Universal Coverage:
The Role of Government in Health Care Reform

December, 2006

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The National Institute of Health Policy

Advancing health policy dialogue in the Upper Midwest

The Midwest States Health Reform Summit

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Midwest States Health Reform Summit: *The Roles of Federal and State Government*

The delivery and financing of health services for those in need has always been the responsibility of government in the United States. From the beginning, state and local governments have borne the brunt of this responsibility. However, in an effort to limit financial liability and to assure universal access for everyone, including the low-income, elderly and disabled, the national government in 1965 enacted Medicare and Medicaid.

Although the national universal coverage and access effort continued, by 1970 it was clear healthcare costs would increasingly impede these efforts. Hawaii was alone in legislating universal coverage in 1974. Most states used their roles as insurance regulators to experiment with rate regulation of insurance premiums and to provide cost limits. Some of these initial state cost-containment efforts, including New Jersey and other all-payer hospital payment systems, led to federal efforts of Medicare's prospective payment system of hospital Diagnosis-Related Groups (DRGs). Similarly, state demonstrations in Medicaid Health Maintenance Organizations (HMOs) and the use of home and community-based services were also later adopted by the federal government.

By the end of the 1980s, as health care costs reached record annual increases, a number of "states that couldn't wait" began to move toward universal insurance coverage through state-financed access initiatives.

Today, while national associations of health care providers continue to launch proposals for universal coverage, the national government has not shown that same eagerness. In fact, the policy of the current administration is the devolution of responsibility to state and local governments, and individuals.

In response, the Commonwealth of Massachusetts put forth a bipartisan effort in 2006 to enact a universal coverage mandate. Several states, including Hawaii, Minnesota, and Vermont, have attempted similar measures in the past, with varying degrees of success.

The University of St. Thomas' **National Institute of Health Policy (NIHP)** is a neutral forum for influencing change in health policy by presenting the spectrum of research, analysis and opinion across multi-stakeholders throughout the Upper Midwest region and beyond.

The University of Minnesota's **State Health Access Data Assistance Center** **(SHADAC)** is a research and policy center providing targeted policy analysis and technical assistance to states around access and coverage initiatives. The focus is on using state and federal data to inform health policy.

The State Health Reform Summit: Introduction

Everyone can agree that universal coverage is a laudable goal. The debate, however, lies on how to attain – and sustain – it. The federal government believes it should not – or cannot - lead us to this goal, and now

has a new reason for asking states to re-shoulder the burden. "States can do it better" since "all health care is local." But is this the best strategy?

In addition to efforts undertaken by states towards universal access and coverage, we also see a growing consciousness for a more consumer-centered, quality-driven health care system aligned with healthier patient outcomes. Recent state initiatives demonstrate this.

These topics and others were the focus of the first **Midwest States Health Reform Summit** held in Minneapolis, Minnesota on November 14, 2006. The Summit provided a forum to share expert opinion and thoughts on current initiatives, and to promote a common understanding and dialogue on these and related issues.

Hosted by the National Institute of Health Policy (NIHP) at the University of St. Thomas and the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota, the one-day event was attended by nearly 200 policy makers, legislators, state officials, healthcare experts, local businesses, and community members from around the country, particularly the Upper Midwest.

Central themes of the summit included:

- The appropriate role of the state and the federal government in providing leadership and creating the right incentives for reform in the health care market;
- The Massachusetts initiative for universal coverage and the exportability of this initiative to other like-minded states such as Minnesota; and
- Select state activities and strategies to increase consumer-focused, quality-driven insurance coverage options for residents.

