIP

Given the respective strengths and challenges of either an all state or all federal approach to health reform, a strong federal-state partnership that builds upon the best of both could be a useful approach. In this scenario, the federal government would use its leverage as the largest purchaser in the country to set minimum standards and guidelines upon which states can build; it would also provide the necessary resources to the states to facilitate reform. States would then be responsible for implementing the programmatic aspects of health reform within an overall framework established at the national level. Key features of this approach are outlined below.

Regulating Insurance Markets. States have significant and lengthy experience with insurance market oversight and consumer protection.⁴⁵ However, while they have the advantage of being more directly accountable to consumers and providers, their purview over some employers is limited by federal law (e.g., Employment Retirement Income Security Act of 1974 [ERISA]). In addition, many of their residents are covered by federal insurance programs such as Medicare, the Veterans Health Administration, the Indian Health Services, and the Federal Employee Health Benefit Plan (FEHBP), and are therefore also beyond the reach of state regulation.

States are limited in their ability to engage with employers regarding the provision of health insurance. States can regulate insurers and the business of insurance but ERISA is often an issue when state law appears to affect whether and how employers offer worker health coverage. The federal law preempts state laws that “relate to” private sector employer-sponsored benefit plans. In effect, health benefits offered by self-funded employers have been exempted from any state regulatory oversight. This exemption limits the scope of cost-containment, quality improvement, and coverage expansion efforts of states.

States recognize the need for large multi-state employers to have national standards within which they can operate more efficiently. However, states who seek to innovate, especially through the use of public-private partnerships, are hampered by their lack of oversight and ability to engage. Tension between these two legitimate concerns is inevitable.

Federal policy steps could be taken to address employer concerns while still allowing for state innovation. For example, two states have recently imposed assessments on employers to help fund health care access initiatives but, because the question about whether they are subject to federal ERISA preemption has only been tested through the judicial system, other states have been reluctant to even consider such a financing mechanism.⁴⁶ While Massachusetts managed to enact a very limited employer mandate that requires certain employers to offer coverage to employees or pay into a state fund to support public health programs, states have mostly felt the need to steer clear of requirements on employers to contribute to the financing of coverage expansions. The federal government could provide clarity on permissible state actions and/or allow safe harbors.

Several clear federal changes would allow states to require ERISA-protected health care purchasers to participate in payment reform collaboratives, quality improvement efforts, Medicaid premium assistance programs, and all-payer databases. States could be allowed to collect enrollment and benefit information from ERISA plans. An explicit allowance could permit states to apply premium taxes to employer plans. Due to federal preemption, states are not able to define the scope of benefits provided by ERISA plans; the federal government therefore could also set a national floor on benefits. Finally, while consumer protections for those covered by ERISA plans are currently provided at the federal level, states have more infrastructure and experience in these areas. Oversight responsibility, using federal standards, could be shifted to the state level.

Public Programs—Medicaid and the State Children’s Health Insurance

Program (SCHIP): Medicaid and SCHIP are currently based on a federal-state partnership. Overall, the Medicaid program provides more than 59 million Americans with health coverage and long-term care services.⁴⁷ The federal government provides broad guidelines within which each state must operate and the states are responsible for implementing the programs on the ground. These programs allow, to a certain extent, variation in eligibility levels, benefit structures, payment parameters, and breadth of optional populations covered.

In recent years, this partnership has been strained. The allowance for flexibility through the waiver process has been granted by Congress in several laws governing these programs. However, many states believe that federal regulatory oversight has become too inflexible and administratively cumbersome, and that

proposed federal changes to the program have been taken unilaterally with little or no consultation with states nor with any regard to the impacts those changes will have to the program on the ground.⁴⁸ National reform should address these tensions, particularly with regard to waivers, dual eligibles, citizenship requirements and other Medicaid policy changes, and SCHIP limitations.

While there are currently processes for approving State Plan Amendments and also for granting waivers that, ostensibly, allow for state flexibility, those processes are now viewed as being too time-consuming (often years), adversarial, and capricious. Waiver parameters that had been granted to some states are denied to others, leaving states with no guidance as to what may be acceptable. The waiver process needs to be more timely and collaborative. States are currently at the forefront of experimenting with payment reforms to contain costs and improve the delivery system; they need a better framework and an expedited approval process for payment reform demonstrations that allow them to experiment and move from a fee-for-service system that incents quantity and disregards quality to one that pays for value by rewarding quality improvement.

Another substantial change to the parameters of the federal-state program that should be considered is related to the “dual eligibles”—the almost 7.5 million individuals who receive both Medicare and Medicaid benefits. Currently, for dual eligibles, Medicaid pays Medicare premiums and cost sharing and clinical benefits such as long-term care that Medicare does not cover.⁴⁹ Dual eligibles represent more than 40 percent of all Medicaid spending and almost a quarter of Medicare spending.⁵⁰ Some states have argued that all health care for the duals should be the responsibility of the federal government. Because dual eligibles have substantial medical needs and cost more per

capita than other Medicaid beneficiaries, both state and federal governments need to be concerned about the impact of these individuals on both public programs. The federal government could support efforts to integrate care to overcome administrative and operational hurdles and financial misalignments between the Medicare and Medicaid programs through a single delivery system.⁵¹

While both states and the federal government share the goal of maximizing public program enrollment and preventing ineligible individuals from taking advantage of benefits to which they are not entitled, the federal government added citizenship verification guidelines to the program that have proven to be severely burdensome to states. Many state officials report that the cost-saving benefit of trying to identify those individuals who are not eligible for programs is far outweighed by the administrative costs of implementing and maintaining such a verification effort.⁵² In addition, many states have reported that the requirements have the unintended consequence of denying benefits to those who otherwise would be eligible but have no proof of citizenship. The federal government should consider allowing a waiver from the citizenship requirement if the state can demonstrate it has effective verification standards in place.⁵³

Changes to federal Medicaid regulations designed to control the rate of growth in these programs have also caused concern for a number of states. States view these proposals as reversing long-standing Medicaid policy. The regulations, most of which are currently under a one-year moratorium, also severely limit state efforts to use their public programs as a building block for coverage expansions.⁵⁴ A state survey noted that “a vast majority of states indicated that the regulations would have a real and significant impact on states and beneficiaries.”⁵⁵

In addition, in a directive dated August 17, 2007, the Centers for Medicare & Medicaid Services (CMS) announced that states would be barred from extending SCHIP coverage to children in families with incomes above 250 percent of the Federal Poverty Level (FPL) unless the state can demonstrate that 95 percent of their residents who are eligible under 200 percent FPL are enrolled in the program.⁵⁶ That directive impacted 23 states—10 that had already increased eligibility beyond 250 percent FPL and 14 others had proposed doing so. (Washington State falls into both categories.)⁵⁷ This directive has not been modified nor rescinded.

Many Medicaid and SCHIP observers expressed frustration that the federal government had not sought state input or greater understanding of the potential impact of these policy changes, which severely reduce the flexibility that states have in their public programs and severely impact their budgets, before moving forward. CMS’s statutory authority to even issue the August 17 directive has also been called into question.⁵⁸ If the federal government wants to continue to support innovation and coverage expansions by states, it will need to rescind the August 17 directive and pursue a more collaborative regulatory process.

System Redesign/Quality Improvement:

States have increasingly recognized that coverage expansions must be accompanied by value-enhancing strategies that contain costs and improve quality. The implementation of delivery system redesign and payment reforms, as well as the integration of public health strategies into other health care reforms, happens primarily at the state and local level. States are able to convene stakeholders and help provide a framework for collaboration to move these efforts forward. State health care system redesign efforts can provide

lessons about how to take on this work and how to overcome challenges. In addition, most of the necessary health information technology (HIT) infrastructure needed to support these redesign efforts must be built on the ground—states have been playing an extensive role in this area as well.

While states have been moving ahead on these issues, the federal government has a number of levers that allow it to have, in a certain way, substantially more impact on the health care system than any individual state. By leveraging and aligning the purchasing power of the federal programs of Medicare, Medicaid, the Veterans Health Administration, the Indian Health Services as well as the FEHBP, payment reforms to encourage better processes and improved outcomes could be accelerated.

Federal programs could provide the leadership to emphasize evidence-based care and to use their claims data to establish better baselines; set goals for improving population outcomes; improve risk-adjustment methodologies; and reward results.⁵⁹ The federal government could also promote the use of comparative effectiveness research in benefit design, value-based purchasing, and for determining best clinical practices. The federal government could consider including state programs (e.g., Medicaid, public employees) in any Medicare demonstration projects on payment reform and delivery system redesign. However, because states can move more quickly, the federal government could also assist states by developing a new process to allow Medicare to participate in state-based all-payer databases and other state pilots.

Federal leadership and support to encourage the rapid adoption of HIT and the use of requisite interoperability standards are critical. The health care sector is in dire need

of uniform interoperability standards—that separate data from software applications—so that providers and health systems that purchase electronic medical record systems and other HIT can be assured that those systems will be able to exchange key medical information. While states are moving ahead in this area in a somewhat limited fashion, it is difficult for them to proceed, in part, because many health care systems, hospitals and employers cross state lines and they do not want to invest in information systems that will not operate across those borders and across systems. States recognize that it does not make sense for 50 states to set 50 different standards, so they are waiting for federal regulators to set the needed benchmarks so that investment in HIT can move forward.

There is a dearth of federal standards and guidelines in the area of quality metrics. To reduce duplication of effort and capitalize on efforts underway, most states are using quality measures that have been approved by the National Quality Forum or national accreditation organizations such as the National Committee on Quality Assurance and the Joint Commission. However, variation in quality and efficiency across the country remains⁶⁰ and a national strategy and national benchmarks coupled with the necessary resources are needed to reduce this variation and the unacceptable amount of poor quality.

STATE VARIATION IN THE CONTEXT OF FEDERAL REFORM

While there may be broad agreement among the many stakeholders in the health care system and across political parties about the overall objectives for health care reform—expand access, improve quality, and contain costs, there is substantial disagreement about how to achieve these goals.

If it can be assumed that national reform will occur in the near future and it will have a federal-state partnership as its foundation, it will be critical to recognize that a national strategy will not lead to uniformity overnight. While working toward equity and less unwarranted variation in the cost and quality of care across states is critical, equity should not necessarily be equated with uniformity in the way that programs are implemented across all states. Understanding the diversity across the country means that any uniform national strategies, especially those targeting the uninsured, will have varying impacts and do not guarantee uniform national outcomes.⁶¹

One major area where extreme variation exists is in insurance market rating requirements; in essence, there are 50 different health insurance markets, so it will be important to understand how a national plan will affect each of those markets. As another example, focusing on the variation in public program eligibility levels, the effects of a federal policy to allow all adults up to 133 percent FPL into the Medicaid program will vary across states depending on previous efforts to expand coverage to adults. In addition, many of the states that have not enacted prior expansions may not have the financial resources to provide the required state match under such a requirement.

Three major possible solutions could address this variation in impacts across states; the federal government could: 1) make no attempt to address the variation in impact and let each state fend for itself; 2) provide variable assistance, both financial and technical, to the states based on each state's need; or 3) recognize that it may need to allow states to comply with the federal guidelines in a sequenced way over



time.⁶² A combination of variable assistance and sequencing could be the best method to help states comply over time. Any federal financial assistance should also aim to not penalize those states that have been able to expand coverage recently. While “maintenance of effort” is almost always encouraged when new programs are enacted, those states at the forefront should benefit in some way from any new federal funding that may accompany requirements to increase eligibility.

Arguably, states will always want more funding from the federal government and also maximum flexibility; a huge open question is what are the minimum requirements that should be expected from the states in exchange for this funding and flexibility? The variability between states also impacts this tension between the need for both leadership and flexibility from the federal government.

CONCLUSION: BUILDING A STRONG STATE-FEDERAL PARTNERSHIP

Many of the ideas related to essential elements of a federal-state partnership are not new—during the national reform discussions in the early 1990s, the Reforming States Group provided recommendations that still hold true today, including the establishment by the federal government of “a timetable for action, standard core benefits, and standards for access to and quality of care, cost containment, administrative efficiency, and portability of coverage between states, ...[and that] the federal government should grant the states flexibility to implement reforms that meet federal requirements and that equitably and efficiently address access, coverage, and cost containment...”⁶³

Despite the need for collaboration between federal and state governments, many state officials fear that some federal reforms could have a negative impact on states. This is based on the experience of the CMS August 17 directive, the citizenship requirements under DRA, the “clawback” provisions under the Medicare Part D legislation⁶⁴ and inflexible, burdensome Medicaid regulations. The federal government has often made changes to federal-state programs without appropriate consultation and communication with affected states. As a result, states have been forced to shoulder additional financial burden in the context of ambiguous or conflicting directives from the federal government.

While states may be skeptical about the possibility of national reform and anxious about the parameters of such reform, inaction is not an option. A collaborative federal-state partnership that builds on the respective strengths of each offers real potential and should be considered.

LESSONS LEARNED FROM STATE REFORM 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. 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 the reform became effective (see page 30 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 2.** The perfect should not be the enemy of the good. There are states in which a moderate, bipartisan 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.⁶⁵ 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. For more information on provider taxes, see the Provider Tax box on page 34.

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.”⁶⁶ 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.⁶⁷

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.”⁶⁸

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.⁶⁹

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.⁷⁰ 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.⁷¹ (Note: For additional information on cost containment and quality improvement, see page 54.)

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. This section only begins to touch on all the state-level health reform initiatives—both large and small—that can be instructive for federal policymakers. The upcoming sections on small group market reforms and quality and cost containment in particular include many additional “lessons learned” from state capitals across the nation.

STATE COVERAGE STRATEGIES: EVOLVING WITH

2008

Minnesota passed comprehensive delivery system reform legislation. Maryland implemented Medicaid expansion and established a small business premium subsidy program. Several states pursued strategies to cover all children, including Iowa, New Jersey,

Alaska—Governor Sarah Palin established the Alaska Health Care Commission to provide recommendations for and enable the development of a state-wide plan to address the quality, accessibility, and availability of health care.

Colorado—Enacted an SCHIP expansion to 225 percent FPL from 205 percent FPL for Colorado's Child Health Plan Plus (CHP+).

Connecticut—Released a draft report, authored by the HealthFirst Connecticut Authority, that makes recommendations for expanding coverage and transforming the delivery system.

Florida—Governor Charlie Crist signed into law Cover Florida and Florida Health Choices. Cover Florida calls for the state to negotiate with insurers to provide a low-cost insurance product for the uninsured. Florida Health Choices expands the number and types of plans available to the uninsured.

Iowa—Enacted health reform legislation to address the quality and affordability of health care among Iowans. The legislation expanded coverage for children up to 300 percent FPL by 2010. It also created the Iowa Choice Health Care Coverage Advisory Council to develop a plan to provide health coverage to all state residents within five years.

Kansas—Passed a health reform bill that includes an expansion of Health-Wave (Medicaid and SCHIP) for children from the current level of 200 percent FPL to 225 percent FPL beginning in 2009, and to 250 percent FPL by 2010—once federal funding becomes available.

Louisiana—Enacted an SCHIP eligibility expansion for children up to 250 percent FPL from 200 percent FPL.

Maryland—Implemented a Medicaid expansion from 30 percent FPL to 116 percent FPL for parents and a premium subsidy program for small businesses. This legislation is expected to cover approximately 100,000 previously uninsured Maryland residents.

Massachusetts—Law enacted to promote cost containment, transparency and efficiency in the delivery of quality health care. The uninsured rate falls to 2.6 percent.

Minnesota—Passed a broad and historic health reform bill focused on the improvement of health care coverage and affordability. It included payment reform, expanded price and quality transparency, chronic care management, administrative efficiency, and public health. The reform requires that health

2007

Both Massachusetts and Vermont began implementing their new reforms. California worked toward comprehensive reform while a number of states continued developing proposals or refining models hoping to enact new reforms in 2008 and 2009.

California—Governor Schwarzenegger announced a comprehensive health care reform proposal, prompting significant state and national debate. Special session of the state legislature convened to address health care reform; revised proposal introduced. Assembly passes reform bill.

Colorado—The Blue Ribbon Commission for Health Care Reform approved a set of recommendations, which would require state residents to purchase health insurance or face a tax penalty, and would expand eligibility for the state's public programs.

Connecticut—Passed reform bill increasing Medicaid reimbursements for physicians and hospitals, expanding eligibility levels for pregnant women and children, and requiring automatic enrollment of uninsured newborns in HUSKY, the state's Medicaid and SCHIP program. New Authorities charged with developing recommendations for overall health care reform and for strengthening the safety net.

Hawaii—Passed several bills that expand health coverage to infants and children, raise the reimbursement rate for Medicaid providers, and reestablish insurance rate regulation provisions.

Illinois—Following the collapse of agreement with the legislature, Governor Blagojevich began implementing, through executive authority, an expansion of the state's FamilyCare plan and other reforms.

Indiana—Reforms enacted that increase tobacco taxes, providing funding for immunization programs, Medicaid expansions, increased Medicaid reimbursement rates, tax credits for employers that establish Section 125 plans, and tobacco prevention and cessation programs. The state received federal waiver approval for the Healthy Indiana Plan.

Kansas—Passed a bill that creates a phased-in premium assistance program that provides subsidies to Kansans who make below 100 percent FPL for purchasing private insurance actuarially equivalent to the state employee health plan. The Kansas Health Policy Authority presented health reform recommendations to the legislature.

