State Coverage Initiatives

Robert Wood Johnson Foundation

State of the States 2009

Overview of State Reform Efforts

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AcademyHealth

State Coverage Initiatives (SCI)

- An Initiative of the Robert Wood Johnson Foundation

Community of State Officials

- Convening state officials

Resources and Information

- Web site: www.statecoverage.org
- State Profiles
- Publications/*State of the States*

Direct technical assistance to states

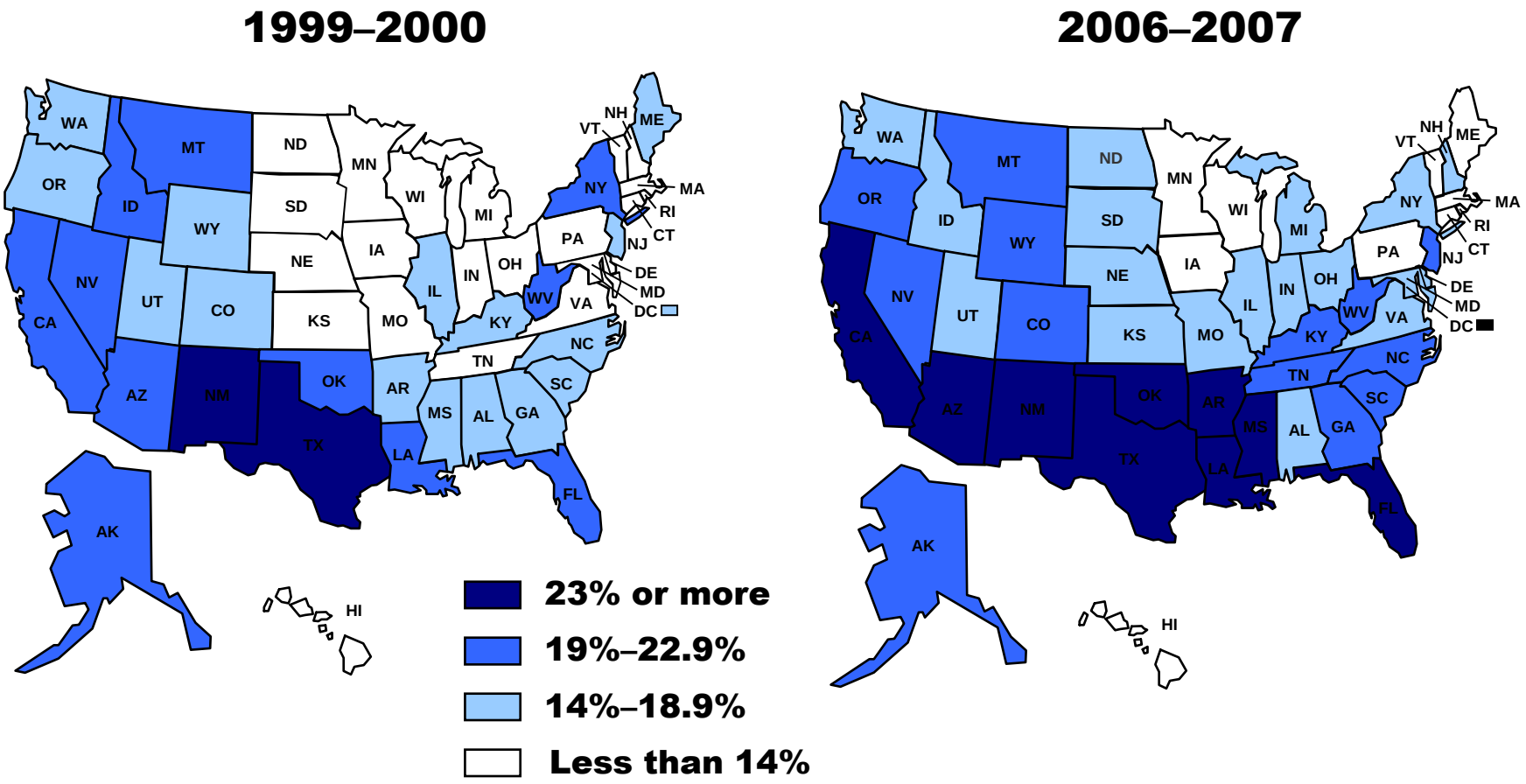
- State-specific help, research on state policymakers' questions
- Grant funding/Coverage Institute