The Changing Federal-State Partnership

The Rise in the "New Federalism," the passage of the Deficit Reduction Act (DRA), and repercussions for Medicare, Medicaid and the State Children's Health Insurance Program (SCHIP)

Panelists offered their thoughts on the existing federal-state relations, the roles each can play and the factors that may limit their involvement in health care reform. Key thoughts include:

- Many states are turning their attention to local health care issues and initiating local health care market reforms because of the recent upturn in state budgets and the increased flexibility states have through the Medicaid waiver program from the Centers for Medicare and Medicaid

The Panelists

Kevin Concannon, *Director, Iowa Department of Health and Human Services*

Rick Curtis, *President, Institute for Health Policy Solutions (IPHS);*

Sheila Kiscaden, *Minnesota Senator (DFL)*

Larry Meuli, MD, *Chair, National Conference of State Legislatures Health Committee (NCSL)*

Timothy Murphy, *Secretary of the Executive Office of Health and Human Services, Commonwealth of Massachusetts*

Honorable Tim Pawlenty, Minnesota Governor

David Riemer, *Director, Wisconsin Health Project*

Ray Scheppach, **PhD** *Executive Director, National Governors Association (NGA)*

Alan Weil, *Executive Director and President, National Academy of State Health Policy (NASHP)*

Moderators:
Senator David Durenberger, *Chair, NIHP*

Lynn Blewett, PhD, *Director, SHADAC*

Senator Durenberger facilitating the discussion

Services (CMS) to experiment with health care delivery and financing. At the same time, states are faced with an increasing number of uninsured, rising health care costs, a downward trend in employer-sponsored insurance (ESI) and an explosion in enrollment for public programs such as Medicaid.

- There was a general consensus that health care costs, including prescription drugs and long-term care expenses especially for dual eligibles, consume big chunks of the federal and state government budgets. These costs need to be contained and stabilized so funds are available for other programs such as elementary, secondary and higher education, social security and welfare programs.
- The two main factors that determine the extent to which the responsibility for health reform and innovation is borne by the federal and state government are fiscal capacity and readiness for reform. The federal government had provided significant leadership up until the Clinton Administration when the country enjoyed a budget surplus and could focus on domestic issues with few international distractions. Both of these have changed for the present administration. In addition, reform actors face considerable roadblocks to leadership at both the federal and the state level such as the split regulation due to ERISA; the presence of third-party payers which interrupts the market; and strict price controls for 35 percent of the Medicare/Medicaid market while the rest of the market is driven by market forces.
- **Ray Scheppach, PhD, *Executive Director of the National Governors Association (NGA)*,** suggested a division of responsibility in tackling the health care system with the states focusing on "micro components" such as quality, information technology and price transparency, and that issues surrounding access to care be left to the federal government. Further, the states should concentrate on the provision of health care for all individuals under the age of 65 years and the federal government should take over the provision of care for all over the age of 65 years, including the dual eligibles, and create a continuum of care, including long-term care to contain costs.
- **Alan Weil, *Executive Director and President of the National Academy of State Health Policy***, noted that federal policy is "rarely benign and neutral" to state policy - "it is either supportive or opposed." He suggested that the more relevant question for states is "what can states do within the context of the existing health care system and the present federal government, and not whether states can do reform on their own."

Alan Weil, NASHP and Ray Scheppach, PhD, NGA

In the existing health care system, there is an erosion of ESI, skyrocketing health care costs and a lack of a national policy on long-term care. Hence, Medicaid becomes the default provider of insurance and long-term care for many. It is no surprise that Medicaid costs have become a major health care driver of state budgets.

The recent elections have also changed the composition of the present federal government. The three major agenda items currently facing the Congress are the reauthorization of additional funding for the SCHIP program scheduled to expire in 2007; issues regarding changes in Medicaid under the 2005 Deficit Reduction Act (DRA); and the current administration's "hostility" towards using Medicaid waivers to redesign state programs, which locks states into budget neutrality and capped federal contributions.

Larry Meuli, MD, NCSL

- **Dr. Larry Meuli,** ***Chair of the National Conference of State Legislatures (NCSL),*** presented key health policy issues facing state legislators today, such as the need to support states' rights and the retention of states' flexibility. Organizations such as the NCSL oppose cost-shifting on states by unfunded or under-funded federal mandates; the withdrawal of federal financial participation for administrative services for state programs; and arbitrary caps on spending for entitlement programs.
- **Minnesota Senator Sheila Kiscaden (DFL)** suggested that leadership and innovation for health care reform should come from the private industry as it has in other sectors such as business, finance and manufacturing, as opposed to the state or the federal government. It is up to the industry to do process improvement, work towards efficiency and remove redundancies from the system. The role of the legislatures is to affirm or refute the ideas presented.
- Finally, it takes tremendous leadership from all actors and sectors, and engagement by the stakeholders to achieve meaningful health care reform.

