State Health Watch

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States move ahead: Tired of waiting for national health care reforms

Not believing that a national solution to a number of pressing health care problems is likely to come soon, states are moving ahead with a variety of reform initiatives to meet local needs.

"Governors cannot wait for federal solutions to the rising cost of health care and the growing number of uninsured," says **Molly Voris**, senior policy analyst with the National Governors Association's Center for Best Practices. "As a result, health care reform efforts at the state level have been a priority for governors in recent years. States are approaching health care reform broadly and are aiming to improve cost containment efforts through quality improvement and measurement, incorporating prevention and wellness into their health plans, and using information technology to further improve care delivery."

Ms. Voris tells *State Health Watch* that she can't comment on the viability of states making reforms on their own rather than pursuing a national solution, but still notes that each state is unique in its reform needs and thus states are approaching reform from a variety of perspectives.

Governors are mindful of the likelihood that their states will again face an economic downturn some

See ***Reforms*** *on page 2*

In This Issue

A great divide in dollars: Wide variation in health care spending across states

Fiscal Fitness: How States Cope

The wide variety in cost and quality across states is a signal that much stronger policies will be needed to achieve high performance on access, quality, and efficiency, according to a commentary by Commonwealth Fund president **Karen Davis** and senior vice president for research and evaluation **Cathy Schoen**. Their *Health Affairs* commentary was on a Centers for

See ***Fiscal Fitness*** *on page 6*

Bush veto throws SCHIP into turmoil

At press time, President Bush had vetoed the SCHIP reauthorization bill and Congress was determining whether to try to override it and/or negotiate the issue with the president. Look for complete coverage and analysis of these developments in an upcoming issue of *State Health Watch.*

State Health Watch
The Newsletter on State Health Care Reform

On-line access / Index

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Reforms

Continued from cover

time in the future and are trying to avoid expenditures that will have to be cut back at that time, she says. "Governors are looking at broader reform efforts and not just coverage expansion," she says. "They are looking at wellness and at quality improvement and measurement. They are making efforts to improve the overall health care system and are looking for ways to save money."

According to Ms. Voris, states are exploring three main areas of reform to improve coverage and care within their health care systems:

1. Innovative coverage approaches using both public and private expansions. Public expansions involve using Medicaid and SCHIP programs to expand coverage to populations that would otherwise likely be uninsured, particularly children with slightly higher incomes. The private expansions use state dollars to provide incentives and subsidies for small businesses to make it more feasible for them to provide health insurance to their employees. States also are using premium assistance programs to help low-income workers buy their employer-sponsored insurance, and are setting up and contributing to health savings accounts to allow individuals to purchase their own health care services.

2. Reforming the private insurance marketplace. States are approaching reforms, Ms. Voris says, by requiring employer participation to discourage employers from dropping the health insurance they offer to their workers, and requirements that individuals have health insurance or face a penalty. Through tax incentives, states are encouraging employers to set up Section 125 plans to allow their workers to deduct their health insurance premiums with pretax dollars. States also are using a connector model that provides access to more affordable and portable insurance, as well as allowing a greater choice of insurance products for those not receiving their insurance through their employer. Some states are creating state-defined benefits packages to ensure individuals are receiving basic health services through private insurers.

3. Improving the health care system. Through quality improvement and measurement, states are using methods such as pay-for-performance, adoption of standard quality measures, and development of electronic data exchange to improve the efficiency and quality of patient care. They also are incorporating prevention and wellness benefits into reform plans and insurance regulations to improve the cost effectiveness of care by treating preventable diseases earlier and improving coverage value.

Numerous states have implemented or are considering expanding the Medicaid and SCHIP programs to include uninsured individuals who would otherwise not qualify. States have used both state and federal funds to expand eligibility by increasing income and asset levels or expanding the categories of individuals who qualify for programs. Other states have offered buy-in programs allowing the uninsured with slightly higher incomes to purchase health insurance coverage through Medicaid or SCHIP.

Individual states take action

Illinois' All Kids Program (**see related story, p. 3**) was implemented to offer affordable health insurance with a Medicaid-like benefit package to all children in the state. To qualify, individuals must have been without health insurance for 12 months. Cost-sharing amounts are based on a sliding scale except for preventive

care, which has no copayments.

Wisconsin's Badger Care Plus health reform proposal focuses on covering all children, providing coverage and enhanced benefits for pregnant women, making the program simple, and promoting prevention and healthy behaviors. Badger Care Plus combines several existing programs into one comprehensive program

Since low-income workers frequently are not offered insurance through their employers or are unable to afford the coverage that is offered, some state initiatives are aimed at increasing access to affordable health coverage in the private insurance market, mainly through employer-sponsored insurance. Several state plans provide incentives to small businesses to offer coverage to their employees and subsidize premiums for low-income workers.

