# STATE OF THE STATES

January 2010

## The State We're In

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## 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. Examples of the assistance are noted throughout the text of *State of the States*. 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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# Letter from the Director

We are delighted to release the State Coverage Initiatives (SCI) 2010 edition of State of the States, titled "The State We're In." It goes without saying that our flagship publication is being released during an unusual time. While states have continued their work at the local level, our collective attention naturally has focused on the national debate and the scope of reforms being contemplated in Washington.

Because State of the States is being published during such a time of uncertainty—with all eyes on Washington and no clear sense of how negotiations will resolve—we are taking a slightly different approach this year. As usual, the publication will summarize the accomplishments of states during the previous year; however, in past years, we also typically would analyze the implications of state reform for future state and federal policymaking. This aspect of the report will be started in the 2010 *State of the States*, but will be continued in subsequent SCI publications as the landscape for state health reform becomes clearer. If national health reform is enacted, we intend to offer a second phase of products and technical assistance that will help states understand the federal changes and their anticipated impact on states. If reform legislation at the national level does not pass, it will be even more critical for states to continue with their efforts at health reform at the local level. Finally, while we share the fondness that many of you have for our printed publication, we are distributing this year's State of the States exclusively on-line. You can find it at www.statecoverage.org/stateofthestates2010.

In 2010, the SCI program stands ready to help states navigate state health reforms whether or not federal reform materializes. In particular, we plan to concentrate on exchanges/connectors and related insurance market reforms. We may be working to help states understand ways to improve and reorganize the market in the absence of federal reform or helping them navigate the responsibilities and options they will have in the context of federal legislation. In any case, states need to know both the possibilities and limitations of stronger regulation and better organization of the small group and individual markets. We have already begun this important work and encourage you to visit our Web site to read our new issue brief, "Preparing for Reform: The Role of the Health Insurance Exchange," (www.statecoverage.org/node/2147) which discusses the potential of state-based exchanges.

The Executive Summary that follows describes the state programs outlined in the 2010 *State of the States*. Once again, we are pleased to highlight the innovative and important accomplishments of states in 2009—achievements that are particularly notable given that states are facing more fiscal challenges than ever.

This year's *State of the States*, in particular, feels more like a beginning than an end. We stand with state officials who are watching federal action with interest and are planning for difficult work ahead with or without federal assistance. We are preparing now to be able to offer timely and relevant assistance in the months ahead.

We hope you enjoy "The State We're In." Stay tuned for more from SCI.

Sincerely,

Enrique Martinez-Vidal

# Executive Summary

The 2010 *State of the States*, "The State We're In," describes a tumultuous year for states. They faced a historic recession that caused dramatic deficits in almost every state. Most enacted across-the-board cuts, hiring freezes, and furloughs. Every state program has been under scrutiny. At the same time, important federal legislation provided critical support to states. The reauthorization of the Children's Health Insurance Program (CHIP) gave new incentives to states to expand outreach and coverage for kids and families. The American Recovery and Reinvestment Act (ARRA) increased the Federal Medical Assistance Percentages (FMAP), giving an $87 billion boost to state revenues. ARRA also included the Health Information Technology for Economic and Clinical Health (HITECH) Act, which bolstered states' roles in the effort to spread the meaningful use of health information technology throughout the U.S. health care system.

Throughout the year, the debate over national health reform had many states in a wait-and-see mode, unsure how their reform plans might be impacted by any eventual federal legislation. Nonetheless, as has been a recurring theme in this annual report, states made many strides forward despite the challenges they faced in 2009. "The State We're In" tells the story of several states that "stayed the course" on a policy improvement trajectory despite the uncertainty of 2009. For example, Oregon passed comprehensive reform in 2009, completing a policy-development process that was set in motion by the 2007 legislature. Vermont's two Blueprint pilot sites matured while the State prepared to launch a third site in January 2010, continuing work that began in 2006 with the passage of comprehensive reform. In Massachusetts, commissions and councils made recommendations for a new direction in how care is delivered and paid for in response to 2008 legislative directives.

"The State We're In" also addresses trends in state health policy. It tells the story of how states protected Medicaid during tough times and increased coverage rates for children through CHIP—a bright spot in the overall coverage picture over the last few years. It also details how states responded to a long trend of falling employer-sponsored coverage with insurance reforms aimed at the small group and individual markets, particularly experimenting with exchanges and other ways to better organize the market; how states responded to rising costs through efforts at delivery system reform; and how they focused on improving care coordination and on multi-payer initiatives to reform payment.

Following are the key sections of "The State We're In."

- **Surveying the Landscape** This section analyzes trends in health care cost and coverage. For the second year in a row, states faced a bleak financial landscape in 2009. The cost of health coverage continued its steady climb, while employer-sponsored coverage fell. While the full impact of the recession on employer-sponsored coverage (and overall rates of uninsurance) remains to be seen, state revenues declined just when demand for services rose.

- **Medicaid and CHIP** States received significant help from the federal government during 2009 in the form of an increased FMAP. This came with the requirement that states maintain Medicaid eligibility levels, causing many states to repeal or cancel planned cuts.[1] States also reacted to incentives in the Children's Health Insurance Program Reauthorization Act (CHIPRA). Eighteen states expanded eligibility for CHIP in 2009 and numerous states improved their outreach and enrollment efforts. The coverage expansions of Iowa, Oregon, and Colorado are highlighted along with the outreach and enrollment efforts of several states including Wisconsin.

- **Insurance Reform** Several states focused on improving the functioning of the small group and individual markets. Exchanges were a hot topic in the national debate, and a handful of states—including Maine, Oklahoma, Oregon, Utah, Washington and West Virginia—enacted or made progress on a version of an exchange at the state level. (These are in addition to Massachusetts, which incited interest in this concept by creating a Connector as a part of its 2006 comprehensive reform.) Implementing an exchange was one way these states could improve the functioning of their insurance market without spending significant resources. These states may be well-positioned if federal reforms include a state-based exchange.

  Rhode Island is catching the attention of state insurance commissioners with an innovative new approach to health plan oversight. Rhode Island's Health Insurance Commissioner, working with the carriers and an advisory board, developed standards to improve affordability in that state. This tactic is a significant departure from typical carrier regulation, which primarily oversees financial solvency, consumer protection, product design, and rating requirements. One such affordability priority requires health plans to increase their investment in primary care; carriers will steadily redirect some of their spending to this area without increasing overall premiums. The state is working with carriers to track their investments and study the impact of reform.

- **Delivery System and Payment Reform** The rising cost of health care continues to be a major struggle for states. Health care costs have been absorbing an increasing portion of state budgets through the Medicaid and state employee insurance plans. After years of effort to control costs in state budgets, many state health

policy officials have begun to recognize that they cannot reform the health system alone. Consequently, many states (including Vermont, Minnesota, Washington, and Pennsylvania, to name a few) have begun to lead multi-payer efforts to improve primary care and increase care coordination. States are also emphasizing price and quality transparency, consumer engagement, and public health. While a few leading states have already paved the way in the area of health information technology (HIT), new legislation from the federal level has brought increased focus on this issue in every state. The states to watch are those establishing an HIT infrastructure that promotes the exchange of health information, assists all types of providers in the adoption of high-quality electronic medical records, and creates opportunities for training and education.

"The State We're In" is being published during a time of great uncertainty for states; federal reform is still under consideration and the state role in implementing proposed changes is not yet clear. If comprehensive or incremental federal reform passes, it will surely impact state public programs, insurance markets, and delivery and payment systems. Tremendous intellectual and financial resources would be needed to implement the types of sweeping reforms that are being contemplated. States also continue to face economic uncertainty; while the economy appears to be improving, is it unclear how quickly employment levels and state revenues will recover. More cuts are likely to be necessary and many states are already operating with very limited resources.

Even in a challenging environment, states continued to show leadership in 2009. Indeed, the financial strain has forced states to be resourceful. At a time when all eyes are on the federal government, policymakers would still do well to look at the examples of leading states. We believe "The State We're In" is a valuable resource to that end.

# SURVEYING THE LANDSCAPE

While the prospect of federal health reform loomed for the better part of 2009, states worked to protect the safety net in the face of some of the worst state budget deficits in recent memory. The dire state of the economy put a damper on most state attempts to expand coverage, although there were a few success stories, both comprehensive and incremental in nature. Throughout the year, high unemployment, lagging wages, and troubled state budgets reminded all too many Americans of the often precarious nature of the nation's health coverage system.

In light of the national recession, state officials worry that much of the progress made during recent years could be threatened by severely strained state budgets. Two key federal-level measures have helped to mitigate this concern: first, the Children's Health Insurance Program Reauthorization Act (CHIPRA), which strengthened the Children's Health Insurance Program (CHIP) in February and, second, the American Recovery and Reinvestment Act (ARRA), signed in February by President Obama.[3,4] CHIPRA has aided states in increasing coverage to children and pregnant women through both Medicaid and CHIP.[5] ARRA allocated $140 billion in overall fiscal relief for state governments to help balance their budgets and minimize cuts to public services—with $87 billion directed to a temporary increase in the federal share of Medicaid costs from October 2008 through December 2010.[6,7]

This section uses a range of data sources to explore the current landscape and discuss some persistent trends. Given that data sources typically lag current conditions by a year, the numbers do not paint a true picture of today's reality—particularly when it comes to the rates of uninsurance. In this section, various facets of the nation's struggling economy are examined within the context of previous trends and with an eye toward their potential impact.

## UNINSURED NUMBERS INCREASE IN 2008

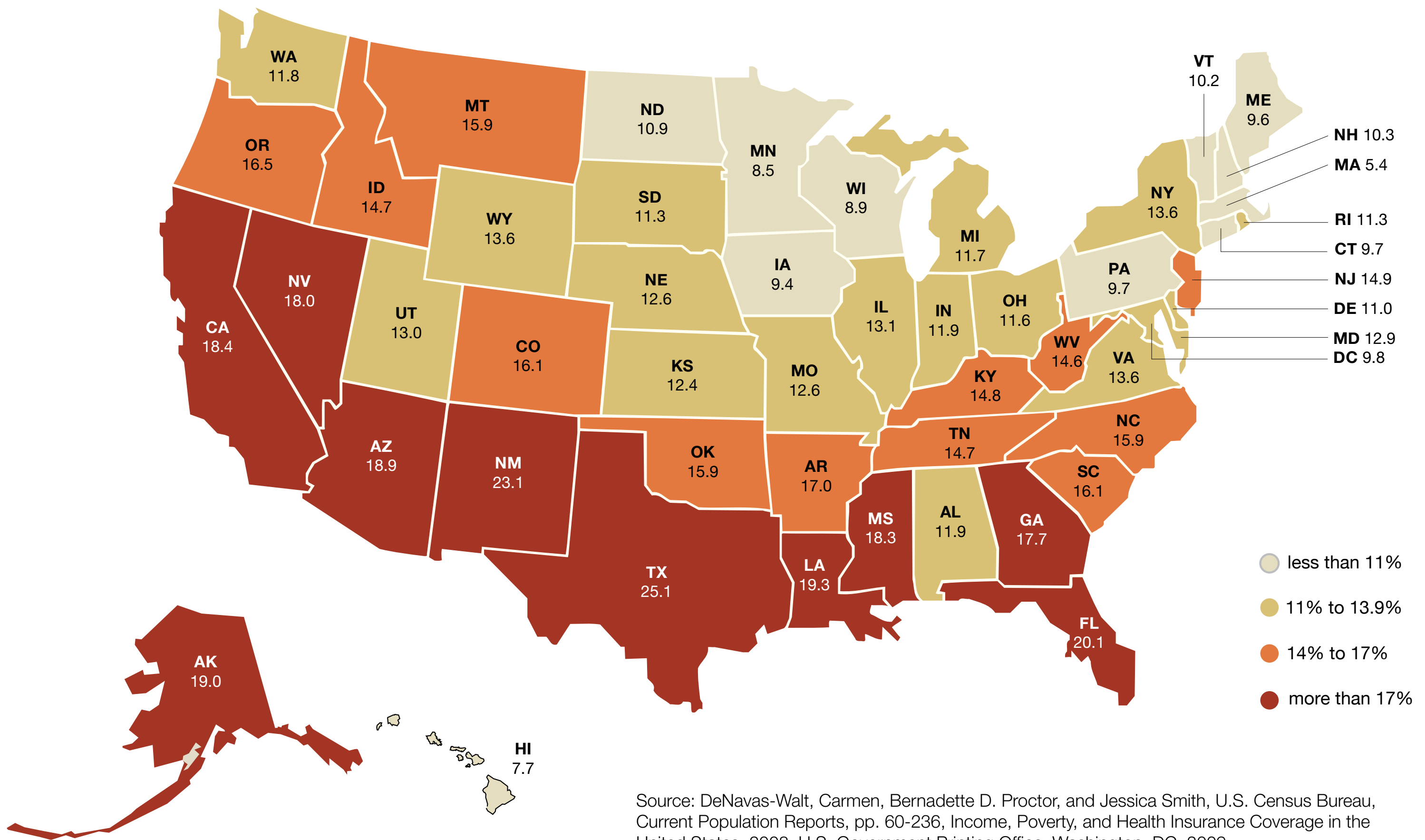
In a reversal from the decline of uninsured people seen in 2007, the number of people without health insurance rose from 45.7 million in 2007 to 46.3 million in 2008. The uninsured rate increased from 15.3 percent to 15.4 percent; however, that change is not statistically significant.[8] While the decline in the number of uninsured in 2007 was an anomaly in the midst of a steady upward trend in uninsurance, the increase in the number of people without health insurance in 2008 partly reflects the initial effects of the recession, along with the long-term trend of a steady erosion of employer-sponsored coverage. Nearly 6.6 million more people were uninsured in 2008 than in 2001, when the previous recession was at its worst.

Undoubtedly, the 2008 uninsured data do not reflect the true toll of the recession,[9] given that the unemployment rate has grown substantially over the last year, from 7.6 percent in January 2009 to 10.0 percent in December 2009.[10,11] The worsening economy and rising unemployment numbers will likely mean a significant increase in the number of uninsured in 2009.[12]

The recession intensified the loss of health insurance nationwide in 2008, but the percentage of Americans without health insurance has been on a near constant rise since 2001 as employer-sponsored coverage has gradually eroded. Yet, the overall percentage of people without insurance remained constant in 2008 because the decrease in employer-sponsored insurance was offset by increased enrollment in public insurance programs.[13]

The 2008 Census data also reveal a growing lack of health insurance, or adequate health insurance, across a number of sub-populations, as well as ongoing variation in the uninsured rate by race. Minorities remain much more likely to be uninsured,

Figure 1 **Percentage of People Without Health Insurance By State, 2007-2008 Average**




Source: DeNavas-Walt, Carmen, Bernadette D. Proctor, and Jessica Smith, U.S. Census Bureau, Current Population Reports, pp. 60-236, Income, Poverty, and Health Insurance Coverage in the United States: 2008, U.S. Government Printing Office, Washington, DC, 2009.

with almost one-fifth (19.1 percent) of African-Americans and nearly one-third (30.7 percent) of Hispanics uninsured last year. This is relative to an uninsured rate of 17.6 percent for Asians and 10.8 percent for non-Hispanic whites. However, the percentage of people without health insurance is increasing fastest among non-Hispanic whites.[14,15]

Another growing problem is high out-of-pocket costs relative to income that leave many people effectively underinsured. The Commonwealth Fund estimates that, in 2007, there were 25 million underinsured people—representing a substantial increase from 16 million in 2003. The ongoing increase in the number of uninsured and underinsured has serious financial and health consequences for families across the country and underscores the need for a national health care reform plan to assist people in meeting their medical needs during a time of slow income growth and rising health care costs.[16]

## EMPLOYER COVERAGE CONTINUES GRADUAL DECLINE

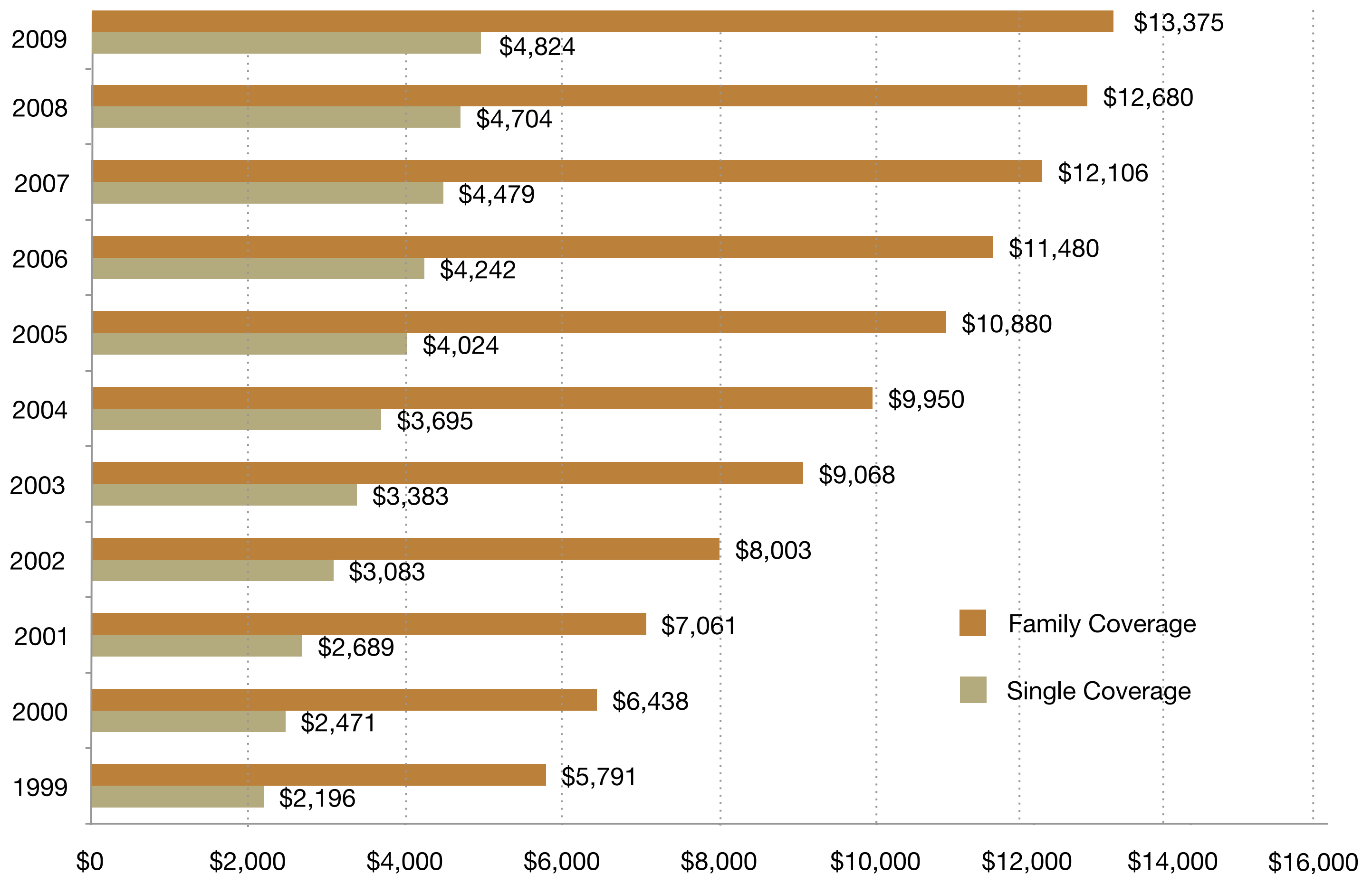
The story of employer-sponsored health insurance, as of late, is one without surprises in that the slow erosion of employer-sponsored coverage continued in 2008, as did the steady increase in average premiums. Most non-elderly people (61.9 percent) were covered by an employment-based health insurance plan for some or all of 2008, down from 62.9 percent in 2007 and 67.0 percent in 2001.[17] Family premiums rose about 5 percent in 2009, which is much more than general inflation and stands in contrast to the 3.1 percent rise in workers' wages. Since 1999, family premiums have increased by 131 percent, workers' wages are up 38 percent, and inflation has been 28 percent. Drew Altman, the Kaiser Family Foundation's President and CEO, suggested that this sort of imbalance goes far in explaining why we are having a health reform debate because "when health care costs continue to rise so much faster than overall inflation in a bad recession, workers and employees really feel the pain."[18]

## NUMBER OF CHILDREN WITH COVERAGE RISES

A positive aspect of the 2008 data is that the number of uninsured children declined from 8.1 million (11 percent) in 2007 to 7.3 million (9.9 percent) in 2008. The number of uninsured children fell by more than 800,000 from 2007 to 2008 due to an increase in Medicaid and CHIP coverage which more than offset declines in employer-provided health insurance among children. In 2008, 1.7 million children were newly enrolled through Medicaid or CHIP.[19]

In spite of state budget deficits, the vast majority of states have managed to hold steady on children's health coverage and almost half implemented changes or enacted legislation to increase the number of children and families receiving health coverage through Medicaid and CHIP. Today, all but three states provide or have adopted plans to provide coverage to children with family incomes up to 200 percent of the federal poverty level

Figure 2 **Average Annual Premiums For Single and Family Coverage, 1999-2009**




Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2009.