A Dialogue on Universal Health Care

The universal coverage mandate in Massachusetts

There is an emerging consensus around the nation that all citizens should have basic health coverage. However, there is much debate over the composition, the payment mechanism, and the delivery systems needed to provide this basic health coverage benefit for all. **Secretary Tim Murphy** ***from the Executive Office of Health & Human Services of the Commonwealth of Massachusetts,*** provided an overview of the state's universal coverage initiative. He traced the developments that led up to the mandate, and steps

undertaken to expand access and create affordable coverage choices for individuals and Massachusetts-based small employers. He concluded by offering updates on the plan's implementation.

Secretary Timothy Murphy from the Commonwealth of Massachusetts

The context for the Massachusetts reform

There were several factors which culminated in a bipartisan consensus to adopt this universal health care mandate, such as:

- Massachusetts was experiencing a double-digit annual increase in premiums and led the nation in the highest per capital health care spending;
- Despite relatively low uninsurance rates, a recent survey indicated that 500,000 Massachusetts residents were uninsured – a trend that policymakers clearly felt the need to address;
- The risk of losing significant annual federal Medicaid funds in the amount of $385 million if efforts to increase insurance coverage were not undertaken. The potential withdrawal of these monies prompted state actors to set aside their differences and work towards retaining this money for Massachusetts residents. Political will and leadership existed to engage stakeholders and develop partnerships to overhaul the existing system; and
- Two previous universal health care ballot initiatives formed the stepping stones for the current universal health care mandate.

Overview of the Massachusetts universal coverage initiative:

Individual responsibility for health insurance is at the heart of the Massachusetts initiative. Other elements focusing on making insurance affordable include premium assistance, tax shelters for employees, the Connector, also known as the Commonwealth Health Insurance Connector Authority and individual and employer mandates.

Notable provisions under H 4850 include:

- Creating the *Commonwealth Health Insurance Connector Authority* (the Connector, or the Exchange), which is a conduit for small employers and individuals to purchase competitively priced health insurance plans;
- Re-channeling existing funds (annual federal Medicaid funds in the amount of $385 million and uncompensated care pool monies) to provide

premium subsidies to residents with incomes between 100-300 percent of the Federal Poverty Level (FPL);

- Mandating all Massachusetts residents to have health insurance coverage beginning July 1, 2007, and requiring all employers to offer Section 125 "cafeteria plans" to employees to facilitate pre-tax premium payment for health insurance;
- Imposing tax penalties on individuals who remain uninsured after July 1, 2007, and on employers who fail to offer Section 125 plans or make a "fair and reasonable contribution" towards health coverage for their employees;
- Reforming the Massachusetts insurance market by merging the small-employer market and the non-group (individual) market to increase risk spreading and sharing; creating a separate market for 19-26 year olds with product choices and costs to better suit their needs and lifestyle; switching to value-driven networks as opposed to "any willing provider;" factoring in lifestyle choices such as tobacco use as a rating factor.

Secretary Timothy Murphy from the Commonwealth of Massachusetts

Supplemental reforms, such as increases in Medicaid reimbursement rates to providers, were designed to ensure market stability and address cost-shifting. To improve efficiency and enforce cost-containment, these rate increases for providers are to be aligned with pay-for-performance measures in year two of the plan. Additional steps include provider re-credentialing and investing more funds in the state Medicaid Fraud Control Unit. Cost, quality and patient safety measures with an increased focus on public awareness of diseases such as diabetes, renal disorders and cancer screening have also been incorporated into the plan.

Can Minnesota do a Massachusetts-type individual mandate?

The recently enacted universal coverage mandate in Massachusetts generated considerable interest among the audience and other states. This Summit presented a unique forum to share thoughts on whether other states can replicate some or all elements of the Massachusetts plan and incrementally move towards universal coverage for their residents. **Rick Curtis, *President of the Institute for Health Policy Solutions,*** critiqued the individual-style mandate in Massachusetts and offered insights into whether a Midwestern state like Minnesota can and should replicate such a plan.