Overview of Presentation

- Background
- Federal-State Partnership?
- State Reform Strategies
- Small Employer Strategies
- Cost-Containment/Quality Improvement
- Lessons Learned from State Reforms

Percent of Uninsured Adults Ages 18–64

(Source: The Commonwealth Fund, 2008)



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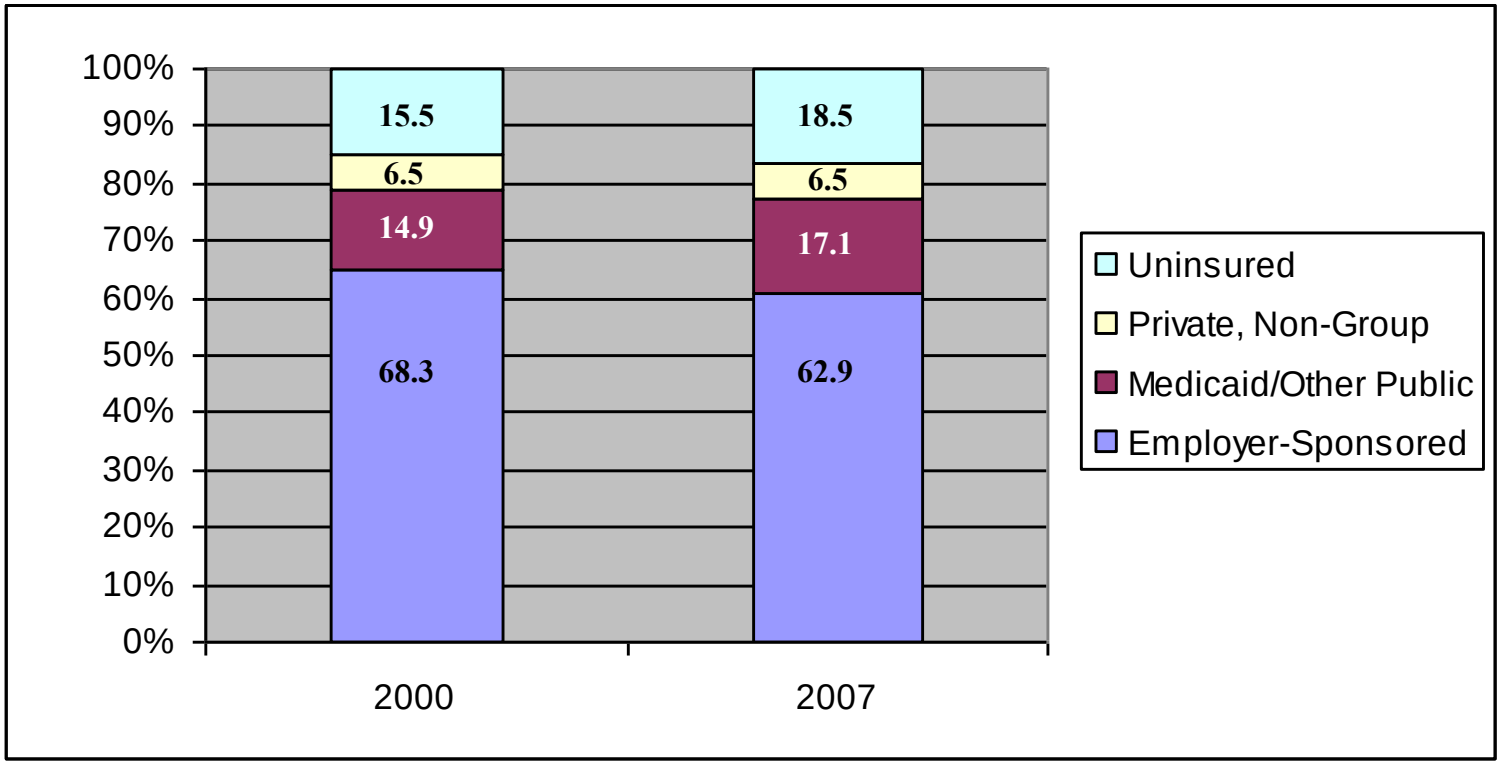
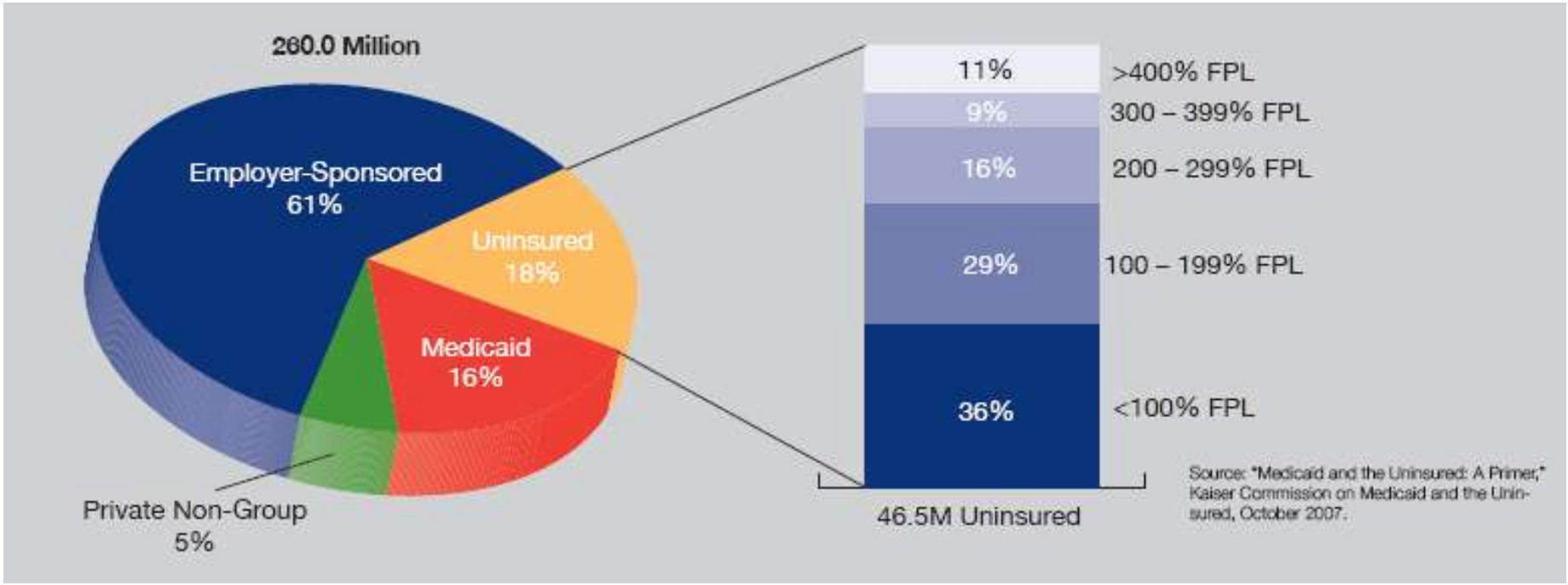
Data: Two-year averages 1999–2000, updated with 2008 CPS correction, and 2006–2007 from the Census Bureau's March 2000, 2001 and 2007, 2008 Current Population Surveys.