Maine—Governor Baldacci signed a bill allowing the DirigoChoice program to be self-administered.

Maryland—Governor O'Malley signed into law a bill that will expand Medicaid eligibility and offer subsidies to small businesses to offset the cost of providing coverage to employers.

Massachusetts—Massachusetts' individual mandate to obtain health insurance took effect July 1. Minimum creditable coverage and affordability standards were determined by the Connector board.

Missouri—Passed a reconfigured state Medicaid system called MO Health-Net. The Legislature restored coverage and benefits to some populations whose services were eliminated two years ago.

2006

Massachusetts and Vermont demonstrated that bi-partisan compromise and comprehensive reforms are possible at the state level. Several other states approved or began implementing coverage initiatives focused on children and working uninsured adults.

Arkansas—CMS approved a waiver to allow Arkansas to receive federal Medicaid funds for a program that will provide low-cost health coverage to small businesses.

Idaho—Taking advantage of the state plan amendment process provided in the DRA, the state split the Medicaid and SCHIP population into three major benefit plans.

Illinois—All Kids program implemented. Many other states propose similar plans to cover all children.

Kansas—Received federal approval for their reform proposal under the DRA.

Kentucky—Moved forward on their Medicaid redesign plans after receiving approval for their state plan amendment under the DRA.

Maryland—Legislature over-rode Governor Ehrlich's veto of the "Fair Share Act." Later in the year, the U.S. District court struck down the bill, declaring the measure was pre-empted by ERISA. The state has appealed the decision.

Maine—Blue Ribbon Commission on Dirigo Health established to evaluate components of the state-subsidized coverage program for the uninsured, particularly Dirigo's funding mechanism.

New York, Wisconsin, Illinois (2006) and Pennsylvania (2007).

care cost savings be measured against projected costs without reform. The bill also expanded public coverage for childless adults from 215 percent FPL to 275 percent FPL.

New Hampshire—Enacted a health insurance plan designed to make coverage more affordable to small businesses by emphasizing wellness programs and prevention.

New Jersey—Governor Jon Corzine signed into law a health reform bill which requires all residents 18 years old or younger to have health insurance coverage and which legislative sponsors describe as the first phase in guaranteeing health coverage for all New Jersey residents. This bill also included an increase in eligibility for parents in the FamilyCare program from 133 percent FPL to 200 percent FPL.

New York—After CMS denied its waiver request, New York implemented an SCHIP eligibility expansion from 250 percent FPL to 400 percent FPL with state funds alone.

North Dakota—CMS approved North Dakota's request to expand SCHIP eligibility from 140 percent FPL to 150 percent FPL.

Ohio—An advisory group appointed by Governor Ted Strickland produced a comprehensive report that included recommendations to reduce the number of uninsured Ohioans by half and to increase the number of small businesses able to offer coverage to their workers.

Oklahoma—The Oklahoma State Coverage Initiative team, a group of state leaders representing the state legislature, government agencies, the private sector and tribal organizations, released their Blueprint for Oklahoma report with draft recommendations for ensuring that all Oklahomans have access to high quality health care and affordable health insurance.

Oregon—Released a comprehensive plan authored by the Oregon Health Fund Board to create a world-class health system for Oregon.

Utah—Early in the year, created a task force to develop recommendations for health reform. Drafted recommendations included various insurance market reforms; streamlining and standardizing various aspects of provider, insurer and consumer interactions and communications; and requiring certain contractors who do business with the state to offer health insurance to their qualified employees.

Congress and the administration failed to reach agreement on the reauthorization of the State Children's Health Insurance Program (SCHIP).

Minnesota—Governor Pawlenty announced his Healthy Connections proposal to make the state's Medicaid program more affordable for children, and expand eligibility. Other features include rewards for healthy behaviors, a requirement that small businesses establish Section 125 plans, and a Massachusetts-style Connector.

New Mexico—Governor Richardson unveiled a comprehensive reform proposal that would require all state residents to purchase coverage.

New York—Finalized a budget that will expand health insurance coverage for children by raising eligibility from 250 percent FPL to 400 percent FPL, the nation's highest ceiling for SCHIP eligibility.

Oklahoma—Governor Henry signed legislation expanding income eligibility from 185 to 200 percent FPL under the Insure Oklahoma program, which provides health insurance subsidies to businesses.

Oregon—Governor Kulongoski signed the Healthy Oregon Act, providing a timeline for comprehensive health reform recommendations, and establishing the Oregon Health Fund Board. Ballot Measure 50 failed, leaving in question funding for a children's coverage expansion.

Pennsylvania—Under his "Prescription for Pennsylvania" plan, Governor Rendell began pursuing an ambitious coverage expansion, alongside health systems improvements and efforts to promote healthy behavior.

Rhode Island—Launched HealthPact RI plans that encourage small businesses to offer health coverage to workers. Initiated a series of stakeholder meetings designed to result in recommendations to the 2008 General Assembly related to cost containment and affordable coverage for uninsured residents.

South Dakota—Legislatively created Zaniya Project Task Force, developed a plan, including action steps and timelines, to provide health insurance to uninsured South Dakota residents.

Tennessee—Launched Cover Tennessee program which includes several expansions to cover children, uninsurable adults, low income workers, and small businesses.

Vermont—Vermont began enrolling eligible residents into Catamount Health on October 1, 2007.

Washington—Passed several bills to provide access to coverage for all children in the state by 2010, and to create a Connector-like program called the Washington Health Insurance Partnership (WHP).

Wisconsin—Increased the cigarette tax by \$1 per pack, providing funding to expand health care coverage to nearly all children in the state through the state's new Badger-Care Plus program.

Several states also took advantage of the flexibility outlined in the DRA to redesign their Medicaid programs.

Massachusetts—Passed a landmark comprehensive bill designed to cover 95 percent of the uninsured in the state within the next three years.

Oklahoma—Legislature approved expansion of O-EPIC program to cover businesses with 50 or fewer employees.

Pennsylvania—Legislature approved funding for Cover All Kids, a program allowing families with incomes above the SCHIP eligibility level to purchase health insurance for their children on a sliding scale basis based on income. Implementation to begin January 1, 2007.

Rhode Island—Legislature passed a number of new health initiatives including several coverage expansions focused on providing premium relief for small businesses.

Tennessee—Legislature passed Cover Tennessee program, which includes several expansions to cover children, uninsurable adults, low-income workers, and small businesses.

Utah—Revamped its Covered at Work program and introduced the new Partnership for Health Insurance program, which provides subsidies for low-income workers who are enrolled in coverage provided through their employers.

STATE STRATEGIES: SUCCESS VARIES; VISION REMAINS

This year's summary of state strategies for health reform highlights the dramatic variation that has existed among the states in 2008. Some states were attempting to enact sweeping reforms, others passed incremental changes, while still others did not have health care high on their agenda. Despite the uncertainty caused by the beginning of the economic downturn and with State Children's Health Insurance Program (SCHIP) restrictions from the Centers for Medicare & Medicaid Services (CMS), many states were able to make progress.

Northeastern states like Maine, Massachusetts and Vermont continue to advance implementation efforts, with Massachusetts demonstrating particularly strong success in covering the uninsured and starting to focus more on tackling unsustainably high health care costs.

Other states entered 2008 with comprehensive plans for health reform, ranging from universal coverage for all state residents to system-wide reforms to address quality improvement and cost containment. California, New Mexico, Kansas, and

Pennsylvania are examples of states that tried but failed to pass comprehensive health reform legislation in 2008. These states will benefit in the coming years from the statewide dialogue that the proposals have stimulated.

Iowa, Minnesota, and New Jersey passed legislation during the year that will increase coverage and, particularly in the case of Iowa and Minnesota, will move the states forward in containing health care costs and improving quality. Additionally, a handful of

other states, such as Arkansas, Connecticut, Ohio, Oklahoma, Oregon and Utah, used 2008 to build consensus and create recommendations ranging from increases in coverage for specific populations to substantial system redesign.

This section categorizes state reforms in order to reflect general similarities in trends and approaches. It organizes the wide range of steps taken and reforms pursued.



NORTHEASTERN STATES CONTINUE IMPLEMENTATION OF COMPREHENSIVE REFORMS

In 2008, the three Northeastern states of Maine, Vermont and Massachusetts continued implementation of their comprehensive health reforms. While Maine and Vermont included measures to address cost containment and quality improvement from the start, Massachusetts is balancing continued implementation of its original health reform initiatives focused on access with more comprehensive measures to address cost and quality.

Maine

Maine enacted its Dirigo Health Reform in 2003. The legislation had three aims: to increase the rate of health coverage, to improve quality, and to control costs. This reform was the first of its kind in the nation.⁷² One piece of the Dirigo Health Reform is the DirigoChoice Health Plan, which is intended to provide an affordable health insurance option to small businesses, the self-employed, and eligible individuals who do not have access to employer-sponsored insurance. Using subsidies, DirigoChoice offers discounts on monthly premium payments and reductions in deductibles and out-of-pocket costs on a sliding scale to enrollees with incomes below 300 percent of the Federal Poverty Level (FPL).

The DirigoChoice subsidies have been funded through a Savings Offset Payment (SOP) mechanism that was designed to capture and redistribute savings in the health care system resulting from multiple cost containment strategies, including:

- The “Capital Investment Fund,” an annual limit on capital investment under the state’s Certificate of Need program;
- Rate regulation in the small-group insurance market;
- Voluntary targets on hospital expenditures;
- An increase in physician and hospital payments to reduce cost shifting; and
- Uncompensated care cost savings resulting from providing coverage to the previously uninsured.

While it was enacted with more than two-thirds legislative support in 2003, the SOP proved to be controversial in practice—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 DirigoChoice.⁷³

Further, the savings determined by the Superintendent of Insurance through the adjudicatory process each year has been lower than the DirigoHealth Agency’s estimates of savings, resulting in reduced revenue for the DirigoChoice subsidies.

In April, Maine Governor John E. Baldacci signed into law a bill aimed, among an array of other reforms, at changing the financing for DirigoChoice. Revenue would come from increased taxes on beer, wine, and soda, and a flat surcharge on insurers.⁷⁴ According to legislative fiscal analysis, malt beverage and wine taxes were expected to raise \$7.5 million in the first year, while soda taxes were projected to provide \$9.2 million. The assessment on insurers would initially have raised \$33 million, increasing to \$37 million in 2010 and \$38 million in 2011.⁷⁵ The new taxes were to fund both DirigoChoice and long-debated insurance market reforms, with close to 20 percent of the revenue to support a reinsurance plan to provide rate relief in the individual market.⁷⁶

After Baldacci approved the new financing structure in April, a political action committee backed by beverage companies and the Maine State Chamber of Commerce, called Fed Up With Taxes, ran an aggressive campaign to repeal the taxes. The group gathered more than 90,000 signatures to get the tax repeal on the ballot as a people’s veto question, and spent an estimated \$3.5 million on their campaign. They focused their advocacy on taxes, not health coverage. The opposing coalition, Health Coverage for Maine, argued that a tax increase on beverages that can

contribute to poor health was a sensible way to fund a health program and that it was necessary to help support the 18,000 people who have coverage through Dirigo. Baldacci urged Maine voters to oppose the repeal but Health Coverage for Maine had just \$440,000 to support a campaign opposing the tax repeal. Voters opted, by a wide margin, to repeal the new taxes. This means that Dirigo will continue to be funded through the SOP system, although this funding mechanism for 2009 again has been challenged in court.⁷⁷

Maine’s health care reform has encountered obstacles along the way. These include lower than expected revenues, which resulted in lower DirigoChoice enrollment numbers, a cap being placed on the program and controversy over funding sources. Nonetheless, the state has made considerable progress in increasing its rate of insured residents, combating escalating health care costs, and creating the framework for a more cost-effective and efficient health care system.

Among the six New England states, Maine had the highest rate of uninsured residents prior to Dirigo, but by 2006 had the lowest rate among those states. Massachusetts then replaced Maine as the New England state with the lowest rate of uninsured after introducing its own health reform legislation, but the rate of uninsured Maine residents continues to fall. Similarly, Maine had the highest average annual growth in premiums of any state in New England before Dirigo, but has had the lowest in the region since enactment of their reforms.⁷⁸

Maine has made significant progress in health reform but the positive developments have largely been overshadowed by conflict over program financing, and it appears that Maine will enter 2009 with continued controversy in this area.

Vermont

In 2005, Vermont was faced with a situation where about 60,000 Vermonters (about 9.8 percent) lacked health insurance. Three-quarters of these reported cost as the central reason for their uninsured status. About half of the uninsured were eligible for existing public programs but were not enrolled.⁷⁹ In response, the Vermont legislature and Governor Jim Douglas reached agreement on a series of health care reform bills aimed at achieving near-universal coverage by 2010.

Since the first health care reform bills were signed into law in 2006, Vermont has been working to implement a comprehensive set of legislation to make health care affordable, accessible, and of high quality for all Vermont residents. Through Green Mountain Care, the state and its partners have made available a family of low-cost and free health coverage programs. One of these programs, the Catamount Health Plan, offers a non-group insurance product for uninsured Vermont residents and began enrollment of eligible Vermonters in 2007. Catamount Health continues to be the centerpiece of the reforms. Vermont also has several programs to address the affordability of health insurance through premium assistance programs. The state provides premium assistance for Catamount Health on a sliding scale basis to enrollees with incomes under 300 percent FPL and also provides premium assistance to individuals and families in this same income category to enable enrollment through their employer-sponsored insurance plan.⁸⁰

Vermont set aside \$1 million for the Green Mountain Care outreach campaign, which began in late 2007. The state contracted with a media firm to create a campaign designed to get the word out about the range of Vermont health programs, especially the new premium assistance programs. The media launch increased visits to their Web site by about four times and calls to their toll-free number by about

40 percent. By the end of February 2008, 3,344 individuals were enrolled in Vermont premium assistance programs out of the estimated 10,341 who are eligible. Vermont's most recent survey in fall 2008 found its uninsured rate is now about 7.6 percent.⁸¹

Vermont's health care reform is financed by:

- Individuals who pay sliding scale premiums based on their income;
- A contribution from employers based on the number of employees;
- Revenue from an increase in tobacco taxes;
- Medicaid savings due to employer-sponsored insurance enrollment; and
- Matching federal dollars under a federal Medicaid demonstration waiver.⁸²

Vermont's health reform efforts related to wellness, prevention, and chronic care management rely on the premise that improving the quality of care and preventing disease are effective ways to reduce overall health care costs in the long run. The Vermont Blueprint for Health is a plan involving a statewide partnership to provide information, tools, and support to Vermonters who suffer from chronic conditions and to the providers who care for them.⁸³ Some of the key components of the Blueprint integrated pilot design include:

- Multidisciplinary Community Care Teams (CCTs)
 - Staffing mix designed by the community to supplement existing resources
 - CCTs in each community include prevention specialists
 - Integration of public health prevention and care delivery

■ Financial Reform

- A common form of enhanced provider payment across the three major commercial insurers in Vermont and Medicaid (Medicare is not participating)
- Shared costs across all payers (except Medicare) for CCTs

■ Health Information Technology

- Web-based clinical tracking system called DocSite
- DocSite supports age and gender appropriate health maintenance and care for chronic diseases

■ Evaluation

- Multi-payer claims database
- Clinical process measures
- Health status measures⁸⁴

Several communities throughout the state have begun piloting the Blueprint and states and communities around the country are watching this model to see if it reduces costs and improves chronic condition management in the state.⁸⁵

Massachusetts

Massachusetts is still the only state that has implemented an individual mandate and therefore continues to draw much of the nation's attention with its unique and comprehensive reform plan. Enacted in spring 2006, Massachusetts' landmark health reform law seeks to cover nearly all of its residents within three years. Enactment of the law represented the culmination of more than a year of negotiations and compromise between lawmakers and former Governor Mitt Romney. Four major principles have guided the state's health care reform initiative throughout its evolution.⁸⁶

- A public/private partnership that requires the participation of a wide range of stakeholders and the dedication of both federal and state funds to ensure subsidized coverage.

- Transparency around health care quality and costs with the 2012 goal of being a state that consistently ranks among those states achieving the highest levels of performance in health care.
- A shift from free-care safety net funding to insurance funding by redirecting public funds previously spent on uncompensated care into coverage for individuals in an insurance-based system.
- An emphasis on shared responsibility among the government, employers, individuals, health plans, and health care providers. Massachusetts is the first state to attempt near-universal health coverage for its residents by issuing an individual mandate, in combination with a requirement that employers of 11 or more provide a minimum amount of health insurance or pay \$295 annually per worker per year.⁸⁷

States continue to follow with interest the developments of the Massachusetts health reform plan. The state's four main measures designed to expand health insurance coverage are:

- A mandate that nearly all adults 18 and older obtain health insurance or face tax penalties;
- The expansion of MassHealth (Medicaid) for children up to 300 percent FPL and insurance subsidies for low-wage small business employers and workers;
- The creation of Commonwealth Care, a subsidized health insurance program for adults up to 300 percent FPL who are not eligible for MassHealth and do not have access to employer-sponsored insurance; and
- The development of the Commonwealth Health Insurance Connector which is a health insurance purchasing mechanism with responsibility for Commonwealth Care as well as Commonwealth Choice—an unsubsidized health insurance program for uninsured adult Massachusetts residents.

