MINUTES

SENATE COMMITTEE ON PUBLIC HEALTH AND WELFARE
HOUSE COMMITTEE ON PUBLIC HEALTH AND WELFARE

September 30, 1993
Auditorium, Pozez Education Center, Topeka, Kansas

Senate Members Present

Senator Sandy Praeger, Chair, Senate Committee
Senator Audrey Langworthy, Vice-Chair, Senate Committee
Senator Janice Hardenburger
Senator Sherman Jones
Senator Lillian Papay
Senator Al Ramirez
Senator Doug Walker

Member Absent

Senator Alicia Salisbury
Senator Janis Lee

House Members Present

Representative Joanne Flower, Chair, House Committee
Representative Susan Wagle, Vice-Chair, House Committee
Representative Tom Bishop
Representative Tom Bruns
Representative Joann Freeborn
Representative Greta Goodwin
Representative Jerry Henry
Representative Carlos Mayans
Representative Jim Morrison
Representative Melvin Neufeld
Representative Rocky Nichols
Representative Kay O'Connor
Representative Carol Sader
Representative Ellen Samuelson
Representative Alexander Scott
Representative Forrest Swall
Representative Galen Weiland
Representative Elaine Wells

Absent

Representative Joel Rutledge

Staff Present

Emalene Correll, Kansas Legislative Research Department
Bill Wolff, Kansas Legislative Research Department

Others Present

~~See attached list~~

Morning Session

The meeting convened at 10:00 a.m., in the auditorium of the Pozez Education Center as a part of the Kansas Health Forum, sponsored by St. Francis Hospital and Medical Center, Stormont-Vail Regional Medical Center, University of Kansas, Kansas State University, The Wichita State University, Emporia State University, Fort Hays State University, and Pittsburg State University. Dr. Ray Davis explained the purpose of the Forum, introduced the representatives of each of the Regents' institutions who were present, and gave the background of each of the major conferees -- David Helms and Lawrence Brown.

Senator Sandy Praeger welcomed the members of the House and Senate committees on Public Health and Welfare and explained the purpose of the meeting in terms of the work of the two committees. She introduced Representative Flower, the Chair of the House Committee, and thanked the Kansas Health Foundation, the two medical centers, and the Regents' institutions for arranging for David Helms and Dr. Brown to be present to share their insights on state and federal efforts at health care reform with those present.

Dr. Davis introduced David Helms, Ph.D., President, Alpha Center, Washington, D.C. and Lawrence Brown, Ph.D., Professor, Columbia University.

National Health Care Reform and the Role of the States

Dr. Helms reviewed the federal framework for health care reform noting, under the Administration proposal, the federal government would set the framework for a health care delivery system that had as its goals universal access and cost control. He described the process outlined by the Administration as a "higher order synthesis" of managed competition and overall expenditure limits. The federal government would create the framework through which the goals of health care reform would be achieved. The goals are: creating security (universal coverage); expanding access; controlling costs; and enhancing quality.

Under the proposed plan the federal roles will be to create a uniform financing system; design a standard uniform benefit package; mandate the participation of employers and employees; and set policies or guidelines for operating the reformed health care system. The latter guidelines will include the development of insurance market rules, setting standards on who must participate in the health alliances, establishing targets for growth in national and state expenditures, establishing the tax treatment of employer and employee contributions to premiums (cap on the amount of exclusions), and designing specifications for data collection and submission by the states. Dr. Helms elaborated on the federal roles as proposed in the Administration health care plan and several other reform plans that are likely to be before the Congress as health care reform is debated.

According to Dr. Helms, the states would retain substantial operational responsibility under the Administration plan, with flexibility to adjust for state differences.

Following discussion of the possible federal role in health care reform, Dr. Helms outlined the proposed state roles in the Administration proposal. He divided the state roles into five major subdivisions -- establishing and overseeing health alliances, fostering the development of integrated health plans, and certifying the eligibility of such plans; assuring adequate access for all eligible populations; assuring the financial viability of all health plans; and controlling costs within a system of national expenditure targets.

Health Alliances. After a brief explanation of a health alliance as that term is used in the Administration proposal, Dr. Helms noted the states will be required to specify the number of health alliances in each state and the geographic areas to be served by the health alliances. In addition, the states will be responsible for ensuring that some type of risk adjustment mechanism is in place.

Development of Integrated Health Plans. Dr. Helms explained the states, under the Clinton proposal, will be expected to provide technical assistance for the development of integrated health networks and services where they are needed, particularly in rural areas of the states. The states will be expected to assess the quality of health plans and the ability of the plans to deliver the comprehensive health benefit package prescribed by the federal government in addition to establishing the criteria to be met by each health plan in order to become a qualified plan under the health delivery system.

Assurance of Adequate Access. In order to assure adequate access to the health care system for all eligible persons, the states will be expected to define the levels of and geographic distribution of services which will be of particular concern in rural and low-income areas. In order to assure access, some plans may be enfranchised to cover an entire area, and the states may be allowed to provide subsidies where necessary to assure that consumers pay only a weighted average premium, even in hard-to-serve areas.

Assurance of Financial Solvency. According to Dr. Helms, the states will be responsible for establishing capital standards for health plans; for defining the type of financial reporting required and the types of audits of fund reserves that will be required; for designating an agency to assume control if a health plan fails and establishing procedures for handling any such failures; and for operating a guaranty fund to establish financial protection to health care providers and subscribers if the health plan becomes insolvent.

Cost Control. The states will be responsible under the Clinton plan for implementing cost controls that will enable national expenditure limits that will be enforced by the federal

government to be met. If the state acts as the health alliance as is proposed by the Commission on the Future of Health Care, the state would assure that all health plans meet any limits set for premium increases. If there are multiple health alliances, the states will be responsible for developing baseline data and monitoring expenditure growth. The states can use premium negotiation and regulation, limitations on enrollment in high-cost plans, setting provider rates, and controlling health investments through planning and programs similar to certificate of need to assist in meeting cost limits.

Dr. Helms briefly outlined several other approaches to health care reform that have been introduced in the current Congress, including:

1. A mandatory tax-financed system under which there would be a single health plan or multiple plans accessed through a health care voucher system.

2. A mandatory multipayor system under which employers would be required to furnish health insurance with two possible directions to the employer mandate -- a true mandate or the "pay or play" approach. As an alternative approach, the mandate would be on each individual to purchase health insurance, with subsidies for low-income and indigent individuals to enable them to purchase health benefits.

3. Voluntary extension of existing insurance and service mechanisms characterized by a further expansion of Medicaid, an increase in the direct provision of services by public agencies, reform of the small group and individual insurance market through the creating of purchasing alliances and the elimination of underwriting restrictions, and subsidies or tax incentives for low-income individuals.

In discussion of the issues, it was noted that it will be hard to achieve universal coverage if there is not a mandate of some type, that subsidies will bring additional individuals to the door of the health care system, and that some employers do not want to participate in the provision of health care or the funding of benefits. The debate is going to center around how to fund access for about 17 percent of the population because there is almost universal skepticism that savings from reform alone will be sufficient to finance this type of additional cost.

Attachment 1, "Excerpts from Clinton Administration description of President's Health Care Reform Plan, *American Health Security Act of 1993*"; (Attachment 2), "Excerpts from Office of Technology Assessment, *An Inconsistent Picture*"; and Attachment 3, "W. David Helms, "State Capacity to Achieve Health Care Reform," were made available to the participants in the Forum.

Politics of National Health Reform

Professor Lawrence Brown, Columbia University, discussed the politics of national health care reform, emphasizing three major areas to be discussed -- the policy context in which the debate will unfold, speculation about how the politics will unfold, and administrative politics.

Dr. Brown noted the diversity of interests that play into the health care system, the diversity of health care delivery systems already in place and the diversity of areas to be served, and the share that health care represents in the total economy and the economy of small geographic

areas. He reviewed the process that any legislation faces in the Congress, *i.e.*, multiple committee jurisdictions and competing plans.

In terms of the policy context in which the debate on health care reform will unfold, Dr. Brown set out five criteria that will shape the debate as:

1. universal coverage;

2. the basic benefit package;

3. financing arrangements;

4. far-reaching and radical changes in insurance; and

5. some type of sensible framework to contain costs.

He stated one has to give the Administration high marks for dealing with all the five policy issues as society moves toward a consensus. Consensus may be achieved, according to Dr. Brown, because we are approaching a crisis in health care. We have tried the laissez-faire system, with all players setting their own rules, and we have tried everything available to avoid a federal policy framework. In general, the system has failed because we have lacked a federally initiated, coherent set of rules. Will consensus happen? Dr. Brown believes we have a consensus on the need for change. The issue is will a consensus remain as we move toward a specific plan? There are many conflicts that will have to be resolved before a consensus is reached on a specific reform plan. This is where politics come in.

Dr. Brown outlined the following disputes, which he described as potential fault lines in consensus.

To Mandate or Not to Mandate. One of the most potentially divisive issues to be faced in health care reform is that of mandates, whether a mandate for each individual in the country to have insurance coverage or a mandate that employers provide coverage for employees. If there is a consensus that taxes are not to be a source of funding for additional health benefits, then employer-based mandates are a fundamental issue. There will be a great deal of opposition, particularly from small businesses who will have a potentially powerful position in the debate since they are the primary source of economic growth and increased employment at this time. Even if subsidies are proposed for certain sized small businesses, small business in general will be distrustful of the future drain resulting from mandates to provide health benefits for employees. Dr. Brown noted that the Robert Wood Johnson-funded projects found that participation by small businesses was only 3 to 4 percent even when subsidies were available, indicating that this will be a hot issue in the health care reform debate. The voice of corporate America is fragmented on the issue of employer mandates, with some corporations seeing a trade-off in terms of less cost shifting if all individuals are covered by insurance, and others opposed to mandates that specify the level and type of coverage the employer must make available and fund. Dr Brown, himself, does not see how health care reform is possible without employer involvement.

A subdivision of mandates is that of subsidies. The major issues involved with creating subsidies for individuals and small business to assist with the purchase of health insurance are where the money will come from to fund the subsidies; the administrative complexities; and equity. Of

these, the states should have concerns about the administrative costs and complexities that would be involved in the subsidization of both business and individual health benefits. However, the debate is likely to center around cost and funding sources, with real concern about creating new entitlements in a climate of budget deficits.

Health Alliances. The second major fault line identified by Dr. Brown is that of the proposed health alliances. As in the economists' idiom, form will follow function, many in corporate America are concerned about the size of the proposed health alliances and would like to see them pared down to 1,000 because they are seen as a threat to the equilibrium that exists. Many see the health alliances as being analogous to the movement toward HMOs 20 years ago, and question the cost effectiveness of the proposed health alliances.

Benefit Package. Too narrow, too broad: both are arguments that have already been advanced in terms of the broad outline of benefits that are proposed in the Administration proposal. The broader the benefit package, the more costly the coverage will be and the more money that will have to be found to finance health care. Cost may end up being a deciding factor in terms of the breadth of the benefit package, and starting with a less expansive core benefit structure with the promise of increasing coverage over time may be the only consensus that can be reached. However, with over 700 interest groups already lined up to lobby Congress about a special constituency or special interest, design of benefits may prove a divisive issue.

Source of Funding and Savings. At this point, the Administration's proposal does not seem plausible to many who will be participants in the debate on health care reform, according to Dr. Brown. There are a lot of skeptics who do not believe that the savings that are projected in the President's proposal are likely to materialize, nor will savings be realized in the short term according to some critics. Politically, there may be great enthusiasm about benefits and universal coverage without really coming to grips with the funding issue. When it is discovered that the benefits and the funding "won't wash," and costs go up, it will be necessary to come back to the basics of the plan and come to grips with the reality of funding. Dr. Brown suggested the latter might take place around the turn of the century.

Premium Caps. Although the issue of premium caps will play a part in the debate, as will other cost containment proposals, the former may well be one of the issues that is not resolved in the initial debate. However, the initial debate over cost containment will "soften up" the issue of caps so that down the road it will be possible to deal with this and other issues on which a consensus cannot be reached until after the basic plan that is approved is in place.

Dr. Brown noted that health care reform has public support, not because the average person is concerned about the uninsured, but because those who are insured are uneasy. They do not believe their insurance will last. The most potentially explosive point is the public's perception of who will pay more for health benefits and what they will realistically receive in return. Another potentially explosive issue is that of managed care. At both the state and federal level, managed care is mostly a conceptual consensus. In reality, the only successful prototypes in terms of containing costs are closed panel HMOs, according to Dr. Brown. He suggested that if we are serious about cost savings and the management of health care costs, we are really talking about rigid managed care, and this is not what is on the table nor is the public apparently supportive of strict managed care that reduces consumer choices at this point.

A somewhat neglected area in the health care reform discussion is that of administration of the health care initiatives that result from reform efforts. Administration represents the next stage

after basic policy discussion, *i.e.*, the structure that will have to be created to carry out the policies on which consensus is reached. Dr. Brown asked, "Do we have the administrative capacity at the state level to carry out the state roles"? The administration of any of the proposals for reform will create whole new roles and tasks that are both quantitatively and qualitatively very complex. For example, the health alliances, as not-for-profit plans with all money flowing through them, raise some very troubling questions about accountability and a very troublesome concept of harmonizing benefits and costs, as well as the issue of equalization. One way or another, Dr. Brown suggested, the states are on the line since the administration necessary to implement new political decisions will fall primarily to the states. States should be players in the policy debate to insure they have some say in the type of responsibilities they are assigned.

In response to questions, Dr. Brown noted the purpose of the comprehensive benefits being proposed is to try to capture all of the current health delivery system because there is a desire on the part of the Administration to avoid the creation of a secondary, supplemental insurance market. The rhetoric is to move the management of health alliances to the providers, but some think management will be carried out through the big insurance companies. Dr. Helms added his opinion that outcome research will be heavily funded and managed care plans will pay more attention to outcomes. He expressed the opinion that the aim is shrinkage in supply side capacity. Dr. Brown noted that one of the attractions of the Administration plan for the Clintons is that by moving decisions to the local level, confrontation is avoided. That may also be attractive to the Congress, but the question is whether a universal system can be maintained in reality with largely local decisions.

Following the presentations and group discussion about health care reform and the politics of reform efforts, the Forum adjourned for lunch at the Pozez Center.

Afternoon Session

Following the luncheon recess, Dr. Helms presented an overview of state health reforms. He reviewed some of the reasons that states have moved ahead to enact and begin implementation of health care reform without waiting for federal action, including the belief that they could not wait for a federal plan or for the implementation of any plan for universal health insurance and a desire to tailor health care reform to the unique circumstances of the state, rather than being forced into a mold created at the federal level. Other factors driving state reform efforts are cost increases, especially Medicaid cost increases; concern about the breakdown in the small employer insurance market; incremental changes proving to be insufficient to assure universal financial access to health care; and a belief that savings can be achieved only through fundamental changes in the financing and delivery of health care.

Dr. Helms stated that most state health care reform efforts have encompassed strategies for increasing financial access, strategies for controlling costs, and strategies for improving health care delivery systems.

He cited as examples of strategies for increasing financial access, the development of new taxes such as a payroll tax on employers, income tax initiatives, provider taxes, and "sin" taxes to support a tax financed system. States are looking at mandates on employers and on individuals in different approaches to increased financial access. In some instances, states are subsidizing access

for the uninsured with public monies, as for example, the several states that currently use public funds to subsidize programs that assure access for children and several pilots in which public funds are used to supplement the ability of the poor and near poor to access insurance. A Medicaid "buy in" is under consideration in at least one state and several pilots have allowed a Medicaid buy in for small segments of the population. Other states are looking at individual and family health accounts as a financing source backed up by subsidies.

Cost control has been an impetus for state health reform efforts and various strategies are either built into adopted reform plans or are under consideration. Several states have moved to some type of target or actual cap on the amount of increase in total health expenditures for the state, with at least one state utilizing the concept of a total budget in its health reform plan. Several states have long experience with rate setting, primarily in hospital rate setting, with consideration being given to an extension of rate setting to other segments of the health care delivery system. Managed competition has been targeted by several states as the basis for controlling the growth of health care costs, and at least two states have built the creation and operation of purchasing cooperatives into their reform plans. Administrative savings have been targeted both in incremental and total health care reform actions. Generally, such administrative efficiencies have taken the form of uniform billing forms, electronic billing, and electronic benefit coordination.

In terms of state action, Dr. Helms discussed the pros and cons of federal direction, as in proposals before Congress, and the Administration proposal versus the flexibility that would result from individual state action. In terms of arguments for state action, he discussed and provided examples of the ability to tailor change to local conditions. It may be easier to build support at the state level, where special interests may be easier to counteract. The states have an opportunity to gain experience in administering reform and in creating a structure for operation of reform efforts. Clearly, the states have a chance to move ahead while they wait for federal action. Finally, the states can serve as laboratories for the viability of various reform options. In the latter case, such concepts as total state health budgets and purchasing alliances are "on the books" in several states, although not fully implemented. These are just concepts, as yet untried, and state experimentation might yield valuable insights into their value, their workability, and the operational structure necessary to put them in place.

In terms of arguments against state-by-state action and the need for federally directed health care reform, it was noted that states lack the financial resources to insure universal financial access to health care. Small businesses may leave the state if certain reform measures such as employer mandates are adopted, and large multistate businesses will face administrative problems if they have to do business under different health care delivery and financing systems. Many believe that if the individual states are allowed to adopt and implement their own health care reform measures, it will be difficult to create a uniform national plan at some later date.

Dr. Helms indicated that many states, Kansas among them, are ready to move ahead with state health reform if the federal reform action is not forthcoming or if sufficient flexibility is built into any federal framework to allow the state to tailor its own reform.

It was noted that regardless of whether health care reform takes the route of a federal framework or state-by-state reform measures, the states need help from the federal government to implement reforms. One type of federal action necessary, given as illustrative, is the need for ERISA exemptions if state efforts to create a universal system are to be fully implemented. Another illustration is the need for waivers from federal requirements relating to Medicaid and federal grant programs and the need for technical assistance and data.

Dr. Brown and Dr. Helms outlined strategic choices facing state governments as noted below.

1. Should the state consider the probable direction of national reform and enact legislation to put the state on a "fast track" for implementation?

2. Should the state build the capabilities needed under reform by enacting components of a new system now, including options such as insurance market reforms, development of a state health purchasing authority for public employees or other groups, building health data reporting requirements and a structure for achieving administrative efficiencies, and state-subsidized insurance for small employer groups?

3. Should the state determine the extent to which it wants to control provider payments and the supply of facilities and technology, both in the short and long run?

4. If the state decides not to move to a "fast track" status, on what areas does it want to concentrate, such as managing direct state costs or total systems costs?

Dr. Helms summarized the reform measures enacted in Florida, Minnesota, Washington, and Vermont. See Attachment 4.

The next agenda item was a discussion of the politics of state health reform led by Dr. Brown, who outlined the major issues that have been addressed in health care reform at the state level and the unique alliances that have been developed in several states that have adopted systemwide reform plans. In addition, he identified major "hot spots" that have arisen as states have pursued reform efforts. It is too soon to determine what issues will need to be "revisited" as a result of the politics of state reform. He emphasized that alliances and opposition to reform can vary from state to state, depending on specific characteristics of the state and the type of tradeoffs that have to be made.

Dr. Brown and Dr. Helms responded to questions and issues raised by those in attendance in lieu of the planned discussion of developing a Kansas approach to health care reform.

Attachments 5, 6, and 7 are copies of three issues of the periodic publication the Alpha Center produces, in which news of the Robert Wood Johnson Foundation-funded "State Initiatives" grant program is reported.

The meeting was adjourned at 4:00 p.m.

Prepared by Emalene Correll

Approved by Committee on:

November 16, 1993

Excerpts from Clinton Administration Description of President's Health Care Reform Plan American Health Security Act of 1993 dated September 7, 1993

Goals for Access, Cost and Quality and Ethical Foundations of Health Reform

Joint Meeting House and Senate Public Health and Welfare
9/30/93
Attachment 1

EXPAND ACCESS

- FINANCING:
  - -- All employers contribute to health coverage for their employees, creating a level playing field among companies
  - -- Everyone shares the responsibility to pay for coverage
  - -- Limits on out-of-pocket payments protect American families from catastrophic costs, while subsidies ease the burden on low-income individuals and small employers
  - -- No health plan may deny enrollment to any applicant because of health, employment or financial status nor may they charge some patients more than others because of age, medical condition or other factors related to risk

- DELIVERY SYSTEMS:
  - -- Health Alliances assume responsibility for building health networks in rural and urban areas with inadequate access
  - -- National loan programs support the efforts of local health providers to develop community-based plans
  - -- Investments in new health programs such as school-based clinics and community clinics expand access to care for underserved populations
  - -- Financial incentives attract health professionals to areas with inadequate care

- BENEFITS AND CHOICE
  - -- A comprehensive benefit package with no lifetime limits on medical coverage guarantees access to a full range of medically necessary or appropriate services
  - -- Guaranteed choice of health plans and providers enhances choice for many Americans
  - -- Elderly and disabled Americans receive coverage for outpatient prescription drugs under Medicare for the first time
  - -- Separate programs increase federal support for long-term care and improve the quality and reliability of private long-term care insurance

CONTROL COSTS

- IMPOSE BUDGET DISCIPLINE
  - -- Health plans receive fixed premiums based on risk characteristics of their patients. Working under a fixed budget, they have incentives to spend resources effectively

- INCREASE COMPETITION
  - -- A standard, universal package of health benefits and reliable information about the price and performance of health plans encourages informed choices
  - -- Consumers pay less for low-cost plans and more for high-cost plans, creating incentives for cost-conscious choice

- REDUCE ADMINISTRATIVE COSTS
  - -- A single benefit package that covers every eligible person eliminates confusion about coverage; reduces costs associated with multiple policies with different benefits and risk selection methods
  - -- Standard forms for insurance reimbursement, the submission of claims and clinical encounter records simplify paperwork and reduce administrative costs
  - -- The cost of administering coverage in small companies declines because they purchase through health alliances that benefit from economies of scale
  - -- Federal regulatory requirements for Medicare, Medicaid, and other programs are simplified
  - -- Health care services covered by workers' compensation and automobile insurance merge into the new health system, reducing duplication and waste
  - -- Reduce fraud and abuse

If savings attained through effective competition and reductions in administrative costs do not achieve the spending goals, the national health care budget provides a backstop, ensuring that health care spending is in line with economic growth.

