

State Roles in Health Reform

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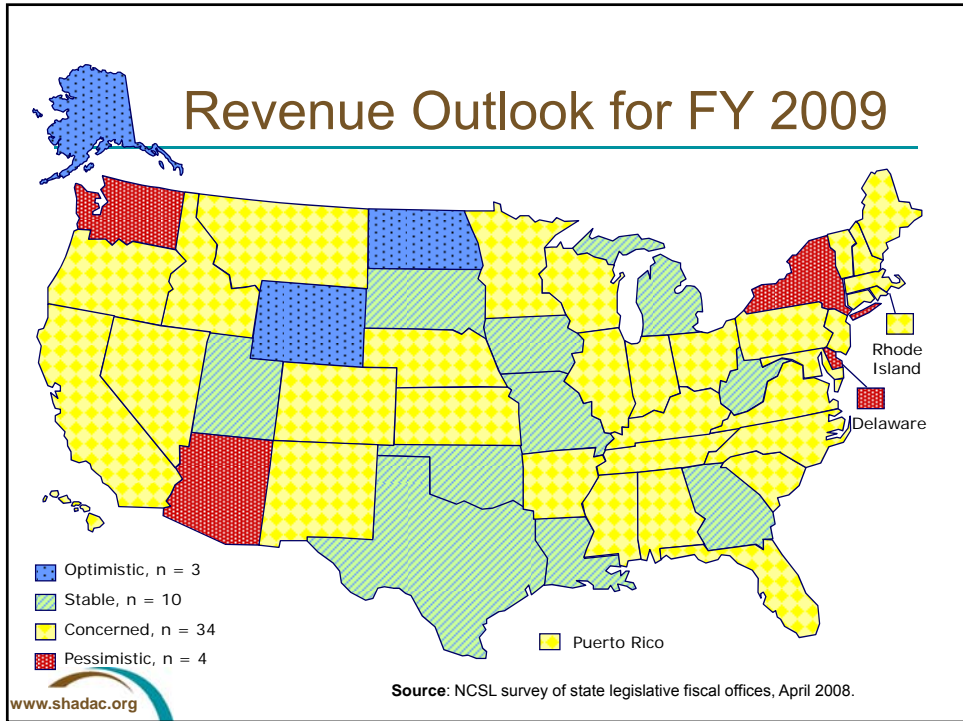
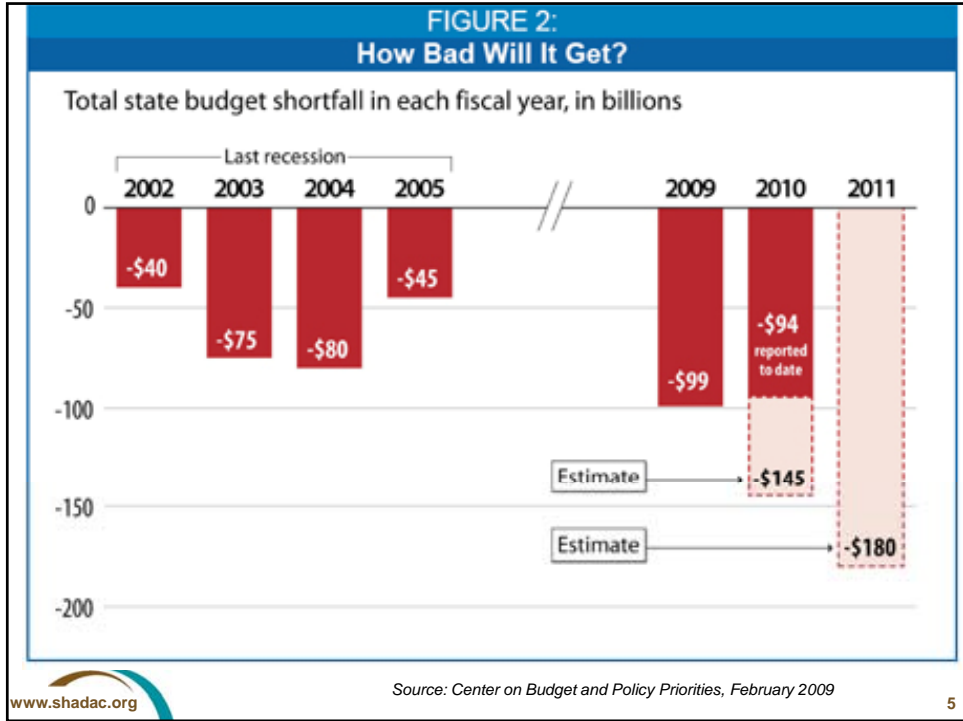
Overview of Presentation