Both the comprehensive benefit design of the Commonwealth Choice plans and the idea of a Connector helping residents obtain affordable health coverage have generated particularly strong interest among states.⁸⁸

When the Massachusetts Division of Health Care Finance and Policy released its August 2008 report, *Health Care in Massachusetts: Key Indicators*, an editorial in the *New York Times* described the Massachusetts plan to provide health insurance to all its residents as “more and more successful with each passing month.”⁸⁹ The most significant finding from the report was that more than 439,000 people have acquired health insurance since the reforms were implemented in mid-2006. That number is two-thirds of the estimated 650,000 people who were without insurance at the time of the plan's inception.⁹⁰ Other key figures for Massachusetts since the time of implementation include:

- The overall uninsured rate dropped from 6.4 percent in 2006 to 5.6 percent in 2007. Massachusetts is now the state with the lowest rate in the nation.
- More than 40 percent of the newly insured gained private coverage without any government subsidies. Among the state's insured population, 82 percent have private insurance, 14 percent are covered by Medicaid, and 3 percent are enrolled in Commonwealth Care subsidized plans.
- The percentage of employers providing health insurance rose to 73 percent in 2007 and increased to 79 percent in 2008.
- The number of residents using free care from hospitals or community centers declined by 37 percent from the past year and the cost of uncompensated care decreased from \$166 million in the first quarter of the pool's 2007 fiscal year (FY) to \$98 million in the first quarter of FY 2008.⁹¹

On December 18, 2008, results from the *2008 Massachusetts Health Insurance Survey* were released revealing that—based on survey results from summer polling—the uninsurance rate in the state had fallen even further to 2.6 percent of the total population. Only 167,300 people remain uninsured.⁹²

While the Commonwealth Care cost per individual has been less than anticipated, the unexpected success of enrollment has required funding adjustments. The first-year cost of the program has grown from an expected \$472 million to \$630 million.

In late September, CMS granted Massachusetts a three-year, \$10.6 billion Medicaid waiver that will enable the state to expand its landmark health reform legislation. The waiver gives Massachusetts the authority to spend about \$21.2 billion over the next three years. This amount is \$4.3 billion more than was permissible under the previous waiver agreement, which expired on June 30. The federal government granted a number of waiver extensions during the intervening months while negotiations were occurring. This waiver agreement preserves existing eligibility and benefit levels, along with federal matching funds for all programs. It also enables Massachusetts to meet all of its health care obligations for FY 2009.⁹³

The governor's plan to pay for the higher costs includes increasing contributions from businesses, insurers, and providers, and instituting a tobacco tax (amounting to an increase of \$1.00 per pack of 20 and \$1.25 per pack of 25). Furthermore, in an effort to prevent crowd-out, premiums in the Commonwealth Care program have been raised by 10 percent, with an additional increase in co-payments for some beneficiaries, to make the plan more in line with private plans.⁹⁴

In September 2008, the Massachusetts Commonwealth Health Insurance Connector Authority Board voted unanimously to proceed with new minimum standards for health coverage

that were first drafted in 2007. The goal of this requirement is to ensure that all Massachusetts residents have sufficient coverage while still making the insurance affordable. In general, in order to meet the state's minimum creditable coverage standards, health benefit plans must offer coverage for prescription drugs, physician services (including preventive and primary care), hospitalization, ambulatory patient services, mental health and substance abuse services, and emergency services.

The new rules also will mandate that effective January 1, 2010, plans must provide coverage for radiation and chemotherapy, maternity and newborn care, medical/surgical care, and diagnostic imaging and screening tests. The board voted to delay until January 2010 the implementation of the new standards to give employers an opportunity to revise their policies, if necessary. Individuals will be responsible for making sure that their coverage meets the state's minimum standards and will be personally assessed for failure to comply. The tax penalty for not obtaining coverage under the universal healthcare law in tax year 2008 ranges from \$210 to \$912 a year, depending on age and income; these penalties are likely to increase in 2009.⁹⁵

At the start of the program, Massachusetts employers were required to meet a premium contribution standard by satisfying at least one of the following: contributing at least 33 percent of the cost of an employer-sponsored group health plan offered to all full-time employees or enrolling at least 25 percent of full-time employees in their health insurance plan (to which the employer must be making a financial contribution). Starting January 1, 2009, the determination of what it means to be a contributing employer will become more stringent for employers with 50 or more full time equivalent employees. Companies with more than 50 full-time equivalent employees will be required to meet both of the above tests, while companies with 50 or fewer full time employees will continue to satisfy the fair share requirement by meeting either of the two tests.⁹⁶

While Massachusetts has initially focused on coverage and accessibility, there has been an increased focus on cost containment and quality improvement measures. In August, the governor signed a bill (S.2863) intended to promote cost containment, transparency, and efficiency in the delivery of quality health care.

The bill includes measures that promote efficiency in the health care system, including:

- Creating a Special Commission on Health Payment Reform to investigate restructuring the current payment system to provide incentives for efficient and effective care.
- Authorizing MassHealth (Medicaid) to establish a "Medical Home" demonstration program to promote coordinated, comprehensive patient care and strengthen the role of primary care providers.
- Establishing a Pharmacy Academic Detailing Program to educate providers on the use of lower-cost brand names and generic drugs in place of expensive brand name drugs, where therapeutically appropriate.
- Authorizing the Department of Public Health to establish a list of so-called "never-events" to be updated annually and that prohibits health providers from billing for costs related to a "never-event."

To improve access to health care services the bill:

- Creates a new Health Care Workforce Center within the Department of Public Health to improve access to health care services in the Commonwealth, with a particular focus on primary care.
- Institutes a new loan forgiveness program for doctors and nurses who commit to practicing certain specialties in medically underserved areas.
- Requires health insurers to recognize and reimburse nurse practitioners as primary care providers.

- Directs the MassHealth Payment Policy Advisory Board to study methods of improving reimbursement or bonuses for those engaged in primary care.

Measures to enhance quality and transparency of health care costs include:

- Mandated reporting of "serious reportable events," adverse drug events, and hospital-acquired infections.
- Regulation of marketing practices to health care professionals from the pharmaceutical and medical device industry based on an industry-accepted code of conduct.
- Regulation and oversight of the disposition of the reserves and surpluses of health insurers and providers by the Division of Health Care Finance and Policy.

And finally, the bill encourages adoption of health information technology by:

- Setting a goal of statewide adoption of electronic health records by the year 2015 to improve patient safety and lower costs.
- Dedicating \$25 million to the new Massachusetts e-Health Institute to facilitate the financing and implementation of a statewide, compatible system of electronic health records.⁹⁷

As Massachusetts introduces its adjusted financing schemes, states considering their own ambitions for state health reform will continue to look to that state as an invaluable case study. In a written statement, Senator Edward M. Kennedy noted that Massachusetts has "made major progress in the program's first two years, cutting the number of uninsured in half and increasing employer-sponsored coverage. [The Massachusetts] experience with health reform...argues well for our debate on national health reform next year."⁹⁸

SUBSTANTIAL HEALTH REFORMS PASSED IN 2008

In 2008, three states—Iowa, Minnesota, and New Jersey—enacted substantial reforms that expanded public coverage programs and included private sector reforms. The laws encompass several components that are emerging as trends among states considering health reform. The Minnesota and Iowa laws included both coverage expansions and significant delivery system redesign. In Minnesota, the state enacted some of the most innovative and wide-reaching payment reforms of any state, including a “baskets of care” concept (described on page 37) and a single statewide payment system to be used across payers. Both the Iowa and Minnesota laws included public health and wellness programs to promote healthier lifestyles among residents.

The New Jersey and Iowa reforms represent a sequential approach to health reform. Neither bill aimed to achieve universal coverage, but both explicitly pointed to future efforts to continue expanding access to health insurance. The sponsors of the New Jersey legislation have already prepared a second phase of their proposed reforms, stating that the recently enacted law is only the first step in more comprehensive health reform efforts. Iowa’s law calls for several commissions charged with considering options for future reforms. A legislatively-created council will develop a plan to cover all Iowa residents within five years.

Iowa and New Jersey set a goal of covering all children in their states. They join Massachusetts, Illinois, Wisconsin, and New York, which have set similar goals. In addition, Iowa and New Jersey are using state tax return forms to check coverage rates.

Iowa

In May, Iowa enacted health reform legislation (House File 2539) based on recommendations developed by the governor and the Legislative Commission on Affordable Health Care Plans for Small Businesses and Families. The commission

MARYLAND: MEDICAID EXPANSION AND SMALL BUSINESS ASSISTANCE

In July, Maryland began implementing health reforms that were enacted in 2007. The aim of the reforms was to expand health insurance coverage under the Working Families and Small Business Health Coverage Act. The law mandated a Medicaid expansion and a premium subsidy program for small businesses in order to provide health insurance coverage to approximately 100,000 previously uninsured Maryland residents.⁹⁹

Maryland will phase in its Medicaid expansion over several years. The first phase, called the Medical Assistance to Families program, increases Medicaid eligibility for parents from 30 to 116 percent FPL (\$20,500 for a family of three).¹⁰⁰ To date, more than 16,000 parents and caretaker relatives have enrolled. The second phase of the Medicaid expansion increases the services offered under the Primary Adult Care (PAC) program. The program will continue to be available to any eligible individual, though the state may have to cap it at some point because of budget constraints. PAC, which for the past few years has provided basic primary care services to low-income adults, will—over the next three years—add benefits such as hospitalization and low-cost or free prescriptions. The goal is to increase the benefit package over a number of years until PAC beneficiaries receive full Medicaid benefits. These benefits would be phased in over a number of years.

The law also creates the Health Insurance Partnership, a premium subsidy program for small businesses that began enrollment in October 2008. A business is eligible to receive a subsidy of up to 50 percent of the premium from the Maryland Health Care Commission if it meets the following criteria:

- The business has between two and nine employees;
- The average employee wage is below \$50,000;
- The employer establishes a Section 125 Plan; and
- The employer did not offer health insurance to employees during the 12 months before applying for the subsidy.¹⁰¹

The Maryland Health Care Commission is responsible for administering the partnership program. It provides assistance to employers establishing Section 125 plans and expects to enroll more than 1,500 businesses in the program’s first year.¹⁰² As of December 1, 2008 more than 80 businesses had enrolled, covering 420 lives. For a health plan to be eligible for a subsidy, it must encourage wellness by providing employees with a health risk assessment and incentives for health-promoting activities, preventive care, and chronic care management.¹⁰³



PROVIDER TAXES: WORTH A SECOND LOOK

As states pursue coverage expansions, they are likely to consider a variety of means to raise the revenues needed to fund those expansions. For states interested in taking significant steps toward universal coverage, they face a substantial financial barrier. Significant coverage expansions require new funding to support subsidies for making private insurance more affordable and to help finance public program expansions. Most coverage expansions require states to raise funds by increasing existing taxes or imposing new ones.

Some tax options are broad-based, and others are more targeted. Broad-based options such as increases in the retail sales or personal income tax have the power to generate substantial revenues from relatively small tax hikes. They also offer the advantage of spreading the burden across a broad population. For this reason, however, broad-based taxes are politically difficult and may face steep opposition. In addition, with the economic outlook increasingly bleak, states may be reluctant to pursue tax increases.

With the recent economic downturn, states are already facing increasing demands on public programs as they experience significant declines in revenues. As a result, most states would be well advised to consider a variety of revenue sources for funding or maintaining health care coverage expansions. While no tax increase is ever popular, a health care sales tax—or provider tax—offers some economic advantages to states looking for ways to maintain current coverage levels or to fund coverage expansions. Under such a tax, providers remit to the state a small percentage of the payments they receive for patient services.

A provider tax offers a stable source of revenue that is largely immune to economic cycles, because the need for medical services is relatively stable in both good and bad economic times. Given that the growth rate of health care costs has historically risen at a faster pace than the growth rate of the economy as a whole, a provider tax represents a largely recession-proof revenue source. Revenues from other sources are not able to keep pace with the rapid growth in health care costs and will eventually

leave states with a gap in funding coverage programs.

While provider taxes have come under criticism for unfairly burdening providers, they offer states a strategy for recouping uncompensated care costs built into the current reimbursement system—costs that would no longer be incurred by providers under a universal coverage system. Furthermore, providers are able to pass the cost of a provider tax on to consumers, who tend to be less price-sensitive, particularly when insurance partially covers costs. A one-time, small increase in the price of medical services is unlikely to deter individuals from seeking needed care.

A further question is whether insurers would cover the price increase that would likely result from a provider tax when providers pass on the extra cost to payers. A state Medicaid program, for example, would need to increase payment rates to providers to make up for the tax increase. Providers may not be able to recoup the tax directly on Medicare services.

Provider taxes also offer a broader revenue base than other “health” taxes such as premium taxes levied on insurers. While premium taxes may generate less political opposition, only non-self-insured plans pay the tax. With self-insured plans exempt, a large segment of the population would not share the burden of a premium tax. In contrast, everyone who uses medical services would share the cost under a provider tax scenario.

States have relied on provider taxes for some time: 43 states have levied some type of provider tax, and 30 tax more than one type of provider. Governor Arnold Schwarzenegger, for example, included a hospital provider tax as a mechanism to help finance the increased state expenditures that would have resulted from his proposal for achieving near-universal coverage in California.

While any tax proposal raises issues of fairness, a provider tax offers some advantages such that it deserves consideration among the menu of state options for raising new funds to finance coverage expansions.¹⁰⁴

Adapted from Wicks, Elliot K., “Can a Sales Tax on Medical Services Help Fund State Coverage Expansions,” State Coverage Initiatives, July 2008

consisted of 10 members of the General Assembly and 19 members of stakeholder groups, including consumers.¹⁰⁵ The reform law includes a broad variety of provisions regarding the affordability of health care for Iowans, including the following:

- **Children’s Coverage**—The law aims to extend health coverage to all children. The state will cover children in families with incomes up to 300 percent FPL beginning in FY 2010, pending CMS authorization and sufficient federal funding. The law requires families earning above 200 percent FPL to pay a premium. The expansion could extend coverage to approximately 9,000 uninsured Iowa children. The Department of Human Services will receive more than \$40 million in General Fund appropriations from 2009 to 2011 to implement the expansion programs. The state intends to launch the program on July 1, 2009, for FY 2010. One significant provision of the law requires Iowans to indicate on their income tax forms if their dependent child has health care coverage.
- **Iowa Choice Health Care Coverage Advisory Council**—The council is charged with assisting the Iowa Comprehensive Health Insurance Association (Iowa’s high-risk pool) with development of a comprehensive plan to provide health care coverage to all state residents within five years.
- **Continuous Eligibility**—The Medicaid program will provide continuous eligibility for 12 months for children who might otherwise become ineligible because of changes in family income.
- **Annual Report**—The Department of Revenue and the Department of Human Services (DHS) must submit an annual report to the governor and General Assembly, providing: 1) the number of families claiming state income tax

exemptions for dependent children; 2) the number of families claiming state income tax exemptions for dependent children showing the presence or absence of health care coverage for those children; and 3) the effect of the tax form reporting requirements and subsequent outreach and education activities on the number of uninsured children.

- Enrollment—The DHS must develop a plan to maximize enrollment and retention of eligible children in all public coverage programs.
- Bureau of Health Insurance Oversight—Located within the Insurance Division of the Department of Commerce, this agency will assume responsibility for ensuring uniformity and transparency of health insurance operations.
- Long-Term Living Planning and End-of-Life Care Education Campaign—The Department of Elder Affairs must implement a public education campaign to inform state residents about long-term care options and end-of-life care.
- Medical Home System—The Department of Public Health (DPH) must create and implement a system of medical homes focused on reducing health disparities, improving quality, reducing costs, and promoting sustainability. The state's Medical Home System Advisory Council will make recommendations to the DPH on the plan for implementing this statewide system, which will coordinate health care services, monitor data collection on patient-centered medical homes, and provide training and education to health care professionals and families. The first phase of system development will create a medical home for children eligible for Medicaid.
- Family Opportunity Act—The act provides a Medicaid buy-in option for individuals under the age of 19 with disabilities whose family income is at or below 300 percent FPL. The act takes

effect on January 1, 2009, and calls for a premium to be charged for those between 100 and 300 percent FPL.

- Healthy Communities Initiatives—A grant program will promote healthy lifestyles, and the Governor's Council on Physical Fitness will develop a strategy for the implementation of a statewide comprehensive plan to increase physical activity, improve nutrition, and promote healthy behaviors.
- Medicaid Quality Improvement—A Medicaid Quality Improvement Council will be established to evaluate clinical outcomes and consumer and provider satisfaction.
- Transparency—A quality and transparency workgroup will develop recommendations on cost and quality measures in order to provide information to consumers.
- Reimbursement Accounts—The Commissioner of Insurance will assist employers with 25 or fewer employees with the implementation and administration of Section 125 plans, including Medical Expense Reimbursement Accounts and Dependent Care Accounts.
- Pre-Existing Conditions—Pre-existing condition exclusions are prohibited for consumers moving between plans, including to and from non-group policies.
- Dependent Coverage—Dependents under age 25 or still full-time students may remain on their parents' or guardians' health plans until they marry or leave the state.
- Iowa Electronic Health Information Commission—The commission is charged with developing a statewide health information technology plan by January 1, 2009. The system will expand the use of electronic health records and improve health care quality to decrease costs.

