

## HEALTH CARE:

# Feds Fight, States Act

**Lawmakers were experimenting with ways to rein in costs and expand coverage long before passage of federal health legislation.**



BY RACHEL BRAND

Insurance reform. Medicaid expansion. Mandates. For months, federal lawmakers—and ordinary Americans—have been debating a national overhaul of our health care system.

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Yet without media fanfare, state legislative leaders have been quietly working on their own versions of health care reform. That's because even with federal action, states face relentless fiscal pressure.

Medical providers are overwhelmed, and the number of uninsured is growing. Democrats and Republicans agree we cannot afford the current inefficient, expensive and inadequate medical care system.

Interviews with five legislators deeply concerned about health care—two Democrats and three Republicans—found some hope that federal reform would help their state cover more uninsured. Others vowed to proceed with market-based reforms, however, despite passage in March of a federal overhaul, and hoped national reform wouldn't supersede their work.

State Legislatures asked leaders to define



**HOUSE SPEAKER**  
**DAVE HUNT**  
**OREGON**

their state's most pressing health care problem and reflect on how the federal government could help them achieve health care goals. They also discussed the best means to provide health care to more citizens, and what they were doing to reform their state's health care systems.

### IT COMES DOWN TO COST

Across the nation, leaders say that skyrocketing health care costs are walloping family budgets and pushing state finances to the brink.

"Like every other state, our most basic problem is controlling the rapidly expanding costs of health insurance," says Oregon House Speaker Dave Hunt. "When employers and individuals see double digit increases year after year, and the share of insurance premiums takes a bigger bite out of business, family and public income, controlling those increases is critical to the health of our health care system."

Underlying medical cost inflation, of course, are both technological innovation and a rising need for services. Ron Ramsey, Tennessee's lieutenant governor and Senate speaker, sees getting individuals to prevent illness before it happens as the state's biggest challenge.

Tennessee's largest hurdle is "figuring out how to get people to take personal responsibility for their health," he says. "More than 30 percent of our population is obese, and obesity is a trigger for a variety of chronic medical conditions, such as diabetes, heart disease, orthopedic disorders, even cancer."

Medicaid's increasing share of state bud-



**LIEUTENANT GOVERNOR AND SENATE SPEAKER**  
**RON RAMSEY**  
**TENNESSEE**

The sweeping health care overhaul signed by President Obama in March will be implemented over several years. These are 10 key provisions that will go into effect at different points in the next year.

- ◆ Insurers can't deny children health insurance because of pre-existing conditions. The same rule applies to adults starting in 2014.
- ◆ Insurers can't place lifetime caps on coverage.
- ◆ New insurance plans cannot impose annual limits on coverage. Beginning in 2014, use of annual limits will be prohibited for all plans.
- ◆ People uninsured because of a pre-existing condition can buy insurance through a temporary high-risk pool, a program that will end when health insurance exchanges become effective in 2014.
- ◆ Young adults can remain on their parents' insurance until they're 26 whether or not they're married.
- ◆ Senior citizens will receive a \$250 prescription drug rebate this year to help pay for their medications, if they have reached the "donut hole" in coverage.
- ◆ New private plans must cover preventive services with no co-payments and preventive services are exempt from deductibles. This will be extended to all plans in 2018.
- ◆ States will receive aid to set up health insurance consumer assistance offices.
- ◆ Small businesses will receive tax credits to help make insurance affordable.
- ◆ Co-payments for preventive services will be eliminated, and preventive services will be exempt from deductibles for Medicare patients.



gets is also a cause of deep concern.

The state-federal health care program for the disabled, poor children and low-income pregnant mothers covers 60 million Americans. Medicaid spending rose 7.9 percent in FY 2009 while enrollment rose 7.5 percent, the Henry J. Kaiser Family Foundation reports. Similar figures are projected for FY 2010. In short, rising unemployment has increased Medicaid enrollment, and reduced state revenues to support the program.

"Funding issues are our biggest problem," says Minnesota Senator Linda Berglin, who explains that Medicaid payment cuts have endangered 27 state-funded group homes for people with developmental disabilities. Without adequate funding, the facilities might lose their licensure and close.

The dismal economy also has increased the number of uninsured Americans, estimated at 46.8 million people in 2008 by the U.S. Census Bureau. The Kaiser Foundation estimates that for every 1 percent increase in unemployment, another 1 million citizens become eligible for Medicaid and child health insurance programs, and another 1.1 million Americans become uninsured.

"Our most pressing problem is the high rate of uninsured Texans, which stands at 26 percent," says Texas House Speaker Joe Straus. "It affects not only the health of fami-



**SENATOR**  
**LINDA BERGLIN**  
**MINNESOTA**



**HOUSE SPEAKER**  
**JOE STRAUS**  
**TEXAS**

lies, but trickles down as an economic strain on local hospitals and communities.”

#### REFORMS UNDERWAY

Despite these challenges, states are leading reform efforts.

Minnesota and Utah are changing how medical care is paid for. The Medicaid program pays doctors and hospitals at levels well below those of Medicare and private insurance, and often below actual costs. Large numbers of doctors, as a result, do not accept Medicaid patients.

Both states are running pilot projects to pay a lump sum for services around “baskets of care” such as replacing a knee or having a baby. Doctors and hospitals couldn’t charge for unnecessary visits and tests, and would receive an incentive if treatment is successful. The bundled payments are generous enough to cover high-quality care, but not enough to encourage waste.

