

A REVIEW OF HEALTH COVERAGE EXPANSION STRATEGIES

AND

LESSONS FOR OHIO



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A Review of Health Coverage Expansion Strategies and Lessons for Ohio

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Summary

The objective of this report is to review the range of policy options being implemented in various states and nationally to extend affordable health coverage to more residents and examine the lessons learned from other states' experiences. In the past, state coverage reforms were often categorized as either a "public" – i.e., expanding enrollment in Medicaid; or "private" – such as insurance market reforms or premium assistance. The line between these two groups is increasingly blurred as states are experimenting with a variety of "public-private" blended strategies. For example, many states are contracting with private carriers to provide publicly-subsidized commercial insurance. They are combining financing from government, employers, and individuals.

With the caveat that such state actions are "crossing the public-private divide," we present here a typology that divides strategies into those focused primarily on expanding public coverage, from strategies that are focused primarily on promoting private and/or employer-based insurance. Strategies primarily focused on expanding public coverage include the following:

- Enhanced outreach and enrollment of already eligible individuals into Medicaid and the State Children's Health Insurance Program (SCHIP);
- Raising income-related eligibility levels, often with cost-sharing requirements, for public coverage;
- Opening Medicaid or SCHIP eligibility to additional populations, such as parents and adults without dependent children, frequently with limited benefits, or focusing on universal coverage for children;
- Creating high-risk pools for individuals unable to purchase affordable private insurance due to preexisting conditions or other health issues.

State strategies that primarily build on private insurance coverage – even if subsidized by federal and/or state funds – include the following:

- Premium assistance to help workers afford employer-sponsored or new public-private health plans;
- State-funded reinsurance of private insurance;
- Requirement that employers who do not provide coverage to workers pay an assessment;
- Requirement that residents obtain a certain level of coverage (individual mandate);
- Insurance market reforms, such as allowing more limited benefit packages or high-deductible plans, extending dependent coverage to young adults, and promoting group purchasing arrangements.

While many states are taking one of the above strategies to target a particular sub-population, others are combining multiple elements as “building blocks” to target simultaneously different subpopulations with particular health, coverage and financial needs. Taken together, these building blocks can form a comprehensive approach aimed at achieving near-universal coverage. The most notable is Massachusetts’ recent, highly publicized Health Care Reform Plan. In this report, we describe some state approaches that are more limited in scope (e.g., Illinois’ All Kids, Healthy NY, and New Mexico’s State Coverage Insurance program), as well as more comprehensive approaches (Massachusetts’ Health Care Reform, Maine’s Dirigo Health Plan, Oregon’s plans for universal coverage). See Summary Table A.

A review of state experiences over many years demonstrates that there is no “magic pill” and all reform options entail tradeoffs. Reforms involving voluntary participation are more feasible politically but will not bring a state to universal coverage, and they can result in adverse selection (disproportionate enrollment of high-risk individuals). Mandatory participation, whether through requirements on employers to contribute or individuals to obtain insurance, are more effective toward spreading the risk and reducing the number of uninsured, but face strong political and possible legal obstacles. Other states’ experiences also illustrate that successful reform requires strong leadership; a clearly defined mission; reliable data about the current health care system, its strengths, and deficiencies; dialogue, input and buy-in among stakeholders; and creativity and flexibility to learn from mistakes and make mid-course corrections. Further, states have learned that it takes time to implement reforms and for the impact to be fully realized.

It is also instructive to understand the experiences of other industrialized Western countries. There are many myths and misunderstandings about national health care systems in other developed countries. They typically *do not* fit the stereotypical model of “socialized medicine,” and they vary substantially from one another as well as from the U.S. system. Like the U.S. system, most involve a public-private mix (in both financing and service delivery), and they evolve over time as reforms are instituted to address specific issues. Unlike the U.S. health care system, virtually all residents are entitled to at least basic health care services, and they manage to spend much less than the U.S., both per capita – in terms of total and even *public* spending – and as a percent of their GDP, while achieving similar or better health outcomes.

Despite the challenges of reform, state policymakers are realizing that the true costs of the *current* system, in terms of direct and indirect costs of treating the uninsured and underinsured, cost-shifting to private payers, inefficiencies, impact on overall public health status, lost productivity, and human suffering, are having dramatic impacts on both state economies and quality of life. These costs are making state action an imperative. The experience gleaned from existing reform efforts provide useful guideposts as Ohio forges its own path to reform.

Table A: Summary of Highlighted State Reform Models

State	Reform	Model/Primary Reform Vehicle	Key Components	Current Status
Illinois	All Kids	Public program expansion targeting all uninsured children	<ul style="list-style-type: none"> Comprehensive coverage for uninsured kids Sliding scale premiums & copays, open to all income levels Builds on Medicaid/SCHIP expansions (to 200% FPL) Subsidies for >200% FPL financed by savings from shift to PCCM 	<ul style="list-style-type: none"> Began July 2006 Early enrollment beyond expectations
New York	Healthy NY	State-funded reinsurance of private HMO plans	<ul style="list-style-type: none"> All HMOs must offer streamlined, lower cost plans “Stop Loss”: state pays 90% claims between \$5k-75k Open to lower income uninsured individuals, sole proprietors, non-offering small firms with low-income workers Financed by enrollees, employers; stop-loss funded with state-only dollars 	<ul style="list-style-type: none"> Began 2001 with slow enrollment, now stable with growing enrollment Will offer high-deductible plans for HSAs in 2007
New Mexico	State Coverage Insurance	Premium assistance for new private plan	<ul style="list-style-type: none"> Private MCOs offer standard, commercial plan 3-share premium: employer, worker, public contributions Open to low-income uninsured adults, non-offering small firms with low-income workers Public share financed by unused SCHIP funds through HIFA waiver 	<ul style="list-style-type: none"> Began 2005 to individuals, 2006 to small firms
Massachusetts	Health Care Reform	Public/Private blend to reach universal coverage	<ul style="list-style-type: none"> Individual mandate Employer assessment on non-offering firms w/ 11+ workers ‘Connector’ authorizing private insurance plans and linking individuals to them Premium assistance to 300% FPL Medicaid/SCHIP expansions Insurance market reforms Higher payments to providers meeting quality standards Financed by individuals, employers, shifting federal funds (under prior 1115 waiver) from paying MCOs to subsidizing private premiums; some new state funds 	<ul style="list-style-type: none"> Phasing in July 2006 through 2009 Enrolling individuals <300% FP RFP to insurers for Connector plans Defining affordability and min. creditable coverage
Maine	Dirigo Health Plan	Public/private blend to reduce uninsurance	<ul style="list-style-type: none"> Medicaid expansion (HIFA waiver) for parents and childless adults Public-private DirigoChoice plan with discounts for those up to 300% FPL, open to small firms and individuals Financed by individuals, employers, federal matching funds, “savings” captured through assessment on insurers, some initial state funds Quality Forum to promote best practices 	<ul style="list-style-type: none"> DirigoChoice began 2005 Enrollment and savings well below targets Insurer assessments in dispute, financing adjustments in process
Oregon	Universal Coverage/ [Archimedes Movement*]	Public/private blend to reach universal coverage for essential services	<ul style="list-style-type: none"> All residents receive cards entitling them to “essential” services [determined through grass roots internet-based participation*] Insurers must accept applicants Program managed through public commission Employers may provide supplemental benefits Financed by federal/state Medicaid funds, employers, employees 	<ul style="list-style-type: none"> Proposals being considered, will require further development

Introduction

Through a grant from the Health Policy Institute of Ohio, Health Management Associates is conducting a comprehensive study to develop workable proposals to cover the uninsured in Ohio. To help inform and provide context for this work, we have prepared this report that reviews approaches to expanding health coverage by other states and developed countries and presents some important lessons from these experiences for Ohio.

As policy-makers in Ohio and around the country have realized, doing nothing is not a cost-free option – in terms of the direct and opportunity costs of caring for the uninsured, the inefficiencies and deficiencies in the current medical care infrastructure, and the effects on community health and human productivity and capital. Particularly at a time when comprehensive *national* health system reform is not on the horizon, and many states are under severe pressure to *contain or cut back* their public health programs, it is critical to acknowledge and assess the options that some states are pursuing to battle the crisis of rising uninsurance in the face of sharply rising health costs. Although there is no perfect solution, and all state reform strategies involve tradeoffs and “growing pains,” state policymakers are realizing that the long-term costs of *neglecting* to act are far too great.