(FPL).[20] While CHIPRA and the economic recovery package have assisted states in their coverage expansion efforts for children, there are still 7.3 million U.S. children who remain uninsured.[21,22]

## STATE FISCAL CONDITIONS REFLECT THE RECESSION

States continue to experience substantial fiscal distress. At the start of the 2010 fiscal year, the combined estimate of the budget gap for fiscal years (FY) 2009 and 2010 was more than $350 billion. The roughly $140 billion in federal fiscal relief provided by ARRA managed to reach states quickly and proved critical in helping address budget shortfalls, preserve Medicaid eligibility, and temper spending cuts.[23] The recovery package continues to assist states in this manner, but many state officials still expect that they will have to make budgets cuts in FY 2011.[24]

Presently, the state revenue situation is bleak. Many states depend heavily on sales taxes for state revenue but this is not a reliable source of funds during a recession, as both personal consumption and business purchases are decreasing. States are faced with a substantial decline in revenue, and continued job losses will depress revenues still further. At the same time, more people are finding themselves and their families without employer-provided coverage and therefore are turning to public programs like Medicaid and CHIP for health coverage.[25]

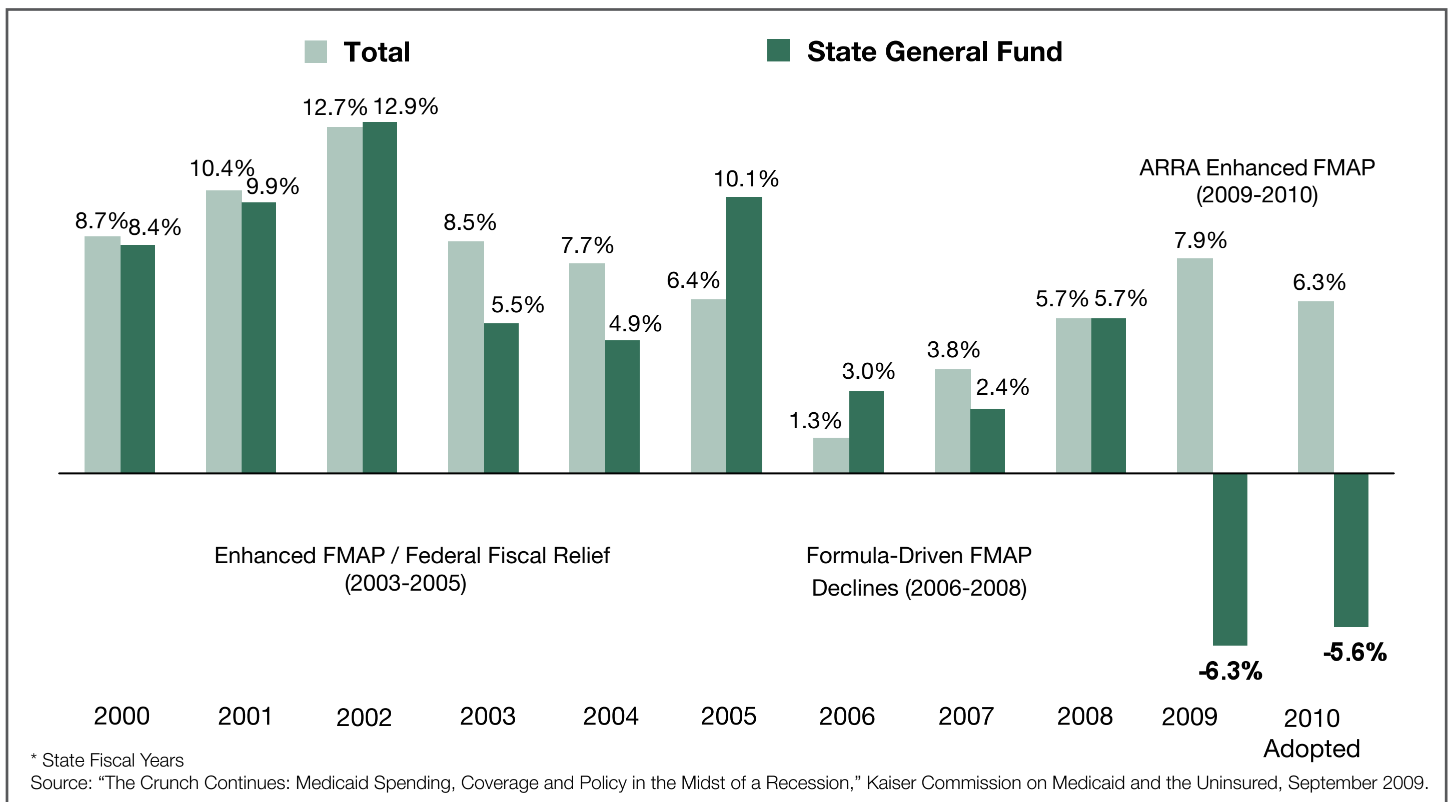
## DEMAND FOR MEDICAID GROWS

Financed by both the federal government and the states, Medicaid provides comprehensive health and long-term care coverage to 60 million low-income Americans. While some recent economic indicators show that the recession is coming to an end, any impact on unemployment rates with their related increases in Medicaid enrollment will lag behind other improvements in the economy.[26]

Enhanced federal Medicaid funds provided through ARRA included an estimated $87 billion for a temporary increase in the federal share of Medicaid costs. In order to qualify for these funds, states were not permitted to restrict their eligibility levels or enrollment processes. Due to this requirement, 14 states reversed and 5 states abandoned plans to restrict eligibility. Medicaid spending and enrollment growth accelerated in FY 2009 and FY 2010 due to effects from the recession. Enrollment growth was also higher than in previous years; the average increase in FY 2009 was 5.4 percent, and an additional 6.6 percent is predicted for FY 2010. With the increased caseload, total Medicaid spending growth averaged 7.9 percent in FY 2009. This was the highest rate of growth in six years.[27]

Medicaid ARRA funding began in October 2008 and ends December 2010. Given this timeframe, states are worried that they will have to cut back on Medicaid eligibility if the supplemental funding is not extended. States

Figure 3 **Total and State Funds Medicaid Spending Growth FY 2000 - FY 2010***




* State Fiscal Years

Source: "The Crunch Continues: Medicaid Spending, Coverage and Policy in the Midst of a Recession," Kaiser Commission on Medicaid and the Uninsured, September 2009.

are already considering this deadline because they are legally required to balance their 2011 budgets by July 2010. While at least 48 states addressed or are facing budget shortfalls for fiscal year FY 2010, 39 states have already looked ahead and foresee deficits for FY 2011.[28]

## STATES NAVIGATE POLITICAL AND ECONOMIC UNCERTAINTY

In 2009, state fiscal assistance from ARRA was instrumental in somewhat alleviating both state budget cuts and state tax increases. It has allowed states to close 30 to 40 percent of their state budget gaps, which in turn has preserved hundreds of thousands of jobs and prevented further distress to the national economy.

Economic forecasters have worked to determine the extent to which budget cuts and tax increases at the state level will negatively affect the economy. Estimates show that state deficits for FY 2011 will total at least $180 billion, with about $40 billion of ARRA funding likely available to states in the same fiscal year. The remaining $140 billion deficit in FY 2011 is projected to equal about 0.9 percent GDP, which could cost the economy about 900,000 jobs.[30] With this loss would come a rise in the uninsured and thereby a greater demand for public health insurance programs, such as Medicaid.

In the area of Medicaid, the President's Council of Economic Advisors has found a strong relationship between the fiscal relief funding provided through state Medicaid programs and the retention of jobs over the last year. There is great concern that the majority of states will be unable to maintain current income eligibility levels when Medicaid fiscal relief from ARRA ends during the middle of the states' fiscal year on December 31, 2010. If states cannot soon expect that they will receive more fiscal relief, then they will have to start making plans for budget cuts and tax increases to take effect in FY 2011.[31] While federal plans for state fiscal relief in FY 2011 is one major uncertainty for states, the other major uncertainty is the many different aspects of what will be expected from states if federal health reform legislation passes.

While state Medicaid officials are generally supportive of an expanded role for Medicaid as one approach to expanding health coverage to more people, states have serious concerns about their ability to take on the fiscal and administrative burden that could potentially be placed on them.

For states, 2009 has been a year truly unlike any other in history. They entered the recession with the largest reserves on record and since then have experienced an unprecedented decline in revenue. In the midst of this, most states have put on hold any plans for state health reform as they look to what will come of federal health reform legislation.[32] States will potentially need to transition from coping with budget shortfalls, to swiftly—in partnership with the federal government—taking on new challenges and responsibilities.

## STATE HEALTH POLICY HIGHLIGHTS IN 2009

Oregon passed comprehensive health reform, Colorado enacted a major coverage expansion, and Connecticut established a roadmap for comprehensive reform. In addition, 18 states enacted or implemented legislation to expand Medicaid and CHIP programs.

**Alabama**—Over Governor Bob Riley's veto, CHIP eligibility increased from 200 percent to 300 percent FPL.

**Colorado**—Expanded its CHIP eligibility levels for children from 205 percent to 250 percent FPL; enacted a bill that will use a fee assessed on hospital services to provide a medical assistance program to childless adults with incomes up to 100 percent FPL; passed legislation that requires the state to establish a process for online and telephone re-enrollment of Medicaid and CHIP beneficiaries; passed a bill that prohibits insurance companies from using gender as a factor in determining rates and benefits for individual health plans; and expanded coverage to lawfully residing immigrant children.

**Connecticut**—The legislature overrode Governor M. Jodi Rell's veto to establish the SustiNet Plan—a framework for universal health coverage and health system delivery innovations. The bill appoints a nine-member board and multiple committees and task forces to produce implementation recommendations in the form of legislation by January 2011, with the plan ultimately taking effect in 2012.

**Iowa**—The legislature approved a $7.5 million CHIP expansion to include children and pregnant women in families with incomes up to 300 percent FPL, and expanded coverage to lawfully residing immigrant children.

**Kansas**—Passed a state budget that includes funding for a CHIP expansion from 200 percent to 250 percent FPL.

**Massachusetts**—In response to 2008 legislation, several Massachusetts commissions issued reports. These included: "Recommendations of the Special Commission on the Health Care Payment System (July);"[33] "Roadmap to Cost Containment: The Massachusetts Health Care Quality and Cost Council Final Report (October);"[34] and a "Framework for Design and Implementation by the Massachusetts Patient-Centered Medical Home Council (November)."[35]

**Minnesota**—Awarded grants to 39 communities to support local, sustainable public health grants to promote system-wide changes that would prevent and reduce obesity and tobacco use. Over two years, the program will award $47 million to 86 communities around the state. The Statewide Health Improvement Program (SHIP) grants are projected to save the state $1.9 billion by 2015.

**New Jersey**—Used state income forms for express lane eligibility for Medicaid and CHIP (Iowa and Maryland also did this).

**Ohio**—Passed legislation that requires dependent child coverage up to age 28 in group health plans, reduces rates that insurers can charge people who have preexisting conditions, and requires employers to offer uninsured employees the opportunity to purchase coverage through Section 125 cafeteria plans.

**Oklahoma**—Enacted legislation that requires the Oklahoma Health Care Authority and the Insurance Department to create a new coordinating entity—the Health Care for the Uninsured Board (HUB).

**Oregon**— Enacted two pieces of legislation that will extend health insurance to nearly 200,000 previously uninsured Oregonians through the Oregon Health Plan and a newly created "Kids Connect" plan (the legislation includes a CHIP expansion from 185 percent to 200 percent FPL); merged a number of government departments into a new entity, the Oregon Health Authority, that will oversee efforts to reduce health care costs and improve efficiency and quality; and expanded coverage to lawfully residing immigrant children.

**Pennsylvania**—Launched three multi-payer regional initiatives to support primary care and improve chronic care in the state. This is in addition to the first regional roll-out that occurred in May 2008, and it will be followed by three more regions in 2010, for a total of seven regional projects throughout Pennsylvania. The demonstration program includes support and training for delivery system reform and performance-based add-on payments for primary care practices.

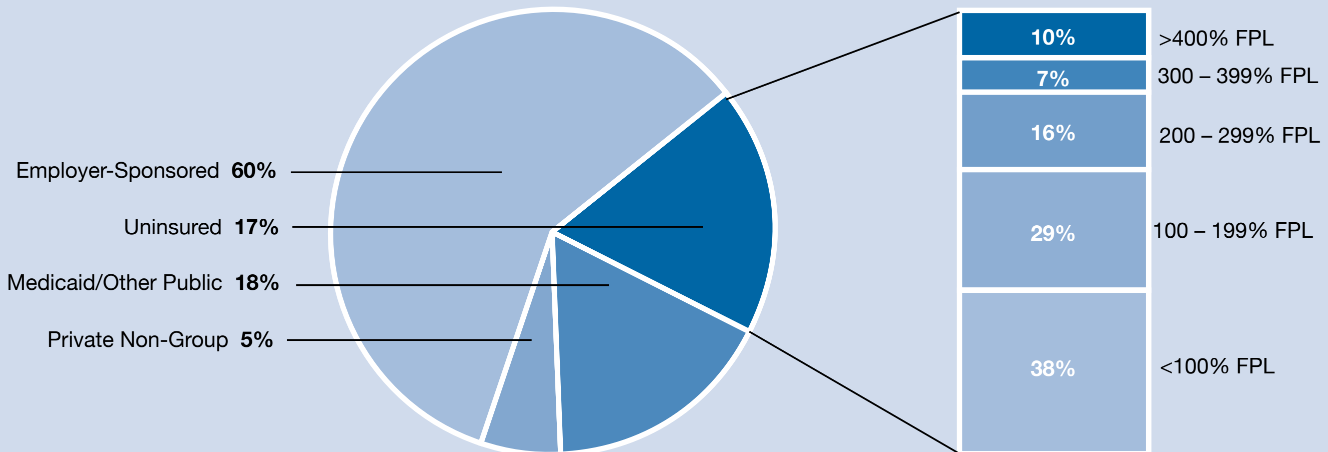
**Texas**—Passed legislation that will create the Healthy Texas program, a reinsurance-based initiative designed to provide affordable health insurance to small business owners, their employees, and their families.

**Utah**—Established the Utah Health Exchange. It was piloted in the fall of 2009 and will be open to all eligible enrollees in the spring of 2010. The exchange will target small businesses and will enable employees to choose plans from a menu of options. These options will reflect those available in the open market. Risk rating is allowed, but there will be some risk-sharing between plans participating in the exchange.

**Washington**—Issued a request for proposals (RFP) for large and small practices to join a Patient-Centered Medical Home Collaborative. The practices for the collaborative were selected and training began.

**Wisconsin**—Expanded coverage to childless adults with incomes not exceeding 200 percent FPL through the BadgerCare Plus program. Due to budget constraints, they were forced to suspend enrollment on October 9, 2009 and institute a waiting list.

Figure 4 **The Nonelderly Uninsured As a Share of the Population and by Poverty Levels, 2008**




Source: "The Uninsured: A Primer," Kaiser Commission on Medicaid and the Uninsured, October 2009.
Note: Statistics cited in this section may differ slightly as a result of coming from different sources. They reflect the same general trends.

### Number of Uninsured Increases in 2008, but Fewer Uninsured Children[36]

- The total number of uninsured increased in 2008 to 46.3 million from 45.7 million in 2007. The increase in the percentage of individuals without health insurance to 15.4 percent from 15.3 percent is not statistically significant.
- The percentage of individuals covered by private health insurance dropped from 67.5 percent in 2007 to 66.7 percent in 2008.
- The percentage of children under 18 without health insurance dropped from 11 percent in 2007 to 9.9 percent in 2008. This is lowest percentage recorded since 1987 when these data were first collected.
- Rates of uninsurance continue to differ significantly across the country (See Figure 1). On a regional level, the Midwest and Northeast had the lowest rates of uninsurance (11.6 percent for each), followed by the West (17.4 percent), and the South (18.2 percent). States with the lowest uninsurance rates include Massachusetts (5.4 percent), Hawaii (7.7 percent), and Minnesota (8.5 percent), while states with the highest rates of uninsurance include Texas (25.1 percent), New Mexico (23.1 percent) and Florida (20.1 percent).
- Three states had statistically significant increases in their uninsured populations: Alaska, Michigan, and Texas.
- Four states experienced statistically significant decreases in their uninsured: Alabama, Massachusetts, Oklahoma, and Utah, as did the District of Columbia.

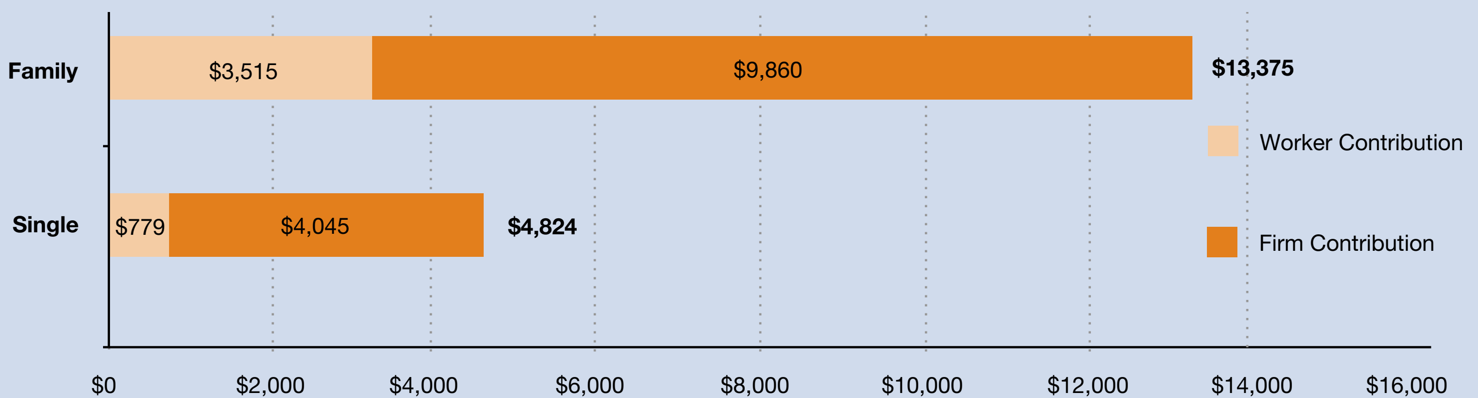
### Employer-Sponsored Insurance Continues Long Standing Decline[37]

- Employer-sponsored insurance rates declined again in 2008 to 58.5 percent, down from 59.3 percent in 2007. This decline continues the long term trend of decreasing employer-sponsored health insurance that began in 2000, when employer based insurance stood at 64.2 percent.[38]
- In 2009, 60 percent of employers offered health benefits to their employees, which is not statistically different from the 63 percent of employers who offered coverage in 2008.
- Employer-sponsored coverage continues to vary dramatically by firm size. Nearly all (98 percent) of large firms with 200 or more employees offered coverage, but only 46 percent of firms with 3–9 employees do so.
- Firm size is not the only factor that affects whether an employer offers coverage. Firms with fewer union workers and a higher proportion of lower-wage workers (defined as a firm where more than 35 percent of workers earn less than $23,000 annually) also offer insurance less often.
- Estimates in 2008 of employer-sponsored insurance may not reflect the full impact of the economic downturn as surveys are only able to capture information from those firms still in business and are unable to determine the extent of workers that lost coverage due to businesses failing. In addition, firms may have downsized, thereby covering fewer people.