- Health Care Coverage to Caregivers—A two-year pilot program will offer premium assistance for health care coverage to direct care workers. The program will help determine if such assistance should be offered across the state.¹⁰⁶

Minnesota

Minnesota passed a historic health care reform bill (Senate File 3780) in May at the end of its 2008 legislative session. The law is broad in scope and includes major provisions that address improved health care coverage and affordability, payment reform and price/quality transparency, chronic care management, administrative efficiency, and public health.¹⁰⁷ Given that the state has one of the nation's lowest uninsurance rates and a history of collaboration and innovation in health care delivery, Minnesota enters the current phase of health reform on strong footing. However, like every other state in the nation, it recognizes that its rising health care costs are unsustainable. The state is particularly focused on remedying misaligned incentives that reward the overuse, underuse, and misuse of care services. In addition, Minnesota is seeking to improve quality relative to funds spent (value) and to reduce variation of quality relative to geography.¹⁰⁸

To improve health care coverage and affordability, the law addresses several aspects of health reform:

- Expand Eligibility for Adults—MinnesotaCare expands eligibility for adults without children to 250 percent FPL, thereby increasing access to health care for an additional 12,000 residents. It also reduces the MinnesotaCare sliding-scale premium to increase affordability.
- Section 125 Plans—Employers who employ 11 or more full-time-equivalent workers and do not offer group health insurance must establish and maintain a Section 125 plan to allow employees

Rhode Island Approved for Global Medicaid Waiver

In August 2008, Rhode Island Governor Donald Carcieri submitted the Rhode Island Consumer Choice Global Compact Waiver application to CMS. The Governor reported that it was approved by the agency on December 22, 2008. The state legislature has 30 days to review and reject the plan otherwise it is deemed approved. Rhode Island's global waiver application would give the state significant authority to make changes to its Medicaid program in exchange for a cap on federal funding of the program.

The proposal calls for the state to operate its Medicaid program under a Section 1115(a) demonstration waiver and would limit total Medicaid spending (state and federal) over the waiver period. CMS approved a \$12.075 billion spending cap through 2013, about \$350 million less than the state requested.

In exchange for the spending cap, the state would gain significant flexibility to change eligibility levels, services, and cost sharing. The waiver would use global budgeting as the funding mechanism for all Medicaid populations in the state across all settings. The state's Medicaid reform plan focuses on three elements. First, the state would seek to enhance the availability of home- and community-based programs as alternatives to long-term care institutional settings.

Second, the state would build on current programs such as Rite Care to manage care approaches across all Medicaid populations. Third, the state would adopt approaches that link reimbursement to performance and quality-of-care improvements. The waiver application also proposed greater care management across all Medicaid populations to ensure better coordination of care and to establish Healthy Choice Accounts to encourage preventive care and healthy lifestyles. Rhode Island estimates that the waiver would save the state \$358 million over five years, including savings that the state is already counting on to help close its FY 2009 budget gap of \$430 million.

Rhode Island's waiver proposal has drawn its share of criticism from both federal legislators and advocacy groups. Lawmakers, including the entire Rhode Island Congressional delegation, have expressed alarm over an apparent lack of transparency in negotiations between Governor Carcieri's administration and CMS. Senate Finance Committee Chair Max Baucus (D-MT) and Senator Jay Rockefeller (D-WV) raised concern that the waiver "could hurt" people and that the "federal guarantee of health benefits for those in need" should not be "negotiated away."¹⁰⁹ Advocacy groups are concerned that Rhode Island's waiver could lead to reduced access to institutional long-term care and raise out-of-pocket costs for some beneficiaries.

Rhode Island Follows Precedent Set by Vermont

Rhode Island is not the first state to seek a global Medicaid waiver that allows for greater flexibility in exchange for a cap on Medicaid spending. In 2005, Vermont won approval for a Section 1115 waiver known as the Global Commitment to Health Waiver, which allowed the state to restructure its Medicaid program in exchange for a five-year, \$4.7 billion cap on Medicaid spending. The state is financially at risk for keeping expenditures below the target. The federal government pays 60 percent of the costs over the life of the program.

Under its global waiver, Vermont established itself as a managed care organization, paying itself a premium for each Medicaid beneficiary served. In addition, Vermont has the flexibility to use federal funds for non-Medicaid health services and programs. Now that the waiver is in its third year, state officials believe that it has been extremely helpful in providing the flexibility needed to pursue financial and organizational reforms. It has allowed Vermont to maintain its expansion programs and to continue investing in other health-related programs essential to the state. In the face of some of the same criticisms leveled against Rhode Island, the state acknowledges that the waiver has not limited access or affected beneficiaries adversely. Like Rhode Island, Vermont's Global

to purchase health insurance with pre-tax dollars. The law provides \$1 million in funding for grants to cover certain employers' cost of establishing Section 125 plans.

- Value-based Benefit Redesign—A workgroup is charged with making recommendations on the design of an "essential benefit set" that provides coverage for a broad range of services and technologies. The benefit set must be based on scientific evidence of clinical effectiveness and cost-effectiveness and must require lower enrollee cost-sharing for certain services.

- Affordable Access—The law calls for a proposal to promote affordable access to employer-sponsored health insurance through the use of direct subsidies and/or tax credits and deductions.
- Administrative Streamlining—The law intends to make it easier for people both to obtain information and applications for state public health care programs and to renew their enrollment. It also provides for more seamless transitions between programs and requires further study of ways to improve coordination between state health care programs and other programs such as the Women, Infant, and Children Nutrition Program (WIC).¹¹²

To promote payment reform and price/quality transparency, the law calls for the following:

- Quality Transparency—Increased transparency and the development of a single statewide system of quality-based incentive payments for use by public and private health care purchasers to encourage quality improvement through:
 - Public reporting of risk-adjusted quality measures based on health outcomes, processes, and other measures such as care infrastructure and patient satisfaction.

Commitment to Health Waiver contains some elements of a block grant approach and waives some federal rules related to benefits and cost-sharing. Policymakers view the level of Vermont's federal funding cap as relatively generous, making the program difficult to evaluate in terms of an alternative approach to Medicaid's traditional funding structure.¹¹⁰ In contrast, the proposed cap on Medicaid spending in Rhode Island's global waiver application has come under considerable scrutiny for fear that it is insufficient.

Rhode Island Pursues Additional Health Care Initiatives

While pursuing its global waiver application, Rhode Island is also embarking on three initiatives to improve the value and quality of health care services in the state.¹¹¹

- **HEALTHpact** plans are a new alternative to high premiums, high deductibles, or reduced health coverage faced by small businesses. All Rhode Island carriers offer HEALTHpact plans based on product specifications outlined in regulations developed by the Office of the Health Insurance Commissioner. The plans offer wellness incentives to employees with cost consequences by targeting five behaviors related to self-management. The plans are available to all Rhode Island small businesses (1 to 50 employees) and their

workers at premiums 15 to 20 percent less than comparable products.

Even though New Hampshire and Florida have already emulated HEALTHpact's program design, uptake of the plan in Rhode Island has been slow in the first year. Rhode Island has commissioned an evaluation of the program to assess its impact and make recommendations for expanding its reach. The initial assessment indicates that marketing has been a challenge given the various actors involved in health plan decisions in the small group market, including carriers, brokers, employers, and employees.

- **The Chronic Care Sustainability Initiative** is a collaboration among health plans and providers that builds on national and local chronic care models and medical home efforts. The initiative targets five primary care pilot sites for a two-year pilot starting on October 1, 2008. Under the pilot, participating providers must agree to become certified as a Patient-Centered Medical Home per National Committee for Quality Assurance (NCQA) standards. The providers must also participate in collaborative training (funded by the Department of Health and Quality Partners of Rhode Island) and self-report on three chronic care conditions. In return, participating health plans agree to pay a

supplemental fee per member per month, fund a portion of a nurse care manager, and provide the providers with consistent enrollment and utilization reporting.

- **Rhode Island is revising its approach to rate factor review.** The Office of the Health Insurance Commissioner (OHIC) is authorized by statute to perform an annual review of the rates that insurers propose to charge small and large employers. Beginning in 2005, this authority was expanded to consider four key factors: 1) solvency and soundness; 2) consumer protection; 3) fair treatment of providers; and 4) improving affordability, quality, and accessibility of medical care. Under its broadened authority, OHIC must evaluate whether the rate factors proposed by the health plans are built on sufficient efforts to improve the affordability, quality, and accessibility of medical care. OHIC is working to define the standards of evaluation to be used in the rate review process for assessing the health plans' affordability efforts. With the evaluation, OHIC will establish a relationship between premium rate approvals and expected system improvement priorities on the part of health plans, such as investment in health information technologies and efforts to encourage the use of primary care through payment reform and delivery system redesign.

- The inclusion of quality measures for primary care related to preventive services, coronary artery and heart disease, diabetes, asthma, and depression.
- Adjustments of quality incentive payments to providers for variations in providers' patient populations, based on a comparison of provider performance against specified targets and improvement over time.
- **Quality Measurement Tools**—A powerful set of tools to allow consumers and health care purchasers to compare providers in terms of overall cost and quality of care. The tools will support the creation

of incentives that: 1) motivate health care providers to deliver innovative, high-quality/low-cost health care, and 2) motivate health care consumers to patronize high-quality/low-cost providers. The tools will be based on encounter-level claims data and information on contracted prices, with the Commissioner of Health developing both a method for calculating providers' relative cost and quality of care and a combined measure incorporating risk-adjusted cost and quality of care. The information will be disseminated to health care providers and the public.

- **Means of Comparison**—The establishment of "baskets" or episodes of health care services promotes transparency and accountability, allowing consumers to make relatively easy comparisons of cost and quality of care across providers while motivating provider innovation on cost and quality. In particular, providers will set their own prices for "baskets" of care to encourage greater transparency and price competition.¹¹³

To promote chronic care management, the law requires:

- **Coordination of Activities**—Health care must be coordinated for people

with complex or chronic conditions, and standards must be established for state certification of health care (medical) homes. Health care homes will receive care coordination payments from public and private health care purchasers.

To promote administrative efficiency, the law focuses on:

- **Electronic Records**—Electronic health records must be consistent with federal standards for interoperability, and all prescriptions should be ordered electronically by 2011.
- **Uniform Claims Processing**—A mandated study and report will address how uniform methods of processing claims can reduce claim adjudication costs for health care providers and health plans.

To advance public health, the law requires a:

- **Statewide Health Improvement Plan**—A total of \$47 million is appropriated for FY 2010 and 2011 to establish and fund a statewide health improvement program in order to reduce the percentage of Minnesotans who are obese or overweight and to reduce tobacco use.

The reform requires health care cost savings to be measured against projected costs in the absence of reform. Estimates suggest that the reform measures will yield a possible cost savings of about 12 percent by 2015, representing a potential savings of about \$6.9 billion compared to baseline projections.¹¹⁴

New Jersey

In July, New Jersey signed into law a health reform bill (S. 1557) described by legislative sponsors as the first phase in guaranteeing health coverage for all New Jersey residents. In sum, the law requires coverage for all residents 18 years old or younger, expands eligibility for subsidized health insurance for adults, and introduces health insurance reforms designed to make individual and small employer health insurance more affordable.¹¹⁵ The health care coverage reform law features the following components:

- **“Kids First” Mandate for Health Insurance Coverage**—All children 18 years of age and younger must have health insurance coverage through an employer-sponsored or an individual health benefits plan, Medicaid, the NJ FamilyCare (SCHIP) program, or the NJ FamilyCare Advantage buy-in program.
- **Increased Health Insurance Accessibility for Low-Income Parents**—Parents with incomes up to 200 percent FPL are eligible for the NJ FamilyCare program.
- **Effective Use of State Charity Care Funds**—Hospitals are prohibited from submitting charity care claims for children under age 19 who present at hospitals for emergency care and are eligible for NJ FamilyCare or Medicaid.
- **Ongoing Enrollment Initiative**—Individual taxpayers must indicate on their tax returns the health insurance coverage status of the taxpayer and dependents, if applicable, as of the filing date. The taxpayer will receive an application for the Medicaid or NJ FamilyCare program if the taxpayer or dependents may be eligible for either program based on reported income.

The law includes several reforms to the individual and small employer markets. Major provisions pertain to:

- **Expanded Rating Band in the Individual Market**—The difference in premium rates from one individual to the next will be expanded to 350 percent. With age as the only basis for a premium rating differential, plans will be more affordable for the young and healthy. As a consumer protection, rate increases for those already covered under an individual policies will be limited for the next five years to an amount no more than the lower of 15 percent or the medical trend assumption used by the carrier to project claims.
- **Greater Carrier Participation in the Individual Market**—A carrier must offer individual market policies as a condition of participating in the small employer market.
- **Coverage for Dependents Age 30 or Younger**—Changes were made to the eligibility criteria, terms, and administration of the law that had been enacted two years ago.
- **Minimum Loss Ratio for Individual and Small Employer Plans**—Premiums must be formulated such that the minimum loss ratio may be no less than 80 percent of the premium.
- **Greater Transparency of Insurance Broker Fees**—An insurance producer (agent or broker) must notify an insurance purchaser of the amount of any of the following: commission, service fee, brokerage, and whatever other valuable consideration the insurance producer will receive from the sale, solicitation, or negotiation of the health insurance policy or contract. A producer must also inform the Department of Banking and Insurance how carriers compensate the producer for the sale, solicitation, or negotiation of the health insurance policy or contract.¹¹⁶

ATTEMPTS TO ENACT COMPREHENSIVE HEALTH REFORMS FACE OBSTACLES

During 2008, state legislatures in California, Kansas, New Mexico, and Pennsylvania considered proposals for comprehensive health reform. Each state either failed to pass the reform proposals in their entirety or considerably scaled back the proposals' reform provisions. Nevertheless, health reform leaders in the four states acknowledge that efforts to achieve comprehensive health reform require a multi-year process organized around education and activism across several sectors. Thus, efforts in the four states should not be characterized as failures but rather as near successes and important first steps. These states are leading a critical national debate as they wrestle with some of the most important questions and issues in health care.

California

For California, 2007 was a year filled with high hopes and much preparation for comprehensive health reform. The previous *State of the States* noted that the outcome of negotiations involving Governor Arnold Schwarzenegger, Assembly Speaker Fabian Nunez, and Senate President Don Perata on the compromise health reform bill (AB X1 1) was unclear. In mid-December, the California Assembly had approved AB X1 1 during a special session, but the bill then failed to pass out of the Senate Health Committee in late January 2007 with a 1-to-7 vote against it. The bill would have provided health coverage for an estimated 3.6 million Californians (about 70 percent of the state's uninsured residents). The main components of AB X1 1 included the following:

- Mandated coverage for all individuals;
- A financing mechanism shared across government, hospitals, employers, and individuals;
- Expansion of Medi-Cal and Healthy Families for children, parents, and childless adults;

- Subsidies and tax credits for low- and moderate-income populations;
- Health plans required to meet an 85 percent medical loss ratio and to guarantee issue by 2010; and
- Cost containment and quality improvement measures, such as implementation of health information technology, significant cost and quality transparency efforts and value-based purchasing initiatives, and employers' required establishment of Section 125 plans.¹¹⁷

In February, Daniel Weintraub of the *Sacramento Bee* wrote an opinion piece about the state's failure to pass comprehensive reform. He argued that the bill died for many reasons but, in the end, was confounded by the reality of a legislature composed of "leftist Democrats and right-leaning Republicans," which made the passage of a centrist proposal remarkably difficult. In addition, Weintraub noted that while "the bill did not suffer from a lack of public support," the process failed to keep the public informed.

Although many meetings were held to garner stakeholder support, failure to conduct enough public hearings limited general awareness of the proposal's transformation into its final form. Even though Weintraub and others have subjected California's reform effort to considerable analysis, agreement is still elusive as to what factors most significantly contributed to the plan's rejection. Without doubt, concern over an insufficient future funding stream was a major factor.¹¹⁸ In any event, a significant majority of Californians are concerned about the state's health care system and the need for health reform legislation. A 2008 Field Health Policy Survey released in April found that 72 percent of voters supported the overall health reform plan.¹¹⁹

Given strong public support in California for comprehensive health reform and the governor's continued advocacy, it is possible that the unsuccessful attempts of 2007–2008 have laid the ground work for future efforts. Unfortunately, California's budget problems have worsened since January 2008. Even though the health reform legislation would not have relied on the general budget for funding, budget concerns are now the main focus among California policymakers.¹²⁰

Kansas

In May, Governor Kathleen Sebelius signed into law a health care reform bill (S.B. 81) that will lead to modest gains in access to health care and delivery system reform. The law expands SCHIP eligibility for children in households with income up to 225 percent FPL beginning in 2009, and to 250 percent FPL by 2010—once federal funding becomes available—from the current level of 200 percent FPL. In addition, the law allocates \$460,000 to expand eligibility for pregnant Medicaid enrollees, \$2.5 million to increase funding for safety net clinics, and \$1.5 million for the Wichita Center for Graduate Medical Education to fund rural rotations by physicians receiving specialized training in Wichita.