This report first describes incremental approaches to coverage expansion taken by numerous states around the country. Given the dynamic nature of state policy, the examples cited are “point in time” descriptions. But they illustrate the wide range of options being pursued. While each option has strengths and weaknesses and cannot by itself achieve universal coverage, these approaches could be considered potential building blocks in a more comprehensive strategy. We then describe some more “sweeping” combination reform approaches by Massachusetts, Maine, and Oregon. These states were selected because they are among the very few that are implementing or are considering approaches intended to reach universal coverage. We also briefly explore key elements of national health plans in other developed countries. Finally, we summarize lessons that have emerged from other coverage expansion experiences.

While this report focuses on *coverage* expansion, we must emphasize that any reform plan should also involve strategies that address multiple deficiencies in the health care *system*. It should include a strong public health component; a focus on quality improvement and error reduction; greater emphasis on wellness, prevention and chronic care management; better access to appropriate services; efforts to reduce health disparities; and serious pursuit of efficiencies and cost control. Subsequent reports from HMA will address some of these issues.

Range of State Coverage Expansions

Budgetary and/or political barriers have led many states to focus on maintaining current coverage and access programs (and trying to avoid cut-backs), or planning incremental reforms to expand coverage. Most of the incremental reforms being explored or implemented involve either expanding public coverage or building on employer-sponsored health insurance – though states are increasingly blending the two approaches, e.g., by using Medicaid and SCHIP funds to subsidize private insurance and by leveraging federal funding along with employer and individual contributions.

Expanding public coverage

To control public expenditures during the difficult fiscal times of the late 1990s and early 2000s, many state Medicaid programs imposed enrollee premiums, caps on enrollment, and/or limited benefit packages for certain groups of enrollees. The reduced benefit packages vary across states, ranging from elimination of non-emergency transportation and limits on mental health visits, to a primary care-only benefit package in Utah's Primary Care Network. Proponents argue that some coverage is better than none, while consumer advocates are concerned that reduced benefits provide inadequate protection that may actually increase costs in the long run.

Despite financial pressures, some states have increased access to existing public coverage programs through enhanced outreach and enrollment of already-eligible individuals. Others, including Connecticut, Illinois, Utah, and Nevada, have expanded eligibility for Medicaid or SCHIP through current federal-state plan options, for example through increasing income disregards or by adding optional eligibility groups (e.g., people with disabilities who can return to work). Still others, including Maine, Oregon, Pennsylvania, and New York, have used Section 1115 waivers to raise the income threshold and/or add new populations that would otherwise not be eligible for Medicaid coverage (e.g., adults without dependent children). One of the most generous and longstanding programs is in Washington State, which covers childless adults up to 200% of the federal poverty level (FPL). Ohio has no coverage for this group, except for pregnant women and very poor disabled adults.

With state revenues improving and health cost growth somewhat moderating in the last year or two, many states are considering other ways to broaden coverage. For example, there is a growing interest in targeting children for public program expansion. Focusing on children is politically more popular and less expensive than adult coverage expansion, and it is seen by some policymakers as a good place to start a movement toward universal coverage. Illinois, Pennsylvania, and Tennessee have passed legislation intended to reach universal coverage for children, and other states are considering similar reforms. Pennsylvania and Tennessee have modeled their programs (still under development) on Illinois' All Kids program, highlighted below.

Illinois: Model of Public Expansion Targeting Children

Beginning July 2006, Illinois began offering ‘**All Kids**’ coverage for all resident children (through age 18) who are uninsured¹ or who meet income requirements.² To “buy in” to the health plan, there are sliding scale premiums and copayments based on family income. There is no maximum income threshold, and rates for middle-income families are lower than in private market plans.³

The program is using federal and state Medicaid and SCHIP funds for children with family income under 200 percent of the FPL. To subsidize premiums and copays for those with higher family income, the state will use savings expected from shifting nearly all Medicaid beneficiaries from fee-for-service into a primary care case management (PCCM) model. For children who do not meet federal citizenship guidelines (including undocumented children), the program uses state-only dollars⁴

The All Kids benefit package is virtually identical to KidCare, the state’s Medicaid-SCHIP program; it includes doctor visits, hospital stays, prescription drugs, vision care, dental care, and medical devices such as eyeglasses and asthma inhalers. Families select a primary care physician to provide regular check-ups and immunizations. The state has implemented a \$4.2 million outreach effort that includes an All Kids Training Tour (nearly 20 events statewide to make sure over 1,500 community leaders, services providers, and social service agencies are informed about the new/expanded program), and partnering with hospitals, schools, multi-ethnic community organizations, religious organizations, radio and TV stations, and shopping malls to inform and enroll eligible children.

All Kids builds on a recent HIFA waiver that expanded Medicaid/SCHIP eligibility for children up to 200% of FPL. As of December 2006, the state already enrolled more than 50,000 children, exceeding expectations.⁵ Approximately 204,000 children are expected to be enrolled in All Kids by the fifth year at an annual cost estimated at \$96 million, countered by expected savings of \$93 million (from PCCM).

Proponents of the All Kids model note that it is a “mainstream” program – open to all income levels and therefore without stigma – while providing financial assistance based on need. And the

¹ In 2006, a child needed to be uninsured since January 1, 2006; beginning in 2007, this uninsured period will be lengthened to one year, in an effort to avoid families dropping their private coverage in favor of the government program.

² Children in families with income up to approximately 200% of FPL (i.e., Medicaid/SCHIP eligibility levels) are eligible even if they are currently insured.

³ A family of four with an annual income between \$40,000 and \$60,000, for example, will pay a \$40 monthly premium per child and a \$10 copayment per physician visit. Families with income up to 150% of FPL pay no premiums. Sliding scale premiums apply for families with income above 150% FPL, with highest level for families at and above 800% FPL, where premium per child is \$300 per month.

⁴ The state is able to accept these children because it foregoes the Medicaid funding match for the children whose families don’t meet federal guidelines on immigration status or income.

⁵ Premiums paid by higher-income families so far have paid 74 percent of the cost of expanding All Kids access beyond Medicaid’s levels.

financing plan provides a way for the state to cover most program costs while potentially improving quality and coordination of care. Opponents argue, however, that a state-subsidized program should be closed to higher income families, who should be able to afford private coverage, and they fear the program will draw people away from the private insurance market (proponents counter that children must be uninsured for at least one year to be eligible). There are also fears that state savings from shifting to PCCM will be inadequate to finance the program in the long run.

High-Risk Pools

The **high-risk pool** is a model used by states to target “uninsurable” populations. Some 33 states have established high-risk pools for those who are denied coverage or cannot afford coverage in the individual market, due to preexisting conditions. Minnesota’s high-risk pool, with 25,000 members, is the nation’s largest, followed by Oregon (5,800) and Nebraska (5,000).⁶ Ohio does not have a high risk pool.

While premiums, deductibles, and copayments for high-risk pool coverage are higher than those found in group or individual insurance plans, state laws generally cap risk pool premiums between 125–150 percent of the base individual market rate. This keeps coverage affordable for some (but not all) of the individuals who need it most. The subsidies are generally financed through assessments on health insurance premiums or general revenues, with federal assistance. In FY 2006, federal grants provided \$75 million for state-run high risk pools, and \$15 million in seed money for states that wanted to start high-risk pools. (As of early December 2006, no legislation has passed to continue federal funding for FY 2007).

The success of some of these high-risk pools is attributed to adequate subsidies that keep the premiums affordable. Minnesota contributes about \$15 million annually to its high risk pool, resulting in premiums at about 125 to 135 percent of the average premium of comparable plans in the individual market. Maryland has a relatively new high-risk pool that has held the average premium to about 130 percent of premium levels in the individual market. Many other states’ attempts to operate a high-risk pool have fared poorly, however, because insufficient subsidies led to negative outcomes such as unaffordable premiums, caps on the number of participants, and limited benefits with high deductibles and/or medical service exclusions.

