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As Feds Eye Health Overhaul, States' Experiences May Prove Helpful

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When Massachusetts' health care overhaul was enacted two years ago, it was held up as both a model for the nation and as proof that liberals and conservatives can agree on a way to cut costs and expand coverage. As the state's then-Gov. Mitt Romney, a conservative, signed the bill into law, the liberal Sen. Edward M. Kennedy said his home state "may well have fired the shot heard round the world on health care in America."

Indeed, the Massachusetts experiment -- as well as those of other states attempting to implement plans to bring about broad-based health care coverage -- shows that it is possible to find compromise on an issue that has divided the two parties for more than a decade.

On a practical level, however, these state efforts also show that attempts to achieve universal coverage have serious limitations, many of them having to do with the same problem that currently afflicts all health care policy nationwide: the inability to get rising costs under control. The experience in California is an example. There, a major overhaul effort failed earlier this year under the weight of cost questions and long-term financing problems.

But the Massachusetts experience, and that of states that have either proposed or implemented health care overhauls, will be key as lawmakers on Capitol Hill prepare for what is expected to be a major legislative debate next year on how to overhaul the national health care system -- although the Iraq war, the troubled economy and a proposed $700 billion government bailout plan of Wall Street firms may complicate efforts for any sweeping change. Congress may not have the amount of time and money necessary to move a major health care bill and may instead focus on smaller, more incremental changes. (See related story, CQ HealthBeat, Sept. 23, 2008).

According to the Kaiser Commission on Medicaid and the Uninsured, 14 states have proposed universal health care coverage plans while three -- Massachusetts, Vermont and Maine -- have begun to implement such proposals. The overhaul in Massachusetts has tested many of the concepts health care analysts say are the best way to achieve universal coverage, such as requiring that individuals have health care insurance and forcing employers to either provide health coverage to their workers or pay into a fund to accomplish that goal. Universal health care plans in Maine and Vermont include subsidies to help workers purchase health care insurance on their jobs. In addition, Iowa has taken steps to expand health care coverage for children and strengthen consumer protections in the private insurance market.

These states' approaches show it's possible to find the middle ground on health care, which usually includes a combination of expanding public programs, subsidizing families and businesses to help make insurance more affordable and focusing on cost control, said Alan Weil of the National Academy for State Health Policy.

"States have eschewed policies at either extreme: avoiding approaches that rely on a single

payer approach or that expect unregulated markets to solve the problems of the health care system," he told the House Ways and Means Health Subcommittee this summer.

Weil also told the panel that states cannot go it alone. "States need a national framework in order to achieve the promise of health reform -- a framework of federal support, assistance and guidance," he said.

A Window Into What Works

One of the architects of the Massachusetts plan, John McDonough, said the plan has provided Washington with a window into how many overhaul concepts could be included in federal health care overhaul legislation, such as an individual mandate, broader employer responsibilities, insurance market changes and a connector-like entity to help individuals purchase health care coverage. McDonough is now a senior adviser for national health reform for Kennedy, who chairs the Senate Health, Education, Labor and Pensions Committee and has been laying the groundwork for comprehensive health care legislation.

The Massachusetts law required state residents (with some exceptions) to have health insurance coverage by July 1, 2007 or face penalties. Individuals who did enroll in coverage by Dec. 31, 2007, lost their state personal tax exemption of $219. For 2008, tax penalties began accruing on a monthly basis beginning Jan. 1 and may be as high as $912. Employers who have 11 or more full-time workers are required to contribute $295 for every employee they do not insure to a state fund that provides care to those who cannot afford coverage.

Among its provisions, the law called for state funds that had been spent to pay providers for uncompensated care be redirected to help low-income residents purchase insurance. The state would also help pay the premiums of low-income individuals and the plan also included a "connector" to help individuals and small employers purchase coverage for workers.

Early analyses of the plan show that it has reduced the number of the state's uninsured while increasing the number of employers offering health insurance. According to an August report prepared by Massachusetts state officials for Gov. Deval Patrick, the number of people enrolled in private or subsidized health insurance plans has increased 439,000 between June 30, 2006, when the program was launched, and March 31, 2008. During that same time, community health care centers and safety net hospitals have seen a 37 percent drop in visits, while the state's uncompensated care pool payments have declined 41 percent, or $68 million. Those figures suggest that greater rates of health insurance have meant fewer visits to those facilities for routine medical care that could otherwise be delivered in a physician's office in a more efficient and cost-effective manner.

Separately, an Urban Institute analysis of the first year of the Massachusetts plan found that the uninsured rate among adults had dropped by almost half, from 13 percent to 7.1 percent. The report, published in the June issue of the journal Health Affairs, also found that access to care for low-income adults had increased and the number of adults with high out-of-pocket health care costs and difficulties paying medical bills had dropped.

Another key finding of the Urban Institute analysis was that the Massachusetts plan found no evidence that employers were less likely to offer coverage to their workers than before the Massachusetts plan went into effect. According to another study, prepared by the state's Division of Health Care Finance and Policy, found that nearly half of the growth in insured people has been in private group coverage, or through employers, or via individuals purchasing health policies on their own.