### Public Program Enrollment Continues to Rise[39]

- The percentage of Americans covered by Medicaid increased again in 2008 to 14.1 percent from 13.2 percent in 2007.
- The decrease in employer-sponsored insurance was primarily offset by an increase in the number of people covered by all government programs. The number of people enrolled in these programs increased from 27.8 percent in 2007 to 29 percent in 2008.

Figure 5 **Average Annual Firm and Worker Contribution to Premiums and Total Premiums for Covered Workers for Single and Family Coverage, All Plans, 2009**




Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2009.

**Family Insurance Premiums Rise, Individual Premiums Remain Unchanged[40]**

- Since their most-recent low point in 1999, family health insurance premiums have risen 131 percent while worker contributions toward premiums have increased by 128 percent.
- Family health insurance premiums continued to rise in 2009 to $13,375, a 5 percent increase over 2008 (See Figure 2 or 5). Individual (single) premiums increased to $4,824 in 2009. However, this increase was not statistically different from the average individual premium ($4,704) in 2008.
- Relative proportions of individual and employer contributions to insurance premiums did not change dramatically during 2008. Covered workers paid 17 percent of premiums for individual coverage and 27 percent of premiums for family plans, compared to 15 percent and 25 percent, respectively, in 2008.
- With the continued increase in health insurance premiums, employers sought ways to better contain costs. One such method was to implement workplace wellness programs (such as weight loss programs, smoking cessation, gym membership discounts, etc.). In 2009, 57 percent of small firms (1-199 workers) and 93 percent of large firms (200 or more workers) offering health benefits also offered a wellness program. For large firms, this is an increase over the 88 percent that offered wellness benefits in 2008.

**American Community Survey Offers New Uninsurance Data[41]**

In September 2009, the U.S. Census Bureau released data from the American Community Survey (ACS), which provides health insurance information for the 2008 calendar year. This new survey includes a sample size large enough to enable state and local level health insurance estimates. There are a number of important differences between the ACS and the Current Population Survey (CPS), the source of much of the data reported in this section. Among these differences are:

- The ACS is a point in time survey that asks whether an individual has health insurance at the time the survey is administered. In comparison, the CPS asks whether an individual had health insurance at *any* point during the last calendar year.
- The CPS does not collect information from smaller cities and metro areas, whereas the ACS does.
- The ACS collects information from individuals in institutionalized settings (nursing homes and correctional facilities), while the CPS does not include those populations.
- The CPS sample size is 100,000, while the ACS sample size is 3 million, because of more robust collection efforts.
- While the CPS includes the names of local public programs, the 2008 ACS did not. Accordingly, there is the possibility that 2008 ACS respondents may not accurately reflect enrollment in state public programs. The 2009 ACS will remedy this problem by including state names for public programs.

  The development of the ACS does not mean CPS measurements should be abandoned, as there are over 20 years of data from the CPS. Using and merging information from both the CPS and ACS represents a major challenge to health services researchers but, with time, the uses and limitations of this new data source will become better understood.

**Who Are the (Non-Elderly) Uninsured?[42]**

Significant differences in the characteristics of the insured and uninsured populations continue. In addition, economic and social disparities persist within the non-elderly uninsured population.

- The majority, 82 percent, of the uninsured live in homes where the head of the household is employed.
- The uninsured tend to be members of lower income families. One-third of the uninsured are members of families that earn less than $20,000 annually. Roughly 35 percent of

individuals in families with incomes below $10,000 were uninsured as compared with only 6.8 percent of individuals in families with incomes above $75,000.

- Workers in certain industries are more likely to be uninsured. Workers employed in agriculture, forestry, fishing, mining, and construction were more likely to be uninsured than other industries, with 34.5 percent of those workers lacking insurance. This compares with 15.2 percent of workers in the manufacturing sector, 18.6 percent in wholesale and retail trade, and 22.5 percent in the service sector.
- The number of hours of work also has a significant impact on uninsurance, with part-time workers less likely to be insured. Workers employed on a part-time or part-year basis make up about 32 percent of the workforce but account for 47 percent of uninsured workers.
- Minority groups were more likely to be uninsured than whites. The 2007-2008 two-year average uninsurance rates are 14.4 percent for Whites, 31.4 percent for Hispanics, 19.3 percent for African Americans, and 17.2 percent for Asians. American Indians and Alaska Natives are particularly likely to be uninsured, with 30.7 percent lacking insurance.[43]
- Variation in coverage is also reflected in whether an individual is native-born or foreign-born, with 33.5 percent of foreign-born individuals being uninsured as opposed to only 12.9 percent of native-born individuals.[44]
- Young adults continue to make up the largest percentage of the uninsured. Young adults aged 18-24 and 25-34 have uninsurance rates at 28.6 percent and 26.5 percent, respectively.[45]

# MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM:

## MEETING THE NEED IN A STRUGGLING ECONOMY

Throughout the current recession, Medicaid and the Children's Health Insurance Program (CHIP) have played a critical role in providing health insurance coverage to individuals and families who have lost affordable coverage. With the national unemployment rate at 10.0 percent in December 2009—up from 4.9 percent at the start of the recession in December 2007—demand for public health insurance programs is high.[46,47] Unemployment attributable to the recession has only compounded the downward trend that has persisted since 2001 in the percentage of people with employer-sponsored health insurance.

At the same time, states have had to cope with weakened state revenues and budget gaps. When states started fiscal year (FY) 2010 on July 1, at least 48 states had recently addressed or were facing budget shortfalls, totaling $179 billion or 26 percent of state budgets.[48] Even before the financial crisis, many states were facing budget deficits that forced them to raise revenues, cut spending, or both. In light of this budget crunch for the vast majority of states, the federal matching funds provided in 2009 through both the reauthorization and strengthening of CHIP in the Children's Health Insurance Program Reauthorization Act (CHIPRA) and the enactment of the American Recovery and Reinvestment Act (ARRA) have been crucial in aiding states to balance their budgets while minimizing harmful cuts in public services.[49]

### CHIPRA AND ARRA PROVIDE CRITICAL SUPPORT TO STATES

President Obama signed CHIPRA into law on February 9, just three weeks into his term, in order to provide states with funding to expand eligibility for their programs, and to create new fiscal incentives and tools for states to cover more children already eligible for both CHIP and Medicaid.[50] On the same day that he signed the renewal of CHIP into law, President Obama issued a memorandum that voided previous restrictions the Bush administration had placed on state efforts to use CHIP funding to expand coverage to children in families with incomes above 250 percent of the federal poverty level (FPL). The Bush restrictions, collectively known as the August 17 directive, were designed to ensure maximum enrollment of children below 200 percent FPL and minimize crowd out of private insurance. However, state leaders argued that the provisions of the directive were impossible to meet and left thousands of children without health care coverage. Though the directive's barriers to expanding coverage have been dropped, the CHIP renewal legislation does contain a provision that limits the federal matching rate to states expanding coverage above 300 percent FPL to the less generous Medicaid reimbursement rate.[51]

Medicaid and CHIP now insure almost one-third of all children in this country. About 1.7 million children were newly enrolled through Medicaid or CHIP in 2008 but about 7.3 million (9.9 percent) remained uninsured

for the same year.[52,53] States are required to extend Medicaid eligibility to children under 6 years old living in families with incomes at or below 133 percent FPL, and to children ages 6-18 living in families with incomes at or below 100 percent FPL.[54] States have the authority to expand Medicaid income eligibility beyond these federal minimum standards or to cover children above their Medicaid eligibility levels through CHIP, which covers about 6 million children.[55]

The key provisions in CHIPRA are:

- Increased funding and a revised formula for distribution of funds among states that leads to more consistent funding levels over time;
- Incentives for increased outreach and enrollment;
- Streamlined documentation of citizenship; and
- Authority to states to allow coverage of legal resident children who are not citizens.

ARRA provided $87 billion to states for a temporary increase in the federal share of Medicaid costs from October 2008 through December 2010. More than half of states (29) reported that the Medicaid ARRA funds and eligibility requirements helped to avoid or restore eligibility cuts in 2009.[56] This maintenance of effort can be attributed to the requirement that states not restrict their Medicaid eligibility standards or procedures more than those in place on July 1, 2008 in order to be eligible for the enhanced federal matching funds.

While ARRA has helped states address budget shortfalls, preserve Medicaid eligibility, and avoid or mitigate severe program cuts, nearly every state implemented at least one new Medicaid policy to control spending in fiscal years 2009 and 2010.[57] For example, many states cut Medicaid provider payment rates. In FY 2009, 33 states either cut rates to one or more categories of providers or froze rates to hospitals and/or nursing homes. This number increased to 39 states in FY 2010. These cuts reverse the trend of recent years in which states

Table 1 **States Moving Forward on Child and Family Health Coverage in 2009**

| State | Eligibility Expansion | Simplification Measures |
|---|---|---|
| Alabama | X | |
| Alaska | | X |
| Arkansas | X | |
| Colorado | X | X |
| Delaware | X | |
| Florida | | X |
| Hawaii | X | |
| Iowa | X | X |
| Kansas | X | |
| Louisiana | | X |
| Montana | X | |
| Nebraska | X | |
| New Hampshire | X | |
| New Jersey | | X |
| New York | X | X |
| North Dakota | X | |
| Ohio | X | |
| Oklahoma | X | |
| Oregon | X | X |
| Rhode Island | X | X |
| Washington | X | X |
| West Virginia | X | |
| Wisconsin | | X |
| **TOTAL** | **18** | **11** |

Source: "Weathering the Storm," Georgetown University Center for Children and Families, September 2009.

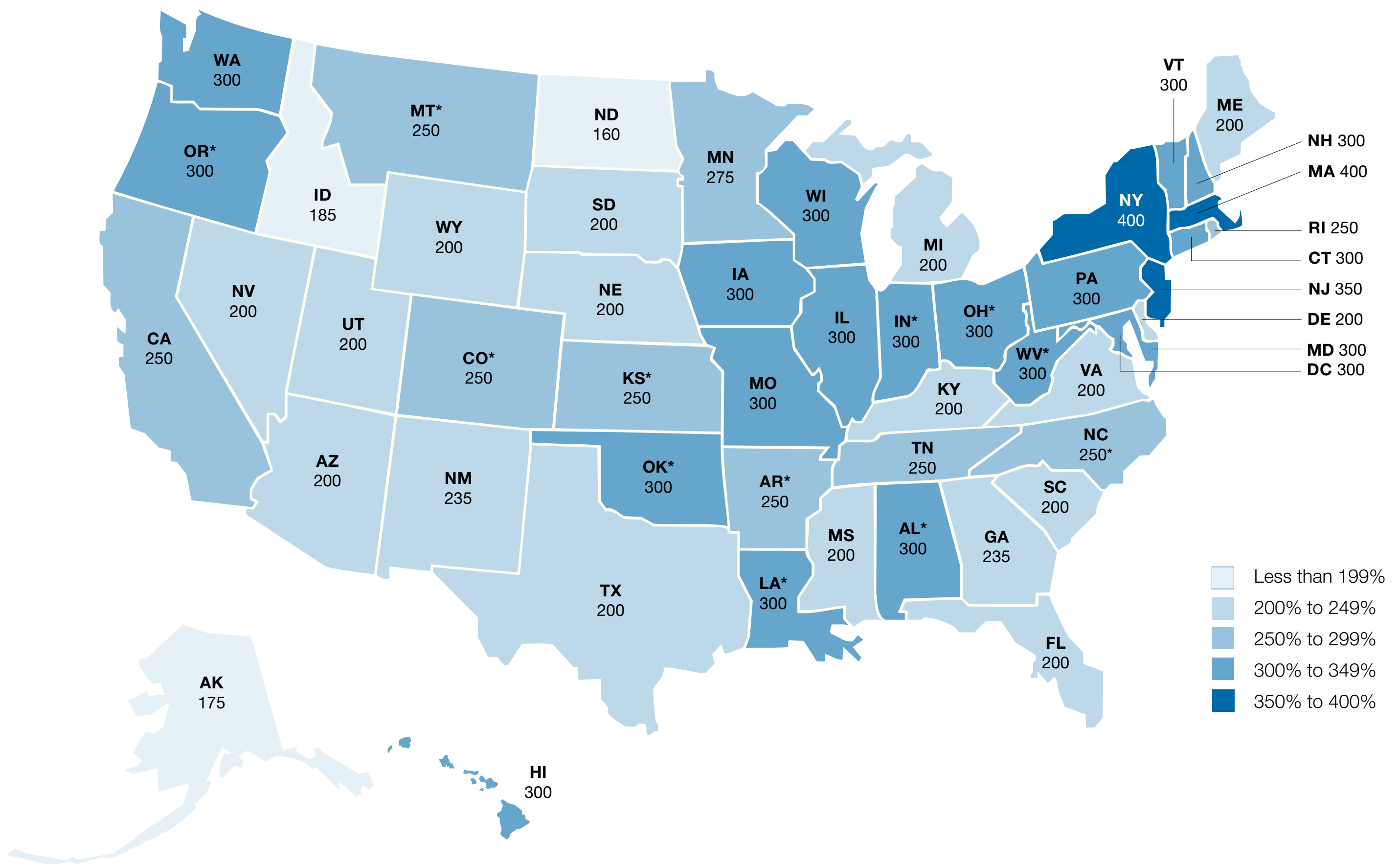
were in a position to use enhanced payment rates to improve physician participation and patient access to the program.[58] While this change is just one aspect of the major story of 2009 for states—the national recession and budget shortfalls—another major story is that CHIPRA and ARRA, in combination, have enabled states to maintain and even expand their coverage for children during tough economic times.

## STATES MOVE FORWARD ON CHILDREN'S COVERAGE FOLLOWING CHIPRA

There was the real possibility in 2009 that states would not be open to the opportunities and incentives in CHIPRA. At a time when children and their families were most likely to lose private health insurance coverage, having no viable public programs would have been greatly detrimental to children's health. A recent study published in the *Journal of Public Health* analyzed data on more than 23 million U.S. children for 18 consecutive years and found that uninsured children who are hospitalized are 60 percent more likely to die in the hospital than insured children.[59] The study also found that children who are hospitalized for complications that could have been avoided by preventive care, such as asthma or colds that progressed to pneumonia, are much more likely to die if they do not have insurance. However, among children hospitalized because of trauma, the death rates are the same for both uninsured and insured children.

This study sheds light on the value of the preventive care that occurs in a pre-hospital setting and underscores the importance of affordable health insurance coverage and accessible health care for all children.[60] It is, therefore, encouraging to see that in 2009 nearly all states avoided cutting children from Medicaid or CHIP and close to half of all states are moving forward to cover more children. Despite major fiscal challenges, a

Table 2: **Enacted Medicaid & CHIP Eligibility Levels for Children by State as of September 1, 2009**




Source: D. Cohen Ross, & C. Marks, "Challenges of Providing Health Coverage for Children and Parents in a Recession," Kaiser Commission on Medicaid and the Uninsured (January 2009); updated by the Georgetown University Center for Children and Families.

Notes: States with asterisks ( * ) have enacted but not yet implemented expansions to the levels shown. Illinois, Massachusetts, and Wisconsin provide state-financed coverage to children above Medicaid/CHIP levels.

substantial number of states expanded eligibility for their Medicaid or CHIP programs, eased the enrollment process for uninsured children already eligible for Medicaid or CHIP, or did both.[61] Medicaid and CHIP improvement efforts tend to fit into two main categories: 1) increasing income eligibility levels; and 2) finding, enrolling, and keeping eligible children covered.[62]

## MANY STATES EXPAND INCOME ELIGIBILITY FOR CHILDREN

Between January and September 2009, 18 states expanded, or enacted legislation to expand, income eligibility for their Medicaid and CHIP programs. Of these states, Colorado, Iowa, Oregon, and Rhode Island also expanded coverage to lawfully residing immigrant children. These four states are added to the 17 states which already had covered this population using state funds. Thirty-one states now provide, or plan to provide, coverage to children at or above 250 percent FPL, and every state, except for Alaska, Idaho, and North Dakota, has chosen to cover children at or above 200 percent FPL (See Table 2).[63]

Iowa was one of the first states following the passage of CHIPRA to expand children's income eligibility. In April, the Iowa legislature approved a $7.5 million CHIP expansion to include children and pregnant women in families with incomes up to 300 percent FPL. The expansion took effect in July and should cover 53,000 uninsured children. The bill passed with full support in the House and broad support in the Senate. Lawmakers looked at this expansion as one step on the way to expanding coverage to everyone in the state.[64, 65]

In a landmark year for Oregon, the state passed a comprehensive health reform package with a significant children's expansion component. The legislation expands CHIP from 185 percent to 200 percent FPL, including coverage to all lawfully residing immigrant children. In addition, the state will create a new subsidized product through private health exchanges called "KidsConnect" for families between 200 and 300 percent FPL. Funding will come from a 1 percent assessment on most health insurance premiums and a 2.8 percent hospital tax on net revenues, combined with matching federal funds from CHIP.[66] (See pp. 22-23 for a full description of the Oregon reforms).

In Alabama, CHIP eligibility increased from 200 percent to 300 percent FPL. This expansion was adopted over the Governor's veto and is expected to cover an additional 14,000 children.[67] Colorado expanded its CHIP eligibility levels for children from 205 percent to number of children 250 percent FPL. Kansas passed a state budget

Table 3 **Year-by-Year Formula for Determining State Allotments**

| Federal Fiscal Year | Formula for State Allotments |
|---|---|
| 2009 | 110% of highest of:<br>• FY 2008 CHIP spending, with adjustments<br>• FY 2008 CHIP allotment, with adjustments or<br>• Projected FY 2009 spending as of February 2009 |
| 2010 | FY 2009 allotment, with adjustments |
| 2011 Re-basing year | FY 2010 spending, with adjustments |
| 2012 | FY 2011 allotment, with adjustments |
| 2013 Re-basing year | FY 2012 spending, with adjustments |

Note: Adjustments for health care inflation and child population growth in state.
Source: "CHIP TIPS: CHIP Financing Structure," Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, June 2009.

that includes funding for a CHIP expansion from 200 percent to 250 percent FPL; the state estimates that an additional 9,000 children will gain coverage. Implementation in Kansas will begin January 2010.[68]

## NEW CHIP FINANCING STRUCTURE PAVES THE WAY FOR INCREASED COVERAGE

While the most prominent change to CHIP's financing structure from CHIPRA is a substantial increase in the amount of federal funding available for that program through September 30, 2013, there has also been a significant change in the formula for distributing CHIP funds among states. The original 1997 CHIP statute set aside a specified amount of federal funding each year for states to use to expand Medicaid eligibility, create a distinct CHIP program, or adopt a combination approach. As CHIP programs multiplied, it became apparent that federal funding for CHIP was insufficient and that the distribution of funds among the states was problematic.[69] Under CHIPRA, states get a mostly steady level of federal funding for two years, followed by a "re-basing year" during which a state's allotment is recalculated based on its actual use of CHIP funds in the prior year. If a state has used all of its available funding then it will lock in that federal funding level for future years. If a state does not use all its available funds then it will receive a reduced allotment, with the unused money then redirected to other states.[70] Refer to Table 3 for more detailed information on the funding structure.

