State Health Watch

Vol. 14 No. 4

The Newsletter on State Health Care Reform

April 2007

AHC Media LLC

In This Issue

Report: Citizenship documentation creating problems for Medicaid

Early reports gathered by the Center on Budget and Policy Priorities (CBPP) indicate that the new citizenship documentation requirement imposed by the Deficit Reduction Act is costing some eligible U.S. citizens their Medicaid benefits and is increasing the administrative burden on Medicaid workers.

The law requires U.S. citizens to present proof of their citizenship and identity when they apply for, or seek to renew, their Medicaid coverage. Before this provision took effect, U.S. citizens applying for Medicaid were permitted to attest to their citizenship, under penalty of perjury.

CBPP analyst **Donna Cohen Ross**, who wrote the report, says the available evidence "strongly suggests that those being adversely affected are primarily U.S. citizens otherwise eligible for Medicaid who are encountering difficulty in promptly securing documents such as birth certificates and who are remaining uninsured for longer periods of time as a result."

According to Ms. Cohen Ross, the new requirement also appears to reverse part of the progress that states have made over the past decade in streamlining access to

*See **Citizenship** on page 2*

States taking on health insurance expansion; sustainability is the universal challenge

Frustrated with federal inaction to reduce the ever-growing numbers of those without health insurance, many states are involved in reforms with a variety of approaches to cover the uninsured, including new mechanisms to subsidize coverage for low-income families, new variations on employer and personal responsibility for health insurance coverage, and new strategies to facilitate purchase of insurance for small businesses and for individuals without access to employer-sponsored coverage. A Commonwealth Fund report on "State Strategies to Expand Health Insurance Coverage: Trends and Lessons for Policymakers" says the boldest state-level efforts are focused on comprehensive, near-universal coverage, while others concentrate on incremental approaches such as providing coverage for children or public-private partnerships to insure low-income workers.

Fiscal Fitness: How States Cope

But even as states are moving forward with their reforms, a word of caution is sounded in a *Health*

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The Newsletter on State Health Care Reform

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Back issues of *State Health Watch* may be searched on-line for a fee at **www.newslettersonline.com/ahc/shw.** Issues may be searched by keyword and date of publication.

State Health Watch (ISSN# 1074-4754) is published monthly by AHC Media LLC, 3525 Piedmont Road, Building Six, Suite 400, Atlanta, GA 30305. Telephone: (404) 262-7436. Periodicals postage paid at Atlanta, GA 30304. POSTMASTER: Send address changes to State Health Watch, P.O. Box 740059, Atlanta, GA 30374.

Subscriber Information:
Customer Service: (800) 688-2421 or fax (800) 284-3291. Hours of operation: 8:30 a.m. - 6 p.m. Monday-Thursday; 8:30 a.m. - 4:30 p.m. Friday ET.
E-mail: customerservice@ahcmedia.com.
Web site: www.ahcmedia.com.

Subscription rates: $399 per year. Discounts are available for multiple subscriptions. For pricing information, call Steve Vance at (404) 262-5511. Back issues, when available, are $67 each.

Government subscription rates: Call customer service at (800) 688-2421 for current rate. For information on multiple subscription rates, call Steve Vance at (404) 262-5511.

(GST registration number R128870672.)

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Citizenship

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Medicaid for individuals who qualify, and especially for children. For example, she says, to improve access to Medicaid and reduce administrative costs, most states have implemented mail-in application procedures, and many states have reduced burdensome documentation requirements. But the citizenship documentation requirement appears to be pushing states in the opposite direction, she says, by impeding access to Medicaid. "Families must furnish more documentation and may be required to visit a Medicaid office in person to apply or renew their coverage, bypassing simpler mail-in and online enrollment opportunities because they must present original documents such as birth certificates that can take time and money to obtain. This is likely to cause the most difficulty for working poor families that cannot afford to take time off from work to visit the Medicaid office and for low-income families residing in rural areas," Ms. Cohen Ross says.

Trying to curb misrepresentation

Although the new requirement, which was insisted upon by the House of Representatives during the conference committee deliberations on the Deficit Reduction Act, was presented by proponents as being necessary to curb a problem of undocumented immigrants obtaining Medicaid by falsely claiming to be U.S. citizens, there never has been any evidence of such a problem, according to the CBPP report, and states' experience to date appears to confirm the lack of a problem.

To develop its analysis, CBPP contacted officials in several states that they knew had enrollment information for the period since the new requirement was implemented July 1, 2006. Ms. Cohen Ross tells *State Health Watch* the six states surveyed—Iowa, Kansas, Louisiana, New Hampshire, Virginia, and Wisconsin—were chosen because of the availability of data and not because they necessarily were representative of all states. But she adds they do cover states in a number of different circumstances and there is no reason to believe that the results reported from these states will differ significantly from those in other states.

According to the report, the data show the following:

- All six states report a significant drop in enrollment since implementation of the requirement began;
- Medicaid officials in these states attribute the downward trend primarily or entirely to the citizenship documentation requirement.

Two types of problems are surfacing, according to Ms. Cohen Ross: Medicaid is being denied or terminated because some beneficiaries and applicants cannot produce the specified documents despite, from all appearances, being U.S. citizens, and Medicaid eligibility determinations are being delayed, resulting in large backlogs of applications, either because it is taking time for applicants to obtain the required documents or because eligibility workers are overloaded with the new tasks and paperwork associated with administering the new requirement.

