



STATE HEALTH ACCESS
DATA ASSISTANCE CENTER

Overview of State Health Access Reform

Elizabeth Lukanen, MPH Deputy Director

Lynn Blewett, Ph.D. Director

State Health Access Reform Evaluation (SHARE)
University of Minnesota School of Public Health

Association of Minnesota Counties
Health Care Task Force Meeting

Anoka, MN

January 16, 2008

Supported by a grant from The Robert Wood Johnson Foundation



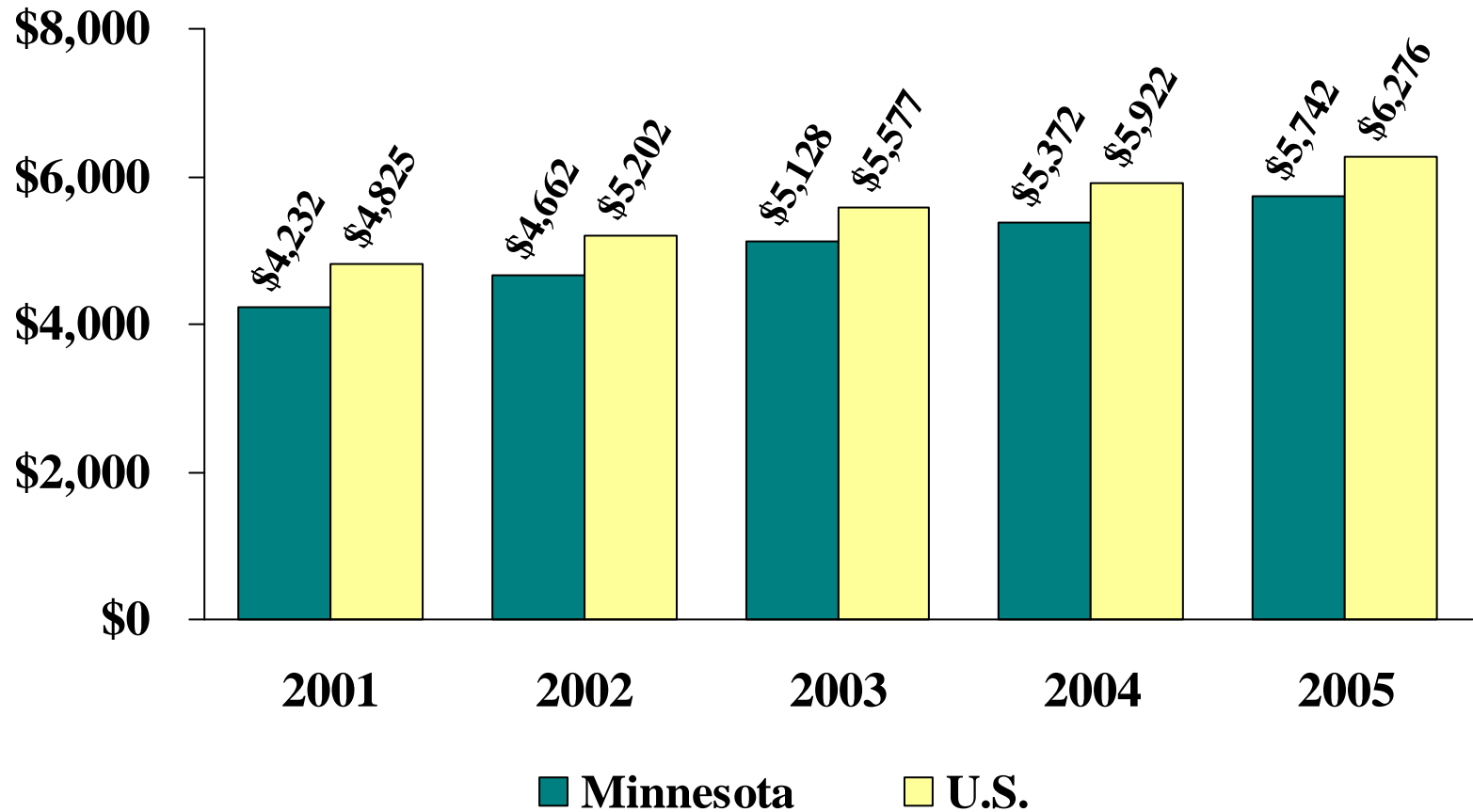
Overview

- Drivers of State Health Reform Activities
- What are Individual States Doing?
- Administrative Simplification
- County Initiatives
- Goals of State Health Reform
- Characteristics of Successful Reform