Health Insurance Coverage Changes Among Non-Elderly, 2000-2007

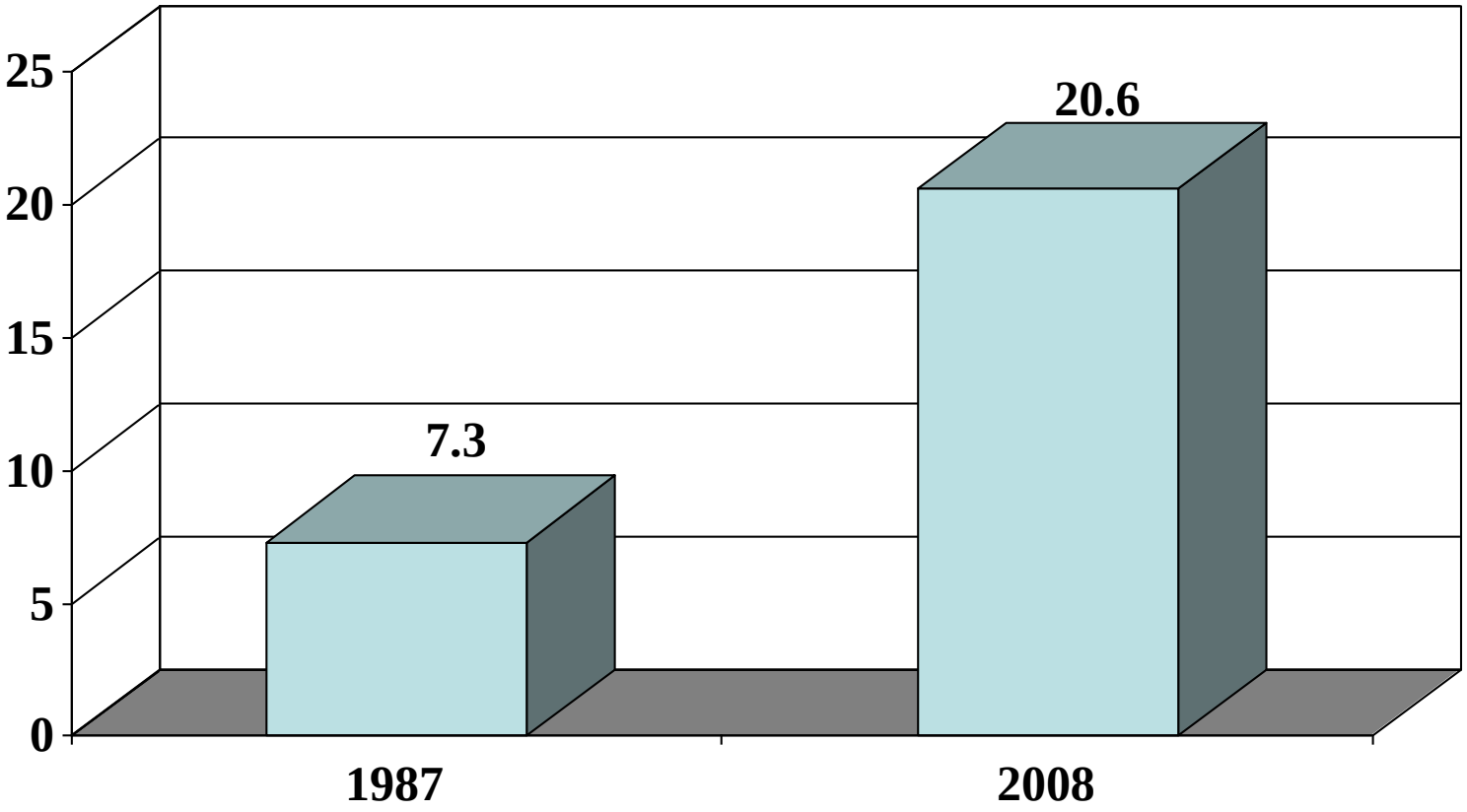


Note: Data from Current Population Survey, Census Bureau, Historical Health Insurance Tables,. August 2008.

