Working Notes: What's Going On Around the Nation (sans WA) (draft – work in progress)

Universal Access / Systemic Health Care Reform (as of May 2006)

- ✓ ME – Dirigo, passed 2003 (multi-pieced)
- ✓ MA – passed 2006 (multi-pieced, e.g., insurance exchange, market changes, indiv & employer mandates, subsidies, uncompensated care pool, Medicaid expansions)
- ✓ 8 states considering(ed) universal coverage bills in 2006 (many are single payer): CA, CT, HI, MI, MO NH, NY, WI (employed individuals & dependents only) (MI, NY, WI legislation modeled after MA)
- ✓ 7 states have commissioned studies to look at possibility of universal coverage: HI, MD, MN, NY, RI, VA, WV (passed)
- ✓ Kitzhaber latest proposal: get OR out of Medicare & Medicaid and end tax-exclusion for ESI; use resulting pool of $$ to cover everyone for "basics"
- ✓ VT – Catamount Health, passed 2006 (universal coverage by 2010) (multi-pieced, e.g., employer mandate; prepaid clinic-based primary care coverage) (will still leave about ½ of uninsured not covered – only ~ 60K uninsured to start with) (voluntary to start, consider mandate if doesn't work)
- ✓ WV – passed 2006 (SCHIP to 300% fpl; clinic-based preventive care pilot program based on prepaid primary & preventive care for uninsured individuals & small businesses; minimum benefit plans for long-term uninsured (limited specialty & hospital)
- ✓ TN – Mar 06 Governor proposal (cover kids up to 250% fpl; SCHIP buy-in for kids over 250% fpl, high risk pool; Cover TN for uninsured low-income workers & non-offering small businesses (3-share model) but with coverage tied to individual not employer

(as of July 2005, single payer bills had been introduced in ~ 18 states – doesn't mean they went anywhere) (single payer defined as: gov't uses tax revenues to pay for hc for all)

Pay or Play / Employer Mandate (as of May 2006)

- ✓ MD - passed (overrode Gov veto Jan 2006) & in courts
- ✓ MA - passed as part of larger health care coverage bill
- ✓ ~ 26 states introduced bills – (NY is also an employee mandate); ~ 16 states with bills still alive (employer sizes vary from 25 in NY to 20,000 in CA, most at 10,000).

Cover "All" Children (as of May 2006)

- ✓ IL – passed 2005, All Kids
- ✓ HI – 3 year pilot delivered to Governor
- ✓ FL - considering
- ✓ MA – unique = use case managers from children's community
- ✓ WV – taking steps close to covering all children
- ✓ PA – proposal to cover all children
- ✓ TN – Governor 2005 proposal to insure all children in families below $50,000 annual income
- ✓ OR – Children's Group Plan (allow small business owners to provide children's coverage even if can't provide employee coverage)

- ✓ Several states raising age of dependency (unmarried children):
  NJ – to 30 (with no dependents)
  CO, IL, MA, NM, SD, TX, UT – to 24, 25, or 26
  CA – passed but Governor vetoed
  NH – not sure if passed
  CT, KY, MD, NY, RI – considering (ed)
  HI – no limit under certain circumstances

- ✓ Community- or county-based programs: e.g., CA's Children's Health Initiatives

New Wave of Medicaid Redesign
Post Deficit Reduction Act of 2005

- ✓ KY and WV = first states to receive CMS approval of Medicaid State Plan Amendments to implement alternative benefit approaches; both use consumer-directed designs involving some type of personal account designed to encourage use of preventive services & healthy lifestyle choices.