Under a 2007 legislative charge, the Kansas Health Policy Authority (KHPA) proposed a 21-item health reform package with the goals of prevention, personal responsibility, and providing and protecting affordable health insurance. The legislature scaled back the original, comprehensive health reform package, leaving in place nine of the original policy recommendations as follows:

- Incorporating the medical home model of delivery into Medicaid, SCHIP, MediKan (a program covering the disabled before the receipt of federal disability payments), and the State Employee Health Benefits Plan while

directing KHPA to develop systems and standards for implementing and administering a medical home by February 1, 2009;

- Moving the Small Business Grant Program (created to help small businesses establish Section 125 plans) from the Department of Commerce to KHPA;
- Standardizing insurance cards for Medicaid enrollees;
- Expanding the Community Health Record pilot project, which incorporates claims data into patient electronic records;
- Expanding HealthWave (Kansas SCHIP) outreach in order to enroll more eligible but non-enrolled children;
- Funding continuation of the Coordinated School Health Program with \$500,000 to continue bringing educational and community resources into schools to help with health education;
- Adding the Commissioner of Education to the KHPA Board as a non-voting ex officio member as KHPA expands the Coordinated School Health Program;
- Providing dental coverage for pregnant Medicaid enrollees; and
- Providing tobacco cessation counseling services for pregnant Medicaid enrollees.¹²¹

In the end, out of these nine reforms, the legislature funded only one—continuation of the Coordinated School Health Program. Accordingly, KHPA Executive Director Marcia Nielsen stated that the goal of comprehensive health reform “is a multiyear effort and the important debate about reform in Kansas has begun.” She explained that “funding for health reform is a smart investment” and that “legislators will need to hear the voices of Kansas health care providers, patients, consumers and businesses” if Kansas is to achieve comprehensive health reform.¹²²

Over the next year, KHPA will focus on securing legislative approval for several health reform recommendations, including a statewide smoking ban, an increase in the tobacco products tax from \$0.50 to \$1.29 per pack of cigarettes, and an expansion of Medicaid for parents and caretakers up to 100 percent FPL.¹²³

New Mexico

New Mexico undertook a multi-year health care reform process with recommendations advanced by the governor that would have led to universal health coverage. Governor Bill Richardson’s HealthSOLUTIONS proposal required state residents to purchase coverage—with lower-cost state-subsidized plans available for eligible residents—and mandated employers to contribute to a fund in support of such coverage, with the contribution offset by the amount paid by any employer for employee health benefits.¹²⁴ After the legislature failed to pass comprehensive health reform earlier in the year, Richardson vowed to return to the issue in a special session. Before the special session, however, he set a scaled-back goal of expanding health coverage to all children. He also proposed streamlining several state health programs to improve efficiency. In August, the governor called legislators into special session, with major health care reform a central priority. When the special session concluded in late August, the legislature had agreed to the following:

- To fund children’s health (including behavioral health) at \$22.5 million to increase enrollment among eligible children not already enrolled in Medicaid and SCHIP; and
- To fund \$10 million to treat developmentally disabled children.¹²⁵

Despite a state budget surplus accruing from oil and natural gas revenues, Richardson was unable to secure agreement on other coverage expansions. He characterized the outcome of the session as “modest” but with

“solid gains” toward achieving his main goal of health insurance coverage for all children.¹²⁶

Pennsylvania

In 2007, Pennsylvania Governor Ed Rendell introduced his health care reform plan. Called Prescription for Pennsylvania, the plan consisted of a comprehensive coverage expansion for adults age 19 to 64, combined with programs to improve health care quality, contain health care costs, and promote healthy behaviors.¹²⁷ The first initiative under Rendell’s comprehensive health care reform, announced even before introduction of the full plan, was passage of a law to provide affordable health care coverage to all Pennsylvania children. The state obtained federal approval in 2007 to subsidize children with family incomes up to 300 percent FPL.

Various components of Rendell’s broad health reform plan encountered significant opposition from the legislature. During 2007 and 2008, the legislature offered components of the health reform plan as separate pieces of legislation. Although most components passed the Democratic-controlled House, many of the reforms failed in the Republican-controlled Senate. However, the legislature passed several laws related to scope of practice for physician assistants, certified registered nurse practitioners, clinical nurse specialists, nurse midwives, and dental hygienists, all aimed at addressing serious workforce shortages. In addition, the legislature passed a bill that, for the first time, mandates hospital evidence-based infection control plans, statewide infection surveillance, and reporting of health care-associated infections.¹²⁸

One of the bills that the Senate passed and the House amended is the proposed Pennsylvania Access to Basic Care (PA ABC); the bill is now awaiting action before the Senate Banking and Insurance

Committee (SB 1137). PA ABC would provide health care access for the uninsured, help small businesses provide health care for employees, and move those enrolled in the state's current program for low-income, uninsured adults (adultBasic) into PA ABC. Pennsylvania has an estimated 900,000 uninsured residents, more than half of whom would be eligible for PA ABC.

Another bill passed by the House and now before the Senate (HB 2098) would allow private insurance companies to refuse to pay for serious, preventable adverse events.¹²⁹ Still another bill, HB 2005, passed the House and would limit rating factors used for small group and individual coverage; it would require adjusted community rating

and standardized benefit packages and give the Insurance Commissioner greater power to review rates. Another bill passed by the House would allow parents to continue coverage on their policy for single children up to age 30.

Governor Rendell was able to implement two measures in 2008 by using his power of executive order. One measure created the Pennsylvania Health Information Exchange, which will provide the information technology architecture needed to support compatible statewide electronic health records and electronic subscribing by sharing data collected in hospitals and health providers' offices.

The second executive order created the Chronic Care Management, Reimbursement and Cost Reduction Commission, which issued a strategic plan to transform how Pennsylvania provides and pays for health care for people with chronic conditions. The Governor's Office of Health Care Reform began implementing the strategic plan with a roll-out in southeastern Pennsylvania for more than 200,000 patients. Roll-out in south-central and southwestern Pennsylvania will take place in winter 2009.¹³⁰

STATES ESTABLISH FRAMEWORKS FOR HEALTH REFORM

A handful of states have either developed recommendations for broad health system reform or are working toward the creation of such recommendations. The Oregon Health Fund Board and the HealthFirst Connecticut Authority have spent the past year constructing plans for health system change with an eye toward immediate legislative action. Ohio and Oklahoma released similar recommendations on a smaller scale while the Utah legislative Task Force released draft bills. Arkansas is on the path toward formulating a plan to rework its current health system.

Oregon

The Healthy Oregon Act of June 2007 created the Oregon Health Fund Board, a group of seven individuals supported by more than 150 Oregon volunteers, who were tasked with reviewing research and expert testimony and studying successful models in other states and countries. In November 2008, the Board released *Aim High: Building a Healthy Oregon*, a comprehensive blueprint for reforming Oregon's health care system. The blueprint's recommendations were 14 months in the making and are the result of the most extensive analysis of health care in Oregon in 20 years—including the collection of testimony from 1,500 Oregonians who submitted comments during statewide town hall meetings.¹³¹

The blueprint's central message is that Oregon's health system is broken and that the pragmatic choice—not the idealist goal—is to transform the system by aspiring to a new vision of world-class health and health care in Oregon. The overarching conclusion of the Board is that the Oregon health system should achieve three objectives: a healthy population; extraordinary patient care for all; and

reasonable per capita costs shared in an equitable way by the entire population.¹³²

One of the central recommendations for the 2009 legislative session is to create an Oregon Health Authority to be a catalyst for change by becoming the organizer and integrator of Oregon health care policy and purchasing and the coordinator of the State's investments in health service innovation. The Authority is to focus on quality, costs, and the health of the population by using seven strategic building blocks for change:

- Improve access for children and low-income adults—Provide health insurance to all children in Oregon within the current delivery system by: increasing public program eligibility levels from 185 to 200 percent FPL with no cost-sharing requirements; through sliding scale premium assistance to those children in families with access to employer-sponsored insurance (ESI); and, for children with no access to ESI, the creation of a new program with sliding scale premiums for those between 200-300 percent FPL and a full-cost buy-in for those with higher incomes. Also, additional low-income adults will be permitted to join a reopened Oregon Health Plan (enrollment is currently capped) which provides health coverage to low-income Oregonians.

These expansions will be financed using a restructured provider tax mechanism and possibly other revenue sources that can leverage federal matching funds. Future phases of coverage expansion to approach near-universal coverage include a requirement that all residents obtain health insurance coverage, reforms to the non-group market, a “pay or play” employer payroll tax, and the development of an insurance exchange/connector.

- Cost containment and quality improvement mechanisms—Improve the quality of care that Oregonians receive and decrease costs using various policy levers including: the establishment of an all-payer/all-claims data collection system; development of a common set of measures and targets for quality improvement; increased use of evidence-based practice; establishment of an Oregon Quality Institute; and simplification and standardization of administrative processes to decrease administrative costs.
- Purchasing strategies and insurance market reforms—Coordinate and align the State's purchasing policies across public entities; create a health insurance exchange/connector to consolidate the non-group market; consider developing a publicly-owned health plan option; and use regulatory powers to monitor and control increases in health insurer administrative expenses as well as provider charges.
- Encourage new models of care delivery—Strategies include developing integrated health homes (sometimes called medical homes) and accountable health communities to support them; integrating behavioral health with physical health; preventing health disparities through the use of culturally-specific approaches to promote health and preventing chronic conditions; restructuring payment systems to encourage better organization of the delivery system; providing appropriate end-of-life care; linking population health and public health strategies to the health care delivery system; and encouraging the development of interoperable health information technology and exchange.

- Ensure health equity for all—Focus strategies to address the social determinants of health through health promotion, chronic disease prevention, reduced barriers to health care, and improved quality of care.
- Train new health care workers—Develop a strategy to improve the training, recruitment, and retention of all levels of health care providers including assuring they are provided the appropriate education to increase cultural competence.
- Federal-state relationship—Advocate for federal changes such as federal waivers, additional funding and numerous other policy changes that support the health care goals of Oregon.

The Board believes that access to health and health care for all Oregon residents is possible within a decade if the state builds the infrastructure needed to deliver health care with higher quality and at lower cost. The report details a strategy for providing universal access that includes building on the present insurance model while also developing a publicly financed insurance plan to fit within the individual market exchange. Currently, about one in six Oregonians is without health insurance coverage.

The blueprint stresses that investment in community clinics and public health initiatives are also crucial for providing health services at the right point in time and for creating a healthier population.¹³³

Ohio

In July, an advisory group appointed by Governor Ted Strickland produced a comprehensive report that included recommendations for meeting two goals set by the governor—to reduce the number of uninsured Ohioans by half and to increase the number of small businesses able to offer coverage to their workers. This report

was the work of the 12-member team who participated in the Coverage Institute hosted by the State Coverage Initiatives (SCI) program; a larger Healthcare Coverage Advisory Committee that included nearly 50 representatives from stakeholder groups aided in their work.

The recommendations in the report include:

- Employer Sponsored Coverage:
 - Design a reinsurance program to reduce the cost of coverage by about 25 percent for eligible small businesses and individuals;
 - Provide premium assistance for low-wage workers;
 - Require employers to offer Section 125 premium-only plans (see page 52); and
 - Extend coverage for dependents up to age 29.
- Covering Lower Income Ohioans:
 - Employ outreach strategies for those individuals currently eligible but not enrolled in public programs;
 - Increase Medicaid eligibility to 200 percent FPL for parents; and
 - Allow childless adults up to 100 percent FPL to buy into Medicaid managed care plans with state subsidies.
- Reforming the Ohio Insurance Market:
 - Require those who can afford insurance to purchase it;
 - Guarantee issue in the non-group market;
 - Adopt increasingly progressive rating rules to reduce the variance in insurance premiums in the non-group market;
 - Provide sliding-scale subsidies

to help low-income individuals purchase private coverage; and

- Create an insurance connector to help implement coverage expansions.

- The report also includes recommendations to improve value in the health care system and to contain costs, including adoption of health information technology, transparency and reporting requirements, and strategies that focus on prevention, primary care, and chronic care management.
- While not specified, the Advisory Committee recommended that funding for health reforms come from current sources where possible and, where this is not possible, from a broad base of funding sources. The funding mechanism adopted should reflect the principle of shared responsibility.

Ohio's SCI team report is now in the hands of Governor Strickland and members of the Ohio General Assembly. Decisions about moving forward with the recommendations will be made as Ohio prepares for consideration of its next biennial budget, to be introduced in early 2009.¹³⁴

Oklahoma

In November, the Oklahoma State Coverage Initiative team, a group of state leaders representing the state legislature, government agencies, the private sector, and tribal organizations, released the latest version of their Blueprint for Oklahoma report.¹³⁵

The report included draft recommendations for ensuring that all Oklahomans have access to high quality health care and affordable health insurance by:

- Lowering the cost of private health insurance;
- Reducing the number of uninsured;
- Increasing access to health care services; and

- Reducing the insurance premium burden caused by cost-shifting from the uninsured.

The primary areas of focus in the draft report include:

- Maximizing enrollment in public programs for those eligible but not yet subscribed;
- Developing an affordable basic health benefits plan;
- Generating sufficient public revenue; and
- Encouraging the take-up of private coverage.

The Blueprint report was shared with statewide participants for feedback and the Oklahoma team expects to have revised recommendations ready by the start of the Oklahoma legislative session in February 2009.

Connecticut

The 10-member, legislatively-created HealthFirst Connecticut Authority released a draft report in December that has identified an urgent need for expanded health coverage and transformation of the system of care. The draft report provides recommendations for ways to expand and improve health coverage, while also addressing issues that affect both the insured and uninsured, such as health information technology, wellness, and chronic diseases. The Authority focused on the complementary goals of universal coverage and access to safe, effective care for all Connecticut residents by first establishing two workgroups—the Cost, Cost Containment, and Finance Workgroup (CCCF) and the Quality, Access, and Safety Workgroup (QAS). More than fifty individuals representing a broad range of interested stakeholders made up each workgroup. The Authority first met in October 2007 and held 27 meetings between then and December 2008, during which time it reviewed research and expert testimony and also hosted nine public forums throughout the state.

While the Authority is waiting for cost estimates before making final recommendations, the basic design of their coverage expansion proposal is:

- Expanded Medicaid/SCHIP eligibility for all residents with family incomes below 300 percent FPL, including sliding scale cost-sharing; the uninsured with access to employer-sponsored insurance would receive premium assistance to purchase private coverage.
- Access to a restructured Charter Oak program, which currently allows families to buy health insurance regardless of their health status at premiums tied to income.
- A Connecticut Health Partnership, using the state employee health benefit plan as a base, will be available to all residents and employers in order to improve employer offer rates and employee take-up rates, and to offer coverage to those in the non-group market.

The Authority also has multiple recommendations for containing costs and improving quality. Particularly, they focus on the role of data collection and analysis, emphasizing that data should drive policy development, implementation, and evaluation. The Authority also recommended that a public entity be assigned or developed to oversee the proposed reforms and better coordinate state spending on health care.

Utah

In March, Utah enacted H.B. 133 which, among other more immediate measures, established a framework for the development and implementation of a strategic health reform plan. The legislation created the Health System Reform Task Force, which was charged with creating a plan for health system reform. In December, the Task Force drafted three bills for introduction in the 2009 legislative session.¹³⁶ Those bills focus on:

- Insurance market reforms, including the creation of a new basic benefit plan called the Utah NetCare Basic Health Care Plan; the allowance of mandate-free benefit plans to be offered in certain circumstances; the establishment of an Internet portal for the purchase of these new plans; the inclusion of sole proprietors in the small group market pool; and the establishment of a reinsurance pool.
- Streamlining and standardizing various aspects of provider, insurer, and consumer interactions and communications; the bill also creates a framework for demonstration projects for delivery and payment systems reforms.
- Requiring certain contractors who do business with the state to offer health insurance to their qualified employees.

Arkansas

Arkansas is developing a strategic plan for health care that encompasses short-term, intermediate, and longer-term components. Work toward this goal is taking place through the Governor's Implementation Group, which is identifying opportunities to implement improvements that do not require legislative or other action, including those that require cross-agency collaboration or coordination, and the Governor's Roundtable on Health Care, which is developing strategies to improve health, deliver needed health care, and enhance both worker productivity and the state's business climate. Nearer-term goals include developing a package of legislative initiatives for recommendation to the governor for introduction in the January 2009 legislative session, while building political consensus to help facilitate its passage.¹³⁷

COVERAGE INSTITUTE OFFERS IN-DEPTH TECHNICAL ASSISTANCE TO STATES

The Coverage Institute (CI), a targeted SCI technical assistance program, was unveiled in 2007 and has helped states address substantial and comprehensive care health reform throughout 2008. The CI was instrumental in helping a group of state leaders from the public and private sectors deepen their understanding of the implications of various programmatic options for expanding health coverage in their respective states.

The CI began with a kick-off meeting that brought together representatives of 14 states (Arkansas, Colorado, Indiana, Kansas, Maryland, Minnesota, New Hampshire, New Jersey, New Mexico, Ohio, Oklahoma, Oregon, Texas, and Wisconsin). Each state selected a team to participate in the highly interactive process for developing policy and program recommendations. While the mix of participants varied by state, the teams included senior executive branch officials, legislators, and decision makers from private purchasers, the advocacy community, and practitioners. Fifteen distinguished faculty members shared their expertise on various issues, including insurance market reforms, reinsurance, other methods to subsidize coverage, connectors/exchanges, Medicaid waivers and the Deficit Reduction Act, health systems improvement, and strategies for building stakeholder and policymaker support.

Following the initial meeting, participating states were then eligible to compete for additional funding for development/microsimulation modeling or other reform development activities. In February, the

Robert Wood Johnson Foundation, through SCI, awarded development grants to Arkansas, Kansas, Maryland, Minnesota, New Mexico, Oklahoma, Oregon, Texas, and Wisconsin. For the most part, the states are using the funds to continue their involvement in a stakeholder consensus-building process, to fund experts to help them develop policy proposals, and to fund the actuarial modeling of various policy options. In addition, Colorado and New Jersey were awarded microsimulation modeling grants. Both states are working with a team from the Urban Institute to develop and delineate a finite number of policy options for use in a microsimulation model, and to understand important design and implementation issues.