Illinois extends coverage to 'All Kids'

In the summer of 2006, Illinois implemented its All Kids initiative that uses all state funds to build on the Medicaid and SCHIP programs to offer coverage to all uninsured children regardless of income, health status, or citizenship. Within a few months of implementation, 50,000 previously ineligible children were added to the rolls of the insured.

A Kaiser Commission on Medicaid and the Uninsured case study on the program says under All Kids, families can purchase insurance on a sliding income basis. The entire Medicaid, SCHIP, and state-only programs now cover 1.3 million children under the All Kids umbrella.

Illinois officials, advocates, and observers interviewed for the case study attribute some of the program's obvious success to the state's considerable outreach efforts that involved innovative strategies including an application agent initiative in which community organizations, medical providers, and insurance agents helped individuals complete applications. The state's consumer-friendly application also was cited as a major reason for the program's early enrollment success. And another important factor is All Kids' availability to all children in the state, making it easy to market and easy for families to understand.

Kaiser says state officials had to deal with several program issues in putting the program together. Thus, because it is available to children at all income levels, the state wanted to deter employers from dropping dependent coverage and families from dropping private coverage to enroll their children in All Kids. The solution they chose was a 12-month uninsurance waiting period for children in families with income over 200% of the federal poverty level, although they also provided several exceptions such as children who lost coverage because a parent lost a job for any reason.

Setting appropriate cost-sharing

Another challenge, the case study says, was how to set cost-sharing to emphasize preventive care and make it affordable for low-income families. At the same time, for higher-income families who typically have other insurance options, officials wanted premiums to be sufficiently high to prevent All Kids from "crowding out" private coverage. Under All Kids, no cost-sharing is imposed for preventive medical and dental care, regardless of income, and cost-sharing is designed so the program is "very affordable" for low-income families. For higher-income families, All Kids premiums were set to be comparable to those in the commercial market.

One of the greatest challenges for the program will be to maintain and sustain its funding, which is intended to come from projected savings from two new managed care initiatives—a primary care case management program and a disease management program. Those two programs are projected to save $57 million a year, which would cover the estimated $25 million first-year costs for All Kids.

Kaiser says the bulk of Illinois' Medicaid and SCHIP populations, along with All Kids expansion children, will be required to enroll in the primary care case management program when it is fully implemented, and about 200,000 high-cost Medicaid beneficiaries are targeted for the disease management program.

The case study reports the two case management programs have experienced some implementation problems and it remains to be seen whether the projected savings will materialize to support All Kids in future years. Another important issue, it says, is whether the program offers meaningful universal coverage to children. Given premiums for higher-income families purposefully were set high, a question is whether All Kids offers true coverage to all children, particularly those with higher family incomes.

Download the case study report at www.kff.org/uninsured/upload/7677.pdf. ■

Other states are offering premium assistance to allow low-income workers to buy their employer-sponsored insurance. And some states are setting up and contributing to health savings accounts for low-income individuals, while others are providing incentives for small businesses that set up health savings accounts for their employees.

The Oklahoma Employer/Employee Partnership for Insurance Coverage (O-EPIC) program was created to assist small businesses in offering their employees health insurance. Participating employers with 50 or fewer employees must contribute 25% of the employee's premium and must offer a qualified O-EPIC plan. Qualifying plans are required to cover state-defined basic benefits and have maximum out-of-pocket spending limits. The state subsidizes the cost of the coverage to ensure affordability.

The Healthy NY program in New York State offers affordable health insurance options to small employers, providing businesses with 50 or fewer employees access to state-defined benefit packages. Plan costs are state-subsidized. Employers must have a 50% participation rate and must contribute at least 50% of the employee's premium.

Under the Insure Montana initiative, tax credits and subsidies to make health coverage more affordable are available for both small business employees and employers. A tax credit is available for small businesses with fewer than 10 employees who currently offer and contribute toward their employees' health insurance costs. On average, participating small businesses receive a credit of up to $100 per month per employee.

Utah's Premium Partnership for Health insurance program is designed to help residents pay for employer-based health insurance that would otherwise be too costly. It is available to employees with low incomes who are eligible for their employer's plan but do not currently have health insurance. Eligible individuals can receive up to $150 for their monthly premium and up to $100 per month for each child. Enrolled children also have options for dental coverage. Utah law requires employers to pay half of their employees' premiums.