Drivers of State Health Reform Activity

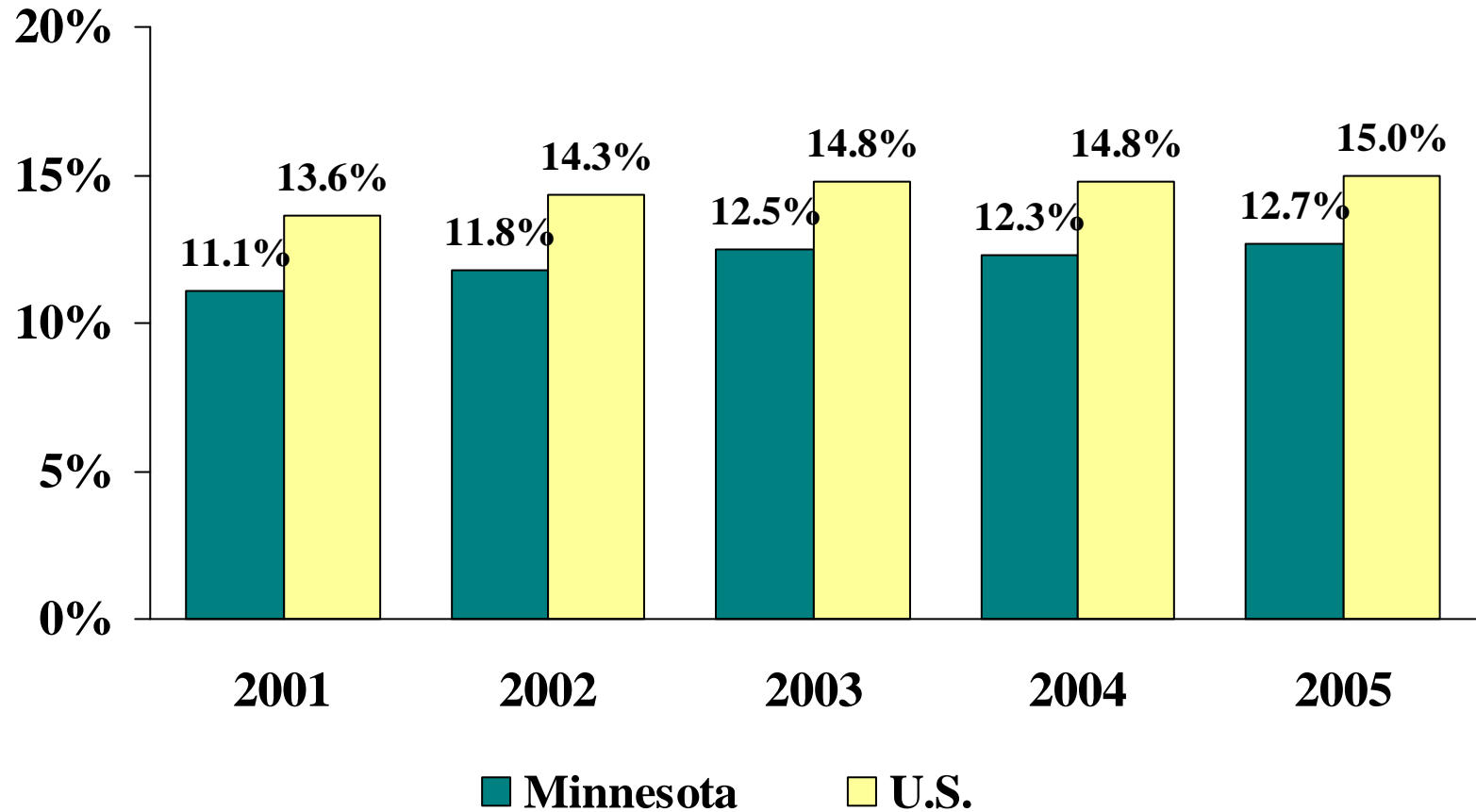
- Increased Health Care Costs
 - Steady increase in public and private spending
- Increasing number of uninsured
 - Reduction in employer-sponsored coverage
- Lack of federal action for reform
 - Large federal deficit