The Non-Elderly as a Share of the Population and by Poverty Level, 2006

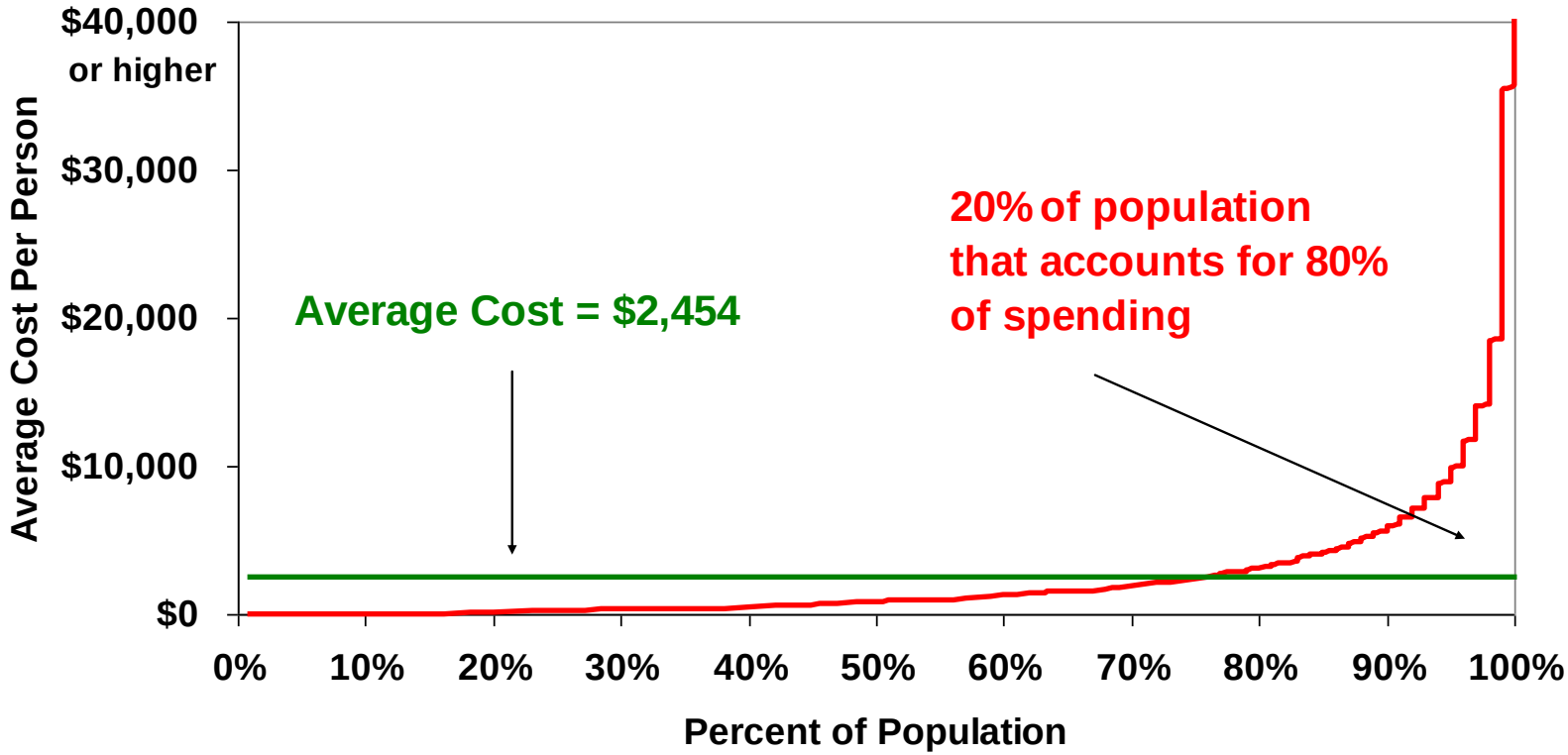


Percent of Median Family Income Needed to Buy Family Health Insurance



Source: Calculations by Len Nichols (1987) and AcademyHealth (2008), using KFF and AHRQ premium data, CPS income data.

Distribution of Health Spending Adults Ages 18-64, 2001



Source: Employee Benefit Research Institute estimates from the 2001 Medical Expenditure Panel Survey.

Drivers of State Health Reform Efforts

- Uninsured still high
- Employer-sponsored insurance down
- Costs/premiums increasingly unaffordable – Indiv; Families; Govt
- Coverage needed for effective and efficient health care system
- Lack of national consensus – future?
- Greater political will at state level

Key Policy and Design Issues

- Different Populations Require Different Solutions
- Subsidies and Financing: Who will pay? Who will benefit?
- Should Health Insurance Coverage Be Required?
- What is Affordable Coverage?
- What is the Most Appropriate Benefit Design?
- Do Insurance Markets Need to be Reformed/Reorganized?
- Best Mechanisms for Cost Containment/Systems Improvement

2008 State of the States

State and National Health Care Reform:
A Case for Federalism

2009 State of the States – pp. 14-19

Federal-State Partnership: State Strengths

- Proximity:
  - Due to the local nature of health care delivery, states are closer to the action for implementing system redesign
- Flexibility to implement system redesign:
  - States have in-depth knowledge of local landscapes and the ability to foster relationships with local stakeholders critical to successful system change.

Federal-State Partnership: Federal Strengths

- Ability to establish minimum national standards for eligibility rates, benefit design, etc.
- Capacity to address budgetary issues:
  - Counter-cyclical budgeting
  - Multi-year budgets
  - Revenue raising capacity

Federal-State Partnership Features: Insurance Market Regulation

- State regulation efforts are hampered by ERISA and lack of oversight of federal insurance programs
- The federal government could take a number of policy steps to alleviate uncertainty on permissible state regulatory actions
  - States could be allowed to collect enrollment and benefit information from ERISA plans
  - Provide more clarity about ERISA and/or allow “safe harbors”
  - Allow states to require ERISA-protected purchasers to participate in payment reform/quality improvement collaboratives/Medicaid premium assistance programs/all-payor databases
  - Freedom to apply premium taxes to employer plans
  - Establish a national floor on benefits
  - Shift consumer protection/oversight responsibility to state level

Federal-State Partnership Features: Public Programs

- Burdensome federal regulations and unilateral program changes have strained the federal-state partnership.
- To reduce the tensions, national reform should address policy changes in the following areas:
  - Waiver process
  - Dual eligibles, citizenship requirements, and other Medicaid policy changes
  - SCHIP limitations – 8/17/07 directive – now rescinded