Minnesota is modernizing existing public programs and increasing subsidies for private coverage rather than the state-managed MNCare program for children in families with income above 200% of poverty. The state will develop a standard benefit package, to be known as MNCare II, which will be offered in the private market to ensure basic services are covered and coverage is affordable. The governor's plan requires insurers with more than 3% of the individual market to offer the MNCare II package. Insurers are free to modify the benefit to make it more attractive to parents of children who may be enrolled. Minnesota also is creating the Minnesota Health Insurance Exchange through which employers will be able to give their employees access to health care coverage. The Exchange also will cover the individual insurance market. It will monitor products to ensure they meet basic requirements and will collect premiums and remit them to plans to reduce the administrative burden for individuals and employers.

Texas is considering a premium assistance program to help low-income uninsured working adults gain access to affordable health insurance. The state will offer varying levels of premium assistance based on a sliding scale. Participating plans must be certified by the state. The plans include a minimal deductible and co-payments, which can be paid for by individuals out of a health savings account established by the state.

Indiana has created the Healthy Indiana Plan for adults and pregnant women with incomes below 200% of poverty. Participating individuals will have a Personal Wellness Responsibility (POWER) account that acts as a health savings account, with $1,100 to cover the deductible. A private health insurance plan approved by the state is available to individuals after they have met the deductible and includes services such as preventive care and disease management. The plan also includes $500 for preventive care such as physical examinations, screenings, chronic disease management, and smoking cessation.

A Kansas small employer health insurance credit offers small businesses a tax credit for offering and contributing to health savings accounts for their employees. The credit is available to businesses with fewer than 50 employees that have not contributed to their employees' health insurance over the past two years. The enhanced credit for newly contributing employers is $70 per member per month in the first year, phasing down to $35 per member per month in the third year and ending after the third year.

Some states are reforming the private insurance marketplace to make health insurance more affordable. Thus, Massachusetts is requiring employers with more than 10 employees to offer insurance or pay a portion of their employees' health insurance premiums and also offer employees the ability to pay health insurance using Section 125 tax-free deductions of premiums. Massachusetts also is implementing a plan to insure every state resident. The plan includes an individual mandate and a way to fine residents through the state income tax if they are found to not have insurance. And the Massachusetts Commonwealth

Health Insurance Connector Authority is offering small businesses and individuals an opportunity to buy affordable health insurance through a large purchasing pool.

Vermont employers are required to pay $365 annually for each full-time employee if the employer does not offer insurance, only offers insurance to some workers, or some employees remain uninsured. This will be required of all employers with nine or more employees in 2007 and spread to employers with five or more employees starting in 2010. Also, individuals without access to an employer-sponsored insurance plan in Vermont will be offered the Catamount Health plan, provided by private insurers that must offer a standard set of state-defined benefits.

Maine Gov. John Baldacci wants to make the state's Dirigo Health Plan a self-insured plan that will be more affordable for small businesses and uninsured individuals.

Tennessee's CoverTN program offers affordable and portable health insurance to employers with 25 or fewer full-time employees that offer the plan to all employees and agree to pay one-third of employees' premiums. Participating employers are required to set up Section 125 plans for employees to have the pretax deduction of insurance premiums.

Missouri Gov. Matt Blunt is redesigning the state's Medicaid program and is reforming the health care system by requiring purchase of insurance premiums with tax-free dollars through Section 125 plans established by employers.

Michigan's uninsured will have access to private sector insurance plans offered by a newly created Exchange, which will administer the program. The Exchange will set a minimum benefit package with flexibility to be able to offer a range of services at various premium levels.

Connecticut Gov. M. Jodi Rell has introduced the Charter Oak Health Plan to create a public-private partnership offering a state-defined benefit package through private insurers.

Although most state-led health reform initiatives have concentrated on coverage efforts, Ms. Voris says, there also are components intended to improve the quality of the health care system as well as the overall health of the population.

Using coverage expansion and Medicaid redesign as vehicles, many states have incorporated quality improvement and measurement into their reform plans to improve efficiency and patient care, according to Ms. Voris. States are using quality standard measures to evaluate the care providers are delivering. States also are using pay-for-performance measures to increase quality of care. And several states are taking steps toward interoperability with electronic data systems by developing a system for electronic data exchange, including electronic health records. "Health information technology advancements help to eliminate duplicative care, reduce medical errors, and increase efficiency with the exchange of real-time medical data," she says.

Minnesota has created QCare (Quality Care and Rewarding Excellence) as a quality standard that will be used to reward top performing providers. QCare will initially set standards for four areas where many of the state's health care dollars are spent—diabetes, hospital stays, preventive care, and cardiac care. The state Department of Health says if QCare standards are met, more than $153 million in health care costs will be saved annually.

North Carolina's Medicaid Community Care is a managed care program emphasizing quality improvement by adopting standards determined by an advisory group, including for asthma and diabetes care.