Building on private and/or employer-based coverage

In order to share the burden of coverage expansion and support the private market, many states are pursuing ways to make private and/or employment-based health insurance more affordable to lower-income individuals and families. For example, states are making federal health care tax credits available to eligible displaced workers and early retirees and their families through the federal Trade Act of 2002. The tax credits pay 65 percent of the cost of health insurance premiums;

⁶ Achman L, Chollet D. “Insuring the Uninsurable: An Overview of State High-Risk Health Insurance Pools.” New York: The Commonwealth Fund, August 2001.

take up has been very slow, however.⁷ There are also a number of strategies that target current workers and small businesses, including the following models.

Premium assistance toward existing employer plans or new public-private plans

While a few states are subsidizing private insurance with state-only dollars, most prefer to attract federal matching funds by offering premium assistance to Medicaid or SCHIP-eligible persons who have access to employer-sponsored insurance.⁸ One mechanism is the Health Insurance Premium Payment program (for example, Pennsylvania, Iowa), outlined in Section 1906 of the Social Security Act, which allows states to subsidize employer-based insurance for Medicaid-eligible persons if it provides “wrap around” benefits and if it is cost effective to the state. Meeting these criteria has been administratively difficult, however, and these programs generally have remained small.

Title XXI allows states with a separate SCHIP program to offer premium assistance to SCHIP-eligible, uninsured children enrolling in employer-sponsored health plans. The plans must meet “benchmark” or “Secretary-approved” benefit packages and cost-sharing rules, and states may supplement the benefits and cost-sharing to meet the requirements.

Section 1115 waivers, particularly “HIFA waivers,” are the third (and currently most popular) mechanism available to states to establish premium assistance programs through Medicaid or SCHIP.⁹ Section 1115 waivers allow states to receive federal matching funds to cover new populations or benefits, and the HIFA initiative offers additional flexibility for operating premium assistance.¹⁰ Illinois has a program, for example, that is exempt from providing wrap-around benefits as long as the enrollee may switch into or out of the traditional state Medicaid plan.

A variation is a premium assistance model, implemented in New Mexico, whereby the state works with private insurers to develop a *new* health plan that targets small firms, low-income workers, or other vulnerable groups, and provides direct premium subsidies tied to income and family size.

⁷ For more information see http://www.cmf.org/publications/publications_show.htm?doc_id=311250&#doc311250 and http://www.cmf.org/usr_doc/dorn_tradeact_ib_721.pdf.

⁸ For more information, see: http://www.patoolbox.org/docdisp_page.cfm?LID=DEB8BB51-6CA6-4C2F-AF1E7897AF1BB972

⁹ The Deficit Reduction Act of 2005 gives states greater flexibility to impose premiums and cost-sharing and to change benefit design for certain Medicaid beneficiaries; this is viewed more as opportunities for cost containment than coverage expansion.

¹⁰Section 1115 of the Social Security Act permits the Secretary of the Department of Health and Human Services (DHHS) to waive certain portions of the federal Medicaid Act, if the demonstration project is budget neutral to the federal government. The waivers are generally granted for five year period, and can permit changes in eligibility, benefits, and payment mechanisms. The Health Insurance Flexibility and Accountability (HIFA) initiative was established by the Bush administration as an additional waiver mechanism to grant states greater flexibility in their Medicaid programs to expand or alter coverage for low-income individuals using existing resources. For more information about the waiver process, see: Centers for Medicare and Medicaid Services (<http://www.cms.hhs.gov/medicaid/1115/default.asp>), and *New Directions for Medicaid Section 1115 Waivers: Policy Implications of Recent Waiver Activity* (Artiga & Mann, Kaiser Commission on Medicaid and the Uninsured, Policy Brief March 2005, <http://www.kff.org/medicaid/upload/New-Directions-for-Medicaid-Section-1115-Waivers-Policy-Implications-of-Recent-Waiver-Activity-Policy-Brief.pdf>)

Under the **New Mexico State Coverage Insurance plan (SCI)**, uninsured individuals with income up to 200 percent of FPL may purchase – either individually or through their small (50 or fewer employees) employer¹¹ – a standard, basic insurance plan offered by private managed care organizations.¹²

SCI exemplifies a 3-share approach to financing that reflects a true spreading of the burden. Monthly premiums are \$0-35 for the employee according to income, \$75 for employers who choose to participate, and the remainder is paid by government. Individual purchasers must pay the employer and employee portion. The public share is funded with state general funds and an 82 percent federal SCHIP match – based on a 2002 HIFA waiver allowing New Mexico to use unspent federal SCHIP funds to provide managed care coverage for adults up to 200 percent of the FPL.¹³ The program opened to individuals in 2005 and to small firms in 2006. As of December 2006, SCI has about 4,000 enrollees, and the state plans to cover 40,000 individuals over the course of the waiver.¹⁴ Further, New Mexico will assess the potential for expansions using county, tribal, and alternative sources of funding.

It will be instructive to monitor the progress of this first state-wide 3-share type model. Proponents like the fact that it utilizes private insurance, while providing financial assistance based on need. But the state faces a number of challenges. It may be too complicated and administratively burdensome for small firms to offer different coverage to low-income workers versus higher income workers (those ineligible for SCI). Also, individuals without employer participation may not be able to afford both the employer and employee shares. And there are technical challenges involving public and private operational differences, information interfaces, and protocols¹⁵

Reinsurance – Healthy NY Model

Unlike the direct subsidies in the above premium assistance models, *reinsurance* involves indirect public subsidies. Under the reinsurance model, a state can pay insurance claims in an otherwise “private” health plan that exceed a certain amount or fall within a designated corridor, thereby protecting the private insurer and helping to keep premiums more affordable.

¹¹Employers must not have dropped coverage during the prior 12 months. Employers can, however, add SCI to existing commercial coverage for workers who could not afford to participate; this allows easier transition to commercial coverage if the worker's income rises. Individuals must not have dropped coverage in prior 6 months.

¹² Managed care coverage is offered by three private health plans selected through a competitive bid process (MCOs were not required to participate or bid), and premiums/copays are identical under the 3 plans. A \$100,000 annual benefit limit applies. Medicaid benefits not included in SCI are non-emergency transportation, vision and dental, chiropractic care, hearing aids, skilled nursing, pulmonary rehabilitation and hospice. Out-of-pocket cost sharing limited to 5% of annual income.

¹³ Despite SCHIP coverage to children up to 235% FPL, state has not spent all of its SCHIP funds. Meanwhile, NM has high rates of uninsured adults: over 42% of adults below 200% FPL are uninsured. The state plans to use Medicaid funds when SCHIP funds are used up.

¹⁴ According to a state administrator, enrollment in SCI has dropped significantly in the past quarter from about 5,000 in August due to the challenges faced as current members recertify eligibility and try to meet the rigorous citizenship requirements for Deficit Reduction Act.

¹⁵ For example, under the Medicaid waiver, SCI meets Medicaid eligibility and reporting requirements; but enrollment processes and interfaces with employers must mirror commercial products.

Healthy NY provides an example of how one program element, such as reinsurance, can be used to create a new infrastructure for coverage expansion that supports the existing private insurance system. New York requires all licensed HMOs to offer a standard, basic insurance package¹⁶ to uninsured, “low-income” small businesses, self-employed, and individuals.¹⁷ The state then pays 90 percent of claims for this product that are between \$5,000 and \$75,000 – thereby reducing the HMOs’ financial risk. This, along with the waiving of certain state mandated benefits,¹⁸ optional prescription drug coverage, and a closed provider network, enables the HMOs to offer Healthy NY premiums that are lower than typical commercial plans – about half the price for individuals and one-third to half for families.¹⁹

After very slow enrollment in its early years, Healthy NY now has more than 120,000 active members and is growing steadily. In 2005, just over half (56%) joined as individuals and spouses, 18 percent as sole proprietors, and 26 percent joined through small businesses (whereby employers must contribute at least half the premium). The state cost was about \$40 million in 2005, and is estimated at \$71 million in 2006, with \$110 million allocated for 2007. The program and its stop loss fund were established by New York’s Health Care Reform Act of 2000, which also implemented Medicaid/SCHIP expansions for children and families (reflecting a compromise among public and private coverage proponents). Some of the subsidy is funded through tobacco taxes, and the state is exploring the feasibility of obtaining federal financing through a HIFA waiver.