Health Care Spending Per Capita, Minnesota and U.S.



Sources: MDH Health Economics Program, Centers for Medicare and Medicaid Services (spending for health services and supplies)

Health Care Spending as a Share of the Economy, Minnesota and U.S.



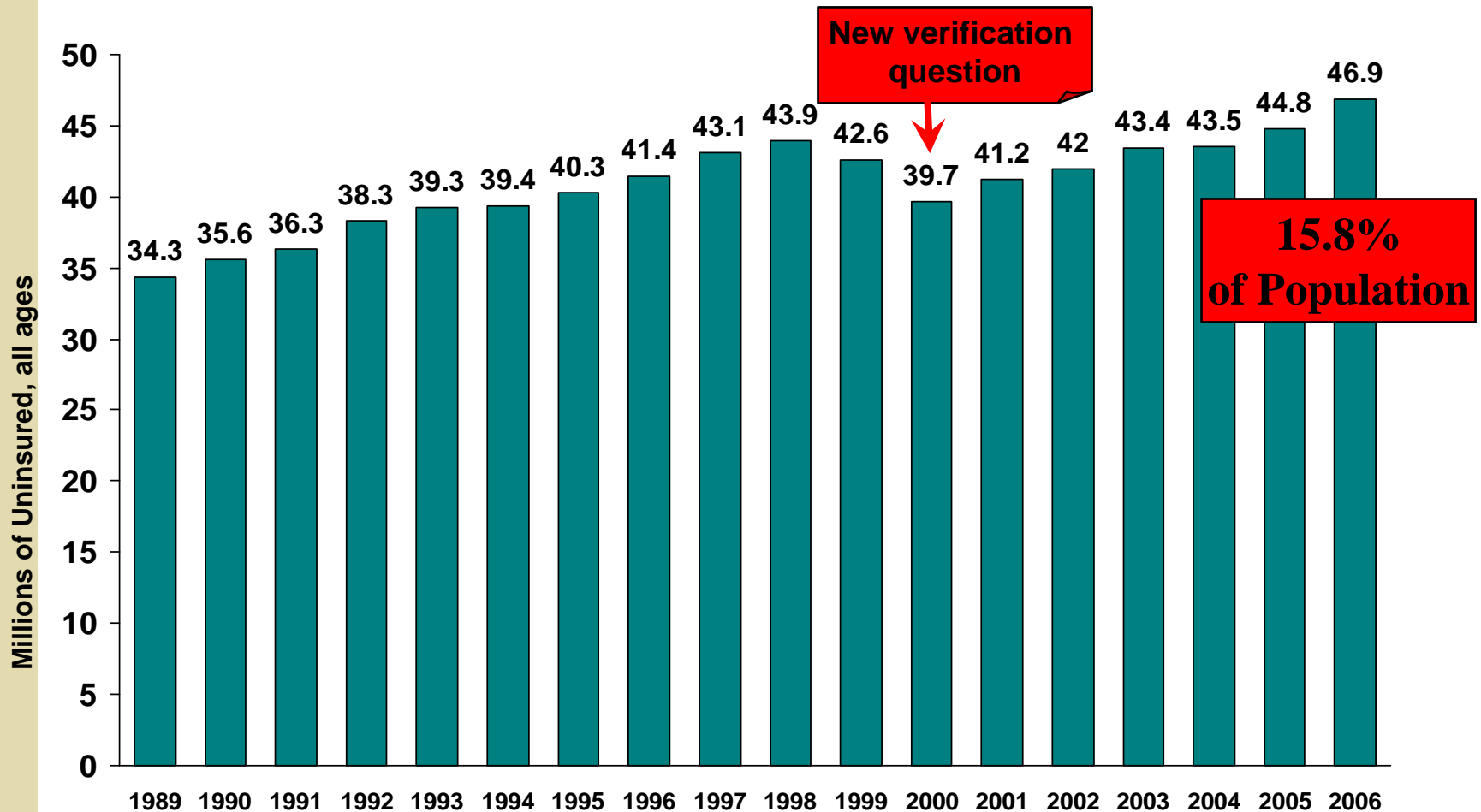
Sources: MDH Health Economics Program, Centers for Medicare and Medicaid Services (spending for health services and supplies)