- Health Reform in the Context of State Budgets
- State Health Reform Examples
- Minnesota Specifics
- RWJF-State Health Access Reform Evaluation (SHARE) project

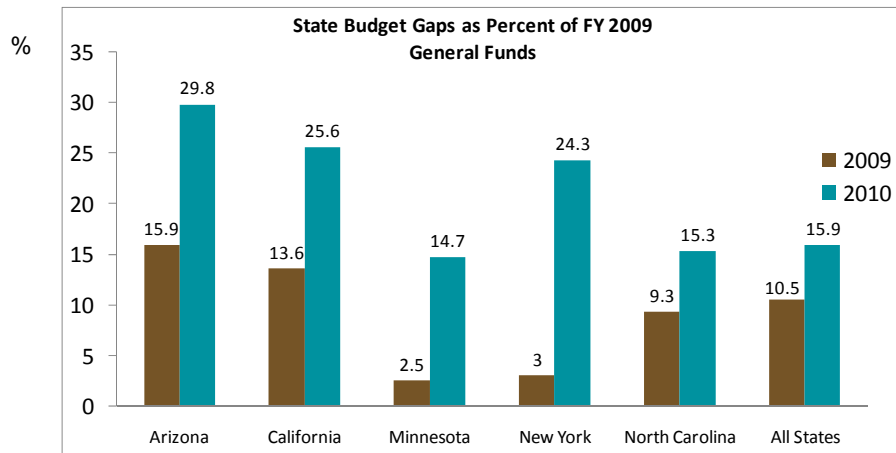
STATE BUDGETS NOT LOOKING SO GOOD

State Budget Deficits

- 46 states facing budget shortfalls for FY 2009/10
- \$350 billion - estimated state budget gaps for FY 09-11
- States cannot run deficits – they must cut expenditures, raise taxes, or draw down reserve funds
- States will have trouble recovering from deficits
 - Unemployment at 7.6% (peaked at 6.3% during last recession) which reduces state income taxes and increases demand for public services
 - Housing market has not recovered, affecting consumption, sales taxes, property taxes



State Budget Deficits



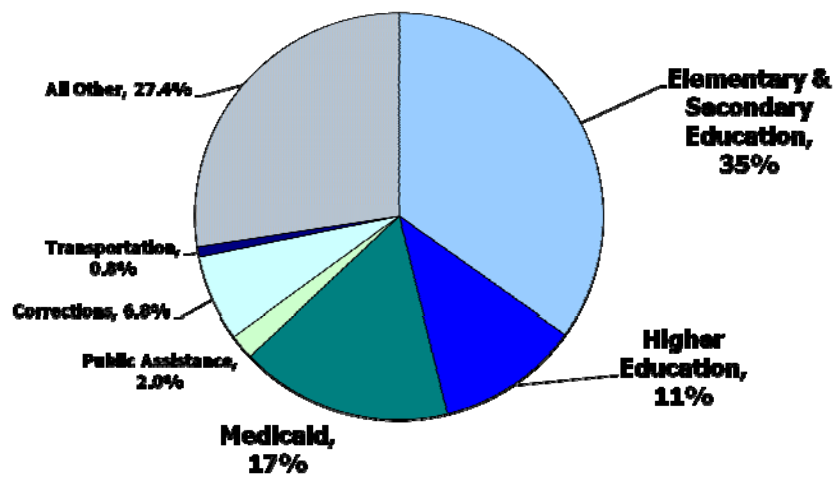
Notes: 2009 gaps are mid-year gaps
2010 gaps are projected