Like the private sector, major government programs, including Medicare and Medicaid, also operate under a budget restraining the growth of federal and state spending for health care.

ENHANCE QUALITY

- CREATE STANDARDS AND GUIDELINES FOR PRACTITIONERS
  - -- Explicit quality goals and standards shape the health care system
  - -- Health plans are held accountable for quality improvement

- REGULAR PUBLICATION OF ACCESSIBLE INFORMATION ABOUT QUALITY (AND COST) ALLOWS CONSUMERS TO MAKE INFORMED CHOICES AMONG HEALTH CARE PLANS

- REORIENT QUALITY ASSURANCE TO MEASURING OUTCOMES RATHER THAN REGULATORY PROCESS

- INCREASE NATIONAL COMMITMENT TO MEDICAL RESEARCH
  - -- A special funding mechanism ensures that academic health centers continue their vital role in research, training, and specialty care

- PROMOTE PRIMARY AND PREVENTIVE CARE
  - -- Investments in public health enhance the level of protection for all Americans
  - -- Changes in Medicare rate schedules and in the allocation of federal funds supporting graduate medical education provide new incentives for primary care physicians
  - -- Preemption of state laws limiting the scope of practice and new funding for the education of health professionals who are not physicians enhance opportunities for nurses, social workers and other non-physicians providers

ETHICAL FOUNDATIONS OF HEALTH REFORM

- UNIVERSAL ACCESS: Every American citizen and legal resident should have access to health care without financial or other barriers.

- COMPREHENSIVE BENEFITS: Guaranteed benefits should meet the full range of health needs, including primary, preventive and specialized care.

- CHOICE: Each consumer should have the opportunity to exercise effective choice about providers, plans and treatments. Each consumer should be informed about what is known and not known about the risks and benefits of available treatments and be free to choose among them according to his and her preferences.

- EQUALITY OF CARE: The system should avoid the creation of a tiered system providing care based only on differences of need, not individual or group characteristics.

- FAIR DISTRIBUTION OF COSTS: The health care system should spread the costs and burdens of care across the entire community, basing the level of contribution required of consumers on ability to pay.

- PERSONAL RESPONSIBILITY: Under health reform, each individual and family should assume responsibility for protecting and promoting health and contributing to the cost of care.

- INTER-GENERATIONAL JUSTICE: The health care system should respond to the unique needs of each stage of life, sharing benefits and burdens fairly across generations.

- WISE ALLOCATION OF RESOURCES: The national should balance prudently what it spends on health care against other important national priorities.

- EFFECTIVENESS: The new system should deliver care, and innovation that works and that patients want. It should encourage the discovery of better treatments. It should make it possible for the academic community and health care providers to exercise effectively their responsibility to evaluate and improve health care by providing resources for the systematic study of health care outcomes.

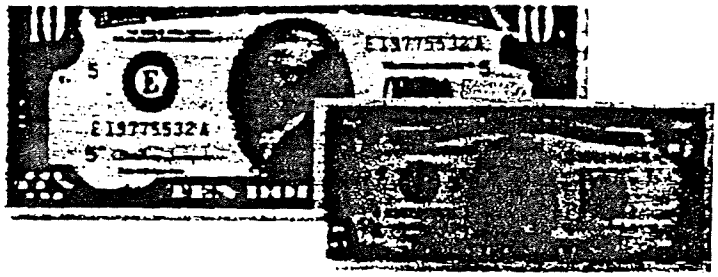
- QUALITY: The system should deliver high quality care and provide individuals with the information necessary to make informed health care choices.

- EFFECTIVE MANAGEMENT: By encouraging simplification and continuous improvement, as well as making the system easier to use for patients and providers, the health care system should focus on care, rather than administration.

- PROFESSIONAL INTEGRITY AND RESPONSIBILITY: The health care system should treat the clinical judgments of professional with respect and protect the integrity of the provider-patient relationship while ensuring that health providers have the resources to fulfill their responsibilities for the effective delivery of care.

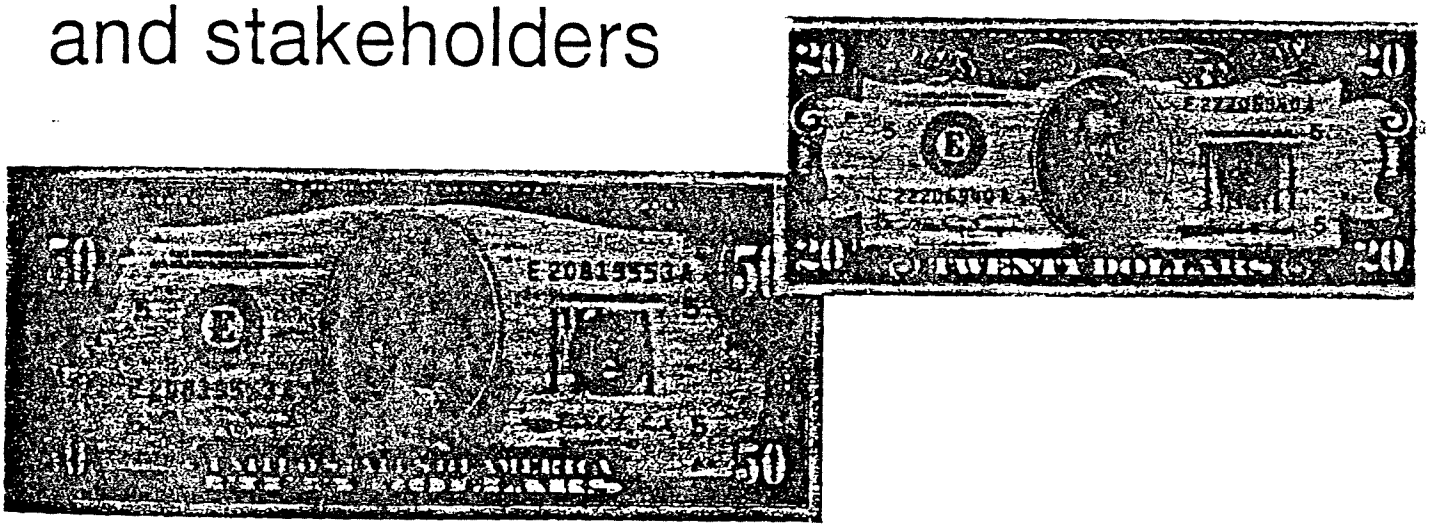
- FAIR PROCEDURES: To protect these values and principles, fair and open democratic procedures should underlie decisions concerning the operation of the health care system and the resolution of disputes that arise within it.

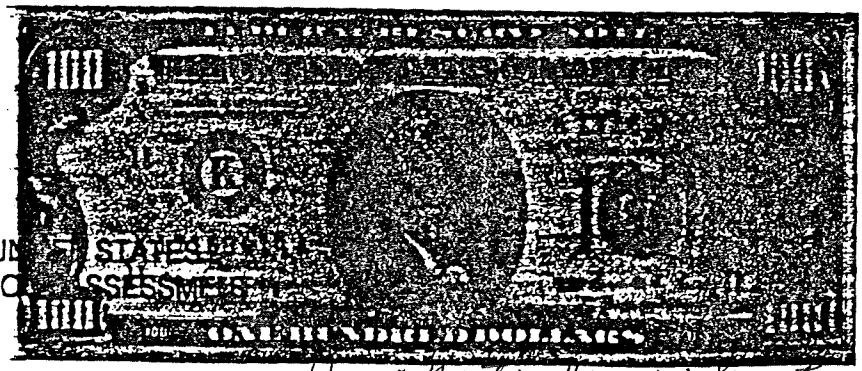
- LOCAL RESPONSIBILITY: Working with the framework of national reform, the new health care system should allow states and local communities to design effective, high-quality systems of care that serve each of their citizens.



An Inconsistent Picture:

A compilation of analyses of economic impacts of competing approaches to health care reform by experts and stakeholders

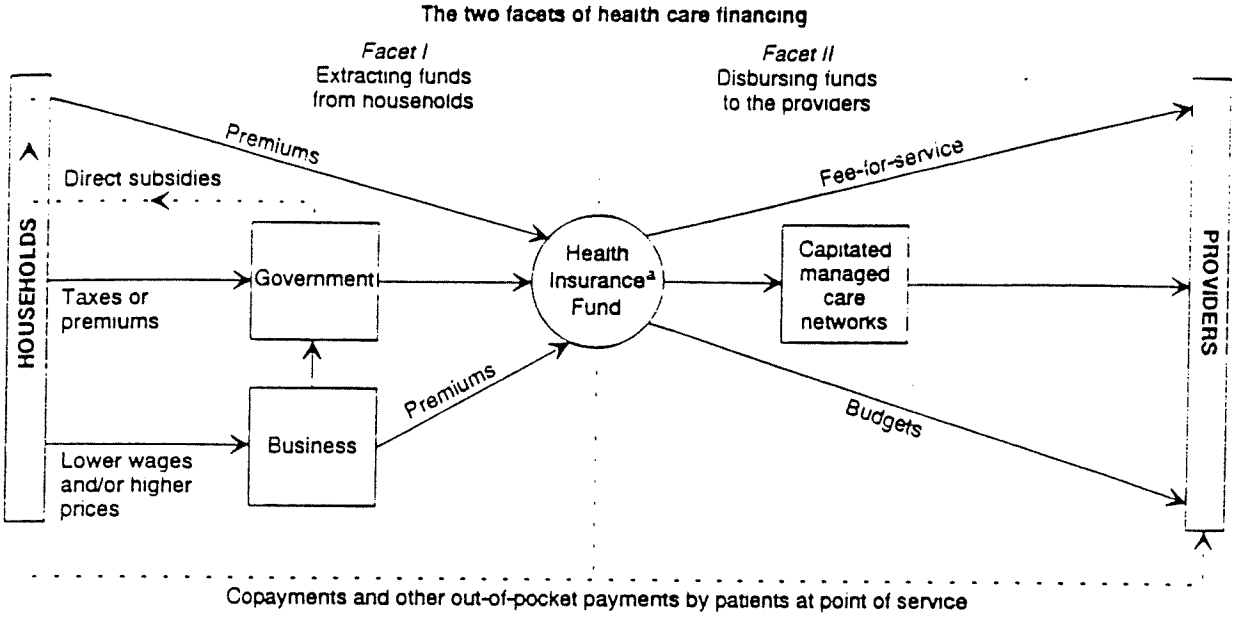




CONGRESS OF THE UN STATES
OFFICE OF TECHNOLO SSESSMENT

Joint Meeting House & Senate Public Health and Welfare
9/30/93
Attachment 2

FIGURE 1: Flow of funds to and from areas of the U.S. economy



Box 10-A—Provisional Checklist: A Guide for Policymakers

Policymakers evaluating approaches to and proposals for health care reform, as well as analyses of them, could use this provisional checklist to guide them in their review. It presents some of the key questions that should be asked in order to analyze the economic impact of reform approaches and proposals, and provides examples of the possible effects that variations in particular assumptions or components may have. It is important to note that estimating the economic impacts of health care reform approaches and proposals is very difficult due to the paucity of details provided regarding the approach or proposal, in many cases, and the speculative nature of many of the assumptions about these details as well as changes in behavior under a new system. Therefore, while policymakers may not need to dissect every assumption, policymakers seeking to implement appropriate and feasible reforms may want to determine whether the assumptions are reasonable, both politically and operationally. This checklist is intended to assist policymakers in this endeavor.

What Assumptions Does the Analysis Make With Respect to *Access* to Health Care Coverage and/or Services?

Questions	Example of Possible Effects
• Are individuals required to obtain health benefits coverage or does coverage remain voluntary?	If coverage is mandatory, universal coverage (coverage for all Americans) would essentially be achieved. However, even if coverage is mandatory, access to health care services will be affected by the scope and depth[1] of coverage, and the cost of coverage and health care services (see below). If coverage remains voluntary, even if it is made more affordable, some people will undoubtedly remain uninsured. This will likely affect their access to health care services as well as have implications for the distribution of the burden of financing health care if they are unable to pay for their own care.
• If the proposal would provide universal coverage, what would the scope and depth of benefits be?	A more inclusive scope and greater depth of benefits is, all other things being equal, likely to result in higher levels of expenditures than is a narrow scope or shallower depth of benefits.
• What is the premium amount or the actuarial cost of coverage?	The premium or actuarial cost of coverage is used to calculate the total cost of coverage for the population which, in turn, affects the total amount of national health expenditures as well as the distributional impacts of the proposal among governments, households, and employers (see below). If the premium or actuarial cost of coverage dollar amount used is too high or too low, the resulting estimates of the impacts of the proposal will be inaccurate.
• Given the assumptions made about who would be covered by an approach or proposal, what is the assumed level of utilization of covered and noncovered services by: 1) people who are currently uninsured; and 2) people who currently have public or private insurance?	Most analyses assume, probably correctly, that currently uninsured people will increase their utilization of services when they become insured. Any changes in utilization in that group of potential beneficiaries, as well as among presently insured people, will affect national health expenditures by changing the total quantity and, thus, the total cost, of health services rendered to the population. The proposal scope and depth of benefits (see above) could affect assumptions about increases or decreases in utilization.

[1] The scope of coverage refers to the range of services, providers, and settings covered. The depth of coverage refers to the level of patient cost-sharing required under the plan (i.e., the deductibles, copayments, coinsurance, out-of-pocket maximums, maximum liability of the insurance plan).

What Assumptions Does the Analysis Make With Respect to *Controlling National Health Expenditures*?

Questions	Examples of Possible Effects
• How are national health expenditures defined in the proposal?	The current definition of national health expenditures is quite broad[2]. If a proposal, for example, narrows this definition for purposes of estimating costs, an analysis of the proposal may result in estimated savings in national health expenditures. These savings could not, however, be attributed to actual changes in health-care-related expenditures but merely to a change in the definition. *These expenses would still exist in the economy.* To date, no proposal appears to alter this definition but some analyses examine relatively narrow aspects of national health expenditures (e.g., businesses' liability for private insurance costs).
• What is the baseline year used for estimating any quantitative impact of the proposal?	Given that health care spending is projected to increase at an average annual rate of 9.6 percent from 1992 to the year 2000,[3] estimates which do not use the same baseline year will not be comparable, all other things being equal.
• What is the baseline amount of national health expenditures used to estimate the impact of the proposal on national health care spending or savings?	Given the projected rate of increase in national health expenditures, noted above, the baseline amount of national health expenditures used to calculate any changes in expenditures will affect any resulting estimates. Furthermore, if the same baseline dollar figures are not used, the resulting estimates will not be comparable.
• Does the proposal assume the implementation of health care cost controls (e.g., a national health budget; hospital global budgets; provider price controls; controls on the use of services; regulation of capital decisions, and of the adoption of and dissemination of new technology; and incentives to alter consumer behavior, for example, cost-sharing[4])? If so, are these limitations enforceable?	To the extent that health care cost control measures effectively limit the rate of growth in health expenditures to its present rate or reduce this rate, they will have a *major* effect on estimated savings in national health expenditures, particularly over time. Absent a future redefinition of aggregate health expenditures, *key to the success of such measures (and the accuracy of any projections) will be whether each measure is strictly delineated, mandatory, and enforceable.* Analyses which assume the implementation of stringent expenditure limits will most likely estimate larger savings, in particular over time. Whether these limits or other cost control measures are reasonable and feasible is a critical determination in assessing the economic impact of a proposal incorporating such measures.

2 "National health expenditures," as defined by the U.S. Department of Health and Human Services, Health Care Financing Administration (HCFA), Office of National Health Statistics, are divided into two broad categories: 1) health services and supplies, and 2) research and construction of medical facilities. Health services and supplies, in turn, consist of expenses related to personal health care, public and private program administration and the net cost of *private health insurance* (administrative costs), and government public health activities.

3 U.S. Congress, Congressional Budget Office, *Projections of National Health Expenditures*, October 1992 (79). CBO recently revised its projections of the average annual rate of growth in national health expenditures downward from 9.6 percent to 8.8 percent for the years 1992 to 2000 (32). The U.S. Department of Commerce recently reported that health care spending increased by 11.5 percent from 1991 to 1992 bringing it to 14 percent of the Nation's GDP (92).

4 A chapter addressing the current state of knowledge of the impact of patient cost-sharing on the use of health care services, the cost of services, and on health status, will appear in the forthcoming main report of OTA's assessment *Technology, Insurance, and the Health Care System.*

Continued on next page

Box 10-A—Provisional Checklist: A Guide for Policymakers—Continued

• **Does the proposal assume savings from insurance market and paperwork (administrative) reforms and, if so, are these savings reasonable?**	Most proposals would modify the insurance market as well as streamline the paperwork burden, for example, through electronic claims submission and billing. The first problem in comparing administrative costs across analyses is definitional; that is, what administrative costs are included in the estimates. Second, are the savings estimates from modifications in administrative costs related to insurance market and paperwork reforms reasonable. Third, are there offsetting costs dictated by the development of new systems, for example, the collection and dissemination of health care information to consumers.

What Assumptions Does the Analysis Make With Respect to the *Redistribution* of the Burden of Financing Health Care?

The redistribution of health care costs among households, governments, and employers has important political significance. In the near-term and possibly the long-term, reforms may produce "winners" and "losers," to the extent that different actors are liable for the direct costs of health care.

Questions	Examples of Possible Effects
• **Does the proposal assume a limit on the tax deduction or exclusion for employer-sponsored health insurance benefits or a limit on an individual tax credit? If so: what changes in individual as well as corporate behavior are assumed to flow from the particular tax policy modification; what likely effects on health care spending are assumed; and are these effects reasonable?**	Limits on the tax deduction or exclusion for employer-sponsored health insurance benefits will result in additional dollars due to the Federal government to the extent that the dollar limit is below current average individual or family health insurance expenses. The extent to which this limit will actually change individual and corporate behavior regarding the amount of health insurance coverage purchased and the utilization of health care services is unknown (51). Thus, assumptions about the likely behavior of individuals and corporations are important yet fairly speculative factors in the estimates of resulting savings.
• **Are the redistributive effects discussed in terms of national health expenditures or only a subset of such expenditures, for example, private health insurance costs only?**	In order to evaluate the redistributive effects on financing of an approach or proposal, total national health expenditures are the usual baseline used (although certain related effects may not be captured by such an analysis [see below]). If an estimate deals with only a subset of these expenditures, the actual redistribution is obscured. For example, if an estimate deals with the change in household private insurance costs, but not with household out-of-pocket costs, a possibly significant cost of reform to households is not available to policymakers.
• **Does the analysis take into account the redistributive effects beyond those pertaining to national health expenditures, for example, impacts on employment?**	A reform approach or proposal may release funds to other areas of the economy thereby stimulating growth and improvements, or may result in employment losses due to changes in the systems of health care coverage and delivery. These changes are not captured by analyses which look strictly at the change in and redistribution of national health expenditures. These types of changes may have important social and political as well as economic implications. Such consequences may be harder to assess, however, given difficulties in amassing appropriate data.

• **Does the system require the collection of new funds by the Federal government in order to implement the proposal? If so, what methods are assumed to raise these revenues (e.g., elimination of tax benefits, new taxes, program benefit reductions)? Does an estimate of "budget neutrality" assume no problems in collecting these revenues? Does it take into account the assumed redistributive effects of these measures?**	Governments' financing obligations for health care shift to some extent pursuant to all proposals for health care reform. It is important to identify whether governments' obligations are new ones or merely the reallocation of current funds (e.g., Federal and State Medicaid funds, Medicare funds, Veterans Affairs funds, public health program funds, block grants). Some analyses assert that a proposal is "budget neutral;" that is, it is fully funded at the Federal level. However, this does not mean that no new government funds are necessary to implement the program. It merely means that the necessary revenues will be raised from various sources in such a way that the Federal deficit will not be affected. The means by which these funds are raised may have important redistributive effects, for example, "sin" taxes v. capping the tax deduction and/or exclusion for employer-sponsored health insurance benefits v. payroll tax v. repealing the Medicare taxable maximum income rate.
• **Does the system require State and local governments to collect new funds? What does the proposal assume with respect to current State and local government health care funds (e.g., State Medicaid share, indigent care programs, public health programs)?**	Many reform proposals shift obligations related to health care, which have most recently been shared among levels of government, to the Federal government (e.g., Medicaid acute care services). In order to avoid shifting the full amount of the financial obligations associated with providing these services to the Federal government, most proposals would require State and local governments to continue to devote all or most of these funds to the Federal program.
• **Do some or all employers take on new obligations with respect to health care financing or are they relieved from present ones? If the former, is there a "cap" on employers' liability? What is the relative impact of the obligations on employers by size, by industry, or by geographic region?**	Some proposals increase employers responsibility for providing health care coverage whereas others relieve them of it. The redistributive effects may differ among employers based upon numerous factors such as size, industry, and workforce characteristics.
• **What is the ultimate or total cost—direct payments plus indirect payments—to households for health care coverage and/or services? And what is the distribution of these expenses among households by income level?**	The total cost of health care is borne, ultimately, by individuals. It is essential to look at what the impact of a proposal is on individuals and families or households, in the aggregate and by income level, in order to determine whether the system will result in acceptable or unacceptable effects.

What Assumptions Does the Analysis Make With Respect to the *Delivery of Health Care*?

Questions	Examples of Possible Effects
• **Is a specific mode of delivery, with particular assumptions about projected changes in the costs of care, required by the proposal; for example, does the proposal assume universal or near-universal enrollment in group-or staff-model health maintenance organizations?**	Assumptions about the ability of the system of health care delivery to manage service delivery and costs can affect estimates regarding the cost of coverage and care.

Continued on next page

Box 10-A—Provisional Checklist: A Guide for Policymakers—Continued

What *General Operational Assumptions* Does the Proposal Make?

Questions	Examples of Possible Effects
• **What is the phase-in period, if any, for the proposal? If the proposal is phased in, are any estimates of spending and/or savings adjusted for the phase-in period?**	If a proposal is phased in, any new costs and savings resulting from a proposal may occur over time. However, a simplifying assumption made by many analyses is that such costs and savings are incurred or accrue immediately, an assumption that will skew the true spending and/or savings effects of a reform proposal.
• **Are the transition costs from the current system to the new system included in the spending and/or savings estimates?**	Any new system will most likely require money to implement. Many analyses take into account the direct costs and savings of the reforms and ignore the indirect costs and savings. These costs may be significant with respect to establishing the infrastructure to support a new system.

What *Background Information* Regarding the Approach, Proposal and/or Analysis is Provided?