Prescription for Pennsylvania will focus on improving patient safety by reducing hospital-acquired infections and targeting avoidable medical errors. The state also will promote use of a proven national model that manages treatment for chronic conditions such as heart and lung disease, diabetes, and asthma.

Washington Gov. Christine Gregoire is taking a comprehensive approach to quality with creation of the Washington Quality Forum to address disparities in care based on the location care is received, expansion of chronic care management in all state health programs, and direction to state agencies to change state contracts and reimbursement to pay for performance and promote prevention.

States also are including wellness and health promotion benefits in many reform plans, state employee insurance plans, Medicaid redesigns, and small group and individual markets.

Rhode Island created a wellness health benefit plan that insurers are required to offer to employers with fewer than 50 workers and individuals purchasing health plans.

A proposal by California's governor would encourage healthy lifestyles and behaviors by providing rewards in the Medi-Cal, Healthy Families, and CalPERS public employee programs.

Nebraska has established a steering committee and advisory committee to improve the health of state employees. The program made a health appraisal survey available to state employees and is addressing the need for improved physical activity, nutrition, and smoking cessation.

The report is available from the National Governors Association Center for Best Practices at www.nga.org/center. Contact Ms. Voris at (202) 624-5395; e-mail mvoris@nga.org. ■

Fiscal Fitness

Continued from cover

Medicare & Medicaid Services (CMS) study also published in *Health Affairs* that found that eight of the top 10 states in per capita personal health care spending were in the New England and Mideast regions, while states with the lowest per capita spending were typically located in the Southwest and Rocky Mountain regions.

CMS economist **Anne Martin** and colleagues reported that in 2004, the top 10 states with the highest per capita personal health care spending were Massachusetts, Maine, New York, Alaska, Connecticut, Delaware, Rhode Island, Vermont, West Virginia, and Pennsylvania. Those states consumed an average of $6,345 per person in 2004, nearly 20% higher than the U.S. average of $5,283.

The researchers say some of the 10 states' characteristics influenced how much was spent on health care. Thus, Massachusetts, New York, Connecticut, and Delaware ranked among the highest in the nation in per capita personal income. And Massachusetts, New York, Connecticut, Rhode Island, Vermont, and Pennsylvania ranked among the highest in concentration of physicians to population. Also, the uninsured share of the population was among the lowest in the nation for some of the top 10 per capita health-spending states.

"This suggests that residents in these states may receive more comprehensive employer-based health insurance benefit packages, or that the states are in a stronger financial position to provide expanded benefits through Medicaid or other state initiated programs," Ms. Martin says.

However, the researchers also found differences in the mix of health care services and goods used and in funding sources. For example, Massachusetts, which had the highest per capita health care spending in 2004 ($6,683), nearly 27% above the U.S. average, ranked near the top for per capita hospital, nursing home, and home health spending and for total per enrollee Medicare and Medicaid spending. Ms. Martin says hospital spending in the state may be driven by higher-than-average use of services such as diagnostic treatments and more intensive services commonly used in teaching hospitals. Massachusetts also has an expansive Medicaid program that could contribute to its higher-than-average Medicaid and overall health spending.

Maine's per capita spending on physician services was second highest in the nation, while per capita physician spending in Connecticut and Massachusetts ranked lower. Also, Maine had higher per capita spending on other personal health care services, including expanded Medicaid coverage for services provided under home- and community-based waivers, than for any other state in 2004. Maine also provides greater coverage of long-term care services and support of those with disabilities through its Medicaid program. The authors say that Connecticut's low percentage of the population that is uninsured and recent expansion of hospital services offered may contribute to comparably high per capita health spending relative to the rest of the United States.

Per capita personal health care spending in New York and Alaska was greatly influenced by Medicaid spending. New York's per capita Medicaid spend was among the highest in the nation ($10,173 in 2004) and accounted for 32% of total state health care spending. Alaska per enrollee Medicaid spending was the highest in the nation at $10,417. It spent the most in the nation per Medicaid enrollee on hospital, doctor, and dental services, possibly because of the state's relative isolation, which decreases access to alternative and more cost-efficient sources of care.

Lowest per capita spending

The states with the lowest per capita personal health spending in 2004 were Utah, Arizona, Idaho, New Mexico, and Nevada. They accounted for an average of $4,244 per person, nearly 20% lower than the U.S. average. Those states tended to have lower-than-average per enrollee Medicare and Medicaid spending. And because of their less populous nature, there could be less access to and availability of doctors and hospitals. Also, demographic similarities such as lower median age of state residents and a smaller proportion of the population older than age 65 may lead to less health care use.

