Robert Wood Johnson Foundation

STATE OF THE STATES

February 2011

Chapter 1: Surveying the Landscape

The ongoing effects of the downturn in the American economy and the passage of the Patient Protection and Affordable Care Act (ACA) were the two major events affecting states in 2010. These two events sometimes worked at cross-purposes: states had to work to comprehend and absorb a major, transformative piece of legislation with staff who were swamped by rising needs as well as stagnant or falling revenue.

Work on implementation of the ACA began soon after passage of the legislation—states had 90 days to decide whether to manage a federally funded high risk pool (or Pre-existing Condition Insurance Plan). Ninety days after that, a number of insurance market reforms took effect. Many states also took an active role in communication about and enforcement of these reforms. States also applied for and received funding for insurance premium rate review and exchange planning grants. Many have either an executive order or legislation to support decision-making around implementation of the federal law.

At the same time, the United States has yet to recover from one of the worst national recessions in memory. As states prepared their state fiscal year (SFY) 2011 budgets (which generally run from July 2010 through June 2011), they faced an average shortfall of 19 percent.[1] Many states responded to that shortfall by enacting hiring freezes, travel restrictions, and furloughs.

States also saw increased Medicaid enrollment in 2010 due to persistently high levels of unemployment. The American Recovery and Reinvestment Act of 2009 (ARRA) helped ease some of that burden by increasing the federal matching rate for Medicaid. Along with the increased federal Medicaid funding came a requirement that states maintain their Medicaid eligibility levels, which limited how much states could programmatically decrease enrollment in their Medicaid programs.

Finally, the election cycle added another layer of uncertainty to the implementation process.

NUMBER OF UNINSURED INCREASES

In September 2010, the Census Bureau released its Current Population Survey data showing that the number of people without health insurance increased to 50.7 million in 2009, a significant increase from the 46.3 million reported in 2008. The uninsured rate increased to 16.7 percent from the previous 15.4 percent.[2] The increase in uninsurance reflects the sustained effects of the recession.

The number of people with health insurance decreased from 255.1 million in 2008 to 253.6 million in 2009. This marks the first time since 1987—the first year that comparable health insurance data were collected—that there was a real decline in the number of people with health insurance.[3] The breakdown of this figure includes a drop in the number of people covered by private health insurance (from 201.0 million, or 66.7 percent, in 2008 to 194.5 million, or 63.9 percent, in 2009) and an increase in the number of people covered by government health insurance (from 87.4 million, or 29.0 percent, in 2008 to 93.2 million, or 30.6 percent, in 2009).[4]