Despite the severe budget setbacks experienced by many of the participating states, many have made extraordinary progress. Throughout, this report highlights the successes of participating states, but a few examples of CI team achievements include the following:

- The Ohio CI Team developed a comprehensive plan to reduce the number of uninsured Ohioans by half; the team presented the plan to the governor in July 2008.¹³⁸
- The Maryland team developed a proposal, subsequently enacted, that included a Medicaid expansion for parents/caretaker relatives with a phased-in expansion for childless adults, along with as a small business subsidy program that started offering assistance to small businesses in October 2008.¹³⁹

- For the New Jersey team, the kick-off meeting brought together key legislative and executive branch leaders for a constructive conversation on health coverage, leading to the development of a sequential coverage expansion proposal. Governor Corzine signed into law the first phase of the reforms, sponsored by Senator Joe Vitale, in July 2008.¹⁴⁰

Perhaps one of the most important aspects of the Institute is collaboration—the result of requiring teams to represent various components of government and the private sector. Such collaboration encouraged states to move beyond political turf, to dampen political rhetoric, and to bring disparate parties together in a neutral environment. As one state official commented, “You can’t put a dollar figure on the importance of having SCI as a neutral third party spearheading the efforts.”

The Coverage Institute has fostered a sense of community among all participating states. Participants stay in contact with one another and are aware of each other’s progress through bimonthly conference calls. The states also have participated in technical assistance meetings that allow them to advise and learn from one another. The CI will conclude in June 2009; however, SCI intends to announce the start of another Institute in spring 2009.

SCHIP MOVES FORWARD IN THE FACE OF UNCERTAINTY

The U.S. Census Bureau reported that the number of uninsured children in 2007 fell from the previous year by 500,000 to 8.1 million. The decrease is primarily attributable to an increase in publicly sponsored coverage of children through Medicaid and the State Children's Health Insurance Program (SCHIP).¹⁴¹



In 2007, Congress and the president failed to agree on legislation that would reauthorize SCHIP. Instead, they extended the current reauthorization until March 31, 2009. In addition, the Centers for Medicare & Medicaid Services (CMS) issued a policy directive on August 17, 2007, that made states ineligible to receive federal SCHIP funds for children with gross family income above 250 percent of the Federal Poverty Level (FPL) unless the following two conditions are met: (1) 95 percent of children with family income below 200 percent FPL are covered; and (2) employer-sponsored insurance for children with family income below 200 percent FPL has not fallen by more than 2 percentage points during the previous five years.

If a state meets these standards, CMS requires additional provisions to prevent crowd-out of private coverage. For children in families earning above 250 percent FPL, the child must be uninsured for at least a year to be eligible for SCHIP coverage, and the state must require the maximum amount of legally permissible cost sharing.¹⁴² Eight states filed suit against the Bush Administration in October 2007, contending that the new eligibility rules either force out children already in the program or leave many thousands of otherwise eligible children without coverage.¹⁴³ In April 2008, lawyers from the Government Accountability Office (GAO) issued their opinion that the Bush Administration violated federal law with the August 17 directive.¹⁴⁴

Despite these challenges, the following eight states enacted or received CMS approval for SCHIP expansions in 2008: Colorado, Indiana, Iowa, Kansas, Louisiana, New Jersey, New York, and North Dakota.¹⁴⁵

PLANNED EXPANSIONS OF 300 PERCENT FPL AND ABOVE

Iowa passed legislation that sets a target of covering all its children by 2010. The law includes an expansion of hawk-i (SCHIP) to 300 percent FPL and 12-month continuous Medicaid eligibility, among other measures.¹⁴⁶ Iowa needs CMS approval for its expansion.¹⁴⁷

New Jersey enacted a law in July mandating coverage of all children through either public or private insurance within one year of the

bill's passage.¹⁴⁸ Children in families with income above 350 percent FPL may buy into the existing FamilyCare (SCHIP) program and receive the same services available to FamilyCare beneficiaries, with monthly premiums ranging from \$137 for a family with one child to \$411 for a family with three or more children. The state estimates that 15,000 children could benefit from the program.¹⁴⁹ The law also increased the FamilyCare income eligibility level for parents from 133 to 200 percent FPL. With the expansion, the number of adults covered under NJ FamilyCare is expected to increase from 97,000 to 153,768 by the end of fiscal year 2011.¹⁵⁰

New York's fiscal year 2009 budget allocates \$19 million in state funds for a SCHIP eligibility expansion from 250 to 400 percent FPL. After CMS denied New York's request for expansion beyond 250 percent FPL, New York decided to fund its expansion with state-only money and initiated implementation in September.¹⁵¹

PLANNED EXPANSIONS OF 250 PERCENT FPL AND BELOW

CMS approved an increase for Indiana's SCHIP up to 250 percent FPL (from 200 percent), which falls short of the state's enacted 2007 SCHIP expansion to cover children up to 300 percent FPL.¹⁵²

CMS approved an increase in Louisiana's SCHIP eligibility level for children from 200 to 250 percent FPL, reflecting a reduction from the 300 percent FPL originally passed by the Louisiana legislature. Implementation of the expansion began in June 2008.¹⁵³

Kansas passed an eligibility expansion of HealthWave (Medicaid and SCHIP) for children from the current level of 200 percent FPL to 225 percent FPL beginning in 2009, and to 250 percent FPL by 2010—if more federal funding becomes available.¹⁵⁴

Colorado enacted a SCHIP expansion for Child Health Plan Plus (CHP+) as part of an \$18.4 billion operating and capital budget. The expansion covers pregnant women and children in families earning less than 225 percent FPL (up

from 205 percent FPL) and, when fully implemented, will provide benefits for an estimated additional 9,040 children and 686 pregnant women. The law also expanded CHP+ mental health benefits to correspond with those offered through Medicaid and allocated funds to provide medical homes to approximately 100,000 Medicaid and CHP+ children. The law permits further expansion to 250 percent FPL if funds are available in the future. Implementation will begin in March 2009.¹⁵⁵

In June, CMS approved North Dakota's request to expand SCHIP eligibility from 140 to 150 percent FPL. Implementation of the expansion began in October, with an additional 800 uninsured children expected to gain coverage during the first year. In North Dakota, however, families may disregard child care expenses, payroll taxes, child support, and other expenses when calculating their income in determining eligibility such that children in some families earning close to 200 percent FPL may qualify for coverage.¹⁵⁶

BEYOND ELIGIBILITY EXPANSIONS

New Mexico and Utah have taken steps to increase enrollment but have not passed eligibility expansions. Utah passed legislation to require the state's SCHIP to operate under open enrollment. In the past, open enrollment has been irregular, but the law mandates that any child qualifying for the program will be guaranteed coverage.¹⁵⁷ New Mexico's legislature agreed to fund \$22.5 million to increase coverage of eligible children through Medicaid and SCHIP.¹⁵⁸

While some states have made SCHIP expansion a priority, approximately 8 million children remain uninsured.¹⁵⁹ As state officials and other interested stakeholders continue efforts to expand health coverage for children, they will be monitoring the new administration's and Congress' consideration of SCHIP reauthorization in 2009.

STATE REFORM EFFORTS TARGET SMALL EMPLOYERS

Several state reforms have focused on assisting small employers' efforts to provide access to health insurance. Between 2005 and 2008, at least 10 states enacted new programs to improve or increase coverage in the small group market.¹⁶⁰ Recent innovations include wellness plans, first-dollar coverage benefit design, and assistance with implementation of Section 125 plans. Other reforms include reinsurance, tax credits, and premium subsidies. This section explores some of the challenges in the small group market and highlights some of the new ideas being pioneered by states.



THE PROBLEM: EROSION OF SMALL GROUP COVERAGE

The continuing erosion of employer-sponsored insurance (ESI) and related increases in the number of uninsured explain much of the ongoing interest in reform of the small group market. While the percentage of large firms offering coverage has remained fairly constant at 98 or 99 percent of workers, the percentage of employers with fewer than 200 workers offering insurance fell from 68 percent in 2000 to 62 percent in 2008 as shown in Figure 7. Even fewer very small employers (3 to 9 employees) offer coverage; their offer rate fell from 57 to 49 percent.¹⁶¹ The loss of ESI, primarily driven by a drop in coverage among small firms, has been a major cause of falling coverage rates in the United States since 2000.¹⁶² More than 62 percent of uninsured adults work for small firms (100 or fewer employees) or are self-employed.¹⁶³

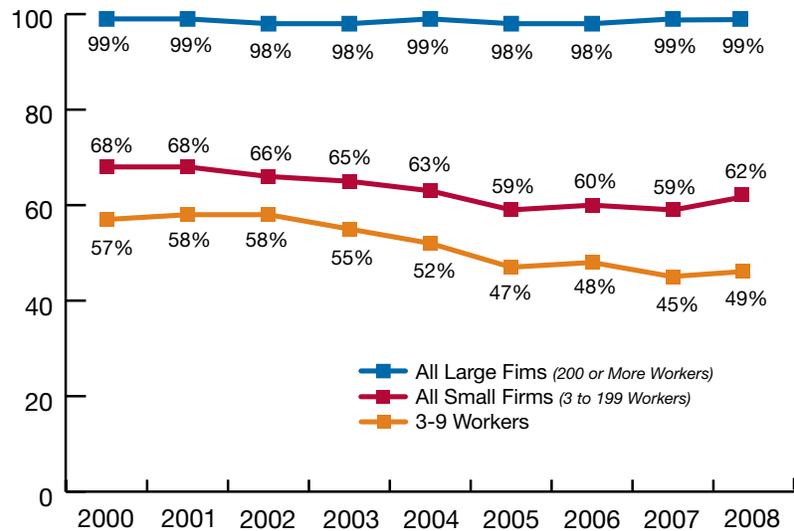
The lower rates of coverage in the small group market are attributable to several factors. First, those in the small group market face higher administrative costs because of the smaller pool of people across whom to spread the fixed costs of marketing, enrollment, and underwriting, thereby driving up per person premium costs.¹⁶⁴ Second, premiums can change dramatically from year to year because of the health experience of one or two workers. Third, insurance plans often mark up premiums out of concern about year-to-year variation in health costs.¹⁶⁵ Fourth, small firms tend to pay lower wages in general than large firms and operate on tighter margins, making it more difficult for them to offer comprehensive health insurance to workers.^{166,167}

Even among employers who continue to offer coverage, the trend is toward greater employee cost sharing. Under one definition of underinsurance,¹⁶⁸ the increase in underinsurance was 60 percent between 2003 and 2007.¹⁶⁹ Those insured in the small group market have been particularly affected by this increase. In 2008 alone, the percentage of small business employees (3-199 employees) with a deductible more than \$1,000 jumped from 16 to 35 percent.¹⁷⁰

APPROACHES TO COVERAGE EXPANSION

To address the low and declining coverage rates among small businesses, states are turning to several approaches, including:

Figure 7 Percentage of All Firms Offering Health Benefits, 2000-2008*



*Test found no statistical differences from estimate for the previous year shown ($p < .05$).

Note: Estimates presented in this exhibit are based on the sample of both firms that completed the entire survey and those that answered just one question about whether they offer health benefits.

Source: KFF/HRET Survey of Employer-Sponsored Health Benefits, 2000-2008.

1) premium subsidies; 2) reinsurance; 3) restructured benefit design; 4) Section 125 plans; and 5) employer mandates. Several of the newer programs employ a combination of these approaches.

Premium Subsidies—Because affordability is one of the greatest obstacles to coverage, many states have enacted legislation to permit subsidization of employers willing to contribute to their workers' health coverage. In effect, the state adds private dollars (from the employer and employee) to state funds as a cost-effective way to expand coverage. Nonetheless, states face several design questions when considering subsidies. Should the state subsidize coverage already sold in the market? Should it try to influence the benefit package? Should a state use Medicaid funds (which constrain benefit design options)? Should a state subsidize the premium through the tax code or through monthly payments? Should a state limit the plan to workers whose employers participate or should they open the plan to individuals as well? Should a state require a person to be uninsured for a given amount of time before qualifying for coverage? Table 1 demonstrates that states have answered these questions in a variety of ways.

Maryland offers a recent example of a program that combines a subsidy with other policy approaches. The Maryland Health Insurance Partnership is a premium subsidy program for

small businesses (2 to 9 employees) that began enrollment in October 2008. The state offers a 50 percent subsidy for health insurance premiums; in return, the employer must establish a Section 125 plan to ensure that the premium is paid out of pre-tax earnings. (See page 52 for more information about Section 125 plans.) For a plan to be eligible, it must encourage wellness by providing employees with a health risk assessment and incentives for health-promoting activities, preventive care, and chronic care management.¹⁷¹ To qualify for the subsidy, the employer cannot have offered coverage in the last 12 months.

Reinsurance—Healthy New York is one of the oldest and largest state-based small group coverage programs. To lower costs for qualified individuals and small groups, the state: (1) reduced the benefit package and increased cost sharing; (2) provided care through limited networks that agreed to a reduced reimbursement; and (3) included a state-funded reinsurance program. Since enactment of the program, the state has enhanced the program's attractiveness by offering additional choices of benefit packages. The Healthy New York plan costs about 40 percent less than average premiums in the small group market and two-thirds less than premiums in the individual market.¹⁷²

Table 1 **Enrollment Experience of Select State Small Business Subsidy Programs**

Program (Start date)	Eligibility	Enrollment Updates Fall 2008 (Individuals)
CoverTN (2007)	Businesses must have less than 25 employees with 50 percent earning \$43,000 a year or less. The plan is available for businesses who have not offered insurance for six consecutive months, or if offered, the employer has not paid 50 percent or more of the premiums. The plan must be offered to all employees.	16,020
ARHealthNet (2006)	Employers with 2-500 employees who have not offered a health plan to employees within the past twelve months. At least one employee must qualify for subsidized premiums and have a household income at or below 200 percent FPL, and all employees must participate in the program or provide documentation of coverage.	5,000
Insure Montana (2006)	Uninsured firms (2-9 employees) that have not offered insurance for 24 months and have no employees who earn more than \$75,000 per year. For employers of small businesses with 2-9 employees offering health plans, a tax credit of up to 50 percent of paid premiums is available.	5,500 5,000
New Mexico State Coverage Insurance (2005)	Low-income, uninsured, working adults with family income below 200 percent FPL. Participating employers must have ≤50 employees and have not voluntarily dropped a commercial health insurance in past 12 months.	33,200
Insure Oklahoma (Previously known as O-EPIC) (2005)	Workers and their spouses, who work in firms with 50 or fewer workers and contribute up to 15 percent of premium costs; self-employed; unemployed individuals currently seeking work; and individuals whose employers do not offer health coverage with household incomes at or below 200 percent FPL. Small employers must contribute at least 25 percent of eligible employee's premium costs and offer an Insure Oklahoma-qualified health plan.	11,000 + 5,000 in the Individual Plan
West Virginia Small Business Plan (2005)	Small businesses (2–50 employees) that have not offered health benefit coverage to their employees during the preceding 12 months are eligible to participate. Employers must pay at least 50 percent of the premium cost. At least 75 percent of employees must participate.	1,500
Healthy New York (2001)	Small employers that have previously not offered insurance and with 30 percent of workers earning less than \$34,000 annually. Sole proprietors and working individuals without access to ESI who earn less than 250 percent FPL and have been uninsured 12 months.	153,080
Idaho Access to Health Insurance (2005)	Income Eligibility up to 185 percent FPL with an employer contributing 50 percent of the premium. The subsidy has a maximum of \$100 per month per person or \$500 per month per family.	400
The Massachusetts Insurance Partnership (2000)	Individuals with income below 300 percent FPL are eligible. Employers contribute 50 percent of the premium. Businesses with 1-50 employees are eligible. Coverage must qualify as comprehensive. Enrollees must show that they have been uninsured for at least six months.	15,600
Maryland Health Insurance Partnership (2008)	Employers can receive a subsidy of up to 50 percent of the premium if the following criteria are met: <ul style="list-style-type: none"> • The business has between two and nine employees; • The average employee wage is below \$50,000; and • The employer did not offer health insurance to employees during the 12 months prior to application. For a health plan to be eligible for a subsidy it must encourage wellness by providing employees with a health risk assessment and incentives for health-promoting activities, preventive care and chronic care management.	420*
Maine Dirigo Choice (2003)	Individual must earn below 300 percent FPL and the employer must contribute 60 percent of the premium. The program offers subsidies to the individual on a sliding scale. Dirigo Choice is currently closed to subsidized employers and all individuals.	10,663
Arizona Health Insurance Premium Tax Credit (2006)	The state pledged up to \$5 million in tax credits to subsidize private insurance premiums. Employers must have from 2-25 employees and have not offered coverage for 6 months. Eligible individuals must earn below 250 percent FPL. The state pays 50 percent of the premium, up to \$1,000 for individuals and \$3,000 for a family.	2,110
North Carolina Small Business Health Insurance Tax Credit (2006)	Small businesses are eligible for a \$250 per year per employee tax credit to off-set their share of health insurance premiums. The business must have 1-25 eligible employees, the employer must cover 50 percent of the premium and the employee's income must be less than \$40,000 per year.	N/A

For additional information on these programs and other state initiatives, visit <http://www.statecoverage.org/node/23>

* 420 individuals and 80 businesses were enrolled as of December 1, 2008. The program began enrollment in October, 2008.

