State legislatures, faced with the challenges of a booming uninsured population nearing 46 million nationwide, are taking the lead in implementing universal health care plans. With increased tax revenues, states are using the better economic conditions to offer a variety of new programs, often public-private partnerships, ranging from providing health insurance for all children (in Illinois) to legislation requiring that all adults obtain health insurance (in Massachusetts).

A recent report by the Kaiser Commission on Medicaid and the Uninsured found that states’ revenue growth, after a decade of skyrocketing Medicaid spending, is helping governors move forward with comprehensive health care reform.

Three states are at the forefront—Maine, Vermont and Massachusetts. Recent reforms in these states have grabbed the nation’s attention and serve as a catalyst for discussion of creative expansion options at both the state and federal levels. The tides may be changing since the Clinton health reform proposals failed 10 years ago.

While states are at the forefront of reform, proposed programs do not rely on the state to be the “single payer,” the insurer of last resort for everyone. Instead, most policy changes are designed to increase affordability for various populations.

Feds Look to States for Models

States are doing something right by taking a more proactive role in health care delivery, and Congress is watching closely. Three similar bills have been introduced in Congress that would encourage states to find ways to make the health care system work better. Sens. George Voinovich of Ohio and Jeff Bingaman of New Mexico introduced the first bill in May 2006. Sen. Russ Feingold introduced his own bill, the State Based Health Reform Act, in July.

Under Feingold’s plan, “the federal government would help a few states provide health insurance for all their citizens, but leave it up to those states to decide how they want to go about it. Rather than directing states to implement a specific health care system, the bill provides a flexible approach that allows states to try innovative ways of achieving universal coverage.”

Wisconsin Rep. Tammy Baldwin, who has backed the idea for

“For under $250 a month, we could address the needs of the working uninsured with a basic health insurance package that would include a full prescription package, laboratory services and pre- and post-natal care.”

—Connecticut Gov. Jodi Rell

Several states are implementing comprehensive health care reform plans, bringing the issue to the forefront of national discussion 10 years after the Clinton health proposal failed.

By Karen Imas
Under the Microscope

States Serve as Laboratories for Universal Health Care Programs

several years, and Georgia Rep. Tom Price, along with two other co-sponsors, also introduced a bill in July. These bipartisan approaches encourage more states to experiment with coverage expansion and cost-containment—the types of reforms achieved in Massachusetts, Maine and Vermont, and of ongoing reform discussions in states such as Illinois, Colorado, Washington, New Mexico and Oregon.

There seems to be bipartisan consensus that Congress will not be able to agree on health care reform. Given the massive cost of health care reform at the federal level, states are the ideal litmus test for various programs. The state proposals would be reviewed by a commission or task force and the most promising ones would be sent to Congress for fast-track approval.

States are customizing health care reforms to their particular needs often with bipartisan legislative consensus. In both Massachusetts and Vermont, laws were passed by Democratic-controlled legislatures and signed into law by Republican governors. The following are innovative programs across the country:

Massachusetts

In 2006, Massachusetts pioneered a market-based system for universal health care, leveraging significant federal funding. By mid-2007, the state will require all residents to obtain health insurance or pay a penalty.

New and affordable policies and subsidies will be created to enable compliance with the mandate. In addition, employers will be required to make a “fair and reasonable” contribution to the cost of coverage for their employees or pay a penalty.

All four Medicaid health plans are participating in the new program. Outreach, public education campaigns, public health initiatives and quality benchmarking activities are moving forward. The Health Care Quality and Cost Council is building a price transparency Web site for consumers and payers with cost and quality information on services and providers.

The state began enrolling uninsured individuals who earn less than the federal poverty level in October. Those enrollees are not required to pay any monthly premiums and would be responsible for very small co-payment fees for emergency room visits and other services. Starting Jan. 1, those earning between that amount and three times the poverty level are able to buy subsidized policies with premiums based on their ability to pay.