Source: Center on Budget and Policy Priorities, February 2009

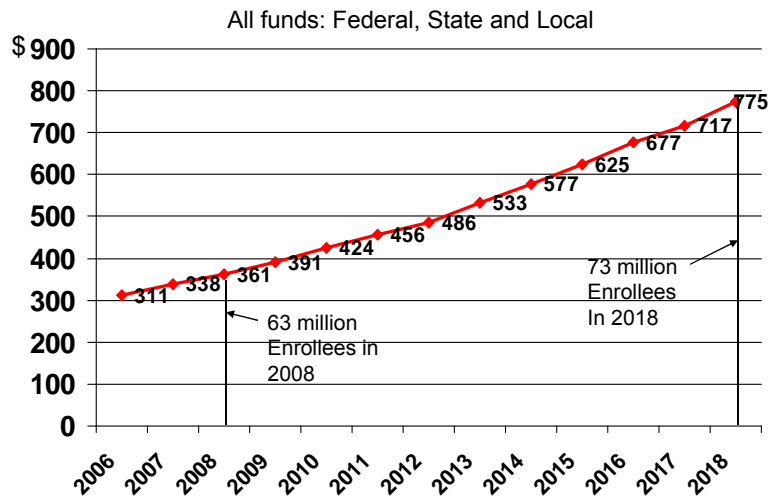
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State General Fund Spending



Source: NASBO 2006 State Expenditure Report

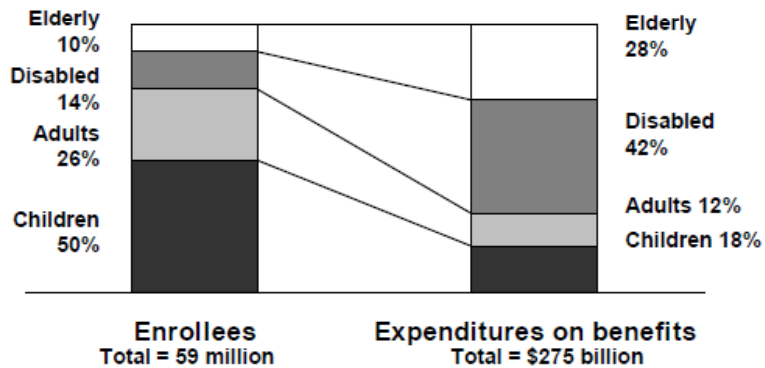
Medicaid Spending Projected to Increase by 8% Annually to Over \$700 Billion in Ten Years: 2008 - 2018



www.shadac.org Source: Health Management Associates estimates based on data from CBO and CMS, 2008.⁹

Figure 2

Medicaid Enrollees and Expenditures by Enrollment Group, 2005



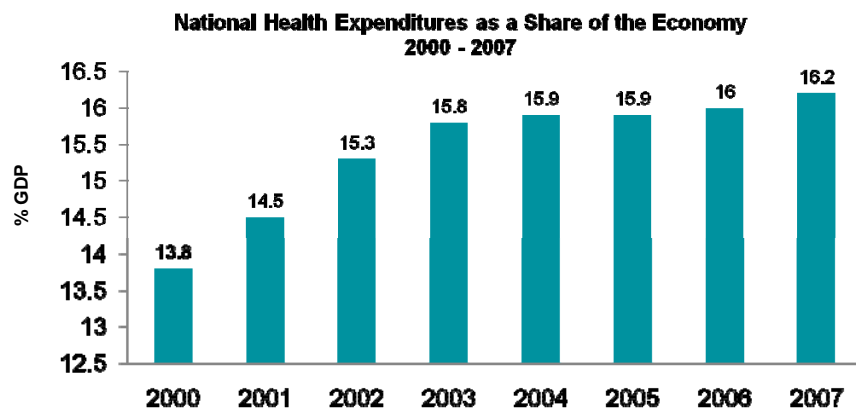
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute estimates based on 2005 MSIS data.