Healthy NY’s experience illustrates that flexibility is crucial to meet the needs of both the target population and participating HMOs. The program has adjusted the benefit package, the stop-loss corridor, and administrative requirements since the program began, and is continuing to make adjustments. For example, Healthy NY plans to add a high deductible plan to be used with health savings accounts in 2007.

While Healthy NY is viewed as a successful reinsurance program and a way to build on the private insurance system, there are criticisms. There are concerns that the limited benefits do not provide adequate protection, and in fact may raise costs in the long run. For example, hospitalization is

¹⁶ Benefits include hospital & physician services, maternity care, preventive services, diabetes management, x-ray & lab, ER services, others; limited prescription drug benefit is optional.

¹⁷ Small business owners may participate if: firm did not offer insurance during past 12 months or did not contribute more than \$50 per employee per month, there are no more than 50 employees, 30% of workers earn \$35,500 or less/year, willing to contribute 50% of HealthyNY premium for FT employees, plan is offered to all employees working at least 20 hours/week and earning \$35,500 or less/year, and at least half of employees offered coverage enroll (with at least one earning \$35,500 or less). Individuals may participate if: the person or spouse worked some time in the past year or person is a sole proprietor, person has been uninsured for at least 12 months and is ineligible for employer coverage or Medicare, person’s household income is no more than 250% FPL (e.g., \$33,375 for a family of two).

¹⁸ The benefit plan does not include mental health or substance abuse treatment, home health or hospice care, physical therapy, dental or vision care, or chiropractic services.

¹⁹ Premiums are community-rated, do not vary by eligibility category (i.e., small employer, sole proprietor, individual), and are divided into four tiers: one adult, two-adult, one parent with child(ren), and family. Rates vary by county and by HMO.

covered but follow-up rehabilitative care is not, resulting in some extended inpatient stays in order to receive needed therapy. Also, restricting eligibility to the uninsured does not allow employers or individuals who had struggled to buy coverage to take advantage of more affordable, state-subsidized coverage. Finally, there are concerns that even subsidized coverage is not very effective in attracting small employers. Research shows that a 30% reduction in premium will cause only 15% of non-offering small employers to newly offer coverage, and then the number of employees who are newly covered is only 5% of those who were uninsured and work for small employers. Indeed, small businesses continue to comprise a minority of Healthy NY members.

Requiring Employers to Contribute toward Coverage

A few states have tried to place *requirements* on employers in an attempt to spread the burden of coverage and reduce the cost-shift from businesses that don't offer coverage to those that do. Hawaii is the only state with an employer mandate to provide coverage in place, because it was grandfathered in when ERISA was implemented.²⁰ Under the "ERISA Preemption," states can not require employers to offer coverage or dictate the terms of health coverage. Indeed, later attempts at employer mandates or "pay or play" (e.g., MD, CA) have been blocked by ERISA rules, influential lobbyists, and/or public referenda. However, both Massachusetts (described further below) and Vermont are imposing modest assessments on employers who do not provide coverage to their workers as part of their new reform strategies.

Requiring Residents to Obtain Coverage

Though the concept of an individual mandate has been discussed for decades, Massachusetts is the first state that is preparing to implement such a requirement on adult residents, under its reform plan (described further below). Such a mandate is only viable if combined with measures to ensure that coverage is *affordable* and *accessible*; that is, it must be combined with subsidies and insurance market reforms. An individual mandate should greatly expand coverage (resulting in improved access to primary and preventive care), reduce costs, increase productivity, spread risk, and reduce cost shifting to those who are purchasing insurance. Opponents object, however, to government intrusion into personal decisions about whether to purchase coverage.

²⁰ For more information on ERISA rules, see: Patricia Butler, ERISA's Implications for State Health Care Access Initiative, March 2005, <http://statecoverage.net/cyberseminar/butler.pdf>

Insurance Market Reforms

States have made various changes to the private insurance market in an effort to promote affordable coverage. Strategies, which tend to be no-cost or low-cost to states, include the following:

- **Relaxation of certain coverage rules** - This may include waiving certain state-mandated benefits to permit a ‘basic’ or ‘bare bones’ insurance packages (e.g., excluding or strictly limiting mental health or prescription drug coverage) while establishing minimum standards. There is clear tradeoff in this attempt at creating affordable coverage: critics claim that such basic plans do not offer adequate protection and do not address either the cost-containment or health management needs of chronic illness, while supporters argue that “some coverage is better than none.” Generally, very basic plans have had very little take-up by employers and individuals. A variation involves high-deductible health plans, which are slowly gaining popularity as employers are looking for ways to stem escalating employer premiums by having employees bear more of the direct costs of their care.
- **Extending family coverage to young adults** - Employer-based health insurance traditionally terminates dependent coverage at age 19 or upon college graduation, leaving young adults as a disproportionate share of the uninsured, though a generally healthy group. In response, some states are requiring insurers to extend dependent coverage to young adults who would otherwise “age out” of family plans. New Jersey, for example, now requires all health insurers in the state to raise the age limit of dependents eligible for coverage under their parents’ plan to 30 – the highest in the nation.
- **Promoting purchasing pools** - There have been both public and private efforts to allow small employers to pool together to collectively purchase health insurance. The intent is to achieve lower premiums by allowing smaller groups to attain the buying power of large groups and by achieving economies of scale. Pools are also intended to offer more health plan choices to employers and workers. Some purchasing pools are established by business associations; one of the largest is in Ohio, operated by Council of Smaller Enterprises (COSE) with over 225,000 lives. Others are established through state legislation or regulation. For example, Ohio has legislation (Ohio Revised Code 1731.01) allowing small businesses to band together to purchase health insurance. Models include association health plans (AHP), employer alliances or health insurance purchasing coalitions (HIPC), and multiple employer welfare arrangements (MEWA). Most pools have been successful at expanding choices, but have struggled to reduce premiums or make any significant impact on the uninsured.²¹

²¹ For more information see: <http://statecoverage.net/matrix/grouppurchasing.htm#1#1>

Examples of State Efforts to Approach Universal Coverage

In addition to the examples of states using incremental approaches to expand health coverage, a few states are implementing comprehensive, combination strategies in order to move toward universal coverage. Below we describe three such approaches.

Massachusetts Health Care Reform

In April 2006, the Massachusetts legislature overwhelmingly passed, and the Governor signed, a bill containing mechanisms for nearly all of its residents to obtain health coverage.²² This was the result of months of wrangling among the House, Senate, Governor, and various stakeholders. Some of the key features of the **Massachusetts Health Care Reform** plan, based on principles and building blocks that span the political spectrum, include the following:

- A requirement that all adult residents obtain health coverage by July 1, 2007 if deemed affordable, with a tax penalty for non-compliance;
- A new “Commonwealth Health Insurance Connector” that will certify and offer insurance products of high value and good quality, connect individuals and small businesses with health insurance products, allow for portability of coverage from one job to another; and facilitate the required offering of cafeteria (Section 125) plans allowing pre-tax purchases of Connector health plans;
- The Commonwealth Care Health Insurance Program, providing public subsidies to families with income up to 300 percent of the FPL toward the purchase of private insurance plans through the Connector;
- Expansion of Medicaid coverage for children with family income from 200 percent to 300 percent of the FPL, removal of some caps and reinstatement of benefits previously cut;
- An assessment of up to \$295 per worker per year on companies with 11 or more employees that do not provide coverage, with the money helping to pay the costs of the uninsured;²³
- Private insurance market reforms including the merging of the individual and small group markets, establishment of a basic health plan for young adults, and extension of dependent coverage to age 25;
- Increased reimbursement to hospitals and physicians, contingent on meeting quality standards.

Legislators expect the plan to cover 515,000 uninsured people – about 95 percent of the uninsured – within three years. Most of the financing will come from federal funds through the renewal of the

²² Governor Romney line-item vetoed eight sections of the bill, including the employer assessment, the restoration of dental, vision and other benefits in Medicaid, and coverage of legal immigrants; the legislature overrode the vetoes in late April, however.

²³ Also, non-offering employers with frequent free care pool users will be charged up to 100% of costs over \$50,000.

state's 1115(a) MassHealth demonstration waiver, but with a shift from supporting individual provider organizations to funding health insurance premiums for uninsured individuals.