Rick Curtis, Institute for Health Policy Solutions

The following factors made the Massachusetts near-universal mandate unique and feasible for Massachusetts:

- A relatively low rate of uninsurance;
- A relatively strong ESI base;
- A dedicated stream of revenue from the annual federal Medicaid payments (approximately $385 million), and a generous uncompensated care pool whose monies would be redirected to offer premium assistance under the new mandate; and
- Political will and leadership to reform the state health care market.

All these factors put Massachusetts in an enviable position. Other states which have a higher proportion of the low-income uninsured and a weaker ESI base would need significant subsidies to cover those below 100 percent FPL - which may not be politically or fiscally feasible since the state would have to shoulder a huge cost burden. Many states including Minnesota do not have sizeable existing revenue streams that can be redirected to an expansion initiative of this sort. In fact, some questioned if the Massachusetts plan is under funded.

Comparing the Landscape in Massachusetts and Minnesota

	Massachusetts	Minnesota
Median Household Income[i]	$54,617	$56,084
Living Below 100 % of the Federal Poverty Level (FPL)[i]	14%	10%
Uninsured[i]	11%	9%
Employer Sponsored Coverage[i]	59%	63%
Medicaid/SCHIP Income Eligibility[i]	200% FPL	275% FPL (Ages 1-19) 280% FPL (Age 0-1)
$ Spent on Uncompensated Care in FY 2004[ii]	$133,700,000	$151,295,254

Design elements which may be modified and adopted by Minnesota and other states:

- The Connector as a uniform point of access: The Connector under the Massachusetts plan is an efficient, uniform point of access which offers administrative ease to (a) small employers who can channel their employees' contributions, (b) other uninsured residents who want to purchase insurance, and (c) insurance carriers who can interact in a "single market" and coordinate the purchase of competitively priced health insurance.

- Uncompensated care cost recovery fee: Under this mandate, all Massachusetts residents would be required to have health insurance. Hence, the state should see a drop in its uncompensated care costs as well as related premium increases. The uncompensated care pool monies that the government has sunk can be recouped by the amount of the cost shifting. These savings may be "captured" by states and redeployed towards premium assistance efforts.

- Health care market reforms to supplement individual mandates: Increasing access to the health care system needs to be accompanied by meaningful health market reforms, as were those implemented in Massachusetts. These create appropriate conditions and incentives aligned with the overall goal of covering all residents.

Design elements which may not be replicable in Minnesota and other states:

Apart from the factors mentioned above, Curtis highlighted some structural imperfections in the design of the Massachusetts plan and reasons why such a plan may not be successful in other states. These include:

- Uneven cost-shifting exposure: Under this mandate, the availability of subsidized coverage is visible and known to all, and employers who do not contribute towards employee premiums but expect to get insurance coverage through the Connector would get coverage at a much cheaper rate than those employers who subsidize coverage for their employees and subsequently pay reduced wages to the employees. Hence employers are able to shift the costs depending on the health insurance arrangements, and employees bear these costs unevenly.

- Ambiguous status of low-income uninsured workers regarding premium subsidies: It is unclear if and under what conditions the low-income uninsured workers with incomes between 100-300 percent FPL who are eligible for ESI but decline it, can qualify for premium subsidies through

the Connector. This raises equity concerns regarding individuals who declined ESI versus those enrolled in employer coverage. How this plays out in Massachusetts is yet to be seen.

Implications for Minnesota and other states that adopt a Massachusetts-style plan:

Mandatory participation is key to pooling risks more broadly while guaranteeing participation and access to all including the "low-risk immortals." Individual mandates ensure that modest-income individuals make a fair contribution towards the purchase of their health insurance. In addition, such mandates present options to those individuals who have been unable to access insurance and related tax benefits. As mentioned earlier, these mandates need to be synergized with reforms in the state insurance market which are easy to access

Governor Tim Pawlenty delivers the keynote address

While elements of the Massachusetts plan such as premium assistance, tax shelters for employees, an exchange, and individual and employer mandates could successfully cover more residents in most states, fiscal, local and political factors specific to states will dictate which of these elements would be more effective than others in increasing coverage. While not all elements of the plan may be exported to all states, Curtis concluded by re-iterating that while some states, especially Minnesota, can adopt a Massachusetts-like plan, most states may not be able to do so without significant federal support.