Questions	Examples of Possible Effects
• **On whose behalf was the analysis prepared, following which rules, with what level of transparency?**	Some analyses are prepared by independent researchers without any apparent stake in the results of the analysis; however, many others are prepared by the proponents of an approach or by researchers or consulting firms working on the proponents' or opponents' behalf. Further, similar groups of analysts may use different rules to guide their assumptions, depending on the needs of particular clients. The fact that many analytic models are proprietary —i.e., not open to public scrutiny—makes it difficult to compare analyses and their results. It is important for policymakers to be aware of the potential for a conflict of interest in the preparation of an analysis. Policymakers could require or strongly encourage analysts to routinely compare the assumptions that guided any particular analysis with assumptions used by other analysts, and/or they could require or strongly encourage analysts to make their assumptions public, using a standard list of key assumptions.

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TESTIMONY BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

STATE CAPACITY TO ACHIEVE HEALTH CARE REFORM

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June 8, 1993

Joint Meeting House and Senate
Public Health and Welfare
9/30/93

Attachment 3

TESTIMONY BEFORE THE SUBCOMMITTEE ON HEALTH
COMMITTEE ON WAYS AND MEANS
UNITED STATES HOUSE OF REPRESENTATIVES

W. David Helms, Ph.D.
President, Alpha Center
1350 Connecticut Avenue, N.W., Suite 1100
Washington, DC 20036

June 8, 1993

STATE CAPACITY TO ACHIEVE HEALTH CARE REFORM

Mr. Chairman, thank you for the opportunity to testify today on state capacity to achieve health care reform. My name is David Helms, and I am President and founder of the Alpha Center, a non-profit organization with an 18-year history of providing technical assistance to states and the federal government in health care policy. The Alpha Center began as a Center for Health Planning, providing technical assistance to northeastern states for that program. Among other activities, we now serve as a contractor for the Agency for Health Care Policy and Research (AHCPR) conducting workshops for state and local public officials. We also serve as the national program office for three initiatives of The Robert Wood Johnson Foundation, including its State Initiatives in Health Care Financing Reform program, a program funding the development and implementation of health care reform in 12 states which will soon be expanded to assist more states.

The states represented on the panel today are leaders in state health care reform. They provide important lessons about the types of reform which are politically viable in different regions of the country. They also provide key insights into how states are combining different reform approaches such as "employer mandates," "managed competition" and "global budgets." Even more important, they will provide useful lessons on key implementation issues such as structuring purchasing cooperatives and administering expenditure targets and caps.

While I want to emphasize the important progress states are making, I also want to stress that states need (and I believe would welcome) federal support and guidance. Once the Clinton proposal is formally introduced and is debated along with Congressional alternatives, states are likely to fall into three categories: 1) those states which will wait for actual legislation to be enacted and then do what is required, 2) those states which will try to anticipate what their roles will be based on the reforms being considered nationally and take steps to get a head start on implementation, and 3) those states which believe they have a better alternative and hope to develop it to the point of being grandfathered in. States in both of the latter categories are likely to have the greatest capacity to implement national reform.

3.2

Once passed, however, some states will move faster than others to begin the operation of a reformed health care system with their speed far more dependent on the incentives provided in federal legislation than on any current indicators of state readiness or capacity. I was reminded recently about how quickly the former East Germany adopted the West German system. They were given 90 days by law and in 90 days, the new system was in place. Few in this country would recommend a 90-day transition. Nevertheless, there are steps that can and should be taken to expedite the efforts already underway to develop the infrastructure for a new system.

In this testimony, I review briefly where states are today in the reform process and the reasons underlying their efforts. After pointing out the issues for Congress raised by state experimentation with health care reform, I discuss the roles and responsibilities for federal and state government under a national reformed system. Finally, I consider what states will need now in order to move forward with reform. Clearly, states are unable to achieve comprehensive health care reform entirely on their own. Without federal leadership, a few will act to the degree they can. For the rest, the capacity to implement reform is highly variable. The federal government can improve state capacity and expedite the transition to a reformed system through clear guidance, funds to develop needed operational capacity and technical assistance.

1. Why have states been pursuing health care reform?

A. The rate of cost increases, especially for Medicaid, is no longer sustainable

B. The increasing number of uninsured coupled with a recognition of a more fundamental breakdown in the small employer market

C. The recognition that incremental changes which states have tried (e.g., market reforms, subsidy programs) will not achieve their generally accepted goal of assuring universal access

D. Belief that significant savings only can be achieved through more fundamental reform of the financing and delivery systems

E. Uncertainty about the likelihood of action at the federal level in the near term

2. Where are the states in the reform process today?

A. Eight states have passed significant comprehensive health care reform legislation and are at various stages of implementing reform.

Hawaii:	employer mandate; subsidized insurance product
Minnesota:	integrated service networks; subsidized insurance product; targets for limits on growth in health expenditures

Vermont:	targets for global expenditure limits; universal access through either single payer or mandated multi-payer system
Oregon:	coverage of highest priority services under Medicaid; high risk pool; play-or-pay mandate
Washington:	employer and individual mandate; purchasing cooperatives; expenditure limits; subsidized insurance product
Florida:	purchasing cooperatives; Medicaid buy-in; small group market reform
Maryland:	small group market reform; limits on physician fees; administrative reform
Massachusetts:	play-or-pay mandate; subsidized insurance product

B. In addition to the 8 states listed above which are implementing various aspects of their legislated reforms, 4 states are undertaking major demonstrations to build capacity for more comprehensive health care reform.

California:	statewide health insurance purchasing cooperative for small employers
New Jersey:	subsidized insurance product
New York:	electronic claims clearinghouse, global budgeting
Iowa:	health insurance purchasing cooperatives and organized delivery system pilots

C. In addition, 22 states have established commissions or task forces to develop recommendations on health care reform. While these states are certainly far less ready than those above to enact reform, the presence of a commission or task force indicates at least a political discussion has begun in a state. In addition, some of these states (e.g., Colorado, Montana) have very active study bills putting them in a position to implement reform quickly should the state pass reform legislation.

D. Virtually, all of the states listed above have included aspects of health insurance market reform among their activities. The Health Insurance Association of America has recently reported that "26 states have forced insurers to issue policies to anyone who applies, regardless of their health. Thirty-four states have forced insurers to guarantee the renewal of policies. Forty states have placed tighter restrictions on insurance rates."[1]

Thus, most of the states are actively reforming the insurance market and studying more fundamental reforms, with the eight states having passed comprehensive reform legislation being the leaders.

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[1]Health Insurance Association of America, as reported in Wall Street Journal, June 2, 1993.

3. What reform strategies are being pursued by leading states?

States are currently at various stages of implementing many of the reform components being discussed at the federal level. These state efforts can be categorized as follows:

A. Major strategies to increase financial access

1. Developing new tax-financed systems
   - Payroll tax on employers and employees
   - Income tax
   - Provider taxes
   - "Sin" taxes

2. Mandates
   - Employer mandates
   - Individual mandates
   - Individual and family health accounts

3. Subsidies for the uninsured
   - Subsidized public insurance program for uninsured
   - Medicaid buy-in

4. Restructuring the insurance market
   - Purchasing cooperatives
   - Standard or minimum benefit packages
   - Small group insurance reforms (i.e. community rating to limit rate differentials, guaranteed issue requirements, limitations on pre-existing condition exclusion periods)

B. Major strategies for controlling costs

1. Expenditure targets and caps
   - Targets for rate of increase
   - Total budget for health care services for state residents

2. All-payer rate setting by sector
   - Hospital & nursing home rate systems
   - Uniform payment systems for ambulatory care and physician services

3. Managed competition
   - Development of purchasing cooperatives
   - Selection by individuals within groups of approved health plans

4. Administrative efficiencies
   - Electronic billing and claims processing
   - Electronic coordination of benefits
   - Electronic remittance

C. Major strategies for improving health delivery systems

1. Development of integrated service networks
   - Promotion of new managed care plans which link hospital and ambulatory services
   - Promotion of networks in underserved urban and rural areas

2. Improvements in access to services for underserved populations
   - Building and expanding primary care
   - Training primary care health professionals to work with underserved communities

4. Should the federal government foster further state experimentation with health care reform?

A. The arguments usually made against promoting extensive state experimentation are:

- States lack the financial resources to cover all of the uninsured without help from the federal government.
- State reforms would require exemption from the federal ERISA statute and waivers under the Medicaid and Medicare programs.
- State reforms, especially those imposing mandates on employers, could adversely affect a state's economy if firms move to other states.
- Large multistate firms would face higher administrative costs with different state systems.
- Allowing states to implement their own reforms runs the risk of dissipating momentum from national health care reform; and once a national plan has passed, it might be difficult to bring those states which moved ahead in a different direction back into the new federal framework.

B. The arguments made in favor of state experimentation include:

- State-specific health care reform strategies are more tailored to local conditions than a national plan.

- It may be easier to build public support for a state-specific reform plan, given its focus on solving local problems.

- State reforms build experience in operationalizing and administering important aspects of reform, such as subsidizing low-income individuals or restructuring the local insurance market.

- Permitting state reforms allows states to serve as laboratories for key reform options heretofore outlined only in policy proposals.

- State experimentation allows states to move now toward access improvements and cost containment while the country awaits major national reform.

5. What are the appropriate roles for the federal government and for states under a national reform plan?

Under a reformed health care system, both levels of government are likely to have key responsibilities appropriate to their roles in a federal system.

A. Important roles for the federal government include:

- *Mandate participation by all parties in the system, including employers and individuals.* Our work with The Robert Wood Johnson Foundation Health Care for the Uninsured Program projects taught that despite significant subsidies of up to 40 percent of the premium for employers, we will be unable to achieve universal access to insurance through voluntary means.[2]

- *Establish a standard uniform financing system.* While a few states have been able to pass legislation specifying how universal access will be financed, this aspect of health reform remains beyond the political means of most states. A federally-specified uniform financing system could reasonably require states to maintain their prior levels of financial contributions. Given their fiscal crises, however, it is unrealistic to expect much of an increase in those levels.

- *Establish a standard uniform benefit package.* A national standard benefit would assure greater equity across states, facilitate coverage by plans covering areas which cross state boundaries, and facilitate coverage by national firms operating in multiple states.

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[2]See W.D. Helms, A.K. Gauthier, and D.M. Campion, "Mending the Flaws in the Small-Group Market," *Health Affairs* (Summer 1992): 7-27.

- *Set clear and consistent national policies for key aspects of operating a reformed health care system.* National rules and guidelines should include:

  1) Parameters for insurance market rules (such as factors which may be used in rating premiums or adjusting for differences in risk)

  2) Minimum firm size eligibility for participation in pooled purchasing

  3) Targets for national and state-specific expenditure limits

  4) Specifications for data to be collected for operating the system, assessing its impact, and making policy improvements

  5) Research on health outcomes, technology assessment, and development of practice guidelines

  6) Quality and access standards

  7) Health personnel distribution goals

  8) Clarification and modification, where necessary, of anti-trust rules

  9) Standards for malpractice reform

B. State roles under national health care reform should build upon states' traditional roles in the health care system, including: 1) developing health personnel training programs; 2) regulating provider quality; 3) controlling the supply of health care resources; and 4) serving as a provider of last resort for those who remain uninsured.

C. Under many of the national health reform plans under consideration, states will need to perform important roles, including the following:

- *Establish and oversee purchasing cooperatives.* States will need to establish the rules and regulations for how these entities operate, including:

  1) the number of purchasing cooperatives and the geographic areas they serve

  2) governance, including composition and procedures

3) data collection and submission

4) methods of adjustment for adverse risk selection

5) the extent to which they may limit the number of qualified plans offered

- *Oversee the development and operation of integrated health networks/plans.* States will need to specify the criteria and standards for qualified networks, monitor adherence to national quality and access standards, assure access to providers in underserved areas, foster the development of networks in selected underserved urban and rural areas, and ensure coordination of certain services with state and local public health systems.

- *Administer eligibility for subsidized insurance.* States will need to determine the need for subsidies for unemployed individuals and low income workers.

- *Conduct a resource allocation process within a system of national expenditure limits.* States will need to play a major role in a number of related areas, including:

  1) Develop a baseline on state expenditures and collect data to understand future expenditures

  2) Establish a process to enforce nationally-set expenditure limits

  3) Implement transitional price controls, if any

  4) Conduct rate-setting or negotiation on unit prices, hospital budgets, and/or capitated premiums

  5) Establish supply controls for specialized services and high technology

  6) Promote and enforce health personnel distribution policies

6. Under a national reform plan, should states be given the flexibility to implement different reforms? How much flexibility do states want? Why do some want flexibility and others don't?

States are ready to accept federal direction within a system of shared responsibilities. In general, states believe they should be held accountable for mutually agreed-upon goals regarding access and cost containment, rather than the specific processes used to achieve these goals. This argues for some flexibility and the time and resources states

will need to build their capacity to perform these expanded roles. States are concerned about the extent of their financial obligation to assure access and their accountability for meeting expenditure targets, but many appear ready to accept these responsibilities if given sufficient resources and flexibility to carry it out.

7. What can be done to expedite the transition to a new system?

As noted above, at least 12 states have already taken concrete steps to develop the infrastructure for a reformed health care system. They are likely to be joined by other states which are also actively considering proposals. Despite this significant progress, I believe that about half of the states will be unable or unwilling to take serious steps until a new national system is put in place. However, the federal government can expedite the transition by the following incentives:

A. Provide state reform development grants.

B. Provide technical assistance on the entire range of tasks that states will need to perform.

C. Foster further state experimentation now, prior to the implementation of a new system. Such experimentation will not only build states' capacities but it will serve to provide models offering lessons for national reform or reform in other states. As you no doubt understand well, states will need exemptions from ERISA, Medicaid waivers, flexibility on inclusion of Medicare and other federal programs within the purchasing cooperative (especially for rural areas), and protection from anti-trust laws in order to move forward with such experiments.

Once national reform legislation is passed, states will continue to need funding as well as technical assistance for further development of their infrastructures. However, perhaps most important, they will need clear guidance in the areas specified above. The clearer the guidance and the stronger the federal incentives to implement the system, the faster it can be put in place.

FLORIDA

Governor: Lawton Chiles (D), 4 year term beginning January 1991

Legislature

Senate: 20 Democrats, 20 Republicans

House: 71 Democrats, 49 Republicans

1994 Session: February - April

Comprehensive Health Care Reform Efforts

Significant Legislation: The Health Care Reform Act of 1992 called for voluntary approaches to reach universal access and achieve cost containment goals by December 1994. The Health Care and Insurance Reform Act of 1993 represented the next step in achieving those goals. It reorganized the health care delivery system based on a managed competition model and established 11 regional Community Health Purchasing Alliances (CHPAs). These alliances will serve a voluntary membership of small businesses, state employees, and Medicaid and two new programs -- MedAccess and Medicaid "Buy-In" plans for low-income individuals. The CHPAs will offer coverage through Accountable Health Plans, or networks of providers that will be certified by the state.

Summary of Reform Provisions

Access: Small businesses (1-50 employees), state employees, and Medicaid and Medicaid Buy-In enrollees should be able to obtain coverage through the 11 regional CHPAs if they begin operations on January 1, 1994 as planned. The MedAccess and Medicaid Buy-In programs will be open to individuals with incomes below 250% of the federal poverty level who have not had private health insurance in the past year. Additionally, a benefit package advisory group is meeting to discuss the necessary benefits for basic, standard, and specified health plans to be offered by the Accountable Health Plans.

The state also supports a small demonstration program called "Healthy Kids", which provides school-based health insurance coverage for uninsured children in a few areas of the state.

Small Group Insurance Reforms. The Health Care Reform Act of 1992 enacted small group insurance reforms (for firms with 3 to 25 employees) including establishment of standard and basic benefit packages, guaranteed issue, limits on pre-existing condition exclusions, and premium escalation limits. A group of health insurers has been brought together to develop a basic benefit package for the small group insurance plans.

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Financing:

The MedAccess Program is financed solely from premiums paid by enrollees and/or their employers. Subsidies for low-income individuals enrolled in the Medicaid Buy-in program may be financed with federal and state Medicaid funds -- if a federal waiver is approved. Funding for the Florida Healthy Kids Program comes from a combination of federal, state and private sources.

Cost Containment:

The cost containment strategy relies on managed competition between AHPs, along with voluntary hospital budget review to control health care costs.

Governance:

The Health Care Reform Act of 1992 established the Agency for Health Care Administration (AHCA), which consolidated several health care functions into one department and centralized all regulatory authority over the health care system into one agency. AHCA is charged with submitting the final health care reform plan to the legislature by December, 1993.

Each CHPA will be governed by a 17-member board appointed by the Governor and Legislature. Members will represent small businesses, Medicaid, state employees and the MedAccess program. Members cannot have provider or payer affiliations. The state will supervise and certify all 11 CHPAs; similarly, the state will designate all qualifying Accountable Health Plans.

MINNESOTA

Governor: Arne Carlson (R), 4 year term beginning January 1991

Legislature

Senate: 45 Democrats; 22 Republicans

House: 86 Democrats; 48 Republicans

1994 Session: January - May

Comprehensive Health Care Reform Efforts

Significant Legislation: The state adopted the HealthRight Act of 1992, which set in motion a plan to achieve universal coverage and health care cost containment. It extended health coverage immediately by expanding the state's Children's Health Plan (CHP) to cover beneficiaries' parents, and eventually other adults in low income families. The law also laid out the framework for Minnesota's cost containment strategy. The MinnesotaCare Act, passed in May 1993, established a more explicit cost control strategy by placing a cap on the annual rate of growth of health care expenditures. It also authorized the formation of integrated service networks (ISNs) and mandated an all-payer rate-setting system for providers not in an ISN.

Summary of Reform Provisions

Access: Among the many strategies to increase access to health care services are efforts to strengthen the rural health delivery system, reforms of the small group insurance market, allowing private employers to join the Public Employees Insurance Plan (PEIP), and authorizing the formation of Integrated Service Networks as focal point for coordinated care.

Children's Health Plan. In 1988, the state was the first to enact a Children's Health Plan, which was extended in 1992 to cover entire families and other adults. Currently, those families with children and incomes up to 275% of the federal poverty level are covered by Children's Health Plan Plus. Beginning July 1, 1994, households without children with incomes up to 275% of the federal poverty level will also be eligible. CHP had only covered limited outpatient benefits, but on July 1, 1993, it began offering inpatient benefits up to $10,000 per year (with a 10% copayment) to eligible adults, and unlimited inpatient benefits to children under age 18.

Financing: Minnesota's access expansions are financed with revenues from an increase in the cigarette tax, a tax on hospitals' and other health providers' gross patient revenues, and a tax on nonprofit health service plans.

Cost Containment:

The reformed Minnesota health care system will rely on competition between ISNs to control costs. The new legislation caps the growth in the expenditures of integrated services networks. Out-of-network provider fees will be controlled through an all-payer rate-setting system. To monitor spending and its growth, a comprehensive data collection effort has been implemented. Additional efforts to contain the cost of health care include: controls on the purchase of technology, development of practice parameters, reduction in administrative costs, public health initiatives, changes in health professional education, and medical malpractice reform.

Governance:

The Minnesota Health Care Commission was established by the 1992 HealthRight Act to recommend a cost containment plan for the state to the Commissioner of Health. The 1993 MinnesotaCare Act charged the Commission with advising the Commissioner on: the implementation of the ISN and the all-payer rate-setting systems, identifying other cost containment strategies, and the development of a comprehensive universal health care plan. Members were appointed by the governor, the legislature, and trade associations, and include representatives of consumers, employers, health plans, providers, unions, and state agencies.

WASHINGTON

Governor: Mike Lowry (D), 4 year term beginning January 1993

Legislature

Senate: 28 Democrats, 21 Republicans
House: 65 Democrats, 33 Republicans

1994 Session: January - March

Comprehensive Health Care Reform Efforts

Significant Legislation: The state's health reform strategy, embodied in the Health Services Act of 1993, relies on employer and individual mandates to assure universal access, and managed competition to contain health care costs. The employer mandate for health insurance coverage is scheduled to take effect on a phased-in basis from 1995 through 1999, at which time all employers must provide coverage to eligible employees and dependents. The Act authorized the establishment of four Health Insurance Purchasing Cooperatives (HIPCs) throughout the state, from which employers and individuals can choose among state-approved "certified health plans."

Summary of Reform Provisions

Access: By 1999, all citizens of the state will be entitled to receive at least a minimum level of benefits that are covered under the Uniform Benefit Package (UBP). Services to be covered will be decided by the Health Services Commission. Optional supplemental benefit packages may be purchased for an additional charge.

The employer mandate will be phased in beginning with large firms (500 or more employees) in July 1995, and ending in July 1999, at which time all firms with fewer than 100 employees must provide coverage to workers and their dependents. Both full-time and part-time employees are eligible for employer-provided coverage. The Commission must make recommendations on how to provide coverage for seasonal employees by December 1994. Small business eligible for subsidies (see below) must employ fewer than 25 workers. The individual mandate requires that every person, including self-employed people, have health insurance coverage by 1999.

Employers have several options for purchase of health coverage for employees. They may provide it directly (if they have more than 7,000 employees), purchase it directly from the certified health plans, purchase it through one of the four regional Health Insurance Purchasing Cooperatives (HIPCs), or they may enroll employees in the state's Basic Health Plan

(BHP). The BHP is a health insurance program for people below 200% of the federal poverty level that will be merged into the State Health Care Authority in 1993. Certified health plans are subject to various insurance regulations, including modified community rating, as well as requirements that they offer the Uniform Benefit Package and guaranteed renewal.

In addition, the BHP and Medicaid will both be expanded over time to cover additional groups of low-income people. Through subsidies and expanded eligibility criteria, an additional 195,000 people should be covered under these programs by 1995. All children living in families with incomes under 200% of the poverty level will be eligible for Medicaid during 1994; adults living in families making less than 200% of poverty will be eligible for the Basic Health Plan by 1995.

Financing:

The employer mandate requires that employers pay at least 50% of the cost of the uniform benefit package for each eligible employee and his or her dependents. Workers must pay the remainder of the premiums, but if they are low income, their portion will be subsidized. Employers must pay a pro-rated portion of this amount for part-time employees. Small businesses will be eligible for short-term subsidies in the first few years. The state intends to finance subsidies for small firms and low-income individuals with increased taxes on cigarettes, alcohol, and nonprofit hospitals (estimated to bring in about $251 million in revenue), with other tax increases possible later on.