Between FY 2009 and FY 2013, the national CHIP allotments will total $68.9 billion. This increase in CHIP funding provides states with the money needed to maintain CHIP programs and to support increased coverage of children. An increase in coverage can include expanding CHIP eligibility, enrolling more eligible but uninsured children, or investing more in the scope and quality of care provided to CHIP children. States that significantly expanded Medicaid for children before CHIP was enacted in 1997 have increased flexibility to use their CHIP funds to help finance Medicaid expansions for children's coverage.[71]

## STATES ARE AWARDED SIGNIFICANT FUNDING TO REACH AND ENROLL UNINSURED CHILDREN

In keeping with CHIP's new financing structure, a major goal of CHIPRA is to cover more of the millions of uninsured children who are already eligible for Medicaid or CHIP, but whose families are not aware of the programs, face administrative barriers to enrollment, or confront numerous challenges when attempting to renew their children's coverage.

As part of CHIPRA, a total of $80 million was set aside for states for the outreach involved in finding and enrolling eligible children. Secretary Kathleen Sebelius of the U.S. Department of Health and Human Services (HHS) announced in September that $40 million would go to 69 grantees in 41 states and the District of Columbia to help achieve this goal. Secretary Sebelius noted the urgency of this funding given the millions of American families who may have lost access to health coverage due to increased unemployment. The first $40 million is for a two-year period ending December 31, 2011, with the other half to be awarded as new grants in a second round. Most of the grantees, primarily community-based organizations, will focus their efforts on multiple, community-based approaches. The grants require that recipients demonstrate increases in enrollment and retention of children already enrolled, and also report activities that were deemed most effective in outreach and maintenance. These lessons learned will help states better understand their under-18 population and the ways that they can enroll and keep children covered in public programs in the future.[72]

## CHIPRA PROVIDES INCENTIVES FOR ENHANCING CHILDREN'S COVERAGE

Under CHIPRA, states that are focused on increased enrollment and retention now have the opportunity for important financial support: the Medicaid Performance Bonus. The bonus program recognizes the additional costs to states that make a concerted effort to enroll eligible children in Medicaid above targets specified in the law, and is designed to help offset some of those costs. The state receives the Medicaid bonus as a lump sum payment, but essentially the bonuses increase a state's federal Medicaid matching rate.[73]

To qualify for the performance bonus, states needed to adopt at least five of the following eight policies (known as the "5 of 8" policy measures) in both Medicaid and CHIP:

Table 4 **Examples of Effective Medicaid Match Rate for Achieving Enrollment Targets**

| Enrollment up to 100% of Target (regular match rate) | Enrollment between 100% and 110% of Target | Enrollment above 110% of Target |
|---|---|---|
| 50.0% | 57.5% | 81.25% |
| 60.0% | 66.0% | 85.0% |
| 70.0% | 74.5% | 88.75% |
| 80.0% | 83.0% | 92.5% |

Source: "CHIP TIPS: Medicaid Performance Bonus," Kaiser Commission on Medicaid and the Uninsured and the Georgetown University Center for Children and Families, April 2009.

- 12-month continuous coverage
- No asset test (or simplified asset verification)
- No face-to-face interview requirement
- Joint application and the same information verification process for separate Medicaid and CHIP programs
- Administrative or ex parte renewals
- Presumptive eligibility
- Express Lane eligibility
- Offer a premium assistance option (not required to be offered to both Medicaid and CHIP beneficiaries)

The strategies required for performance bonus eligibility have been shown to be effective in increasing enrollment and retention of eligible children. Better enrollment and retention leads to greater access to children's preventive care and improvement in health outcomes. If states determine that their existing enrollment and renewal policies do not allow for bonus eligibility, states may need to consider implementing additional strategies in order to qualify for the bonus. Bonus calculation for the first three years will be based on the number of children enrolled under the state's eligibility criteria as of July 1, 2008. For 2010 and beyond, the "5 of 8" policies must be in place for the full federal fiscal year for the state to qualify for a bonus. Bonuses will be paid by December 31 following the end of the fiscal year.[74]

## STATES CONTINUE TO MODERNIZE MEDICAID AND CHIP OUTREACH, ENROLLMENT, AND RENEWAL

While the Medicaid Performance Bonus is a major incentive for the improvement of Medicaid and CHIP enrollment and renewal procedures, states learned prior to bonus availability that these strategies expand coverage, increase efficiency, and strengthen program administration; many have implemented these types of changes proactively. This progress continued in 2009, with 11 states (including 6 that also expanded eligibility) opting to improve enrollment and renewal procedures.[75] Although significant variation exists among states in the extent to which they have adopted different enrollment simplification strategies, most states have implemented three key strategies for both Medicaid and CHIP programs: 1) elimination of the asset test, 2) elimination of in-person interviews, and 3) use of joint Medicaid-CHIP applications.[76]

In addition to expanding CHIP coverage for children, Colorado passed legislation in May that requires the state to establish a process for online and telephone re-enrollment of Medicaid and CHIP beneficiaries. The bill codifies a project that was underway administratively in the state's Department of Health Care Policy and Financing.[77] The state also enacted legislation to provide children in Medicaid with a full year of coverage, regardless of slight monthly fluctuations in family income.[78] Oregon opted to do the same, along with eliminating the asset test for CHIP and simplifying the application and renewal process.[79]

### Express Lane Eligibility: Some Promising Strategies

To help states address the challenge of reaching uninsured children who qualify for public programs, CHIPRA created a new Express Lane Eligibility (ELE) option. ELE's basic concept is straightforward: if another government agency or program (e.g., food stamps, the National School Lunch Program, etc.) has already found that a child meets an eligibility requirement for Medicaid or CHIP, a state implementing ELE can rely on that finding to grant health coverage, even if the other agency uses a different methodology for eligibility determination.

States can apply the ELE option within the context of state income tax forms.[80] CHIPRA specifically permits states to find children income-eligible for Medicaid or CHIP based on gross income or adjusted gross income shown on state income tax forms. The value of this application of ELE is suggested by the recent Urban Institute research finding that nearly 8 in 10 (79.4 percent) uninsured children who qualify for Medicaid or CHIP live in families who are legally required to file federal income tax returns. In states with income tax systems, a very high percentage of eligible, uninsured children are likely to live in families who file state income tax returns. States can therefore give parents an opportunity on their income tax forms to identify their uninsured children. Iowa, Maryland, and New Jersey did this in 2009, and hundreds of thousands of such children have been identified. New Jersey is taking the additional step of using ELE to qualify children as income-eligible for Medicaid and CHIP based on their parents' state income tax returns for the prior year.[81]

Unfortunately, very few children have been enrolled in response to these efforts, because each state requires parents to file an application form separately from the state income tax form. Iowa and New Jersey pursued a direct mail approach, sending

parents an application for health coverage. As has been seen with other campaigns that use direct mail to encourage low-income families to take advantage of available benefits, very few parents responded. Maryland sent notices telling parents how to apply for their children's coverage but very few applied. Given these disappointing responses, states could take these initial efforts a step further. Income tax forms could be modified to give parents an opportunity to request that the state tax agency share the parents' income tax information with the state health agency to facilitate more automatic eligibility determinations. Some experts believe that, in most states with income tax systems, this may be the single most promising post-CHIPRA approach for identifying and enrolling large numbers of eligible, uninsured children.[82] For more information about approaches to reaching uninsured but eligible children through express lane eligibility, refer to the State Coverage Initiatives' June 2009 issue of *St@teside.*

## CHIPRA REDUCES SOME OF MEDICAID'S CITIZENSHIP DOCUMENTATION RED TAPE

When U.S. citizens apply for Medicaid or attempt to renew their coverage, they must prove their citizenship by submitting a passport or a combination of a birth certificate and an acceptable identity document. Until CHIPRA, this documentation requirement enacted in 2006 also applied to children and often had a harmful impact on them because it caused many eligible citizen children to lose or be denied coverage. To help address this problem, CHIPRA requires that states provide otherwise-eligible applicants with a reasonable opportunity to submit documents before denying an application. The regulations state that the reasonable opportunity period should be consistent with the processing time for a Medicaid application, which is about 45 days.[83]

In addition, CHIPRA exempts from the documentation requirement infants born to women who were eligible for and receiving Medicaid and considers them automatically enrolled upon birth for one year. Once the year ends, parents no longer have to document their babies' citizenship in order to retain Medicaid eligibility. One last provision requires that states accept documents issued by federally recognized Indian tribes as documentation of citizenship.[84]

Starting January 1, 2010, states were given the option to verify a Medicaid or CHIP applicant's claim of U.S. citizenship or nationality by working with the Social Security Administration (SSA) to conduct a search of the SSA database. A successful match is considered as reliable as a valid U.S. passport, and thereby serves as proof of both citizenship and identity. States can receive a 90 percent federal reimbursement match rate for the development of systems capable of providing the name and Social Security numbers to SSA electronically. States also can receive a 75 percent match rate for the maintenance and operation of such a system.[85]

## CHIP AND MEDICAID ARE INCREASINGLY WORKING IN TANDEM

As evidenced in sections above, many CHIPRA provisions are designed to improve the efficiency and quality not only of CHIP programs, but also of Medicaid programs. While the federal government provides guidelines, sets rules and incentives, and shares responsibility for some elements of administering these programs, the states are charged with the day-to-day responsibility for managing these programs.[86] Alongside the evolution of the CHIP program, states have been increasingly working to improve coordination between Medicaid and CHIP. The vast majority of states with a separate CHIP program use the same application for Medicaid and CHIP. These coordination efforts, along with initiatives to simplify eligibility and streamline the application process, have all been integral to improving enrollment and retention in both programs.[87]

Included in these efforts, a handful of states are overhauling their information technology systems. For example, both Iowa and Pennsylvania have successfully implemented electronic referral systems between their Medicaid and CHIP systems. Evaluation of both systems demonstrates that effective coordination is preventing gaps in health coverage for eligible children and families.[88] Florida substantially revamped its enrollment processes to employ a highly-automated application and redetermination system that allows consumers to submit online applications. New York has developed a Web-based application for health providers which allows them to automatically enroll infants into Medicaid if the babies are born to mothers who are Medicaid beneficiaries.[89]

## STATES CAN LEARN FROM WISCONSIN'S EXPERIENCE WITH THE BADGERCARE PLUS PROGRAM

As part of Wisconsin's goal in 2008 to significantly increase its insured population, the state decided on a policy solution of expanding income eligibility limits for already-covered populations (pregnant women, children, parents, and caretaker relatives), creating coverage for a set of new populations (youth exiting out of home care, child welfare parents, certain self-employed parents, and childless adults), and—most substantially—housing all of these covered populations under a single program called BadgerCare Plus (BCP). By merging these various subprograms into one and simplifying eligibility rules, the state also significantly streamlined operations in order to provide more accessible, continuous, and efficient health care and to decrease administrative costs. Prior to the creation of BCP, Wisconsin, like most states, had a patchwork of complex eligibility rules and laws that were very costly to administer and often discouraged qualified families from enrolling because it was difficult for prospective applicants to determine if they might qualify. This uncertainty meant that many individuals and families delayed applying for assistance until they were very ill or suffering from an injury. Medicaid officials who designed BCP decided that simplifications to eligibility and enrollment processes could increase coverage while also saving the agency money.[90]

BCP is financed using state general revenue, federal matching funds from Medicaid and CHIP, and premiums paid by members. No federal funds are claimed for BCP coverage of individuals with family income between 250 and 300 percent FPL. BCP provides benefits under two different plans, the Standard Plan and the Benchmark plan. The Standard Plan is Wisconsin's benefit package that was offered in the past to Medicaid recipients. BCP members with incomes below 200 percent FPL and all youth leaving foster care are enrolled in the Standard Plan. Most BCP members have incomes below 200 percent FPL. Children and pregnant women with income above 200 percent FPL are enrolled in the Benchmark Plan. The Benchmark plan was modeled after the largest commercial plan and has more limitations and higher copayments than the Standard Plan. The rationale for this difference is that those with higher income have less financial need, but it is also meant to control costs and prevent crowd out.[91]

With the changes made to create BCP, approximately 42,000 individuals became newly eligible for coverage in February 2008. The program managed to rapidly enroll a remarkable number of participants, largely due to substantial outreach efforts focused on partnerships with community organizations, promotion of an online application tool, and financial rewards to organizations that submitted approved BCP applications.[92] By August 2009, BCP covered nearly 700,000 adults and children.[93] For more information on the design, challenges and operations of BCP, refer to the SCI's *Profile in Coverage* on BCP.[94]

## STATE EFFORTS TO COVER CHILDLESS ADULTS

Despite the many successes of the BCP program, Wisconsin has had to suspend enrollment for childless adults because the number of needy, low-income, uninsured adults has outstripped the resources the state had allocated.[95] Throughout the nation, a majority of uninsured Americans are low-income, childless adults who are not eligible for public programs. When Wisconsin's Governor Jim Doyle announced the BCP enrollment suspension in October, he pointed to the staggering demand for health coverage among low-income adults in the state and stated that he could "think of no clearer demonstration of the need for national health care reform" and that "despite the tremendous work (they) have done in Wisconsin, BCP and state plans like it are merely bridges to get (them) to national health reform."[96]

Wisconsin is one of 21 states and the District of Columbia that have attempted to cover childless adults through public programs.[97] Of those, only nine and the District of Columbia are currently operational, open to new enrollees, and not utilizing a waiting list.[98] This reflects both the need felt by states to cover this population and the financial challenges involved in maintaining these programs (often with only state funds). This was a particularly difficult year for childless adult programs. Indiana was forced to close its Healthy Indiana Program to new enrollees and Tennessee closed enrollment for CoverTN, a program that subsidizes employer-based coverage for low-income individuals and families. Washington state was unable to proceed with the start of the Health Insurance Partnership, which was scheduled to begin in early 2009, but have recently announced that they secured funds through the State Health Access Program (SHAP–see page 32) to enable them to move ahead with implementation in 2010.

## OREGON PASSES COMPREHENSIVE HEALTH REFORM

Oregon continued on its path to comprehensive reform in 2009 with the passage of two landmark health reform bills (HB 2009 and HB 2116) in June.[99,100] The bills represent the culmination of a two-year process to plan, propose, and enact a comprehensive redesign of the $19 billion spent in Oregon's health care system.

This process was first initiated with the passage of the Healthy Oregon Act (SB 329) in June 2007.[101] The Healthy Oregon Act created the Oregon Health Fund Board (OHFB), a seven-member board appointed by the Governor, confirmed by the Senate, and tasked with developing a plan to ensure adequate access to health care for all Oregonians, reduce the increasing growth of health care costs, and improve the quality of health care in the state. Over the course of its 14-month planning process, the OHFB created 7 committees, 2 working groups, and was assisted by more than 150 volunteer experts in various fields. The Board held 108 board and committee meetings and 25 statewide community forums soliciting the input from more than 2,000 citizens.[102] As a member of SCI's Coverage Institute, Oregon received funding for an actuary to assess the cost for a basic benefit package for the uninsured and a microsimulation modeling study of the impact of private market reforms, including employer requirements, a health insurance exchange, and Section 125 plans.

As a result of the robust planning process, in November 2008, the OHFB released *Aim High: Building a Healthy Oregon*, the board's blueprint for transforming Oregon's health care system. This blueprint called for a redesigned health care system that achieved three primary goals: a healthy population, extraordinary patient care for all, and reasonable per capita costs shared in an equitable way by the entire population. A central recommendation of the blueprint was to create an Oregon Health Authority to be a catalyst for change. The Authority will be an organizer and integrator of Oregon health care policy and purchasing functions, and the coordinator of the state's investments in health services innovation. The blueprint also called for a number of additional changes, including:

- Expanding insurance coverage to all children and low-income adults;
- Creating an all-payer claims database;
- Establishing a health insurance exchange;
- Setting standards for medical homes;
- Taking steps to help smaller medical practices adopt electronic health records; and
- Investing in public health measures, including programs that focus on tobacco use reduction and obesity prevention.[103]

As the OHFB moved to promote its proposals to state lawmakers in preparation for the 2009 legislative session, SCI assisted in funding a study to assess the level of public support for the blueprint's proposed overhaul. A household survey of 500 Oregonians and 2 focus groups showed strong support for all policy proposals of the blueprint (ranging from 77 percent to 89 percent depending on the policy).[104] With this broad public support as a basis, the Oregon legislature approved HB 2009 and HB 2116, which enacted nearly all of the OHFB's recommendations.

**Coverage Expansion:** HB 2116 represents the largest expansions of health insurance in Oregon since the creation of the Oregon Health Plan (OHP) in 1994, with a specific emphasis on coverage for all children. The bill expands health insurance coverage to all children in the state via four different mechanisms:[105]

- Children in families with incomes below 200 percent of the federal poverty level (FPL) and without access to employer-sponsored insurance can enroll in the OHP Plus benefit plan[106] with no premium costs.

On the other hand, both Colorado and Oregon passed reforms in 2009 to extend coverage to childless adults (in addition to expanding coverage for children and pregnant women). Colorado enacted legislation that will use a fee assessed on hospital services to provide a medical assistance program to childless adults with incomes up to 100 percent FPL.[111]

Oregon passed comprehensive legislation that includes funding for about 35,000 low-income adults to enroll in the Oregon Health Plan (OHP), enabling them to re-open a program that had been closed to new enrollees for several years. The funding to expand coverage to this and other populations in the state will come from a 1 percent assessment on most health insurance premiums and a 2.8 percent tax on hospital net revenues. These state resources, when combined with federal matching dollars, will provide approximately two billion dollars to support the coverage expansions.[112]

Both Oregon and Colorado have learned from previous state efforts and established a dedicated funding source for their program. They both are using provider taxes, which will generally grow at the rate of health care inflation. Other states have sought to make their initiatives sustainable by securing a Medicaid waiver to cover childless adults. Waivers create limitations on how the program can be designed and still requires a state match, but the use of federal funds can make the programs more resistant to being cut during difficult financial times.

- Children in families with incomes below 300 percent FPL with access to employer-sponsored insurance can now enroll in the existing Family Health Insurance Assistance Program[107] and receive sliding scale income premium assistance.
- Children in families with incomes between 200 percent to 300 percent FPL without access to employer-sponsored insurance can receive premium assistance in a new state created health plan—Kids Connect—offered by approved private insurance companies. In November, the Oregon Health Authority announced that it had awarded five companies contracts to administer this private program.[108]
- Children in families with incomes above 300 percent FPL can buy into Kids Connect, but must pay the full premium cost.

Enrollment for the OHP components of the bill began in August; the private insurance option will open for enrollment in January 2010. The bill also provides funding for 35,000 low income adults to enroll in the existing OHP Standard benefit plan[109] and for 88,000 additional low-income and disabled individuals to join the OHP Plus benefit plan. In total over 200,000 previously uninsured Oregonians will gain coverage.[110]

HB 2116 generates funding from a 1 percent assessment on most health insurance premiums and a 2.8 percent hospital tax on net revenues. These state resources, when combined with federal matching dollars, will provide approximately two billion dollars to support the coverage expansions.