Ms. Cohen Ross says the Medicaid enrollment declines identified in her report do not appear to be driven by broader economic trends or a change in the employment of low-income families. If that were the case, she says, parallel enrollment declines would appear in the Food Stamp program, which is the means-tested program whose enrollment

levels are more responsive to such developments. Instead, Food Stamp caseloads have been increasing slightly in recent months. Also, each of the states identified in the report as having sustained a drop in Medicaid enrollment saw the Food Stamp caseload grow during a similar period. "Both Medicaid and the Food Stamp program serve similar populations of low-income families and are often administered by the same agencies and caseworkers," Ms. Cohen Ross wrote. "A key difference is that the citizenship documentation rules were applied to Medicaid, but there were no such changes in the Food Stamp program. It thus appears that the changes in Medicaid enrollment are a result of changes in Medicaid policies, particularly citizenship documentation, that do not affect eligibility for Food Stamps.

State reports

Wisconsin reported that between August and December 2006, more than 14,000 Medicaid-eligible individuals were either denied Medicaid or lost coverage due to the documentation requirement. And the loss of coverage occurred despite state efforts to minimize the requirement's impact by obtaining birth records electronically from the state's Vital Records agency. Wisconsin observers said more people had difficulty obtaining proof of identity than proof of citizenship. Some 69% of those who were denied Medicaid or who lost Medicaid coverage due to the new requirement did not have a required identity document, compared to 17% who did not provide the required citizenship documents and 14% who were missing both a citizenship and an identity document. Ms. Cohen Ross said this situation indicates that most of those who were denied were, in fact, U.S. citizens.

The Kansas Health Policy Authority reported that between 18,000 and 20,000 applicants and previous beneficiaries, mostly children and parents, have been left without health insurance since the citizenship documentation requirement was implemented. Some 16,000 of them were classified as "waiting to enroll" or "waiting to be re-enrolled," and state officials said their eligibility determination was being delayed by a large backlog of applications related to the difficulties confronting individuals and eligibility workers alike in attempting to comply with the new rule.

Iowa officials reported identifying an unprecedented decline in Medicaid enrollment attributed to the documentation requirement. Before July 1, 2006, overall Medicaid enrollment had steadily increased for several years. But between July and September 2006, Medicaid enrollment sustained the largest decrease in the past five years. It also was the first time in five years that the state experienced an enrollment decline for three consecutive months.

"Although other factors may contribute to the recent decrease in enrollment, state officials point out the state is now experiencing a more severe effect on enrollment than it has following any of the Medicaid changes that have occurred over the past several years," Ms. Cohen Ross states. "The state's conclusion that the citizenship documentation requirement is driving the decline is supported by the fact that enrollment has dropped among the populations subject to the requirement (children and families) but has remained steady among groups not affected by the requirement (individuals receiving Medicare and SSI).

In September and October of 2006, Louisiana experienced a net loss of more than 7,500 children in its Medicaid program despite a vigorous back-to-school outreach effort and a significant increase in applications during September. State officials said the enrollment decline is not driven by population loss from Hurricane Katrina, and contrasts dramatically with enrollment spikes that usually occur in September. They cite two reasons for the drop-off: First, Medicaid is being denied or terminated for some people because they have not presented the required citizenship or identity documents, and second, the additional workload generated by the new requirement is diverting the time and effort eligibility workers would normally spend on activities to ensure that Medicaid beneficiaries do not lose coverage at renewal.

Since July 2006, enrollment of children in Virginia's Medicaid program has declined steadily each month and by the end of November, the total net decline was close to 12,000 children. In contrast, enrollment in the state's separate SCHIP program during the same time frame, which is not subject to the new requirement, increased. Virginia also reported a substantial backlog in application processing at its central processing site.

Data from the New Hampshire Healthy Kids Program, a private organization that processes mail-in applications for the state's Medicaid and SCHIP programs, indicate that the percentage of applications submitted with all necessary documents in September 2006 dropped by almost half compared with the percentage of complete applications submitted in September 2005.

Officials also estimated a significant effect of the new requirement on administrative expenditures. Illinois projected $16 million to $19 million in increased staffing costs in the first year of implementing the requirement. The Arizona legislature has allocated $10 million to implement the citizenship documentation

requirement, including costs associated with staffing, training, and payments for obtaining birth records.

The FY 2007-08 budget request for the Colorado Department of Health Care Policy and Financing includes a request for an additional $2.8 million for county administration costs.

Washington hiring more staff

Washington State is projecting costs associated with hiring 19 additional FTEs in the current fiscal year due to the new requirement, and retaining seven of them in the next two fiscal years.

Wisconsin is expecting increased costs of $1.8 million to cover the workload associated with administering the requirement in the current fiscal year and $600,000 to $700,000 in each of the next two fiscal years.

And Minnesota is estimating it will spend $1.3 million in this fiscal year for new staff, birth record fees, and other administrative expenses.