KAISER COMMISSION ON
Medicaid and the Uninsured

STATES CONTINUE INCREMENTAL HEALTH REFORM

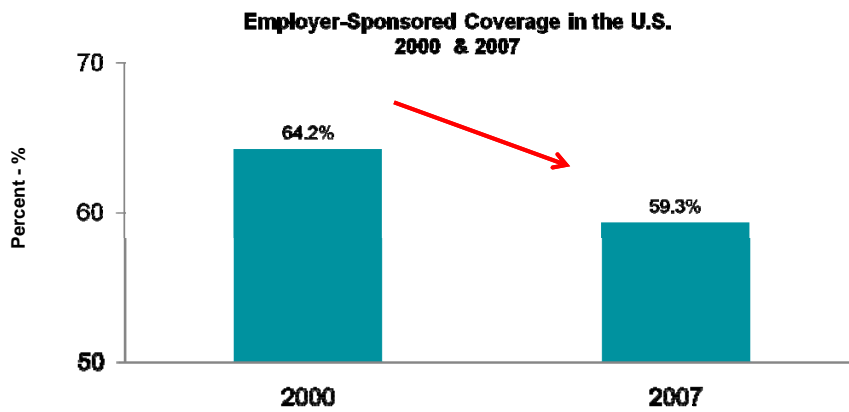
Drivers of State Health Reform

Increasing Health Care Costs



Drivers of State Health Reform

Reduction in Employer-Sponsored Coverage

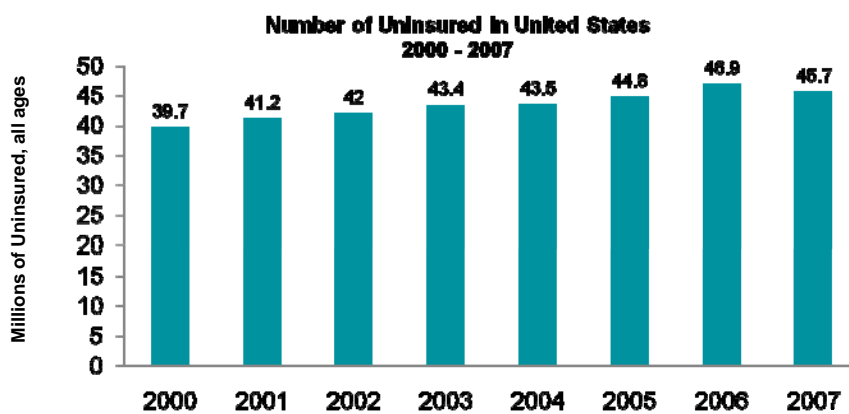


Source: U.S. Census Bureau Income, Poverty and Health Insurance Coverage in the U.S.

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Drivers of State Health Reform

Increasing Number of Uninsured



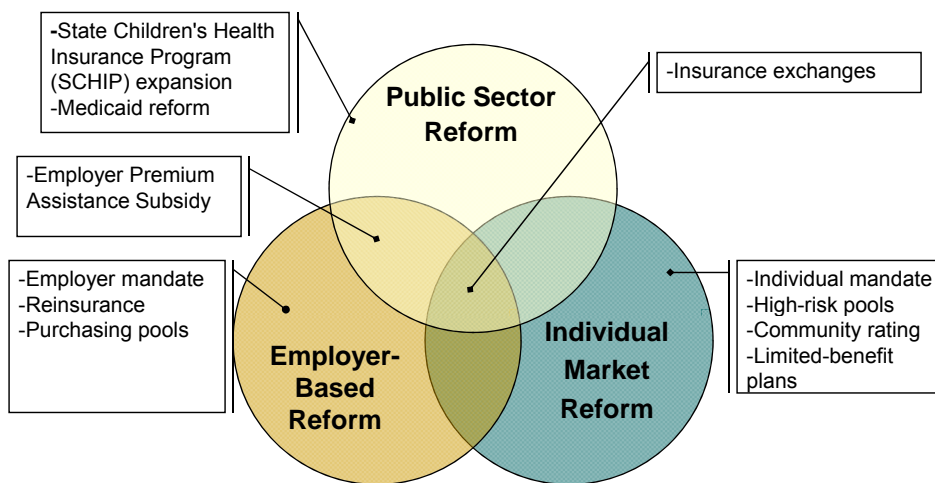
Source: U.S. Census Bureau, Current Population Surveys (March) 2000 - 2007

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Not to mention...

- Increase in obesity for all ages
 - 63% of adults in MN are overweight or obese
- Increase in aging population
 - chronic care and LTC needs
- Quality of care continues to lag
 - 14% of MN diabetics got optimal diabetic care in 2007 (*community measurement project*)
- Increase in public program enrollment
 - Now 25% of the MN population

State Options: Reform Framework



Cover All Kids: IL, PA, WA

State	Free	Sliding Scale Premium	Full Cost	Eligibility
IL	< 150%	> 150%	> 300%	All children
PA	< 200%	200-300%	> 300%	Citizens, legal residents, refugees
WA	< 200%	200-250%	NA	All children