“We want to restructure payments so we pay for value rather than quantity of care,” says Berglin. Large, self-insured companies and even mom and pop businesses, fed up with the high cost of health care, are willingly joining the pilot.

To set rates and measure results, Minnesota, Utah and other innovative states are passing laws to build a database of all the state’s health care claims and costs. So-called “all-payer databases” provide a treasure trove of what’s working, or not, in medical care.

More information, in turn, is expected to drive transparency and empower consumers to make smart health care purchasing decisions, a common Republican theme of health care reform.

The development of a statewide health information database, says Utah House Speaker Dave Clark, offers a remarkable tool. “We are now going to be able to provide, through our electronic portal, side-by-side comparisons of health plans and information on the lowest prices and best outcomes for the same procedures. We have never agree-



**HOUSE SPEAKER**  
**DAVID CLARK**  
**UTAH**

gated this information and made it available to consumers.”

#### MEDICAID VS. THE MARKET

While Republican and Democratic legislators support similar experiments with lowering costs and improving quality, they often part ways in other areas. Some Republicans favor using financial incentives, including health savings accounts paired with high deductible health plans, to control costs. They turn to the private market to cover the uninsured and believe federal reform can’t

*“I’m a firm believer in the individual hand of the marketplace not the heavy hand of the federal government.”*

DAVID CLARK, UTAH HOUSE SPEAKER

solve their states’ unique problems.

“In Texas, we face the challenges of a large population, a high uninsured rate, a low rate of employer-sponsored coverage, and access issues, especially in rural areas of the state,” says Straus. “This is a completely different set of challenges than a smaller, Northeastern state like Massachusetts faces, with its small population, high rates of employer-sponsored health insurance and few, if any, areas that could be categorized as remote.

“A one-size-fits-all approach just won’t work,” he says, adding that the “private market should be the first place we turn to expand coverage.”

Utah’s Clark echoed that sentiment. “Medicaid is a high-value insurance product paid for by the taxpayer. I don’t know how we are going to do more,” he says.

Clark would like to see Medicaid changed to use health savings accounts to provide people with an incentive to take care of their

own health.

While many states—and the new federal health overhaul—seek to expand Medicaid to cover the uninsured, Tennessee’s Ramsey proudly points out how, in recent years, his state cut Medicaid rolls.

TennCare, launched in 1994, was an ambitious public insurance program to cover the uninsured. For skeptics of national reform, TennCare exemplifies the pitfalls of a large government health care program.

Tennessee expanded Medicaid to cover destitute single adults and childless couples, as well as people who were denied private insurance coverage. These groups would normally fall outside Medicaid’s boundaries. Enrollment skyrocketed to 1.4 million by 2005, threatening to bankrupt the state.

“Since 2005, we have reined in the cost of our Medicaid program, TennCare, by nearly a third. It was 38 percent of the state budget and growing, and now it is 26 percent,” Ramsey said. “We did this by dis-enrolling 140,000 people who had other options, such as people who could buy health care through their spouse, or people who no longer lived in Tennessee.”

To further cost-cutting efforts, in 2008 the Tennessee General Assembly passed a tort reform bill that makes it more difficult for plaintiffs to sue. And this year, in an effort to curb “defensive medicine,” Ramsey is promoting a bill that caps non-economic, punitive damages in medical malpractice suits at \$1 million.

Further, the state increased the number of inspectors tasked with finding Medicaid fraud.

“They are doing an excellent job,” Ramsey says, “identifying not only providers who are billing for services they did not render, but also people who are doctor shopping and buying pills to sell on the street. If we doubled or tripled our staff, they would more than pay for themselves.”

#### MEDICAID AND EXPANDING COVERAGE

Some lawmakers support covering the uninsured through Medicaid, noting that federal health care reform will speed that expansion. They support federal laws that would require insurance companies to cover people with pre-existing conditions—also known as “guaranteed issue”—and want the federal government to require state-led insurance exchanges.

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DAVE HUNT, OREGON HOUSE SPEAKER

have a role in covering the uninsured,” says Minnesota’s Berglin. Very poor people, such as the homeless, do not fit well into the private insurance market, she said. But young adults, or even recently unemployed working adults, can deal with insurance, “they just can’t afford to pay \$800- to \$1,000-a-month premiums.”

Oregon’s Hunt agrees. “Federal reform is critical to the success of states’ health care efforts,” he says, “in providing matching funds to help those in need and aid to help the elderly and uninsured pay for prescriptions and health care.”

Hunt proudly points out that in 2009, Oregon legislators voted to extend government health care to 35,000 more adults and 80,000 children. To pay for it, the state increased taxes on hospital revenues and levied taxes on health insurance premiums. The new money then won a federal match to total \$2 billion. States seeking coverage expansions nationwide are using the same approach.

Despite differences, legislators sounded a final note of similarity: All saw states as a proving ground for health care experiments. Hunt summed up their sentiments.

“The federal government should be a willing partner with state governments to try innovative approaches to providing care.”

Clark sounded a similar note, although with a greater distrust of federal intervention. “If states really are the laboratories for policy invention, it gives us the opportunity to find our own solutions,” he says. “I’m a firm believer in the individual hand of the marketplace not the heavy hand of the federal government.”

 **CHECK OUT** more on what leaders think about health care reform and how new federal legislation at [www.ncsl.org](http://www.ncsl.org).