**State Agency Restructuring:** HB 2009, the companion bill to HB 2116, establishes the Oregon Health Authority, which will consolidate most health related agencies (Public Employee Benefits, Medicaid, Public Health, and Mental Health and Addictions amongst others) into a single agency by 2011. The purpose of the Authority is to create major reductions in health care costs and bring more efficiency and transparency to the system. The Oregon Health Policy Board, a nine-member, citizen-led group appointed by the Governor and approved by the Senate, will be responsible for leading the Authority in its effort to increase access, reduce costs, and improve the health of Oregonians. In October, the Oregon Senate confirmed all members of the Health Policy Board, paving the way for it to begin implementing the changes called for in the Oregon reforms.

**Redesigning the Health Care System:** The Oregon Health Authority is working to spearhead a package of delivery system reforms. These reforms include the development of a business plan to implement and sustain a health insurance exchange (see pp. 28-31) and the simplification and standardization of transactions between medical providers and insurance carriers, and a requirement to collect all medical claims data in order to develop tools to allow the policymakers and consumers compare the cost and quality of care. The state will also be evaluating available options for reinsurance and other risk-sharing strategies in the individual and small employer health insurance markets to help control costs and reduce premiums. The Health Policy Board will investigate and report on the feasibility of insurance market reforms including an individual mandate requiring all Oregonians to purchase insurance, a payroll tax to fund coverage expansions, an expansion of the exchange to include a premium assistance program, and to advance the statewide implementation of interoperable electronic health records.

Other initiatives in the reform package will address health care workforce shortages, statewide electronic health information exchange, and guidelines for a primary care home model and payment reform.

## CONCLUSION: LOOKING FORWARD

If some form of federal health reform legislation passes in 2010, we could see an expansion of public health insurance programs. The reforms could include a Medicaid expansion to all individuals with incomes between 133 percent and 150 percent FPL. It is much less clear what the long-term fate of CHIP would be.[113]

In broad terms, state Medicaid officials are generally supportive of an expanded role for Medicaid, particularly because they have long used Medicaid as a means to expand health coverage. However, they do have a number of serious concerns. In light of the grim budget situation across the states, three-quarters of states reported in a recent Medicaid budget survey that they are worried about the potential fiscal impact of federal health reform on states. Many officials think it likely that their states would be unable to finance the cost of a Medicaid eligibility expansion unless the federal government assumed all of the costs—especially in the early years when states will continue to face severe fiscal constraints due to aftereffects of the recession.[114]

Some costs that states could be expected to bear, aside from the state portion needed for eligibility expansions, include mandated minimum provider rates, administrative costs related to enrollment and education, and—in response to an individual mandate—the cost of greater program enrollment among those who are currently eligible but not enrolled, also known as the

## CONNECTICUT PASSES PLAN FOR COVERAGE EXPANSION

In July 2009, Connecticut's Democrat-controlled legislature overrode Governor M. Jodi Rell's veto of House Bill 6600 (The SustiNet Plan) to establish universal health coverage and health system delivery innovations in the state.

The veto override brought to a close a politically-charged health reform effort that began in 2007, when the Connecticut General Assembly commissioned the HealthFirst Connecticut Authority, a 10-member blue ribbon commission to consider ways to achieve both universal coverage and access to safe, effective care for all Connecticut residents.[115]

To achieve these goals, the Authority established two workgroups: the Cost, Cost Containment and Finance Workgroup (CCCF) and the Quality, Access, and Safety Workgroup (QAS). More than 50 individuals representing a broad range of interested stakeholders made up each workgroup. The Authority held 27 meetings between October 2007 and December 2008 to review research and expert testimony, and also hosted nine public forums throughout the state.

The Authority released a final report in March 2009 outlining a coverage expansion proposal that included:

- Expanded Medicaid/CHIP eligibility for all residents with family incomes below 300 percent of the federal poverty level (FPL) with sliding scale cost-sharing; uninsured persons with access to employer-sponsored coverage receive premium assistance to purchase private coverage;
- Access to a restructured health insurance program which allows families to buy health insurance at premiums based on family income and regardless of their health status; and
- A Connecticut Health Partnership, based on the state employee health benefit plan, that would be made 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 recommended that a public entity be assigned or developed to oversee the proposed reforms and to better coordinate state spending on health care.[116]

At the same time, the Universal Health Care Foundation of Connecticut (UHCF) was developing a proposal, that it unveiled in January 2009, to create a large, self-insured, public health insurance option that would compete with private insurance. State employees would receive their coverage through this plan, called the SustiNet Plan, as would those already enrolled in the HUSKY program (the state's Medicaid and CHIP program for children and families). Additionally, the SustiNet Plan would be made available to any state resident who wanted health coverage. It would initially be offered to those who do not have access to employer-sponsored insurance and then would be gradually expanded to include small employers, individuals with inadequate employer-sponsored insurance, and eventually large employers. Rather than pursuing an individual mandate, the program was designed to automatically enroll those without insurance unless they opt out. While those individuals and groups choosing the SustiNet plan would have a different benefits package from state employees and from HUSKY enrollees, all plan members would benefit from key health care delivery changes. The result of this new plan would be that up to 98 percent of all state residents would have health coverage by 2014. UHCF officials also projected the program would save individuals and employers as much as $1.7 billion by 2014 and would lead to significant quality improvement.[117]

Key features of the SustiNet proposal included:

- Guaranteed health coverage paid on an income-based sliding scale, regardless of pre-existing conditions, job changes, or self-employment;
- A medical home for everyone in order to enhance care coordination, chronic care management, prevention and screenings, and culturally appropriate care;
- Implementation of electronic medical records;
- Incentives that encourage high-quality, evidence-based medicine;
- An emphasis on prevention and the reduction of ethnic and racial health disparities;
- Increased provider reimbursement rates for Medicaid and greater investment in health workforce development; and
- Improved public health interventions, with a focus on fighting obesity and tobacco use.[118]

Governor Rell vetoed the SustiNet plan on July 8, citing the measure as too costly in light of the state's bleak fiscal situation. Connecticut faces a projected $8.85 billion deficit over the next two fiscal years and the SustiNet plan, once fully implemented, was projected to cost the state government an estimated $1 billion per year due to higher Medicaid provider reimbursement and the provision of subsidies to those who can not afford the full cost of purchasing insurance. While Rell noted that the Democrats had not come up with a way to pay for the plan, the Democrats responded by noting that the bill will not be enacted immediately and will not cost the state money for the next two years. Both Rell and Republican legislators cited the possibility of imminent reform on the federal level as a reason to hold off on passing any sort of major reform in Connecticut. In fact, on the same day that Rell vetoed the health care bills, she also issued an executive order to create a 15-member advisory board that would create policies to respond to President Obama's expected reforms.

The legislature passed another health care bill—House Bill 6582, the Connecticut Healthcare Partnership plan—which the Governor also vetoed. The Partnership plan would have created a timetable for

## CONNECTICUT PASSES PLAN FOR COVERAGE EXPANSION (continued)

opening up the state employee health plan to municipalities, small businesses, and nonprofit agencies and would have converted the plan from fully-insured to self-insured. The bill would have enabled participating organizations to benefit from the large group bargaining power of the state pool, allowing them to purchase comprehensive coverage with lower premiums than what is currently available to them in the small group market. While the Governor vetoed the bill, she included in her proposed budget a provision to convert the state employee health plan to a self-insured plan.

Prior to Rell's July 8 vetoes, the two health care bills, cited as a priority among legislative leadership, had been broadly supported in both chambers of the legislature and passed with margins wide enough to expect that the legislature should have been able to override the vetoes if support for the bills had been maintained. In the end, both houses of the legislature overrode the Governor's veto of the SustiNet plan, but the Senate fell short by one vote in overriding her veto of the Connecticut Healthcare Partnership bill.[119,120]

Ultimately, the SustiNet legislation, HB 6600, that passed the Connecticut General Assembly maintains the framework of the SustiNet proposal, but postpones establishment of the health plan and financing until implementation planning can be done and the shape of federal health care reform is known. The bill appoints a nine-member board and multiple committees and task forces to produce implementation recommendations in the form of legislation by January 2011, with the plan ultimately taking effect in 2012. The bill also instructs the board to bring recommendations to the Connecticut General Assembly regarding the impact of federal reform on Connecticut's health care system 60 days after a federal health care reform bill is enacted.

"woodwork" effect. In addition, the current draft legislation requires that states maintain their current Medicaid eligibility levels, which would give them less flexibility as they attempt to deal with budget shortfalls, forcing them to use either provider payment cuts or benefit cuts to reduce program expenses. States could be helped with this dilemma if their increased FMAP rates are extended. Medicaid and CHIP directors say that coping with budget shortfalls is their most immediate priority.[121]

Many states are accustomed to playing a leading role in the expansion and improvement of health coverage, but the recession has highlighted the unique obstacles that states face in these efforts—particularly in the area of financing. While some governors have expressed real concern about additional coverage requirements during a time of financial crisis, others—like Governor Doyle quoted above—have publicly recognized the value of additional federal resources to address a long-standing problem: state residents who are unable to pay for needed health care or health coverage. Many states welcome an expanded federal role in providing health coverage for those who are unable to afford it on their own. These states just hope that federal policymakers understand the financial challenges facing states, and that they would be willing to enter into an effective partnership as both states and the federal government work toward the same goals.[122]

# STATE INSURANCE MARKET REFORMS

Over the past couple of years, states have continued to evaluate their insurance market structures and assess what options might be available to create opportunities for uninsured residents to access comprehensive coverage at a lower cost.

In general, state insurance market reform efforts have most recently focused on:

- Individual and small group rating reforms, including guaranteed issue and community rating, and prohibiting rating on certain factors such as gender and health status;
- Requiring or encouraging employers to offer Section 125 plans;
- Establishing/Implementing connector-like entities (exchanges); and
- Reinsurance mechanisms.

This section highlights some of the most innovative state-level efforts this year, with a particular emphasis on states' consideration of implementing exchanges, following in the footsteps of Massachusetts' efforts. Of course these efforts all occurred against the surrounding backdrop of the drama and uncertainty of health reform negotiations in Washington, D.C. As is often the case, states have been determined to focus on improvements they can make within their state borders with hopes that federal reform may bolster their ongoing efforts.

***Colorado:*** Governor Bill Ritter signed legislation in late May that prohibits insurance companies from using gender as a factor in determining rates and benefits for individual health plans. By preventing such gender discrimination, Colorado will join 12 other states that prohibit or restrict gender-based rating in the individual market. Middle-aged and younger women were being charged as much as 30 to 40 percent more than their male counterparts for the same coverage. In 2006-2007, more than 130,000 women in Colorado were insured through the individual market.[123]

***Ohio:*** Governor Ted Strickland signed House Bill 1 into law in the summer of 2009. The bill included several private insurance market provisions that will help more than 109,000 Ohioans gain access to health insurance over the next three years. The provisions of HB 1 include the following:

- Expand dependent child coverage in group coverage up to age 28, providing Ohioans with the opportunity to purchase coverage for their children who are just starting out, and reducing taxes by extending the state tax deduction for employer-sponsored coverage to all family and dependent coverage, making this coverage more affordable.
- Reform Ohio's individual open enrollment programs. Ohio's current open enrollment program requires carriers to guarantee issue at certain times of the year; that is, during specified open enrollment periods carriers must enroll individuals who have preexisting conditions such as diabetes, cancer, and pregnancy. However, the state had not placed any limits on the extent to which carriers may charge higher rates for such individuals. The change to the

law will now place limits on the ability of carriers to increase rates for individuals who have preexisting conditions such as diabetes, cancer, and pregnancy.

- Require employers to offer to uninsured employees the opportunity to purchase coverage with pre-tax dollars through Section 125 cafeteria plans, saving up to 40 percent of the cost of coverage for employees and their families by reducing the income taxes they pay, with only a very minimal cost to employers to set up these tax accounting mechanisms.

***Oklahoma:*** On May 6, 2009, Governor Brad Henry signed HB 2026 aimed at providing residents with increased access to affordable private health coverage. While a significant component of the legislation is the creation of a health insurance exchange (see pp. 28-31), HB 2026 also requires plans offered through Insure Oklahoma—the state's premium assistance program for low-income employees—to make additional low-cost options available, such as high-deductible plans that are compatible with a health savings account.

Other measures in the bill include:

- Providing incentives to businesses that offer Section 125 plans so employees can use pre-tax dollars to purchase health care coverage;
- Reforming the individual market to enable insurers to offer basic catastrophic coverage plans with pre-deductible preventive services; and
- Establishing a program to initiate health insurance enrollment of uninsured patients at the point of health care service delivery.[124]

***Texas:*** The Texas legislature recently passed SB 78 that will create the Healthy Texas program, designed to provide affordable health insurance to small business owners, their employees, and their families.[125] The program was created in response to legislation enacted in 2007 which directed the Texas Department of Insurance (TDI) to conduct a study and develop recommendations for a small employer insurance program.

While there are some distinct differences, the Texas program builds on the experience of New York's HealthyNY program which uses a reinsurance mechanism to lower premium costs. The reinsurance approach is driven by the fact that a small percentage of people account for most health insurance costs. Reducing private insurers' responsibility for high-cost claims allows them to provide lower cost insurance to everyone.

Employers that meet Healthy Texas eligibility criteria will choose between a standardized benefit package or several customized options offered by a variety of comprehensive, state-approved, private market health plans, including approved three-share programs which are often community-based programs where the employer, employee, and a public entity each pay for one third of the premium. The state-funded reinsurance fund will pay 80 percent of an individual's total claims between $5,000 and $75,000 incurred in a calendar year. The health plan covers 100 percent of claims below the $5,000 threshold and above $75,000 as well as 20 percent of claims between $5,000 and $75,000, up to the maximum annual benefit limit. Based on Texas data reported to TDI by health insurers and similar national data, approximately 10 percent of insured people incur claims of $5,000 or more in a year and less than two percent incur claims exceeding $25,000 in a year.

As part of SCI's Coverage Institute, Texas was able to procure actuarial analysis which estimated that Healthy Texas premium costs will be reduced by at least one-third through the provision of reinsurance. Total employer/employee premiums are expected to average approximately $200 per month, with the employer paying a minimum of 50 percent. Carriers are limited to rating on age, gender, and geographic area. All Healthy Texas rates are subject to TDI approval. To ensure the program reaches the lowest wage workers, small employers are eligible for the program if at least 30 percent of their workers earn wages that do not exceed 300 percent of the federal poverty level (FPL). Businesses also must not have offered insurance within the past 12 months. The program allows a lower minimum employee participation rate of 60 percent compared to 75 percent in the current small employer market.

The legislature provided $35 million to pay reinsurance claims for fiscal year 2010– 2011, with unspent funds remaining in the program for subsequent years. Depending on when Healthy Texas begins enrolling members and the level of actual claims costs, TDI estimates that enrollment in the first full year of the program will cover 26,000 to 30,000 lives. TDI has also received a grant through the federal Health Resources and Services Administration (HRSA) State Health Access Program, providing the state with funds to potentially increase enrollment and also provide qualifying enrollees with financial assistance to meet their premium or cost-sharing requirements. TDI hopes to begin enrolling groups by the summer of 2010.

***Rhode Island:*** Rhode Island's Office of the Health Insurance Commissioner (OHIC) recently embarked on an innovative project to address the affordability of health care in Rhode Island by focusing on the inadequacies of current provider payment systems to support primary care.[126] The priorities include:

- Expand and improve the primary care infrastructure in the state (with limitations on the ability of insurers to pass on the additional costs to consumers through premiums);
- Spread adoption of medical home models focused on chronic care;
- Standardize incentives for electronic medical records (EMR); and
- Work toward comprehensive payment reform across the delivery system.

Standards were developed to reflect these priorities and assure that health plans would be held accountable. Using these standards, starting in January 2010, health plans will:

- Be held accountable for increasing the proportion of their medical expenses spent on primary care by 5 percentage points over the next five years. This money is an investment in improved care coordination, not a simple shift in fee schedules. So, for the first year, a 1 percentage point increase in primary care spending equates to

## ARRA CREATES OPPORTUNITY FOR STATES TO EXPAND MINI-COBRA PROGRAMS

During 2009, ARRA provided an enormous amount of financial resources to states. Among the myriad of programs that ARRA has helped to maintain, significant relief for uninsured laid-off workers under the Comprehensive Omnibus Budget Reconciliation Act of 1985 (COBRA) was provided. COBRA allows for the temporary extension of group health coverage at group rates to people whose health benefits otherwise would be terminated. ARRA pays 65 percent of premiums for COBRA coverage. An eligible, laid-off worker pays 35 percent of the premium. After receiving the worker's payment, the health plan collects the 65 percent subsidy by reducing the income and payroll tax withholding it would otherwise owe the federal government for all of its own employees.

For each subsidy recipient, the federal assistance ends after nine months. To qualify, laid-off workers must meet the following requirements:

- They lost their jobs between September 1, 2008 and December 31, 2009.
- Their only current access to employer-sponsored insurance is through their former employer. Accordingly, they do not have an offer of dependent coverage from their spouse's employer, and they have not begun a new job that offers them insurance.
- They are ineligible for Medicare.
- Their income is below $145,000 a year for an individual or $290,000 a year for a couple.

COBRA governs firms with 20 or more workers. However, ARRA's premium subsidies also pay for coverage offered by employers that are subject to state "mini-COBRA" laws, which extend COBRA regulations to smaller employers (generally those with 2-19 employees).[127] While forty states and the District of Columbia have existing mini-COBRA laws, not all pursued changes to their programs given the new opportunities under ARRA. Nonetheless, many states have played a vital role in helping these subsidies achieve their goals, including strengthening existing mini-COBRA laws. Ohio, for example, is one of several states that extended the state's mini-COBRA program from 6 to 12 months so that employees of small businesses who lost their jobs could maintain health insurance coverage for themselves and their families.

ARRA provided the authority for states to require companies subject to mini-COBRA requirements to give their laid-off workers the same new opportunity to obtain premium subsidies that ARRA provides to larger employers governed by COBRA. Normally, COBRA enrollment is limited to a 60-day period that begins when a worker is laid off or receives a notice from the employer about the worker's COBRA rights. However, for workers who lost their jobs between September 1, 2008, and the enactment of ARRA, their former employers were required to send them a new COBRA notice describing the ARRA subsidy. For such workers, these notices triggered a second 60-day opportunity to enroll in COBRA.

States pursued many different strategies to address the upswing in laid-off workers, particularly those employed by small employers. First, some states created an extended election period for eligible individuals to enroll in mini-COBRA policies.[128] Second, states revised the federally-required notice sent to ARRA eligibles by insurers under state mini-COBRA laws to reflect state-specific regulations.[129] Some states also provided a supplemental subsidy that added to ARRA's 65 percent premium payment for COBRA and state mini-COBRA. For example, through regulation, Massachusetts extended its pre-existing subsidy program to reduce workers' share of premiums from 35 percent to 8 percent, and Minnesota enacted a bill that covers the entire 35 percent that is owed by the individual for those eligible for ARRA premium assistance who elect COBRA coverage and would otherwise be eligible for a state health program.[130] The ARRA subsidy funds were scheduled to expire on December 31, 2009, but were extended an additional 6 months by legislation passed in late December.[131]

approximately $11 million in incremental primary care spending that would not have otherwise been spent. This is an average increase of $14,000 per primary care provider per year.[132]

- Participate in the expansion of the all-payer chronic care-focused patient centered medical home project (The Rhode Island Chronic Care Sustainability Initiative) by at least 25 physicians in the coming year.
- Offer electronic medical record incentive programs that meet or exceed a carrier-specific minimum standard established by the state.
- Commit to participation in a broader payment reform initiative as convened by public officials in the future.