Advocates in several of the states tell *State Health Watch* their states have had great difficulty in implementing the requirement. **Jill Hanken** of the Virginia Poverty Law Center says U.S. citizens "have been experiencing huge delays in Medicaid applications" and says there are 4,000 cases pending for children. Virginia, she says, has worked hard to develop a Medicaid processing system that can handle applications coming in by telephone, mail, or on-line, but that system can't easily accommodate the federal requirement that original documents be submitted and verified.

New procedures that were drafted, she says, represent "bureaucracy at its worst" and have created an unrealistic and unwieldy requirement. A big issue for U.S. citizens in Virginia is obtaining out-of-state birth certificates, which can cost $50 or more, she says. The state plans to help people pay for the documents, but no procedure to do that is in place yet. The need to present original identity documents also is creating problems, she says, with many applicants unwilling to mail in their driver's license and wait for it to be returned.

Ms. Hanken says there are a number of changes that could be made to the federal requirement that would ease implementation, including accepting copies of original documents and finding a better way to verify identity of children younger than age 16 who don't have a driver's license or other picture ID. She also would like to see the very frail elderly and disabled who are not on Medicare exempted from the requirement.

Even with such changes, however, Ms. Hanken thinks the most appropriate thing would be to reexamine the assumptions that led to the requirement and ask why U.S. citizens are being made to go through such hoops.

"Virginia was doing great work in enrolling eligible kids in Medicaid, but now net enrollment has dropped by 10,000," he reports.

No need to lie about citizenship

Linda Katz at The Poverty Institute in Rhode Island tells *SHW* her state was covering all children, including those who are undocumented, in its RIteCare program and thus there was no need for people to lie about their citizenship to get coverage. The governor's budget for fiscal year 2008 projects a loss of 5,300 Medicaid recipients. Ms. Katz says the state is trying to implement the program in ways that are the least harmful. One thing Rhode Island has done is to authorize outreach workers to certify that they have seen original documents and then submit a copy on behalf of their clients.

She says it would be most helpful if the requirement to verify identity through picture IDs and other difficult means would be dropped. "Tweaking the state process can't make it better," she says. "States should have the option of whether to verify citizenship. Then eliminate the identity requirement. This all interferes with the goal to simplify the application process."

In Arizona, **Kim VanPelt** at the Children's Action Alliance says implementing the requirement has been fairly costly for the state. "It's creating a ton of work and a ton of costs," she says. "And the results suggest we didn't have many noncitizens in our system. The decline we're seeing in enrollments is because of the hassle factor."

Ms. VanPelt says she is concerned the requirement is not addressing a problem that congressmen thought needed to be fixed. "States should have the flexibility to determine eligibility requirements," she says. "Federal micromanagement does not help produce the best results."

Interestingly, data were collected too late in Ohio to be included in the report but information now available confirms the experience in the other states. **Mary Wachtel** of Voices for Ohio's Children says two trends are being seen: a reduction in Medicaid enrollment and a reduction in the number of Medicaid applications being processed in a timely fashion.

Both trends started appearing one month after the state implemented the new requirement, she says, and there have been no other policy or operational changes that could account for the shift.

"We had been seeing consistent, incremental increases in the number of covered families and children," she tells *State Health Watch*, "and now we're seeing consistent drops."

She says the Ohio Department of Job and Family Services, which administers Medicaid, recorded a reduction in 22,000 Medicaid beneficiaries between August and December 2006. And there was a 3% drop in the number of timely applications processed in November and another 3% drop in December.

Asked her view of a solution, Ms. Wachtel said Congress should go back to the previous law, which gave caseworkers discretion to ask for proof of citizenship as appropriate. "The previous law worked well," she says. "It would be a mistake to assume that citizenship was never checked. We know our caseworkers often asked for proof when they had reason to do so."

Ms. Wachtel says another problem that is arising is that caseworkers now are suspending applications while waiting for people to obtain an original birth certificate instead of moving on to request lower-level acceptable proofs of citizenship that the federal government has said can be used. The resulting delays, she says, are costing people access to needed health care.

Report author Cohen Ross tells *SHW* those who saw a need for the new requirement should go back and look at what happened under prior law. Four states had required proof of citizenship, with rules that were not nearly as restrictive as those set forth by the Centers for Medicare & Medicaid Services to implement the new requirement. "Other states could have required proof of citizenship," she says, "but chose to rely on signed statements given under penalty of perjury. States that were concerned about citizenship had the discretion to run their programs in a way that addressed their concerns. Other states were doing what the law permitted. Everyone agrees that only those who are eligible for benefits should receive them. But we shouldn't be accomplishing that goal by creating barriers for those who are eligible. These are very important basic health care benefits that are at stake here."

Ms. Cohen Ross wants to see improvements in state processing systems to handle the new requirement, but also would like to see a reassessment of the need for the requirement. "We need to ask if this rule is addressing a real problem," she says. "In the last 10 years, states have made great strides in simplifying Medicaid and making it more accessible. And this requirement takes them in the opposite direction."

Download the CBPP report at www.cbpp.org/2-2-07health.htm. Contact Ms. Cohen Ross at (202) 408-1080. Contact Ms. Hanken at (804) 782-9430, ext. 13; Ms. Katz at (401) 456-4634; Ms. VanPelt at (602) 266-0707, and Ms. Wachtel at (877) 881-7860. ■

Fiscal Fitness

(Continued from cover)

Affairs study of what happened in Oregon when its comprehensive reforms could not be sustained (**see related story, p. 8**).