Health Savings Accounts: Indiana

- Check Up Program
 - HSA “Power Account” + high-deductible back-up plan
 - Qualifying Hoosiers pay a portion of the accounts on a sliding scale
 - State contributes remaining funds to establish accounts of \$1,100 per adult
 - If the funds are depleted within a year, the commercial plans kick in to provide continued coverage - premiums from state general fund revenues
- Financing: Increase in cigarette tax

Comprehensive Reform: Vermont

- VT began in 2006 with the goal of near universal coverage by 2010
 - Catamount Health Plan: affordable non-group plan for uninsured VT residents
 - Premium Assistance: available for Catamount Health and ESI for those with incomes less than 300% FPL
- Financed by premiums, contributions from employers, tobacco tax revenue, matching dollars from Medicaid waiver
- In 2008, uninsurance rate was 7.6% down from 9.8%

Maryland Kids First Act – Innovative Outreach

- Enacted by Maryland legislature and signed by Governor in May 2008
- Requires a Medicaid/SCHIP outreach initiative based on information from state income tax forms
- Comptroller must send a notice to a taxpayer with a dependent child or children and income that does not exceed the highest income eligibility standard for Medicaid/Maryland Children's Health Program (MCHP)
 - *Notice must indicate that the dependent(s) may be eligible for Medicaid/MCHP and provide information on how to enroll*

...and of course Massachusetts

- Individual mandate
 - Penalties enforced through tax filings
- Required employer contributions
 - Fair Share” contribution of up to \$295 annually per employee
 - required to offer a Section 125 “cafeteria plan” that permits workers to purchase health care with pre-tax dollars
- Commonwealth Care
 - subsidized health coverage for individuals with income below 300 percent of the federal poverty level
- Commonwealth Health Insurance Connector

340,000
Newly insured

MINNESOTA SPECIFIC HEALTH REFORM ACTIVITIES

Economic Crisis Brewing-MN

- Unemployment continues to increase
 - 4.5% in January of 2008
 - 6.9% in December 2008
 - 7.6% in Jan 2009 (*equal to the national rate*)
- 75,000 jobs lost last year
- Largest unemployment rate since 1984
- *Unemployment will increase the number of uninsured*



MN Department of Employment and Economic Development (DEED)

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Minnesota Monthly Unemployment Rate, 2003 - 2008



Source: MN Dept of Employment and Economic Development

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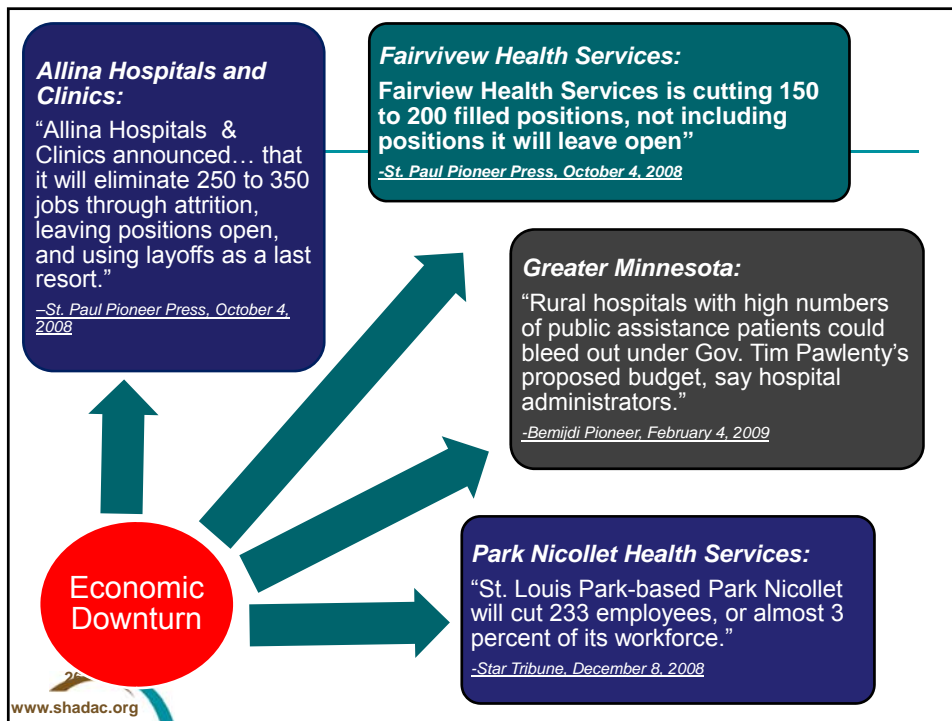
Health Care as Employment Sector - MN