Ms. Davis and Ms. Schoen say in their commentary that the spending information is especially timely given the renewed interest in state health reforms (**see related story, p. 8**). They say most of the reforms enacted so far are primarily designed to improve health insurance coverage, but also have some features aimed at controlling costs or improving quality.

They note that in line with the state-by-state variations, the Commonwealth Fund Commission on a High Performance Health System state scorecard found two- to threefold or greater spread from top-ranked states to bottom-ranked states on 32 indicators across five dimensions of health system performance—access, quality, potentially avoidable use of hospitals and costs of care, equity, and ability to lead healthy lives.

Analyzing the state spending data, Ms. Davis and Ms. Schoen found that personal health spending per capita does not appear to be correlated with mortality amenable to medical care. They also found an inverse relationship between states spending more on personal health care and state rankings on quality of care. Also, state rankings on Medicare spending per capita are highly correlated with preventable hospitalization, including 30-day Medicare hospital readmission rates.

"These relationships affirm previous research that has documented either no relationship or a negative relationship between spending and quality," the two wrote. "They point to promising strategies for improving health system performance by reducing preventable hospitalizations and improving insurance coverage….The variations show that every state has room to improve its health care system, and states can learn by critically observing innovative strategies at work."

Reasons state costs converging

The Commonwealth Fund analysts say the most important implication of the new analysis that finds that state costs are converging because of relatively rapid increases in low- as well as high-cost states is that states cannot afford to concentrate only on insurance coverage when considering reforms. "Improving insurance coverage is likely to improve access to care, but the issue of cost will require specific policy strategies—some of which could be built into the design of insurance coverage," they say. "These efforts will also require coherence across payers to improve whole system performance."

Ms. Davis and Ms. Schoen say states have the chance to "test drive" promising approaches designed to meet the needs of their populations. They suggest there might be 50 solutions as diverse as the states themselves or a few innovative strategies flexible enough to be spread across the country.

They assert that ultimately federal leadership will be needed, if only to help finance insurance expansion, set high standards of performance, urge public-private collaboration, and help coordinate public-private payment and other policies. But in the meantime, state initiatives serve as valuable learning laboratories.

In another commentary on the CMS data, Urban Institute director of health policy **John Holahan** says the variation among states on Medicaid spending actually is greater than that for Medicare or for overall health spending.

There are many reasons spending per Medicaid enrollee can vary, Mr. Holahan says, including the extent of benefits states choose to cover and whether the state is actively involved in ways to take advantage of upper payment limits and disproportionate share programs. Spending per enrollee also varies because of differences in the price and quantity of services provided, and because states cover very different shares of their low-income populations.

"In the end," he says, "state spending is determined by federal matching rates that vary inversely with state per capita income and with states' willingness to spend from their own resources….The incentives in Medicaid to have low-income states spend more by having federal payments offset lower state per capita incomes have simply not been successful."

While some variation is inevitable and also exists in Medicare and private coverage, Mr. Holahan says the policy question is whether the very large variation in Medicaid spending is acceptable. "We have shown elsewhere that states with lower levels of spending have lower levels of access and worse health outcomes," he says. "Thus, the spending variations have consequences that are felt at the national level."

It can be argued, Mr. Holahan says, that while there is considerable flexibility given states in their Medicaid programs, the federal government picks up more than half the cost of Medicaid and SCHIP and there is a national interest in how these programs work. And if there is a strong national interest, he says, then wide state variations are problematic. "The large federal contribution to Medicaid and SCHIP and the fact that state matching rates vary inversely with state per capita income seems to recognize a national interest in extending coverage to low-income groups, regardless of where they live," he says. "Moreover, the recent interest in extending subsidies to low-income people through federal tax credits suggests that even those who oppose expanding government insurance programs in general accept the need to extend health insurance coverage to low-income Americans, regardless of where they live."

Mr. Holahan says it is ironic that the recent interest in state health reform actually is likely to make current inequities worse. Some progressive states such as Massachusetts, New York, Connecticut, Vermont, Pennsylvania, and Illinois have enacted or are seriously considering proposals to extend coverage to all residents. "In American politics today," he says, "it is likely that only these more progressive states can achieve the political consensus necessary to substantially extend coverage. Other states will be left with the current mix of programs. Coverage of individuals and spending on health services will be subject to state officials' willingness to pay, regardless of the generosity of federal matching payments available

to them."

National solution needed

Mr. Holahan insists a national solution will be needed to eliminate the extensive variations that the current system has produced. But, he says, such a solution would have huge costs to the federal government and political agreement on an approach to extending coverage to all will be difficult to achieve.