Cost Containment:

The law directs the Health Services Commission to set the maximum annual premiums that can be charged for the uniform benefit package and any supplemental benefits packages offered by certified health plans. The law specifies that every year, the rate of increase in premiums must be reduced by 2% until it equals the state's rate of personal income growth.

The law also attempts to control the state's health care costs by consolidating most state purchasing of government employees' health benefits into one agency -- the Health Care Authority. In addition, the state expects that certified health plans will lower costs by instituting managed care and reducing administrative overhead.

Governance:

The Act created a Health Services Commission, comprised of 5 full-time paid members and the state's Insurance Commissioner. Their responsibilities include establishment of the Uniform Benefit Package, setting of the maximum allowable premium caps, and accountability for health system reform and cost containment policies. Several advisory

committees have been authorized to provide input to the Commission, including those related to the benefit package, small business, and organized labor. The Health Care Authority retains responsibility for purchasing government employees health insurance.

The HIPCs will be regulated by the Insurance Commissioner. All HIPCs must be non-profit organizations; employers must belong to and govern them. They must offer every certified health plan that wants to contract with it.

VERMONT

Governor: Howard Dean (D), 2 year term beginning January 1993

Legislature

Senate: 14 Democrats, 16 Republicans

House: 87 Democrats, 57 Republicans

1994 Session: January - April or May (no set ending date)

Comprehensive Health Care Reform Efforts

Significant Legislation: Act 160 of 1992 created the Vermont Health Care Authority and Board, which were charged with designing two models to assure universal access to health coverage for all citizens in the state: 1) a single-payer system, in which everyone in the state would become part of the same health insurance program that would negotiate prices with doctors and hospitals, and 2) a multi-payer regulated system, that would allow people to choose among health plans, but would set strict rules for the plans and for insurers regarding provider payment. Under either plan, the state required that all health care costs be capped. The legislature must decide which plan to implement in its 1994 session, with a target implementation date of October 1994.

Summary of Reform Provisions

Access: If the state adopts a universal access plan, all citizens of the state will be entitled to health insurance coverage. The universal access plan to be adopted by the legislature in 1994 must include a uniform set of health care benefits. The law stipulates only that the plan provide "universally accessible, medically necessary and preventive care." The Health Care Authority is currently developing a proposed benefit package for the legislature's consideration, based on a set of principles, but its costs must still be estimated by an actuary. In addition, an interim report from the Authority to the legislature must recommend whether and how long-term care services might be covered in the universal access plan.

Until a plan is adopted by the legislature, the state has undertaken several steps to increase access to health coverage. It passed several **small group insurance reforms** designed to make health insurance more affordable, including requirements that insurers use common claims forms, submit cost management plans to the state, and set community rates for individual policyholders (small groups must be community-rated as of July 1992).

In addition, the 1992 law required the creation of a statewide purchasing pool, comprised of state employees, teachers, and

Medicaid beneficiaries, to increase their ability to bargain for lower rates from health insurers. Small employers may also be able to join the statewide purchasing pool later in 1993.

Children's Health Plan. The law also expanded the "Dr. Dynasaur" program to provide additional low-income children with Medicaid-like benefits. All children, ages 0-18, are eligible to receive coverage from the Dr. Dynasaur program if their family's income is below 225 percent of the federal poverty level.

Financing:

Financing options for the universal access plan are still under consideration by the Health Care Authority. The costs of the Dr. Dynasaur program are about $2.2 million annually, funded with state and federal revenues and some co-insurance payments by families.

Cost Containment:

The Health Care Authority was granted power to set global budget targets for the entire health care system. In 1993, these targets are voluntary, but by July 1994, the Authority must adopt a unified health care budget with binding expenditure limits. Currently, all hospital budgets must be reviewed and approved by the Authority.

Vermont is also encouraging health care providers and insurers to act together to contain health care costs. Providers were granted exemptions from anti-trust laws in order to form networks and to jointly negotiate rates with the Authority. In addition, insurers, doctors and hospitals are being encouraged to organize "Integrated Systems of Care", or networks that can coordinate care and stay within an overall budget. Finally, the statewide purchasing pool may be able to negotiate lower rates from insurers and providers.

Governance:

The Vermont Health Care Authority is an administrative and regulatory body charged with developing the two universal access proposals. It was also given authority to perform other key health care regulatory functions, including certificate-of-need reviews, hospital budget review and approval, and unified health care database development. The Authority is governed by three paid Board members and staffed by an Executive Director and 14 other staff members.

NUMBER 1
OCTOBER 1992

STATE INITIATIVES IN HEALTH CARE REFORM

States Developing Broad Spectrum of Plans to Increase Access and Control Costs

State Initiatives in Health Care Financing Reform is a $25.5 million program of The Robert Wood Johnson Foundation to support states' efforts to achieve comprehensive health care reforms. "State governments are being challenged to do what the federal government up to now has been unable to do: implement health care reform," said Steven A. Schroeder, M.D., president of the Foundation, who announced the program's grantees in August. The program is intended, he explained, "not only to help states develop new ideas and test models for reform, but for federal policymakers to learn from these state-based experiments as they consider what should be included in a national health policy."

A total of 35 proposals were received by the Foundation and reviewed by an independent national advisory committee comprised of experts in the field of health care financing and delivery. Twelve states have been awarded grants totaling $8.4 million to develop implementation plans for their reform strategies during the first phase of the program. Grantees include: Arkansas, Colorado, Florida, Iowa, Minnesota, New Mexico, New York, North Dakota, Oklahoma, Oregon, Vermont, and Washington. After developing their plans, the states can request additional support for up to three years to implement their reforms.

The states' proposals "span the political and ideological spectrum of health care reform strategies," observed Nancy Barrand, senior program officer at the Foundation and originator of the State Initiatives program. Cost control initiatives range from creating statewide "global" health care budgets, to setting expenditure targets, to relying on managed care delivery systems. Approaches for expanding insurance include a single state-run insurance program, state-initiated insurance cooperatives, promoting greater use of the federal Earned Income Tax Credit to pay for health insurance premiums, and "play-or-pay" programs requiring employers to offer coverage to workers or contribute to a state insurance pool. While all the states share the ultimate goal of reducing the number of uninsured, Barrand explained, "we are hoping to test what works and, equally important, what won't work or may be less effective in expanding access."

The states are at various stages in the reform process. Some have already adopted major reform legislation and have moved the

PROGRAM DIRECTOR'S NOTE

This is the inaugural issue of *State Initiatives in Health Care Reform*, the newsletter for The Robert Wood Johnson Foundation's State Initiatives in Health Care Financing Reform Program. It provides an overview of the program, highlighting the broad range of reforms being pursued by the program's 12 grantees, and features summaries of each state's project. Future issues will focus on the activities and analyses being carried out by specific projects and explore health reform issues of common interest to both states and the national government.

Please feel free to share copies of *State Initiatives in Health Care Reform* with your colleagues. Persons wishing to be added to the newsletter's mailing list should write to the Alpha Center, 1350 Connecticut Avenue, N.W., Suite 1100, Washington, DC 20036. Additional comments or suggestions would also be welcomed.

W. David Helms, Ph.D.
President, Alpha Center

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9/30/93

STATE INITIATIVES IN HEALTH CARE FINANCING REFORM IS A NATIONAL INITIATIVE OF THE ROBERT WOOD JOHNSON FOUNDATION.
ALPHA CENTER PROVIDES TECHNICAL ASSISTANCE AND DIRECTION FOR THE PROGRAM.

Jt. Meeting Senate and House Public Health and Welfare

STATES PLAN REFORMS *Continued from page 1*

locus of the reform effort from their legislature into their administrative agencies. For example, Oregon passed a bill three years ago calling for a play-or-pay program to begin in 1995 if statewide targets for covering uninsured workers are not met voluntarily. Minnesota, Vermont, and Florida all passed comprehensive legislation in 1992 and have created new health care authorities for overseeing their multi-part reform efforts. Colorado has passed legislation authorizing a comprehensive analysis of its proposal. Some states, like Washington and New York, have substantial experience in expanding Medicaid, promoting managed care, running demonstration projects for the uninsured, or setting provider reimbursement rates, but have yet to adopt an overall strategy for reforming the health system. In other states, public task forces or coalitions are taking the lead on new reform efforts, such as in North Dakota, Iowa, or New Mexico.

To assist grantees in assessing their options, analyzing data and understanding the legal and regulatory issues involved in reform, specialized technical assistance and consulting services are being supplied by the Alpha Center, acting as the national program office, together with RAND, the Urban Institute, and the National Governors' Association.

"Most of the states need to move very quickly with their analytic work," observed Joel Cantor, Sc.D., the Foundation's senior program officer overseeing technical assistance resources for the program. "We will facilitate the grantees' work by providing technical assistance through surveys, generic analyses of common topics, and consultations on state-specific needs," he explained. The Foundation plans to commission surveys of households and employers in most of the twelve states to generate critical data not available from existing state or national data sets. Also being developed are technical assistance monographs addressing topics such as the economic effects of health system reform, global budgets and expenditure targets, risk adjustment for mandated multi-payer systems, and others.

Undertaking the major health system changes envisioned by the states will require assessing the feasibility, costs, and benefits of different approaches at both the policy and implementation levels. "Historically, states have paved the way for a number of new national policies, and in many ways they will be testing the reality of health care reform strategies," added Dr. Schroeder. ■

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STATE PROFILES

ARKANSAS
Seamless Universal Health System for Children

Arkansas intends to create a seamless, universal health system for uninsured children. The goal of the state's initiative, called Arkansas Project Access, is to provide well-child, preventive and primary care services (both inpatient and outpatient) through a single enrollment mechanism that facilitates access to Medicaid, a private basic policy, or a publicly-subsidized basic policy. There are four key objectives in the project's development phase: developing financing mechanisms, linking providers into a statewide access network, utilizing physician practice guidelines, and developing an information management system for eligibility and claims information.

As part of the first objective, the project would tap state, federal and private financing sources to make coverage affordable. Since the state has already expanded Medicaid eligibility to the allowable limits, Arkansas officials estimate that the majority of uninsured children can be brought into the program. For uninsured children ineligible for Medicaid, the state will design a basic health insurance package to be administered through a trust arrangement, with premiums established through community rating. Families would be expected to pay a fair share of the monthly premium for children enrolled in the basic policy, and the state would promote use of the federal Earned Income Tax Credit to offset these expenses. Additional state funds would be used to subsidize premiums for low-income families still unable to afford the plan.

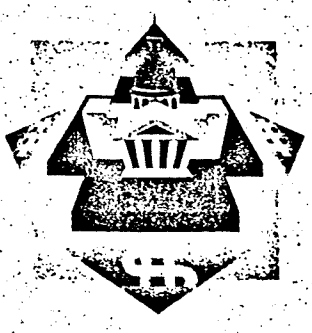
The project's second major activity will be to establish a network of primary care physicians, pediatricians, hospitals, and other health care providers, with linkages to public-sector health programs and community-based agencies. The state will use this network as a preferred provider organization, with primary care gatekeepers and a managed-care approach to serving enrollees in the children's basic health plan and Medicaid. Special efforts will be made to provide access to services for those living in health professional shortage areas.

Under the third objective, participating physicians will be encouraged to use practice guidelines developed by the American Academy of Pediatrics in designing their care plans. The state believes these measures should reduce malpractice costs, as well as cut down on unnecessary procedures and tests. An important project task will be designing payment and quality assurance procedures that create incentives for using these guidelines.

The fourth objective is to develop a model health care management information system that integrates multiple payers into a unified claims processing system. The project has a unique opportunity to utilize the state Medicaid agency's Arkansas Eligibility Verification Claims System (AEVCS), a statewide system for verifying eligibility and transmitting claims information, which is scheduled for implementation in early 1993. The first state to implement such a statewide system, Arkansas projects a savings of $1.5 to $2 million over four years.

According to Ray Scott, a consultant to the project from the Arkansas Children's Hospital Research Center, "In return for participating in the network, providers will get an automated eligibility and claims processing system to ensure more efficient management and expedited payment, plus a network of backup and referral providers, and possibly, reduced malpractice premiums, especially for physicians in rural areas." The state also plans to explore the feasibility of extending AEVCS to accept Medicare, Blue Cross and Blue Shield, and private insurance claims information.

"Through Arkansas Project Access we seek to establish a 'medical home' for each child in the state...," observed Project Director Rebecca Peacock. "From the enrollee's perspective, the eligibility and claims payment processes will be transparent, and from the provider's viewpoint, payment will be timely and accurate," she said. ■



"WE SEEK TO ESTABLISH A 'MEDICAL HOME' FOR EACH CHILD IN THE STATE."

REBECCA PEACOCK
ARKANSAS

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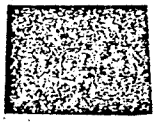

"IF WE'RE GOING TO MOVE COLORADOCARE FORWARD WE NEED TO BE ABLE TO PREDICT ITS EFFECTS ON BUSINESSES AND INDIVIDUALS."

ALAN WEIL, COLORADO

COLORADO
Statewide Plan With Multiple Insurers

In May 1992 the Colorado legislature passed Senate Bill (SB4) requiring a comprehensive study of ColoradoCare, a proposed statewide insurance program that would be managed by a newly established State Health Authority. According to Alan Weil, Governor Roy Romer's health policy advisor and the director of this project, the legislation signaled broad agreement on the need to reform the state's health care system "around a framework of universal coverage using the private insurance system." By contracting with a limited number of insurers and HMOs, ColoradoCare would provide a comprehensive set of health care benefits for all Colorado residents who are not enrolled in Medicare, regardless of their employment status or family income.

Each year every eligible person in Colorado would choose an insurance plan in which to enroll and then would remain a member of that plan until the next enrollment period. Contracted insurers would have to enroll all applicants, provide full coverage without waiting periods or pre-existing condition exclusions, and use uniform billing, payment, and reporting forms. With ColoradoCare, residents of Colorado would be assured of insurance coverage from birth to the age of Medicare eligibility.

The *State Initiatives* grant will allow Colorado to examine issues surrounding the development and implementation of a minimum benefit package. Weil predicts that rather than defining a specific benefit package, a menu of benefit plan options, along with an analysis of the costs and effects of each option, will be presented to the legislature, allowing "extensive leeway for the political process." In addition to studying the economic impacts of ColoradoCare (e.g., costs, tax revenue, etc.), the state will analyze the effects of the program on health outcomes and access to health care.

A critical component of the ColoradoCare study process is to "get substantial public and interest group support," Weil said. The Colorado Coalition for Health Care Access (CCHCA), which developed the ColoradoCare concept included representatives of the health care community, consumers, and some of the insurance industry. Committees are now being formed to develop program details, and public hearings will be scheduled to allow additional input from business and consumers on program design. Weil acknowledges that garnering the necessary support for ColoradoCare will require extensive, credible analytic work, which the project will complete under its grant. "If we're going to move ColoradoCare forward," Weil states, "we need to be able to predict its effects on businesses and individuals. Clearly, people don't like the way things are now, but they are concerned about the consequences of change."

Colorado's proposed program would provide a model for national reform with significant state control. While operating within a federal framework, it would allow states to make their own decisions about such details as benefit packages and participating providers. If the program is implemented, it will demonstrate the feasibility of maintaining a market-based approach, with significant reform of the insurance industry. ■

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FLORIDA
Expanded Private Coverage for Small Employers and Medicaid Buy-In

Florida Governor Lawton Chiles signed into law last March the Health Care Reform Act of 1992 calling for universal access to health care by December 1994 and promoting voluntary approaches to expand insurance coverage. If the goal is not achieved by that deadline, the newly created Agency for Health Care Administration would be required to submit a backup plan such as a play-or-pay employer mandate to the legislature. Florida's ambitious goal puts health reform on the fast track. Under its *State Initiatives* grant, Florida will work on five critical components of the Governor's broader reform package.

One major focus of the project is to assess the feasibility of creating a Medicaid Buy-In Plan (MBI), which would extend coverage to low-income, unemployed individuals and families who are not eligible for Medicaid. The state would like to cover individuals up to 250 percent of the federal poverty level, an expansion that would require a waiver from

federal Medicaid rules. By taking advantage of Medicaid's low-cost administration, long experience in dealing with high-cost cases using utilization review and case management, and the program's managed care options, project supporters believe an MBI product could be an affordable health insurance option for this target population. According to Robert Sharpe, director of health planning for the Agency for Health Care Administration, if the state is successful in delinking medical assistance eligibility from public welfare eligibility and in getting additional federal support for medical assistance without additional support for welfare, "Florida will help lead the way for other states to uncouple these traditional program ties. We want to do for everyone what we are now allowed to do for pregnant women and mothers with children," he said.

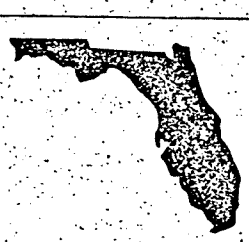
The project will also support the expansion of coverage for small employers through the Florida Health Access Corporation (FHAC), a public-private partnership already covering over 13,000 enrollees from about 3,000 previously uninsured, small businesses. By expanding FHAC, which was started under a previous grant from The Robert Wood Johnson Foundation, the state can offer insurance coverage to a portion of the small employer health insurance market that other insurers have traditionally refused to insure. Under this new grant, Florida can explore methods for increasing enrollment while decreasing employer dependence on state subsidies.

According to Thomas Wallace, project director for the overall state reform effort and assistant director of the Agency for Health Care Administration, "We learned from FHAC that the larger the group, the more leverage the group has in controlling costs." The state will use this lesson in planning the second component of its reform initiative: extending the Florida Healthcare Purchasing Cooperative (FHPC) into the private sector. The FHPC pools state and local government purchasing power to achieve economies of scale by negotiating volume discounts and lowering administrative costs per enrollee. By expanding the cooperative to state government contractors and other private sector employers, the state hopes to offer these groups lower-cost health insurance coverage.

Reforming private health insurance markets is the fourth component of the project. The Department of Insurance will assist in developing reforms, such as reducing administrative overhead and instituting uniform billing practices. Project organizers will also examine the potential use of community rating and its impact on health care costs.

The fifth part of the project is the development of the Florida Specific Health Insurance Data Base. Florida does not currently have a data base that will support much of the needed health care reform analyses. Under the project, the Agency for Health Care Administration is designing a statewide health data system and will begin collecting data about health insurance coverage, costs, and plan design from multiple sources, including a new employer survey and a household survey that will be conducted by a Foundation consultant. The Agency plans to use these data to set health care coverage and cost containment targets and to monitor progress in expanding health insurance coverage.

According to Wallace, all the principal interest groups have been involved in the state's reform process and agree on the basic goals of insurance reform, cost control, and increased access for health care, but they have not yet reached consensus on how to achieve them. "It's great just to have business and unions sitting down at the same table and agreeing on issues and goals," he said. The reform initiatives staked out by Governor Chiles and supported under the Foundation's grant should provide more experience and information for these diverse groups to consider as the health reform debate moves forward in Florida. ■



"FLORIDA WILL HELP LEAD THE WAY FOR OTHER STATES TO UNCOUPLE THESE TRADITIONAL PROGRAM TIES."

ROBERT SHARPE
FLORIDA

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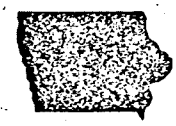
IOWA
Managed Competition Under Expenditure Caps

Iowa's health system reform efforts have been greatly assisted by the efforts of the Iowa Leadership Consortium (ILC), a public/private, nonpartisan, voluntarily-convened group, comprising a broad-based coalition of representatives of organizations, all of whom



"IT WILL TAKE EXTENSIVE TIME AND EFFORT TO MAKE SURE LEGISLATORS ARE EDUCATED ABOUT THE REFORM BECAUSE A PLAN OF THIS MAGNITUDE MAY NOT PASS IN ITS INITIAL INTRODUCTION."

DAVID FRIES, IOWA

agree that reform of Iowa's health care system is necessary. The ILC has been meeting since August 1990 under the direction of Blue Cross and Blue Shield of Iowa, and in April 1992 released its draft proposal calling for comprehensive health care reform and universal access to health care for all Iowans. Although the state has not yet reached consensus on the avenue of reform to be taken, there is general agreement that further development and analysis of the ILC proposal should be the starting point for cultivating a reform plan.

Key aspects of the ILC health care proposal include: 1) establishment of a public process for determining expenditure targets for health care providers and services; 2) reduction in bureaucratic oversight in the provision of services; 3) establishment of organized delivery systems, to provide comprehensive health care services to an enrolled population at a prepaid capitated rate; 4) creation of quality improvement mechanisms; 5) provision for balanced financial contributions by individuals and businesses to broaden the financial base of the health care system; and 6) establishment of an Iowa Health Commission to oversee health care reform, based on a mix of regulatory and competitive strategies to limit costs within the state.

The ILC, under the chairmanship of Robert D. Ray, chief executive officer of Blue Cross and Blue Shield of Iowa, and Paul von Ebers, senior vice president of health care management at Blue Cross and Blue Shield of Iowa, is now in the process of publicizing its plan in order to meet the next challenge in moving toward health care reform—building public support. According to von Ebers, "there is a schism between policymakers and the general public about health care reform, and the public needs to be educated about the impacts of reform." David Fries, deputy director of the Iowa Department of Health, notes that "the business community is concerned about the impact of a play-or-pay mandate on small businesses and about the concept of a regulatory body overseeing health care spending. In addition, providers are anxious to know the likely effects of organized delivery systems."

Under its *State Initiatives* grant, Iowa plans to analyze three major components of the ILC plan. The project team will study the potential impacts and feasibility of the establishment of health care expenditure targets, the formation of organized delivery systems, and the implementation of a play-or-pay employer mandate. These analyses will assist in defining the process for setting expenditure targets, designing the organized delivery systems (including the identification of incentives for provider involvement and services to be provided), and predicting the effects of a play-or-pay insurance mandate.

Armed with these data, the state will hold forums to seek public comments and educate the public about the effects of health care reform. Through these forums for consumers, providers, and the business community, Iowa hopes to build broad support for its reform initiatives. Moving the ILC plan forward is a "major undertaking," said von Ebers, but the grant will "provide a mechanism to move the process along." Once the analyses are completed, and the public supports the plan, the final challenge will be to convince the legislature to enact health care reform. Fries added that it will take "extensive time and effort to make sure legislators are educated about the reform...because a plan of this magnitude may not pass in its initial introduction. It is more likely to be adopted after further debate and research."