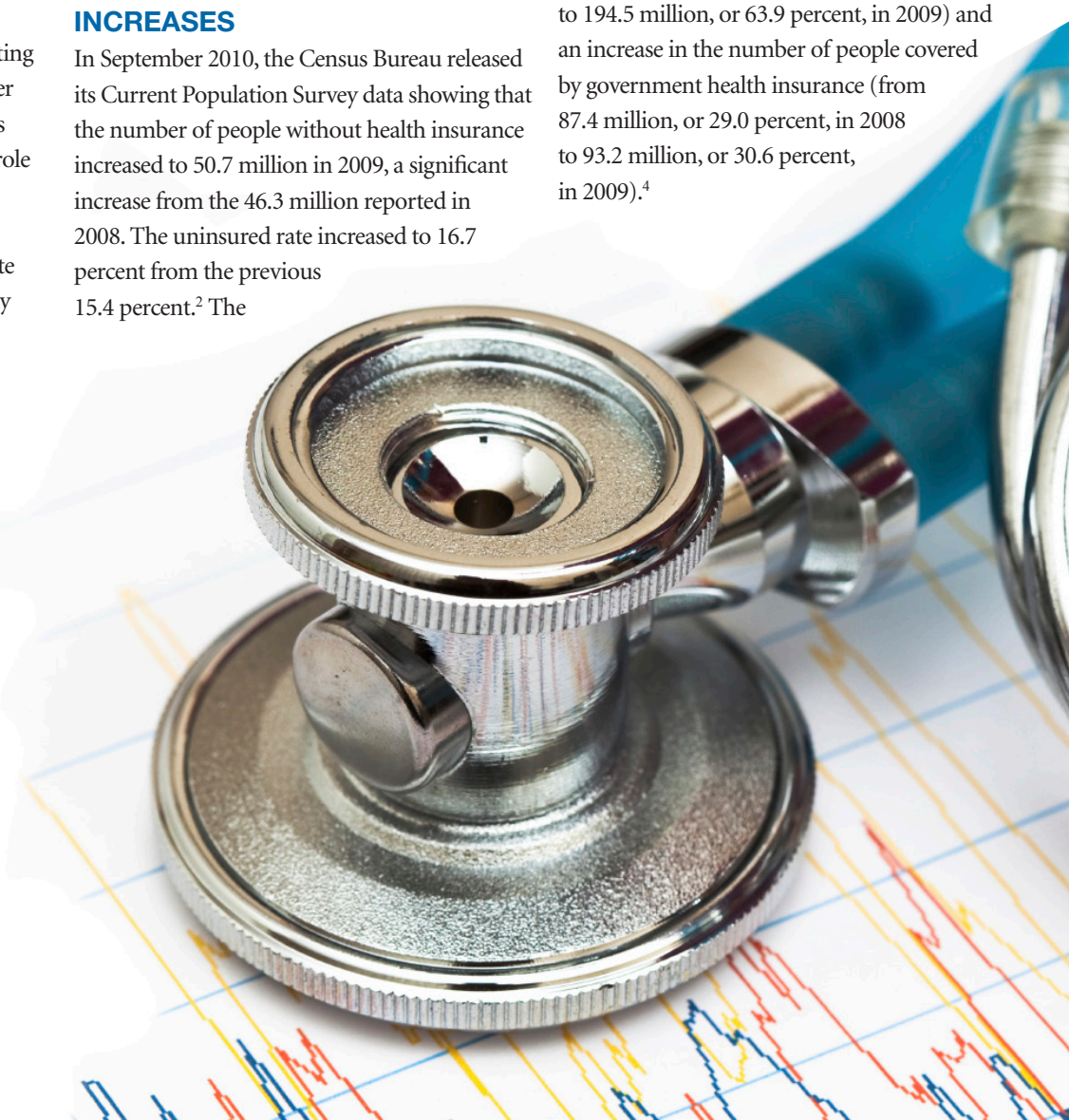
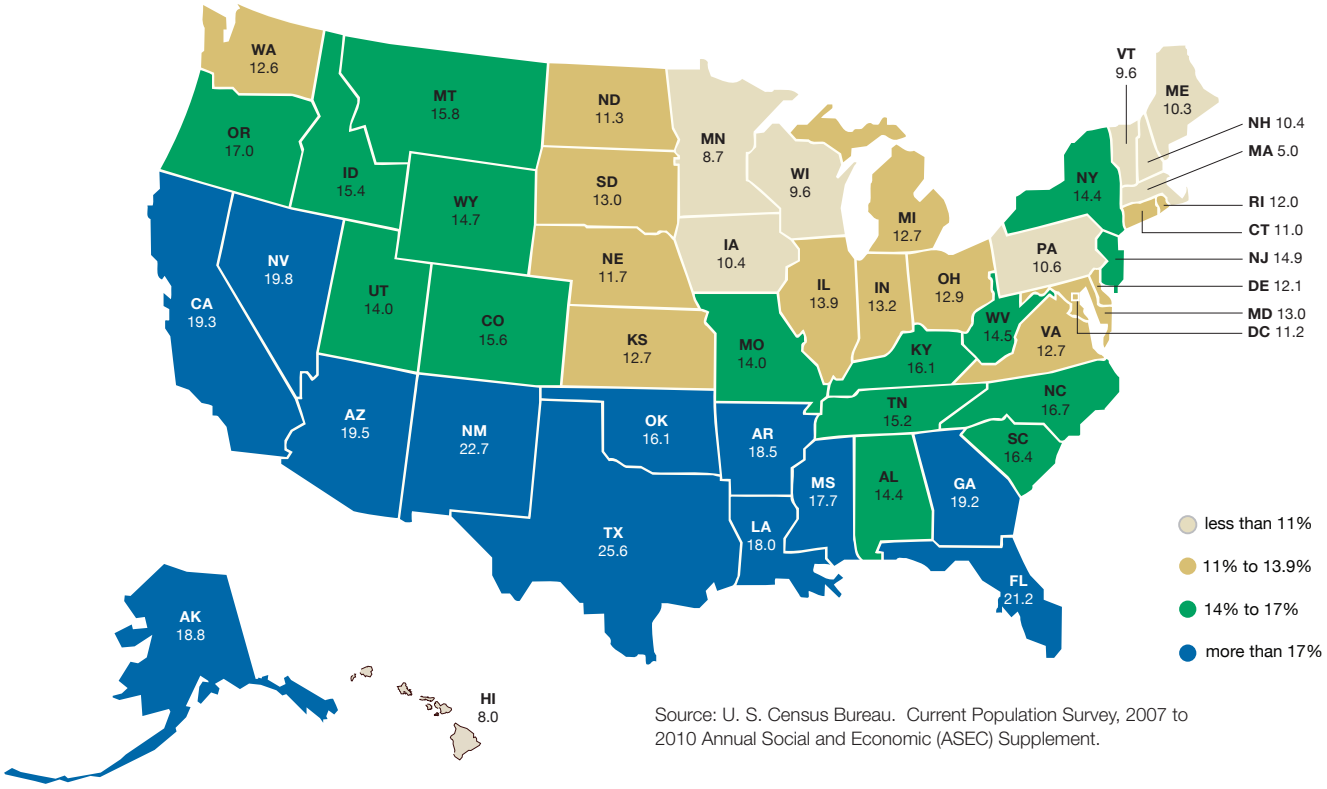