The Commonwealth Fund strategies report notes the number of uninsured climbed to 47 million in 2005, the result of a steady increase since 2000. However, even more disturbing to analysts is a trend line indicating the number of uninsured could reach 56 million by 2013. The increase in the number of uninsured can be explained in large part by a decline in employer-sponsored insurance, the report says. In 2000, 68% of working-age adults were insured through their employer or through a family member's employer. By 2004 only 63% had employer-based insurance, and there were 3.4 million more uninsured.

The study says almost 75% of the decline in employer-sponsored insurance resulted from fewer employers offering coverage and more employers tightening eligibility requirements for workers and dependents. Thus, lack of access to affordable health care has become a major concern for many people.

The boldest reform proposals coming out of states, say authors **Alice Burton**, **Isabel Friedenzohn**, and **Enrique Martinez-Vidal**, have come from states in the Northeast. Comprehensive reforms in Massachusetts, Vermont, and Maine go further toward helping low-income families purchase health insurance than in any other states. One of the key elements in all three states, they say, is that they subsidize coverage for families with annual incomes up to approximately $53,000 for a family of four (300% of the federal poverty level). Each of the states uses Medicaid to partly fund its subsidized product, showing how important Medicaid still is as a financing source. But they also have included other reforms that reflect local priorities.

New approach in Massachusetts

Massachusetts broke new ground with its requirement that individuals purchase health insurance. Those who can afford insurance are required to obtain it by July 1 or risk loss of their personal exemption for 2007 income taxes. In future tax years, the penalty will include a fine equaling half the monthly cost of health insurance for each month without coverage.

Vermont's Catamount Health has a goal of assuring insurance coverage for 96% of Vermonters by 2010. The plan provides a new subsidized insurance product for uninsured families

with incomes up to 300% of the federal poverty level and a requirement that employers contribute to health care costs. Employers will pay an annual assessment of $365 per full-time employee for their uninsured workers. And Catamount will offer a premium assistance program to low-income individuals with access to employer-sponsored insurance who have previously been unable to afford insurance.

Funding for Catamount comes from several sources, including an increased tobacco product tax. The plan also relies heavily on chronic care management.

Maine's Dirigo Health comprehensive reform program relies exclusively on voluntary measures to expand insurance coverage. There is no individual mandate and no assessment on employers who fail to provide coverage.

A DirigoChoice health insurance product is available to small businesses, the self-employed, and eligible individuals without access to employer-sponsored insurance. The program offers sliding-scale discounts on monthly premiums, reductions in deductibles, and out-of-pocket maximums to enrollees with incomes below 300% of the federal poverty level.

The report says several other states are pursuing less-than-comprehensive but still significant approaches. For example, some states are moving toward covering all children. Thus, Illinois passed the Covering All Kids Health Insurance Act, making insurance coverage available to all uninsured children. As of the beginning of the year, All Kids was made available to any child who has been uninsured for at least 12 months, with the cost to the family calculated on a sliding scale. Pennsylvania has announced development of a Cover All Kids program, Tennessee has passed a Cover Kids Act, and Oregon, Washington, Wisconsin, and New Mexico are considering similar initiatives.

Partnering with private employers

Also, several states have developed partnerships with private employers and insurers to cover low-income workers. Such collaborations have taken a number of different forms, reflecting the different regulatory and market environments in each state, as well as particular compromises that state policy leaders were able to achieve, the authors say.

The study notes this "is not the first time that state policy leaders have taken the lead in attempting to improve insurance coverage in their states. The recent reforms build on at least a decade of state experiments, most of them of limited impact, that ranged from comprehensive attempts to numerous incremental approaches."

Ms. Burton and her colleagues say these latest reforms are more promising than the earlier ones because they are based on some common, hard-won lessons, such as:

- Comprehensive state reforms take time because they build off prior efforts and in-place financing mechanisms;
- Reforms attempt to stem the erosion of employer-sponsored insurance;
- Successful efforts to enact reforms often expect shared financial responsibility, and some state officials are beginning to recognize the need for mandatory participation;
- Coverage expansions often rely on private insurers to deliver care;
- Voluntary purchasing pools, as a stand-alone strategy, are not likely to be sufficient to expand coverage;
- Medicaid benefits are being redesigned through new reforms, but so far those efforts don't include coverage expansions;
- Many state reforms address cost and quality as well as health insurance coverage.

State efforts have fueled enthusiasm that states can lead the way in addressing the problem of the uninsured. Ms. Burton says that state efforts can test coverage strategies both politically and practically, informing and providing lessons to other state and national leaders; however, her sense is that the variations among states are far too great for state-by-state reform to lead to a national solution for the country's uninsured.

The most recent data on the uninsured show a threefold variation across states, the report says. The states leading the way with comprehensive solutions all have uninsured rates lower than the national average. But a few states have uninsured populations that are close to a quarter of their population, making it unlikely they will be able to consider the universal coverage goals of the comprehensive reform states. And there are significant differences in the resources and funding streams that states have available, typically because of variation in income distribution. States often build their current reforms on prior strategies to expand coverage and on public investments in coverage for low-income individuals. States with prior health coverage investments through Medicaid and safety net funding have already addressed a portion of their uninsured problem. But states that have not made significant prior investments in coverage have to find new funding sources, and without federal financial assistance to help low-income states, they will not be able to act, the report says.