Policymakers believe the plan can be achieved without imposing new taxes or borrowing money because financing would come largely from funds now being used for other health care expenses, such as reimbursing hospitals for care they provide to uninsured residents. It will be up to the new governor, Deval Patrick, to carry the plan forward. Both Maine and Vermont have passed health care coverage expansions that aim for universal coverage in their states, but stop short of requiring individuals to purchase insurance.

Maine

Maine’s Dirigo Health Reform Act drew national attention when it was signed into law in 2003 by Gov. Jon Baldacci, making it the first state in recent years to enact legislation aimed at providing universal health care access.

The law, which went into effect Jan. 1, 2005, is designed to contain health care costs, improve quality and ensure access to health care for all. The key vehicles for coverage expansion are a health insurance product for small businesses, self-employed
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—State Based Health Reform Act
Proposed by U.S. Sen. Russ Feingold

and unemployed Mainers with subsidies for low-income people, and expansion of Medicaid to additional parents and adults without dependent children.

The Dirigo Choice health insurance program had 12,153 enrolled at the end of October 2006.

A Blue Ribbon Commission examining Dirigo recently approved a set of recommendations that includes looking into the idea of mandated employer group coverage for workers and requiring individuals above certain income levels to get coverage for themselves. The commission also expressed support for new taxes to expand the program.

Funding for Dirigo has come under scrutiny from some legislators who dismiss the initiative as too costly and ineffective and for stifling competition for other private insurers. However lawsuits challenging the funding mechanism, a savings offset payment recouping savings to the system due to fewer uninsured, have been unsuccessful. If the legislature doesn’t approve new taxes, the state next year would revert to the original funding mechanism. The state is already collecting a $43.7 million savings offset payment to cover 12,500 people in 2006.

Vermont

Vermont’s Catamount Health, approved in May 2006, is a state-subsidized voluntary program designed to help people without insurance buy it on their own in the private marketplace. Vermont’s legislation focuses on managing chronic illnesses in the hopes of improving the quality of care, while reducing the rate of growth in health care costs. It takes effect in October 2007.

The state estimates as many as 25,000 of 60,000 uninsured Vermont residents may enroll in coverage under this program. If coverage goals are not reached by 2010, the legislature may consider coverage mandates.

Catamount Health provides sliding scale subsides for premiums and cost-sharing under commercial health insurance plans. The plan will be offered by private insurers, and its benefits and charges will be similar to those in the average BlueCross BlueShield plan in Vermont. Under Catamount Health, enrollees will pay $10 for office visits, 20 percent coinsurance for medical services, tiered co-payments of $10, $30 or $50 for prescription drugs, and a $250 annual deductible for an individual or $500 for a family for in-network services (double those amounts for out-of-network).

Catamount Health premiums are projected to range from $60 per month for individuals with household income of less than 200 percent of the federal poverty level to $135 per month for individuals with household income between 275 and 300 percent of the federal poverty level.

Small businesses are concerned with these reforms because employers who do not provide their workers health insurance will have to begin paying $365 a year per full-time employee. They will also have to make payments for part-time workers, which is a sticking point for many employers.

To fund the program, tobacco taxes will increase a total of 80 cents per pack over a few years.

Pending Proposals

Connecticut

Legislators have labeled health care access a major priority for 2007. In December, Gov. Jodi Rell unveiled the Charter Oak Health Plan which would offer adults of all incomes the opportunity to enroll in a state health care plan with comprehensive coverage. The plan will address the needs of about 400,000 uninsured Connecticut residents—some 11 percent of the population—who are uninsured. The plan includes $1,000 deductibles, co-payments ranging from $10 to $55 per visit and 20 percent coinsurance to a maximum of $1,000. No state funds and no legislative changes are expected to be needed for the program.

“To develop the Charter Oak Plan, my administration will work with representatives of major managed care providers in Connecticut to develop an affordable, accessible product,” Rell said. “For under $250 a month, we could address the needs of the working uninsured with a basic health insurance package that would include a full prescription package, laboratory services and pre- and post-natal care.”

Connecticut already provides coverage to the poor through Medicaid and to children through the Healthcare for Uninsured Kids and Youth (HUSKY) insurance program.