"The result of a stalemate," he says, "will be that low-income people will continue to be treated very differently depending on where they live. This not only will have consequences for the states in which they reside, but because poor access to health care will affect health outcomes, it will have implications for the nation as well."

Download the CMS report at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.6.w651. Download the Commonwealth Fund commentary at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.6.w664. Download Mr. Holahan's commentary at http://content.healthaffairs.org/cgi/content/abstract/hlthaff.26.6.w667. Contact Ms. Martin at anne.martin@cms.hhs.gov, Ms. Davis at kd@cmwf.org, and Mr. Holahan at jholahan@ui.urban.org. ■

Amid obstacles, Massachusetts strives toward universal coverage

Although Massachusetts' individual mandate for health care coverage took effect July 1, the first-year penalties for people who remain uninsured are relatively light. Likewise, most small employers had already renewed coverage for 2008, so it will be some time until observers can determine more about the effects of reform on their behavior regarding health insurance coverage.

A report from the Center for Studying Health System Change (HSC) says the issue for Massachusetts may come down to how close to the goal of universal coverage is realistically attainable. The state has a lower percentage of uninsured people compared to most other states, which increases the feasibility of achieving near universal coverage. But, the HSC asks, at what point do the costs to the state in getting one additional individual insured outweigh the benefits? "At some point, and probably not too far in the future, this is a question that Massachusetts will likely be required to answer," the report declares.

The state's universal coverage reform legislation, which was signed into law in April 2006, required most uninsured adult residents (an estimated 300,000 people or 9% of the adult population) to have health insurance coverage by July 1, 2007. Nearly three quarters of the uninsured are believed to be employed. Approximately two-thirds of them work more than 35 hours a week and approximately two-thirds work for small firms.

The lowest income and most vulnerable adults are covered with free or subsidized coverage through Medicaid expansions or a new Commonwealth Care program. And most of the remaining uninsured—those with incomes above 300% of the federal poverty level—were required to purchase insurance on their own or through their employer. Some 44% of the uninsured earn more than 300% of poverty.

The law requires employers to set up cafeteria plans through which employees can purchase health insurance with pre-tax dollars, which can reduce employee premiums by an average of 41%. Employers with 11 or more FTE employees that do not meet this requirement may be subject to a "free rider" surcharge if their employees' or dependents' care is paid for by the state uncompensated care pool.

Also, employers that don't offer a "fair and reasonable" contribution for their employees' coverage will be assessed up to $295 per worker per year. Observers have said they don't expect this requirement to have much impact overall, the Center report says. They view the fee as a way to offset the cost-shifting that occurs when employers that provide health coverage to their workers also contribute to the uncompensated care pool. They don't expect the fee to induce employers that do not currently offer coverage to workers to begin doing so since insurance costs significantly more than the fee. Observers also believe the fee is not large enough to impose a substantial financial burden on employers.

HSC researcher **Laurie Felland**, the lead author on the Massachusetts report, says the greatest pressure on employers to offer health insurance to their employees should come largely through the individual mandate. Because state residents will face tax penalties for going without health insurance, Ms. Felland says observers predict that employers that don't offer coverage may become less attractive to workers. While the direct employer requirements are targets firms with 11 or more employees, the individual mandate applies to all residents so it is likely to affect employers more broadly. Thus, workers who until now have declined coverage offered by their employer may now choose to participate due to the individual mandate, which would raise the employers' costs.

Reform also is expected to affect some already insured people. Since individuals are required to have a

minimum level of coverage, employers offering less than that might be pressured by workers to increase their coverage, Ms. Felland says. That would likely increase costs, unless offset by wage cuts.

There remains a question of whether the individual mandate actually will force people to obtain insurance. Some observers have expressed skepticism that the tax penalty in years after the first year will be large enough to change behavior. They note, as an example, that a 37-year-old living in Boston would be assessed some $1,000 in tax penalties, but that would be about half the annual premium of the lowest-cost health plan available.

Another key element in the reform plan was the merger of the small group and nongroup insurance markets to pool the health care risks of some 750,000 people in the small group market (one to 50 workers) and 50,000 people in the nongroup, individual market.

Many market observers said they expect the individual mandate to bring younger, healthier people who currently don't purchase coverage to the combined pool and lower the overall risk, as well as increasing the number of insurance product choices available. But Ms. Felland says other observers are skeptical that the individual mandate is strong enough to encourage healthy people to purchase insurance to balance the costs of insuring sick people.

"In rapid fashion," Ms. Felland says, "Massachusetts has made efforts to both ignite demand for health insurance and establish a marketplace for individuals and small employers to purchase coverage. Market observers applauded the reform's coverage of more than 135,000 of the lowest-income uninsured residents through the Medicaid expansion and the subsidized Commonwealth Care program. Yet there are many challenges ad unknowns ahead…including many that pose substantial threats to the goal of near universal coverage."

