A Brief Analysis of Health Care Reform in Five States: Utah, Montana, Maine, Massachusetts and Vermont

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Submitted by:

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INTRODUCTION

In July 2006, the Wyoming Healthcare Commission requested that health and human services consultant Julia E. Robinson prepares a brief analysis of health care reform efforts in Utah, Montana, Maine, Massachusetts, and Vermont. The focus of this analysis is to highlight key features of the reforms which might provide lessons for Wyoming as it moves ahead with its strategic planning process. The review is limited to salient features of the various proposals and a summary of "Lessons to be Learned" from these state initiatives as Wyoming moves ahead. The "Closing Thoughts" section provides Dr. Robinson's suggestion on how the Commission might want to proceed in light of Wyoming's current gubernatorial support for health care reform, history with Medicaid expansions, and identified uninsured populations.

The five state approaches provide an interesting contrast. The western states (Utah and Montana) represent reforms that are operational and provide tested models. The scopes of the reforms are limited to specific uninsured or underinsured populations rather than providing models which will lead to "coverage for all". The western reforms also represent a new effort by these states to use Medicaid as part of a reform effort without letting Medicaid dictate the effort through limiting beneficiaries, reducing benefits, and capping overall expenditures. The western states are starting from a very different place than their eastern cohorts. The percentages of uninsured in the western states are much higher than in the eastern states while the western Medicaid programs are much less expansive.[1] The models they have adopted are best characterized as "pragmatic". There is recognition that this is not a full solution, but a place to begin.

The eastern states (Maine, Massachusetts, and Vermont) have been working on reform for many years (since the eighties). The initial waves of reform in these states were aggressive expansions of Medicaid programs through raising the Federal Poverty Level (FPL) for beneficiaries, adopting Medicaid optional programs, undertaking extensive outreach for the Children's Health Insurance Program, and pursuing creative funding approaches for uncompensated care in hospitals. The eastern states, in contrast to the west, represent the new wave of states which have implemented aggressive Medicaid expansions in the past, have relatively low percentages of uninsured and are undertaking initiatives which are "grand designs" intended to lead over time to "Universal Coverage" of most of their population. "Universal" should not be misread as everyone having the same coverage or the same payer but rather that everyone (similar to automobile insurance) will have coverage. All three of these states launched there initiatives because of concerns about loss of Medicaid funding for some of the expansion areas (issues with the federal government about design) and/or significant budget shortfalls in the Medicaid

[1] In comparison to Wyoming both Utah and Montana have much more expansive Medicaid programs including such optional programs at "Medically Needy" a spend-down program that allows individuals with higher incomes to access Medicaid because of large health care costs.

program. As of this writing, Maine is the only state with actual experience (the Maine Dirigo Program has been operational for about 18-months) the other two (Massachusetts and Vermont) are developing rules and regulations to implement their programs as of this writing. The commitment by all of these states to "Universal Coverage" is multi-year with specific benchmarks along the way.

The single common denominator driving reform in all of the states is <u>gubernatorial support</u> for and leadership of reform. The experiences of these states make it clear if the Governor isn't supportive they don't succeed. Reform efforts are controversial enough that actions by advocacy groups and the legislature are not enough to lead to passage of major initiatives. Action by these groups can "jumpstart" reluctant Governors. In Massachusetts, there was the potential for single payer ballot initiatives. In Vermont, Republican Governor Douglas had vetoed an expansive government administered universal coverage program passed by the Democratic controlled legislature the year before.

Another striking feature of all five models is the movement away from traditional Medicaid entitlements with comprehensive benefits to coverage in which public programs mirror private insurance products (premiums and co-pays) and/or public dollars are used to purchase private insurance. As part of this movement, state reform efforts are usually located outside of Medicaid agencies (the exception is Utah) in matrix organizations that have easy access to policy leaders, provide high visibility for activities and allow for stakeholder involvement.

This move towards private insurance design should not be as read disenchantment with Medicaid as a funding stream. In fact, these states have a tradition of utilizing Medicaid as one of the key financial drivers of reform and wherever possible these states are still accessing Medicaid match for their new designs. Part of all five designs are instituting reforms that make it much easier to enroll in Medicaid (outreach, reductions of premiums and co-pays) with the goal of 100% enrollment of all potential Medicaid recipients.