The state covers 90 percent of the costs for an individual between \$5,000 and \$75,000.¹⁷³ To manage the costs of enrollees, New York retained the incentives for insurers by requiring enrollees to pay 10 percent of premiums between \$5,000 and \$75,000 and all additional costs above that threshold. Healthy New York has been operating since 2001 and covered about 153,000 enrollees as of fall 2008.

Restructured Benefit Design—Across the insurance market—in large businesses, public employee plans, and publicly funded coverage—purchasers are adopting strategies to promote wellness and improve health through an emphasis on prevention, primary care, and healthy lifestyle choices. These strategies are being applied to the small group market as well. In general, state policymakers are seeking to slow or reverse the trend in declining coverage rates in the small group market without resorting to the typical strategies of cutting benefits and increasing cost sharing. They believe that they can use the state’s regulatory power to encourage health plans to use strategies that would help enrollees become healthier, thus reducing underlying costs over time.

Rhode Island has been leading the way in promoting wellness plans in the small group market. They issued a request for proposals to carriers for a wellness product, indicating that the benefit package should emphasize preventive care and noting that the average premium for the plan could not exceed 10 percent of the state’s average annual wage, or \$314 for single coverage (in 2007).¹⁷⁴ Now that carriers have responded with benefit package proposals, the state is expected to meet its legislatively defined price point, reducing to approximately 20 to 25 percent below market rate the premiums for all small businesses. In 2008, the New Hampshire and Florida legislatures enacted similar initiatives (see page 57).

Benefit designs emphasizing first-dollar coverage, along the lines of benefit plans being offered in Tennessee and Arkansas, provide another strategy that merits consideration. Tennessee set guidelines during the procurement process for two state-sponsored products that require the successful carriers to emphasize preventive care at an average premium of \$150 per member per month (2007 rates). After the state and the employer each contribute one-third of the total

premium, individuals pay between \$35 and \$99 per month depending on age, tobacco use, and body weight. An annual limit of \$25,000 per person applies, along with limits on hospitalization costs, prescription drugs, and physician visits. To participate, an employee must work for a low-wage firm that had not offered health coverage for at least six months. Once purchased, the coverage is portable and can even cover the individual during periods of unemployment. Subsequent expansion of the program applies to individuals working for large businesses who have been without health coverage for at least six months.

Advocates of Tennessee’s approach argue that low-income individuals are less worried about protecting their assets in the case of a catastrophic event and more interested in a policy that pays for routine care. Despite continuing concern about individuals who exceed benefit limits, the hope is that patients will receive the primary and preventive care that helps them avoid the need for expensive specialty or hospital care.

Both the Tennessee and Rhode Island reforms set a target price and asked insurers to bid on the services they could provide for that premium within certain parameters. These states are attempting to use their negotiating power to secure a better deal for enrollees.

Employer Mandate and Section 125

Plan Requirement—In 2006, Massachusetts began taking an aggressive approach by implementing a series of reforms that address both the individual (non-group) and small group markets. The reforms called for merging the state’s small group and individual markets; establishing the Health Connector (which is a clearinghouse of commercial insurance plans); requiring employers to offer a Section 125 plan (a tax shelter for premiums paid by employees); and imposing a penalty on employers with 11 or more full-time employees who fail to offer coverage to full-time workers. According to a recent survey of employers in the state, coverage in the small group market increased between 2007 and 2008 from 63 to 70 percent among employers with 3 to 10 workers and from 88 to 92 percent among employers with 11 to 50 workers.¹⁷⁵ While several reasons could explain the uptick in coverage—including the

possibility that the state’s individual mandate caused higher demand among employees—it is still remarkable that Massachusetts has been able to counteract or possibly even reverse the national trend of declining coverage rates in the small group market.

Implementation and Evaluation—As states work on a range of strategies, they discover that even the most well-conceived policy interventions do not always achieve expected results if the interventions are not properly implemented and evaluated. Implementers should work closely with business groups to ensure that a program meets the needs of local businesses and that participation is simple. An effective marketing campaign requires reliance on many outlets for communication; a state cannot expect a program to succeed if the state does not promote it. Careful consideration should be given to the role of brokers in the program, as they are the traditional conduit for small businesses’ purchases of insurance and selection of insurance products.¹⁷⁶ Finally, states will not know if a program succeeds unless every program includes a strong evaluation component. Evaluation enables policymakers to recast programs midstream to address barriers and help ensure effectiveness.

CONCLUSION

A word of caution is in order about coverage expansion programs that target small businesses. Even “successful” programs have attracted only a small segment of the insurance market. It is difficult and expensive to engage small and often low-wage employers. A small employer may have only one or two uninsured workers, and those workers may or may not be interested in paying part of the premium for coverage. States have had greater success in enrolling large numbers of uninsured workers by targeting individuals, often with initiatives funded through Medicaid. However, if a state has set the more modest goal of achieving increased affordability, choice, and fairness for employers and employees in small firms, many of the policy options discussed above are worth consideration. The small group market is costly, unstable, and eroding, yet several tools are available to states to help employers offer health insurance to their employees.

SECTION 125 PLANS: POLICY IMPLICATIONS FOR STATES

A growing number of states are expressing interest in reducing the number of uninsured workers and making their health coverage more affordable by requiring or encouraging employers to set up Section 125 plans—also referred to as “cafeteria plans.” These plans refer to Section 125 of the U.S. Internal Revenue Code, which establishes rules related to taxable and non-taxable benefits offered by employers. Section 125 plans reduce the effective cost of health care coverage for many employees (depending on their total income and family situation) by allowing them to purchase coverage on a pre-tax basis. This administrative mechanism reduces both employees’ and employers’ share of Medicare and Social Security taxes, as well as employee income taxes and employer unemployment payments.

Section 125 plans are an attractive option to state policymakers because they are a very low-cost way to make coverage more affordable. (States with an income tax that is tied to the federal tax forego a small amount of revenue.) This tax shelter has been available to small businesses for years, so the question is how to increase participation without: a) running afoul of other legal issues; or b) creating an onerous burden on small businesses. States have made it easier for small businesses to participate by: a) conducting outreach and education; b) helping them with forms and paperwork; c) offering mini-grants to help small businesses set up plans; and d) combining a requirement to use a Section 125 plan with a premium subsidy to make the package more attractive. For employees that take advantage of the Section 125 plan, savings on health premiums are typically around 25 percent, but vary based on income and family size from a negative tax liability (for those with very low incomes who benefit from the Earned Income Tax Credit) to a 50 percent savings on premiums.

Legal and Policy Issues¹⁷⁷

Several federal laws affect implementation of these Section 125 plans. Because these plans qualify as “group health plans” under the Internal Revenue Code, they appear subject to employer notice provisions

under the Consolidated Omnibus Budget Reconciliation Act (COBRA), as well as nondiscrimination and benefit design requirements under the Health Insurance Portability and Accountability Act (HIPAA). It appears that Section 125 plans are not subject to the Employee Retirement Income Security Act (ERISA), however, as long as employers do not promote purchase of specific individual health insurance policies. Further, state policies that require employers to adopt Section 125 plans should not be preempted by ERISA as long as the state law applies to employers and does not refer to employer-sponsored plans.

To minimize the potential for problems under ERISA and the tax code, states that are considering a Section 125 cafeteria plan requirement should draft that mandate very broadly. States should also avoid terms such as “employer group,” “employer-sponsored,” and “group plans.” States may simply choose to refer to these plans as “plans available under a cafeteria plan.” States may also wish to consider providing model cafeteria plan materials and technical assistance to employers, as well as model COBRA notices.

Exchanges or Connectors that offer a selection of competing health coverage choices offer an advantage to states seeking to implement Section 125 plans. These exchanges help minimize the potential that individually purchased health insurance could be interpreted as an employer-sponsored plan.

Massachusetts’ Experience

Massachusetts’ experience in implementing Section 125 plans offers lessons to other states considering a similar approach. As part of Massachusetts’ comprehensive 2006 health reform law, employers with 11 or more full-time workers are required to establish Section 125 plans that enable workers to purchase health insurance with pre-tax dollars regardless of whether or not employers offer coverage to their workers or contribute to the premium. Massachusetts also established the Commonwealth Health Insurance Connector Authority to help small employers and individuals purchase affordable insurance, and to help all

employers facilitate their offering of Section 125 plans. As part of the reform package, adults in the state were required to purchase insurance if they could afford to do so. While most employers report a positive experience with Massachusetts’ Section 125 plans, take up rates have been relatively low, especially during the initial implementation period. Massachusetts has found wide variation in the education and outreach offered by employers about the benefit of Section 125 plans. As of November 2008, just 1,129 of the 14,879 adults purchasing coverage through the Connector without an employer contribution did so through Section 125 plans. While this number is relatively modest, there has been a steady increase in the numbers of people using a Section 125 plan when purchasing their health insurance.

The state’s experience thus far offers several lessons for other states, including the importance of frequent communication with employers to keep them engaged, the need to target specific types of employers and individuals who have the most to benefit from Section 125 plans, the necessity of simplifying the administrative process, and the importance of providing easily accessible, jargon-free outreach materials that employers can give to workers.¹⁷⁸

Other States Explore Section 125 Plans

A number of other states have considered or are implementing Section 125 plans as part of reform efforts aimed at reducing the number of uninsured. For example, Minnesota’s comprehensive health care reform legislation, passed in 2008, includes a provision that employers with 11 or more full-time workers who do not offer group health insurance are required to establish a Section 125 plan so that employees can purchase health insurance with pre-tax dollars.¹⁷⁹ Minnesota has taken an additional step by establishing a \$1 million fund to help cover certain employer costs associated with establishing Section 125 plans. Other examples of state approaches to Section 125 plan policies are described in Table 2.

Table 2 Overview of State Approaches to Section 125 Policies Designed to Expand Coverage

(Note: information deemed accurate as of 7/29/08)

		Policy
State (Effective Date)	Applicable Firm Size/Type	Section 125 Requirement
Connecticut (October 2007)	Connecticut employers of all sizes that (a) offer fully insured health coverage and (b) require an employee contribution to that coverage	Such employers are required to establish a Section 125 plan.
Indiana (January 2008)	All Indiana employers that do not currently offer health coverage or a Section 125 plan	Created a tax credit to encourage employers to establish a fully insured health plan in conjunction with a Section 125 plan. The tax credit is equal to the lesser of \$50 per employee or \$2,500 for two years if the employer offers such a plan.
Maryland (September 2008)	Non-offering Maryland firms with 2 to 9 full-time employees participating in Maryland's new subsidized coverage initiative	To qualify for a premium subsidy, the employer must establish a Section 125 premium conversion plan.
Massachusetts (October 2007)	Massachusetts employers of 11 or more employees	Such employers must (a) maintain a Section 125 plan, (b) enable employees to pay for their coverage (either through their employer or through the Connector) on a pre-tax basis, and (c) file a copy of the Section 125 plan document with the Connector.
Minnesota (July 2009)	Minnesota employers that do not offer health insurance with more than 10 employees	Such employers are required to establish a Section 125 plan. This proposal does not require employers to offer health insurance coverage or contribute to it and includes an opt out provision.
Missouri (to be determined)	Missouri firms offering fully-insured coverage with an employer contribution	Such employers are required to establish a Section 125 plan.
Rhode Island (July 2009)	Rhode Island employers of 25 or more employees	Such employers are required to establish a Section 125 plan. The legislation does not require companies to contribute to their employees' insurance or to offer workers the chance to buy insurance at a group rate.

Sources are:

<http://www.cga.ct.gov/2007/rpt/2007-R-0690.htm>; <http://www.statecoverage.net/programs-indiana.htm>; <http://mhcc.maryland.gov/partnership/about.aspx>; <http://www.mahealthconnector.org/portal/site/connector/>; <https://www.revisor.leg.state.mn.us/bin/bldbill.php?bill=ccrsf3780.html&session=ls85>; <http://www.house.mo.gov/billtracking/bills071/billpdf/truly/HB0818T.PDF>; <http://www.rilin.state.ri.us/billtext07/senatetext07/s0448b.pdf>

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COST CONTAINMENT AND QUALITY IMPROVEMENT PRIORITIZED BY STATES

The rising cost of health care and new research about variation in quality of care have spurred many states to focus on increasing value in their respective health care systems. States want better value for their health care dollar, first in the public sector as well as throughout the health care system. Increasingly, states are considering coverage reform in tandem with improved mechanisms for providing and paying for health care. While much remains to be learned about promoting quality health care at a fair price, some states are leading the way with pilot projects and innovative programs that will inform future federal and state reforms.

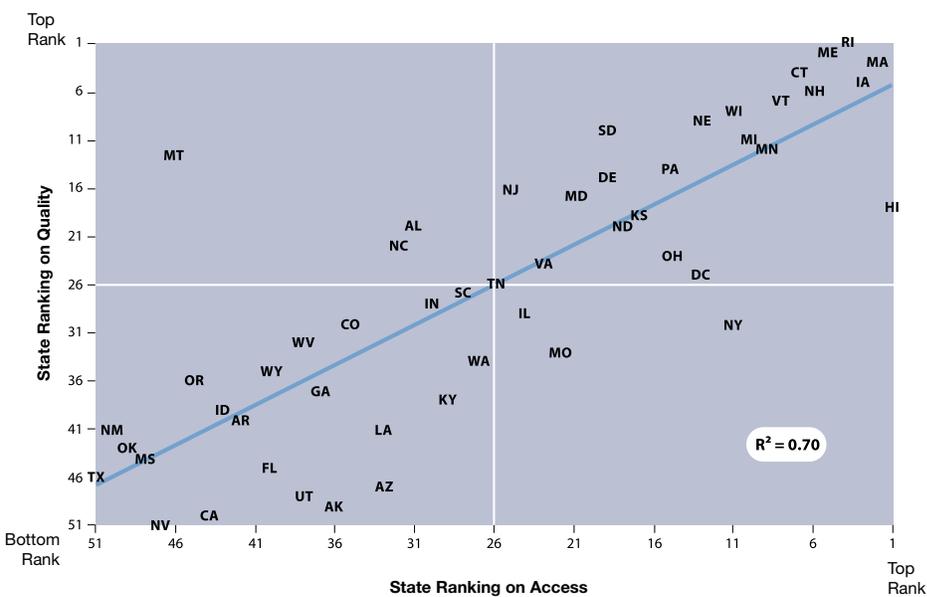


WHY IS REFORM NEEDED?

In 2007, The Commonwealth Fund released its *State Scorecard on Health System Performance*, which revealed wide state-to-state variation in access to care, cost, efficiency, and quality. As shown in Figure 8, quality was highly correlated with access to care, indicating that increased coverage is an important strategy for improving the overall health of a state's population.

The Scorecard also showed that higher spending levels do not necessarily lead to quality improvement, as confirmed by research from the Center for Health Policy Research, which developed the *Dartmouth Atlas*. In fact, a recent study of several common conditions demonstrated that higher spending correlates with higher morbidity, lower satisfaction with hospital

Figure 8 State Ranking on Access and Quality Dimensions



Source: Commonwealth Fund *State Scorecard on Health System Performance*, 2007

care, worse communication between physicians, and less access to primary care.¹⁸⁰

The negative correlation between cost and quality is of special concern in today's environment of dramatically increasing health care costs. Between 1999 and 2008, the cost of health insurance premiums more than doubled (increasing by 119 percent) while wages grew by only 34 percent.¹⁸¹ At the same time, deductibles and cost sharing for those with coverage have been on the rise. Despite paying more than twice as much for health coverage, Americans are buying less comprehensive protection. In addition, with rising costs and increasing enrollment, Medicaid now consumes an average 21.2 percent of state budgets, which is twice the amount of eight years ago.¹⁸²

Even if cost was not a concern, a large body of evidence shows that the U.S. health care system fails to deliver consistently high-quality care. Care is often poorly coordinated¹⁸³ and falls short of best-practice standards.¹⁸⁴ The seminal 1999 Institute of Medicine report, *To Err is Human*, shone a light on the pervasiveness of medical errors in the U.S. health care system, estimating 98,000 deaths per year attributable to medical errors.¹⁸⁵

CARE COORDINATION AND MEDICAL HOMES

Many states are exploring the possibility of supporting and strengthening primary care as a way to improve quality and reduce costs. States believe that a strong primary care system can help coordinate patient care, promote prevention and healthy lifestyles, educate patients on their health conditions, and reduce costly emergency room visits and duplication of services. Investing in relatively inexpensive primary and preventive care as an alternative to costly specialty services and acute care is such an obvious solution that some now worry that primary care providers will soon be asked to solve the full range of problems plaguing the health care system, piling unrealistic expectations on an already overworked and—some would argue—underpaid segment of the medical profession. It is possible that the term “medical home” (and related concepts such as patient-centered primary care and chronic condition management) is quickly coming to mean all things to all people. The challenge for states is to define what is expected from primary care providers; to decide how to pay for additional services such as care coordination, patient education, and health information

technology that are not currently part of the fee-for-service payment model; and to determine the target populations for such services.

The following examples describe projects undertaken by states to coordinate care:

- Community Care of North Carolina has a long and successful track record with what it calls Primary Care Case Management (PCCM). Beginning in 1998 with Medicaid providers, Community Care divided primary care providers into regional networks that support quality improvement through the development of standards, data collection and reporting, and the provision of community-based resources such as care managers and patient educators. Both the provider and the network receive a monthly payment per member for each Medicaid patient for care coordination and case management.