Unexpected Costs

Despite its success, there are problems with the Massachusetts plan that could give federal regulators pause. An analysis published in the Annals of Internal Medicine points to a shortage of primary care physicians to care for newly insured residents. A study in the June 26 New England Journal of Medicine also noted the physician shortage as well as high limits on annual deductibles (capped at $2,000 for an individual and $4,000 for a family) and out-of-pocket spending (capped at $5,000 for an individual and $10,000 for a family). In addition, 62,000 state residents were exempted from the mandate as of March 30 because they cannot afford to purchase coverage but make too much money to qualify for subsidized coverage, according to the Massachusetts Department of Revenue.

The cost of the program has exceeded initial cost projections because the number of uninsured adults exceeded initial state projections, although some analysts have said the plan intentionally contained artificially low estimates to make the proposal's cost more appealing to lawmakers and the public.

"The long-run success of Massachusetts's efforts will hinge in part on sustaining support for the new policies in face of these higher costs," wrote Urban Institute researcher Sharon K. Long. Another unknown is what impact the higher penalties will have on individuals who have not yet purchased coverage.

Grace-Marie Turner, president of the Galen Institute, a conservative think tank, said financing continues to be a major concern as the Massachusetts law evolves. "Being able to make this coverage and this care affordable is really going to be the critical issue and whether or not people are going to be able to continue to increase the number of people that do have coverage in the state," she said at an Alliance for Health Reform forum in May.

Massachusetts may not be able to be duplicated nationally for a variety of other reasons. Before enactment of the law, the state already had a high number of insured individuals and employers offering health care coverage to workers. In the mid-1990s, it had implemented a number of insurance market changes, such as no medical underwriting and guaranteed renewal of coverage, and it had $385 million in federal Medicaid funds that the state was allowed to use as part of a Medicaid waiver to reduce the number of uninsured. The waiver, which expired June 30, is currently being negotiated with the Centers for Medicare and Medicaid Services (CMS), and federal funding is needed to help the Massachusetts plan continue.

Finding Financing

Massachusetts isn't the only state struggling with financing a health care plan. In Maine, lawmakers voted to increase taxes on soft drinks, beer and wine to help finance the state's universal health care program, although the new taxes have drawn heavy opposition and a measure to overturn them may be on the state's November ballot. The law signed by Democratic Gov. John Baldacci also allows the state to borrow from its tobacco settlement fund and general fund and assess a 1.8 percent surcharge on health insurance claims.

In Vermont, state officials had hoped to use federal funds to help finance coverage for uninsured individuals with incomes of up to 300 percent of the federal poverty level, but CMS allowed matching funds only for individuals up to 200 percent of the federal poverty level, so state officials increased tobacco taxes to raise an additional $15.8 million and assessed

employers (with some smaller firms exempted) $365 for every full-time worker who either is not covered by an employer's insurance or who chooses not to enroll in an employer's coverage and is uninsured.

Financing woes were the main reason the California state Senate Health Committee in January rejected a $14.9 billion proposal Republican Gov. Arnold Schwarzenegger had negotiated with Democratic leaders.

The California plan, which would have required individuals to have health insurance but gave subsidies to those who could not afford coverage, was thought to be too expensive at a time when the state faced a $14.5 billion budget gap. News accounts point to opposition from tobacco companies -- who opposed higher cigarette taxes to fund the proposal -- as well as from some insurers and employers, which would have also faced new financial obligations as part of the plan. Some lawmakers feared that consumers might be forced to purchase health insurance they could not afford.

The proposal would have covered an estimated 3.6 million uninsured California residents, with fees assessed on employers and hospitals to fund the program. A series of insurance market overhauls, including requiring guaranteed issue by 2010 and caps on premium increases, were also included. Some elements of the plan, such as a requirement that insurers spend at least 85 percent of their earnings on patient care and tougher restrictions on canceling health insurance policies for individuals who need extensive medical care, advanced through the state legislature and have been sent to the governor's desk.

The same financial hurdles that California has faced will make health care overhaul difficult to achieve on the national level. "Democrats want to be fiscally responsible," said Rep. John D. Dingell, D-Mich., and they will want funding offsets for any health care legislation. "This is going to be a huge problem" that Congress faces when it considers health care, said Dingell, who chairs the House Energy and Commerce Committee.

Rep. Dave Camp, R-Mich., called financing "the single greatest challenge facing health care reform, at both the state and federal levels … How can you create a system that finally makes health insurance available to all Americans that is financially sustainable for both the patient and the taxpayer?" Camp asked at the July Ways and Means Health Subcommittee hearing on states' efforts to cover the uninsured.

Differences In the Details

While finding enough money to fund health care overhaul efforts is a challenge for states and the federal government, finding consensus on legislation may prove just as difficult.

