Tracking State Health Reform Initiatives

IN THIS ISSUE OF *CONTINGENCIES*, both presidential candidates lay out their proposals for health care reform. Although there are differences—one favors a comprehensive approach to covering the uninsured, the other a more incremental approach including market reforms and tax incentives—clearly, health care reform will be a high priority in either administration in coming years.

As the nation waits to see where future federal activity may take us, however, there's much to be gained from analyzing various state health reform models to see what does and doesn't work. Many states are now experimenting with different approaches to health care reform, both comprehensive and incremental, and their successes and failures will provide additional insight into the potential outcome of any similar federal effort.

The ultimate objectives of reform vary from state to state. Those seeking to provide universal coverage of the uninsured population are more likely to put forward proposals that are comprehensive in nature. These proposals include (but aren't limited to) individual and/or employer mandates, small-group and individual health insurance market reforms, use of subsidies for low-income populations, and the creation of regional purchasing alliances. In addition to the states that have introduced comprehensive proposals or have set up commissions to make recommendations for such proposals, many more are engaging in incremental reforms. These reforms focus on improving access and affordability for a portion of the uninsured and primarily include Medicaid/State Children's Health Insurance Program (SCHIP) expansions, although tax incentives and creation of high-risk pools also fit into this category.

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Models of Reform

So, let's take a look at the states—specifically those that have implemented some form of comprehensive reform, those that have established commissions and/or are pursuing incremental measures, and those that have considered but have been unsuccessful in passing reform.

Among states that have already enacted reform, Massachusetts has probably received the most attention nationwide. This is not only because of the program's aim to achieve universal health coverage for all the state's residents, but also because of the bipartisan nature of the program's implementation, the creation of the Commonwealth Health Insurance Connector to facilitate individual and small-business access to affordable coverage, and the comprehensive nature of the reform, including both an individual and an employer mandate.

It's important to note that Massachusetts was particularly motivated to enact its proposal because of the impending expiration of its Medicaid waiver. The state stood to lose nearly $400 million in federal money if it didn't develop a plan to redirect the use of that money to insurance coverage.

In 2006, Massachusetts passed health care reform legisla-

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tion that included an individual mandate, requiring uninsured individuals to obtain health insurance by Dec. 31, 2007, or lose a personal tax exemption of approximately $219 on their 2008 income tax. The penalty is scheduled to increase each year, up to 50 percent of the cost of health insurance. It also includes an employer mandate that requires employers with 11 or more employees to contribute to health insurance coverage or face an annual penalty of approximately $295 per full-time employee. Employers must establish a Section 125 plan that allows for the purchase of health care with pre-tax dollars.

The Connector Board defined minimum creditable coverage, setting standards that cap deductibles at $2,000 for individuals and $4,000 for families and out-of-pocket limits of $5,000 for individuals and $10,000 for families. Subsidies on a sliding scale are provided to individuals under 300 percent of the federal poverty level (FPL). Legislation that passed in April of this year made adjustments to the subsidy allocation so that individuals with incomes under 150 percent of FPL can receive the full subsidy and be exempt from paying a monthly premium.

The Massachusetts reforms have been funded through $385 million in federal matching funds, investment of $308 million in general revenues, and individual and employer contributions.

According to the Kaiser Family Foundation, as of March 2008, over 350,000 previously uninsured individuals had obtained health insurance coverage. Original estimates placed Massachusetts' uninsured population at approximately 650,000. While many consider the program to be relatively successful, the reforms have been more expensive than anticipated, and it's uncertain, given funding concerns, whether Massachusetts will be able to sustain the reforms.

While Massachusetts has garnered the most attention, Vermont and Maine have also implemented comprehensive reform programs.

Vermont's Health Care Reform Plan was enacted in 2006. The plan established Catamount Health, a subsidized insurance plan that was implemented in 2007. It provides sliding-scale subsidies for individuals with incomes under 300 percent of FPL.

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According to the Kaiser Family Foundation, as of the end of 2007, some 1,352 people had enrolled in Catamount Health, less than the initial target of 4,245. The standard benefit package resembles a Blue Cross Blue Shield PPO plan with a $250 deductible, 20 percent coinsurance, $10 co-pay, no prescription drug deductible, no out-of-pocket requirements for chronic care and preventive treatment, and an out-of-pocket maximum of $800 per year.

Vermont doesn't include an individual mandate, but it does have an employer mandate. Employers not providing coverage are assessed $365 per full-time employee in the first year, with annual increases. The assessment will be made for any employee who isn't offered coverage, isn't eligible for offered coverage, or is eligible but chooses not to enroll.