Consumer-centered health care

Panelists and audience members alike expressed their interest in a high-quality, consumer-centered health care system which stabilizes health care costs. More efforts on the public health side such as possible smoking bans and obesity and physical inactivity prevention tools were encouraged.

Minnesota Governor Tim Pawlenty shared his thoughts on the access, cost and quality issues facing Minnesotans and urged the audience to rethink the role of the health maintenance organizations (HMOs) in regards to cost-containment measures and healthier outcomes. He also cautioned against the idea of an individual mandate without accompanying health care market reforms. Governor Pawlenty's recommendations and proposed critical next steps include:

Governor Pawlenty's Plan for Minnesota

- Universal coverage for all Minnesota children with a redefined benefits package.
- Increasing the eligibility levels for state health programs such as Medicaid and SCHIP so more low-income individuals can qualify and get covered while ensuring that the payer (in this case, the government) put in place quality and outcomes measures.

Cost control measures:

- Mitigate the role played by the third-party administrators by standardizing billing and treatment codes to ensure uniform economies of scale around bills/claims processing;
- Ensure cost transparency with provider buy-in either through reimbursement incentives or mandates;
- Incentivize the use of electronic prescribing and EMRs in health care settings;
- Limit advertisements for drugs if they impart "next to no meaningful information" to consumers regarding drug efficacy or appropriateness to curb the consumer-driven appetite for name brand drugs unless necessary;
- Allow Congress to bulk purchase prescription drugs to lower costs.

Lynn Blewett, SHADAC, and panelists

Quality improvement measures:

- Alter the reimbursement system which is currently based on the volume of procedures performed to a system based on positive health outcomes of patients;
- Tier providers by evidence-based measures – quality and efficiency - when available, and in a way that is consumer-friendly and promotes informed decision making;
- Put greater emphasis on price and quality transparency to ensure a more consumer-driven market.

Additional State Strategies: Iowa and Wisconsin

States have become active participants in health care reform. According to the NCSL, state health reform initiatives have focused on ensuring affordability of insurance for small employers and individuals (AZ, MA, MO, OK, WV); incremental (ME & VT) or comprehensive (HI & MA) approaches towards universal coverage; redesigning state Medicaid programs (FL, IA, KY, WV); and coverage expansion for children (IL). States are also beginning to invest in health information technology (HIT) and electronic medical records (EMRs) and in 2006, 29 states introduced or passed HIT-related legislation.

Medicaid redesign for quality improvement

Kevin Concannon, ***Director of the Iowa Department of Health and Human Services*** presented on the steps taken by the state of Iowa to redesign its Medicaid program to deliver quality services to its enrollees. Iowa waived its additional provider fees and taxes on nursing homes which it had considered

to be institutionally biased. In exchange they set up a Health Transformation Account which incorporates a series of strategies designed to improve quality and to transform health outcomes. It builds on efforts made under the Medicaid, SCHIP and the Iowa Care program and includes inexpensive, web-based EMRs for Medicaid patients. This increases portability and provides claims records for Medicaid patients to Federally Qualified Health Centers (FQHCs) and safety-net providers. The program has been well received by patients and providers.

Iowa has also mandated a comprehensive health assessment for all individuals with mental retardation and developmental disabilities who are enrolled in Medicaid. Another element of health transformation undertaken by Iowa is commonly known as the "cash and counseling" program. This is targeted at Medicaid home-based waiver recipients and gives them the option of having an agreed-upon amount of money that would be typically spent on Medicaid providers for their care to be alternatively used to hire a family member or other professionals to provide this care. This money is deposited in a credit union and case managers work with families to make prudent choices. This initiative focuses on high health outcomes, high satisfaction levels and autonomy while containing health costs. Six other states across the nation have implemented a similar initiative.