The most fundamental issue, she says, is affordability. While most market observers agree that the primary goal of the reform is to improve access to health insurance, they contend that its ultimate success depends on affordability in both the short and long term.

If affordable coverage is not available, Ms. Felland says, it is unlikely that small employers on the cusp of offering insurance to their workers will be motivated to do so. Instead, they are more likely to pay the $295 annual fee rather than incur the greater costs of offering insurance.

Affordability is a key concern

Affordability also is a concern of individuals and, despite the individual mandate to have health insurance, there are likely to be some people who will forego coverage and pay the tax penalty. They may decide, according to Ms. Felland, that basic needs such as housing and food must take precedence over obtaining health insurance.

"Efforts in other states to reduce the number of uninsured by creating purchasing pools, offering insurance subsidies to employers and employees, tax credits, or limited benefits have struggled for precisely this reason—individuals' perceptions that they cannot afford coverage or that what they are buying is not worth the cost," the report says.

The researchers say the challenge of affordability extends to a policy debate about what should be the balance between the financial obligations of individuals and the state. The less affordable coverage is for consumers, the more likely the state will have to commit additional monies to subsidize people to achieve near universal coverage.

Aside from the affordability issue, the report says, there are a number of other reasons individuals may opt not to comply with the mandate. For example, they may not understand the individual mandate and their specific responsibilities under it. Others may dislike what they perceive as government interference in requiring that they have health insurance coverage. In some ways, the situation is similar to that with automobile insurance—while it is required, still not all car owners buy it.

If people who have decided not to obtain health insurance receive care, there are a number of impacts on the system. While some employers will be assessed a surcharge for costs their uninsured employees incur for care paid for by the state's uncompensated care pool, this has significant implications for the reform since much of

the reform is expected to be financed by reallocating funds from the uncompensated care pool. Ms. Felland says Massachusetts is working to update the uncompensated care pool rules in an effort to align incentives so that individuals with access to affordable insurance take up coverage instead of relying on the pool.

A question that remains to be answered is what happens to the reform when the state's economy weakens. Right how, the researchers say, it is being implemented at a time when the economy is strong and unemployment is low. Typically during economic slowdowns, unemployment rises and people lose their employer-sponsored health insurance. Then costs for public programs such as Medicaid increase as more people become eligible. Finally, state revenues decline, reducing the ability to support the programs.

Ms. Felland tells *State Health Watch* that affordability was the central issue raised in the center's interviews with Massachusetts leaders. "There's a lot of uncertainty over whether the employer mandate and individual responsibility are sufficient," she says.

Download the report at www.hschange.org/CONTENT/939/. Contact Ms. Felland at (202) 484-4833 or e-mail lfelland@hschange.org. ■

Power of prevention: 100,000 lives could be saved a year

The Partnership for Prevention says more than 100,000 lives could be saved every year in the United States if use of five preventive services were increased. The total includes 45,000 lives the group says would be saved each year if more adults took a daily low-dose aspirin to prevent heart disease. The study was funded by the Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation, and the WellPoint Foundation.

The study found that better use of measures such as more adults getting flu shots and being screened for cancer could save tens of thousands of lives each year. It documented serious deficiencies in use of preventive care for the nation as a whole, and particularly troubling problems among racial and ethnic populations.

"A lot of Americans are not getting life-saving preventive services, particularly racial and ethnic minorities," said National Commission on Prevention Priorities chair **Eduardo Sanchez**. "As a result, too many people are dying prematurely or living with diseases that could have been prevented. We could get much better value for our health care dollar by focusing upstream on prevention."

Indeed, the power of prevention could yield a considerable impact, as the study projected:

- 45,000 additional lives would be saved each year by increasing to 90% the portion of adults who take aspirin daily to prevent heart disease. Today, fewer than half of Americans take aspirin preventively.
- 42,000 additional lives would be saved each year by increasing to 90% the portion of smokers who are advised by a health professional to quit and are offered medication or other assistance. Today, 28% of smokers receive such services.
- 14,000 additional lives would be saved each year by increasing to 90% the portion of adults ages 50 and older who are up to date with any recommended screening for colorectal cancer. Today, less than 50% of adults are up to date with screening.
- 12,000 additional lives would be saved each year by increasing to 90% the portion of adults age 50 and older immunized against influenza annually. Today, 37% of adults have had an annual flu vaccination.
- Nearly 4,000 additional lives would be saved each year by increasing to 90% the portion of women age 40 and older who have been screened for breast cancer in the past two years. Today, 67% of women have been screened in the past two years.
- 30,000 cases of pelvic inflammatory disease would be prevented annually by increasing to 90% the portion of sexually active young women who have been screened in the past year for chlamydial infection. Today, 40% of young women are screened annually.