Minnesota and U.S. Health Care Expenditure Growth

	2004		2005	
	MN	U.S.	MN	U.S.
Public Spending	5.9 %	7.8 %	6.6 %	8.5 %
Private Spending	5.2%	6.8%	8.2%	6.7%
Total Spending	5.5%	7.2%	7.6%	7.5%

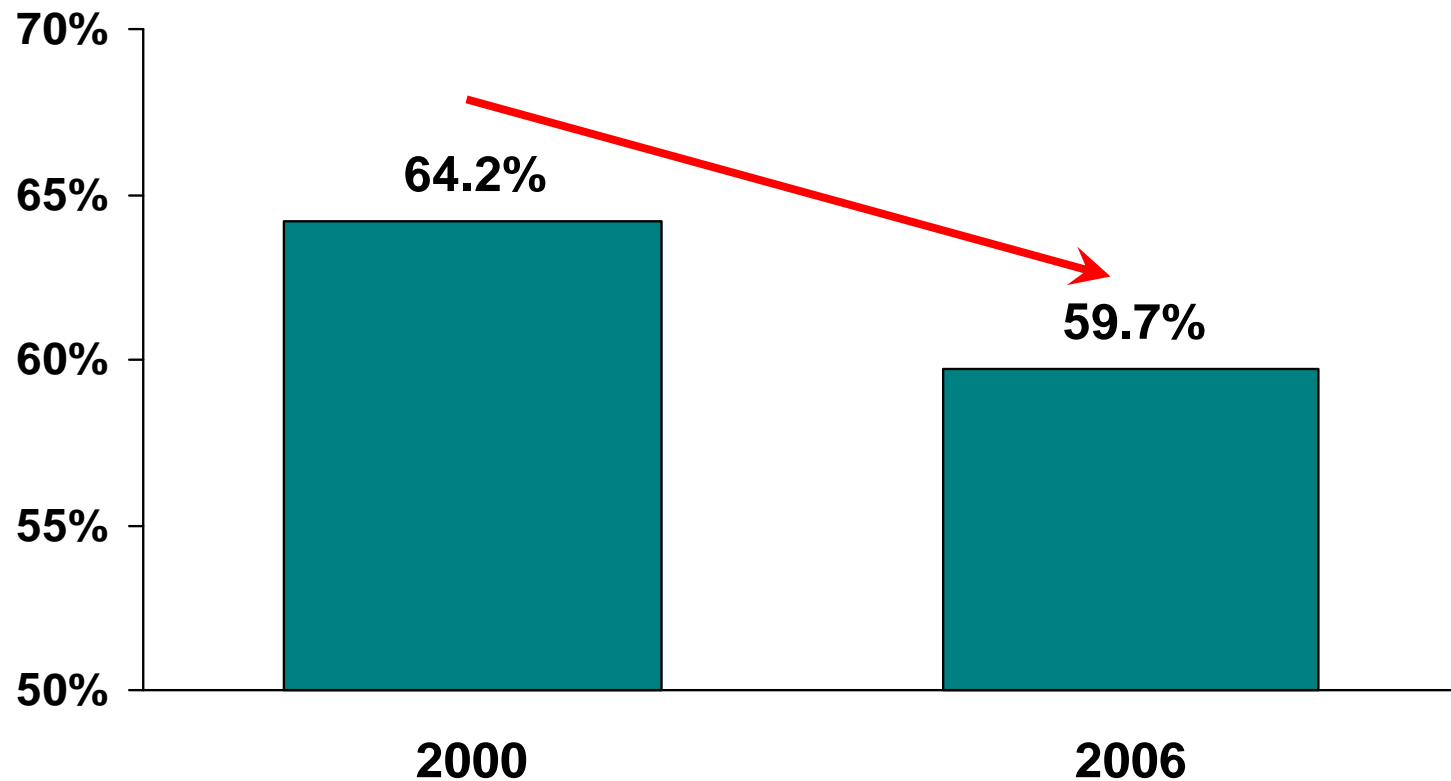
Sources: MDH Health Economics Program, Centers for Medicare and Medicaid Services.