Although there is a history of the federal government fostering state innovations, issues now arising include how new state strategies will be financed and whether states will be required to find savings to finance coverage expansions.

Report co-author **Enriques Martinez-Vidal**, deputy director of Academy Health's State Coverage Initiatives Program, tells *State Health Watch* he believes a national solution will ultimately be needed, despite the current state activities. "But in the meantime," he says, "states have to do what they have to do and can demonstrate things that work." He says there is a question of scale replication and whether there are things the federal government could do that individual states can't do for a number of reasons.

"One hopeful thing is the politics in Massachusetts and Vermont where leaders were able to develop bipartisan answers with all stakeholders participating," Mr. Martinez-Vidal says. "They reached a comprehensive solution that furthers their desire to help people."

Mr. Martinez-Vidal agrees that sustainability of any reform effort is a key issue. He tells *SHW* states are seen trying to address sustainability by looking at the health care system as a whole rather than trying to deal with only coverage issues. "They're trying to figure out how to make the system better and more efficient," he says, "by merging delivery system improvements with coverage expansion." He cites Vermont's chronic care management plan as a good example of taking a broader system approach.

The report says Vermont's reforms heavily emphasize chronic care management, both in the benefit design of the Catamount Health product and in other products offered by the state such as the State Employees' Health Plan and Medicaid. The coverage expansion is aligned with the Chronic Care Initiative of the state's Blueprint for Health. Managed by the Vermont Department of Health, the Blueprint is a public-private collaborative approach that seeks to improve the health of Vermonters living with chronic diseases and to prevent the complications of chronic disease. It uses the Chronic Care Model as the framework for system changes.

Mr. Martinez-Vidal says that while one hears a lot of talk in Washington about the importance of reducing the number of uninsured, it's hard to imagine the federal government coming up with significant funding to support state efforts because there are so many competing priorities.

No silver bullet

"There's no silver bullet to solve the problem of the uninsured," he says. "If there was one, we would have done it by now."

Meanwhile, Commonwealth Fund president **Karen Davis** said in a Feb. 17 *British Medical Journal* analysis that it is not likely the federal government will legislate a way to reduce the number of uninsured for several reasons. First, she says, uninsured people are not politically organized and do not represent a strong voting bloc. Also, funding options are scarce because the federal budget is in deficit and tax revenues are at their lowest point in 40 years. Adding to the political inertia, she says, Congress is deeply divided along party lines, with Democrats supporting comprehensive solutions to expand public programs and employer-based coverage and Republicans favoring market-based solutions that encourage consumers to shop around for cheaper health insurance and health care prices.

Ms. Davis suggests an alternative way to finance expanded coverage through reinvesting savings gained through increased efficiency. She says aligning incentives with results by reforming provider payments to reward high-quality, patient-centered, and efficient care is one strategy for financing expanded coverage.

She lists these actions the federal government could take to help achieve universal coverage:

- legislate to match state funding for coverage of low-income adults up to 1½ times the federal poverty threshold;
- allow small businesses and uninsured people to purchase coverage through the Federal Employee Health Benefits Program;
- require all businesses to either provide health benefits to all employees or contribute $1 per hour of work toward coverage under public programs, coupled with a requirement that everyone purchase coverage;
- extend Medicare to uninsured adults ages 55-64 and eliminate the two-year wait before disabled people are eligible;
- revise Medicare's payment system to reward higher quality and greater efficiency, with savings used to expand coverage;
- dedicate 1% of income to financing expanded coverage and use existing subsidies for low-income charity care to finance expansion.

According to Ms. Davis, states could:

- revise the SCHIP program to include low-income adults up to 1½ times the federal poverty threshold and children up to three times the threshold;
- revise Medicaid's payment system to reward higher quality and greater efficiency, with savings used to expand coverage.

Download the Commonwealth Fund/Academy Health report at www.cmwf.org/publications/publications_show.htm?doc_id=461903. Contact Mr. Martinez-Vidal at (202) 292-6700. Download Ms. Davis' article at www.bmj.com/cgi/content/full/334/7589/346. Contact Ms. Davis at (212) 606-3800. ■

Oregon experience can influence state reform efforts

With states attempting to take the lead in health care reform, and especially doing things to reduce the number of uninsured (**see related story**), the reform lessons learned by the state of Oregon through its Oregon Health Plan and prioritized list of medical conditions and treatments may help other states avoid some mistakes. That's the thesis of a Dec. 19, 2006, *Health Affairs* report on "the unraveling of the Oregon Health Plan" by University of North Carolina-Chapel Hill associate professor **Jonathan Oberlander**.

Mr. Oberlander says that while Oregon overcame early controversy surrounding its embrace of explicit rationing to earn widespread praise for its success in expanding coverage to the uninsured, that success has been difficult to sustain. And he urges all state policy analysts to be very aware of the potential pitfalls in sustaining the plans they develop.