In accordance with these standards, carriers were required to submit detailed reporting of baseline spending and performance indicators in August 2009 and an implementation plan in September.

Chris Koller, the health insurance commissioner, recognizes that it is not a foregone conclusion that increased primary care spending will result in improved system performance. Likewise, he recognizes that successful implementation of these standards will require significant OHIC leadership, project support, and program monitoring in the coming year. Over the next three years, assuming a 9 percent medical trend, OHIC estimates that this primary care spend requirement will add almost $75 million in primary care spending in Rhode Island. Monitoring the proposed investment plans, and ensuring that this substantial investment translates into system improvements, will be the important work of the Office of the Health Insurance Commissioner in the coming years.

### EXCHANGES

Since the implementation of Massachusetts' Connector, there has been great interest —both at the state level and at the federal level—in the connector or 'exchange' mechanism as a way to facilitate the purchase of affordable health insurance

by individuals and small businesses. The Connector, as a key mechanism in the comprehensive health reform plan in Massachusetts, was created to:[133]

- Promote administrative ease and reduce paperwork;
- Administer a premium assistance program for those under 300 percent FPL;
- Facilitate affordable, portable individual insurance coverage;
- Make it easier for businesses to offer pre-tax contributions to part-time employees and contracted employees through Section 125 plans;
- Develop and administer a health insurance plan specifically for the young adult population (ages 18-26); and
- Provide standardization and choice of plans for small employers by providing different benefit options.

As a result of the system-wide reform, Massachusetts now has the lowest rate of uninsured in the country, with less than 3 percent of the population currently uninsured. Likewise, according to a report by the Massachusetts Division of Health Care Finance and Policy, use of free care such as emergency rooms and free clinics has decreased significantly since health reform was enacted in 2006. Furthermore, the program continues to garner significant public support.

The Connector has been remarkably successful in administering the subsidy program for low-income individuals and providing coverage options for individuals without access to commercial insurance. In general, it has created a transparent, simple, and accessible mechanism for thousands of people. Nonetheless, the Connector itself still faces some ongoing challenges, particularly with regard to its non-subsidized product for small employers which is only currently available in a pilot phase. The Connector has faced some resistance from some carriers and brokers making it difficult to implement a new distribution channel that competes with the old channel, particularly in the small group market. Some brokers have been hesitant to facilitate use of the Connector, perhaps in part because they receive smaller commissions through the Connector than they do when placing business directly with the carriers. Furthermore, Blue Cross Blue Shield of Massachusetts (BCBSMA), the largest carrier in the state, may have the most to lose from easy comparison shopping based on price.[134] BCBSMA is also concerned that they will attract a disproportionate share of sicker people who are willing to pay more for a more well-known carrier that offers a broad provider network.

The unsubsidized product for small employers sold through the Connector currently in a pilot phase has not fared well. Approximately 45 employer groups with an average size of three employees have signed up since the small group offering was introduced on a pilot basis in February 2009. However, results from a recent evaluation of the pilot program highlighted several encouraging elements in the program design including:

- Employees having several plan options from which to choose;
- No significant adverse risk selection; and
- A streamlined electronic approach for comparing plans.

The evaluation also highlighted several issues that have impeded program growth. In response, the Connector intends to adjust and improve several components of the program in order to strengthen its role as a distributor of more affordable, greater choice products for small employers. The improvements will focus on the broker distribution channel, technical pricing issues, Web functionality limitations, and product options for out-of-state coverage.[135]

## STATES CONSIDER EXCHANGES

Several states including Maine, Oklahoma, Oregon, Rhode Island, Utah, Washington, and West Virginia are in different stages in the process of considering, planning for, and implementing an exchange. Given the economic situation, states have been forced to consider more narrow reform—one focused on a core set of goals with a more limited exchange infrastructure. Furthermore, exchanges are viewed as a favorable strategy because of some unique aspects, including high bi-partisan support, the potential to reduce administrative costs, increases in plan portability, and the ability to provide assistance in reaching individuals who are notoriously difficult to reach such as part-time workers with multiple jobs, sole proprietors, and employees working for small firms.

**Washington:** In 2007, the Washington state legislature along with Governor Chris Gregoire authorized the creation of the Health Insurance Partnership (HIP), a Massachusetts-style Connector designed initially to target small employers with low-income workers and provide sliding scale premium subsidies for employees with family incomes at or below 200 percent FPL. Under the direction of a seven-member Board, the HIP completed a great deal of preliminary work and was prepared for enrollment to begin in January 2009. Unfortunately, due to a large budget deficit, the HIP implementation was temporarily put on hold. In October 2009, Washington State was awarded a five-year federal grant under the HRSA State Health Access Program (SHAP) in the amount of $34.7 million. With the federal funding, Washington will implement the HIP as it was initially developed. Once the program is up and running, the Board will consider expansions to the program, including portability and allowing the individual rather than the employer to choose the plan. The new enrollment date for the HIP is September 2010, with coverage beginning in January 2011.

**Oregon:** Under HB 2009 (see pp. 22-23 regarding Oregon's reforms), the Oregon legislature directed the new Oregon Health Authority to create an implementation business plan for an exchange for the 2011 legislative session. The Oregon Health Fund Board sponsored an exchange

workgroup which spent almost a year assessing the applicability of an exchange to Oregon's insurance market and made a final recommendation supporting the creation of an Oregon Health Insurance Exchange.

The Health Policy Board, a nine-member Board that will lead the Oregon Health Authority, is tasked with establishing a health benefit package to be used as a baseline for all plans offered through the exchange. This benefit package will be based on the OHP Prioritized List[136] and will promote a patient-centered, primary care home model; require little or no cost sharing for evidence-based preventive care services; require greater cost sharing for elective services; and, create incentives for individuals to improve their health status. The Board will also develop a plan for a publicly-owned health benefit plan that would operate within the exchange under the same rules and regulations as all other plans offered through the exchange.

**Rhode Island:** Rhode Island went through an important process to identify and evaluate options for the establishment of an exchange-like entity "HealthHub RI." A public process was convened which brought together a variety of stakeholders including carriers, brokers, employers, consumers, legislators, and other interested parties. As a result of undergoing a process where the concept of an exchange was clarified and evaluated, options and recommendations were established. While the stakeholder group reviewed four models that ranged from no exchange to a full exchange model, the group was not asked to develop a consensus for one model over the rest. However, the group, in general, favored moving incrementally. As outlined below, a number of lessons were learned through this process that may be useful to other states considering similar reforms.[137]

*Definition, Goal Setting and Prioritization*—It is important that an exchange be defined, that its goals and objectives are clearly articulated, and that all parties participating in the development of the reform understand them. If there are multiple goals, it may be necessary to prioritize them. This process may be iterative and goals may need to be revisited at each step of the process.

The Connector in Massachusetts had numerous responsibilities and functions delegated to it because of the extensive legislation and the need for an accountable, coordinating entity. States considering an exchange could consider the roles of the Connector separately—that is, a board could be established with minimal administrative infrastructure, which could be responsible for setting policy (such as determining eligibility rules), while program administration could be facilitated through other existing state agencies. States should carefully consider their starting point, and the advantages and disadvantages of different approaches.

*Target Population*—Any state considering an exchange must first consider which populations to target. It is clear that the financial success of the model depends on sufficient enrollment in the exchange. In Massachusetts, most of the covered lives in the Connector are subsidized. Without a subsidy or other requirements for participation, states need to think carefully about whether the infrastructure they build can be financially viable and sustainable.

*Mandates*—By themselves, exchanges developed thus far have done little to increase the offer or take-up of health insurance. To ensure that the risk pool remains healthy, it may be necessary to require the offer and/or purchase of some level of health insurance. In Massachusetts, the individual mandate increased take-up of both individual and employer-based coverage. States considering an exchange will probably want to consider mandates for people with access to affordable coverage. An "affordability based" mandate, requiring all state residents to have health insurance coverage that meets an exchange-specified standard, as long as it is deemed "affordable," might provide an interim step for states considering more comprehensive reform but lacking state resources to support low-income subsidies. Any new federal mandate to purchase insurance may make this policy decision moot for states.

*Cost Containment*—To date, exchanges have done little to constrain the growth of health care costs. They have had little impact on product pricing, and the rate determination process is quite similar to what occurs in the outside markets. It is conceivable that a large exchange with market exclusivity could help drive system affordability through creative benefit design and product standards, but an exchange is not a necessary nor sufficient element to constrain the growth of health care costs.

Other important questions states should consider:[138]

- What minimum administrative infrastructure is necessary to achieve goals?
- Will enough individuals enroll in the exchange to achieve sufficient volume for it to be self-sustaining?
- How much product and plan choice should be offered?
- Are products rated for quality/value? If so, how?
- Are there minimum contribution and participation requirements for employers?
- How is the exchange governed?
- What specific target population should this entity serve? Who can purchase?
- Is a mandate needed? Who is required to purchase?
- What is the role of state policymakers in the exchange? If a state chooses to pursue a regional exchange – how will that work?

**Oklahoma:** One of the key measures of HB 2026 (see p. 27) is the requirement that the Oklahoma Health Care Authority (OHCA) and the Insurance Department create a new coordinating entity— the Health Care for the Uninsured Board (HUB). The HUB will be tasked with:

- Certifying health insurance programs;
- Educating consumers about how to choose a certified health plan;
- Teaching consumers about efficient use of care; and
- Helping qualified individuals become enrolled in Insure Oklahoma, a public-private partnership that provides premium assistance to small business employers and employees, as well as to individuals without access to employer-sponsored insurance.

The new law will serve as a foundation of the creation of a significant health insurance exchange that will empower Oklahomans

with information concerning cost, quality, wellness, and coverage.

**West Virginia:** As part of a broader reform—WV CONNECT—West Virginia is planning to develop a health insurance exchange in order to expand access to insurance products and knowledge, reduce administrative costs, and increase product and price transparency. The state envisions a web-based "Connector" which will be phased-in over time with the following functions:

- Information on all available health insurance products filed in the state, the state's high risk pool, direct service plans (pre-paid clinic services) pilot programs, the state's small business plan, the state's temporary and seasonal workers plan, and newer, more affordable plans which the state intends to develop in 2010;
- Information on available sources of health care including community health centers, free clinics, rural health clinics, and other community-based providers that offer services to the uninsured on a discounted or sliding-fee basis;
- Call center/live chat for questions and assistance;
- Health insurance education, tutorials, and frequently asked questions;
- Quality measures of participating healthcare providers;
- Online enrollment into insurance plans;
- Premium collection and remittance; and
- Eligibility determination and processing for premium subsidies.

The state would like to permit small businesses to voluntarily sign up to designate WV CONNECT as the employer group plan for its workers. Because this arrangement qualifies as an employer-sponsored plan for purposes of federal law, the employer's workers could purchase coverage of their choice through the exchange on a pre-tax basis. Employers who participate in the exchange would be relieved of most of the burdens of selecting and administering group coverage for their workers. The state will evaluate the feasibility of using the exchange to administer premium support contributions to supplement individual and employer funding for low-income residents.

West Virginia, like Washington State, recently received funding from HRSA's SHAP grant program to assist in the development of WV CONNECT. Given their timing for planning and implementation, the current proposal is dependent, in part, on the possible enactment of federal health reform legislation. The state intends to be flexible to accommodate various scenarios.

**Maine:** The Dirigo Health Agency is designing an exchange to administer a voucher program that enables uninsured, low-income, part-time, and seasonal workers to purchase employer-sponsored insurance that meets a test of creditable coverage. The details of the program are not finalized, but they plan to use funding from the State Health Access Program to fund subsidies for those who enroll.

**Utah:** Following Massachusetts, Utah is the next state in the country to implement an exchange, albeit in a substantially different form. In 2008, the state passed legislation giving the state authority to implement a Web-based exchange for consumers to purchase insurance in 2009.[139] Currently focused on small businesses, the Utah Health Exchange is designed so that employers can contribute a fixed amount toward employees' health insurance, as opposed to buying the coverage for them. With the employer's contribution, employees can visit the exchange and have the flexibility to select from the more than five dozen policies.[140]

Policymakers hope that the new exchange will create a more transparent and competitive marketplace that will pressure insurers to keep premium costs down.[141] Norman Thurston, the health policy and reform initiatives coordinator for the state, is hopeful that the exchange will spur insurers to "create innovative policies that the existing market doesn't support, because they'll have to appeal directly to consumers rather than companies."[142]

# STATE HEALTH ACCESS PROGRAM GRANTS FUNDED IN 2009

As a part of the fiscal year 2009 omnibus appropriations bill, Congress authorized $75 million for the Health Resources and Services Administration to create the State Health Access Program. This grant funding was designed to support states that were ready to implement a coverage expansion program targeted at the uninsured. A variety of program types were allowable under the law, including three-share community coverage (employer, state or local government, and the individual); reinsurance plans that subsidize a certain share of carrier losses within a certain risk corridor; subsidized high risk insurance pools; health insurance premium assistance; creation of a state insurance "connector" authority to develop new, less expensive, portable benefit packages for small employers and part-time and seasonal workers; development of statewide or automated enrollment systems for public assistance programs; health savings accounts; and innovative strategies to insure low-income childless adults.[143]

Awards were announced on September 15, 2009, and the following projects[144] were funded.

| State | Project Summary |
|---|---|
| Colorado | Grant funding will support seven comprehensive and interrelated projects called Colorado's Comprehensive Health Access Modernization Program (CO-CHAMP). CO-CHAMP includes coverage expansions for childless adults, buy-ins for people with disabilities, programs that focus on outreach, enrollment, and retention, plans with new evidence-based benefit designs, premium assistance, and three-share programs. |
| Kansas | The Kansas Health Policy Authority (KHPA) will expand health insurance coverage to children between 200 percent and 250 percent FPL and offer presumptive eligibility for pregnant women. The KHPA plans to do this through a dual approach: (1) development, implementation, and community-based deployment of an online, web-based, user-friendly eligibility/enrollment information system; and (2) development and implementation of a statewide, community-based outreach, marketing, and education plan. |
| Maine | Maine's Dirigo Health Agency will develop an Insurance Exchange to connect part-time/seasonal employees with their employers' health benefit plans and provide financial assistance toward lower income employees' share of premium costs. |
| Minnesota | Minnesota will improve eligibility for public health care programs by speeding up eligibility screenings, offering online applications and electronic verification and routing to public coverage programs, and partnering with community organizations. The state is also planning to expand access to coverage for uninsured individuals up to 350 percent FPL through local access to care programs built on three-share models. |
| Nevada | Grant funds will be used to maximize the outreach and enrollment capabilities of Great Basin HealthNet in Clark County and Access to Healthcare Network in Washoe County, two non-profit health networks. The state is also developing an insurance product for low-income individuals aged 60-64 years to be provided by a health maintenance organization (HMO). Grant funds will also create and sustain The Center for Sustainable Healthcare. From this hub, families and individuals will be referred to the various spokes of health care products offered in Nevada. |
| New York | New York's Gateways to Coverage proposal supports the expansion of health insurance to an additional 650,000 New Yorkers, one-half of all uninsured New Yorkers who do not already qualify for public programs. It includes an increase in eligibility for public programs to 200 percent FPL and three separate three-share programs that will use public subsidies to bolster employer-sponsored insurance. |
| North Carolina | The grant will be used to develop CCNC-UP, low-cost subsidized health coverage for working poor parents with incomes below 125 percent FPL. CCNC-UP will build off of and expand the successful North Carolina Medicaid primary care case management model, Community Care of North Carolina (CCNC). It will provide a medical home, care and disease management to a group of uninsured working-poor parents who are not currently eligible for Medicaid. |
| Oregon | Oregon will institute health insurance market reforms and new community coverage programs for adults over 100 percent FPL. Funding will also support three-share coverage programs in a number of communities. To improve quality, efficiency, and effectiveness across the system, funding will be used to develop a value-based benefit package to be used across expansion programs and to implement payment reform to further control costs. These efforts are designed to make the recently-enacted coverage expansions sustainable. |
| Texas | Texas will implement the Healthy Texas reinsurance program, a comprehensive statewide program using a state-funded reinsurance pool to lower premiums for small employers by an estimated 33 percent. The state will also use grant funds to fund and test the effectiveness of a Health Care Cost Sharing Account model in three different delivery systems: the small employer market, three-share programs in six communities, and a commercial HMO product that utilizes a large urban safety net model. |
| Virginia | Virginia will establish the Virginia Healthy Small Business Initiative to expand small business health coverage by market-testing a three-share health plan that will be supplemented by a wellness program for employees and their families and promoted with a rigorous outreach and education strategy. |
| Washington | Washington State plans to use funds to provide expert technical assistance and premium assistance to implement the Health Insurance Partnership (HIP), a small business exchange. The HIP target population comes from the approximately 175,000 uninsured employees (and their dependents) of small businesses (approximately 25 percent of the uninsured population) who work in small firms for whom affordability issues are most acute. |
| West Virginia | This initiative, called WV CONNECT, utilizes the collective resources of community-based health care providers, private and public insurance programs, and parties engaged in health improvement and use of health information technology (HIT). Their goal is to expand access to high-quality, culturally-appropriate health care services to uninsured West Virginians. The program links families and small businesses to health coverage options through a health information exchange. It utilizes an insurance and safety net hybrid model that combines premium assistance stipends for a scaled-insurance product along with access to basic primary and preventative care and some extended care through community-based medical homes. |
| Wisconsin | Wisconsin is expanding the BadgerCare Plus program to low-income childless adults up to 200 percent FPL. The state is also working to centralize enrollment via the Enrollment Services Center and establish a committee to control costs. |

Source: The National Academy for State Health Policy

In August 2009, the state opened the exchange in 'pilot' mode, by only allowing a limited number of companies (2-50 employees) in the small group market to participate during a two-week enrollment period. In all, 99 eligible employers were allowed to test drive the exchange. While the primary purpose of the limited launch was to ensure that the technology functioned properly, a side benefit was that 256 employees (plus dependents) are now enrolled in plans they chose. Based on this success, the state intends to open the program to all small businesses in spring 2010. By fall 2011, all large businesses will also be eligible to participate as well.

While the Utah Health Exchange is very much in its infancy, it already has encountered criticism, in part, because it is being compared to its predecessor, the Massachusetts Connector. Quite simply, the Utah Health Exchange is very different with regard to its structure and rules. While Utah did not implement any type of individual or employer mandate, nor specific requirements on small businesses in terms of how much they have to contribute toward their workers premiums, the exchange has already enrolled more individuals in their program compared to Massachusetts' unsubsidized product. Of note, the Utah Health Exchange was not designed to set benefit standards which advocates are concerned may impact consumers' ability to make 'apple-to-apple' comparisons of plans offered.[145] Utah's exchange was built following the state's current market rules. Premiums for businesses entering the exchange will be determined by how healthy or sick employees are in the company.[146]

Along with the implementation of the exchange, Utah officials created the Risk Adjuster Board to assure that risk is spread across insurers. Since employees can select among a variety of insurers, there is a possibility that some carriers may have a higher proportion of sicker, more-costly employees enrolled. Consequently, participating insurers with healthier enrollees have agreed to subsidize those with sicker policyholders.

While some observers are concerned that Utah has missed the mark with the exchange in its current structure, only time will reveal how well this effort will fare. Officials in the state are confident that a less-prescriptive approach can work in Utah and other states.[147]

## CONCLUSION: LOOKING FORWARD

The enactment of significant federal regulatory changes in the individual and small group health insurance markets—an individual mandate, exchanges/connectors, the guaranteed issue requirement, elimination of medical underwriting, no pre-existing condition limitations or waiting periods, limitations on rate bands, etc.—could have an enormous impact on state insurance markets. If Congress passes legislation that includes some or all of these reforms, states will spend the next several years grappling with their implementation.