The Vermont program is financed through individual premiums, the assessments on employers, tobacco tax increases, and federal matching funds.

Maine enacted the Dirigo Health Reform Act in 2003, with full implementation expected by 2009. The program focuses on quality initiatives, cost containment, and the creation of a new health plan (Dirigo Choice) for small businesses, individuals, and the self-employed. The Kaiser Family Foundation notes that as of early 2008, Dirigo Choice had enrolled 23,000 individuals and 725 small businesses. In 2007, significant reforms to the plan were proposed but not passed, including individual and employer mandates as well as a reinsurance component.

Owing to a lack of funding, Dirigo Choice isn't able to currently offer subsidized coverage to new members. In April 2008, the governor signed legislation that provides a new source of funding through taxes on soda, alcohol, and an insurer surcharge; however, a repeal of this new funding strategy is being sought by the legislature.

Incremental Options

While Massachusetts, Vermont, and Maine have been the primary models for comprehensive reform, a number of other states are attempting to achieve similar objectives. For some, this has meant the creation of commissions with the charge of making recommendations for comprehensive proposals. Most of these commissions have or are expected to present their recommendations during their 2008 legislative sessions.

As many of these states wait for those recommendations, they and other states have passed incremental measures that focus on improving access and affordability for a portion of the uninsured.

Connecticut—In 2007, the state legislature created the Charter Oak Health Plan to provide coverage for uninsured adults. This plan would offer premium subsidies for individuals up to 300 percent of FPL, provide a benefit package with a target monthly premium of $250, eliminate pre-existing-condition exclusions, and provide lifetime coverage of $1 million (no maximum annual benefits). The state also created a commission to develop a comprehensive proposal by the end of 2008.

Colorado—Early in 2008, a Colorado blue-ribbon commission made recommendations to the state legislature for a comprehensive health reform plan. Those recommendations include an individual mandate, expansion of Medicaid and SCHIP, the creation of an insurance connector, premium subsidies for individuals up to 400 percent of FPL, and the creation of a minimum benefit plan.

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Medicaid Expansions Enacted, Fiscal Years 2007 and 2008

State	Medicaid Benefit Expansion	Medicaid Eligibility Expansion
Alaska	2007	2008
Arizona	2007/2008	2008
Arkansas		2007
California	2008	
Colorado	2007	2007/2008
Connecticut	2007/2008	2008
Delaware		2008
District of Columbia	2007	2007/2008
Florida	2007	
Georgia		2008
Hawaii		2008
Idaho	2007	2007
Illinois		2007
Indiana		2007/2008
Iowa	2007/2008	2007/2008
Kansas	2008	2008
Louisiana	2007/2008	2007/2008
Maine		2007
Maryland		2007
Massachusetts	2007	2007/2008
Minnesota	2007	2008
Missouri	2007	2008
Montana		2007/2008
Nevada		2007/2008
New Hampshire	2008	
New Mexico	2007/2008	2007/2008
New York		2007/2008
North Carolina		2008
North Dakota		2008
Ohio	2008	2008
Oklahoma	2007	2007/2008
Pennsylvania	2007	2008
Tennessee	2007	2008
Texas	2008	2007
Utah	2008	2007
Vermont		2008
Virginia	2008	2007
Washington		2008
Wisconsin		2007/2008
Wyoming	2008	

Kaiser Family Foundation, *As Tough Times Wane, States Act to Improve Medicaid Coverage and Quality: Results from a 50-state Medicaid Budget Survey for Fiscal Years 2007 and 2008*. Appendix A-2a-b.

Iowa—In legislation passed in May, Iowa joins the list of states with a plan to provide universal coverage to its residents. The legislation creates two task forces that must recommend, by Dec. 15, 2008, ways to ensure every adult has affordable coverage, with a cost-sharing cap of 6.5 percent of family income. The plan will provide coverage to every child by 2011 and every adult resident by 2013. It expands SCHIP eligibility to 300 percent of FPL and extends dependent age to 25.

Kansas—The Kansas Health Policy Authority made recommendations regarding comprehensive health reform measures to the legislature that are expected to be considered during the 2008 legislative session. In May 2008, a number of the provisions were signed into law, including an expansion of SCHIP eligibility to 225 percent of FPL in 2009 and 250 percent in 2010 and a requirement for employers to create Section 125 plans for employees.

Minnesota—In early 2008, the Health Care Transformation Task Force made recommendations for a universal health care plan including the creation of a health exchange, imposition of an individual mandate, and provision of premium subsidies. In May, the governor signed legislation that would expand eligibility in MinnesotaCare to adults with incomes up to 250 percent of FPL and would require employers (with more than 11 employees) who don't offer insurance to provide Section 125 plans to employees.