Oregon has been at health care reform perhaps longer than any other state, starting in 1989 with a series of steps, including an employer mandate, intended to achieve universal coverage in the state. But the employer mandate never took effect and the state's health reform efforts moved to a Medicaid expansion as part of the Oregon Health Plan.

"Put simply," Mr. Oberlander says, "Oregon intended to expand Medicaid to more people by covering fewer services. Expanding coverage for the poor—all Oregonians with incomes below 100% of the federal poverty level were made eligible for Medicaid—would be made affordable by offering a basic health benefits package that was more limited than traditional Medicaid."

A prioritized list ranking medical conditions and treatments was developed and, every two years lawmakers literally drew a line in the list, with Medicaid paying for all services above the line and none of the services below it. The state also sought to impose access and control costs by enrolling Medicaid recipients in capitated managed care organizations.

Early reviews of the Oregon Health Plan were generally favorable, with positive attention paid to the expansion of Medicaid coverage to more than 100,000 "new eligibles" each month that cut the state's uninsurance rate from 18% in 1992 to 11% by 1996. Also, fears about the impact of rationing on Medicaid patients were eased by the plan's generous benefit package and the absence of extensive rationing.

In 2002, however, state officials moved ahead with plans to expand the Oregon Health Plan, submitting a federal waiver through the Health Insurance Flexibility and Accountability initiative to amend their demonstration project by creating the Oregon Health Plan 2. The aim was to raise the eligibility for the Oregon Health Plan's Medicaid expansion population from 100% to 185% of poverty over time as budgetary circumstances permitted and to gain federal matching funds for the Family Health Insurance Assistance Program, enabling it to expand significantly.

While the waiver was approved during budget pressures and a downturn in the state's economy, officials still pursued plans to extend coverage to low-income Oregonians. No new state funds were available to extend Oregon Health Plan coverage and so reform had to be self-financing, primarily looking to the original logic for health reform in Oregon: provide fewer services for more people. Benefits for existing enrollees were to be reduced so the state could generate funds to bring more uninsured people into the Oregon Health Plan.

Expansion to 185% of poverty was to be financed by dividing the health plan into two parts—OHP Plus and OHP Standard. OHP Plus was to cover populations categorically eligible for Medicaid such as pregnant women and children with benefits still based on the prioritized list. OHP standard was to cover the expansion population such as single adults, couples, and parents not eligible for Medicaid under federal guidelines. OHP Standard enrollees were to receive a reduced benefits package.

OHP Standard premiums were increased and enrollment rules were tightened so providers could refuse to see those who could not pay copayments. The state also asked federal permission to set an enrollment cap for OHP Standard so, based on available funding, it could stop accepting new enrollees or establish a lower poverty level for eligibility. The waiver also gave state officials authority to reduce the OHP Standard benefit package, if necessary, depending on available revenues, to a level actuarially equivalent to the federally mandated Medicaid minimum.

OHP 2 operating since 2003

The Centers for Medicare & Medicaid Services approved the waiver in October 2002 and OHP2 began operating in February 2003. Mr. Oberlander says although the benefit reductions were implemented, the planned coverage expansions mostly never came to pass. "Rather than serving as the cornerstone of OHP's renewal, the implementation of OHP2 triggered

a meltdown in OHP Standard enrollment," he says. "In the year following OHP2's implementation, enrollment of the Medicaid expansion population in the health plan fell 53%, dropping from 104,000 in January 2003 to 49,000 in December 2003. And in the ensuing 18 months, OHP Standard enrollment fell by another 50%. Only about 24,000 enrollees remain in the state's Medicaid expansion program, and it has been closed to new enrollment since 2004. Oregon's uninsurance rate has climbed to 17%, virtually the same level that prevailed in Oregon before OHP began operation in 1994. Moreover, no state general funds are used to pay for OHP Standard (now financed entirely from provider taxes and beneficiary premiums), a staggering retreat for a state that had been a national leader in expanding coverage for the uninsured."

Mr. Oberlander says a significant cause of the problems is that state officials badly miscalculated the likely effects of new OHP policies. While the waiver application projected "no negative impact on access due to cost-sharing," within four months of the introduction of OHP2, enrollment among the OHP Standard population had dropped by nearly 40% and much of the decline came after new premium payment policies were implemented. Under OHP2, people who failed to pay their premiums were disenrolled from the program and subject to a six-month "lock-out" before they could reapply. Premiums were increased, and even zero income beneficiaries were required to pay premiums, with a result that their enrollment in the plan sharply declined.

In retrospect, Mr. Oberlander says, OHP2 "revealed a clear mismatch between policy-makers' understanding of low income populations and their actual behavior. Oregon failed to anticipate how price sensitive OHP enrollees were and their troubles navigating the new system, a cautionary tale for states enamored with consumerism and the prospect of having Medicaid recipients put 'more skin in the game' through added cost-sharing."

But miscalculation is not the only issue, according to Mr. Oberlander. Even if OHP2 policies had not unintentionally triggered sharp enrollment declines, he says, OHP still would have been in trouble. If enrollees had not left the plan en masse through attrition, the state would have had to cut them off due to deteriorating fiscal conditions.