Without Congressional action, states will continue to play an important and influential role in regulating insurance markets. The national health reform debate has brought to the forefront some of the regulatory tools states can use to improve their existing markets. In addition, the examples provided in this report point to some of the innovative reforms that states have already been able to enact. Unfortunately, it is all too well known that only so much of the insurance system can be transformed without an individual mandate and the associated subsidies needed by some individuals for the purchase of insurance.

Meanwhile, the problems in the individual and small group market that have generated public concern and prompted the attempt at federal action remain. Americans are still concerned about whether people in the most need of health insurance will be able to purchase it. Concerns also remain about abusive practices and excessive profits of some insurance companies. If federal reform is unable to address these issues, it will fall to states to attempt them through both comprehensive and incremental measures.

# DELIVERY SYSTEM AND PAYMENT REFORM

The national health reform debate in 2009 centered around two central problems in the health care system: lack of health coverage for more than 15 percent of Americans and the high and rising cost of health care. While the federal reform proposals currently being discussed would make major reforms to the insurance market and significantly expand access to insurance coverage, it is less clear which cost containment mechanisms will make it into the final bill.

While states welcome a greater emphasis on cost containment and delivery system reform from the federal level, they have not waited for federal action. States have begun to lead the way with innovative programs and pilot projects that attempt to improve the value equation—to contain health care costs while improving quality. In some cases, states have proven to be better positioned to impact the complex and diverse market because they are able to bring together local stakeholders and to help broker local relationships. It is also easier for states to experiment and try new things. Health care markets are local, and the coordination and consensus-building that needs to take place ideally occurs at the local level.

The innovations being undertaken by states focus on improving the coordination of care, making innovations in the way we pay for care, and expanding the use of health information technology. They also include initiatives to improve price and quality transparency and consumer engagement and to invest in public health.

## WHY IS REFORM NEEDED?

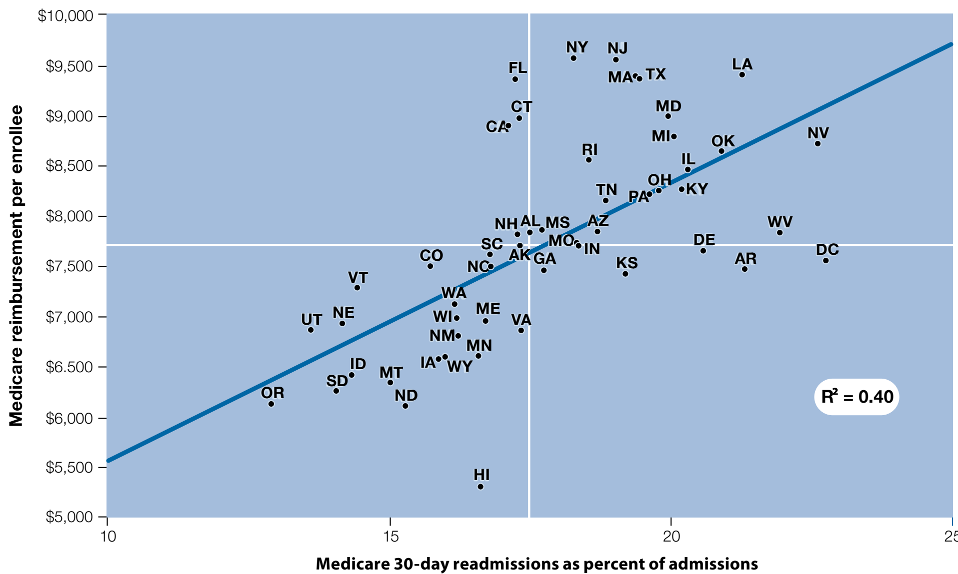
Atul Gawande's *New Yorker* article, "A Cost Conundrum: What a Texas Town Can Teach Us About Health Care,"[148] grabbed the attention of policymakers and media in 2009. This was not because it included new information, but because it was the right story at the right time: it made a compelling case about some of the key health policy dilemmas facing the nation.

The article compared two towns in Texas with similar demographics. Medicare expenditures in one town were double those in the other. He was able to show how health care providers in the more expensive town were able to drive up costs and make additional money by prescribing more health care services. In general, the article pointed out that costs vary dramatically across the country, and that you may not get higher quality by paying more. It also showed how fee-for-service reimbursement can drive volume, even when additional services may not be warranted. Finally, it pointed to communities where providers work together (without profit motive) to offer quality care at a relatively low price.[149]

Of course, there are many reasons the United States spends "roughly twice the average of the ten richest countries other than the United States"[150] relative to gross domestic product (GDP). In 2009, *Health Affairs* devoted an entire issue to "Bending the Cost Curve." In that issue, Aaron and Ginsburg cited several causes of high health care costs, including:

- High unit prices (we pay more for doctor's visits, drug costs, tests, etc.);
- Inefficient production made possible by lack of competition or effective regulation;

Figure 6: **Medicare Cost Per Beneficiary and 30-Day Readmissions by State**




Source: Commonwealth Fund State Scorecard on Health System Performance, 2009

- Misallocation of spending (paying for things that do not make us healthier);
- Tax provisions and insurance plans that shelter consumers from the cost of health care;
- Inefficient organization of health care delivery; and
- The costs of over-used or inefficient new medical technologies.[151]

The authors conclude the article by asserting that, "to lower spending without lowering net welfare, it is necessary to organize the delivery of care to promote efficient cooperation among the many providers and practitioners involved in delivering modern treatment."[152] The report also recommends a variety of strategies to encourage the right treatment at the right time, including conducting and utilizing comparative effectiveness research.

The updated version of The Commonwealth Fund's *State Scorecard on Health Performance*[153] shows that some states are doing a better job of controlling costs and improving quality than others. The report shows wide variation among states in five areas: access; prevention and treatment; avoidable hospital use and costs; equity; and healthy lives. The report provides further evidence that paying more does not result in higher quality. In fact, it shows a negative correlation between quality and cost. Figure 6 provides one example; it shows how higher costs correlate with a higher 30-day hospital readmission rate. Variation in avoidable hospitalizations and cost of care by state is shown in Figure 7.

## CARE COORDINATION: MEDICAL HOMES, ACCOUNTABLE CARE ORGANIZATIONS, AND PAYMENT REFORM

Both public and private payers have made a significant investment over the last several years in programs designed to improve chronic care management, coordination of care, and patient self-management as all of these have been shown to improve patient outcomes and cut costs.[154] Now that some consensus has emerged on the need to address these areas, states and others are asking which strategies will best accomplish those goals?

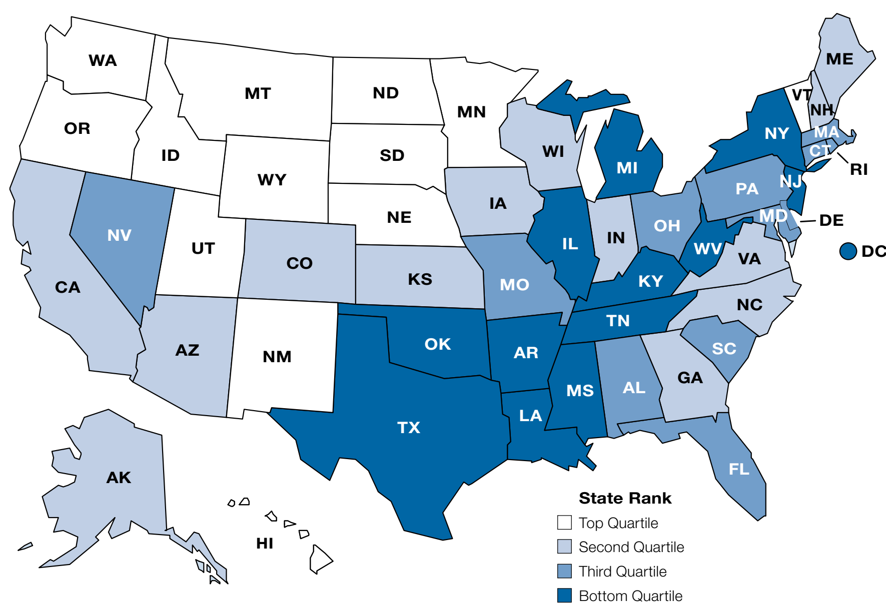
### Care Coordination and Care Management Programs

The Kaiser Commission on Medicaid and Uninsured recently released results from its survey of state Medicaid Directors. The survey distinguished two types of programs being undertaken by Medicaid agencies. Twenty-two states have or are planning some type of disease or care management program. These programs contract with health plans or disease management vendors to focus on a specific disease or target high-risk individuals.[155]

The survey also reports that several states have undertaken or have plans to develop medical homes initiatives. (Another source puts the total number of states with Medicaid-led medical home initiatives at 31.)[156,157] The report points out that while the term "medical home" has been used in Medicaid since the 1980s to describe a full set of services expected from primary care providers, there is new focus on the issue in recent years coupled with more clearly-defined standards and expectations for those claiming to be a "medical home." The National Committee for Quality Assurance (NCQA) worked with the American College of Physicians (ACP), American Academy of Family Physicians (AAFP), American Academy of Pediatrics (AAP), American Osteopathic Association (AOA), and others to develop certification criteria for Patient-Centered Medical Homes.[158] The criteria are shown in Table 5. While this measurement tool may not be perfect, several states are using it because it has the support of the key physician organizations. In states like Pennsylvania and Vermont, it has become a tool for payment reform (pages 38 and 41).

As public and private groups have experimented with various ways to provide better primary care and care coordination services, a growing research base has developed related to effectiveness of various strategies. In 2009, an evaluation of a four-year Medicare care coordination demonstration project made headlines because so few of the demonstration sites were able to achieve positive results. While three of the programs did reduce hospitalizations, none of the demonstration sites yielded net savings and there were limited gains in selected quality measures.[159]

Figure 7: **State Ranking on Potentially Avoidable Use of Hospitals and Cost of Care Dimension**




Source: Commonwealth Fund State Scorecard on Health System Performance, 2009

A follow-on report by one of the authors of the evaluation highlighted several "lessons learned" that compared more and less successful strategies used in the demonstration with proven strategies from the growing body of care coordination research. Findings from "The Promise of Care Coordination: Models that Decrease Hospitalizations and Improve Outcomes for Medicare Beneficiaries with Chronic Illnesses" show that successful programs:

- Target patients at high risk of hospitalization in the coming year;
- Include in-person, rather than telephonic, contact;
- Give providers access to timely information about hospital and emergency room admissions;
- Promote close interaction between care coordinators and primary care physicians;
- Provide educational and assessment services to help patients manage their own conditions (medication management efforts were particularly effective); and
- Use a nurse or possibly a social worker to coordinate services between the patient and the primary care provider.[160]

These findings are getting the attention of both public and private payers, many of whom have invested significant resources into telephonic disease management programs. Clearly, all care coordination programs are not created equally. Insurers are beginning to understand that they will need to *work together* to promote change in primary care practices and communities if they want to be effective. A single insurer does not have the market power to change the behavior of primary care providers, who are critical members of any care management team. When many payers work together, it can send a strong enough signal to get the attention of providers and can improve the care for all patients within a physician's practice.

## Multi-Payer Medical Home Initiatives

Several states are starting to lead multi-payer medical homes projects. These initiatives bring the major insurers in a state together, including Medicaid, to agree on both delivery system changes and payment reforms. This collaboration is increasingly recognized as a critical success factor in achieving system change—ultimately, the goal is to change the interaction between the primary care provider and the patient, and that change requires a consistent program, support incentives, and funding across all payers. Mixed incentives and varying levels of support will likely result in mixed outcomes.

Typically, these changes have meant investing more money into primary care. At least some of the additional funds are typically tied to performance measures. As these programs are being developed, payers must decide how much reimbursement should be tied to structure and process measures (like use of an electronic medical record) and how much should be based on outcome measures (like reduced inappropriate emergency room visits). States with many small physician practices are also wrestling with how to enable those practices to provide all of the enhanced medical home services. Several innovative models are developing.

In early medical home initiatives, it seemed easier politically to add more money to the system than to pay for the extra medical home services out of savings elsewhere in the system. The downturn in the economy has put new pressure on insurers and policymakers to keep premiums low, forcing them to find more creative ways to pay for medical home initiatives. Rhode Island has put the burden on insurers by asking them to find a cost-neutral way to add funds to primary care without increasing overall premiums. Other states are considering shared savings models or other ways to pay for medical homes on the back end by rewarding physicians for savings achieved.

A major hurdle to forming a multi-payer initiative has been the lack of participation of Medicare. Medicare can account for a large portion of the patient base of any practice, so many physicians are not willing or able to change their delivery model unless Medicare is willing to change its payment model along with other payers. On September 16, 2009, Secretary Sebelius announced that the Centers for Medicare and Medicaid Services (CMS) will develop a demonstration project that will enable Medicare to participate in state-based "Advanced Primary Care models," also known as medical homes. It will build on the model being developed by Vermont in their Blueprint initiative testing that and other similar models.[161] This was welcome news to state policymakers who have been leading similar multi-payer initiatives. Now it remains

Table 5: **PPC-PCMH Content and Scoring**

| Standard 1: Access and Communication | Pts |
|---|---|
| A. Has written standards for patient access and patient communication** | 4 |
| B Uses data to show it meets its standards for patient access and communication** | 5 |
| | 9 |
| **Standard 2: Patient Tracking and Registry Functions** | **Pts** |
| A. Uses data system for basic patient information (mostly non-clinical data) | 2 |
| B. Has clinical data system with clinical data in searchable data fields | 3 |
| C. Uses the clinical data system | 3 |
| D. Uses paper or electronic-based charting tools to organize clinical information** | 6 |
| E. Uses data to identify important diagnoses and conditions in practice ** | 4 |
| F. Generates lists of patients and reminds patients and clinicians of services needed (population management) | 3 |
| | 21 |
| **Standard 3: Care Management** | **Pts** |
| A. Adopts and implements evidence-based guidelines for three conditions ** | 3 |
| B. Generates reminders about preventive services for clinicians | 4 |
| C. Uses non-physician staff to manage patient care | 3 |
| D. Conducts care management, including care plans, assessing progress, addressing barriers | 5 |
| E. Coordinates care//follow-up for patients who receive care in inpatient and outpatient facilities | 5 |
| | 20 |
| **Standard 4: Patient Self-Management Support** | **Pts** |
| A. Assesses language preference and other communication barriers | 2 |
| B. Actively supports patient self-management** | 4 |
| | 6 |

| Standard 5: Electronic Prescribing | Pts |
|---|---|
| A. Uses electronic system to write prescriptions | 3 |
| B. Has electronic prescription writer with safety checks | 3 |
| C. Has electronic prescription writer with cost checks | 2 |
| | 8 |
| **Standard 6: Test Tracking** | **Pts** |
| A. Tracks tests and identifies abnormal results systematically** | 7 |
| B. Uses electronic systems to order and retrieve tests and flag duplicate tests | 6 |
| | 13 |
| **Standard 7: Referral Tracking** | **Pts** |
| A. Tracks referrals using paper-based or electronic system** | 4 |
| | 4 |
| **Standard 8: Performance Reporting and Improvement** | **Pts** |
| A. Measures clinical and/or service performance by physician or across the practice** | 3 |
| B. Survey of patients' care experience | 3 |
| C. Reports performance across the practice or by physician** | 3 |
| D. Sets goals and takes action to improve performance | 3 |
| E. Produces reports using standardized measures | 2 |
| F. Transmits reports with standardized measures electronically to external entities | 1 |
| | 15 |
| **Standard 9: Advanced Electronic Communications** | **Pts** |
| A. Availability of Interactive Website | 1 |
| B. Electronic patient Identification | 2 |
| C. Electronic care management support | 1 |
| | 4 |

| Level of Qualifying | Points | Must Pass Elements at 50% Performance Level |
|---|---|---|
| Level 3 | 75 - 100 | 10 of 10 |
| Level 2 | 50 - 74 | 10 of 10 |
| Level 1 | 25 - 49 | 5 of 10 |
| Not Recognized | 0 - 24 | <5 |

** Must Pass elements
Source: Levels: If there is a difference in Level achieved between the number of points and "Must Pass," the practice will be awarded the lesser level; for example, if a practice has 65 points but passes only 7 "Must Pass" Elements, the practice will achieve at Level 1. Practices with a numeric score of 0 to 24 points or less than 5 "Must Pass" elements do not qualify.

to be seen how flexible Medicare will be in its implementation of this demonstration.

Additional hurdles include ERISA (the Employee Retirement Income Security Act) and gaining timely access to Medicare and public health data. ERISA exempts certain self-insured employer-based plans from state regulation, meaning they cannot be compelled to participate in multi-payer collaboratives. In some states, these self-insured plans have agreed to participate (even without being compelled) and other states have required that plans who contract with the state must comply with certain requirements throughout their book of business. In other states, self-insured plans are refusing to participate, which leaves a major hole in any multi-payer initiative.

In another example, the Medicare medical home demonstration sites did not get access to Medicare data to help them determine their progress until the demonstration was complete. This time lag made it more difficult to identify any course corrections that could have improved the program. Clearly, this track record must be improved if Medicare is going to be an asset to state multi-payer initiatives.

## Accountable Care Organizations

As medical home models are tested and improved, there is the recognition that even the most well-conceived, multi-payer primary care model faces barriers outside of its control. A recent *New England Journal of Medicine* article points out two in particular: first, while a medical home encourages primary care providers to do a better job of coordinating and managing care, it offers no incentives to other providers (hospitals and specialists) to cooperate with primary care providers; and second, while is has been shown that primary care providers have the ability to

## PENNSYLVANIA CHRONIC CARE INITIATIVE

On May 21, 2007 Pennsylvania Governor Ed Rendell issued an Executive Order to create the Pennsylvania Chronic Care Management, Reimbursement, and Cost Reduction Commission. The Commission developed a strategic plan that recommended payment reform and delivery system redesign in primary care practices throughout Pennsylvania. Regional steering committees, including providers and payers, developed pilot programs for interested primary care providers in the southwest (May, 2008), south central (February, 2009), southeast (May, 2009) and northeast (October, 2009) regions of the state.

The Pennsylvania Chronic Care Initiative is using the Ed Wagner Chronic Care Model to redesign local practices. The practices receive training, practice coaches, and help with data analysis. All patient data are entered into registries. NCQA Patient-Centered Medical Home standards are used for validation of primary care practices as medical homes. The payment model varies by region, but all major payers in each region have agreed to a common methodology for add-on payments to practices based on performance. The northeast region uses a shared savings model.[162]

Early data from the southwest show improvement in quality measures for diabetics, including a 43 percent increase in patients with healthy cholesterol levels and a 25 percent increase in those with blood pressure that is under control.[163]

limit unneeded tests and hospitalizations, there is no way for them to share in the savings to the health system if that occurs.[164] So, while multi-payers medical home initiatives bring all the payers to the table, they do NOT bring all providers to the table. Fundamental payment reform must encompass all aspects of the delivery system—most notably, hospitals, specialists, and primary care providers.

The concept of the accountable care organization (ACO) was developed to address these two concerns. An ACO is defined as "a provider-led organization whose mission is to manage the full continuum of care and be accountable for the overall costs and quality of care for a defined population."[165] While various types of financing arrangements currently exist that look similar to ACOs (including integrated delivery systems and capitated payments to providers), the ACO model is envisioned to incorporate more quality measures and oversight by the payer(s) than previous capitated models.