Health Purchasing Accounts (HPAs) Give More Options to the Uninsured

The Wisconsin Health Plan (WHP) relies upon the consumer driven philosophy and market forces to hold down costs while ensuring that all residents have access to health insurance through the Health Purchasing Accounts (HPAs). **David Reimer, *Director of the Wisconsin Health Project*,** provided an overview of the innovative insurance product offered in Wisconsin, designed to serve approximately 500,000 residents. In addition to mandating health savings accounts for all residents under the age of 65, the WHP offers "core floor" benefits and wellness incentives, and encourages decision-making based on quality and price - not solely on costs. The key design elements can be found in Appendix A.

Sheila Kiscaden, David Riemer, and Kevin Concannon

A Call for Change

There was a collective call to reform by panelists including Minnesota Governor Tim Pawlenty and Senator Sheila Kiscaden who said that "…we (Minnesotans) are capable of innovation. We have done it before." This is true of all states in the Upper Midwest regions. Senator Kiscaden urged

stakeholders from all sectors - the public, private, faith-based and grassroots communities - to create the political will for reform and provide leadership to get "collaboration, cooperation, communication and commitment" from the actors engaged in the reform process.

Other participants expressed their confidence in Minnesota's ability to take the necessary steps towards near-universal coverage with responsive markets, appropriate incentives and a redesign of the delivery of health care, always keeping the consumer as the focus.

Additional information from the Summit, including audio files, can be found on the NIHP website.

NIHP Annual Meeting – Appendix A
The Wisconsin Health Plan (WHP)

The Wisconsin Health Plan (WHP)

What is it?	A health purchasing account mandatory for all Wisconsin residents under 65 years of age. Ensures access to health insurance for all
Rationale behind it	Relies on consumer driven philosophy and market forces to contain health care expenditures and make provider networks more efficient and value-driven. Aims to make consumers more price and quality sensitive in purchasing the needed care; includes incentives for routine check-ups; is portable and provides a wide choice of providers
Design elements	The WHP has two main parts: • A $500 annual tax-free HSA credit for adults to pay for coinsurance, dental and vision benefits • Premium credit for "core floor" benefits which include medical, hospital and prescription drug benefits from all health insurance plans
Services covered	"Core floor" benefits include medical, hospital and prescription drug benefits. These require cost-sharing. Routine primary care services are covered without any cost-sharing to encourage prevention. Additional/richer benefits can be purchased either through the employer or individually in a reformed market. Dental, Vision and long-term care services are not covered
Cost-sharing	Cost-sharing levels for adults include a $1,200 deductible ($100 for children), a coinsurance of 10-20 percent with an out-of-pocket (OOP) max. of $2,000 ($500 for children) is required. Once the OOP is reached, catastrophic coverage kicks in with no more cost-sharing from the WHP enrollee
Choice of providers	Residents are expected to direct their premium credits to one of the three tiered plans in the market. These tiers, I, II and III are based on risk-adjusted bids by plans. These tiers are not a reflection of richer benefit designs, or better quality providers. Instead, tiers are meant to indicate how efficiently carriers have organized their provider networks including primary and specialty care providers and hospitals. Members/carriers in Tier I can be assumed to have the lowest cost and the most efficient provider network, higher HIT usage and better health care management tools for chronic conditions,
Cost containment strategies	WHP ensures that all Wisconsin residents have access to health insurance. This initiative encourages consumers to be quality and price sensitive so they can be cost conscious and prudent in making health care choices. It also creates

	incentives for enrollees who engage in wellness behavior and make lifestyle decisions that are shown to reduce health care costs. Those who participate in evidence-based protocols will be rewarded by contributing lesser costs or be awarded higher HPA amounts. Carriers who integrate wellness initiatives will be assessed at a lower rate. The tiers are designed to make the provider networks and the health insurance carrier market more efficient and value-driven
Administration	A Private Health Insurance Purchasing Corporation would be established with representatives from labor, management, farm and other consumer boards
Estimated enrollment	WHP expects to serve over 500,000 residents
Estimated budget	The cost per person is about $3,200 to $3,300 per person. This translates into a $12 to $14 billion budget for WHP

[i] Kaiser Family Foundation State Health Facts: www.statehealthfacts.kff.org
[ii] Massachusetts: http://www.mass.gov/ig/publ/ucpempan.pdf
Minnesota: http://www.health.state.mn.us/divs/hpsc/hep/chartbook/index.html