Fig. 1. **Two-Year Average Percentage of Uninsured by State: 2008-2009**



Source: U. S. Census Bureau. Current Population Survey, 2007 to 2010 Annual Social and Economic (ASEC) Supplement.

The 2009 uninsurance data are the first to reflect the toll of recession. (While the recession began in December 2007, significant declines in unemployment were not recorded until late in 2008.[5]) Unemployment went from 7.6 percent in January 2009 to 10.0 percent in December 2009. This increasing rate of unemployment accounted for a drop in the number of people covered by employer-based health insurance, which decreased to 55.8 percent in 2009 from the previous rate of 58.5 percent in 2008. In 2010, the rate of unemployment remained high, 9.3 percent in November after peaking at 9.9 percent in April, decreasing to 9.6 percent from August to October, and then rising again.[6] For comparison, the unemployment rate was only 4.9 percent in December 2007, before the onset of the recession. It should be noted that there is a significant variance in unemployment rates among states; as of November 2010, the rates ranged from 3.8 percent in North Dakota to 14.3 percent in Nevada.[7]

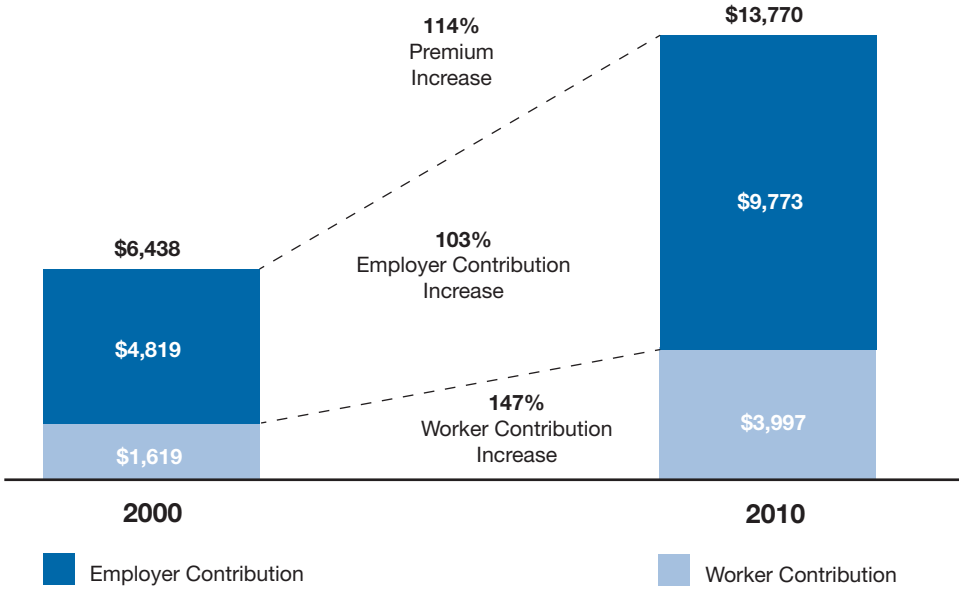
The census data also confirmed a trend of uninsurance among several population subgroups. While the uninsured rate for non-Hispanic whites increased from 10.8 percent to 12.0 percent, the rate increased from 19.1 percent to 21.0 percent among blacks, and from 30.7 percent to 32.4 percent among Hispanics.[8]

EMPLOYER COVERAGE

The Employer Health Benefits Survey found that annual health insurance premiums for single coverage increased by almost 5 percent from $4,824 in 2009 to $5,049 in 2010. Additionally, the premiums for family coverage rose 3 percent above the 2009 figures, increasing from $13,375 to $13,770. With the inclusion of this increase in 2010, premiums for family coverage have risen 114 percent in the past 10 years. In addition, workers with coverage also paid a larger portion of premiums in 2010. On average, covered workers contributed 19 percent of the total premium for single coverage, up from 17 percent in 2009. For family coverage, workers contributed 30 percent in 2010, up from 27 percent in 2009. It is important to note that the average figures disguise great variances; for instance, 28 percent of workers with single coverage pay more than 25 percent of the total premium, while 16 percent make no contribution. Similarly, 51 percent of workers with family coverage pay more than 25 percent of the total premium, while 5 percent make no contribution.[9]