Federal-State Partnership Features: Systems Redesign/Quality Improvement

- Need to link value (cost/quality) enhancement strategies with coverage expansion
- The **implementation** of quality initiatives has occurred on the state level
- Feds can leverage federal programs to encourage better processes - improved outcomes could be accelerated
  - Promote evidence-based care; comparative effectiveness research; include state programs in Medicare payment/delivery redesign demonstration projects; include Medicare in state demos
  - Develop interoperability standards to ease HIT adoption
  - Develop a set of national standards and guidelines in the area of quality metrics

State Variation in the Context of Federal Reform

- There is broad agreement on the need for reform, but significant differences on means to needed to achieve it.
- Uniform national strategy will not have uniform effects at the state level and will not guarantee uniform outcomes
- Three possible solutions for federal government to address state level variation:
  - Don't address variation and let states fend for themselves
  - Provide variable assistance based on state need
  - Allow states to comply with federal guidelines in a sequenced fashion over time.

- ***Combination of variable assistance and sequencing likely best method to help states comply with national reform over time***

Federal-State Partnership: Future?

- Funding vs. Flexibility
- Ideas related to federal-state partnership not new, many similar to those proposed in early 1990s
- States fear federal reforms may hinder, rather than help state efforts
- Despite state hesitance, inaction not an option. Federal-state partnership offers real potential and should be considered

Major Health Care Provisions in Stimulus Package (ARRA 2009)

- Medicaid FMAP increase: $90 b.
- Promotion/Adoption of HIT: $20 b.
- COBRA subsidies (9 months): $25 b.
- Comparative Effectiveness Research: $1.1 b.
- Extension/New Moratorium on Medicaid Regulations
- Community Health Centers: $0.5 b. for services and $1.5 b for capital investments/HIT
- Temporary increase in Disproportionate Share Hospital (DSH) Payments: FY09 & FY10 – 2.5%

Comprehensive/Substantial Efforts

Implementation Continues

Maine (’03)
Massachusetts (’06)
Vermont (’06)

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Strategies for Comprehensive Reform

	Maine	Massachusetts	Vermont
Individual Mandate	*No*	Yes	*No* *Will consider if coverage targets not met*
Purchasing Mechanism	DirigoChoice	Health Insurance Connector	Catamount Health
Subsidies for Low-Income	Up to 300% FPL	Up to 300% FPL	Up to 300% FPL
Public Program Expansion	Parents <200% FPL Childless Adults <125% FPL	Adults <100% FPL Children <300% FPL	*Builds upon previous expansions* *Children <300%* *Parents <185%* *Childless Adults <150% FPL*
Employer Requirements	*Voluntary* *Participating employers must pay 60% of premium*	$295/employee fee for non-offering. Must offer § 125 Plan	$365/FTE fee for non-offering

Massachusetts Pillars of the Reform

- Employer Responsibilities
  - Section 125 Plan Requirement
  - Offer Coverage or Be Assessed
- Personal Responsibility/Individual Mandate
- Expansion of Publicly-subsidized Programs
- Major Changes to Insurance Market
  - Merged Small Group and Individual Markets
  - Raising age of dependents – up to 25
  - Connector

Current State of the Commonwealth

- More than 439,000 newly-insured between June 2006 and March 31, 2008
- 191,000 more in private coverage (no public $$) – more than 40% of all newly covered have no subsidies
- Employer-sponsored insurance remains predominant source of coverage (82% of non-elderly): no crowd-out
- Non-group premiums are down over 40% and membership has grown over 50%
- Approximately 1-2% of the MA population or 60,000 persons may be exempted from the mandate

Vermont - Blueprint Components

Public Policy	▪Blueprint legislation and funding ▪Executive Director at Governor's Office level ▪Integration with Public Health Disease Prevention Programs
Community	▪Community Grants ▪Environmental and Policy Strategies, Smart Planning ▪211 as statewide resource tool
Self-Management	▪Healthier Living Workshop—All conditions - Over 40 statewide; 500+ enrolled - +60% reduction in MD and ED visits post at one year ▪Patient portal planned
Information Systems	▪ Statewide RHIO, Health IT Plan ▪ Web-based chronic care information systems ▪ EMR
Physician Practices	▪Consensus treatment standards—7+ Diseases ▪Clinical Microsystems support in practices –training, coaching, peer support ▪75% participation in 6 Communities (HSAs)□200 practices
Health Systems	▪Required coordination across all payers in 3 pilots in 2008 ▪Contract with National Payment Reform Consultant