Other Recent Medicaid Redesigns of Interest

- ✓ FL – change from defined benefit to defined contribution; implement health credit accounts (Medicaid version of HSAs)
- ✓ OK & SC also using personal health accounts in Medicaid

Employer (especially small business), Employees, Self-employer

- ✓ Slew of states doing things around small employers & their employees, generally involving 1 or more of
  - Reinsurance mechanisms (many not publicly subsidized)
  - Limited or customized benefit plans (sans many otherwise mandated benefits; or focus on primary/preventive with no catastrophic, or all catastrophic)
  - Group purchasing or pooling / insurance exchange arrangements / piggy-back on state employee program reimbursement rates
  - Tax incentives / credits
  - Premium assistance / 3-share financing / vouchers (some tied to employer & some tied to individual for portability)
  - Information clearinghouses
  - Versions of health savings accounts, personal health accounts or credits
  - Mandates (individual, employer, insurer)

(often involve use of unspent SCHIP $$ or getting Medicaid match for new population; sometimes blending individual & small group markets)

- ✓ Twists of interest
  - RI - Governor March 2006 proposal to create "value-based" plan for small businesses – make affordable by focusing on medical cost drivers – includes reinsurance & mandate exemptions
  - CA - employers offering workers health insurance that pays for care in Mexico
  - Large employers: offering discount card program for uninsured part time, temporary, & seasonal workers and independent contractors
  - PA - use of "excess carrier surplus" to help cover uninsured low-income adults in various state programs (mainly adult Basic) – part of money (~40%) goes to community health access programs.

Delivery System Changes

- ✓ MN – hospitals to provide discounted care to uninsured with incomes < $125,000/year
- ✓ WY – programs to help all residents (regardless of age & income) obtain lower cost drugs
- ✓ 8 states (e.g., GA, IN, MN) - Mini-clinic programs i.e., use APRNs to diagnose & treat patients with simple ailments; walk-in clinics located in large retail stores (e.g., K-Mart)
- ✓ Pay for performance – as of Jan 2006 ~ 12 states have adopted P4P programs in Medicaid (e.g., CA, IA, ME, MD, MA, MI, NM, NY, NC, PA, RI, TX, VT, DC) (PacifiCare, CA: began in 2003 with physician networks getting bonuses)

Health Savings Accounts (Personal Health Accounts, etc.)

- ✓ ~ 26 states (as of Dec 05) had HSA-related laws (aimed at making them more available) – some incorporated into Medicaid (e.g., FL, IA, KY, OK, SC); some into public employee programs (e.g., AR, FL, KS, OK, SC, SD, UT)
- ✓ ~ 12 states with HSA-related laws for high risk pool plans

Hi-Risk Individuals / Pools

- ✓ ~ 33 states (as of Oct 05) have high risk pools (OH, NC, TN, GA, NV, AZ, ME are contemplating)

- ✓ Twists of interest
  - IN – 2003 legislation allows state to withdraw coverage for high risk pool enrollees who refuse to participate in disease mgmt programs

Benefit Mandates / Limited Benefits

- ✓ ~ 28 states (as of Mar 06) require cost of a new mandate be assessed before implementation
- ✓ ~ 5 states (as of Mar 06) allow sale of basic-benefit packages that do not comply with all existing state mandates
- ✓ UT – primary care network only "benefit package" for adults < 150% fpl

What Else?

- ✓ Governor's major initiatives
- ✓ Federal Legislation

WASHINGTON BLUE RIBBON COMMISSION: FLORIDA OVERVIEW

General Nature of Program/Proposal: Goal of redesigning (modernizing) the Medicaid program to slow future program growth, increase personal responsibility, and increase choice through market competition and private coverage.

Key Substantive Elements

- Pilot demonstration in 2 counties with evaluation in 2008 to determine feasibility of expansion statewide by 2011.

Managed Care

- **Defined contribution managed care model** (to replace defined benefit model) for all Medicaid recipients in fee-for-service, managed care and the MediPass primary care case management system
- Managed care carriers and provider service networks compete for recipients through **customized benefit packages** designed to meet the needs of specific Medicaid groups (and subject to state approval)
  - **Comprehensive care**– i.e., basic care coverage expected to cover most services needed by most people
  - **Catastrophic care** – i.e., covers services above a specified threshold up to a maximum amount (details unclear)
- **Plan choice locked-in** for 12 months after 90 days enrollment - for individuals mandated to participate
- Managed care **rates based on risk adjusted premium allotment** for each person in each category of care – premiums based on historical Medicaid expenditures (initial process unclear since historical data incomplete)
- Minimal cost sharing subject to federal limits (consistent with current Florida levels)
- **Integrated (acute and long-term care) fixed-payment delivery system** for elderly Medicaid recipients
- Voluntary participation to be tested in one county for special populations (e.g., foster care children; individuals with developmental disabilities, residing in nursing homes, or with Medicare coverage) – participation will be mandatory when networks developed to meet population needs
- Infrastructure to be developed **for performance measurement of managed care plans** and **public reporting of consumer satisfaction** - State will contract with independent choice counselor to ensure enrollees fully informed on options and to gather consumer satisfaction details.