Community Care achieved \$240 million in savings in state fiscal year 2005–2006. While this figure represents just a fraction¹⁸⁶ of the total North Carolina Medicaid budget, Community Care

realized the savings along with significant quality improvements for Medicaid recipients.¹⁸⁷ The program is succeeding for several reasons. First, as a provider-led effort, Community Care can easily promote buy-in from a critical group of health care system participants. Second, the regional networks report quality information back to providers so they know when they are not meeting best-practice standards of care. Third, the regional networks provide care coordination and case management services either in a provider's office or in a community setting, shared by several providers. The North Carolina Community Care program is now trying to spread the model beyond Medicaid providers to all primary care providers in the state.¹⁸⁸ At the same time, the state is working to develop a demonstration project to apply the model to Medicare patients.

- In 2007, Vermont passed legislation that promotes medical home pilots in communities around the state under the Blueprint for Health. As reported in the 2008 *State of the States*, the program brings together all payers except Medicare.

It establishes community care teams to help with care coordination, patient and provider education, and other patient services. In addition, Vermont has levied a 0.02 percent surcharge on all insurance premiums in the state to create a health information technology infrastructure. The Blueprint for Health launched its pilot communities in 2008.¹⁸⁹

- Rhode Island's Chronic Care Sustainability Initiative requires primary care providers to: 1) implement components of an advanced medical home; 2) participate in a local chronic care collaborative; 3) submit data that will be publicly reported; and 4) engage and educate patients¹⁹⁰

The program estimates that it represents 67 percent of the state's insured residents. The state is using the Health Insurance Commissioner's regulatory power to require insurance plans to: 1) provide a supplemental payment to primary care providers; 2) pay for nurse care managers; and 3) share data and report on common measures.¹⁹¹

STATE QUALITY IMPROVEMENT INSTITUTE

In March 2008, AcademyHealth and The Commonwealth Fund announced the selection of nine state teams to participate in the State Quality Improvement Institute—an intensive effort to help states plan and implement concrete action plans to improve performance across targeted quality indicators. The states selected for participation were Colorado, Kansas, Massachusetts, Minnesota, New Mexico, Ohio, Oregon, Vermont, and Washington.

The states are currently implementing their action plans, which focus on making system-wide changes to the health care delivery system. The participating states are addressing the following:

- **Medical Homes**—Several states are either working to define medical homes or implementing pilots to strengthen and support primary care.
- **Payment Reform**—States are looking at their own purchasing strategies and building public/private partnerships to formulate a coordinated plan for paying for quality across payers.
- **States as Conveners**—States are establishing formal groups to bring stakeholders together to advance a health care quality agenda.
- **Data Collection and Transparency**—Several states have assembled all-payer databases that include all claims

information from both public and private payers. The available information should permit better measurement of quality and effectiveness across health care systems. In addition, states are setting benchmarks for quality care and publicly reporting the performance of hospitals and providers.

- **Public Health and Prevention**—As states consider the underlying causes of rising health costs, they recognize the impact of the rising level of disease burden. Several states are working to divert funds upstream to prevent chronic conditions such as diabetes and heart disease by investing in public health and prevention.

STATES WORK WITH INSURERS TO PROVIDE MORE AFFORDABLE PLANS FOCUSING ON PRIMARY CARE AND WELLNESS BENEFITS

This past year saw two additional states (following Rhode Island's lead¹⁹²) attempt to provide a more affordable insurance option that emphasizes primary and preventive care. Both New Hampshire and Florida are asking insurers to offer bids to the state for a plan that meets prescribed benefit and affordability standards.

Florida: *Cover Florida* and Florida Health Choices Corporation

In May, Governor Charlie Crist signed into law a bill (S.B. 2534) that creates a new health insurance option, *Cover Florida*, for Florida's uninsured residents starting January 2009. The bill outlines a plan that allows private insurers to competitively negotiate with the state to provide benefit plans which should cost approximately \$150 or less per month.¹⁹³ *Cover Florida* sponsors must offer at least two plans: one with lower-level coverage, and one with catastrophic coverage. Nine carriers submitted proposals and six of those were selected by the state to participate in *Cover Florida*.¹⁹⁴ The benefit designs must focus on primary and preventive care in order to discourage people from using emergency rooms as their source of primary care. At minimum, all benefits plans must include:

- Coverage for preventive services
- Screenings
- Office visits
- Urgent care
- Prescription drugs
- Durable medical equipment
- Diabetic supplies
- Hospital care

The higher level plan must also include catastrophic coverage. Generally speaking, only individuals who have been uninsured for at least six months will be eligible for the program. Health plans in the future may also competitively negotiate with the state to provide supplemental coverage, such as vision, dental, and cancer care.

The legislation also creates the Florida Health Choices Corporation, described as a clearinghouse designed to promote health insurance choices for small business and help them fill out the necessary forms and paperwork. Through the Corporation, small employers with 50 or fewer employees will be able to access coverage for their employees. Employees will have the ability to choose from a variety of health plans and services, including prepaid services, flexible savings accounts, and traditional insurance products. Employers will be required to establish Section 125 plans. The program will be administered by a 15-member board made up of appointees chosen by the Governor, the Senate president, and the House speaker.¹⁹⁵

New Hampshire: *HealthFirst* Plan

In May, Governor John Lynch signed legislation to enact *HealthFirst*, a health insurance plan designed to make coverage more affordable by emphasizing wellness programs and prevention. The law requires that plan designs address wellness, prevention, and chronic disease management and be made available to consumers by October 1, 2009.¹⁹⁶ The insurance department has convened an advisory group to make recommendations on

the benefit design. The general requirements of the program include the following:

- The base rate of the plan, calculated on a per member per month basis, may not exceed 10 percent of the previous year's median wage, which is approximately \$310. The benefit plan must also include limits on out-of-pocket spending.
- If one carrier files rates for the HealthFirst plan that meet the target rate, then all carriers with at least 1,000 members in the small group market must also offer the HealthFirst plan. If no carrier files a rate that meets the target rate, the commissioner will hold a hearing to determine the reasonableness of the target rate for the HealthFirst plan. Depending on the outcome of the hearing, all carriers may be required to offer the product at the target premium.
- The Insurance Commissioner must certify that the HealthFirst wellness benefit design creates incentives for consumers, health care providers, employers and health carriers to:
 - Encourage wellness strategies;
 - Promote primary care, preventive care, and a medical home model;
 - Manage and coordinate care for persons with chronic health conditions or acute illness;
 - Advance the use of cost effective care; and
 - Promote quality of care by the use of evidence-based, best practice standards and patient-centered care.¹⁹⁷

The National Academy for State Health Policy conducted a scan of state Medicaid programs and SCHIPs and found that 31 states are working to advance medical home projects.¹⁹⁸ Some other states are working to establish medical homes throughout their health care system regardless of payer. States with multi-stakeholder initiatives include Colorado, Louisiana, Maine, New Hampshire, Pennsylvania, Rhode Island, and Vermont.¹⁹⁹

WELLNESS INITIATIVES

About a quarter of the rising cost of health care can be linked to the growing prevalence of “modifiable population risk factors,” such as obesity.²⁰⁰ Patient lifestyles and health choices are one of the primary reasons for the nation's growing disease burden and related increase in health care costs. Doctors, employers, insurers, and government agencies are looking for ways to encourage Americans to make healthier

choices—to prevent disease or to manage chronic conditions once they develop. Despite sharp disagreements about the appropriate solutions for expanding health care coverage and reforming health care financing, there is widespread agreement—both among health care experts and the general public²⁰¹—on the value of promoting wellness and prevention. Many states have started implementing

wellness programs as part of their state employee health benefit plans. According to a recent National Conference of State Legislatures survey, 14 states have adopted some type of wellness program for their state employees.²⁰² Examples include the following:

- Alabama recently announced that, as of January 2011, obese state employees will be required either to start getting fit or pay an additional \$25 per month toward their premiums. Employees who smoke already pay an additional \$24 per month.
- Arkansas state employees can earn up to three days of vacation leave per year by participating in the Healthy Lifestyle program.
- Missouri operates an incentive program for employees, permitting them to save up to \$25 per month if they take a personal health assessment and participate in a health improvement program.
- Delaware, Montana, and West Virginia have launched programs that offer screenings, health coaching, fitness, and education to help employees improve their health.
- King County, Washington, operates a comprehensive health and wellness program that saved the county an estimated \$40 million between 2007 and 2009.²⁰³

During 2008, both New Hampshire and Florida passed legislation requiring insurance brokers that conduct business in the state to work with health plans in the state to develop a lower-cost insurance product focusing on prevention, primary care, and healthy lifestyle promotion. Both states followed the example set by Rhode Island, which passed similar legislation in 2007.²⁰⁴ For more information on these programs, see page 57.

PATIENT SAFETY

When the Institute of Medicine's *To Err is Human* estimated that more than 98,000 deaths per year are attributable

to preventable medical errors, it became clear that "business as usual" was no longer sufficient to protect patients; the time for systemic reforms had arrived. The report emphasized that, while all humans make mistakes, systems must be put in place to protect against errors and promote best-practice care. To encourage system improvements, particularly in hospitals, states have undertaken the following:

- Hospitals are required to report serious adverse events, medical errors, or near misses. Some states require these events to be made public while others keep the information confidential but encourage the affected hospital to develop plans to prevent similar errors in the future.
- Collaborative groups have been established to share best practices and promote safe and effective care. To that end, a number of states have established Patient Safety Centers.
- A few states have joined Medicare and national health plans in refusing to pay for "never events" in their Medicaid and state employees health plans. "Never events" are errors such as wrong-site surgeries or hospital-acquired infections that hospitals should be able to prevent.²⁰⁵

PRICE AND QUALITY TRANSPARENCY

Recognition is growing that it is time to engage health care consumers in the effort to promote affordable, high-quality health care. An increasing number of health plans have high deductibles and copayments designed to steer patients to high-value providers and services. However, in many cases, consumers lack appropriate information for making informed choices. For that reason, both federal and state policymakers have made data collection and price and quality transparency a priority.

A recent issue brief by the National Governors Association Center for Best Practices outlines four strategies used by

states to promote data collection and transparency.²⁰⁶

- **Setting a Common Vision**—State governments have been able to set and articulate priorities that require data sharing and transparency. Examples of the policy goals that transparency can help achieve include improving chronic disease care, reducing medical errors, enabling patients to "comparison shop," and promoting quality improvements among providers.
- **Convening Key Stakeholders**—States command the influence to bring stakeholders to the table. Ongoing conversations can lead to agreements on data-sharing standards, common claims processes, and payment incentives to providers who deliver high-value care.
- **Regulating Providers and Insurers**—States can use their influence as regulators to require insurers and providers to share data. Such information can then be made public and used as a tool for patients or shared only with providers and purchasers. When providers see how they compare with similar providers, they often take steps toward quality improvement. The hurdle for states is that they do not have the authority to compel self-insured employers or Medicare to share information.
- **Leveraging State Purchasing Power**—States can require data sharing, compliance with data standards, and price and cost transparency through contracts in the Medicaid, SCHIP, and state employee health benefit plans.

The type of data collected by states must reflect their plans for data use. Several states are leading the way in developing all-payer claims databases. Such databases are typically used for billing purposes so they are most useful for assessing costs, but they may also be used for making some quality and value determinations. States engaged in chronic care collaboratives

or other practice improvement programs have developed patient registries to collect additional information about patient outcomes, such as blood pressure readings and blood sugar levels. States seeking to use data for health information exchanges will need additional data such as laboratory values, physician notes, and test results, although such data (e.g., chart reviews and laboratory results) are much more expensive and difficult to obtain. Much of that information is still housed in file cabinets and not generally available by electronic means.

HEALTH INFORMATION TECHNOLOGY AND EXCHANGE

There is broad agreement that electronic health information technology and communications can improve quality and save costs in the health care system. Not surprisingly, 70 percent of states responding to a 2007 survey reported that “eHealth”²⁰⁷ was a very significant priority while no states reported that it was not a priority. When asked about their top state eHealth priorities, 25 of 42 responding states listed

adoption of a health information exchange (HIE). In addition, 12 states reported HIE policy development as a priority, 9 states listed development of electronic health records, and 7 states listed e-prescribing.²⁰⁸ The Commonwealth Fund’s Commission on a High Performance Health System estimates that the investment of 1 percent of health insurance premiums in health information technology could save the country \$88 billion over 10 years out of projected national health expenditures totaling \$4.4 trillion.²⁰⁹

PREVENTABLE HOSPITAL READMISSIONS

Both state and federal policymakers are increasing their focus on preventable patient readmissions after hospital discharge. A 2007 MedPAC (Medicare Payment Advisory Council) report found that 17.6 percent of Medicare patients were readmitted to the hospital within 30 days of discharge and that the Medicare program spent \$15 billion on readmissions in 2005.²¹⁰ The prevention of readmissions requires an effective transition from inpatient providers to outpatient providers

and effective medication management. In many cases, the current payment system does not offer financial incentives for coordination of post-discharge care. Policymakers recognize that efforts to prevent readmissions can have significant return on investment, saving the system money while fostering patient health.

CONCLUSION

President Obama’s health care plan includes many initiatives aimed at containing costs and improving quality. Several of the initiatives align with recent state efforts, including the support of chronic care management programs, investment in health information technology, coordinated and integrated care, required transparency in cost and quality information, and promotion of patient safety.²¹¹ The challenge facing the new administration will lie in coordinating with and building on state efforts in these areas. The significant variation in health care delivery models both between and within states will make it critical for federal policymakers to take advantage of the on-the-ground expertise of state governments.

MINNESOTA EXAMPLE ILLUSTRATES NEED FOR CHRONIC CARE COORDINATION

One example of a program designed to prevent hospital readmissions is the St. Mary’s/Duluth Clinic (SMDC) Health System Heart Failure Program. The national average for hospital readmissions after six months for patients with congestive heart failure (CHF) is 40 to 50 percent. Minnesota’s state average is 20 to 25 percent, and the SMDC’s CHF readmission rate is 3 to 4 percent.²¹² The SMDC achieved a low rate of readmissions and improvements in patient health and satisfaction by delivering outpatient services that included treatment planning, disease and medication management services, use of telescales and telephonic oversight, education for patients and relatives, and support groups. Overall costs for patient care were cut in half.²¹³

While the SMDC can be proud of its accomplishments, the Heart Failure Program caused a major loss in revenue for the health system owing to significant uncompensated costs for outpatient services that were not covered, including telescale and patient monitoring. In addition, the hospital realized decreased revenue with fewer CHF patient admissions. Partly as a result of this program Minnesota recognized that its payment models in use through private payers, Medicaid, and the Medicare program did not align with the achievement of the state goal of higher quality, lower cost health care. Transformational reform cannot take place unless innovative, care-improving providers are rewarded for their efforts rather than

punished. That is why the state, as part of its comprehensive health reform efforts, is developing a “baskets of care” payment model. Under this model, the state will establish the parameters, and providers will set a price, for a series of baskets of care. Providers will be reimbursed this set price for all care related to a specific diagnosis or chronic condition, or for episodes of care, such as full joint replacements (including pre- and post-operative care). The goal of the approach is both to ensure that prices and quality of services are transparent, but also to encourage providers to use the most cost-effective, quality-improving methods to achieve health outcomes for their patients. It will reward high quality, efficient care like that being provided at SMDC.

LOOKING FORWARD

As we enter one of the most challenging economic times our country has faced in recent memory, it gives us pause to consider that a new window of opportunity may be opening with respect to health reform. Despite all the bad economic news and worsening forecasts for the coming year, there is a tinge of optimism that comes with one of the most popular words this year — change.

Will there be national health reform under the Obama administration? The answer varies depending on who you ask. Many think that the economic crisis and its widespread impact—especially the on health care system, the uninsured and state budgets — make the case for, not against, reform. They believe a crisis warrants action.

While many hoped the passage of comprehensive reforms would continue to define state health reform in 2008, the year brought more struggles than successes. The recession has already caused profound dismay in state capitols around the country and we predict that 2009 is likely to bring further retrenchment. States have weathered tough economies in the past, and they will build upon those lessons to mitigate the impact on their most vulnerable populations. Yet difficult decisions will have to be made. In some circumstances, states are likely to consider and implement cuts to public health care programs.

During the next few years, the health reform debate will place an enormous spotlight on the issues surrounding health coverage and systems reform. It is our hope that this important discussion will also include the role of states and their potential contributions to national reform. While federal action could range from a stalemate to sweeping changes, it is unclear how these changes would impact individual states. Regardless, states are likely to continue to play a critical role in meeting the nation's health care needs.

In the meantime, states find themselves in a precarious position: should they wait for a federal solution to their health care problems or continue to forge policy innovations within the domains over which they have control? Several states have been working for years on a policy-development process and a sequential approach to health reform. It is unclear whether economic pressures will force these states to halt their processes mid-

stream or whether health care leaders will continue to push for reform and support those efforts.

The challenges are enormous and history tells us that health care coverage expansions—and overall health reform—are difficult to enact and sustain. Yet it is possible that the size of the problem and the focus of the American people on the issue will lead to positive changes, at either or both the federal or state level.

The cost of inaction continues to mount, both in lives lost and costs to the system. It is our hope that 2009 will be the year the country turns its attention to health care and finds real, workable solutions to the problems of access, cost, and quality. We hope this can be accomplished through a partnership between states and the federal government that will enable each to use their respective strengths to improve the health and health care of all Americans.

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