- Key employer in MN
 - Over 20% of all non-farm employment
- Educational and Health Care Services *added* 11,000 jobs over 2008
 - 1,400 in January 2009
 - Unemployment rates could have been worse
- Recent evidence of some job loss in health care industry

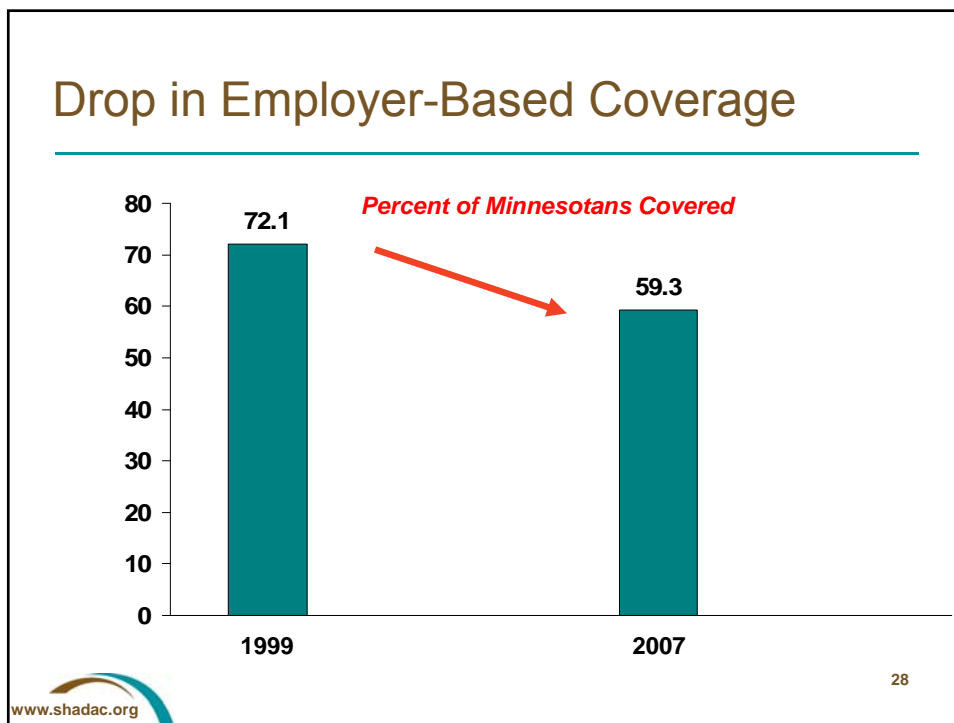
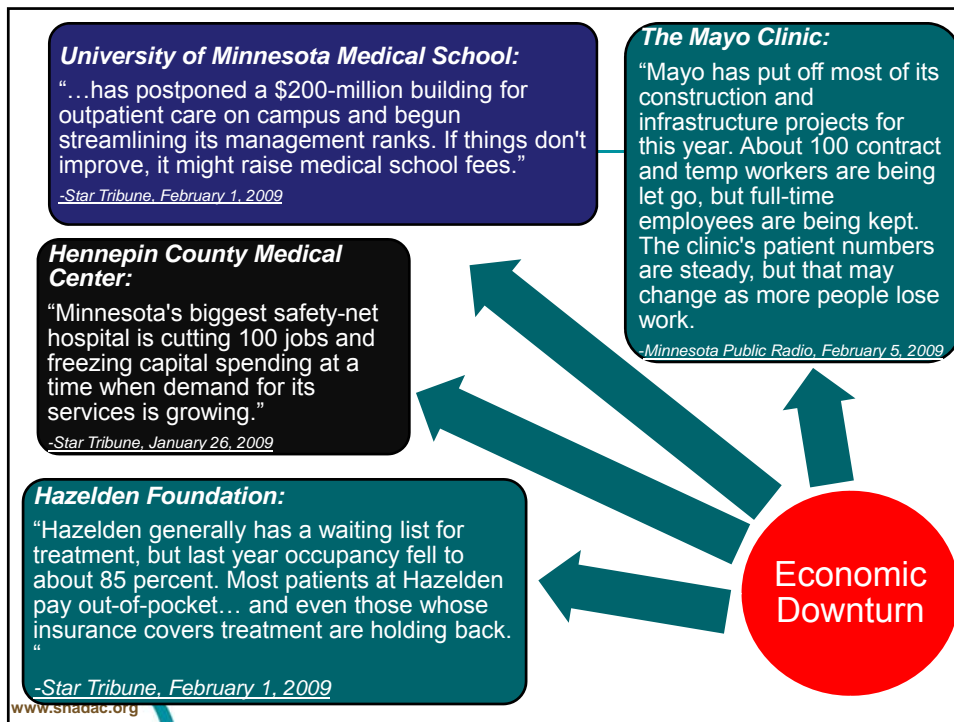