New Jersey

New Jersey is crafting a new bill for introduction in the legislature that would overhaul the state’s health care system and require all New Jersey residents to carry medical insurance. Policies would be affordable for low-wage earners. This model, based on the Massachusetts plan, would require residents to get
“Living in the world’s most affluent society, it shocks the conscience that any child should be forced to live without access to basic medical care. With Cover All Kids, Pennsylvania parents will no longer need to make the impossible choice between paying the rent and taking their child to see a doctor.”

—Pennsylvania Gov. Ed Rendell

health insurance and prove they have it when they file their state income tax returns.

The plan seeks to provide health insurance for the 1.4 million adults and children who don’t currently have it by creating a state-subsidized HMO or PPO. To help pay for the coverage, the state would reallocate the $983 million it now spends on charity care and grants to hospitals for caring for the uninsured.

New Jersey has almost twice as many uninsured residents as Maine, Vermont and Massachusetts combined—the only states that currently provide or plan to provide universal coverage.

Sen. Joseph Vitale, chairman of the Senate Health, Human Services and Senior Citizens Committee, is a key architect of the plan. He hopes to introduce a bill this spring.

Pennsylvania

Pennsylvania is the second state to try to provide insurance to all children who otherwise would go without coverage. A bill signed by Gov. Ed Rendell in November aims to meet this goal through an initiative his administration calls Cover All Kids. Under the initiative, parents will be able to afford to insure their children because the monthly premiums will be based on family income. Currently, the Childrens’ Health Insurance Program (CHIP) is free for children from families with annual incomes under $40,000 and available at a reduced cost for children from families with incomes up to $47,000.

Under Cover All Kids, all parents who cannot afford to insure their children will get assistance from the state to ensure that the cost of health insurance for their children is reasonable.

“Living in the world’s most affluent society, it shocks the conscience that any child should be forced to live without access to basic medical care,” Rendell said. “With Cover All Kids, Pennsylvania parents will no longer need to make the impossible choice between paying the rent and taking their child to see a doctor.”

Illinois became the first state to do so under a program called All Kids that debuted July 1; the state has since enrolled more than 35,000 children who were previously ineligible for government subsidized coverage.

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What Can Canada’s Model Teach the States?

Canadian provinces, which have a single payer system, are experimenting with a two-tiered system where some private care is subsidized by the government or offered at a fee to the consumer. Canada is one of the few countries with no user fees and the only country that outlaws privately funded purchases of key health services. Clinics could be prosecuted for charging patients for procedures that would be covered under the public health system—a violation of Canada’s Health Act.

Per capita, Canada spends approximately half of what the United States spends on health care.

“Canada’s landscape is public with stealth privatization. The U.S. landscape is becoming the opposite,” said MPP Dr. Shafiq Quadri of Ontario.

A Supreme Court decision last year on private medicine has rapidly altered the options available to patients in Canada. In June 2005, the Supreme Court of Canada ruled that the Québec government cannot prevent people from paying for private insurance for health care procedures covered under Medicare. The justices said banning private insurance for a list of services ranging from MRI tests to cataract surgery was unconstitutional under the Québec Charter of Rights, given that the public system has failed to guarantee patients access to those services in a timely way.

Canada is anticipating an infusion of private care for core services in at least some provinces—Alberta, British Columbia and Québec—and various experiments combining public and private care. Such efforts aim to reduce patients’ waiting times for treatment, as well as to control public spending. The differing levels of private care from province to province are in part a function of how open provincial governments are to private medicine.

In February 2006, Québec announced that it would improve access within the public system to tertiary cardiology and radiation oncology services and would provide hip and knee replacements and cataract surgery within six months after they are recommended by a specialist. If these operations cannot be performed at a government-funded hospital within that time, Québec will pay for surgery at an affiliated private clinic in the province. If the wait extends beyond nine months, patients can receive publicly funded care at a private clinic outside Québec or even Canada. The government will allow Québec residents to buy private health insurance specifically for these designated services, although the scope of such insurance may be expanded in the future.