Enhanced Benefit Accounts (EBA)

- Medicaid version of HSAs - created as incentives for beneficiaries to participate in state-defined "healthy" activities (to be defined by new EBA Board)
- Can offset health care expenses (e.g., OTC medications) or keep for purchasing private coverage if Medicaid eligibility lost and income remains under 200% of federal poverty.

Opt-out for ESI

- Opt-out of Medicaid-certified plans allowed if individual's premium allotment used for individual or employer-sponsored insurance
- Enrollee responsible for premiums in excess of allotment, all cost sharing, and costs of uncovered benefits.

Safety-net Support

- **Low-Income Pool** (capped at $1 billion annually) created to reimburse safety-net providers for serving the uninsured

Financing

- Establishes a per capita cap that limits the amount of federal funds the state can receive per beneficiary for the eligibility groups covered
- Low-Income Pool financed with state and federal matching funds
- Enhanced benefit accounts financed by savings from waiver and federal matching funds
- Growth in Medicaid budget tied to growth in state revenues rather than growth in Medicaid enrollment.

Fiscal Context when Waiver Approved:

- Florida Medicaid program had 2.2 million enrollees; costing $14 billion (FY2004-05); expenditure growth averaged 13% per year over last 6 years; 24% of Florida budget in FY 2005; 59.1% federal matching rate.

Current Status: Medicaid Section 1115 Waiver submitted to CMS 10/3/2005; approved by CMS 10/19/2005; approved by Florida legislature 12/8/2005; pilot begins 7/1/2006; waiver good till 2011.

WASHINGTON BLUE RIBBON COMMISSION: MAINE OVERVIEW

General Nature of Program/Proposal:

System reform (known as Dirigo Health) to expand access to coverage for all residents, bring down cost growth, and continually improve quality of care

Key Substantive Elements:

Access to Coverage: Created DirigoChoice Program

- New insurance product available through Blue Cross to improve coverage for small business (under 50 employees), self-employed, and individuals without employer-coverage
- Program linked with MaineCare (Medicaid), with joint application and eligibility screening
- Sliding scale discounts on monthly payments and reduction in deductible and out-of-pocket expenses for those below 300% of federal poverty
- Voluntary individual and employer participation.

Quality: Created Maine Quality Forum

- Clearinghouse of best practices and information to improve health
- Resource for providers and consumers
- Will create quality standards to evaluate and compare quality and provider performance, and assess needs for new medical technologies.

Cost Control: Package of efforts to contain the growth of health care spending

- Reduce bad debt and charity care through access to coverage
- Changes in Certificate of Need:
    - One-year moratorium on CON
    - Expansion of CON to include ambulatory Surgical Centers and capital improvements costing over $2.4 million or new technologies over $1.2 million
- Create statewide Capital Investment Fund – limit annual capital investment in health care industry
- Transparency in prices for consumers
- Voluntary cap on costs and operating margins for hospitals - cost growth limited to 3% per year, operating margins limited to 3.5%
- One year voluntary cap (3%) on revenue growth for doctors and other health care practitioners and on underwriting gains for carriers – cap ended 2004
- Insurance carriers permitted to offer financial incentives for consumers to travel further for non-emergency surgical procedures
- Strengthened oversight of insurance rates for small and large group
- Accountability for insurers with annual reporting requirements to allow easy comparisons of loss ratios and profit across lines of business and across insurers.

Administration

- Independent agency (with Board of Directors nominated by Governor and approved by Legislature) established to administer Dirigo Health plan and establish Maine Quality Forum.