MN Department of Employment and Economic Development (DEED)

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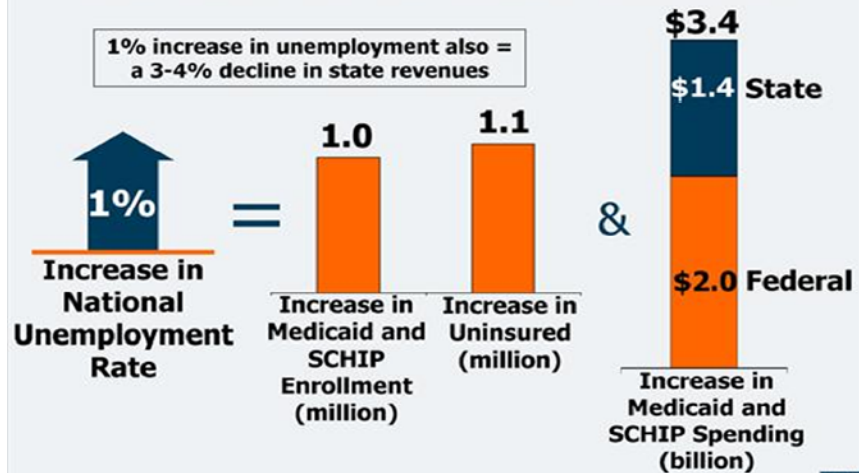
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Drop in Employment and Employer-Based Coverage

- Increase demand in the individual market and on MCHA
- More uninsured
- Increase pressure on public programs for those with lower incomes

Impact of Unemployment Growth on Medicaid and SCHIP and the Number Uninsured



Source: Stan Dorn, Bowen Garrett, John Holahan, and Aimee Williams, *Medicaid, SCHIP and Economic Downturn: Policy Challenges and Policy Responses*, prepared for the Kaiser Commission on Medicaid and the Uninsured, April 2008

Governor Pawlenty's Proposed Cuts

	Current Guidelines % Federal Poverty Level	Governor's Proposed Guidelines % Federal Poverty Level
Medical Assistance		
Pregnant Women	≤ 275%	≤ 275%
Parents with children < 19	≤ 100%	≤ 100%
Infants < 2	≤ 280%	≤ 280%
Children ages 2 – 18	≤ 150%	≤ 150%
Children ages 19 - 20	≤ 100%	≤ 100%
General Assistance Medical Care		
Full Medical Benefits	≤ 75%	≤ 75%
Hospital Only Coverage	76% - 175%	No coverage for adults without children
MinnesotaCare		
Adults without children	≤ 200%	No coverage
Pregnant Women	≤ 275%	No coverage
Parents with children < 19	≤ 275%	No coverage
Infants < 2	≤ 275%	151% - 275%
Children ages 2 – 18	≤ 275%	151% - 275%
Children ages 19 - 20	≤ 275%	101% - 275%