Currently, according to the report, available funds can only support OHP Standard at 24,000 enrollees and it remains closed to new enrollment. Also, the provider tax that is sustaining the program can only pay for a limited benefit package. OHP Standard enrollees now have access to a limited hospital benefit, and the plan doesn't cover any physical, speech, or occupational therapy or home health care, although copayments have been dropped as a result of a court decision and legislation has eliminated premiums for the lowest-income enrollees.

"It is no longer a tradeoff of covering fewer services in order to cover more people," Mr. Oberlander says. "OHP is now covering both fewer services and fewer people and the elimination of entire benefit categories and rollback in enrolled beneficiaries looks more like the arbitrary cuts common in other states than the rational and equitable model of prioritization to which Oregon aspired."

States face unique challenges

According to Mr. Oberlander, it would be a mistake to discount the work of Oregon's health reformers, saying they have proved themselves to be resourceful and adaptive in their drive to expand coverage. Now that the state's economy is recovering, he says, reformers are once again at work and there is an emerging consensus around the idea of extending insurance coverage to Oregon's 117,000 uninsured children with financing from a new tobacco tax.

Policy-makers and analysts should be wary of generalizing too much from one state's experience, Mr. Oberlander says, because states vary in political culture and fiscal circumstances and thus confront different challenges and opportunities in pursuing innovative health policies. "OHP's fate is explained partly by

This issue of *State Health Watch* brings you news from these states:

political and fiscal circumstances unique to Oregon," he points out, "and partly by the limits of the state's chosen reform strategy of explicit rationing. Other states have proved more resilient and stable than Oregon in maintaining Medicaid expansions; failure is hardly an inevitable outcome for states that extend coverage to the uninsured (although universal coverage is a more elusive target). Yet the parallel meltdown of TennCare suggests that it is not strictly an Oregon story.

"The most important lesson is that the task is not simply to enact coverage expansions—it is to sustain them. State-led reforms must navigate their way through changing political environments as reform pioneers fade from the scene, political conditions fray, and fiscal pressures mount. As Oregon has discovered, sustaining political commitment is no easy feat.

"The strongest challenge to sustainability, though, may come from rising medical costs. As medical inflation increases, and with it the number of uninsured people who lose employer-sponsored coverage and qualify for public insurance, the price tag for maintaining—let alone broadening—coverage expansions also increases, and retrenchment may supplant activism on the agenda. And as Medicaid spending consumes a higher percentage of state budgets, outpacing revenue growth and threatening to crowd out spending for education and other politically popular priorities, ambitious plans to cover the uninsured become more difficult to fulfill. Economic downturns exacerbate these pressures, especially since states must live with balanced budget requirements. Cost control, which triggers intense opposition from the medical industry interests that profit from the status quo, requires much more political will to impose than insurance expansions do. Avoiding cost control and gaining the support of system stakeholders is perhaps the key to short-term political success. However, its absence may be, in the long run, the Achilles' heel of state-led health reforms that seek to move toward universal coverage without serious mechanisms to control spending in their own programs and without limits on medical care inflation in the broader health system."

Still, Mr. Oberlander says the obstacles are not insurmountable, noting that some states find the political will and fiscal capacity necessary not only to craft innovative programs, but also to hold onto hard-won gains and push farther ahead, even when economic conditions sour and political environments shift.

Speaking with *State Health Watch*, Mr. Oberlander stresses the importance of the really difficult issue of sustainability. He notes the impact of rising health care costs and the fact that states have little influence over them. And, he says, it is difficult to find the political will in states to change the financing system.

No state has yet achieved universal coverage, he tells *SHW*, and suggests that Massachusetts' highly touted reform program will not get there and California's latest reform proposal will not make it through that state's legislature. "There's only a small universe of states that can do anything significant towards universal coverage," he says.

Overall, Mr. Oberlander says, it's exciting to see what states are doing. "If the federal government was willing to come up with serious money to finance the states that want to do the right thing, they could do still more," he says.

An abstract and pay-per-view access to the report is available at http://content.healthaffairs.org/cgi/content/abstract/26/1/w96. E-mail Dr. Oberlander at oberland@med.unc.edu or telephone him at (919) 843-8269. ■

Can the increase in health care expenditures be slowed?

Analysts say health care expenditures will continue to increase rapidly over the next decade, outpacing income and placing financial stresses on families, businesses, and public budgets. Does it have to be that way?

A Commonwealth Fund report says there is evidence that the United States should be able to achieve savings and better value for the investment it makes in health care by creating more efficient and effective health care and insurance systems. The report looks at the factors that contribute to high expenditures and examines strategies that have the potential to achieve savings, slow spending growth, and improve health system performance.

The strategies are in six areas: 1) increasing effectiveness of markets with better information and greater competition; 2) reducing high insurance administrative overhead and achieving more competitive prices; 3) providing incentives to promote efficient and effective care; 4) promoting patient-centered primary care; 5) investing in infrastructure such as health information technology; and 6) investing strategically to improve access, affordability, and equity.

Health spending, which has risen rapidly in the last six years, is rising faster than the economy as a whole and faster than workers'

earnings, the Commonwealth Fund report says. "In recent years," it says, "insurance administrative overhead has been rising faster than other components of health spending, while pharmaceutical spending has increased more rapidly than spending on other health care services."