Although it is not clear what plan for health care reform will ultimately be presented to the legislature, it is hoped that the analyses of the components of the ILC plan and the process by which the state reaches consensus on health care reform will provide lessons for national health system reform. This grant gives Iowa an opportunity to test many options being considered for national reform and to identify those that are most appropriate for its political, economic, and demographic environment, as well as for similar areas throughout the country. ■

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MINNESOTA

State Plan for the Uninsured and Insurance Market Reform

Minnesota passed the HealthRight Act of 1992 last April after intensive debate on health reform. The law's primary goals are to provide expanded access to affordable health care for all Minnesotans and to reduce the rate

of growth in health care spending. It lays out an incremental, comprehensive approach to increasing access to care, starting with a state-run program, now known as Children's Health Plan Plus, to cover children and their parents and adding other uninsured through a phased-in enrollment process. The law also contains significant cost containment provisions and newly devised public processes for setting overall health care spending targets, monitoring providers, reviewing the distribution of new health care technologies, and evaluating methods for collecting health care data.

Children's Health Plan Plus will build on the state's successful Children's Health Plan by making a revised benefits package available to uninsured adults and children in families with incomes below 275 percent of poverty. Families will pay premiums of up to approximately $330 per month, according to an income-based sliding scale. Coverage will initially include primary and preventive care only, with inpatient hospital services beginning July 1993. State subsidies for the program will be financed through a combination of dedicated taxes to be phased in by 1994, including a two percent tax on the gross patient revenues of hospitals, plus taxes on cigarettes, prescription drugs, the gross revenues of health care professionals, and premiums collected by nonprofit health insurers.

A second major component of the state's health insurance plan targets the small-employer health insurance market. The legislation eliminates or restricts certain underwriting practices and authorizes the creation of a statewide reinsurance pool and a health insurance buying cooperative for small firms. Insurance carriers will be required to offer at least two plans to firms with 2 to 29 employees that would be exempt from state-mandated benefit requirements and would presumably be more affordable than currently available plans.

According to Project Director Mary Jo O'Brien, deputy commissioner of the Minnesota Department of Health, "cost containment was a driving force behind the legislation." The state "must find ways to spend more money on health care and less on irrational incentives," she said. Under its *State Initiatives* grant, Minnesota will seek to coordinate various state health care purchasing programs, develop a uniform claims processing and billing system, and consolidate data systems.

Framers of the HealthRight law also believe that both the public and private sectors should be involved in state health care reform. Project officials will staff and/or help establish several committees integral to the reform process. A key body is the 25-member Minnesota Health Care Commission, which will develop a plan for setting financial targets to reduce the rate of growth in health care spending by at least 10 percent a year for the next five years.

In addition to the Commission, the state is establishing four locally-controlled Regional Coordinating Boards to review major capital expenditures, monitor voluntary agreements between providers, and educate consumers, providers and purchasers of health care services. The state will also set up a Health Planning Advisory Committee, a Data Collection Advisory Committee, a Practice Parameters Advisory Committee, and a Rural Health Advisory Committee.

The overall goals of this public process, O'Brien explains, are to "rationalize and coordinate health services," and ensure that "dollars are spent on health care and not on competing with other providers."

During phase one of the grant, the Department of Health will begin developing plans for merging the state's health care programs and for bringing those programs not utilizing managed care into a managed care system. Additionally, the state will refine its cost containment strategies and begin access expansion.

Minnesota's initiative will test the capacity of public-private partnerships to achieve broad access and cost containment goals. A major question O'Brien said "is whether the state can foster effective partnerships and maintain an appropriate balance between competition and regulation." ■

"THE STATE MUST FIND WAYS TO SPEND MORE MONEY ON HEALTH CARE AND LESS ON IRRATIONAL INCENTIVES."

MARY JO O'BRIEN
MINNESOTA

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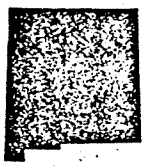
NEW MEXICO
State Cooperative Plan as Primary Payer

With New Mexico facing the highest rate of uninsurance in the country—28 percent overall, 38 percent for Hispanics, and 52 percent



BECAUSE THE COOPERATIVE WILL BE THE PRIMARY PAYER, IT WILL HAVE A DOMINANT POSITION IN THE MARKET, AND CONSEQUENTLY, WILL POSSESS MOST OF THE EFFICIENCIES THAT WOULD BE GENERATED BY A SINGLE-PAYER SYSTEM.

NEW MEXICO

for Native Americans—the New Mexico Health Policy Commission has proposed establishing an independent statewide Cooperative Health Care Plan to provide all necessary health care, directly or indirectly, to its members. The Commission is charged with creating health policy for the state and reports to both the executive and legislative branches, while remaining independent of each. Its eight members may have no "fiduciary or pecuniary interest in the health care industry," according to the statute which created the Commission in 1991.

Under the proposed plan, premiums for members will be collected by employers and paid to the Cooperative. Additionally, all current government payments for health care will be made through the Cooperative. Because the Cooperative will be the primary payer, it will have a dominant position in the market, and consequently, will possess most of the efficiencies that would be generated by a single-payer system, including lower administrative costs, control of medical technologies, and incentives for hospitals to operate within a global budget.

The project will formulate a package of comprehensive benefits that would provide all members with a standard of health care equal or superior to that currently offered to employees of the State of New Mexico. Each state resident will be required to become a member of the plan by paying a set membership fee in exchange for a guaranteed, comprehensive health services package. These membership fees, coupled with an increase in state revenues to pay for some services, would result in a community-rated premium below the actual cost of coverage provided. For those individuals who cannot afford to join the Cooperative, the state would pay that portion of the membership fee that exceeds seven percent of an individual's (or family's) federally-taxable income. Residents who are insured by a plan that offers services comparable to the Cooperative plan, would be exempt from the requirement to join.

According to Janet Rose, program director and executive director of the Commission, the goal of this proposal was to restructure the state's health care system and provide financial access to care, especially in rural areas. New Mexico's *State Initiatives* grant will permit the state to assess the feasibility of the plan, gather and analyze demographic and actuarial data, and develop the basic benefit package. In addition, the state hopes to calculate the Cooperative's budget and structure, determine membership fees, and seek waivers and agreements with other government payers.

Many challenges must be overcome prior to implementing the Cooperative, Rose noted. For example, some insurers currently offering coverage may not be able to offer a competing affordable benefit package; those whose role is likely to diminish if the Cooperative is implemented as envisioned may oppose it. In addition, neither the legislature nor the public has reached consensus on the best way to reform the health care system.

"The first step," Rose said, "is to figure out the cost and revenue projections for the Cooperative. We need to determine how to generate the revenue necessary to meet the health care needs of the state's population." The state is also exploring the current tax structure and during this process may identify other revenues that might be directed toward health care.

Rose believes that New Mexico's plan calls for a radically different health care system, providing universal coverage, mechanisms to include consumer participation, more effective allocation of resources, and health promotion and education. The project provides a unique opportunity to assess various aspects of a regulated national health care system on a smaller scale. ■

■ ■ ■

NEW YORK
Single Payer Authority, Insurance Reform, and Physician Reimbursement

New York plans to expand its Single Payer Demonstration statewide, reform the insurance industry, and develop a uniform system of physician reimbursement. The state believes these measures could greatly reduce health care costs and put in place systems to be used under any universal insurance program. The plan grew out of an existing demonstration program and a series of 12 town meetings on four different reform proposals developed by the New York State Assembly, the state hospital association, the state medical society, and a consumer coali-

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tion. To advance the broad public debate the Governor will create a Task Force on Health Care Financing Reform that includes these parties and other key stakeholders. This Task Force will oversee the project.

According to Ronald Rouse, acting director of the Division of Planning, Policy and Resource Development of the New York State Department of Health, who will oversee the project, "Our plan doesn't say what the system will look like, but lays a foundation for universal coverage. No matter what type of program is implemented, we think you need standardized billing and payment procedures, statewide community rating, and reimbursement reform for physicians," he explained.

Under its Single Payer Demonstration project, New York has developed an on-line electronic billing, claims processing and payment system to reduce health care administrative costs. After two-years of design and implementation work, supported by a previous grant from The Robert Wood Johnson Foundation, 28 hospitals are participating in the system that will be expanded to include all 260 hospitals, as well as physicians' offices, clinics, and pharmacies statewide. The system is designed to be the technical support for a single-payer governmental authority between third-party payers and providers that could pay providers directly for all services, bill the consumer and private insurers where appropriate, and even negotiate and set uniform reimbursement rates for providers. During the next two years, the project will analyze the impact of the electronic claims processing system on participating providers and design and test enhancements, such as automated coordination of benefits, electronic funds transfer, scheduled provider payment, a single card insurance system, and uniform data requirements.

An electronic claims clearinghouse to support the vast network of providers should make the billing and payment system more efficient and responsive, according to Raymond Sweeney, director of the Office of Health Systems Management and co-principal investigator for this grant. "All these reforms are technically complex...but obviously, we anticipate that this effort will result in a significant savings in overall administrative costs," he said.

In conjunction with the Department of Insurance, the insurance industry and other experts, the project staff will develop a program of insurance reform with the goal of creating affordable insurance products for all New Yorkers. The project staff hopes to remove barriers that currently prevent thousands of residents from participating in insurance plans. Analyses of the impacts of implementing statewide community rating, and eliminating medical underwriting and pre-existing condition clauses will also be conducted. Finally, the project will develop a uniform reimbursement methodology for physicians. By using innovative payment methods, this segment of the project will include increased emphasis on primary care, higher quality, greater efficiency, and the elimination of micro-management of physicians. According to the project's other co-principal investigator, Dan Beauchamp, Ph.D., of the State University of New York at Albany, "these physician payment reforms, coupled with New York's existing all-payer reimbursement methodology for hospitals, will move the system closer to a uniform statewide reimbursement system." ■

■ ■ ■

North Dakota
All-payer, Rate-setting System and Universal Health Coverage

North Dakota will use its grant to develop a proposal for an all-payer, rate-setting system and explore a variety of mechanisms for expanding health insurance coverage. The North Dakota Health Task Force, a 28-member state-chartered advisory body representing all the major constituencies concerned with health reform, developed the state's proposal. The project is a collaborative effort of the Task Force, the Department of Health and Consolidated Laboratories, and the University of North Dakota.

The Task Force believes that a prospective, all-payer, rate-setting system can be used to control costs and direct money toward improving access to services particularly in the rural sections of North Dakota. The initial step in this reform would be to establish the North Dakota Health Commission. This new commission would be responsible for administering the rate-setting system and develop-

"ALL THESE REFORMS ARE TECHNICALLY COMPLEX...BUT OBVIOUSLY, WE ANTICIPATE THAT THIS EFFORT WILL RESULT IN A SIGNIFICANT SAVINGS IN OVERALL ADMINISTRATIVE COSTS."

RAYMOND SWEENEY
NEW YORK

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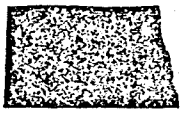

"WE ARE PURSUING NEGOTIATED RATE-SETTING USING A NEW STATE COMMISSION THAT IS A QUASI-PUBLIC MECHANISM."

ROBERT WENTZ, M.D.
NORTH DAKOTA

ing a global statewide health care budget comprising separate budgets for each area of the health care delivery system, including physicians, hospitals and nursing homes. The health commission would also set uniform rates for the reimbursement of the providers and monitor the system using a data system based on the claims filed for both inpatient and outpatient services. This uniformity would help eliminate cost shifting from the system. For this reform to include both Medicare and self-funded group health plans, the state would have to seek federal waivers.

The second major reform is to develop a mechanism to provide universal health insurance coverage for all residents of North Dakota. Under this reform, the state would develop an insurance product that provides basic benefits to its users and a publicly-sponsored insurance pool to subsidize coverage for uninsured employer groups and individuals not in the workforce. The state will assess the costs and impacts of different approaches, including a play-or-pay program or an employer mandate to require all employers to offer health coverage to their workers.

In describing the project's policy significance, State Health Officer and Project Director Robert Wentz, M.D., said "While what we are pursuing implies increased regulation of health providers, it would be negotiated rate-setting using a new state commission that is a quasi-public mechanism; this approach is less threatening than having government set rates alone."

One of the challenges facing project organizers is working within the time frame of a legislature that meets no more than 80 days every two years. The have to plan both their analytic tasks and public relations efforts to culminate in a widely-supported proposal ready for consideration by the legislature in January 1995. Still in the early stages of the reform process, the Task Force must first examine the state's basic choices for designing a rate-setting system and expanding health insurance coverage before developing a detailed implementation plan. The project staff will assist the task force in studying these options and in modeling the fiscal and economic impacts of specific proposals. Over the next two years, town meetings will also be held across the state to educate citizens about the proposed health reforms and solicit feedback for the Task Force's consideration. In a show of bipartisan support, the North Dakota Interim Health Care Committee passed a draft bill in August, requiring the Task Force to report its findings and proposals regarding the two reforms by July 1994. ■

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OKLAHOMA
Individual Health Accounts

Oklahoma is developing a financial reform that would increase statewide access to insurance coverage for basic health services. The state's approach is based on the assumption that given a choice of health plans, consumers can shop around and make good decisions. Typically, according to Garth Splinter, M.D., the project director, "an individual will choose to purchase a low cost plan, often a managed care product." In order to match the controls needed in a health care system with existing personal financing incentives, Oklahoma is proposing to establish Individual and Family Health Accounts which would be tax-deferred like Individual Retirement Accounts, plus structured to more closely resemble Section 125 flexible spending accounts.

All current sources of health care funding, including employer and employee contributions, would be deposited into a state fund and tracked individually through Individual and Family Health Accounts. Balances could accumulate from year-to-year, and there would be incentives for individuals to conserve account funds. The funds would be used by account holders to purchase their own family or individual health insurance policies in a competitive marketplace with tax-exempt dollars. Under this plan, the accounts would be portable, permitting individuals to change jobs without changing insurance plans. In cases where employers were contributing to the accounts, the source of funding would change. Splinter believes that "this approach to restructuring the provision of health insurance could virtually eliminate group health insurance and lead to health insurance industry consolidation."

As currently envisioned these accounts could also be used for other authorized health expenditures which are not covered by insurance. Leigh Brown, program director, says,

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"we believe that consumers who are involved in the selection and purchase of their own insurance and who are not insulated from the costs of health care are less likely to obtain coverage for unnecessary services." The state hopes to be able to use the interest which accrues on the funds to help increase access to health care for the uninsured and small businesses.

Oklahoma has developed a unique approach to health care reform. The *State Initiatives* grant will permit Oklahoma to explore legal issues (including obtaining necessary changes in the Internal Revenue Tax Code), design a basic benefit package, and begin educating the public regarding health system reform. In addition, the state needs to identify new sources of revenue, and will consider the impact of various revenue enhancements including "sin" taxes.

Oklahoma hopes to demonstrate that developing an atmosphere in which consumers can make informed choices about their health care will result in reduced costs and more appropriate utilization. Analysis of the impact of various components of Oklahoma's reform initiative should help to shed light on the likely impacts of various reforms in a competitive market. ■

■ ■ ■

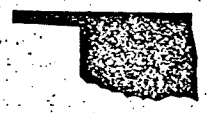
OREGON
Play-or-pay Employer Mandate

Over the past three legislative sessions, Oregon has established a framework for health care financing reform with the passage of major legislation, including Medicaid expansion, incentives and mandates for employment-based insurance coverage, insurance market reform, and health coverage for persons currently considered uninsurable. To make these legislative initiatives a reality, the state has embarked on the following new programs: a proposed Medicaid demonstration project; a self-funding high-risk pool for those otherwise unable to obtain coverage due to pre-existing medical conditions, already implemented and operating; and a play-or-pay program scheduled to go into effect in 1995, if voluntary enrollment goals are not met. Developing a detailed implementation plan for the latter program—the play-or-pay mandate on employers—is the primary focus of Oregon's State Initiatives grant project.

As originally proposed in its 1989 law creating the Oregon Health Plan, the state would design a single basic benefits package that would be made available to an expanded pool of Medicaid beneficiaries, as well as to formerly uninsured small businesses. Oregon is still seeking federal approval, however, of its prioritized list of Medicaid benefits and expanded eligibility standards, which would allow the state to offer standard coverage to all persons under 100 percent of poverty. In August 1992, the Department of Health and Human Services rejected Oregon's waiver application, but the state is working toward reapplication. Chadran Cheriel, Ph.D., director of Oregon's Office of Health Policy, explained that "rejection of the waiver application should not interfere with development of other components of the plan, because the legislature can pass a bill to uncouple the priority list from the play-or-pay program."

Since 1989 the state has provided tax credits to noninsuring small businesses that begin to offer an approved health benefit plan to their workers and their dependents. By July 1995, if fewer than 150,000 persons become enrolled through this voluntary effort, the state will implement a play-or-pay program requiring all employers either to offer coverage or to contribute to a State Insurance Pool Fund, which would provide subsidized coverage to uninsured workers and their families. With fewer than 15,500 new lives covered to date, implementation of the mandatory system seems inevitable.

To make the play-or-pay program successful, the project must address several specific issues. First, it must assess the potential economic impact of health insurance mandates on business and the work force. According to Robert DiPrete, project director, "we don't want to drive out businesses...but we must identify firms or types of firms more likely to be harmed and develop ways to help them," such as providing hardship subsidies or allowing them more time to comply with the mandate. Second, the project must develop an administrative structure for implementing the program. On the "play" side, the state must figure out how to monitor compliance by employer groups and how to ensure fair and equitable treatment. On the "pay" side, it must determine where to set the payment



"THIS APPROACH TO RESTRUCTURING THE PROVISION OF HEALTH INSURANCE COULD VIRTUALLY ELIMINATE GROUP HEALTH INSURANCE AND LEAD TO HEALTH INSURANCE INDUSTRY CONSOLIDATION."

GARTH SPLINTER
OKLAHOMA

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"REJECTION OF THE WAIVER APPLICATION SHOULD NOT INTERFERE WITH DEVELOPMENT OF OTHER COMPONENTS OF THE PLAN, BECAUSE THE LEGISLATURE CAN PASS A BILL TO UNCOUPLE THE PRIORITY LIST FROM THE PLAY-OR-PAY PROGRAM."

CHADRAN CHERIEL, PH.D., OREGON

level so that employers already providing coverage will be encouraged to continue doing so; how to collect the payments; and how to allocate subsidies. Third, the project must address many other policy and technical questions, such as how to keep employers from converting employees from full-time to part-time status; what to do about dual coverage; and how to avoid adverse selection through the funneling of people with higher than average health care needs into the state high-risk pool.

Five task forces will assist the project staff in the areas of economics, demographics, health care financing, insurance, and governance of the health care system. Their members represent the sectors most likely to be affected by the play-or-pay program. The task forces afford citizens an opportunity to participate in the state's decision-making process.

The state continues to pursue other components of its reform strategy that compliment its work on the play-or-pay program. It seeks to expand and refine the high-risk pool for persons who cannot get group coverage due to pre-existing medical conditions; currently, around 3,000 persons are enrolled. A state-initiated Small Business Advisory Committee is examining community rating and other issues. To control costs and improve efficiency in the delivery system, the state's Health Resources Commission is studying ways to eliminate duplication and waste and is developing approaches for promoting the use of managed care organizations through the state's various initiatives to expand insurance coverage. The Department of Insurance is also investigating ways to coordinate worker's compensation insurance with other health benefits to provide 24-hour coverage. ■

■ ■ ■

VERMONT
Universal System with Global Budgets

Governor Howard Dean, M.D.—the only state chief executive who is also a physician—signed a comprehensive health care reform bill in May 1992, emphasizing three major themes: universal access to care, global budgeting for all health expenditures, and an overall statewide plan for the allocation of health care resources. With the bill's passage, the focal point for reform efforts has shifted from the legislature to a new state agency, the Vermont Health Care Authority (the Authority), which takes advantage of organizational structures and significant expertise already present in the state. It combines the staffs and resources of the state's health planning agency, its hospital budget and health data organization, and its certificate of need (CON) program into a single, coordinated agency responsible for overseeing the reforms and shaping a more integrated health care system. According to Richard Brandenburg, Ph.D., chairman of the Authority, "We are building on efforts that have preceded us, and are seeking the advice and participation of all stakeholder groups in the work of the Authority."

The Authority is required to design and evaluate two alternative systems for financing universal coverage in Vermont: a single-payer plan based on a tax-financed system with centralized claims processing like that in Canada, and a regulated multi-payer plan, which would require all insurers to offer a uniform, basic benefits package. Each model must ensure cost containment through global budgeting, binding hospital budget reviews, the CON program, and compliance with the state's plan for the distribution of health care resources. The Authority has until November 1993 to report to the legislature and governor its assessment of each strategy for achieving universal financial access to health care services.

A second major task is to develop a global budgeting process as a framework for controlling health care costs and redirecting health care resources. The global budget is intended to capture the total amount of money spent for all health care services statewide and will be used to guide hospital budget reviews, the state's CON program, and other regulatory processes where authorized. The project must define specific sectors of the health care system for identification in the budget, as well as parameters for measuring health spending growth. The legislation calls for setting non-binding expenditure targets by July 1993 and a unified health care budget by July 1994.

The project will build on the state's existing capacities to develop a unified health care data base and prepare a health resource management plan. The data base will incorporate data on health care expenditures and the utilization of services. It will be designed to help

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the Authority determine the capacity and distribution of resources, identify unmet needs, compare costs, and provide information to consumers and purchasers. The health resource management plan will assess the adequacy of the state's supply and distribution of health resources and be linked to the review of hospital budgets and CON applications.

The state will create a health insurance purchasing pool designed to enhance the purchasing power of participating groups. Participants may include employees and dependents covered by the state government, state colleges, the University of Vermont, municipalities, school districts, and portions of the Medicaid case load. In the future, the pool may be made available to other groups, including employers, associations, and trusts.

Project resources also will be used to develop standards and procedures for cost management plans that health insurers will be required to submit to the state. Insurers must spell out their plans for using "integrated systems for health care delivery" that provide a continuum of health services, primary care case management, continuous quality improvement procedures, financing mechanisms that encourage quality, efficiency and the appropriate use of health services.

To reduce health insurance administrative costs, the Commissioner of Banking, Insurance and Securities will develop a uniform medical claims form to be used statewide. The Authority will also develop uniform utilization review procedures for payers to monitor the use of health services.

The Authority will also make recommendations for including long-term care services in its universal access plans. It can recommend an alternative funding mechanism for long-term care, but must project costs of the existing system over the next 20 years.