Comprehensive/Substantial Efforts

Substantial Enactments

Iowa

Minnesota

New Jersey

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Attempts at Comprehensive Reform

Significant Proposals

California – near-success

Kansas – some pieces

New Mexico – very small pieces

Pennsylvania – in process

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Substantial Reforms

States with Recommendations for 2009 Session

Connecticut
Kansas
Ohio
Oklahoma
Oregon
Utah

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State Reform Efforts Target Small Employers

2009 State of the States – pp. 48-53

The Erosion of Small Group Coverage

- Higher admin costs: smaller pool to spread fixed costs – increases per person premium
- Premiums can change dramatically annually: one/two people with high costs
- Risk premium added: cover year-to-year unknown variation
- Small Employers: more employ low-wage workers; operate on tighter margins – difficult to even offer coverage
- Greater cost-sharing by employees

State Approaches to Declining Coverage

- Premium Subsidies
- Reinsurance
- Restructured Benefit Design
- Section 125 Plans
- Employer Mandates

Cost Containment and Quality Improvement Prioritized by States

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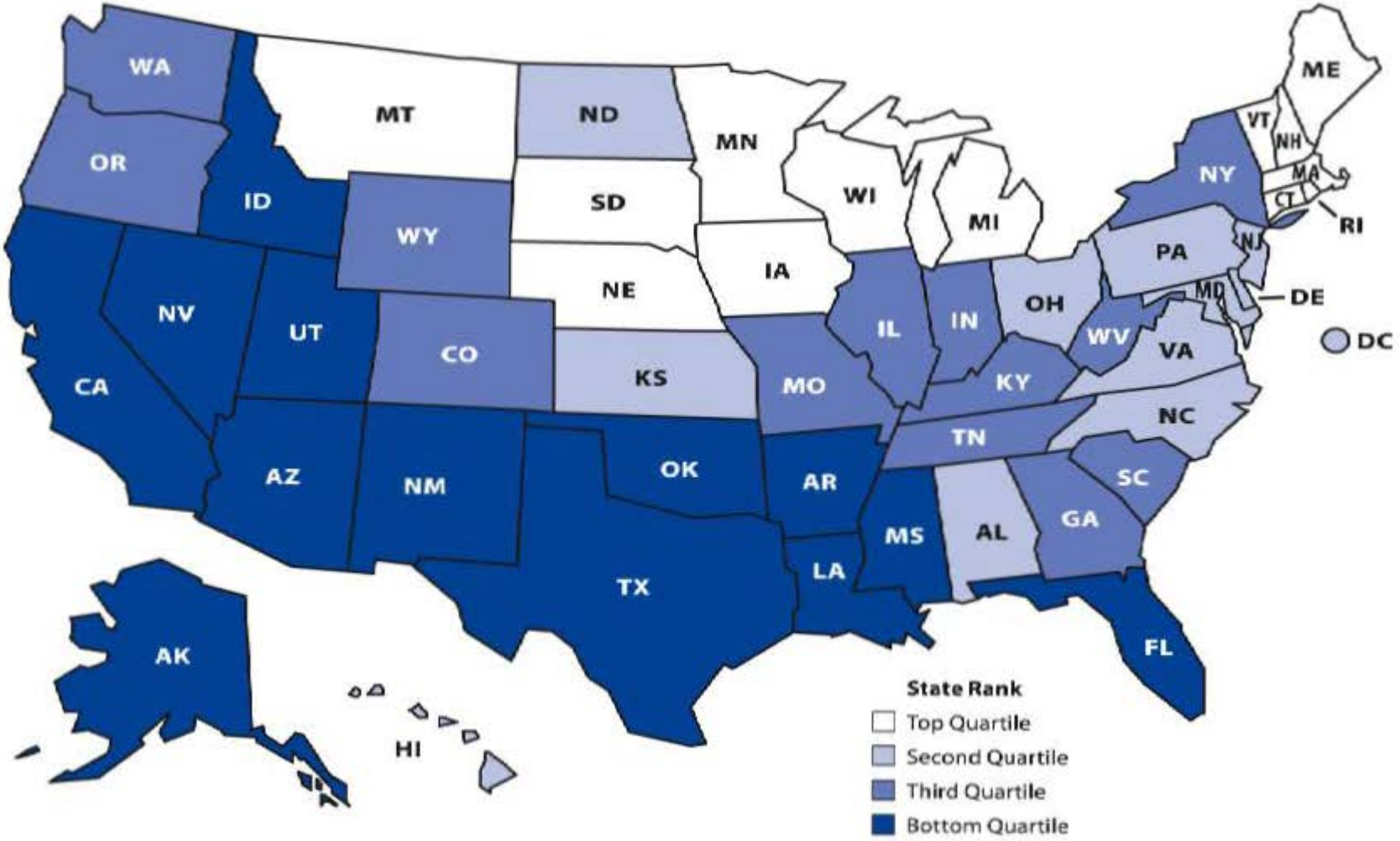
State Ranking on Quality Dimension