Interestingly, there was an increase in the percent of employers offering health benefits, rising from the 60 percent reported in 2009 to 69 percent in 2010.[10] This change is primarily attributed to an increase in the offer rate of firms that employ three to nine workers, going from 46 percent in 2009 to 59 percent in 2010. This increase is significant but the specific reason for the jump is still unclear. Given the economic circumstances and the rate of unemployment, it is doubtful that more firms began offering coverage. The 2010 Employer Health Benefits Survey postulates that this change may be attributed to the attrition of non-offering firms (typically the smallest) during the recession, thereby skewing the numbers.

Fig. 2. **Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2000–2010**



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2010

STATE FISCAL CONDITIONS BLEAK, BUT STABILIZING

Although the worst of the recession seems to be over, states are still faced with difficult fiscal conditions. In SFY 2009, general fund revenues (consisting of state sales, personal income, and corporate income taxes) dropped a drastic 8.7 percent below the SFY 2008 figures.[11] On top of that, in SFY 2010, states experienced an additional 2.1 percent decrease from SFY 2009.[12]

As they developed their SFY 2011 budgets, states had to close a budget shortfall (referring to a deficit that must be addressed via spending cuts or revenue increases before a budget can be adopted) that equaled $122.6 billion or 18.9 percent of state budgets on average.[13] This was down from a 29 percent budget shortfall in SFY 2010. No relief is in sight for SFY 2012, with projected shortfalls that are similar to those felt in SFY 2011.[14] Making matters worse, budget stabilization, or "rainy day" funds, have been depleted across most states. These funds typically allow states to set aside excess revenue in order to close gaps in times of unforeseen shortfalls or budget deficits. The total state "rainy day" fund balance fell nearly half from a high of $69 billion in 2006 to $39.2 billion (6.4 percent of general fund expenditure) in 2010. It is projected to drop to $36.2 billion in 2011 (5.6 percent of general fund expenditure). However, these figures are somewhat deceiving: removing "rainy day" funds from Texas and Alaska reveals that the other 48 states possess funds matching only 2.8 percent of general fund expenditure.[15]

In 2009, Congress enacted the American Recovery and Reinvestment Act (ARRA) which temporarily increased the federal Medicaid matching rate (also known as Federal Medical Assistance Percentage, or FMAP) until December 2010. Given the expected SFY 2011 shortfalls, Congress also implemented a scaled back version (costing $16.1 billion rather than the $24.0 billion projected for a full extension) of this FMAP extension in August 2010, which is set to expire on June 30, 2011.[16] Because the majority of the SFY 2011 budgets were already passed when the FMAP increase was extended, many states needed to reexamine their SFY 2011 budgets.[17] Real concern lies ahead for states as they contemplate the loss of the FMAP increase in SFY 2012. While the FMAP extension can alleviate immediate financial burdens for SFY 2011, the loss of the FMAP extension in June 2011 will result in a dramatic increase in states' share of Medicaid spending of as much as 25 percent or more according to the Kaiser Commission on Medicaid and the Uninsured. This will have a substantial impact on states' SFY 2012 budgets.[18]