Commenting on Vermont's overall strategy for health reform, Paul Wallace-Brodeur, a senior staffer at the Health Care Authority, explained, "If the goal is to expand access, you have to have aggressive, systems-wide control of health care costs. You can't control expenditures by looking at the pieces; you have to have an overall perspective, i.e., unified budgeting." ■

WASHINGTON
Multiple Competing Health Plans and a State-operated Subsidized Plan

Major stakeholders in Washington State's health care debate agree on numerous basic tenets for reform, but still disagree on several key policy issues. They agree on the need for a private-based, managed care delivery system and for insurance market reforms; but they are still wrestling with fundamental questions, such as whether employers would continue to sponsor and manage health benefits for their employees, or whether a single organization should sponsor benefits for all state residents. Washington has been an innovator in such areas as expanding coverage for the uninsured, coordinating state health care purchasing functions, and using managed care. Comprehensive reform efforts have stalled, however, due to the complexity of the proposed strategies and the inability of the legislature in 1992 to reach an agreement on a single health reform approach. In an effort to break this deadlock, Washington will use its grant award to enhance the state's current capabilities for impact analysis, managed health care plan evaluation, and interagency planning for the transition to reform, so that health policy makers are better able to make decisions about specific proposals, suggest necessary changes, and prepare to implement the reforms.

Washington plans to carry out analyses and planning in three areas. First, the state will develop computer models to assess the impacts of reform options and to project changes over time. These models will be used to forecast the impacts of reform on businesses (by size and industry), employment patterns, and families. A plan also will be developed to track changes over time in the cost of health care, state expenditures and revenues, business expenditures, and access to health care. To more accurately assess actual conditions within the state, these analytic and tracking efforts will use Washington-specific data, where available.

Because any reform effort in Washington is likely to rely on managed care plans as the basic mechanism for organizing and delivering health services, the state wants to develop a strategy for monitoring the efficacy of these plans. Some common measures for evaluating organized systems of care have already been

"YOU CAN'T CONTROL EXPENDITURES BY LOOKING AT THE PIECES; YOU HAVE TO HAVE AN OVERALL PERSPECTIVE, I.E. UNIFIED BUDGETING."

PAUL WALLACE-BRODEUR, VERMONT

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"WE HAVE ALREADY ADDRESSED BASIC CONCEPTS. THE RWJ GRANT ENTERS AT A TIME WHEN WE'RE READY TO ENACT SOME REFORMS; WE ARE READY FOR PRAGMATIC CHANGE."

DAN RUBIN
WASHINGTON

developed, including measures of access, the quality of service delivered, and the cost and efficiency of care. The next goal is to design a systematic approach that consumers, employers, and the legislature can use to monitor plan performance and make contracting decisions.

In addition, Washington will plan for the coordination, consolidation and evolution of existing state health programs as reforms are phased in. This advance planning is necessary immediately to show legislators and political stakeholders how a new health care system would work, and longer term, as a step toward implementation of reforms. The first topics addressed will include waiver requirements and strategies, the impact of health insurance reform on state programs, and requirements for stimulating a truly statewide network of managed care plans. Project staff will also identify ways to integrate various state-funded health care coverage programs focusing on eligibility levels and processes, benefits, and efficient administrative procedures. The project's transition planning priorities will be reexamined regularly to make sure they are of maximum value in speeding reform.

The project has been organized through Governor Booth Gardner's four-year-old Health Policy Group, consisting of the directors of Washington's principal health-related agencies or their chief deputies for health. Robert Crittenden M.D., Gardner's special assistant for health who chairs the Health Policy Group, observed, "We're on the verge of a consolidation point. There has been a lot of incremental change and it is nearing the threshold of a major breakthrough."

Project Director Dan Rubin, formerly chief of the Department of Health's Office of Health Policy Support, noted that the project will build on the work of the state's high-level health care commission created by the governor and the legislature three years ago, which will report its final recommendations for universal coverage and cost control reforms by December 1, 1992. "Through the commission, we have already addressed basic concepts. The RWJ grant enters at a time when we're ready to enact some reforms; we are ready for pragmatic change," he concluded. ■

STATE INITIATIVES

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STATE INITIATIVES IN HEALTH CARE REFORM

Leaders of State Health Care Reform Efforts Meet

Does ERISA Prevent States from Implementing Comprehensive Health Care Reform?

Virtually all comprehensive health care reform strategies now under consideration by the states face legal challenge under the federal Employee Retirement Income Security Act of 1974 (ERISA). Unless Congress is willing to amend the law, most states will be blocked from implementing their plans to expand health insurance coverage for the uninsured through major changes in their health care financing systems. Some reform measures may require states to apply for and receive waivers from Medicare or Medicaid requirements before being put into effect, but states have no such recourse for broad-based proposals that run up against ERISA's preemption authority since there is no statutory provision for exemptions or waivers.

That was the message from ERISA experts to representatives of the *State Initiatives* project staffs attending The Robert Wood Johnson Foundation's State Initiatives in Health Care Financing Reform Workshop, held in Washington, D.C., last October. "There is no loophole" in ERISA, concluded David Abernethy, staff, House Ways and Means Committee, Subcommittee on Health, and moderator of a panel discussion on the need for regulatory and legislative flexibility. If states, including the twelve Foundation grantees, are to proceed with their reform efforts, clearly new federal legislation is needed to relieve them of ERISA's strictures, he said.

ERISA's Preemption Authority Detailed

Panel member Phyllis Borzi, counsel for employee benefits, House Education and Labor Committee, Subcommittee on Labor Management Relations, described how ERISA constrains states from implementing major health care reforms. ERISA covers all employee welfare benefit plans, including health plans, that are "established or maintained by employers," she said. "To the extent that there is an employer involved in the provision of health benefits to employees," that plan is regulated by ERISA, Borzi explained.

Under ERISA, states have the authority to regulate the contracts, financial conditions, and other activities of insurance companies; but they are prohibited from regulating employers' benefit plans. Because states have authority to regulate and tax insurance carriers, they can control premium rates and mandate benefits in employee plans purchased from an insurer. States have virtually no authority when employers provide coverage through self-insured plans. ERISA also preempts states from mandating employers to provide health insurance or specific health benefits. In addition, the state cannot tax employers' benefit plans. According to the National Governors' Association's "Flexibility and Waiver Authority for Health Care Reform: A Primer for States," about 60 percent of employees work for employers with self-insured benefit plans that are not subject to state insurance regulations.

Many of the strategies states have proposed, to date, to finance expanded coverage to their growing uninsured populations will be challenged. New Jersey has already faced such a challenge with respect to its surcharge on hospital patient bills to finance care for the uninsured and its inclusion of an additional surcharge to finance uncompensated care through its hospital rate-setting methodology.

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9/30/93
Jt. Meeting of Senate and House Public Health and Welfare

ERISA and State Reform

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Both of these provisions were overturned in court on the basis of the ERISA preemption clause. In addition, an important part of New York's hospital billing system was recently struck down. The court found that tacking surcharges onto the hospital bills of commercial insurers and HMOs violated ERISA, since they unfairly increased insurance costs for the benefit funds and diverted resources to "a state specified use which is unrelated to the health care of plan participants." Originally intended to protect workers and retirees, ERISA is now being used "to protect employers, insurance companies, third-party administrators" and "to insulate them from consumers, from regulators on the state level and from accountability," Borzi said.

"ERISA stands...as a barrier to virtually every single proposal that you or others are considering," Borzi told the meeting attendees, "because the test that the court uses is whether or not the state rule or regulation imposes a burden on the employer in connection with a plan." A play-or-pay system, a single-payer program, even a plan where the employer does not contribute anything to employee premiums but collects premium payments through the payroll—all can be challenged under ERISA because of their financial and administrative impact on self-insured employers subject to ERISA's requirements. The only way to get around ERISA, Borzi suggested, would be to collect payments through income or corporate taxes, "where there is no employer-employee relationship," she explained. States have also faced an ERISA preemption problem in trying to fund uncompensated care pools through hospital rate-setting mechanisms or provider taxes. One of the grounds used in such cases is ERISA's rule that "plan assets be used for the exclusive benefit of participants and beneficiaries," Borzi said.

THE LEAHY-PRYOR BILL WOULD HAVE PERMITTED LIMITED WAIVERS FROM ERISA PREEMPTIONS FOR CERTAIN STATE INITIATIVES.

Past Efforts to Amend ERISA Failed

Several attempts have been made in Congress to give states more flexibility under ERISA, as well as under Medicare and Medicaid. One proposal, sponsored by Sen. Patrick Leahy (D-Vermont) and Sen. David Pryor (D-Arkansas), grew out of a 1991 policy statement on national health care reform developed by NGA. According to Alicia Smith-Pelrine, NGA's director for human resources at the time of the workshop, the Leahy-Pryor bill would have permitted limited waivers from ERISA preemptions for certain state initiatives, including all-payer systems, play-or-pay systems, reinsurance or cross-subsidization pools, or single claims forms and electronic billing. But to be eligible for a waiver, a state's program would have had to meet three strict conditions: 1) provide coverage to at least 95 percent of the population or, for states "really far behind," increase coverage by 10 percent; 2) implement cost controls; and 3) provide for federal budget neutrality, she said.

"The business community went crazy" over the proposal, fearing that "if that floodgate was opened or if that crack was made in the wall," businesses would be subjected to a host of state mandated benefits, especially mental health and substance abuse benefits, Smith-Pelrine told the workshop participants. The bill's sponsors offered to omit the ERISA preemption provisions, but NGA protested that "without the ERISA provisions, we haven't got anything." In the end the bill was dropped; it was just "too controversial for Congress to handle," she said.

Sen. David Durenberger (R-Minnesota) and Sen. Bill Bradley (D-New Jersey) also introduced legislation addressing the ERISA

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problem, but rather than getting involved with state-mandated benefits, the bill focused on the problem as "an equitable financing issue," Susan Foote, health legislative assistant in Durenberger's office, said at the workshop. The Durenberger-Bradley bill would have allowed states providing universal access to care to apply to the Department of Labor for permission to tax private and self-insured insurance plans. In addition, it would have provided a vehicle for states to impose a tax or surcharge on private or self-insured plans to help finance state risk pools for the medically uninsurable, as well as a vehicle for implementing a broad-based provider tax. Currently, small businesses without the resources to self-insure, and therefore subject to state insurance regulation, shoulder a disproportionate burden of financing health care for the uninsured. The Durenberger-Bradley proposal, however, met the same opposition and ultimately suffered the same fate as the Leahy-Pryor bill.

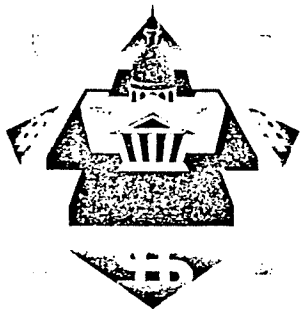
Prospects for Future Legislation are Improved

Foote and other panel members saw the prospects for Congressional action on ERISA to be much improved in the coming year. "My sense is if the states continue to act and continue to come up with plans, they are going to have a force in Congress that will possibly override some of these interest groups," Foote said. In addition, Durenberger is working on the more fundamental issue of how the federal government should relate to the states, Foote said. There can be no progress on health care reform if the states continue to be pitted against the federal government, she explained. Unless the federal bureaucracy is revitalized to allow "input by states and the private sector" and to give states some flexibility, "all those programs [including 'managed competition'] that look so good on paper are going to die because they will be HCFA-ized to death. The role of the states is absolutely essential. Your voice should be heard," she concluded.

Borzi's outlook, on the other hand, was far less optimistic. "The likelihood is real slim" that Congress will grant ERISA waivers for "states to go off and do their own thing," even if they meet the conditions proposed in the Leahy-Pryor bill, she predicted. "Congress is more likely to say [to states], 'Show us what you have done. Point out to us where your ERISA problems are, and then let's talk.' " Then, "Congress can look at what has been done and determine whether or not it is worth giving discrete exceptions," she said. Borzi acknowledged, however, that it would be difficult for states "to expend time, money and political capital" to do something that may or may not be ultimately acceptable under ERISA. "Better understanding of the states' need for flexibility is one of the purposes of the Foundation's State Initiatives program," Alpha Center president David Helms said at the end of this panel session. We want the projects to document their need for flexibility in order to implement their proposed reforms, he told the project representatives. "We either get that flexibility provided legislatively, or we will be able to the say to the federal government that we tried to help with the problems that the American people clearly want us to help them with, and you prevented us from taking action," he concluded. ■

> "WE EITHER GET THAT FLEXIBILITY PROVIDED LEGISLATIVELY, OR WE...SAY TO THE FEDERAL GOVERNMENT... YOU PREVENTED US FROM TAKING ACTION."
>
> W. DAVID HELMS
> ALPHA CENTER

Each newsletter features reports on activities in selected states.



MINNESOTA

Health Care Commission Submits Cost Containment Plan

In January, the Minnesota Health Care Commission submitted its health care cost containment plan to the Minnesota legislature and Governor Arne Carlson. The plan lays out a basic strategy and a series of first steps for achieving the state's goal of reducing the growth in overall health care spending by ten percent a year over the next five years. Major elements of the plan include incentives for developing integrated service networks (ISNs), global limits on the growth in public and private health care spending, managed competition between ISNs, reformed payment systems, health insurance pooling mechanisms, an extensive health care data system, and a method for assessing technology.

THE COMMISSION'S PLAN INCLUDES INCENTIVES FOR DEVELOPING INTEGRATED SERVICE NETWORKS (ISNs), AND GLOBAL LIMITS ON THE GROWTH IN HEALTH CARE SPENDING.

MINNESOTA

ISNs, organizations that would be accountable for managing the costs and outcomes associated with delivering a full continuum of health care services to a defined population, would be similar to a health maintenance organization (HMO), but have greater flexibility in terms of the types of providers, the coverage offered, and the other entities participating in such a network. To further promote these new networks, the State of Minnesota intends to move toward purchasing coverage from ISNs for persons enrolled in state-sponsored programs, such as Medicaid and the state public employees group.

Under the proposed plan, the Commissioner of Health will set and enforce annual targets for limiting the rate of growth in health care spending by setting an overall limit on each ISN and implementing an all-payer reimbursement system for non-ISN services. The ISN limits would be adjusted to reflect enrollment, case-mix severity, and benefit design, but each network would be responsible for managing its own overall costs. Non-ISN systems would be subject to greater regulatory controls to contain costs. An all-payer payment system would be developed for services not covered by an ISN to control both prices and utilization. These ISN and non-ISN systems would be designed to complement one another and to prevent adverse risk selection.

In addition, the state's Health Planning Advisory Committee will evaluate selected technologies for safety, efficacy, health outcomes, and cost effectiveness. ISNs would bear the risk if they do not make appropriate cost-effective decisions about technology, but regulatory controls might be necessary to control the diffusion and use of technology in the regulated system for non-ISN services.

It is also anticipated that comprehensive, coordinated health care data systems will be established to collect, analyze and disseminate data on quality, price, revenues and expenditures. The data will be used to set annual growth limits, provide information to consumers, and evaluate and improve the quality of health care throughout the state.

Many details of the cost containment plan still need to be developed. It is anticipated, however, that by May, the necessary implementation legislation will be passed. If the plan gets implemented as envisioned, the Commission estimates that Minnesotans will spend about $150 to $200 million less on health care than anticipated in 1994 and will have saved a cumulative total of about $6.9 billion at the end of five years. ■

■ ■ ■

NEW YORK

Electronic Claims Clearinghouse

In December, Foundation and Alpha Center staff conducted a site visit to the New York Department of Health in Albany to review the current status of the electronic claims clearinghouse demonstration whose development was supported by the Foundation's Changes in Health Care Financing and Organization (HCFO) Initiative and is now part of New York's *State Initiatives* project. In addition,

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the site visit team heard a report of the first meeting of the state's Task Force on Health Care Finance Reform, where the statewide expansion of the demonstration, as well as the other components of the state's reform initiative—uniform reimbursement for physicians and health insurance reform—were discussed.

Currently, twenty-seven hospitals from northeastern New York State, New York City, and Long Island have signed memoranda of understanding to participate in the electronic claims clearinghouse demonstration. These hospitals have agreed to implement systems for the electronic transmission of inpatient and outpatient claims to all major payers. They have also agreed to participate in pre- and post- system performance evaluations. At the time of the site visit, electronic claims processing had been implemented in twenty-two of the hospitals. Electronic eligibility verification has also been implemented in several of these hospitals, and the state anticipates that it will be implemented in all of the participating hospitals by spring.

The electronic claims clearinghouse will be operating for clinics, as well as hospitals, within the next several months, following requests by the clinics that they be able to participate. As an important source of primary care, clinics currently carry a high administrative burden and are anxious to realize the anticipated administrative savings through participation in the demonstration. The state has also identified some physician groups that are interested in participating in the demonstration and is currently working with both the medical society and individual physicians to address their concerns about the use and confidentiality of the data which would be collected through the electronic claims clearinghouse.

According to the state, the electronic claims clearinghouse has resulted in three major outcomes: 1) increased administrative efficiency; 2) an electronic network of providers and payers; and 3) a comprehensive database with the potential for use in resource allocation. Hospitals have experienced administrative savings through reduced staffing, elimination of outside billing contractors, and reductions in accounts receivable due to better eligibility verification and bill collection. A hospital administrator who participated in the site visit confirmed that the hospitals are pleased with the improved efficiencies of the electronic claims clearinghouse. The state anticipates that physician savings will result from fewer lost bills, more timely payments due to fewer errors in claims filing, and improved accounts receivable.

The state's goal is to develop and institute a completely electronic claims filing and remittance system. To that end, several technological improvements to the clearinghouse are currently being developed, including tracking claims which are not paid, automating the coordination of benefits, instituting electronic funds transfers, and standardizing claim forms and payer requirements. In the future, the state hopes to expand the electronic claims clearinghouse to all hospitals, clinics, physicians, and payers throughout the state. ■

ELECTRONIC CLAIMS PROCESSING HAS BEEN IMPLEMENTED IN TWENTY-TWO HOSPITALS.

NEW YORK

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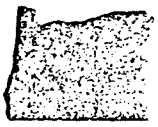
OREGON

Progress Toward Implementing a Medicaid Demonstration Program and Mandated Play-or-Pay

A key component of Oregon's strategy for health care reform includes a fundamental change in the state's Medicaid program which would expand eligibility to 120,000 currently uninsured Oregonians with incomes less than 100% of the federal poverty level. All Medicaid enrollees would receive a basic benefit package, which was derived from a prioritized list of services based on medical outcomes data, social values and relative cost factors. To expand Medicaid eligibility and contain program costs, certain procedures previously reimbursed by Medicaid would no longer be covered. However, some services not currently covered by Medicaid would be added, such as preventive care and dental care for adults and hospice care for all Medicaid enrollees. Of the 709 conditions/treatments on the state's original priority list, 587 were to be included in the basic benefit package. To implement the program, Oregon submitted a Medicaid waiver application to the Health



OREGON MAY SEEK TO "DECOUPLE" THE MEDICAID PRIORITY-SETTING PROCESS FROM IMPLEMENTATION OF ITS PLAY-OR-PAY STRATEGY.

OREGON

Care Financing Administration (HCFA) in August 1991. In August 1992, HCFA notified Oregon that its application for Medicaid waivers was not approved, arguing that the state's process for developing the Medicaid basic benefit package appeared to violate the rights of the disabled as they appear in the American Disabilities Act. HCFA invited the state to address its concerns and resubmit a revised application.

Oregon revised and resubmitted the waiver application in November 1992. Oregon dropped input from the public opinion survey from its ranking process. Several controversial items were merged into broader line items. For example, the "old list" distinguished liver transplants for alcohol-caused cirrhosis from other liver transplants; the "new list" has combined these two line items. The new list contains 688 line items, of which 568 are proposed for funding under the demonstration. The state did not receive approval from HCFA during the final two months of the Bush administration, and project director Robert DiPrete reports that Oregon hopes for a prompt response on its revised application from the new Clinton administration.

The Medicaid basic benefit plan awaiting HCFA approval is also integral to Oregon's mandated employer play-or-pay program, the second critical piece of the state's overall reform package. Under current legislation, the benefit plan proposed in the Medicaid waiver application would also serve as the minimum benefit plan in the employer-based system. If the state does not receive approval of its Medicaid waiver request, it may seek legislative authorization to "decouple" the Medicaid priority setting process from the implementation of their employer based play-or-pay strategy and develop an alternative approach for assuring access to care for Oregonians below federal poverty level. ■

■ ■ ■

VERMONT

Health Care Authority Begins Work on Calculating Expenditure Targets

The Vermont Health Care Authority was created last April to develop specifications for two systems of universal health care coverage —a single payer system and a regulated multi-payer system. The three-person Authority commissioned by Governor Howard Dean has begun its work and will report to the legislature in November, 1993. Both models would feature health care expenditure targets to contain costs and the development of organized delivery systems to promote efficient delivery of care.

The Health Care Authority is currently grappling with significant design issues related to the implementation of expenditure targets. Using the national health expenditure matrix developed by the federal Health Care Financing Administration as a starting point, the Authority is trying to enhance it for use at the state level. The state's need for comprehensive data on health care expenditures has led the Authority to utilize a number of data sources within the state as well as to adjust national level data to reflect Vermont's particular circumstances. In addition, the Authority is considering how data collected and maintained by providers and insurer groups can be incorporated into expenditure target calculations.

As a step towards the creation of organized delivery systems, the Health Care Authority now requires all insurers in Vermont to submit cost insurer management plans for the state's review. The objective of the management plans is to improve efficiency in the delivery of health care services. Insurers are expected to develop proposals for integrating their health care delivery systems and/or to develop innovative cost management strategies. These strategies might include alternative approaches to claims processing, benefit design and delivery, payment for services, utilization review, quality assurance, data collection and/or coordination of benefits. The insurer cost management plans will be reviewed by the Health Care Authority with the objective of working together with insurers to develop more comprehensive systems of primary health care throughout Vermont.