The final set of reforms passed and now being implemented in Massachusetts did not come easily, but rather resulted from long and difficult debate and compromise. The bill was developed with input from multiple stakeholders, and the final plan appears to have the support of many representatives of the business community, health care industry, and consumer advocates. Importantly, there was agreement in Massachusetts across political lines that comprehensive reform was needed. This appears to be driven by a public that values health care, a strong existing coverage base (including an historically expansive use of Medicaid) supplemented by a state-wide pool for uncompensated care and the availability of federal funds that can be applied to the program, growth in the number of uninsured, and the acknowledgement that the state is already paying a substantial sum for the uninsured. The widespread concern resulted in multiple comprehensive reform proposals on the table. To move forward, the parties had to acknowledge that there is no one "right way" to fix the problem and that to be successful they needed some type of compromise and bipartisan agreement.

The Massachusetts experience provides some useful guideposts for a coverage expansion effort in Ohio. By estimating the current costs to state taxpayers, employers, and other stakeholders of having a significant number of people without adequate health coverage and educating the public about these "hidden costs," Ohio may be able to build comparable support for reform. Massachusetts' experience illustrated the ability of a foundation (Blue Cross Blue Shield of Massachusetts Foundation) to play an important role in documenting the problem (through timely research on the number of uninsured, the costs borne by the state and the private sector, and the state's economy), identifying options and tradeoffs for expanding coverage, and developing a plan for moving toward universal coverage.

Maine's Dirigo Health Plan

In 2003, Maine passed the **Dirigo Health Plan**, a multi-faceted set of reforms designed to move toward universal coverage over a period of five years through a combination of public/private approaches. The Maine plan combines expansion of MaineCare (Medicaid) with a new DirigoChoice insurance plan for small firms, the self-employed, and individuals. It also develops a series of measures to improve quality of care and contain costs. Key components of the Dirigo Health Plan are the following:

- Public program expansion: Authority granted under a HIFA waiver²⁴ permits the state to expand MaineCare to adults without dependent children with income up to 125 % of the FPL²⁵, and expand MaineCare eligibility for parents from 150 % of the FPL to 200%.²⁶

²⁴ Maine's HIFA waiver proposal to use unspent Disproportionate Share Hospital (DSH) funds to help finance Medicaid coverage for low-income adults without dependent children with income up to 125 % of the FPL was approved by the Centers for Medicare and Medicaid Services (CMS) in September 2002. Approval may have

- DirigoChoice: Maine’s health plan designed to help small businesses and uninsured individuals obtain affordable, quality health coverage, DirigoChoice is a collaborative between Maine’s Dirigo Health Agency and Anthem Blue Cross Blue Shield of Maine. Coverage for small businesses and the self-employed took effect January 1, 2005, and benefits for individuals without access to job-based coverage began April 1, 2005. DirigoChoice²⁷ offers comprehensive benefits with full coverage for preventive care services. Enrollees with family income up to 300% of the FPL receive discounts (up to 100%) on premiums and deductibles, based on a sliding scale. The plan may be open to larger businesses at a later phase.
- Cost containment: Cost containment depends primarily on voluntary limits on revenues and prices by hospitals, providers, and insurers, as well as some limits on Certificate of Need-related projects. The state has also allowed for the possibility of developing more stringent cost containment measures, including a capital expenditures budget and premium regulation, if voluntary measures are not adequate.
- Quality improvement: The program establishes the Maine Quality Forum as a watchdog group to promote evidence-based medicine, best practices, and electronic technology (e.g. moving toward electronic medical records for patients). It has launched the Safety Star Recognition Program that will award a “Safety Star” to hospitals meeting or exceeding thresholds established for 28 specified safe practices.
- Financing: Financing comes from individuals and businesses who volunteer to join DirigoChoice (through premiums and cost sharing), newly available federal matching funds, an assessment (up to 4 % of premiums) on insurers beginning in year two (intended to capture savings from reductions in uncompensated care), and an initial infusion of \$53 million in state funds during the first year of enrollment (the state planned to make this program “budget neutral” after this start-up outlay).

The state hoped to provide coverage to over 189,500 uninsured and underinsured individuals over the course of the first five years of operation. But it is experiencing difficulties and “growing pains,” with new coverage nowhere near the projections. As of late 2006, DirigoChoice covers about 12,500 people; the majority have household income below 300 percent of FPL and received

been facilitated by the fact that the proposal was uncomplicated, and it was submitted soon after the release of the HIFA initiative, when CMS may have been especially motivated to approve waivers. For more detail about Maine’s Medicaid expansion, see *Childless Adult Coverage in Maine* (Alteras & Silow-Carroll, , Economic and Social Research Institute, August 2004, <http://72.14.207.104/search?q=cache:7q30GoPieKAJ:www.kff.org/medicaid/loader.cfm%3Furl%3D/commonsport/securty/getfile.cfm%26PageID%3D46180+maine+childless+adults&hl=en>).

²⁵ A previous Medicaid expansion granted eligibility to childless adults up to 100 % of the FPL.

²⁶ : Due to budget constraints, the state has kept eligibility for adults without dependent children at 100 % of the FPL, and limited some benefits for this group in order to stay within the allowed federal cap.

²⁷ DirigoChoice did not require federal approval; the section 1115 waiver (extending Mainecare coverage to childless adults, etc.) applies to all individuals eligible for MaineCare, regardless of whether they enroll in MaineCare through DirigoChoice. DirigoChoice members who are eligible for MaineCare receive wrap-around services for MaineCare benefits not included in the DirigoChoice package.

discounted rates. The state will spend an estimated \$44 million to subsidize those premiums next year.

A 2005 independent ruling by the state's Superintendent of Insurance estimated that the Dirigo Health reforms such as voluntary spending caps by hospitals and limits on hospital expansion have resulted in nearly \$44 million in savings over the last year.²⁸ Although this is significantly less than earlier estimates by the governor's Administration, the savings will allow the program to continue. The state's health insurance companies have been assessed an amount (close to the \$44 million) under the premise that the savings should have trickled down to insurers. These "Savings Offset Payments" would help fund the premium discounts and quality initiatives. But the health plans filed a lawsuit against the Dirigo program regarding the assessment, leading to the establishment of a Blue Ribbon Commission to conduct an analysis of all the program's components. Its goal is to make "recommendations with respect to long-term funding and cost-containment measures." These recommendations are scheduled to be submitted in December 2006.

Importantly, since Dirigo Health was passed, legislators and administrators have made a number of changes to address new concerns and circumstances, and plan officials emphasize that adjustments will continue in the future. For example, the individual membership cap was lifted, and there will be greater legislative oversight.

Maine illustrates one version of a "building blocks" approach that maintains and adds to existing systems (Medicaid and the employer-based insurance system). It seems unlikely, however, whether the mixture of strategies will allow the state to reach its long-term "universal" coverage goals. The reasons include the fact that participation in DirigoChoice is voluntary, and even subsidized coverage may seem unaffordable to most low-income workers and employers. In fact, the underrepresentation of businesses and "working poor" in the plan's early experience indicates that this may be the case.

Maine's experiences so far underscore that significant changes to the health care system will invariably hit some "snags," and that flexibility and creativity to address new problems is critical. It will be helpful to examine the Blue Ribbon Commission's recommendations for strengthening the financing of the program and thereby improving its stability.

Additional lessons from Maine's experience were delineated by one of Dirigo's principal architects, Trish Riley, director of the Governor's Office of Health Policy and Finance in a profile by State Coverage Initiatives.²⁹

²⁸ News release, October 29, 2005, Maine Office of State Policy and Finance, http://www.me.gov/governor/baldacci/healthpolicy/news/10_29_05.htm

²⁹ State Coverage Initiatives, an initiative of the Robert Wood Johnson Foundation, *Profiles in Coverage: Maine Dirigo*, 2005 (<http://www.statecoverage.net/maineprofile2.htm>).

- Political will is an essential element of success – health reform is hard work and it requires vigorous and persistent political leadership.
- Even compromises like Dirigo Health do not fully bridge the ideological divide – advocacy for high-risk pools, AHPs, HSAs, and a roll back on insurance mandates continues.
- Employer skepticism is real – the product must be sustainable before they will commit to initiate coverage for employees.
- Do not underestimate the level of risk aversion in private insurance.
- Support from the public, press, advocates, and elected official is key to success.
- Everybody wants lower premiums – but not the tough choices that go with reducing health care cost growth.
- Sustained leadership is essential – keep an eye on the political will to do the task.
- It’s hard work and requires vigilance and the capacity to change and revise as needed.