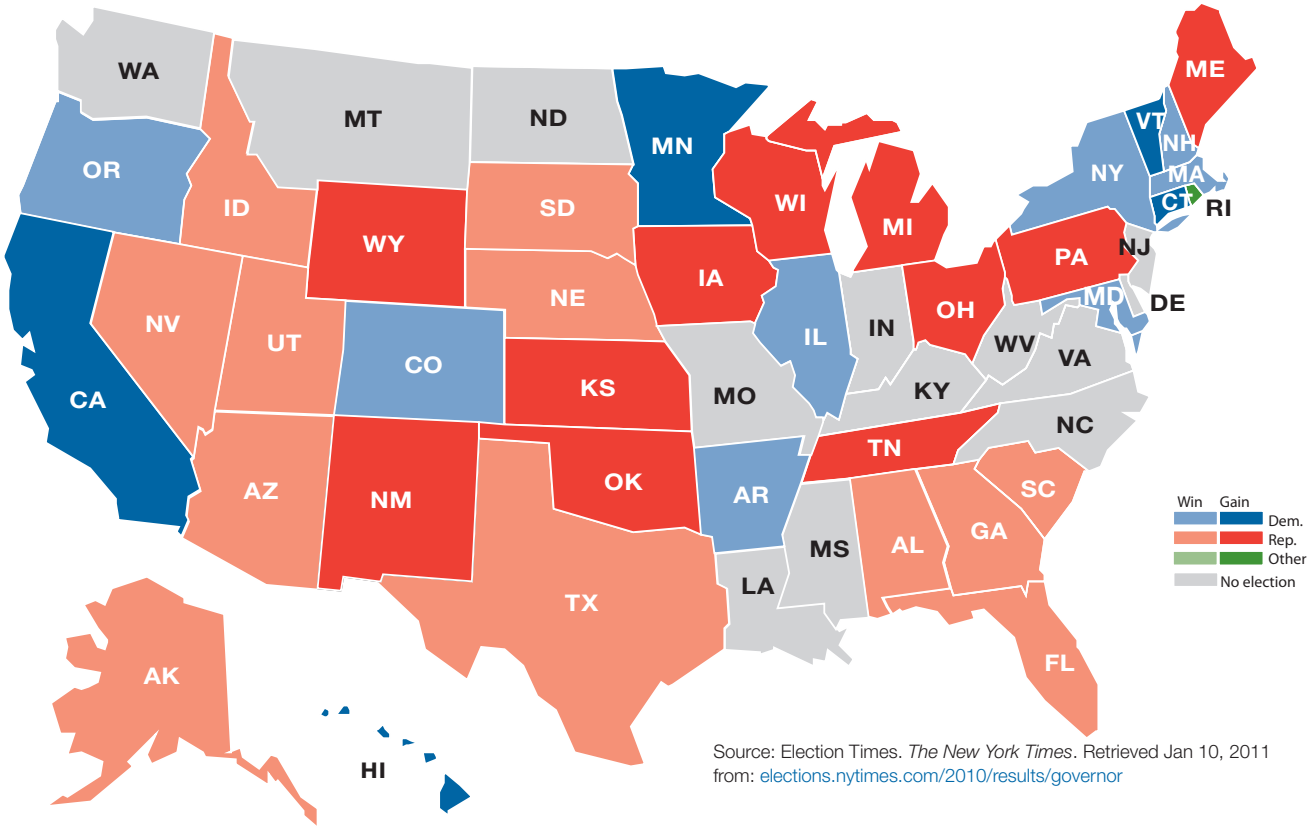
Despite the gloomy economic forecast, there are signs of slow stabilization. A Rockefeller Institute report in late November 2010 indicated that the July-September quarter of 2010 saw a 3.9 percent increase in revenue for states compared to the same quarter in 2009. Gains are likely to be limited; because personal income taxes collections are the largest source of revenue for many states, more substantial gains are unlikely while unemployment hovers around 10 percent.[19]

RECESSION RESULTS IN INCREASED MEDICAID ENROLLMENT AND SPENDING

The demand for Medicaid rose sharply in 2010, continuing the trend from the previous year. Projections for Medicaid spending growth at the beginning of SFY 2010 predicted a 6.3 percent growth through the 2010 fiscal year. However, the actual spending in SFY 2010 averaged 8.8 percent across all states, which is the highest rate of growth in eight years. Enrollment growth also outpaced the projections, averaging 8.5 percent—well above the projected 6.6 percent.[20]

The most oft-attributed factor for this increase in Medicaid spending and caseload is the recession. With the rise of unemployment (and subsequent loss of employer-based coverage), more individuals begin to rely on Medicaid. The ARRA-enhanced FMAP reduced the burden of Medicaid costs on states by 10.9 percent in 2009; in 2010, the relief equaled 7.1 percent. Despite this relief, nearly every state has had to implement at least one new policy to control Medicaid spending.[21]

Fig. 3. **Gubernatorial Election Map 2010**



Source: Election Times. *The New York Times*. Retrieved Jan 10, 2011 from: elections.nytimes.com/2010/results/governor

STATES FACE WORKFORCE WOES

As states grapple with implementing the Affordable Care Act, there are looming concerns related to the staff required for projects of the scale envisioned by federal reformers. Administrative cuts and workforce reductions will amplify the already considerable challenges associated with implementation of health care reform. On top of the recession causing workforce woes, many states are concerned about the amount of forthcoming retirements, the limitations of state hiring processes, and salary schedules. An astounding 33.3 percent of state government workers are eligible to retire in the next five years. This level of retirement eligibility occurring during a transition to new leadership (in those states where new governors were elected) may further increase states' loss of institutional knowledge. An online national workforce survey reported that 90 percent of respondents said their state government had implemented hiring freezes, with 65 percent instituting pay freezes and about 46 percent furloughing employees.[22] The diminishing workforce is of great consequence and bears troubling implications for the transitioning health policy environment.