While the ACO concept has been a "hot topic" in health policy circles, it is not currently being widely implemented. Federal reform legislation is likely to include language to support a Medicare demonstration of the concept, but their measured movement into this area reflects that there is still much we do not know. A potential pioneer in this area could be Massachusetts, which recently established a roadmap that—if followed—would lead the state in this direction over the next five years.[166]

The Massachusetts legislature established a Special Commission on the Health Care Payment System to develop recommendations on payment reform in the state that would lead to lower costs and higher quality.[167] The Commission recommended that the state establish a five-year path toward global payments to providers. The global payment would be a capitated payment to groups of providers who meet specified quality metrics (similar to the ACO concept). The payment system would rely on reform of the delivery system to include more medical homes and greater integration of providers.[168] The Commission's report will be considered by the legislature during the 2010 legislative session.

## HEALTH INFORMATION TECHNOLOGY

Nearly every major industry in the United States has embraced information technology to increase productivity and improve quality control. Health policymakers have bemoaned the failure of the health care industry to do the same. The Commonwealth Fund's Commission on a High Performance Health System estimates that the investment of one percent of health insurance premiums in health information technology (HIT) could save the country $88 billion over 10 years out of projected national health expenditures totaling $4.4 trillion.[169]

When the American Recovery and Reinvestment Act of 2009 (ARRA) was signed into law on February 17, 2009, HIT adoption efforts got a huge infusion of resources and new leadership in the form of the Office of the National Coordinator (ONC) of Health IT.[170] The legislation provides for bonus payments to health care providers who adopt electronic medical records (EMR) that meet standards for "meaningful use." The ONC will issue regulations to define "meaningful use" for Medicare and states are charged with setting standards in the Medicaid program. One of the aspects of "meaningful use" will be the ability to share health information with other health care providers, creating the need for regional or statewide health information exchanges (HIEs).

In addition to funds that will go directly to providers, nearly $1.2 billion will be granted by the U.S. Department of Health and Human Services (HHS) to: 1) support planning and implementation by states (or state-designated entities) to organize and maintain HIEs; and 2) support HIT Regional Extension Centers that will offer technical assistance, guidance, and information to providers seeking to utilize HIT and comply with meaningful use standards. As a result, states were busy throughout the late summer and early fall of 2009 preparing HIT plans to be submitted to HHS.

In her presentation at the 2009 State Coverage Initiatives Summer Meeting, Ree Sailors of the National Governors Association laid out several activities that states will need to undertake in response to ARRA. They include:

- Preparing or updating the state roadmap for HIE adoption;
- Engaging stakeholders;
- Establishing a state leadership office;

- Preparing state agencies to participate;
  - The Medicaid agency will need to set "meaningful use" standards and set up systems to reimburse those who are eligible for bonus payments;
  - The public health agency will need to prepare to integrate population health data into the HIE; and
  - A state finance agency will need to consider establishing a loan program for interested providers;
- Implementing privacy strategies and reforms;
- Determining the HIE business model;
- Creating a communications strategy; and
- Establishing opportunities for health IT training and education

The hope is that HIT can become an effective tool to help promote the coordination of care discussed in the previous section. States can set up an HIE that meets basic standards or they can use the infusion of funds to help accomplish long-standing goals of greater communication and coordination among providers and between health care providers and public health.

## PREVENTION AND WELLNESS INITIATIVES

In the conversation about health reform, many make the obvious point that one of the most cost-effective ways to reduce health care costs is to prevent illness in the first place, or to slow its onset. In fact, 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.[171] In addition, two-thirds of the growth in health spending is attributable to the treated prevalence of chronic disease, such as diabetes and heart disease.[172]

During the 2009 policy debate, public health officials made an effective argument against making false distinctions between population health and health care. Some of the most cost-effective interventions prevent disease from developing in the first place. At the same time, there has been growing criticism of the current federal (and, by extension, state) approach of funding many separate disease or population-oriented programs that fail to interact with one another and the overall environment.

Significant new funding enacted as a part of ARRA seeks to respond to these historic weaknesses by supporting projects that are "high-impact, broad-reaching policy, environmental, and systems changes in schools (K-12) and communities."[173] These programs will address whole communities, targeting physical activity and nutrition, and reducing obesity and tobacco use. Competitive grants will go to communities. In addition, states will receive funds to support and evaluate these programs.[174]

A few states have already put these ideas into practice. In April 2009, Minnesota announced that they awarded a first round of grants to 39 communities across the state to target obesity and tobacco use. Communities are required to use proven, systemic strategies. The announcement of these grants notes, "The interventions focus on four settings—schools, communities, worksites and health care—to make sustainable improvements to the policies, systems and environments that determine how Minnesotans live, learn, work, play and receive care."[175] These programs will be rigorously evaluated to determine their impact on overall health care costs in Minnesota.

The Vermont Blueprint pilots (see page 41) intentionally link public health with their health care reforms. One of the primary innovations of the Blueprint model is to embed "community health teams" into community-based practices. These teams will expand the effectiveness of primary care practices by helping with patient education, care coordination, and ancillary services like behavioral health and nutrition counseling. Local public health employees are being integrated into these teams. Public health data and de-identified information from patient EMRs will inform both population health and health care strategies.[176]

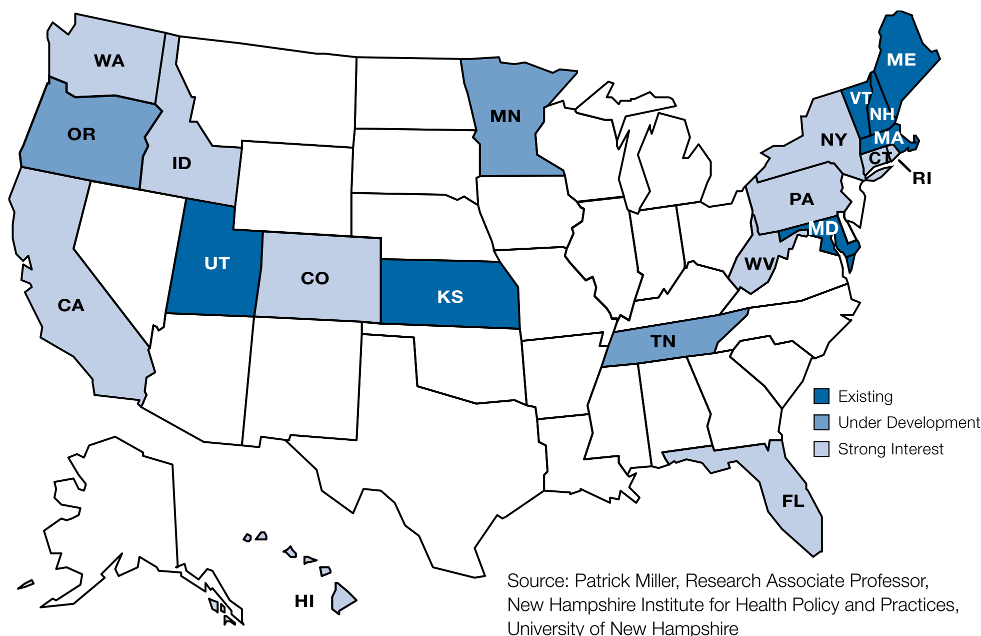
The nationwide effort to reduce the use of tobacco has informed some of the science behind the new calls for a system-wide approach to prevention. Research on tobacco cessation programs found that prevention efforts became more effective when people were hearing the same reinforcing messages from multiple places and when policymakers make it easier for people to do the right thing. For example, every state has a tobacco tax. In the 2009 legislative session, 33 states had tobacco tax bills under consideration and five (Arkansas, Hawaii, Kentucky, Rhode Island and Oregon) passed a tobacco tax increase.[177] All but five states cover some sort of smoking cessation program under Medicaid.[178] Thirty-one states and the District of Columbia have passed at least one form of indoor smoking ban.[179]

## TRANSPARENCY AND ALL-PAYER CLAIMS DATABASES

As mentioned above, consumers and payers rarely know whether they are getting good value for their health care dollar. Consumers often have few reliable tools with which to compare various providers so they can choose health care providers who offer the highest quality for the lowest cost. In many cases, public and private payers know almost as little as consumers. Payers negotiate independently with providers and often pay very different rates for the same product. They do not know how much it actually should cost to produce a given service, and they do not know what their competitors are paying. While providers seem to benefit from an opaque environment, they, too, lack information about how they compare to their peers in terms of quality and resource utilization.

Many states have undertaken projects to compare the quality (and sometimes the prices) of various providers, particularly hospitals. A number of initiatives are underway that give providers more feedback on whether they are meeting agreed-upon standards of care. This feedback works best when it is timely and actionable.

Figure 8: **Status of State Government Administered All Payer/All Provider Claims Databases**




Source: Patrick Miller, Research Associate Professor, New Hampshire Institute for Health Policy and Practices, University of New Hampshire

One tool that has proven to be effective for meeting many transparency goals is an All-Payer Claims Database (APCD). Ten states have already implemented APCDs and several others are considering doing so (Figure 8).[180] Uses of these databases include:

- Determining utilization patterns and rates;
- Identifying gaps in disease prevention and health promotion services;
- Evaluating access to care;
- Analyzing statewide and local health care expenditures by provider, employer, geography, etc.;
- Assisting with benefit design and planning;
- Establishing clinical guideline measurements related to quality, safety, and continuity of care;[181] and
- Analyzing whether providers meet basic quality standards.

As this list of uses indicates, the impact of APCDs goes far beyond transparency for consumers—it can shed a light on the entire health care system. In order to reform our payment system, for example, we need to fully understand and analyze the flaws in the current system. An APCD can help make that possible.

## CONSUMER ENGAGEMENT

One way APCDs can be used is to rate providers according to quality and cost (i.e., value) and then give consumers a discount when they choose to go to low-cost, high-quality providers. This type of benefit design is one way to encourage consumers to make cost-effective choices without a gatekeeper-type system.

States have been using a variety of mechanisms to engage consumers in seeking better health care and effectively managing their health conditions. These include:

- Value-based provider tiering (as described above);
- Higher cost-sharing for brand name pharmaceuticals in Medicaid and public employee plans;
- Web sites that compare providers;
- Web sites that estimate the cost of specific services from various providers;
- Developing, funding and/or encouraging the use of patient decision support aids;
- Providing comparative effectiveness data; and
- Supporting chronic care collaboratives and other programs that emphasize patient education and self-management.

## WHAT IS THE ROLE OF STATES IN DELIVERY SYSTEM REFORM?

After describing many of the delivery system reforms that are happening at the state level, it may seem redundant to make the point that states can and should be a key locus for reform of the delivery system. But this may not be an obvious point. Why not enact delivery system reforms at the federal level? Or, why should government be involved at all—why not let the private or non-profit sectors lead reforms?

Health care markets are, by nature, local. Therefore, states are closer to the action than the federal government when it comes to implementing many of the delivery and payment systems changes necessary to truly transform the health care system. This proximity and flexibility in system redesign are key strengths for states. Huge variation exists in the way care is delivered between rural and urban areas, and between places with integrated health care systems and areas with a "disorganized" market. Concentration of providers and insurance plans vary. Amid wide variation, states have first-hand knowledge of their unique local landscape and have the relationships with stakeholders that will be necessary to change the system.

In addition, states can play an important convening role that many private and non-profit entities cannot. Many task forces and work groups have come together with the best of intentions, but if no one is held accountable (with the threat of legislation or regulation), key players, in order to protect their own business interests, can slow down the process or derail it by refusing to compromise. State policymakers can play a key leadership and convening role to ensure the broader public good is achieved.

State officials can coordinate the significant policy levers at their disposal, including purchasing power in the Medicaid and public employee programs and the ability to regulate health plans and set provider conditions of practice. Public health resources can also be

brought into a project to improve prevention and community-based interventions. States can also use their relationships with federal officials to achieve buy-in when needed (for example, when CMS needs to sign off on a Medicaid state plan amendment).

Many projects benefit from shared infrastructure, and the state can help make sure that infrastructure is developed and financed. Community-based care coordinators, nutritionists, behavioral health providers and physical therapists are examples of the types of services that can be shared in a community. The state can also help set up health information exchanges and assist providers in making needed technology improvements through grants, loans, bulk purchasing, training and other technical assistance. The state can invest in evaluation, pilot projects or new initiatives as needed. They can develop data-sharing agreements and create common reporting tools.

Importantly, states can provide antitrust protection when providers and insurers come together to discuss payment reform. As stated above, real delivery system change will not happen until the major payers align their quality and cost-containment incentives. When the state is facilitating a conversation, those who are party to the discussion gain an exemption from antitrust claims. States can also help ensure that the discussions are transparent and in the public interest.[182]

## VERMONT BLUEPRINT INTEGRATED PILOTS

The Blueprint Integrated Pilot Program is a multi-payer initiative designed to improve care coordination, primary care, and prevention. It includes broad transformation in the following areas:

**Financial Reform**

Additional payments to practices based on achievement of criteria established by the NCQA for a patient-centered medical home (PCMH)

Payers (including Medicaid, commercial payers and the state currently subsidizing the Medicare portion) share the cost of community-based Community Health Teams

**Community Health Teams (CHTs)**

Local multidisciplinary team including nurse coordinators, medical social workers, behavioral specialists, dieticians, and others

Guideline-based care coordination for individual patients as well as population management

**Community Activation and Prevention**

Public Health Prevention Specialist (PHPS) as part of CHT

Integration of public health prevention and care delivery

PHPS-guided, systemic approach to community assessment, broad stakeholder engagement, consensus building, planning, and targeted intervention

**Health Information Technology**

Web-based clinical tracking system that produces visit planners and population reports

Electronic prescribing

Electronic Medical Records (EMRs) used by participating doctors updated to match program goals and clinical measures

Health information exchange network transmits data between EMRs in clinical and hospital settings

**Multidimensional Evaluation**

Bonus payments to primary care offices that achieve certain NCQA PCMH scores

Clinical process measures

Health status measures

Analysis of claims-based health care patterns and expenditures using an All-Payer Claims Database

Financial impact modeling and return on investment analysis based on claims[183]

Affirming the role of states in delivery system reform does not rule out a role for federal, private, and non-profit groups. Delivery system reform will not happen without everyone working together. In particular, federal health reform legislation includes many delivery system innovations that would strengthen the efforts of states (in the area of ACOs and medical homes, for example). Medicare is a major force in the health care system, and even small changes to that program can have huge ripple effects throughout the system. Anyone seeking to make delivery system reform changes, including states, will eventually need the cooperation and support of the Medicare program. Federal changes to ERISA that would enable states to encourage self-insured plans to participate in multi-payer initiatives would also be beneficial.

Private and non-profit groups have also demonstrated their value by leading important quality initiatives. The Puget Sound Health Alliance described in the Washington vignette (on page 42) serves as just one example of the many that exist.

Finally, in states with strong anti-government sentiment or with political leaders who have not taken a leadership role in the area of delivery system reform, federal and local leaders can play an important galvanizing role. States are well-situated to be leaders in this area, but a host of other organizations and individuals across the health care system can and have been the instigators of needed change.

## WASHINGTON EXHIBITS LEADERSHIP IN HEALTH CARE PURCHASING AND DELIVERY SYSTEM REFORM

The state of Washington has made it a priority to promote higher quality care at a lower cost, and their efforts yielded several innovative programs. A rallying point for state officials came in October 2005 when Governor Chris Gregoire announced a five-point strategy to "make the state government a national leader in the way we buy and use health care."[184] The highlights of several innovative programs that have developed out of these strategies are listed below.

**Emphasizing Evidence-based Health Care.** The Governor called for and the 2006 legislature passed a Health Technology Assessment (HTA) program that evaluates the efficacy and cost-effectiveness of new and emerging technologies. A clinical committee made up of community clinicians evaluates evidenced-based reviews of procedures, devices, or medications that are at risk of over- or under-use or that have questionable efficacy. Estimated first-year savings for the nine areas that have been reviewed is $21 million (with a cost of $1 million for the program).[185]

In 2007, the state passed legislation to encourage and study the use of patient decision aids. These video aids help patients make difficult health care decisions by providing both the potential of the intervention and its possible side effects. The state is currently studying the impact of several pilot programs using these decision aids.

**Better Managing Chronic Care.** Washington is the home of Ed Wagner and the MacColl Institute, developer of the Chronic Care Model, which has been implemented in many places around the country. Washington has a particularly strong track record with this program. In 2009, the state initiated the Washington State Patient Centered Medical Home Collaborative (PCMHC), which focuses on redesigning the whole practice rather than focusing on a specific disease like diabetes or heart disease. The solicitation for participating practices focused on recruiting both large and small practices. Learning sessions for the first cohort began in September 2009 and will continue through 2011.

At the same time the legislature initiated the PCMHC, they charged the Health Care Authority and the Department of Social and Health Services with convening key stakeholders to develop a new payment model to promote implementation of PCMHs. This group met throughout the Fall of 2009, and they co-hosted a meeting with more than 100 interested stakeholders in October to seek input. They hope to have pilots initiated by fall 2010.

**Creating More Transparency in the Health System.** The Puget Sound Health Alliance is an organization of state and private health purchasers, providers, and consumers launched in December 2004 as an independent non-profit. (While the Alliance is not a state entity, the state is a strong supporter and contributor to the program.) The group produces the Health Alliance Community Checkup, which provides public, comparative information about the quality of care provided at clinics, medical groups, hospitals and health plans in the Puget Sound (Seattle) area.[186]

**Make Better Use of Information Technology.** The Washington State Health Care Authority launched Consumer Managed Health Record Bank pilots in three communities in the summer of 2008. They partnered with Microsoft HealthVault and Google Health to develop record banks where consumers can view, verify and share with their providers.

## CONCLUSION: LOOKING FORWARD

Delivery system and payment reform is likely to continue whether or not health reform is enacted. The reforms currently being considered by Congress are similar to those being tried in several states; they would make the federal government a more effective partner in the work to improve care coordination and improve value.

While neither the states nor the federal government have collected sufficient data and program evaluations to make sweeping reforms in payment policy, the federal legislation under consideration does establish advisory boards, demonstrations, pilots, and new reporting mechanisms. It also takes initial steps toward payment policy change.

The bill passed by the U.S. Senate establishes an Independent Medicare Advisory Board, which would be charged with making recommendations to hold cost growth in the program to 6 percent (down from expected growth of 8 percent). Congress would then be required to approve the recommended changes or pass other measures that reduce spending by a similar amount.

The Senate bill also takes several steps toward value-based purchasing. It penalizes hospitals with too many readmissions and those that fail to prevent hospital-acquired infections. It rewards hospitals that meet performance measures. It tracks the prescribing patterns of doctors and then establishes a "value-based payment modifier" that rewards efficient physicians and reduces payments to those with practice patterns that are out of the norm.

Legislation in both houses would establish a Center for Medicare and Medicaid Innovation in the U.S. Department of Health and Human Services. This Center would be charged with testing payment reforms, and would have authority to implement those reforms that have proven effective for reducing costs without congressional approval.

The bills also establish demonstration programs to test and evaluate accountable care organizations and medical homes models. In addition, they attempt to head off a problem encountered in Massachusetts, which had difficulty meeting the demands on health care providers generated by newly-covered residents. Both bills include grants to develop the health care workforce.

While these changes move the Medicare and Medicaid programs in the right direction, they do not supplant the need for state action. The changes being contemplated are measured and incremental. They rely on innovators who are willing to test new ideas. Most would only be strengthened through state and local participation.

As more quality improvement and cost containment initiatives are implemented in both the public and private sector and at the federal, state and local level, there will be an even greater need for leadership and coordination. The Medicare demonstration (initiated by CMS) that was announced by Secretary Sebelius (mentioned above) is a step in the right direction. State officials hope other Medicare demonstration projects will foster the same type of coordination with state and local efforts. Clearly, cooperation between the federal and state governments will be critical for successful delivery system change regardless of whether or not the current set of federal reforms being considered by Congress are ultimately enacted.

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