The United States spends 16% of gross domestic product on health care, compared with 8%-10% in most major industrialized nations. The Centers for Medicare & Medicaid Services says growth in health spending will continue to outpace gross domestic product over the next 10 years. Wide variations in cost and quality across the United States underlie these national trends, indicating opportunities to increase efficiency.

From a public perspective, according to the report, the most desirable strategies to address high and rising health care costs would involve eliminating duplicative or unnecessary care and reducing administrative overhead; preventing illnesses or complications and detecting conditions at an early stage; avoiding unneeded hospitalizations; and enhancing productivity and efficiency in providing care.

"Although there may come a time when the nation is compelled to make a tradeoff between spending on health care and other high priorities," the report says, "there is currently ample evidence that we can achieve savings and efficient payment, insurance, and care delivery systems and still improve health outcomes, quality of care, and access to care."

The Commonwealth Fund notes there are wide variations in health care costs across the country. Thus, the Dartmouth Atlas of Health Care shows that Medicare outlays per beneficiary adjusted for area wage costs ranged from $4,530 in Hawaii to $8,080 in New Jersey in 2003. But studies demonstrate no systematic relationship between higher spending and achieving longer lives or higher quality of care for Medicare beneficiaries. Evidence of extensive variations in costs and quality and studies documenting provision of duplicative, inappropriate, and unnecessary care have led the Institute of Medicine (IoM) and other experts to conclude that the U.S. health care system could improve quality, access, and cost performance. "Whether comparing U.S. performance to international benchmarks of high value or to benchmarks set within the United States, it is clear there are opportunities to improve the yield we reap given the resources we invest in health care," the report concludes.

Factor in high expenditures

The report says that addressing factors that contribute to current high levels of U.S. expenditures, inefficiency, and waste will result in one-time savings. Such factors include:

- overuse, inappropriate, or ineffective use of care;
- payment incentives that reward delivery of more services without considering clinical value or cost-effectiveness;
- market power of insurers, providers, and the health industry, including drug companies, device manufacturers, and other suppliers to set prices about competitive market levels;
- a low ratio of primary to specialty care physicians and services;
- access barriers to preventive and primary care contributing to avoidable hospital admissions, emergency department use, and complications of chronic and acute diseases;
- a lack of well-coordinated care leading to unsafe, duplicative, or conflicting care;
- inadequate information systems and information exchange; and
- high administrative costs, including the high proportion of insurance premiums used to cover overhead costs, the complexity of insurance benefit design and duplicative and uncoordinated requirements, and administrative costs for providers.

The report says the principal factors contributing to long-term trends in rising expenditures that might be amenable to policy change are somewhat different, and include:

- introduction of new technologies/innovations without comparative information on clinical outcomes or cost-effectiveness to guide decisions on adoption and use;
- wages and prices of other hospital-purchased goods and services;
- growing market power and consolidation of insurers, providers, and the health industry, including drug companies, device manufacturers, and other suppliers contributing to less choice and higher prices;
- the increasing prevalence of chronic diseases.

Substantial cumulative gains could come over time from both the strategies that achieve one-time savings and those that address cost trends. Thus, a policy option that could achieve a one-time 5% reduction in the level of health care spending this year would achieve $1.32 trillion in cumulative savings over the eight years from 2007 to 2015. And a policy option that has the effect of lowering the average rate of increase in health care outlays by 1% a year would yield cumulative savings of $1.39 trillion over the same period.

The Commonwealth Fund report says potential strategies to move the United States to a higher value, more efficient health care system

cluster into six main areas:

1. increase market effectiveness by improving access to information on the quality and costs of care, promoting greater competition, and developing better information on the cost-effectiveness of health care technology and procedures;
2. reduce high insurance administrative overhead and achieving more competitive prices;
3. provide payment incentives to promote efficient and effective care;
4. change the health care system to promote patient-centered care;
5. invest in infrastructure such as health information technology and information exchange systems;
6. invest strategically to improve access, affordability, and equity.

Commonwealth Fund president **Karen Davis** and her colleagues who worked on the report say effective policy options should focus on changing total national expenditures rather than simply shifting costs from one payer source to another. Some policies may have a greater effect on federal budget outlays, while others may affect outlays by state government, employers, or households. Achieving improved value for the national investment in health care requires policies that achieve net gains for the whole country.

Thus, they say, at the national level policies should be amenable to federal policy action; improve health outcomes, quality, access, efficiency, or equity; have a high likelihood of significant reduction in expenditure levels and/or trends compared with current projections, or achieve a net improvement in value; be evidence-based and feasible to implement; and be reasonable first steps toward longer-term reforms.

Legislation in four areas

Legislative proposals that have been introduced in Congress address four major areas, according to the Commonwealth Fund: simplifying, standardizing, and introducing negotiated pricing into Medicare Part D; enhancing use of health information technology and building a national interoperable technology system; integrating value-based purchasing into Medicare payments; and improving public access to information on the quality and price of medical services.

"There is a compelling need for a coherent public and private sector strategy, with all parties working in concert toward agreed-upon health system aims," the report concludes. "Such a strategy should place high priority on policies and practices that have the potential to move our nation toward benchmark levels of performance on access, quality, and efficiency, so that the U.S. health system could achieve commensurate value for the significant resources it commands."

Download the report from www.cmwf.org/publications/publications_show.htm?doc_id=449510. ■