Finally, project staff in Vermont have been working closely with project staff working on Colorado's *State Initiatives* project to identify

the similarities in both states' approaches toward reform. These discussions have expanded Vermont's definition of a regulated multi-payer system beyond what was originally envisaged. The Health Care Authority will expand its analysis of a multi-payer system to include the proposal under consideration in Colorado, i.e. a scenario in which a single state agency would collect and distribute all health care dollars in Vermont. Health care coverage would be provided through a limited number of competing networks of providers and insurers. ■

■ ■ ■

WASHINGTON

State Health Care Commission Recommends Comprehensive Reform

After two years of deliberation and study, the Washington State Health Care Commission concluded that fundamental reform of the health system is needed to ensure universal access and to control costs. The Commission submitted its final report, detailing seventy-six recommendations for comprehensive health reform, to out-going Governor Booth Gardner on November 30, 1992. It is expected that these recommendations will guide the debate over health reform now that Washington's new Governor, Mike Lowry, has taken office and the state legislature has reconvened.

The Commission recommended that all Washington residents should have access to a "uniform set of health services," including: (1) a comprehensive and affordable "uniform benefits package" of personal health services delivered by competing certified health plans; (2) a variety of services provided through the public health system; and (3) health system support, such as clinical research and continuing education for health personnel. It also endorsed the concept that a reformed health system should encourage the development of "managed health care systems"—integrated networks of providers who agree to abide by the system's practices, reimbursement levels and other requirements. These systems (called "certified health plans") would integrate preventive and primary care, specialty medical care, long-term care, mental health services, and dental services. In addition, the Commission recommended that individuals, employers and governments must all share equitably in financing a reformed health system. It proposed that individuals should pay at least five percent of the premium charged for the uniform benefits package and a reasonable share of point-of-service costs. Businesses should pay 50 to 95 percent of the premiums for their employees, as well as a portion of the costs for dependents. Government should pay the full premium (or the individual's share, if employed) for people below 100 percent of the federal poverty level, and subsidize the cost of coverage for others with low incomes.

The Commission was almost equally divided over the issue of whether employers should continue to sponsor (fund and offer choice of health plans) health benefits for their employees (a multiple-sponsor system), or whether a single organization should sponsor benefits for all state residents (a single-sponsor system). The Commission recommended a single state sponsor for all state residents or, if the legislature rejects this option, a multiple-sponsor, play-or-pay system with immediate efforts to obtain necessary changes in ERISA. Under a multiple-sponsor, play-or-pay system, the sponsors, comprising large employers or large consortia of small employers or individuals, would be required to meet certain criteria related to size and other factors. This employer-based system would also include a state sponsor which would provide coverage to the self-employed, the unemployed, employer groups choosing to join, and those being subsidized. Such a state sponsor might also integrate programs such as Medicare, Medicaid and workers compensation. If necessary ERISA changes were not obtained by a certain date, the Commission recommended that the state implement a single-sponsor system.

A major objective of Washington's *State Initiatives* project is to improve the state's capacity to model the impacts of various health reform proposals. To that end, state staff assisted the Commission by projecting the economic impact of its recommendations on business, government and individuals. The report estimates that if the Commission's comprehensive recommendations for health-system reform are implemented, per capita spending growth would be reduced from the

VERMONT'S HEALTH CARE AUTHORITY IS CURRENTLY GRAPPLING WITH SIGNIFICANT DESIGN ISSUES RELATED TO THE IMPLEMENTATION OF EXPENDITURE TARGETS.

VERMONT

THE COMMISSION RECOMMENDED THAT INDIVIDUALS, EMPLOYERS AND GOVERNMENTS MUST ALL SHARE EQUITABLY IN FINANCING A REFORMED HEALTH SYSTEM.

WASHINGTON

RWJF Contracts for Multi-State Family and Employer Surveys

The Robert Wood Johnson Foundation has contracted with Westat, Inc. to conduct an employer survey in all twelve grantee states and with Mathematica Policy Research, Inc. to conduct a family survey in at least nine of the grantee states. This major effort to collect state-specific data is necessary since readily available national data are not representative when broken down by state. The data collected through these surveys will permit grantee states to model the effects of their proposed reform initiatives on employers and individuals. In addition, pre-implementation baseline data on the characteristics of employers and families may prove useful in later evaluations of the *State Initiatives* projects, as well as to other states who might be considering similar reform initiatives.

Westat is currently in the process of pretesting the questionnaire for the employer survey, and plans to begin the fieldwork for the survey in Colorado, New York, Oregon, and Vermont in early April. The survey is designed to collect information from employers on the number of employees, their hours worked, and their demographic characteristics. In addition, information on employee salaries, health insurance coverage offered and accepted, health insurance premiums and source of payment, other benefits offered, and reasons for not offering health insurance will be solicited. These data will permit the states, with the assistance of Steven Long and Susan Marquis at RAND and other members of the program's Technical Assistance Group (Alpha Center, National Governors' Association, and Urban Institute), to analyze the expected effects of their proposed reforms on employers' health insurance offerings, employment levels, wages, and location. In addition, the data and related documentation will be placed in the public domain to serve as a standard set of instruments and procedures for state health insurance surveys and to allow the other states to replicate the survey as they begin developing their own reform initiatives.

The family survey, designed by Mathematica with input from the Foundation, the Technical Assistance Group, and the states, will include questions on the health insurance coverage of family members, family income, employment status including industry and firm size, whether the employer offers health insurance, family structure, health status, and recent health care utilization. This information will be used to assist in analyzing the expected effects of the states' proposed reforms on access to care, health care utilization, and the distribution of the burden of health care expenditures. As with the employer survey, the data collected and related documentation will be placed in the public domain for future use by all states. Mathematica is scheduled to begin fielding the family survey in Florida, Minnesota, and Vermont in the spring. ■

WASHINGTON

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current 11 percent per year to about five percent per year by the year 2000. It projects that total health system costs would be reduced by $2.6 billion in the year 2000, with cumulative savings of around $4.3 billion by that time.

Less than three weeks into the 1993 state legislative session, the impact of the Commission's work is evident. On January 21, a joint statement of principles for health reform legislation, strongly reflecting the Commission's recommendations, was issued by six key political leaders: Governor Lowry, Senate Majority Leader Marcus Gaspard, House Speaker Brian Ebersole, Chairman of the Senate Health Committee Phil Talmadge, Chairman of the House Health Committee Dennis Dellwo, and the independently elected Insurance Commissioner, Deborah Senn. At this time, approximately ten major health reform bills have been introduced, most of them consistent with the statement of principles. Committee action to refine and combine proposals is expected to begin within the next month. ■

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JULY 1993

STATE INITIATIVES
IN HEALTH CARE REFORM

RWJF Holds Annual Meeting of *State Initiatives* Program
Availability of Additional Grants and Technical Assistance Announced

The annual meeting of The Robert Wood Johnson Foundation's *State Initiatives* program was held on June 10-11, 1993 in Washington, D.C. Nancy Barrand, Senior Program Officer at the Foundation, announced that in response to the increased reform activity in states and the interest many states have shown in the *State Initiatives* program, the Foundation is expanding the program to support additional states undertaking health care reform. As a first step, the governors from all the states were invited to send representatives to participate in the June meeting.

The Foundation's expanded activities will include 1) additional grant monies to states developing comprehensive strategies for health care reform; and 2) the availability of technical assistance. Barrand announced that approximately ten additional development grants for states would be made available. Proposals will be due on January 1, 1994. If necessary, a second round will be due on July 1, 1994 and applicants not funded in the first round will be eligible to reapply for the second round. The criteria for awarding these new grants will include the comprehensiveness of the reform strategy, political commitment by the governor and the state legislature, a decisionmaking process which includes all relevant agencies and constituencies, understanding of the capacity necessary to carry out the reform, and the generalizability of the lessons likely to be learned from the proposed reform effort.

States will also be able to receive some of the technical assistance now being provided to states already receiving development grants under the *State Initiatives* program. Under this program, the Foundation provides technical assistance to states through its support of the Technical Assistance Group (TAG Team) comprised of staff from the Alpha Center, National Governors' Association (NGA), RAND, and Urban Institute. According to David Helms, President of the Alpha Center, the assistance to be provided falls into four general categories: 1) written products of interest to all states on major policy and technical issues; 2) regional workshops for states facing similar issues; 3) national meetings; and 4) technical assistance to individual states on key design and operational issues. In addition, the NGA will continue to serve as a liaison with the national government for the states undertaking health care reform.

Specifically, the technical assistance provided will include briefings for national executive officials, congressional staff, and key interest groups (i.e., insurers, providers, and consumers) to inform them about issues faced by states and the lessons they are learning as they develop and implement health care reform. The program also plans to convene small working groups with national policymakers to resolve specific technical issues such as the criteria for approving waiver requests. The program will further assist states by conducting policy review retreats for states considering reform options and providing assistance in estimating the cost and other impacts of different reform options under consideration. Workshops and consultations among states that are working on similar issues will also be held.

The Alpha Center, RAND, and the Urban Institute are preparing a series of monographs and technical memoranda on topics on which several states would benefit from the analyses. The monographs are designed to be

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RWJF Announces Expansion

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useful to all states, although some will include applications or simulations that consider state-specific parameters or options. The topics of monographs and memoranda currently under consideration include: the impact of health care reform on states' economies; expenditure targets and global budgets; participation under voluntary health insurance plans; risk adjustments for mandated multipayer systems; state health data systems; and potential cost savings from administrative efficiencies. At this time, three monographs and four technical assistance memoranda have been completed and distributed. The box on page 3 lists those products currently available.[1]

THE FOUNDATION IS EXPANDING THE PROGRAM TO SUPPORT ADDITIONAL STATES UNDERTAKING HEALTH CARE REFORM.

Three regional meetings per year are planned to report on national and state health care reform progress. These meetings will allow states implementing reforms to share their early lessons and provide an opportunity to inform states about policy progress or implementation issues at the national level. It is envisioned that states will send delegations comprising key state executive and legislative leaders to these regional workshops. In addition to the regional meetings, two national meetings will be held each year for grantees and other interested states.

The June meeting provided an opportunity for the participants, representing nearly forty states and territories, to share information about their current reform efforts. Paul Starr, currently an advisor to the Clinton administration's health care reform effort, provided the state officials with an overview of the status of the President's proposal for national health care reform, as well as the likely role for states under the Administration's plan. While Starr noted that the Clinton Administration has not yet reached consensus on its proposal for national health care reform, he said the proposal would likely be centered around the concept of health care purchasing alliances. Starr stated, "There will be a federal framework, a nationally guaranteed benefits program, and new rules for health care. But it is also clear that it [health care] will not be run at a national level—it will be run by states."

Starr's presentation was followed by a panel of grantee states who discussed the implications of implementing a system of managed competition. Alan Weil, Rachel Block, and Mary Jo O'Brien—representing Colorado, Vermont, and Minnesota, respectively—discussed decisions that states will have to make regarding purchasing alliances. In particular, they will have to decide whether to have a single alliance or multiple alliances in the state, as well as the governance structure for the alliance. This panel also discussed the design of integrated delivery systems and the administration of cost control mechanisms under an expenditure limit.

Celinda Lake, a partner at Mellman, Lazarus, and Lake who has conducted polling and analysis of public sentiment regarding health care reform at both the national and state level, provided data on the public's values, attitudes, and tolerance for change. Lake noted that there are many apparent contradictions in the minds of voters regarding health care reform. For example, while most voters believe that the system is "terrible" and advocate bold change, they are generally satisfied with their own care. Polls also indicate that individuals are most interested in assuring "health security" for their families and controlling costs. At the same time, they are also concerned about maintaining the quality of care. Lake stated that the public is worried that global budgets could lead to decreased quality of care. In addition, those polled are not wholly supportive of the concept of man-

[1] Anyone interested in receiving one of the completed documents should send a written request, specifying the title of the desired document, to the Alpha Center, 1350 Connecticut Avenue, N.W., Suite 1100, Washington, DC 20036.

STATE INITIATIVES

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RWJF Announces Expansion

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aged competition. They feel that competition in health care has failed to control costs or increase access, and they believe that the government has generally shown itself to be a poor manager.

Another panel of grantee states discussed the importance of public education efforts and some of the activities that are underway. Each of the panelists acknowledged that one of their state's primary goals was to garner public support for the health care reform effort. Robert DiPrete noted that the process leading to the Oregon legislature's passage of an employer mandate and Medicaid reform was "very public." All of the task force meetings were open; town meetings to reach consensus on health care values were held; and time was allotted for public testimony at meetings and hearings. Daniel Winegarden indicated that Iowa is attempting to replicate Oregon's very public process by holding a teleconference summit and public outreach focus groups to garner public support. In Colorado, according to Barbara Yondorf, the state is also conducting a large number of

THE JUNE MEETING PROVIDED AN OPPORTUNITY FOR THE PARTICIPANTS TO SHARE INFORMATION ABOUT THEIR CURRENT REFORM EFFORTS.

Completed Monographs and Memoranda

Technical Assistance Monographs

1. *Managing Health Reform: Managed Care and Its Implications for Managed Competition* by the Urban Institute, April 22, 1993

This paper reviews the research evidence on the effects of managed care on reducing health care costs and concludes that tightly controlled managed care plans such as group and staff model HMOs demonstrate some potential for decreasing costs relative to traditional plans. However, it finds little evidence that loosely structured managed care plans such as preferred provider organizations decrease health care expenditures. The bulk of the evidence concluding that even tightly controlled managed care plans can be successful is itself based on relatively few studies. The paper concludes that one reason for the lack of convincing evidence is the limited research that has been conducted as well as the quality of that research.

2. *Analysis of Expenditure Targets and Global Budgets: Alternative Approaches to All-Payer Rate-Setting* by the Urban Institute, June 25, 1993

Some approaches to implementing global budgets envision a major role for all-payer rate-setting. This paper addresses the issues that states must face in developing an all-payer rate-setting system for hospital inpatient and outpatient care and for physician services. It considers issues in deciding on the unit of payment, the level of payment, geographic and other adjustments to payment rates, and controls on the volume of services or expenditures. States must address these issues in developing a rate-setting system regardless of whether it applies to all providers or only to those not under capitated health systems.

3. *State Efforts to Develop Standard Health Benefits Packages* by the Alpha Center, July 1993

Focusing on the work in Washington, Oregon, and Virginia, this paper describes key lessons from state efforts to develop standard benefit packages. It discusses the role of benefit package design within the context of comprehensive reform efforts, the use of commissions, and the need to reach consensus on a basic set of principles early in the design process. The impact of the Americans with Disabilities Act on benefit package design and the need to develop a mechanism to modify the package over time are also discussed.

Technical Assistance Memoranda

1. *Residency Requirements for a Universal Health Care Program*, December 29, 1992, prepared by Patricia Butler, J.D. for the Coalition for Health Care Access.

This memorandum provides a legal analysis of issues such as durational residency requirements, waiting periods, and additional premium payments for new residents and suggests alternatives to assure that individuals enrolled in a state health care program are paying fairly for the privilege.

2. *Power To Tax Employees of the Federal Government*, December 29, 1992, prepared by Patricia Butler, J.D. for the Coalition for Health Care Access.

This memorandum summarizes states' constitutional and statutory authority to tax federal employees and outlines how the statutes and case law apply to financing a universal health care financing program.

3. *A Preliminary Legal Analysis of the Iowa Leadership Consortium's Health Care Reform Proposal*, February 19, 1993, prepared at the request of the Iowa Leadership Consortium on Health Care.

This memorandum is a preliminary inventory of legal issues which might be raised regarding reforms such as a play-or-pay employer mandate, an individual mandate, expenditure limits, and the development of organized delivery systems.

4. *Methodological Improvements in Risk Adjustment*, April 5, 1993, prepared by the Alpha Center.

This memorandum summarizes state-of-the-art methods for adjusting capitation payments for differences in patients' health status that were discussed at a HCFA-sponsored conference on risk adjustment held in September 1992.

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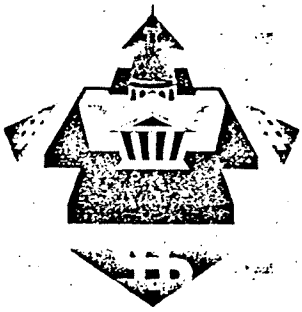
Each newsletter features reports on activities in selected states.



COLORADO

Health Care Reform Initiative Committees Begin Studies of Proposed ColoradoCare Program

Colorado's health care reform initiative advisory committees, established under the *State Initiatives* grant to study the proposed ColoradoCare statewide insurance program, held their first organizational meetings in January and since then have met several times to discuss specific issues relating to the structure, financing and implementation of the program. The study of ColoradoCare was mandated by the state legislature in May 1992 (SB92-4). After the committees have completed their initial analyses and conducted public hearings on the proposal during the summer, they are to revise and refine the proposal and then draft a bill to be introduced in the 1994 legislative session.

ColoradoCare, a proposal developed by the Colorado Coalition for Health Care Access (CCHCA), would offer a comprehensive set of health care benefits to all residents not enrolled in Medicare, using a limited number of private insurers and health maintenance organizations (HMOs). Contracted insurers would have to enroll all applicants, regardless of employment status, family income, or pre-existing conditions, and would have to use uniform billing, payment and reporting forms.

In addition to a panel of health advisers that oversees the study process, there are five advisory committees: the Access Committee, which is focusing on availability, accessibility and acceptability issues; the Actuarial Advisory Committee, which is developing cost estimates; the Benefit Design Advisory Committee, which is working on the structure of the benefit packages; the Program Finance and Economic Effects Committee, which is studying various financing options for the program and their effect on different businesses and on families with different income levels; and the Quality of Care Committee, which is analyzing the impact of ColoradoCare on health care quality and developing specific quality management strategies. The separate Cost Containment and Guaranteed Access Commission is also examining the proposed program's cost containment features.

One of the important elements of the ColoradoCare concept is the availability of a comprehensive benefit package to all enrollees. The benefits committee is in the process of reviewing and revising three sample benefit plans. The proposed benefit packages all cover the same services, but differ in cost, in the level of managed care required, and in the level of copayments and deductibles. During their meetings in February and

ADVISORY COMMITTEES HELD THEIR FIRST ORGANIZATIONAL MEETINGS IN JANUARY.

COLORADO

RWJF ANNOUNCES EXPANSION

Continued from page 3

meetings in order to obtain public support for the state's health care reform effort. In addition, the state writes and distributes a quarterly newsletter to educate the public and keep them informed about the state's progress on health care reform.

In order to assist states as they continue to estimate the potential impacts of various reform options, John Holahan, Director of the Health Policy Center at Urban Institute, demonstrated how states could use existing data to develop preliminary cost estimates for health care reform alternatives. Susan Marquis, Senior Economist at RAND, presented an update on the progress of the Foundation's state-specific employer and family surveys.[2] Finally, Joel Cantor, Director of Evaluation with the Foundation, moderated a panel with Lynn Etheredge, a Washington-based health care consultant who served on the Clinton transition team, James Scanlon, Director of the Division of Data Policy of the Office of Health Planning and Evaluation, and Stephen Long, Senior Economist at RAND, who discussed the data and data systems that states are likely to need as they begin to implement a state or national health care reform plan. ■

[2] For a description of the surveys, see *State Initiatives in Health Care Reform*, newsletter prepared by the Alpha Center under a grant from The Robert Wood Johnson Foundation, Number 2, February 1993, p. 8.

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March, the committee members agreed on several basic principles to guide the structure of the benefit plans: a preference for richer benefits with managed care requirements over leaner benefits with greater provider choice; an emphasis on prevention, primary care, and care for infants and children; the use of income-based sliding scales for copayments and deductibles for low-income families; and the goal of keeping people as independent as possible.

The Program Finance and Economic Effects Committee is considering four proposed options for financing ColoradoCare's universal health insurance coverage plan. The first option would rely on a payroll tax applied to Social Security wages (the first $59,700 in wages), but exempting the first $3 per hour in wages. Under the second package, the program would be financed from an increase in income tax plus a payroll tax applied to Social Security wages, while the third would use only a payroll tax applied to all Social Security wages. The fourth financing option under consideration would require employers to purchase insurance for most full-time and part-time employees and require all individuals to purchase insurance, but provide a subsidy for low and moderate income families. The committee is also considering adding other taxes for some financing options, such as cigarette and/or alcohol tax increases or income-based taxes for self-employed people and early retirees. ■

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FLORIDA

Project Assisting State in Designing Managed Competition Model Enacted by Legislature

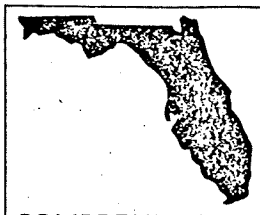
For the second year in a row, Florida has passed comprehensive health care reform legislation that creates a framework for the development of a statewide managed competition system. Building on the public-private health care coverage and cost containment program enacted in 1992, the new law, passed April 3, 1993, establishes eleven Community Health Purchasing Alliances (CHPAs) throughout the state. The CHPAs would assist members in buying health insurance coverage from approved provider networks, called Accountable Health Partnerships (AHPs). The Agency for Health Care Administration (AHCA), which was created by the 1992 law, is authorized to implement this new managed competition model, including the certification and designation of the CHPAs and AHPs. As a *State Initiatives* grantee, the agency has proposed a revision in its project work plan and budget to complete the design work needed to fully implement the new system.

The regional CHPAs are nonprofit, private corporations, governed by local boards whose 17 members may not be providers or insurers. Although the exact role of the alliances has yet to be defined, the law appears to limit their primary functions to securing participation of employers in the purchasing pool, ensuring that members have a variety of plans from which to choose, obtaining bids for health insurance, and helping members in selecting an approved health plan by providing information on benefits, cost, quality, and patient satisfaction. A CHPA may not perform any insurance functions or collect premiums from members on behalf of the AHPs unless the agency has determined that such collection would be cost effective.

Membership in the alliances is open to firms with 50 or fewer workers, state employees, Medicaid recipients, and participants in the MedAccess Program, a newly-created state health insurance program for uninsured people with incomes below 250 percent of the federal poverty line.

The Agency for Health Care Administration plans to use funds available through the *State Initiatives* grant to design, implement and evaluate the managed competition system. The first task will be to develop rules for designating and certifying CHPAs and AHPs, and once these entities are formed, to facilitate their development by holding retreats and providing technical assistance. The project expects to make use of the expertise of the staff of the Florida Health Access Corporation in helping set up the alliances.

In addition, the project will use the grant funds to conduct studies of the managed competition model, as required by the 1993 law. Among the issues to be addressed: using savings to extend coverage, cost shifting, effects of uninsurance on the CHPAs, employer options under the alliances, characteristics and requirements of AHPs, enrollment and marketing requirements, community rating, and the effect of antitrust



COMPREHENSIVE HEALTH CARE REFORM LEGISLATION CREATES A FRAMEWORK FOR MANAGED COMPETITION SYSTEM.