Financing

- First year from employer contributions, individual contributions, federal and state dollars (State cost initially estimated at $53 million)
- On-going funding for premium discounts to be generated through "Savings Offset Payments", an assessment on gross insurance premium revenues of insurers and third party administrators, not to exceed 4% of paid claims. (Initial savings identified at $44 million.)

Current Status: Legislation signed June 2003; Enrollment began January 2005; Maine Association of Health Plans filed suit November 2005 in disagreement over savings calculation and resulting assessment.

WASHINGTON BLUE RIBBON COMMISSION: MARYLAND OVERVIEW

General Nature of Program/Proposal: Employer mandate (also known as "Pay or Play", "Fair Share") - goal of ensuring that all large employers pay for or provide health insurance to their workers.

Key Substantive Elements

Employer Mandate

- Fair Share Health Act (FSHA) requires all large employers (more than 10,000 employees) spend minimum percent of payroll on health insurance costs for their employees
  - For-profit employers required to pay minimum 8% of payroll (bill impacted 5 companies, 1 of which didn't meet the 8% threshold)
  - Not for-profit employers required to pay minimum 6% of payroll
- Pioneering Maryland FSHA fashioned after AFLCIO template – "standard" for most Fair Share legislation being introduced around nation
- FSHA introduced with further "standard" legislation that requires state to collect data from public programs identifying employers whose employees/dependents have coverage via state programs and the cost to the state of providing coverage to them. (Did not pass in Maryland).

Fair Share Health Care Fund

- Employers that don't spend required payroll minimum must contribute difference between what they do pay and minimum to state-operated fund (Fair Share Health Care Fund) to provide health benefits to uninsured
- Investment earnings retained within fund.

Administration

- Department of Labor, Licensing and Regulation (DOLLR) to administer and enforce requirements
- Large employers must report health care expenditures to DOLLR annually or face financial penalty
  - For calculation purposes, payroll excludes wages paid in excess of Maryland's median household income (per Census Bureau).

Current Status: Fair Share Heath Care Fund established by legislation (SB 790) vetoed by Governor but veto overridden by legislature 1/12/2006. Currently under challenge in court – suit filed by Retail Industry Leaders Association (RILA) whose primary argument is that law violates:

- ERISA because it acts to compel employers to provide minimum level of health benefits to their employees and
- The Equal Protection Clause of the Constitution because it singles out a specific company (Wal-Mart).

WASHINGTON BLUE RIBBON COMMISSION: MASSACHUSETTS OVERVIEW

General Nature of Program/Proposal: Near universal health coverage for all residents

Key Substantive Elements

- Multi-pronged effort targeted to cover the uninsured (550,000):
  - Target (39%) to get covered via Commonwealth Health Insurance Connector.
  - Target (38%) to get covered via Commonwealth Care Health Insurance Program.
  - Target (17%) to get covered via Medicaid Expansion (children up to 300% FPL)

- **Individual Mandate:** Mandates everyone purchase coverage by 7/07 or face financial penalty up to 50% of cost of coverage via income tax filings. Packaged with expectation for 'affordable' coverage, purchasing opportunity via the Connector, and subsidy for low-income individuals.
- **Employer Mandate:** Employers with 10 or more employees provide coverage or pay a contribution up to $295 annually per employee. Employers with fewer than 10 employees required to offer Section 125 cafeteria plan to allow workers to purchase health care with pre-tax dollars.

- **Group Purchasing:**
  - Creates private Commonwealth Health Insurance Connector to "connect" people to commercially offered, affordable, quality, insurance products. Small business and individuals not offered employer coverage can join. Connector will offer specially designed, lower-cost products for 19-26 year olds. Pre-tax dollars (Section 125) can be used for premiums.
    - Merges individual and small group markets by July 2007, 24% reduction in individual premiums expected.
  - Creates public Commonwealth Care Health Insurance Program to offer sliding-scale premium subsidies to individuals up to 300% FPL. No enrollee premium contribution if income below 100% FPL. Will offer no-deductible products via managed care organizations that participate in Medicaid.