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Don’t Forget the Delivery/Payment Systems

- Prevention/primary care/wellness
- Chronic care management and coordination
- Public health initiatives
- Value-based purchasing/payment reforms
- Medical error reduction/patient safety
- Health-acquired infection reduction
- Price and quality transparency
- Heath information technology and exchange
- Administrative and regulatory efficiencies

Lessons Learned in State Reform Efforts

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Comprehensive Reform is Possible: Massachusetts Shows the Way

- Massachusetts' passage of universal reform in 2006, demonstrated bi-partisan support for broad reform is possible
- Massachusetts public-private plan represents compromise between single payer and strict market-based approaches.
- This approach has been broadly accepted and incorporated into other comprehensive reform proposals.

Compromise and Consensus Building

- Though consensus on the necessity of reform is growing, significant political hurdles still hinder reform in many states.
- There are a number of lessons learned from the states related to building stakeholder support:
  - Leadership is essential
  - Be inclusive
  - Build relationships early
  - Find supporters wherever possible
  - Get supporters on the record
  - Keep your eyes on the prize(s): big picture & perfect vs good
- States have established a consensus-building process for many reasons
- Consensus building is not a magic bullet

No Free Solutions: Who Will Pay? Who Will Benefit?

- Shared responsibility – Who helps cover the costs?
  - Individuals; Employers; Federal government; State government; Health plans/insurers; Providers
  - Potential downside: “shared responsibility” means “shared pain”
- Enough money in current system?
  - If yes, then – Redistribution (Who will pay? Who will get paid?)
  - States have attempted to recoup savings from the system:
    - Maine and the Savings Offset Payment (SOP)
    - Minnesota’s 2008 health reform law
  - If not, then need new forms of revenue: Sin taxes; Sodas; Provider taxes; Payroll taxes; Lease lottery; Slots revenues; Gross Receipts Tax

Sustained Effort Needed

- Health reform takes sustained effort/built on previous efforts, financing mechanisms
  - Massachusetts
  - New Jersey, Iowa, and Wisconsin
  - Oregon, Colorado, and New Mexico
- Sustained effort during implementation of reform is especially critical. To ensure success of reform:
  - Outreach and education are crucial
  - Strong evaluation mechanisms which allow reform to be adapted as it moves forward

A Sense of Urgency Creates Opportunity

- Massachusetts reforms propelled by potential to loose federal funds
- Other states seek way to create similar sense of urgency
- Comprehensive reform will remain difficult without a sense of urgency or a sense of inevitability as many stakeholders are invested in status quo

Individual Mandate

- Voluntary strategies will not result in universal coverage - some states are beginning to recognize the need for mandatory participation - Massachusetts
- Unenforceable? Impingement on individual freedom? Money for subsidies?
- Those pursuing individual mandate must consider:
  - Affordability of mandate
  - Richness of benefits package
  - How to enforce mandate
- Though there are significant policy challenges, there are also notable benefits:
  - Distribution of risk
  - Fairness
  - “System-ness”

Relationship Btw Reducing Costs, Improving Quality & Expanding Coverage

- Little success so far in addressing underlying cost of health care but a new focus on chronic care management/preventive care holds potential
- Massachusetts leads on health coverage reform, while Minnesota is at the forefront of cost containment
- The trend in states is to address access, systems improvement, cost containment simultaneously—concern about long-term sustainability of coverage programs and improved population health
- Concerns about rising costs are an impetus for reform, but cost cutting is likely to raise opposition from various stakeholders.

States Can Advance Reform Initiatives But Need Federal Support

- States face growing pressures for reform
  - Uninsurance continues to rise as ESI declines
  - Cost increases threaten state budgets and capacity to sustain Medicaid/SCHIP
- States play critical role in moving the conversations about coverage expansions
  - Testing new ideas (politically and practically)
  - Creating momentum for national policy solution
- States cannot achieve universal coverage without a federal framework and funding BUT remember variation
- State and National: Comprehensive reforms need sequencing
  - Sequential = incremental with a vision