Increasing Number of Underinsured



Source: U.S. Census Bureau, Current Population Surveys (March), 1989-2006

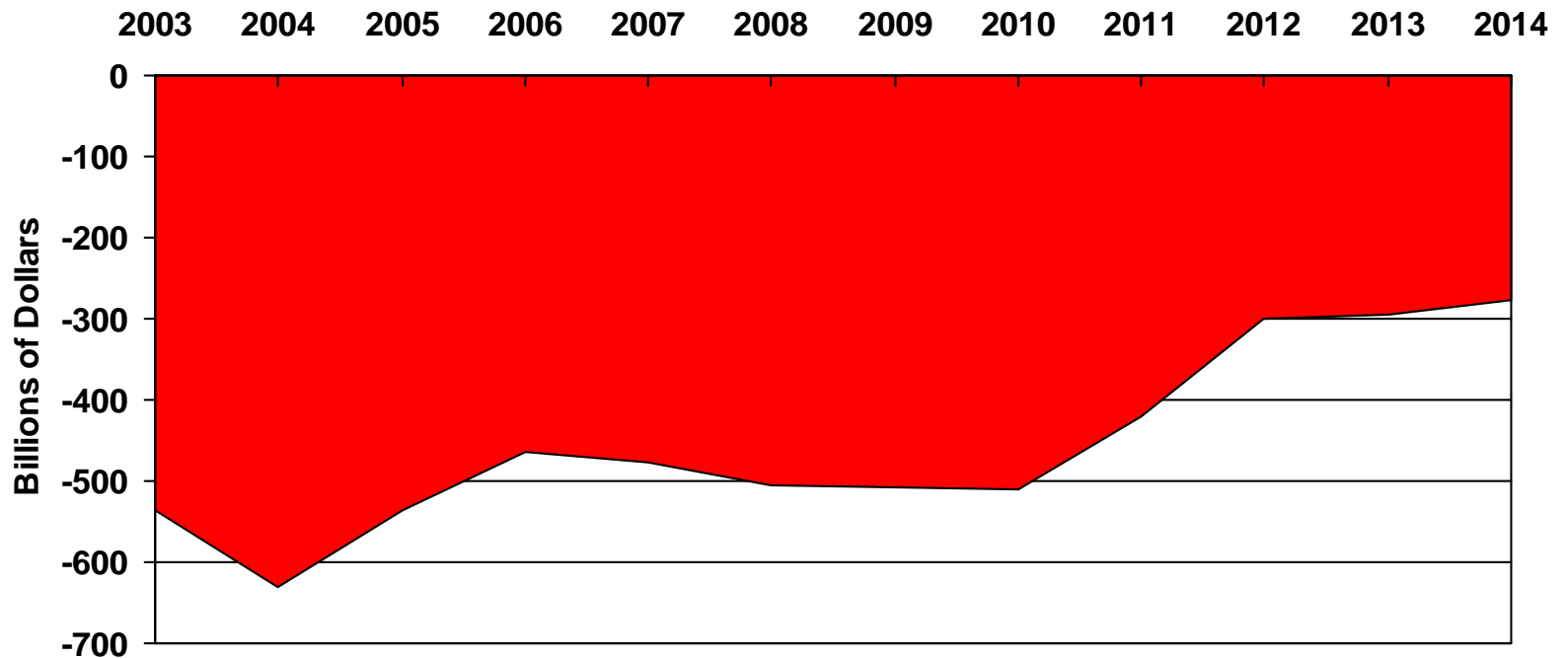
Drop in Employer-Sponsored Coverage (U.S.)