Oregon’s Movement Toward Universal Coverage

In Oregon, there are two parallel movements toward universal coverage. A state Senate commission is drafting legislation for a **universal coverage plan**, and former Governor Kitzhaber is spearheading the “**Archimedes Movement**” with the goal of establishing a floor of services to everyone in the state. The state legislature will consider both of these proposals when it returns in January 2007.

Interest in universal coverage is growing in the state under a Democratic Governor, Senate, and a newly Democratic House. As of early December 2006, the Senate plan includes the following components:

- All state residents would receive a health card entitling them to essential medical services;
- Health insurers would be required to enroll any resident with a card, and would compete for members;
- “Essential” covered benefits have not yet been defined, but early estimates indicate that the cost of the plan would be about \$350 per person per month;
- Employers could supplement the plan by offering comprehensive coverage;
- The program would be managed by a public board or commission;
- The program would pool federal and state Medicaid funds, and contributions from employers and employees.

Meanwhile, former Governor Kitzhaber is leading the Archimedes Movement. In an effort to replicate the participatory political process that led to the Oregon Health Plan,³⁰ the Movement

³⁰ OHP, implemented in 1994, prioritizes funding for medical services by ranking them in theory according to medical efficacy and population impact. Depending on available funds, a line is drawn on the ranked list of

relies on an internet community as “the engine behind this effort -- the vehicle through which we will seek to build...critical mass...”³¹ At the next level, the Archimedes Council, composed of a broad spectrum of stakeholders, is charged with formulating the design principles based on a coherent synthesis of the internet-based vision and developing the operational details of the new system.³² In October 2006, the Movement published a draft legislative concept paper that authorizes the state government to seek Congressional waivers to reallocate health care dollars in Oregon to meet the needs of its citizens according to defined principles.³³ Upon receiving Congressional approval, development of an implementation plan would be delegated to the Oregon Health Policy Commission or some similar entity. (For more information, see Appendix A).

services: services above the line are included in the OHP benefit package while services below the line are not available through OHP.

³¹ <http://www.archimedesmovement.org/plan>, accessed 11/30/2006.

³² Ibid.

³³ <http://www.archimedesmovement.org/draft>, accessed 12/04/2006.

Exploring “National Health System” Models

There are many myths and misunderstanding about health care systems in other countries. The health care systems of other developed countries typically *do not* fit the stereotypical model of “socialized medicine,” as they are frequently rhetorically described. Moreover, health care systems in Canada, Europe, Japan, and other regions vary substantially from each other as well as from the U.S. system. Further, these systems are far from static; they evolve over time as reforms are instituted to address their own issues and challenges.

Nearly all other industrialized countries have a “national health plan,” providing virtual universal coverage at a much lower per capita cost than the U.S. system in which more than 45 million people are uninsured. Exhibit 1 compares health spending in ten developed nations in 2003.³⁴ Not only does the U.S. spend about two-and-a-half times as much on health per capita (\$5,635 in 2003) than the median for OECD countries (\$2,280), but we even spend more *public dollars* on health per capita than any other nation despite the fact that government spending is a smaller portion of total spending (a little less than half of all US spending for health care is paid for by federal, state, or local governments while in the typical OECD country about three-fourths of all spending is undertaken by the public sector). The extra spending on health care in the U.S. does *not* result in better health, higher life expectancy, and greater satisfaction with the health care system, or more services, health care professionals or hospital beds per capita.³⁵ Life expectancy for people age 65 is lower in the U.S. than in 8 other OECD nations, despite the claim that we offer more advanced medical technology and end-of-life interventions.

There are many types of national health plans, but they generally share certain underlying fundamental features. A national health plan typically offers all legal residents in a nation “publicly” funded insurance for at least basic health care services. The cost of health care is generally controlled through negotiated fee schedules for providers of care, tightly regulated management and distribution of capital and technology, regional or national budget targets or caps on spending, and significantly lower costs associated with administration, marketing, and profits. Despite these cost controls, national health plans struggle with cost increases, and many nations have been implementing reforms aimed at improving efficiency and outcomes such as decentralization, privatization, and incentives – with mixed results.³⁶

³⁴ B. K. Frogner and G. F. Anderson, “Multinational Comparisons of Health Systems,” Chart Book, The Commonwealth Fund, April 2006.

³⁵ Ibid; U. E. Reinhardt, P. Hussey and G. Anderson. “U.S. Health Care Spending in an International Context,” *Health Affairs*, 2004, 23(3):10-25; G. F. Anderson, B. K. Frogner, R. A. Johns, U. E. Reinhardt, “Health Care Spending and Use of Information Technology in OECD Countries,” *Health Affairs*, May/June 2006 25(3):819-31.

³⁶ The evidence to date remains uncertain, however, as to whether decentralization, privatization, and financial incentives intended to increase efficiency result in overall improvements in health outcomes, service delivery, or cost containment.

Single Payer versus Multi-Payer Models

As noted above, virtually all residents are “entitled” to at least basic health care services under national health plans. There are different models, however, for the way universal coverage is structured and financed, and how health services are accessed. A national health plan often evokes a *single payer* model, in which a government agency (rather than a multitude of insurance companies and health plans) collects premiums through taxes and pays health care providers directly. But the more common model is a *multi-payer* system whereby the government acts as a centralized collector of revenues, but directs funds to a several large trust funds that, in turn, negotiate fees with and reimburse providers, and provide other key functions.

Exhibit 1

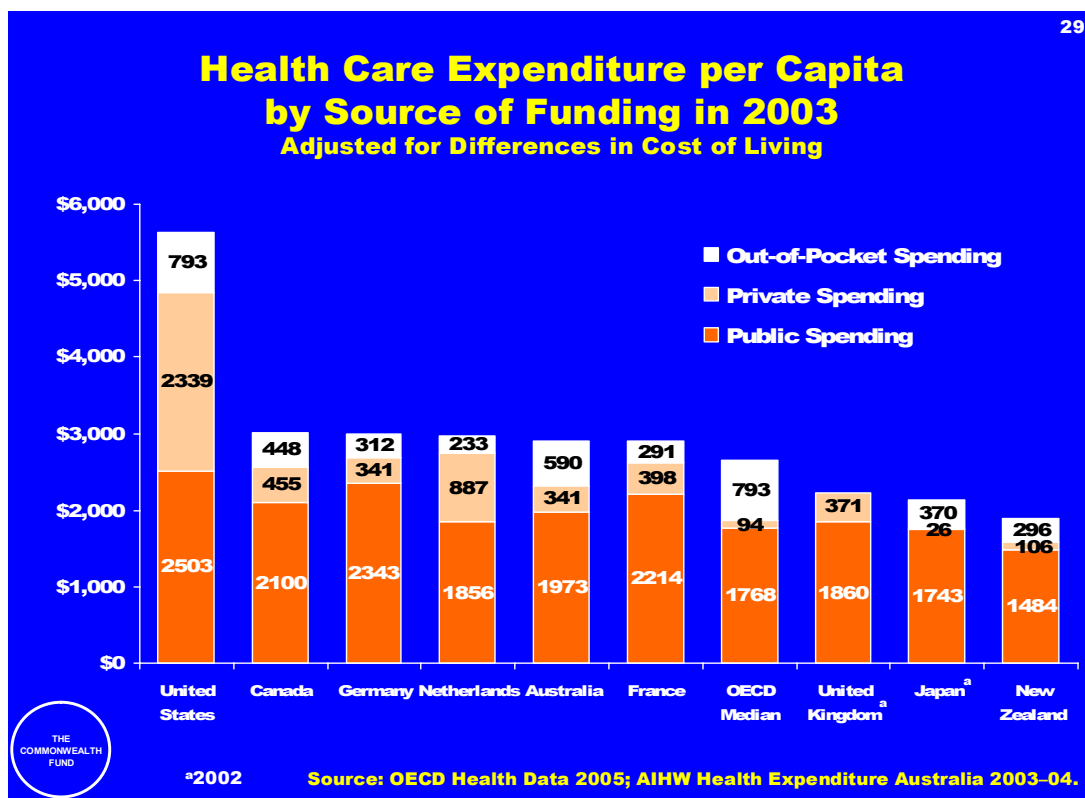


Chart reproduced from chartbook: B. K. Frogner and G. F. Anderson, *Multinational Comparisons of Health Systems*, The Commonwealth Fund, April 2006.