FLORIDA

THE IOWA HEALTH REFORM COUNCIL IS DEVELOPING THE FOUNDATION FOR A STATE HEALTH CARE REFORM PROGRAM.

IOWA

laws on CHPAs and AHPs. Results of the studies will be incorporated in the final Florida Health Plan, which must be submitted to the legislature by December 31, 1993.

Finally, grant funds are planned to be used to evaluate the process of forming the CHPAs and AHPs and to develop procedures for monitoring and evaluating the alliances to measure the extent to which they are controlling costs, expanding access, and maintaining quality. ■

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IOWA

New Health Reform Council Holds First Session, Plans Town Meetings to Draw Public Comments

In early 1993, the Iowa Health Care Reform Project enlarged and reconstituted the Iowa Leadership Consortium on Health Reform (ILC), establishing the Iowa Health Reform Council. Governor Terry Branstad appointed the 56-member council—a voluntary, nonpartisan group representing providers, insurers, business, government, and consumers—and named Insurance Commissioner David Lyons as chairman. Daniel Pitts Winegarden continues as the project director of the Iowa Health Care Reform Project.

In addition to including a broader range of parties interested in health care reform than the ILC, the new council helps to ensure that the primarily private sector efforts of the ILC will be converted into a publicly-led, public-private partnership where consensus can be reached and public policy developed. Meeting for the first time in April, the Iowa Health Reform Council is now well on its way to developing the foundation for a state health care reform program. The council faces a deadline of December 1, when it must submit its recommended reform plan to the Governor; the goal is to have a legislative proposal ready for consideration in the 1994 session.

The governor's charge to the council is to develop legislation that will conform Iowa law to the federal health care reform plan, but that will also accommodate specific concerns of Iowa. In early July, the council conducted a televised Health Care Summit to lay out the basic problems and principles the state's reform effort should address. Fifty town meetings are now being held throughout the state to solicit the opinions of the public. After the council reaches consensus on the overall principles, goals and priorities for health care reform, various subcommittees will begin analyzing specific issues, with support from the *State Initiatives* grant. Among the issues under study: the potential impact and feasibility of establishing health care expenditure targets, organized delivery systems, a play-or-pay employer mandate, and an all-payer rate-setting system. The subcommittees will then develop alternative solutions and implementation recommendations, which the full council will act on as it drafts its final proposal in the fall. ■

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MINNESOTA

Cost Containment Law Sets Spending Limits, Authorizes Integrated Service Networks

With passage of the 1993 Minnesota Care Act on May 17, the Minnesota Department of Health got the green light to proceed with its plan to reduce the annual growth in health care spending by 10 percent over the next five years. The major cost containment legislation sets specific limits on spending increases for the years 1994 through 1998. In the first year the limit is the consumer price index (CPI) plus 6.5 percent, with the rate gradually declining to the CPI plus 2.6 percent in the last year.

The cost control bill was developed by the 25-member Minnesota Health Care Commission and submitted to the legislature and the Governor in January 1993 in response to the HealthRight Act enacted in April 1992. The earlier law authorized expansion of the state-administered Children's Health Plan to cover uninsured children and their parents, adding other uninsured people through a phased-in enrollment process. Over 53,000 children and their families are enrolled in this subsidy program, known as MinnesotaCare. By 1997, more than 170,000 people will be enrolled. The 1993 law directs the commission to develop a plan that will lead to universal coverage for Minnesotans by 1997. The 1992 act also contained significant cost control provisions, including the goal of setting targets to reduce the annual rate of growth in health care expenditures by 10 percent over the next five years. The 1993 law now describes the initial steps the Department of Health will

take to achieve the overall cost containment goal.

A major vehicle for reducing costs is managed competition through the use of integrated service networks (ISNs). These regional networks of providers, similar to HMOs, will offer enrollees a range of covered services and will be responsible for managing their total costs within the growth limits set by the law. Services that are not covered by ISNs will be subject to price and utilization regulatory controls set by an all-payer system, to be phased in over a two-year period, beginning July 1, 1994.

Many details of the program still must be worked out. The Minnesota Health Care Commission is charged with developing plans for implementing the ISN regulatory system and designing the all-payer system for non-ISN services. Its proposal is due January 15, 1994. The *State Initiatives* grant will help support the commission in drafting the implementation plan.

The law also authorizes the Department of Health to establish an information clearinghouse to collect, analyze and disseminate data on health care costs and quality. Providers and health plans will be required to provide the clearinghouse with cost and quality information. A separate Data Institute, governed by a 20-member board, will be created to direct and coordinate public and private data compilation efforts. In addition, the Health Technology Advisory Committee, formerly called the Health Planning Advisory Committee, will evaluate the safety, efficacy and cost-effectiveness of new and existing technologies and advise the Commissioner of Health on the treatment of new technologies under the state's health care and cost containment programs. ■

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NEW MEXICO

Model and Data Matrix Developed to Compare Costs of Reform Proposals

The New Mexico Health Policy Commission has developed a computer spreadsheet model called Simplified Healthcare Analysis for Reform Planning (SHARP) to compare the costs of various health reform measures for the state. The model is based on total 1991 health care expenditures in New Mexico, which include direct costs of services and administrative costs for both providers and insurers.

The SHARP model allows the user to estimate percentage cost increases or savings for certain features of a health care reform proposal, based on the state's current health care system and on research literature. For example, one can quantify the effects of utilization controls on the number of services needed by individuals, payment mechanisms and levels on the price per service, administrative structure on providers' and payers' overhead costs, and eligibility rules on the number of beneficiaries.

Under the *State Initiatives* grant, staff of the commission's Health Care Initiative are collecting and analyzing demographic and actuarial data to assess the feasilibity of establishing an independent statewide Cooperative Health Care Plan. The project will continue to refine the SHARP model and gather and analyze data as it begins the task of designing the cooperative plan's financing and delivery systems, benefit package, and legal structure.

The Health Care Initiative is the hub of a network of New Mexico health care reform organizations. The project will work closely with the Health Care Reform Task Force, formed by the 1993 legislature. The Health Policy Commission has organized over 200 volunteers into four task forces and eight smaller workgroups. These groups meet regularly and work with the Commission to improve financial access, geographic access, health information, and health promotion and education. Four projects funded by The Robert Wood Johnson Foundation—the Health Care Initiative, the Practice Sites rural access project, the Generalist Initiative, and the University of New Mexico School of Medicine Curriculum Reform project—meet monthly to exchange information and to coordinate their efforts.

In addition, the Health Care Initiative has developed a data needs matrix for decision support. The matrix organized specific research questions into groups around key health care reform issues, such as delivery system structure and cost control mechanisms. Each question is assigned to a staff member, who gathers secondary research, solicits comments from interested groups and individuals, and organizes the information for summary reporting. ■

COST CONTAINMENT LEGISLATION SETS SPECIFIC LIMITS ON SPENDING INCREASES FOR THE YEARS 1994 THROUGH 1998.

MINNESOTA

GOVERNOR MARIO CUOMO HAS CALLED FOR MAJOR HEALTH CARE REFORMS, EMPHASIZING THE NEED FOR AN AMBULATORY CARE REIMBURSEMENT SYSTEM.

NEW YORK

NEW YORK

Governor's Health Reform Plan Calls for Ambulatory Care Reimbursement System and Statewide Expansion of the Electronic Claims Clearinghouse.

With the goals of expanding access to primary care, controlling costs and improving health care quality, New York Governor Mario Cuomo has called for major health care reforms, emphasizing the need for an ambulatory care reimbursement system. In a March 23, 1993 special message to the legislature, he proposed extending the state's all-payer hospital rate-setting program to all outpatient care, including private practice physicians. The supply and distribution of primary care providers could also be improved, he told the legislators, through enhanced reimbursement and educational incentives. In addition, the governor proposed further insurance reforms, including a requirement that small group and individual health insurance policies have standard benefit packages.

The Task Force on Health Care Finance Reform, supported by a *State Initiatives* grant, has made progress in developing the mechanisms that would achieve the goals set out by the governor. At its first meeting last November, the task force established three committees, the Insurance Reform Committee, the Reimbursement Reform Committee, and the Electronic Claims Clearinghouse Committee, which have met several times since and have already reached consensus on a number of issues.

To achieve the goal of spreading risk and stabilizing premium costs, the Insurance Reform Committee has agreed to define and refine a regional community rating system and open enrollment process. But committee members are also concerned about the costs of community rating for employers. Project staff will continue to analyze the impact of such reforms on small groups, individuals and insurers, and to study the need for caps on premium increases and for subsidies due to community rating.

The committee has also reached consensus on the need for a standard benefit package. Most proposals under consideration include coverage of prenatal and delivery care, well-child care and immunizations, physicians' services, and inpatient care, but there is less agreement on coverage of dental care and prescription drugs.

Although the Reimbursement Reform Committee has not yet developed a uniform payment methodology for physicians, members have agreed on several principles that such a system should adhere to: emphasize and expand access to primary care; provide incentives for practice in underserved areas; eliminate balance billing but assure fair and adequate reimbursement; increase Medicaid fees; limit the annual increase in physicians' spending; include volume control mechanisms as part of the controls on ambulatory care spending; and link reimbursement to quality.

As part of the overall cost containment strategy, the governor has also proposed expansion of the electronic claims clearinghouse to cover hospital inpatient services, hospital and clinic outpatient services, and physician office services statewide. Providers will be phased in over a three-year period. In addition to the central features of claims transmission and eligibility, the clearinghouse will provide the capacity for automated coordination of benefits, electronic funds transfer, and creation of a statewide database to support other new initiatives. ■

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NORTH DAKOTA

Task Force Completes Town Meetings, Begins to Review Health Reform Options

The North Dakota Health Care Task Force, charged with developing a health care reform proposal for the next legislative session in 1995, has concluded a series of town meetings in 18 communities scattered across the state. The two-a-day sessions were aimed at informing the public about the task force's operations and soliciting the public's views on health care reform. According to Bruce Briggs, project coordinator, the meetings were successful in meeting those aims. Not only did the task force members who attended the meetings hear directly from the public about their health care needs, they also gained much needed visibility and became very much involved in the process, he said.

The 35-member public-private task force was established in 1990 by the former governor, a Democrat. Although generally supportive, he and other members of the

administration were not directly involved in task force activities, with aides or agency assistant directors usually participating. The 1993 legislature unanimously approved a bill expressing support for the task force, but the newly elected governor, a Republican, vetoed it on the grounds that the process outlined in the bill represented a needless layer of government. Since then the task force has worked hard to build a relationship with Governor Schafer and other government officials and "to establish credibility as a legitimate body," Briggs said.

The hard work has paid off: the governor is interested and supportive of the task force process, and the newly appointed Medicaid director and newly elected insurance commissioner are members and active participants. Recently two more legislators joined the task force, so now each party and house has three representatives, two from the majority and one from the minority party. With the involvement of these legislative representatives and the participation of other groups besides providers, all parties "are at the table, where they weren't before," Briggs said. "The task force is now recognized as a positive force in the health care reform debate in North Dakota."

At the task force's first retreat, May 4-5, members began to discuss the basic values and principles they see for reform and to lay out their future agenda. The next step is to start analyzing various broad reform options, with support from the *State Initiatives* grant. Working with RAND consultants, the staff selected six options to explore over the next few months: a single-payer system; an all-payer, government-financed system; an all-payer system with an employer mandate; an all-payer system with employer and employee mandates; a mandate for individuals; and a totally voluntary system. At the task force's next meeting, July 20-22, the staff will describe these options and present preliminary estimates on their projected impact on costs and access. The task force will then select which options to analyze further. By December the group is to decide on one or two basic options and then to prepare detailed analyses of each strategy's impact and to solicit views from the public and from various provider organizations. The final steps involve the development of a final legislative proposal, to be presented in January 1995. ■

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WASHINGTON

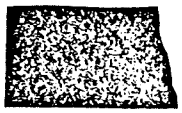
Universal Coverage by 1999 Mandated Under New Health Care Reform Law

A major health care reform law enacted May 17, 1993 in Washington State includes both an individual and an employer mandate for health insurance coverage through state-approved managed care plans called "certified health plans." Under the Health Services Act of 1993, all Washington residents must be covered by July 1999 by a certified health plan offering certain minimum benefits. The law also requires employers to offer all their workers a choice of at least three certified health plans and to pay at least 50 percent of the premium for full-time, nonseasonal employees and their dependents, with pro-rated contributions for part-time workers and their families. Employees will pay the remaining share of the premium payment, but the state will subsidize payments for low-income workers.

The employer mandate will be phased in, with effective dates ranging from July 1995 for employees of large firms (500 or more employees) to July 1999 for the dependents of employees of small firms (fewer than 100 employees). Short-term subsidies will be available for some small businesses (under 25 employees) in the first few years of the program. Washington will seek Congressional action to exempt the state's employers from portions of the federal Employee Retirement Income Security Act (ERISA) so that the mandate can be applied to all employers.

Employers may purchase health care coverage directly from the certified health plans, or they may join one of four regional Health Insurance Purchasing Cooperatives (HIPCs), which would increase members' ability to shop effectively and reduce administrative burdens. Alternatively they may enroll in the Washington Basic Health Plan (BHP), the state health care program for uninsured people below 200 percent of the federal poverty level. Businesses with over 7,000 employees may operate their own certified plans.

The package of benefits that the certified plans must include at a minimum, called the Uniform Benefit Package (UBP), is outlined



HEALTH CARE TASK FORCE HAS CONCLUDED A SERIES OF TOWN MEETINGS ACROSS THE STATE.

NORTH DAKOTA

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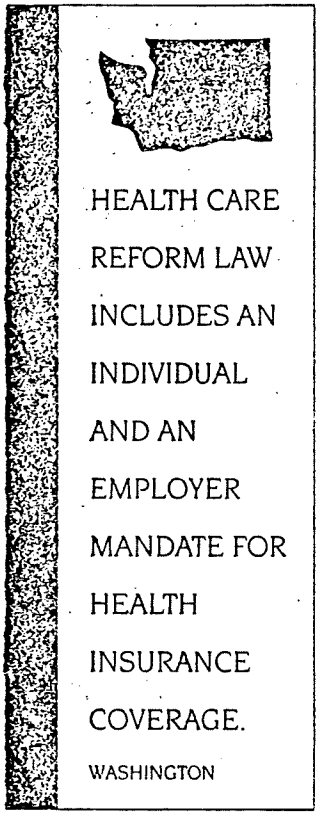

in the law, with details to be determined by the newly-created five-member Health Services Commission (HSC). The commission will also design optional supplemental benefit packages, which may be purchased for an additional charge. In addition, the law directs HSC to set the maximum annual premiums that can be charged for the UBP and supplemental benefit packages. Every year the rate of increase in premiums is to be reduced by 2 percent until it equals the state's rate of personal income growth. Premiums are to be community rated, but modified to reflect geographic and family size differences. The HSC has many other roles in shaping the state's health system.

Another important component of Washington's universal access program is the expansion of existing government health care programs for low-income people. By July 1995 an additional 195,000 people under 200 percent of the poverty level will be enrolled in the BHP or Medicaid, with further expansions planned through 1999. Funding for primary care at migrant and community health centers has also been increased. To help finance these public program expansions, the legislature has provided for increased revenues of $251 million over the next two years through taxes on cigarettes, hard liquor, beer, and nonprofit hospitals, with additional increases later in the decade.

The law also seeks to control the state's health care costs by consolidating most state purchasing of government employees' health benefits into one agency, the Health Care Authority, which now administers state employees' insurance. Effective immediately, administration of the BHP and community and migrant clinics programs will be transferred to the HCA, and by July 1995, BHP enrollees and school employees will be merged into a single community-rated pool with state employees. The state plans to transfer administration of other health programs to HCA, including Medicare and Medicaid, and to merge enrollees into the state risk pool, subject to necessary federal waivers and legislation.

Other provisions of this comprehensive law include insurance and liability system reforms, strengthening the public health system and the state's programs for supply and distribution of primary care practitioners, establishing an extensive encounter-based health information system, and beginning processes intended to assure the efficacy and quality of health services. A number of special studies are mandated.

With passage of the Health Services Act, Washington's *State Initiatives* project, which helped the Health Care Commission develop the overall health care reform strategy, can now help develop the plan for implementing the new law. Project staff are facilitating the intensive interagency effort to develop an implementation plan. They will further analyze the economic impacts of the law on employers, individuals, and the government. A contractor will convene focus groups to try to determine how small businesses are likely to react to the employer mandate. The project also will develop measures to be used by the state purchasing agents and (on a voluntary basis) by other purchasers and consumers in evaluating the performance of managed care organizations interested in becoming certified health plans. ■

HEALTH AFFAIRS
Summer 1993

The Summer 1993 issue of *Health Affairs* focuses on eight states, each of which embodies a different approach to health system reform: Florida, Hawaii, Maryland, Minnesota, New Jersey, Oregon, Vermont, and Washington state. In an overview essay Deborah Rogal and David Helms note that "These state reform initiatives provide useful insight into how the major actors... react to various initiatives. They also demonstrate the capacity of states to undertake the responsibilities they are likely to have under national reform."

Health Affairs is a multidisciplinary, quarterly journal devoted to publishing the leading edge in health policy thought and research. The Summer 1993 issue is available for $20 from: *Health Affairs*, 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814 phone, 301-656-7401, fax, 301-654-2845.

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States Gain Valuable Experience in Designing Standard Health Benefits Packages

At recent Congressional hearings on the topic of standard benefits packages, more than 70 groups and individuals sought to speak, forcing a second day of testimony to be scheduled. In the past several years, in the context of mandated health insurance benefits, state legislatures around the country have debated which services and providers must be covered by health plans. These debates reflect an increased interest in, and a growing conflict, over what benefits should be included in a standard benefits package within a system of universal health insurance.

A standard benefits package defines the minimum set of services to which all individuals are entitled and, therefore, gives meaning to the term "universal access." If all insurers and health plans were required to cover these benefits, a standard benefits package might alter the nature of competition in the insurance market by making it easier for consumers to use information to compare health plans and forcing all insurers to compete on their ability to provide quality, not different, services. Finally, a standard benefits package is also likely to reduce administrative costs by reducing insurers' design and marketing costs as well as consumers' search costs.

The states of Oregon, Washington, and Virginia have all gained valuable experience in designing standard benefits packages. This article briefly describes five key lessons based on Alpha Center's assessment of these state efforts.

Overview of State Efforts

Oregon's overall health care reform strategy represented an attempt to allocate resources rationally and increase accountability by making the tradeoffs in public spending explicit. As part of this strategy, Oregon created a Health Services Commission in 1989 to develop a prioritized list of benefits by ranking "condition/treatment" pairs.

In Washington state, a subcommittee of the Washington State Health Care Commission has defined a "uniform set of health services," including both personal and public health benefits. Two actuarially equivalent sample packages were designed based upon previously established principles. In Virginia, a special Essential Benefits Panel was charged with designing a standard benefits package to be used in any health care reform strategy.

AT RECENT CONGRESSIONAL HEARINGS ON THE TOPIC OF STANDARD BENEFITS PACKAGES, MORE THAN 70 GROUPS AND INDIVIDUALS SOUGHT TO SPEAK.

Key Lessons

1. ***Using a special commission or task force that is insulated from legislative politics can be an effective forum for designing a standard benefits package.***

Extricating the debate over government-mandated benefits from the legislative arena can be an important strategy for increasing the objectivity of the decision-making process. To design their benefits packages, the governors and legislatures of Washington, Oregon, and Virginia appointed commissions which included both "experts" and general citizens. In all three states, the commissions sought input from the public, not only to gather vital information on their views, but also to build broad support for the commissions' recommendations.

2. ***It is important to reach a consensus on guiding principles for determining the content of a standard benefits package.***

Early on, commission members need to achieve a common understanding of the underlying principles that will guide their work. This helps to build commitment to one another and to the task and prevent the group's process from getting sidetracked by special interests. The principles also serve as a check list on which to assess specific elements of the package. Some of the principles that have been used to guide states' design processes are: equity; universality; responsibility of individuals and society; focus on services, not providers; as well as specific criteria for determining the types of services that will be covered (e.g., clinical effectiveness).

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A STANDARD BENEFITS PACKAGE MIGHT ALTER THE NATURE OF COMPETITION IN THE INSURANCE MARKET BY MAKING IT EASIER FOR CONSUMERS TO USE INFORMATION TO COMPARE HEALTH PLANS.

3. The current interpretation of the Americans with Disabilities Act imposes new constraints regarding the use of both social values and medical effectiveness measures in designing a standard benefits package.

In August 1992, the Bush Administration rejected Oregon's initial application for a Medicaid waiver as being "inconsistent" with the Americans with Disabilities Act (ADA). According to Robert DiPrete, project director in the Oregon Office of Health Policy, the federal government held that any consideration of the "ability of a treatment to eliminate or reduce symptoms," or of consumers' opinions about the "quality of life based on residual symptoms," would be in violation of the ADA. He explained that Oregon can now use only "content neutral" factors to rank services, such as cost or whether a treatment saves lives.

Neither Washington state nor Virginia policymakers anticipate that their standard benefits packages will be scrutinized under the ADA. States and the national government, however, may be subject to such tests if they explicitly ration covered benefits based on the perceived quality-of-life that results from specific treatments.

4. Pricing a benefits package requires making key assumptions about the current health care system and how that system may change under health care reform.

The estimate of a monthly premium relies on many assumptions about how the delivery system operates currently and how it would change under health care reform. David Axene, an actuary with the firm Milliman and Robertson, Inc., with whom the Washington Health Care Commission consulted, explained that it is important to understand how different variables interact and they might change depending on different assumptions, such as how aggressively the system will eliminate unnecessary utilization. These different variables include the types of health care services reimbursed; the extent of cost sharing; the extent to which the system is "managed;" the quantity and intensity of care; and the administrative cost to run the system.

5. A process must be developed for modifying the standard benefits package over time.

An expert commission, similar to that used in defining the original standard benefits package, could be an appropriate body for recommending modifications to the package. For example, such a body could assess how to improve the package based on the latest advances in medical procedures, technology assessments, and practice guidelines. Adjustments might also be needed to combat new diseases or improve the health status of certain populations. Commissioners could be required to provide a "budget impact statement" for legislators and consumers regarding their recommendations.

For more details on these state experiences with developing benefits packages, see the Alpha Center monograph on State Efforts to Develop Standard Benefits Packages. For more details about the specific plans developed by these states, please contact the Center. ■

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