State staffs working on health reform will also see a considerable amount of turnover as a result of the November 2010 state gubernatorial elections. New governors were elected in 26 states; 17 of these governorships saw a change of party in control.[23] A new team of senior level staff will need to get up to speed not only on state policies but the new decisions that will be required of them as a result of federal reform. In states where there is a lack of goodwill between the incoming and outgoing governors, it is possible that early planning efforts will be discarded and critical momentum will be lost.

LEGAL AND POLITICAL CHALLENGES TO FEDERAL HEALTH REFORM

A number of states have taken both political and legal steps to prevent the enactment of federal health reform. As of December 15, 2010 there were 24 lawsuits challenging the constitutionality of the ACA from a variety of types of jurisdictions (including states).[24] As of February 2011, the attorneys general of 26 states had joined a lawsuit in the federal court's Northern District of Florida against the U.S. Department of Health and Human Services, Department of Treasury, and Department of Labor, challenging the constitutionality of the ACA.[25] The attorneys general contend that mandating the purchase of insurance exceeds the powers authorized under Article I of the Constitution, and that the ACA infringes on the sovereignty of the states and the 10th Amendment to the Constitution. In November, legislators from 27 states responded with an amicus brief supporting federal health care reform. The brief contends that the ACA does not violate the principles of federalism due to the substantial amount of policy options offered as well as the level of control afforded to states for constructing mechanisms such as the health insurance exchanges.[26]

On December 13, 2010, Judge Henry E. Hudson, federal judge on the United States District Court for the Eastern District of Virginia, passed down a decision in another case filed by the attorney general of Virginia. The judge deemed the individual mandate piece of the ACA unconstitutional in the suit submitted by the attorney general of Virginia. Judge Hudson regarded this key provision of the ACA, requiring most Americans to purchase health insurance, as beyond the scope of congressional authority to regulate interstate commerce. Less than two weeks prior to this ruling against the mandate, U.S. District Judge Norman Moon of the Western District of Virginia had ruled in favor of the mandate in a case against the ACA brought forth by a university in Lynchburg, Va.[27] On January 31, 2011, Federal District Judge Roger Vinson of Florida went farther than Judge Hudson by not only finding that the individual mandate is unconstitutional, but that the entire law should be struck down because it is "inextricably bound" to the mandate.[28] The question of the constitutionality of the mandate is likely to be decided by the Supreme Court.

Forty states have also seen formal resolutions or bills that are intended to curtail federal health care reform from going forward.[29] While the majority of these motions did not pass or died in committee, there were some notable exceptions where states have signed laws or enacted statutes. In March 2010, shortly prior to the passage of the ACA, Virginia passed a law stating that no resident of the Commonwealth of Virginia would be "required to obtain or maintain a policy of individual insurance coverage" and that there would be no penalties associated with the failure to "procure or obtain health insurance coverage."[30] Idaho and Utah followed suit.

In June 2010, after passage of the bill, Georgia signed into law a statute stating "no law or rule or regulation shall compel any person, employer, or health care provider to participate in any health care system."[31] Louisiana enacted a similar statute a month later, stating that residents will be free from "governmental intrusion in choosing or declining to choose" health coverage.[32] In addition to an April law securing the right of Arizonans to accept or decline "any mode of securing lawful health care services" without penalty, Arizona's House and Senate has passed an amendment to the state constitution with similar language. This amendment received voter approval in the November 2010 election. In addition Oklahoma passed a ballot initiative that allow residents of that state to opt out of the requirements of the federal law. While these state laws are evidence of the sentiment of the legislature and public in those states, they are unlikely to have an impact on the enforceability of the federal law.

Despite the political opposition and significant economic hurdles, most states are moving forward with, at the minimum, planning for federal health care reform. For instance, Virginia passed measures to block the individual mandate (as described above) and the state's attorney general was among the first to set into motion a case against the federal government in March 2010. Regardless, the governor's office established the Virginia Health Reform Initiative Council in August and appointed members to the council.[33] Virginia has also established six health care initiative task forces that are making recommendations to the council.[34] The story is a similar one in states such as Michigan and Texas, where steps to move forward in health reform have been taken despite challenges originating from the same state.

STATE AND FEDERAL INTERDEPENDENCY IN HEALTH CARE REFORM

It may be worth noting that 2010 marked a shift in the focus of national health reform efforts. After a multi-year process of crafting a federal bill, Congress finally passed legislation in March 2010 that gave states a central role in implementation. While all eyes had been on federal policymakers (and they will continue to play a strong role in funding and regulating reform), attention has now shifted to states. States are likely to face a higher level of scrutiny from stakeholders and advocacy groups going forward.