Source: US. Census Bureau, *Income, Poverty, and Health Insurance Coverage in the United States: 2006*.

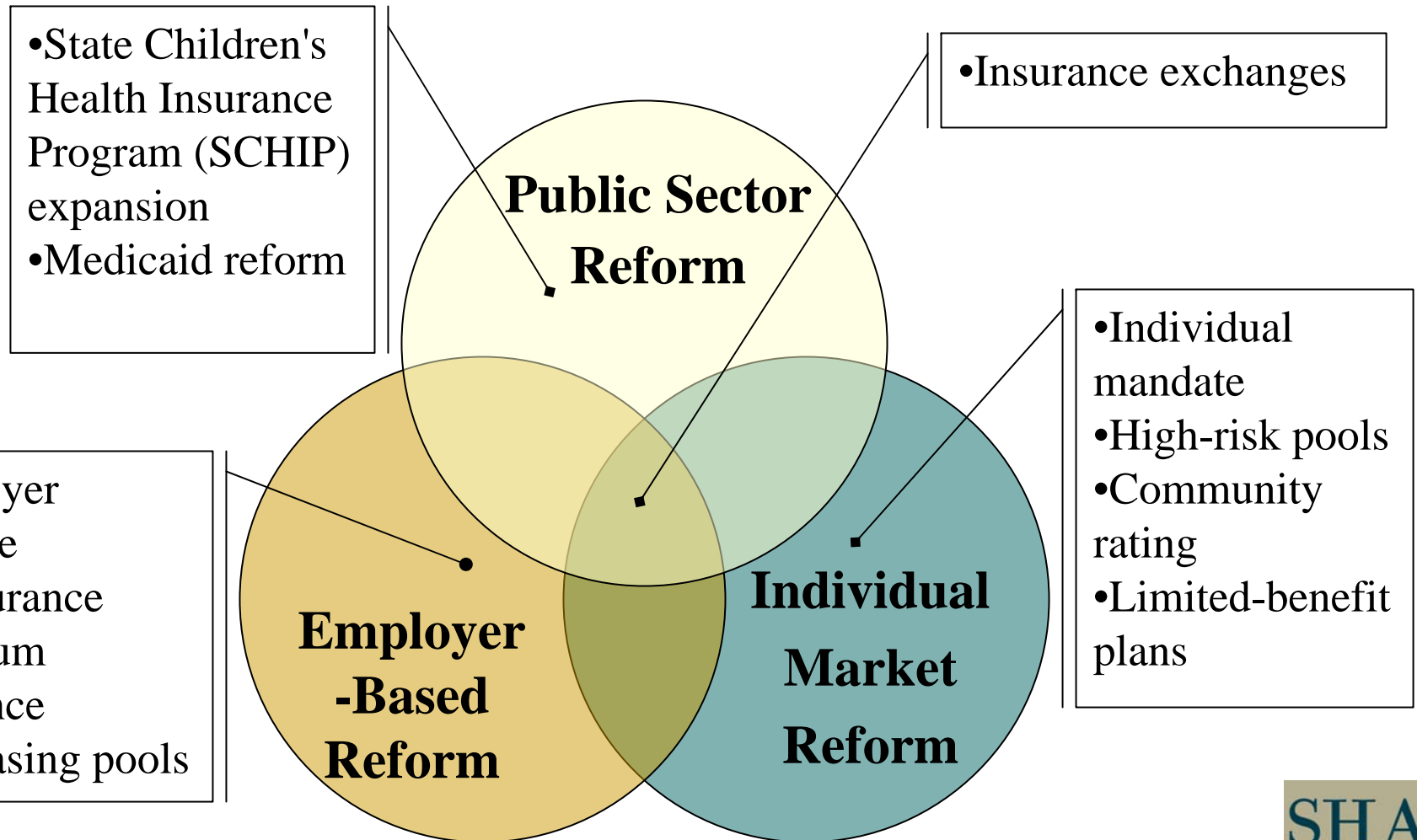
Federal Relief ?

