State-Based Health Reform Efforts

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Senator Lincoln, Senator Grassley, and other participants at this health reform summit, thank you for the opportunity to discuss the topic of state health reform. My name is Gary Claxton and I am a Vice President at the Henry J. Kaiser Family Foundation.

Over the past several years, a number of states have enacted or considered meaningful changes to their health care systems intended to reduce the number of people without health insurance. Several states, including Massachusetts and Vermont, are implementing comprehensive coverage expansions. Other states have started down that path, taking concrete steps that include expanding public programs for lower income uninsured residents and establishing commissions or other bodies charged with implementing or designing significant coverage expansions and other reforms. State efforts also are focusing on other critical health system issues, including cost, quality and health insurance market reform. Chronic care management initiatives, support for health information technology and the creation of new purchasing pools are examples of innovative state efforts. A document from the Kaiser Commission on Medicaid and the Uninsured briefly summarizing efforts in 16 states toward comprehensive health reform is attached.

A key aspect of many recent state efforts has been the use of Medicaid and the State Children's Health Insurance Program (SCHIP) as a foundation for coverage expansions and financing. Over the past several decades, the Medicaid and SCHIP programs have played vital roles in extending coverage to lower-income populations, and they continue to play important roles in state comprehensive reform initiatives. These programs offer a mechanism for extending coverage to the low-income uninsured and also serve as a source of funds for state subsidy programs targeting the working poor. As can be clearly seen from the attached summaries, public expansions can be used in combination with other state strategies targeting employers and private insurance options to design comprehensive approaches aimed at substantially reducing the number of people without insurance.

The variety of state efforts illustrates the innovation that states can bring to complex health care issues as well as the wide-spread interest in health care reform. They also reflect the deep public concern over the issues of health care access and costs. In a recent Kaiser poll that

asked adults about problems that they were experiencing due to changes in the economy, almost three in ten (28%) reported serious problems paying for health care and health insurance, ranking behind problems paying for gas (42%) and about tied with problems getting a good job or raise in pay (29%). Among nonelderly, uninsured adults, 42% reported problems accessing health care due to costs.[1] As health costs continue to rise faster than incomes, the pressure for significant health reform will increase, and finding ways to get beyond the ideological battles that have stalled federal progress on health reform in recent years becomes more of a political and policy imperative.

State reform efforts, in addition to improving the health and security of their residents, may provide valuable lessons that could help motivate national reform. States are embarking on innovative strategies in a number of areas that could provide valuable insights for broader reform, including insurance market reforms, development of new purchasing and pooling arrangements, expanding coverage to new populations, benefit design, individual requirements to have health insurance, defining affordability, creating health information exchanges, and chronic disease management. State implementation of innovative strategies is being closely watched by the policy and research communities, as evidenced by the keen interest in the Massachusetts health reform effort.

At the same time, those seeking to learn from state approaches, and particularly those who advocate for a more formal role for states as laboratories for health reform, need to recognize some of the significant constraints facing states attempting major changes in their health care systems and markets. The federal government, through its laws, health programs and tax policy, exercises enormous influence over how health care is financed and delivered, reducing state influence and control over key institutions and policies. States also have budget constraints that can make it difficult for them to fund major coverage expansions or even to sustain current coverage levels during economic downturns. These limitations narrow the policy options available to states, and restrict their ability to develop innovative health care solutions and to test different approaches to financing. Currently enacted reforms necessarily reflect the limits imposed by federal rules and tight budgets, and may not reflect the best that states could have done if they had more control over their health policy environment and more resources. If

it is a federal policy objective to encourage state experimentation and learn from state innovation, the federal government may need to provide states with more control over how health care is financed and delivered.

Federal Policies and Programs

There are several key areas in which federal law and practice limit the potential for state innovation:

Employee Retirement Income Security Act (ERISA). ERISA is a federal law that regulates employer-provided pension and welfare benefits, including employer-provided health benefits. The vast majority of people with private insurance are covered through the workplace, with most covered by employee-benefits plans regulated under ERISA. A key provision in ERISA preempts, with some exceptions, state laws that "relate to" an employee benefit plan. This provision significantly limits the ability of states to pass laws that affect many aspects of employer benefit plans, in particular for those employers that self-insure.