Peter Harbage, a California-based health care consultant who helped advise Schwarzenegger's team that assembled the state's health care legislation, said the legislative process relied too heavily on the top leaders of the state's Assembly and Senate. The assumption was that if those leaders were on board with the plan -- already under fire from some insurers, employers and health care providers for its provisions to assess new taxes for financing -- the proposal would succeed. "It would have benefited by a broader-based legislative strategy that included a range of lawmakers," Harbage said.

Other obstacles included Republican opposition to new taxes to fund the program -- and Republican support was needed to attain the two-thirds vote required by state law to raise taxes. "As the year went on, it became very clear no Republican was going to break ranks" and back the governor's health plan, Harbage said.

California's struggles also illustrate the complexity of the issue. "We've spent 40 years building a dysfunctional system. We can't fix it overnight," Harbage said. "It was just a big hill to climb. It was hard to do."

Federal lawmakers will face much of the same issues if they try to pass sweeping health care legislation. Some favor legislation (S 334) from Sens. Ron Wyden, D-Ore., and Robert F. Bennett, R-Utah, that would replace the current employer-based health insurance system with a system in which people would buy coverage directly from insurers through new state-run "purchasing pools." Another measure (S 2795, HR 6210) would allow small businesses and the self-employed to band together across state lines to buy health care coverage for their workers. Its sponsors include Sen. Richard J. Durbin, D-Ill., and Rep. Jo Ann Emerson, R-Mo. In the House, Ways and Means Health Subcommittee Chairman Pete Stark, D-Calif., has introduced legislation (HR 1841) that focuses on prevention, lowering administrative costs and providing health care to all Americans.

Another obstacle to congressional attempts to pass comprehensive health care legislation may be the Employee Retirement Income Security Act (ERISA), a 1974 law that pre-empts state laws that govern private employer-based health plans. The law, which covers more than 140 million Americans who receive health insurance through their employers, permits individuals covered by the law to sue their insurers only in federal court and generally limits damages to the cost of denied care and does not allow for punitive damages that result from the denial of care. ERISA was a major focus in Congress during the late 1990s when it debated whether to give patients broad rights to sue their health plans, known as the "patients' rights" debate.

Some state health care laws have run afoul of ERISA. For example, the U.S. 4th Circuit Court of Appeals ruled that ERISA pre-empts a Maryland law requiring companies with more than 10,000 employees spend at least 8 percent of their payroll costs on medical benefits or pay into a state fund to provide health coverage to the poor. Similar laws in Suffolk County, N.Y., and the city of San Francisco have also been pre-empted by ERISA. In 2004, the Supreme Court ruled that ERISA mandates such suits must be heard in federal court.

There have been no ERISA challenges yet to Massachusetts' law, but that could change. In 1983, Hawaii secured a legislative exemption for its health plan that required health coverage for all employed people who work more than 19 hours a week, but the exemption "contained a warning that other states should not consider this a precedent for future exemption" and the ERISA law itself does not allow for exemptions, according to the Employee Benefits Research Institute.

While ERISA has prevailed so far, some business leaders fear a federal health care overhaul effort may interfere with the law. Since ERISA allows multi-state employers an exemption from many state mandates governing insurance, changes in that exemption could make it more difficult -- and more importantly more expensive -- for employers to operate in several states.

"ERISA is in our minds at all time. Preservation of ERISA is one of our top priorities," said Maria Ghazal, director of public policy for the Business Roundtable.

Urban Institute President Robert D. Reischauer said "a reasonable fear" is that lawmakers could amend ERISA to mandate a minimum benefits package that "over time would get richer and richer." But he doubts that will happen. "I think that was a bigger fear a decade ago than it should be now because everybody is so cost conscious," he said.

Advocates for sweeping health care overhaul say it is just as important for the federal government to set standards for health insurance policies for all Americans, so the type of health care individuals receive does not depend on the state in which they live.

John C. Lewin, now CEO of the American College of Cardiology who formerly was an architect of Hawaii's health plan when he served as the state's director of health, said Hawaii continues to struggle to provide health care to its residents.

"While every full-time worker in Hawaii still has coverage -- and that is no small thing -- increasing numbers of dependents are not covered," Lewin told the Ways and Means Health Subcommittee in July. "The unemployed, self-employed and part-time employed have the same difficulties getting coverage now as anywhere else in America. Hawaii's accomplishments will further unravel in the absence of national reforms."

Health care's importance to the nation's economy may spur lawmakers to work harder to reach consensus. In an address at a "Health Reform Summit" sponsored by the Senate Finance Committee in June, Federal Reserve Chairman Ben S. Bernanke said decisions made about changes to the health care system "will affect many aspects of our economy, including the pace of economic growth, wages and living standards and government budgets, to name a few."

Dingell believes the high cost of health care for both employers and workers will push Congress to pass legislation that will address the issue. "There will be new opportunities for reform, largely because the debate in the country over health care has shifted," he said. "Support for comprehensive reform … is now widespread."

But it remains to be seen whether Massachusetts, or any other state, will be the model for Washington.

Source: **CQ HealthBeat**
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