The sweeping changes envisioned by the bill at both the federal and the state levels will require a strong partnership between policymakers in each level of government. Relationships between state and federal policymakers regarding health care have sometimes been characterized by a lack of communication and trust. This is accentuated by embittered sentiments from those who feel they were not consulted enough during the formation of the ACA and who do not agree with the approach it envisions. For reform to work as planned, strong working relationships, characterized by two-way conversation, answers in real time to pressing questions, and mutual respect, must be developed.

The federal government will face important questions about when to set standards that states are required to meet and when to promote healthy experimentation and diversity of approaches. States will need their roles further defined while providing input into what those roles should be. There will be times when there is no right answer (and multiple approaches could be successful in different ways) and other times when the right answer is not yet clear. In the past, state experimentation has not always been connected to strong evaluation, which limits the ability of states to learn from each other and for the federal government to learn from successful states. Increased attention must be paid to determining what works and what does not so that all states can adapt policies appropriately. These evaluations can help prevent large disparities between states and will enable states to build on each other's successes.

Overall, the primary challenge is that states need federal guidance for a multitude of issues quickly, but that guidance will almost certainly be slow and gradual. This has created differences among states' reactions. Some have been proactive—moving forth with the requirements under the law despite ambiguities—while other states have opted

for a more conservative approach awaiting more legal and federal guidance before moving forward.

CONCLUSION

In general, 2010 was a transitional year for states. After a recession that resulted in some of the highest rates of uninsurance and unemployment in recent history, most states warily held off any plans for state health reforms and chose to see what would come of federal health reform legislation. When that reform legislation arrived in March, it led to more questions about state capacity to achieve meaningful reform. Fiscal stress compounded as state revenues ran low and budgetary demands increased. Many states had to rely on layoffs, furloughs, hiring freezes, and other budgetary cuts to balance their budgets. As a result, states must execute the provisions of the ACA with limited staff and financial resources.

Despite grim economic circumstances and daunting challenges, many states have taken the cue from the federal government to advance their health care initiatives using the tools and resources contained in the Affordable Care Act. The majority of states are considering big questions related to their goals for the health system and strategies for carrying out the ACA in ways that will work in their state's environment. These conversations have the potential to yield innovative and interesting results, particularly in the states that emerge as leaders in a national health reform movement.

ENDNOTES

1 McNichol, E. et al. (2010, December 16). *States Continue to Feel Recession's Impact.* Center on Budget and Policy Priorities. Retrieved January 6, 2011, from www.cbpp.org/cms/index.cfm?fa=view&id=711.

2 DeNavas-Walt, C. et al. (2010, September). *Income, Poverty, and Health Insurance Coverage in the United States: 2009.* U.S. Census Bureau. Retrieved November 9, 2010, from www.census.gov/prod/2010pubs/p60-238.pdf.

3 Ibid.

4 Ibid.

5 The National Bureau of Economic Research. (2010, November). *Last Four Recessions and their Durations Chart.* Retrieved November 9, 2010, from www.nber.org/.

6 U.S. Bureau of Labor Statistics. (2011, January 4). *Metropolitan Area Employment and Unemployment - November 2010* [News Release]. Retrieved January 6, 2011, from www.bls.gov/news.release/pdf/metro.pdf.

7 U.S. Bureau of Labor Statistics. (December 2010). *Regional and State Employment and Unemployment Summary.* Retrieved December 22, 2010, from www.bls.gov/news.release/laus.nr0.htm.

8 DeNavas-Walt, C. et al. (2010, September). *Income, Poverty, and Health Insurance Coverage in the United States: 2009.* U.S. Census Bureau. Retrieved November 9, 2010, from www.census.gov/prod/2010pubs/p60-238.pdf.

9 All data in this paragraph from the Kaiser Family Foundation and Health Research & Education Trust. (2010). *Employer Health Benefits: 2010 Summary of Findings.* Retrieved November 9, 2010, from http://ehbs.kff.org/pdf/2010/8086.pdf.

10 Ibid.

11 National Governors Association and the National Association of State Budget Officers. (June 2010). *Fiscal Survey of States*, pp. 40-41. Retrieved November 9, 2010, from http://nasbo.org/LinkClick.aspx?fileticket=gxz234BlUbo%3d&tabid=38.

12 Ibid.

13 McNichol, E. et al. (2010, December 16). *States Continue to Feel Recession's Impact.* Center on Budget and Policy Priorities, p. 5, Table 1. Retrieved January 6, 2011, from www.cbpp.org/cms/index.cfm?fa=view&id=711.