As a result, a state is unable to influence the scope or administration of health benefits for a large portion of the employees and dependents residing in the state. State authority to include self-funded employers in risk pools or risk adjustment programs also is likely limited by ERISA. Equally important, there are significant issues about the extent and scope of state authority to require employers to offer health benefits (i.e., an employer mandate) or to contribute to the costs of health care for their employees if the employer does not offer health benefits (i.e., a pay or play approach). Given the very large roles that employers and employer-based coverage plays in current health financing and delivery, the lack of state authority over self-funded employer benefit plans significantly limits state options relating to how these plans might participate in a broader system reform and what benefits their employees might receive.

Of course, broadening state authority over employee benefit plans will be controversial with large employers (and potentially their employees) who want to be able to operate their plans under the same set of rules across states. This is a situation where federal policy may need to

balance the policy of uniform benefit administration embodied in ERISA against the potential for states innovation in health reform.

Federal Tax Policy. Federal tax policy also imposes significant constraints on state reform options. Although it is not always recognized, federal tax policy plays a very large role in health care financing and heavily influences employer and employee decisions about health insurance. Under current law, amounts that employers contribute toward the cost of employer-provided coverage for their employees are not treated as income to those employees for determining either income tax or FICA payroll taxes. Employees also are often able to pay their share of premiums for employer-provided coverage with pre-tax dollars. As a result, families getting coverage through work receive tax subsides that can easily exceed 40% of the cost of the benefit, depending on their income and marginal income tax rate. In contrast, families who are not offered coverage at work and purchase it directly from insurers are eligible for only a limited tax deduction. The dollars involved here are not small and are an important part of public spending on health care: the revenue lost to the federal government due to this tax exclusion is estimated to be more than $200 billion per year.[2]

There are prominent proposals at the federal level to change the current tax exclusion for employer-provided health insurance. Some advocates of market-based health reforms, in particular, have argued to eliminate the preference for employer-provided health insurance and to provide directly-purchased coverage with the same tax treatment as employer-provided coverage. Proposals to change the exclusion to a flat standard deduction or tax credit that could be used for any type of health insurance are examples of such proposals. Others have proposed to cap the value of the current exclusion.

States developing reform approaches must operate largely within the contours of current tax policy or risk losing the benefits of the current subsidies for state residents. Approaches which would redirect the current federal tax subsidies to more equally subsidize directly-purchased and employer-based coverage may not be a realistic option for state reform efforts unless some federal accommodation can be developed. States can find ways to extend tax subsidies for directly-purchased coverage (e.g., state tax credits or Section 125 plans for workers

of non-offering employers), although trying to equal the total value of the current income tax and payroll tax exclusion could be quite costly. Further, the federal subsidies for employer-provided coverage would still exist and strongly influence both employer and employee decisions.

To enable state innovation in this area, the federal government might consider an alternative tax regimen for a state wanting to experiment with a different financing scheme for health care. Federal tax policy does not typically vary by state, so this may be seen as a fairly radical notion, and it may be too complicated to implement and administer. This is another area where uniform federal policy conflicts with the potential for states to demonstrate innovative approaches on an important aspect of health reform, and may be an area where state reform efforts are unable to inform national reform efforts.

Federal Health Programs and Regulations. The federal government plays important financial and regulatory roles in the health care system. Medicare, for example, is a significant payer for many health care providers. The federal government also plays a large and vital role in financing the health care safety-net – those providers who serve large numbers of patients without the ability to pay for care. Medicare and Medicaid, for example, provide financing (about $18 billion in 2007) for hospitals that serve disproportionate shares of patients who are uninsured or public program participants. The federal government also funds (almost $2 billion in 2007) community health centers and similar organizations to provide a range of primary care services in cities and rural areas across the country to people of limited means.