- **Safety Net Care:** Creates **Safety Net Care Fund** to reimburse providers for uncompensated care. Combines dollars from existing Free Care Pool with other Medicaid funds like DSH. Creates **Essential Community Provider Grant Program** to support safety net hospitals and community health centers.

- **Quality Improvement:** Creates Health Care Quality and Cost Council to develop performance measures and publish comparative cost and quality information on a new consumer web-site. Creates Health Disparities Council to extend existing special commission. Requires hospitals report health-care data related to race, ethnicity and language. Data will be used in a Medicaid pay-for-performance (P4P). Hospitals to meet performance benchmarks to get Medicaid rate increases.

Financing:

- Total cost of $1.2 billion over 3 years – Funding sources include:
  - Redistribution of existing funding
  - Employer contributions
  - General fund ($308 million over 3 years)
- No new funding after 3 years.

Current Status: Legislation signed 4-12-2006; Full implementation targeted for 7-1-2007

WASHINGTON BLUE RIBBON COMMISSION: VERMONT OVERVIEW

General Nature of Program/Proposal: Goal of universal coverage via voluntary approach; if 96% coverage not achieved by 2010 will look at mandating individual coverage.

Key Substantive Elements

- Catamount Health
- Prevention & management of chronic diseases

Catamount Health – 2 components

1. Creates new health plan offered in commercial market (i.e. fully insured), with option to move to self-insurance if commercial offering is not cost-effective for the state.
    - single standardized product defined by the state (e.g., $250/$500 individual/family deductible PPO with higher deductible if out-of-network) with **no cost to enrollee for preventive care or for recommended services related to a chronic illness.**
    - voluntarily bid-on by carriers (i.e., carriers not required to offer the plan; option to review in future & decide if it should be a mandatory offering); community rated as a distinct, separate pool.
    - only available to uninsured.
    - state subsidizes premiums & cost-sharing on sliding scale if under 300% federal poverty.
    - estimating coverage of 25,000 of state's 60,000 uninsured (enrollment cap based on funding).
2. Provides state-funded financial assistance to employed uninsured or public program eligibles who have access to employer-sponsored insurance & have incomes under 300% federal poverty.
    - employer's coverage must meet specific coverage standards including **chronic condition coverage & management consistent with the Blueprint for Health**
    - sliding scale assistance for employee's (& dependents) portion of premium.
    - **waiver of cost-sharing** (e.g., deductible & coinsurance) **for care related to chronic conditions if** participating in chronic care management program, and for preventive care.
    - for public program enrollees: mandatory enrollment in employer coverage for employee if cost-effective for state; at parent's discretion for children.

- Financing for both components via individual premiums, assessment on employers for employees without coverage, new tobacco taxes, and possible federal matching funds under Vermont's global commitment Medicaid waiver (similar to a block grant).

Prevention & Management of chronic diseases – woven throughout various pieces of reform, for example

- Cornerstone is Blueprint for Health: committee charged with creating & implementing a 5-year strategic plan for the development of a statewide system of chronic care & prevention, including aligning provider reimbursement with managing care of individuals with or at risk for chronic conditions.
- Catamount Health includes components that encourage chronic condition management (see bolded pieces above).
- Implementation of chronic care management program in public programs (e.g., Medicaid), with components that reflect the Blueprint for Health including (1) chronic care information system, (2) standardized health risk assessment, (3) process & outcome measures to provide performance feedback to providers, and (4) payment methods (e.g., pay for performance, payment for technical support, increased rates for evaluation & management services) to encourage a focus on chronic condition identification, prevention, management, & health outcome improvement.
- State-funded incentive grants & stipends to physician practices that participate in Blueprint pilot projects.
- Healthy lifestyle discounts up to 15% off premium on commercial products for individuals & small employers if individuals/employees adhere to health promotion & disease prevention programs.