Under a single payer system, health care providers may be government employees, but more often hospitals and physician practices are private entities. In the U.K. and Sweden, for example, the government both funds and operates the majority of health care services, with most physicians actually on the public payroll. Alternatively, in Canada provincial governments act as the single *insurer*, but physician practices are *private* entities, and hospitals may be private or public. The

single payer model breaks the link between health insurance and employment, so portability of coverage if someone changes or loses his/her job is not an issue.

A commonly proposed way to apply a single payer system to the U.S. is by expanding Medicare (public insurance covering residents age 65 and over) to residents of all ages. As under the current Medicare program, the government would collect funds primarily through taxes, and would reimburse private providers under an administered pricing system. Under this approach, employers could continue to offer some health benefits by providing private wrap-around coverage that filled in gaps (such as Medicare's substantial patient cost-sharing, dental insurance, expanded mental health benefits, etc.) These would be equivalent to contemporary Medigap policies.³⁷

An alternative to a single payer system is the *multi-payer* model of national health insurance used in many other industrial nations including France, Japan, and Germany. Instead of direct government control over the health care system, this model utilizes large *intermediaries* that negotiate fees with medical societies, reimburse providers, and are increasingly overseeing the management and delivery of care within prospectively determined budgets. These may be private but heavily regulated entities (as in Japan³⁸) or quasi-public "sickness funds" (as in France and Germany). These sickness funds function in some ways like very large HMOs, and governments are developing ways to compensate those funds that enroll older or sicker populations.

Just as in Canada's single payer model, these multi-payer "social health insurance" systems generally feature privately owned and operated entities that *deliver* care, with government or public-private *financing*, often through payroll taxes or "premiums," providing the bulk of funding and private supplemental payments (employers and households) funding the remainder. An individual's (and family) enrollment in a sickness fund may be determined by employment status and occupational or general industry criteria. Thus, these systems are essentially *employment-based*, but no one loses coverage when they are between jobs or retired. The Unemployment Insurance systems in these countries pay the premiums of workers who are unemployed, and welfare programs pick up from there if the person exhausts unemployment insurance. The financing of the health care system is also sufficient to cover the care of retirees. These features of national health systems assure virtually universal coverage.

³⁷ This scenario is developed and described by James Marone in "Medicare for All," in ***Covering America: Real Remedies for the Uninsured, Volume 2***, The Robert Wood Johnson Foundation, November 2002.

³⁸ An exception is large companies (more than 700 employees) in Japan; these employers generally set up their own health insurance plans through intermediaries that are private and autonomous, but heavily regulated by the Ministry of Health and Welfare. (Silow-Carroll, et. al.. *In Sickness and in Health? The Marriage Between Employers and Health Care*, Economic and Social Research Institute, 1995.)

Financing

National health plans require major government expenditures, and decisions must be made about how to raise the necessary funds. Income tax-based financing, the predominant source of Canada's health care system, represents the most progressive³⁹ approach to financing, but economic theory holds that higher income taxes have adverse effects on work incentives. The payroll tax, used to finance health systems in France, Germany, Japan, and other nations, is also tied to ability to pay, but is less progressive than the income tax. The payroll tax on employers and employees is levied as a proportion of earnings, so higher-wage workers and lower-wage workers pay the same share of income as tax; but higher-income people tend to have substantial income from sources other than employment, and this income is not taxed, making the tax slightly regressive. Adopting this approach in the U.S. would shift employers' role in financing coverage from voluntary premium payments to mandatory payroll taxes. The burden, however, would be spread across *all* businesses, which means that ultimately, it would be spread across all workers who bear much of the actual burden of payroll taxes.⁴⁰ This can be contrasted with the current U.S. system, in which the burden is borne disproportionately by workers in firms that *choose* to purchase health coverage. Regardless of the tax vehicle used, patients may also be subject to deductibles, copayments, and coinsurance.

Ultimately, of course, all health care costs are borne by households – in the form of premiums, out-of-pocket expenditures, higher taxes, lower wages, higher prices for goods and services, or lower distributed earnings from business. This is an important point to keep in mind, given the controversy that usually surrounds the decision about who will *initially* bear the financing burden. It is also important to recognize that the important cost issue is really how much the system will ultimately cost households, and less about how much it will cost government. Systems with a high proportion of their health spending in government budgets do not cost any more in terms of medical resources consumed than the U.S. system, which has more of the bill paid initially by private sources. Indeed, as noted above, the total cost as well as the public cost is less under national health plans than in the U.S.'s system.

³⁹ A progressive tax is one that collects a higher proportion of income from high-income people than from low-income people, thus leaving higher income people with a somewhat lower share of after-tax income than before and lower-income with a somewhat higher share.

⁴⁰ Economists contend that payroll taxes, employer health premiums, and, in fact, all costs associated with compensating workers are ultimately passed on to workers in the form of lower wages. The reasoning is based on the proposition that in deciding whether it pays to hire a worker, employers consider the total compensation costs, not just the wage costs.

Lessons and Conclusion

Despite an upturn in the economy, states are still very much concerned about rising numbers of uninsured and underinsured residents, escalating health care costs, and the prospect of reduced federal contributions toward Medicaid and SCHIP. They are experimenting with a wide range of reform strategies to address these crises. Policymakers have learned that there is no “magic pill,” and each approach entails tradeoffs. Incremental reforms that try to make the system more efficient while leaving the basic system essentially intact are worthwhile, but limited in their impact on coverage and costs over the long run.

Yet sweeping health care reforms – including national health system models seen in other nations – as well as comprehensive strategies considered by a few states, entail tradeoffs as well. There is greater potential to move closer to universal coverage and to gain control over escalating health costs. But such reforms face major challenges, such as opposition to significant increases in public spending, strong lobbying by powerful stakeholders who fear that they would be negatively affected; the risk of attracting chronically ill and high-risk people from other states; the need to persuade the federal government to continue to finance care for Medicare and Medicaid populations; and legal barriers posed by ERISA’s prohibition on state regulation of employer benefit plans.

Despite all of these the challenges, policymakers are understanding the true costs of the *current* system – in terms of direct and indirect costs of treating the uninsured and underinsured, cost-shifting to private payers, inefficiencies, lost productivity, and human suffering. They understand that they must explore combinations of strategies that target different groups of under- and uninsured and improve stability of coverage for those who have insurance, while trying to impose some cost containment and quality improvement on the health care system.

Evaluations and our own research and experience with state health reform uncover the following:

- Assessing and educating the public about the true costs of uninsurance can mobilize public and political will for reform; foundations and advocacy groups can play a major role in this area;
- Built into any reform plan must be significant efforts to educate and garner support and buy-in from state leaders, major stakeholders and the public, for example, by inviting them into the planning process at an early stage;
- Developing a critical mass of support for reform may result in multiple reform proposals on the table, underscoring the need for dialogue and compromise among stakeholders;
- All reform options entail tradeoffs and take time to develop, implement, and see results;
- Reforms involving voluntary participation are more feasible politically but will not bring a state to universal coverage (e.g., voluntary purchasing pools alone are insufficient to expand coverage in any meaningful way);

- Mandatory participation, whether through requirements on employers to contribute or individuals to obtain insurance, will be more effective in reducing the number of uninsured but often face strong political and possible legal obstacles;
- Any reforms involving employer participation must strive to minimize new administrative burden and technical complexities;
- States are trying to leverage their dollars by sharing the financial burden – with the federal government through Medicaid and SCHIP matching contributions, with employers through premium assistance or assessments, and/or with enrollees through premiums, deductibles and copayments;
- Recent coverage expansions generally depend on private insurers to provide services, with public subsidies – crossing the public-private divide;
- States will continue to be learning laboratories, and it will be critical to evaluate initiatives;
- States struggle in enacting initiatives without sufficient stable funding options, and capturing expected “savings” can be illusive;
- More successful reforms require the following:
 - strong leadership;
 - a clearly defined mission;
 - reliable data about the current health care system, its strengths, and deficiencies, patterns and amounts of spending, including spending by and on behalf of the uninsured, the health status of the state’s population, and the comparative status with other states of public programs and health care gaps;
 - dialogue, input and buy-in among stakeholders;
 - creativity;
 - commitment over time; and
 - flexibility to learn from mistakes and make mid-course corrections.