Federal Budget Deficit, Fiscal Years
2003 (Actual) - 2014
(in billions of dollars)



Source: Congressional Budget Office, August 2007.

State Options: Reform Framework



Reform Process – States Taking Action

In Discussion	Legislation Introduced	Legislation Passed/ Implementation	Post – Implementation
Colorado Minnesota Illinois (all) New Jersey New Mexico Pennsylvania (all)	California Oregon	Massachusetts Pennsylvania (kids) Vermont Wisconsin (kids)	Illinois (kids) Maine

Maine: Dirigo Health

- Enacted in 2003 with goal of providing universal coverage by 2009
- Three approaches:
 1. “Dirigo Choice” health plan (private insurance plans offered at discount to self-employed and small businesses)
 2. Cost-control systems (reducing bad debt & charity care, strengthening CON process, price transparency, voluntary caps on financial margins)
 3. Quality initiatives (Maine Quality Forum, incentives for Electronic Medical Records)

Maine: Financing

- “Savings offset payment” – recovery of reductions in charity care and voluntary savings targets from insurance carriers and TPAs
 - 1.85-2.41% of paid claims from insurers and TPAs
- Employer and individual contributions to “Dirigo Choice”
- State General Fund Contributions (in year 1)
- Federal match for Medicaid/SCHIP premium subsidies for eligible who buy-in to DirigoHealth Choice

Vermont: Blueprint for Health & Catamount Health

- Enacted in 2006 with the goal of insuring 96% of Vermonters by 2010
- Two Major Components:
 1. “Catamount Health” a subsidized health plan for adults. Includes an employer assessment for those that don’t offer and contribute to coverage.
 2. Blueprint for Health a prevention program for chronically-ill Medicaid beneficiaries (to be expanded to all chronically-ill Vermonters)

SOURCE: <http://hcr.vermont.gov/>

Vermont: Financing

- Assessment on employers (\$365 per FTE)
- Individual premiums to “Catamount Health”
- Tobacco tax increase (increase in cigarette tax by 60 cents on July, 2006 and an additional 20 cents in July, 2008)
- Federal matching funds

Massachusetts: Massachusetts Health Care Reform

- Enacted in 2006 with the goal of covering all 95% of residents in three years
- Major Components:
 1. Individual Mandates
 2. Employer Requirements
 3. Creation of Commonwealth Health Insurance Connector
 4. Subsidies for low-income
 5. Insurance Market Reform
 6. Changes to Safety Net Care Fund

Massachusetts: Financing

- \$385 million in federal funds redirected from the uncompensated care pool (per year for 2 years)
- Federal matching funds
- Existing assessments on hospitals and TPAs
- General fund allocation
- Individual contributions to Commonwealth Care
- Employer assessment (“fair share” payment)

Illinois: All Kids

- Enacted in October 2005, implemented July 2006
- Integration of Medicaid and SCHIP to cover all Illinois children regardless of family income or immigration status
- Cost-sharing in the form of monthly premiums and co-pays starting at 150% FPL
- Financing: program gets federal matching funds for children under 200% FPL who meet immigration requirements, state funds pay for all other

SOURCE: <http://www.allkids.com>; KFF Webcast 6/19/2007

Wisconsin: BadgerCare Plus

- Enacted in October 2007, implementation February 2009
- Merges Medicaid and SCHIP programs to have one comprehensive program to cover all kids and expand access for adults
- Simplify eligibility determination
- More aggressive premium assistance to promote ESI enrollment

SOURCE: <http://dhfs.wisconsin.gov/badgercareplus/benefits.htm>

Wisconsin: Financing

- Wisconsin estimates that the expansion will be budget neutral as a result of enrolling all participants in managed care and reducing administrative expenses