Other Elements

- **Creates Oversight Commission** to monitor implementation & recommend needed legislative actions.
- **Multi-payer price & quality database**: requires insurers, 3rd party administrators, drug benefit managers, state plan, & Medicaid (& Medicare to extent possible) to provide data for price & quality information for consumers.
- **Reinsurance** for insurers in individual market to cover 5% of claims costs.

Current Status: Signed by Governor, May 25, 2006 (majority of implementation dates are in 2007)

WASHINGTON BLUE RIBBON COMMISSION: WEST VIRGINIA OVERVIEW

General Nature of Program/Proposal: Preventive Care Pilot Program (clinic-based, primary care, for a pre-paid fee)

Overall Purpose: Allow health clinics & private medical practitioners to provide primary & preventive health services for a prepaid fee.

Key Substantive Elements

- 3-year pilot with defined evaluation plan to determine its value for expanding access on a statewide basis.
- 8 providers, offering services at 3 sites each, will be given "preventive care pilot program licenses" to market & sell prepaid memberships (providers are not considered to be offering insurance).
- State will define minimum set of preventive & primary care services to be included in the prepaid package.
- Individuals, families, and employer groups are eligible to participate -- cannot currently have nor have had coverage within last 12 months unless it was lost due to a qualifying event (e.g., employment termination); in the case of employers, they cannot currently offer nor have offered coverage within the last 12 months. (May allow participation by employers offering high deductible plans.).
- Unclear how the "prepaid fee" will be determined; appears it will be "bid" by providers applying for the license.

Financing: No direct increase of state dollars is needed for design or implementation.

Current Status: Signed by Governor, April 2006, HB 4021; pilot to begin July 2007

General Nature of Program/Proposal: Other Key Elements of HB 4021 (signed April 2006)

- **Individual Limited Health Benefits Plans**: "no frills" individual insurance plan that emphasizes preventive & primary care (limited to physician, inpatient & outpatient care).
  - For adults ages 18-64 who have not had coverage for the past 12 months or lost coverage due to a qualifying event (if employed, cannot be eligible for employer's coverage, if offered).
  - May limit eligibility based on health status; may have pre-existing condition exclusion of 12 months.
- **Interagency Health Council**: Responsibilities in relation to evaluating unmet health care needs & recommending approaches to meet them. Most notable charge = how to implement access, cost, quality, & financing goals of the Legislature including how to work toward universal health coverage for all residents.
- **SCHIP Expansion**: Expand state SCHIP eligibility from 200% to 300% federal poverty (leaves about 800 children without coverage). Children not eligible if had employer-sponsored coverage during the previous 12 months (unless coverage was lost because parent lost employment).

General Nature of Program/Proposal: Other Notable Activities in West Virginia

- **Medicaid**: Early adopter of Medicaid flexibility built into the federal 2005 Deficit Reduction Act.
  - CMS approval in May 2006 to provide scaled-back basic benefit package for most children & parents; have access to an enhanced package if sign and adhere to a member agreement (e.g., do best to stay healthy, go to medical home if sick, participate in health improvement programs recommended by provider)
  - Adherence to the agreement is monitored by providers; if don't adhere, coverage reverts to the basic package and there is a significant waiting period to reapply for the enhanced coverage.
  - Some disagreement as to whether the scaled back, basic package for children is contrary to federal law related to EPSDT services.
  - Implementation is phased-in over 4 years, starting July 1, 2006 in 3 rural counties.
- **West Virginia Small Business Plan** (SB 143, passed in 2004)
  - Sets criteria & rules under which 3 partners work together:
    - private insurance companies underwrite all risks & perform most administrative duties; agree to lower administrative costs; offer policies that mirror their commercial ones (as of Jan 05, 1 carrier offering).
    - West Virginia Public Employees Insurance Agency (PEIA) allows use of its lower service payment rates.
    - Participating providers agree to accept the PEIA service payment rates as payment in full.
  - Available to businesses with 2-50 employees; that have been in existence for 12 months; that have not offered coverage during prior 12 months; and where the employer agrees to pay 50% of individual premium costs and 75% of eligible employees participate.
  - **Financing**: No state funds used to support the program – start-up costs financed by a grant after which the program must determine how to be self-supporting without use of state dollars.