Appendix

Oregon and the Archimedes Movement

Background

In 1994, Oregon implemented the Oregon Health Plan (OHP), a fundamental reform to its state Medicaid program that acknowledged the balancing act between available funding and availability of services in an effort to achieve greater equity in the health care system. In a nutshell, in order to pay for coverage expansion to all poor people in the state rather than just covering the conventional Medicaid categories, the OHP prioritizes funding for medical services by ranking them in theory according to medical efficacy and population impact. Depending on available funds, a line is drawn on the ranked list of services: services above the line will be included in the OHP benefit package while services below the line will not be available through OHP. Funding decisions by the legislature then become a highly transparent process of deciding what specific medical treatments for the poor the state or society is willing to finance – and what treatments are denied. The enactment of the OHP is widely regarded as the first and only American experiment with explicit rationing to contain costs and expand coverage.

Since 1994, the OHP has grown in popularity and stability. Oregon is relying on OHP's basic framework in the development of legislation to provide universal coverage in the state. Former Governor John Kitzhaber, who was instrumental in the conceptualization and enactment of the OHP, is currently leading the Archimedes Movement for universal coverage that builds on applying OHP principles to get to a fundamentally different vision of how to contain costs, expand coverage, and achieve greater health care equity. In order to fully understand potential applications and limitations of the OHP, its actual implementation is described briefly below. It is followed by a summary of the vision of the Archimedes Movement. The obvious and often debated ethical concerns surrounding this approach, especially concerns related to confining prioritization to the poor under OHP and denying care that may be extremely efficacious in individualized clinical presentations are not included in this discussion which focuses on operational and structural considerations.

OHP: Operation and Results

The prioritization process in Oregon rests on the work of an independent commission charged with ranking in order of importance of availability the thousands upon thousands of medical interventions used to treat patients. This commission consists of people from government and clinical experts, including practicing physicians, who evaluate the medical efficacy and impact of different treatments on a scientific evidentiary and technical basis. They also receive input at the

community level on what kinds of benefits people value, e.g. mental health services.⁴¹ The commission reduced over 10,000 medical interventions to a list of 710 medical condition/treatment pairs. In 2005 -2007 Oregon covers 530 of out of the 710 condition/treatment pairings.

Contrary to the popular perception that Oregon traded coverage for rationing, the process actually led to an increase in both benefits and coverage. In 1994, when OHP began, Oregon ranked 46th in the nation in the percentage of state revenues it devoted to Medicaid. Many benefits available in other states such as mental health services and bone marrow transplants were not covered under Oregon's Medicaid program. The process of engaging the public in the debate over what medical services would be excluded actually served to increase awareness, leading ultimately to a broadening of covered services and expansion of coverage compared to that offered by its Medicaid program.⁴² This, in turn, fueled public willingness to fund the additional services resulting in a 17 percent increase in general funds and a 10-cent cigarette tax increase.⁴³ In other words, because of Oregon's low baseline on Medicaid and the ensuing debate over care allocation, OHP actually gained resources and popularity.

As a result of the expanded funding, services even "below the line" were often available. Because of the more generous compensation to providers and plans, they were able to offer "non-covered" care. Moreover, many conditions below the line exist as co-morbidities with conditions above the line and required treatment in order to appropriately treat the covered condition. Five years after implementation, two percent of program savings were attributable to the prioritization of services; the conversion of most of OHP into managed care with its increased access to primary care for low-income people and its discounting practices accounts for a much larger share of the savings.⁴⁴

Notwithstanding these reality checks, OHP represents a coherent effort to deal with health reform at a systemic level, reconciling health care choices with financing and creating more equity among low-income people. OHP has evolved into Oregon's current legislative initiatives to achieve universal coverage using the commission model to define basic covered services purchased through a large pool of insurers and financed through federal and state Medicaid dollars and employer and individual contributions.

⁴¹ Lawrence Jacobs, Theodore Marmor, Jonathan Oberlander, "The Oregon Health Plan and the Political Paradox of Rationing: What Advocates and Critics have Claimed and What Oregon Did," *Journal of Health Politics, Policy and Law*, 24:1, 1999

⁴² Ibid.

⁴³ The process of "drawing the line" based on current available funds creates volatility in covered services and continuity of care from year to year. For example, in 2004, OHP eliminated many mental health services from coverage due to budget shortfalls. The Government Performance Project, "Mental Health: Promise Unfulfilled," 2004, accessed at www.governing.com on March 25, 2004.

⁴⁴ Jacobs, et al. 1999

The Archimedes Movement

The Archimedes Movement, spawned by the experience with OHP, represents a visionary approach to fundamental and structural change in American health care. It rejects the notion that some segments of society have theoretically unlimited care through tax and other subsidies while others get none. The goal of the Archimedes Movement, like that of OHP, is to assure a floor of health services for everyone while allowing those able to do so to augment their care through additional purchasing. Its vision extends to the entire community beyond the low-income community currently insured through OHP

Created by former Oregon Governor John Kitzhaber, the Archimedes Movement (the Movement) has a formal organizational structure designed to develop a consensus view of the basic elements of a health reform plan and then to achieve adoption of that plan through political action. It focuses on achieving these reforms in Oregon. In an effort to replicate the participatory political process that led to OHP, the Movement relies on an internet community as “the engine behind this effort – the vehicle through which we will seek to build...critical mass...”⁴⁵ Defining the vision emanates from this internet dialogue. At the next level, the Archimedes Council, composed of a broad spectrum of stakeholders, is charged with formulating the design principles based on a coherent synthesis of the internet-based vision and developing the operational details of the new system.⁴⁶ Through the continued engagement of the internet community combined with active community implementation initiatives beyond the scope of this discussion, the proposed reforms will be promoted.

As a result of this effort, the Movement published a draft legislative concept paper on October 22, 2006 that describes the limitations of the current system and proposes elements of reform. The dialogue around the draft appears to be ongoing within the membership of the Movement. Rather than provide actionable legislative specifications for a health care insurance program, this legislative concept authorizes the state government to seek Congressional waivers to reallocate health care dollars in Oregon to meet the needs of its citizens according to defined principles.⁴⁷ Upon receiving Congressional approval, development of an implementation plan is delegated to the Oregon Health Policy Commission or some similar entity.

Archimedes Movement Major Principles

- Universal eligibility to a common set of “essential, effective health services;”
- Broadly based and affordable financing;
- Prioritization of services to achieve the greatest health benefit for the largest number of people based on medical evidence;
- Explicit and transparent decision-making where criteria for inclusion and exclusion of services is clearly defined and observable;
- Aligned financial incentives to support investment in activities that promote better overall health;
- Emphasis on health promotion and disease prevention; and
- Structuring services to promote coordination of care.

⁴⁵ <http://www.archimedesmovement.org/plan>, accessed 11/30/2006.

⁴⁶ Ibid.

⁴⁷ <http://www.archimedesmovement.org/draft>, accessed 12/04/2006.

Conclusion

Experience with the prioritization process does not suggest that it will automatically yield savings that can be applied to coverage expansions. Rather, that experience suggests that the process of deciding what medical services are important fuels a commitment to expand coverage and insure a basic benefit package while other reforms continue. The effects of allowing benefits to fluctuate as envisioned in these proposals may have implications for the management of chronic disease and coordination/continuity of care, and it remains unclear to what extent the participatory political process based on community initiative on display in Oregon can be replicated elsewhere. However, these experiments provide an important jumping off point for analyzing what care should be regarded as the universal minimum and how it is paid for.

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Health Management Associates is a national research and consulting firm specializing in complex health care program and policy issues. Founded in 1985, in Lansing, Michigan, Health Management Associates provides leadership, experience, and technical expertise to local, state, and federal governmental agencies, regional and national foundations, multi-state health system organizations and single-site health care providers, as well as employers and other purchasers in the public and private sectors.

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