14 Ibid.

15 National Governors Association and the National Association of State Budget Officers. (Fall 2010). *Fiscal Survey of States*, pp. 10 and 53. Retrieved January 5, 2011, from www.nasbo.org/LinkClick.aspx?fileticket=C6q1M3kxaEY%3d&tabid=38.

16 National Conference of State Legislatures. (2010, April 29). *FMAP Extension and the Impact on States.* Retrieved November 9, 2010, from www.ncsl.org/documents/fiscal/NALFOEnhancedFMAPExtension.pdf.

17 Kaiser Commission on Medicaid and the Uninsured. (2010, September). *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends – Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010-2011.* Retrieved November 9, 2010, from www.kff.org/medicaid/upload/8105.pdf.

18 Ibid.

19 The Rockefeller Insititute. (2010, November). *State Tax Revenues Reboard Further, Growing for Third Straight Quarter.* Retrieved December 16, 2010, from www.rockinst.org/pdf/government_finance/state_revenue_report/2010-11-30-state_revenue_flash.pdf.

20 Kaiser Commission on Medicaid and the Uninsured. (2010, September). *Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends – Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2010-2011.* Retrieved November 9, 2010, from www.kff.org/medicaid/upload/8105.pdf.

21 Ibid.

22 Henry J. Kaiser Family Foundation. (2010, September). *Staying on Top of Health Reform: An Early Look at Workforce Challenges in Five States.* Retrieved November 9, 2010, from www.kff.org/healthreform/upload/8106.pdf.

23 http://elections.nytimes.com/2010/results/governor.

24 Goldstein, A. (2010, December 15). Mandatory health insurance now law's central villain. *Washington Post.* Retrieved January 5, 2011, from www.washingtonpost.com/wp-dyn/content/article/2010/12/14/AR2010121407704.html.

25 Office of the Attorney General of Florida. (2010). *The States' Lawsuit Challenging the Constitutionality of the Health Care Reform Law.* Retrieved January 14, 2011, from www.healthcarelawsuit.us/.

26 Constitutional Accountability Center. (2010). *Brief of Amici Curae State Legislators In Support of Defendants' Motion for Summary Judgment.* Retrieved December 22, 2010, from http://theusconstitution.org/blog.history/wp-content/uploads/2010/11/State-Legislators-Amicus-Brief.pdf.

27 Manos, D. (December 1, 2010). "Federal district judge rules in favor of healthcare reform." Healthcare Finance News. Retrieved on February 1, 2011, from www.healthcarefinancenews.com/news/federal-district-judge-rules-favor-healthcare-reform.

28 Sack, K. (January 31, 2011). "Federal Judge Rules That Health Law Violates Constitution." *New York Times.* Retrieved on February 2, 2011, from www.nytimes.com/2011/02/01/us/01ruling.html.

29 Cauchi, R. (2011, January 3). *State Legislation and Actions Challenging Certain Health Reforms, 2010.* National Conference of State Legislatures. Retrieved January 6, 2011, from www.ncsl.org/?tabid=18906.

30 Individual health insurance coverage; resident of State shall not be required to obtain a policy, SB311, VA State Senate, 2010 Session. Retrieved November 9, 2010, from http://leg1.state.va.us/cgi-bin/legp504.exe?ses=101&typ=bil&val=sb311.

31 Healthy Georgians Act of 2010, SB411, Georgia General Assembly, 2010 Session. Retrieved November 9, 2010, from www.legis.ga.gov/legis/2009_10/fulltext/sb411.htm.

32 House Bill No. 1474. (Regular Session, 2010) "Provides relative to the sale and purchase of health insurance coverage." Retrieved on February 2, 2011, from www.legis.state.la.us/billdata/streamdocument.asp?did=704601.

33 GovMonitor. (2010, August 16). *Virginia Chooses Health Reform Initiative Advisory Council.* Retrieved November 9, 2010, from www.thegovmonitor.com/world_news/united_states/virginia-chooses-health-reform-initiative-advisory-council-37079.html.

34 GovMonitor. (2010, September 15). *Virginia Announces Members of Health Reform Initiative Taskforce.* Retrieved November 9, 2010, from www.thegovmonitor.com/world_news/united_states/virginia-announces-members-of-health-reform-initiative-taskforce-38587.html.

ACKNOWLEDGEMENTS

Contributers to the writing and editing of this section: Imran Mahmud, Shelly Ten Napel, Enrique Martinez-Vidal, Kristin Rosengren, Brian Haile, Hunt Blair, Alice Burton, and Ed Brown.