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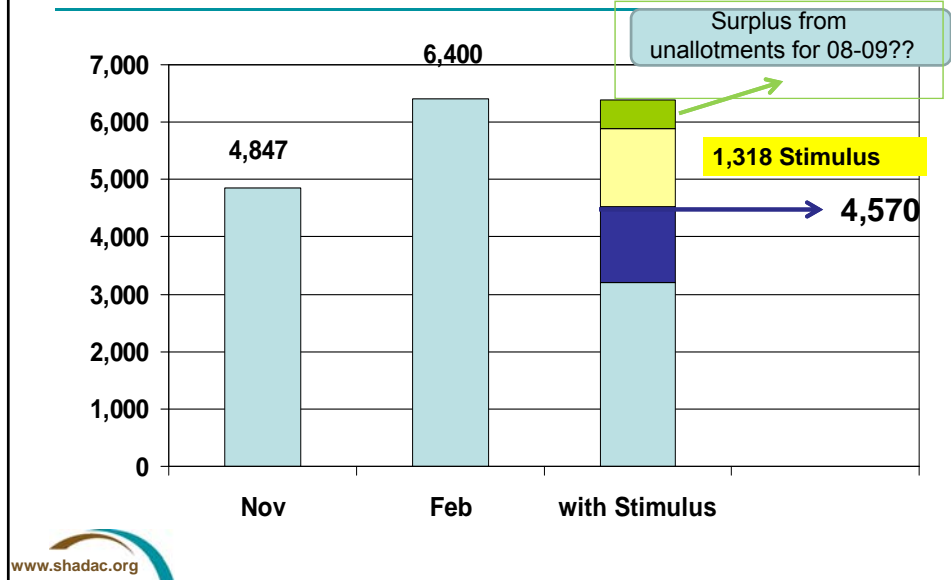
Estimated Impact on MN Uninsurance Rate

- 84,000 uninsured from proposed cuts
 - *more uninsured from cuts to MN public programs*
- 11,000 - 25,000 potential uninsured
 - *more uninsured from unemployment*
- Total of 95,000 - 109,000 more uninsured
- Potential 25% increase in uninsured rate

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Minnesota Budget Deficit (in millions)



American Recovery & Reinvestment Act (ARRA)- State Provisions

- \$100 billion in flexible funding that **SUPPLANTS** state spending (*Medicaid and flexible funding under the Fiscal Stabilization Fund*)
- \$130 billion in formula funding that **SUPPLEMENTS** state spending (*Transportation, Education, Job Training, etc.*)
- \$100 billion in competitive grant funding **OPPORTUNITIES** (*Energy Efficiency Grants, Education Incentive Grants, etc.*)

American Recovery & Reinvestment Act- Enhanced Medicaid Match

- FMAP base rate increased 6.2 percentage points
 - MN from 50% to 56.2%
- Additional FMAP increases based on state's unemployment rate (*MN in top tier*)
 - Plus subsidy for 65% of COBRA costs for 9 months
- States cannot cut eligibility if they want to receive the FMAP increases
- MN \$1.3 billion for 09-10

MN Health Reform from 2008 (1)

- Statewide health improvement program (SHIP) to reduce obesity and tobacco use in Minnesota
- Expands eligibility for MinnesotaCare for adults without children to 250% FPG (now cut completely with Pawlenty cuts)
- Development of certification standards for medical home and increased payment

MN Health Reform from 2008 (2)

- Promotes transparency and accountability by establishing “baskets” of health care services to:
 - *Allow consumers and other purchasers to compare cost and quality of care across providers*
- Requirement for electronic health records by ensuring providers use nationally-certified electronic health record systems
 - All prescription drugs electronic orders by 2011

State Role in Health Reform

- States still innovating around the margins
- Need the federal funding to do more
 - Now tied to Medicaid/SHIP
 - Guarantees an increasing role for states
- Many barriers to reform including ERISA, financing, and political will
 - Universal coverage will require federal action
- State role in discussions at national level not clear....

Minnesota Climate

- Fight to maintain existing coverage with no new revenue
 - *Sales tax, cigarette tax are on the table*
- Some minor refinements and possibly delays of 2008 reform
- Fight over moving the HCAF to the general revenue fund –
 - *will be part of politics to get the deal done*

Silver Lining

- Our good health insurance coverage and non-profit climate may have insulated us from early impact
- Crisis is a time for efficient, safe, and appropriate health care – no extra money to waste
- Push for more price and cost transparency
- Use the health care access fund for health care
- Time to think creatively and “outside the box”

A FEW WORDS ON: THE STATE HEALTH ACCESS REFORM EVALUATION (SHARE) PROGRAM

State Health Access Reform Evaluation

- National Program of the Robert Wood Johnson Foundation at the UofM
- In response to increased state activity in discussing and passing legislation to improve health care access
- SHARE will provide evidence on the specific mechanisms that contribute to successful state health reform efforts
- Inform both the state and national health reform debates

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