Administrative Simplification

- Presumptive Eligibility
 - 31 States apply it for pregnant women
 - 9 States apply it to Medicaid and 6 apply it to SCHIP
- 12 Month Continuous Eligibility
 - 16 States apply it to Medicaid and 25 apply it to SCHIP
- Auto enrollment
 - Massachusetts

SOURCE: <http://www.statehealthfacts.org>

County-Based Initiatives

- Access to Care Plan: Counties work with other local agencies and providers to secure access to care for the uninsured (MN, MI, NM, etc).
- Three Share: community-based initiatives to provide healthcare coverage for low-income uninsured persons (MI)
- County Medical Indigent Program: Provides financial assistance for medical care expenditures under \$10,000 over a 12 month period for each eligible indigent (ID).

Goals of State Reform

1. Cost Savings
2. Increased Access
3. Enhanced Quality

Goals of State Reform – Cost Savings

Policy Interventions:

- Care delivery models
- benefit reduction
- insurance market regulation

Considerations:

- The cost savings timeline
- Cost saving to whom?
 - Employers
 - Individuals
 - States
 - System
- Financing mechanism

Goals of State Reform – Enhanced Access, Universal Coverage

Policy Interventions:

- Individual and employer mandates
- Public program expansion

Considerations:

- Most states define universal health insurance coverage as health care for all residents (excluding undocumented immigrants)
- Many states use a defined threshold to determine universal coverage:
 - Massachusetts: 95%
 - Minnesota: 95%
 - Vermont: 96%
- Rhode Island set a goal of insuring 100% of Rhode Islanders under 65 years of age

Goals of State Reform – Enhanced Quality

Policy Intervention:

- Care delivery models
- incentive payments

Considerations:

- What quality metrics should be used?
- Who should be responsible for enhanced quality?
 - Individual
 - Health Plan
 - Providers
- How should cost and quality be balanced?

Characteristics of States Implementing Successful Reform

- High Medicaid eligibility levels before reform and low rates of uninsured
- Large commitment of federal money – either through matching or disproportionate share
- Bipartisan support, and political climate of reform
- History of discussions and prior attempts at reform
- Grassroots efforts for universal coverage and strong advocacy organizations
- Involvement of various stakeholders in reform proposals and design

Lessons Learned to Date

- State reform is alive and well
 - Both comprehensive and incremental
- There are no free solutions to access issues
 - Concern for states is sustainability without additional federal financial support
- There has been little success in addressing the underlying costs of health care
 - Some recent focus on chronic care may hold potential in the long term

Source: Adapted from SCI, State of the States, 2007.

Resources Information on State Reform

- Alliance for Health Reform
<http://www.allhealth.org/>
- Kaiser Network <http://www.kaisernetwork.org/>
- National Governor's Association
<http://www.nga.org/portal/site/nga>
- State Coverage Initiatives
<http://www.statecoverage.net/>
- National Association of Counties (NACo)
<http://www.naco.org>

State Health Access Reform Evaluation

- National Program of the Robert Wood Johnson Foundation
- In response to increased state activity in discussing and passing legislation to improve health care access
- SHARE will provide evidence on the specific mechanisms that contribute to successful state health reform efforts by:
 - developing a coordinated approach to the evaluation of current state health reform,
 - identifying and filling gaps in research, and
 - organizing and disseminating findings in a manner that is meaningful and user-friendly for state policy makers, state agencies, and researchers.

SHARE Contact Information

Principal Investigator: Lynn Blewett, Ph.D. - blewe001@umn.edu

Center Director: Kelli Johnson, M.B.A. - johns706@umn.edu

Deputy Director: Elizabeth Lukanen, M.P.H. - elukanen@umn.edu

Senior Research Fellow: Donna Spencer, M.A. - spen0143@umn.edu

Research Coordinator: Karen Soderberg - soder145@umn.edu

www.statereformevaluation.org

(612) 624-4802