New York—Recommendations regarding a plan to achieve universal coverage had been expected by the end of May. The state has taken interim steps to expand eligibility in SCHIP and other state programs.

Oregon—The Oregon Health Trust Board has been charged with making recommendations for a comprehensive health reform proposal to be enacted by the 2009 legislature.

Washington—In 2007, the state of Washington adopted the recommendations of an existing commission to establish a road map for providing universal coverage by 2012. The plan creates an insurance connector (the Health Insurance Partnership) and develops the Washington Quality Forum. Recent legislation signed by the governor implements a number of these initiatives, most notably the creation of the Health Insurance Partnership, which will provide coverage options to small businesses and subsidize premiums for employees with incomes up to 200 percent of the FPL.

This list is not all-inclusive—other states are also in the process of considering various initiatives that would expand coverage. In addition, a majority of states have expanded Medicaid eligibility and/or benefits during the 2007-2008 legislative session (see table).

Unsuccessful Efforts

In addition to the states that have implemented comprehensive reform programs or created commissions to recommend comprehensive reform plans, some states have unsuccessfully attempted comprehensive reforms or are considering such reforms on an ongoing basis.

California's comprehensive reform legislative proposal was notably unsuccessful. The legislation would have created a statewide pool; provided premiums subsidies for individuals below 250 percent of the FPL; included an employer and individual mandate, with some exceptions; and imposed guaranteed issue and modified community-rating rules. The proposal was passed by the state Assembly but was rejected by the California Senate Health Committee before reaching the full state Senate.

Illinois, New Mexico, and Pennsylvania have active proposals in their respective legislatures that haven't yet been passed. Each of these states would provide premium assistance for individuals below a specified percentage of the federal poverty line. Some would also call for the creation of a statewide purchasing pool and the inclusion of an individual and/or employer mandate.

The Illinois legislature didn't pass a proposed reform package in 2007, but legislative options are still being discussed. The proposal would have included a state purchasing pool and premium subsidies for individuals between 100 and 400 percent of FPL.

New Mexico's proposal, Health Solutions New Mexico, didn't pass during the most recent legislative session. The proposal included individual and employer

mandates, created a risk pool, provided for guaranteed issue without pre-existing exclusions, and established a health information technology initiative.

Comprehensive legislation in Pennsylvania, called Prescription for Pennsylvania, has been introduced but hasn't been voted on. However, the portion of the legislation that would offer affordable coverage to adults and small businesses through the individual market (Cover All Pennsylvanians) has been passed by the state House and has been sent to the state Senate for consideration. The plan would subsidize individuals with incomes up to 300 percent of FPL and would include a mandate for individuals above that percent. It would also increase dependent coverage to age 30.

Funding Limitations

For all of the advantages and disadvantages, right now states are leading the way in efforts to provide universal coverage. Complicating matters, however, are the states that are facing or have faced funding issues, resulting in an inability to continue providing subsidies (in the case of Maine) or concern about the long-term sustainability of the program (in the case of Massachusetts). The California legislature recognized before passage that there wouldn't be enough money to allow it to proceed with its ambitious coverage plan, which is one reason the legislation has failed to pass.

Recognizing funding limitations, several federal policymakers have introduced legislation that would provide funding for states to pursue comprehensive health care plans. For instance, Sen. Russ Feingold (D-Wis.) introduced the State-Based Health Care Reform Act (S. 1169), which would authorize funding for five-year state pilot projects. Similarly, Sen. Bernie Sanders (I-Vt.) introduced the States' Right to Innovate in Health Care Act of 2007 (S. 2031, with companion House bill H.R. 3507), which would create a task force under the Department of Health and Human Services to review state applications for demonstration grants. These grants would be used to develop comprehensive health care proposals with cost-effective delivery systems. The conditions of S. 2031/H.R. 3507 are that states must provide coverage for all eligible residents with health benefits at least equal to the actuarial equivalent of the standard Blue Cross/Blue Shield benefit under the Federal Employee Health Benefit Program.

Though none of these bills appear to have any momentum at this time, if the states are, in fact, going to be the models for potential national reform, then it may be necessary to consider ways to assist with funding concerns.

It's unclear whether states will be given assistance or find other ways to sustain comprehensive programs, whether coverage will be expanded to growing numbers of each state's uninsured population, whether these reforms will significantly change access and affordability, and how they may affect rising health care costs. However, states are proposing and considering reforms on an ongoing basis, and new insights on implementation are available almost daily. The future of health care reform may be uncertain, but for the time being, keep your eyes on the states. ●

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