Minorities use less preventive care

According to the report, African Americans, Hispanic Americans, and Asian Americans all use preventive services at lower rates than the white, non-Hispanic population in the United States.

"This report documents that minority groups in America use less preventive care," said former U.S. Surgeon General **David Satcher**. "One reason is that many Americans, particularly minorities, have no continuity in their healthcare, no relationship with a doctor or other medical professional who can ensure that they are getting the preventive care they need. We have to transform our sick care system into a health care system that works for everybody."

One question that arises out of the report is why people don't receive the preventive services they need. The report says the reasons are complex, but offers these contributing factors:

1. Many health care providers lack systems or fail to use systems to

1) track their patients to determine who needs preventive services; 2) contact those patients to remind them to get the services; 3) remind themselves to deliver preventive services when they see their patients; 4) ensure the services are delivered correctly and that appropriate referrals and follow-up occur; and 5) make certain the patients understand what they need to do.

2. The U.S. health care system benefits specialty care and acute care treatment at the expense of primary care and prevention, as evidenced by limited investment in developing a prevention-oriented health care work force and limited training for doctors and other health care providers in delivering preventive care. For example, there is too little emphasis on delivering effective brief counseling messages to change behavior and improve compliance with prescribed medications that prevent disease and death.

3. Demand for preventive services among consumers is weakened by high out-of-pocket costs for preventive services faced by the uninsured and those who have high-deductible insurance plans without exceptions for preventive care. Some 46 million Americans have no health insurance coverage. Two-thirds of the uninsured are either poor or near poor, and minorities are more likely to be uninsured than white Americans.

4. Many Americans, particularly minorities, have no connection to a regular source of health care with providers that will help ensure they are getting all the preventive services they need. In a 2006 survey, only 27% of Americans ages 18-64 reported having a regular doctor or source of health care and a medical home. Three-fourths of white, African Americans, and Hispanics with medical homes reported getting the health care they need when they need it, compared to 38% of adults without any regular source of health care.

5. People often are unaware of the preventive services that are recommended for individuals of their age, gender, and risk factors, do not consider themselves to be at risk, or are uncertain about the effectiveness of certain preventive services. Behavior change also is very challenging. Many people have great difficulty increasing and maintaining their exercise levels, changing and maintaining their diets, and permanently quitting smoking. Some preventive services, such as colorectal cancer screening, can be difficult to prepare for and are time-consuming.

Download the report at www.prevent.org. ■

Clip files / Local news from the states

This column features selected short items about state health care policy.

RIte Care rolls drop, losing poorest

PROVIDENCE, RI—Enrollment in the Rhode Island's RIte Care program has shrunk by nearly 6,000 in the past year, and advocates say they are concerned that a change in federal policy is causing the poorest of the poor to lose their state-subsidized health coverage.

Among families earning less than the federal poverty level — $17,170 a year for a family of three — enrollment dropped by more than 4,000 people, according to Rhode Island Kids Count, which gets regular updates on enrollment figures from the state Department of Human Services. "That's the core population that RIte Care is intended to reach," says **Jill Beckwith**, a policy analyst with Kids Count.

The bulk of the enrollment drop also came in the last six months. Since January, the program has seen a net loss of 4,852 members, said **Lisa Franchetti**, a membership analyst with Neighborhood Health Plan of Rhode Island, whose plans cover about 60% of RIte Care subscribers. Since January 2005, RIte Care enrollment has fallen from 119,000 to 111,000, but the drop in the last six months is "unprecedented," says Neighborhood Health Plan spokesman **Tom Boucher**.

Mr. Boucher, Ms. Franchetti, and Ms. Beckwith say the federal Deficit Reduction Act is responsible. The bill, passed by Congress last year, contained a variety of measures, including stricter requirements for documentation and proof of identity for people receiving government-subsidized health insurance. The stricter standards have applied to all new enrollments since January. People now need an official copy of their birth certificate, which costs $20 in Rhode Island and can cost substantially more if ordered by mail from another state. Beckwith noted that she paid $75 to the State of New York for a copy of her own birth certificate before a recent trip to Mexico. For a family of three making $17,000 a year or less, that's a significant burden, she said.

New enrollees also need four pay stubs to substantiate the income level they are claiming. Each of the requirements is "another piece of paper that has to be in someone's file before eligibility can be determined, and another reason for denying them if they fail to get that piece of paper in there," says **Linda Katz**, policy director for the Poverty Institute at Rhode Island College.

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