That said; these initiatives require substantial infusions of new dollars. Funding streams are also changing with new programs being based on funding from the employer, employee, and government. State funding is frequently coming from other sources than the general fund including cigarette taxes (both Settlement Funds and new state initiatives), assessments on insurance (Maine), taxes on hospital and nursing home beds (Vermont). In all five states, the Governor provided significant leadership in achieving some type of reform but the various proposals reflect by-partisan support. In general, policy makers have tended to be more comfortable with designing hybrids of the Medicaid program by combining low deductible insurance coverage with initiatives emphasizing prevention, primary care, and chronic disease management. Policy leaders in the five states reviewed have shied away from more extreme proposals on both the left and right such as Health Savings Accounts funded with public dollars or single payer systems (either government run or government provided insurance).

Utah's HealthPrint: ***Expanding Preventive/Primary Care for Adults***

Background

Utah's HealthPrint is a seven year incremental guide to health care reform focusing on market-based approaches. The effort was launched by then Governor Mike Leavitt in 1994. The redesign of the Utah Medicaid program was the centerpiece of the reform effort. *Utah's Primary Care Network (PCN) was the first Medicaid 1115 Waiver in the nation to provide publicity funded preventive/primary care coverage with donated hospital and specialty care for low income uninsured adults.* The PCN program was originally designed for 25,000 adults. The PCN program began in February 2002 and was capped in November 2002 with 17,000 enrollees. The cap was established based on dollars available and estimated costs. This rapid enrollment was a surprise to Utah Medicaid officials.

The success of the waiver put Utah at the forefront of national discussions to allow for more state flexibility in Medicaid populations and benefit design. Governor Leavitt testified before Congress on the Utah experience and that testimony was instrumental in guiding some of the Medicaid flexibility reforms recently passed by Congress in the Deficit Reduction Act. Leavitt currently serves as the Bush Appointed Director of federal Department of Health Resources and Services Administration (HRSA). Under his leadership, state requests for flexibility in the Medicaid program are being met with positive prompt approvals.

Over the seven year period, Utah's HealthPrint Reforms focused on the following areas:

1. **Expansion of the State Children's Health Insurance Program (SCHIP) to 200% of poverty.**
2. **Establishment of a managed care primary Care Network (PCN) for up to 25,000 adults, ages 19-64, with incomes below 150% of the FPL.** Medicaid pays the network providers to provide a prescribed prevention and primary care package of services to qualifying adults. The benefits are considerably reduced from traditional Medicaid benefits (inpatient and specialty care are not covered). There is a yearly enrollment fee for participants of $50, $25, or $15 depending on income and low co-pays. Covered benefits are as follows:
   a. Primary care provider visits
   b. Emergency room visits for life threatening emergencies
   c. Emergency medical transportation
   d. Lab services
   e. X-rays
   f. Up to four prescriptions per month
   g. Dental exams, dental X-rays, cleanings, and fillings
   h. One eye exam per year; no glasses
   i. Family planning methods

j. Case management assistance in accessing specialty and physician care. Utah has developed a large volunteer specialty physician network in the Salt Lake Area.

3. **Development of a premium assistance program (Covered at Work) funded with Medicaid dollars through the waiver for low income individuals who have access to insurance to purchase insurance.** The premium provided is $50 per month per qualifying employee. This premium has proved to be too low to be appealing and very few individuals (less than 100) are enrolled. This is far below the original projections and cap of 6,000 enrollees.
4. **Passage of a legislative package of small group and individual insurance reforms.** Insurance reforms were designed to provide a private sector minimum benefit package, allow for portability within the small group market, provide for guaranteed renewability, limit pre-existing conditions waiting periods to 12 months, provide for dependents up to age 26 on the parent's policy, and adjust rating bands.
5. **Establishment of Medical Savings Accounts (MSAs).** The MSAs allows state income tax credits of up to $2,000 for medical expenses. Over time, the state authorizing legislation has been revised to be consistent with federal MSAs.

Lessons to be Learned from Utah

1. Utah has won a number of awards for financial management because unlike other states, Utah has been able to manage its Medicaid expansion and stay within available dollars. Because program managers have been willing to reduce benefits, control eligibility, negotiate rates with network providers, and cap enrollment, Utah was able to expand coverage to previously uncovered adults and meet federal waiver requirements of "cost neutrality". The Utah Medicaid program accomplishes "cost neutrality" by capping the number of enrollees in accordance with the estimated cost of the benefits package per individual and the total budget available. Evaluators of the program have suggested the "quick take up" demonstrates that low income individuals know they need insurance and lack of enrollment in Utah's Cover at Work program is "cost based". PCN has remained near capacity since it was capped in 2003. Utah only hosts open enrollment for PCN when sufficient individuals move off the program or additional funds become available.
2. By putting the coverage emphasis on a primary care/prevention services, Utah has been able to meet the health needs of a large number of adults. But this approach places a heavy burden on specialists and hospitals to provide uncompensated charity care. As this burden grows, the Utah model may not be sustainable.
3. A Patient Outcome Evaluation of PCN funded by Utah Medicaid (Martin, June 2004) found enrollees got more needed care after enrolling in the program; were less likely to have utilized a hospital; and reported increased problems in visiting a specialist from before enrolling in the program. The program has reduced hospital utilization but left primary car physicians managing chronic care patients without the usual specialty physician backup.
4. The premium assistance amount in the Covered at Work Program of $50 is <u>too low</u> to be attractive to employees. There has been very little interest or enrollment in this program.