For states attempting to reorganize and improve their delivery systems, federal payment rules and regulations may run counter to (or at least not reinforce) state efforts to encourage provider accountability and improve efficiency and quality. States undertaking comprehensive reforms also may want to redirect a portion of safety-net expenditures to address needs that reflect their reformed system. While the potential conflicts between states and the federal government are much smaller here than in the areas discussed above, there may be opportunities for federal programs to make reasonable accommodations to support state efforts. States already have substantial authority over how Medicaid interacts with other parts of the delivery system, but state authority over other programs is more limited. Medicare, for example, could try to

participate in state-wide quality efforts, data-reporting, or perhaps even modify its payments to reinforce innovative payment policies created under state reforms. There are demonstration authorities for Medicare and Medicaid that permit the federal government to modify operations, potentially allowing the federal government to support states delivery system and other initiatives. Medicaid demonstration authority, for example, has been broadly used to support state initiatives to change how care is delivered and to expand coverage. If the federal government wants to encourage state health reform more broadly, some flexibility in other federal programs may be appropriate.

State Budgets

Perhaps the biggest obstacle to state reforms that provide for major coverage expansions is figuring out how to pay for them. Some state efforts to pass comprehensive health reform over the recent past have failed because governors and state legislators could not reach agreement on how to finance the high costs associated with expanding coverage. This is not surprising because many of the uninsured have low or moderate incomes and are unable to afford coverage unless it is heavily subsidized. Those that have identified resources, such as Vermont and Massachusetts, relied in part on federal Medicaid funds to help fund subsidies for the newly insured. States are unlikely to be able to undertake significant reforms with coverage expansions without meaningful federal financial assistance. Federal help is likely needed not just to get a state reform program up and running, but also to sustain expansions when the economy weakens.[3] States have limited ability to deficit spend, and may not be able to meet the increased demand for subsidized care that is likely during weak economic periods. The decision by the government to boost the Medicaid match rates for 2004 in response to the weak economy demonstrates the importance of increased federal assistance during these difficult periods.

There are clearly many ways that the federal government could financially support state reform efforts. One approach might be to allow states to expand Medicaid and SCHIP coverage with federal financial participation to low and moderate income children and adults that are not currently eligible for the programs, such as poor childless adults who generally are not eligible for Medicaid. This approach could provide significant help to states and provide them with a

reasonably firm financial basis from which to build. It also is consistent with the current approaches in many states seriously considering reforms. As discussed above, Medicaid and SCHIP have played key parts in state reform efforts, although federal laws and policies have limited the funds available to support expansions. Another method of extending financial assistance might be to establish a new federal program that guarantees payments to states enacting comprehensive reforms. Payments from the program might vary with the level of new coverage achieved, perhaps with adjustments based on the income level and health status of the populations that attain coverage.

Conclusion

States have shown commitment and innovation as they have tried to improve health care access, costs and quality. A few states have shown that they are not willing to wait for federal action on health reform, and despite the challenges discussed above, they are attempting to do what they can to address some of the serious health care issues affecting their residents. As states take on these difficult issues, they are considering and implementing approaches that can provide valuable lessons to those that will hopefully follow. Researchers, policy makers, the public and the press all will be closely examining reform efforts in Massachusetts and other states, trying to figure out what experiences in these states mean for the prospect of broader national reform. Those scrutinizing their efforts, however, need to keep in mind that these states are attempting comprehensive reforms with limited authority over the health care systems in their states and with limited resources. We can potentially learn much from how states implement the laws that they are able to enact. However, if it is a federal objective to encourage state experimentation and learn from state innovation, the federal government may need to provide states with more control over how health care is financed and delivered and with more resources to implement and sustain expansions through difficult economic times.

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[1] Survey Brief: Economic Problems Facing Families, Kaiser Family Foundation, April, 2008, http://www.kff.org/kaiserpolls/7773.cfm.

[2] See note 1 in David Auerbach and Stuart Hagen, "CBO's Health Insurance Simulation Model: A Technical Description," Congressional Budget Office, October 2007, p. 1. Available online at: www.cbo.gov/doc.cfm?index=8712.

[3] Altman, Drew. "Perspectives on State Health Reform" *Pulling It Together, No. 4.* Kaiser Family Foundation; June 11, 2008. Accessed on June 12, 2008, at http://www.kff.org/pullingittogether/061108_altman.cfm.

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