Other research has found that low income adults have very little discretionary income and that "elasticity" in terms of premiums and co-pays is very small. The limited take-up in the Covered at Work Program provides an interesting contrast to the **Insure Montana** program described next which in comparison appears very successful but provides significantly higher premium assistance.

Montana: *Insuring One Small Business at a Time*

Background

In 2005, through the joint leadership of Democratic Governor Brian Schweitzer and Democratic State Auditor, John Morison the state legislature passed HB 667, "the Small Business Health Care Affordability Act". The Act established the Insuring Montana Program (IM).

The program is designed to assist Montana's small business employers in providing health insurance through a two part program. Approximately 40% the available funding is used for financial incentives in the form of tax credits offered to small businesses (small business is defined in the law as 2-9 employees) which are currently subsiding at least 50% of their employees health insurance costs[2]. The majority of the funding (60%) is used to subsidize a small business purchasing pool to allow currently uninsured small businesses to offer insurance. Blue Cross Blue Shield of Montana (BCBSMT) is the pool administrator. BCBSMT has created two health insurance programs (The Standard and the Premier). The Standard Plan is a $1000 individual/$2000 family deductible with 70% insurance/ 30% individual pay. The Premier Plan is a $500/$1000 deductible and 80%/20% pay. A premium assistance program is tied to the voluntary purchasing pool program to help both employers and employees purchase insurance.[3] The Montana State Planning Grant estimates that once operational, there are about 47,000 Montanans, working in qualifying small businesses that would be eligible for the pool.

In contrast to many other state insurance expansions, this program is located and administered through the elected State Auditor's Office. The program is funded by cigarette tax revenues which flow into the Health and Medicaid Special Revenue Fund. The legislative fiscal note is clear that no general fund dollars are used in this program. The IM program was capped by the authorizing legislation at $11.7 million in FY 2007 with the tax incentive portion of program capped at $4.5 million.[4] Program implementation is tied to the accumulation of revenues. If revenues are not available, eligible businesses are put on a wait list on a first come/first serve basis. The authorizing legislation is also clear that other parts of the Medicaid program have first draw on the Special Revenue Fund (i.e. SCHIP etc) before this program receives funding ($25 million must accumulate in the fund to begin operations). The authorizing legislation directs the

[2] Please note all materials and information on the web site for businesses interested in enrolling define small business as 2 to 5 employees.
[3] The average incentive payment is $194 per month and the average assistance payment is $145. $302 is the average monthly premium amount, before assistance payment. Wyoming Health Care Commission Minutes, July 2006.
[4] Please note entire program appropriation was about $13 million including administrative and start-up costs.

IM Governing Board to work with the Montana Department Public Health and Human Services to pursue a Medicaid 1115 Waiver to partially fund this program.

The program has been positively received. In January 2006, when the pool first began, 600 businesses had already registered for the estimated potential 300 slots incrementally available until July 2006. Increased funding in the new fiscal year, the program was able to expand capacity. As of July 2006, 450 businesses were receiving tax credits for an average credit of $5200. Mr. Morrison, the State Auditor, is running for the United State Senate and touting "Insure Montana" as one his major success stories while in elected office.

Program specifics:

IM Refundable State Income Tax Credit for Insured Small Business for employers who currently pay some or all of the cost of group health insurance for their employees and provides additional tax credits when employers pay for insurance for the employees spouse or their dependants. To qualify employers must be providing insurance and meet the State Auditors Office criterion for small employer (2-5 employees)[5]. The tax credit cannot be more than 50% of the premium paid and no employee other than the owner can make more than $75,000. The table below presents the potential tax credits (please note: If the average employees is 45 or older, the tax credit for an employee increases to $125.00). Tax credits are credited to employers annually as part of Montana's Income Tax System.

Tax Credit Amounts	Employee Only	Employee's Spouse	Employee's Dependants
Employer Tax Credits	$100/month	$100/month	$40/month

Premium Assistance and Incentive Payments for currently uninsured small business and employees of small business. When a previously uninsured employer enrolls in the new State Health Insurance Purchasing Pool created by HB 667, the employer becomes eligible for premium incentives. After receiving premium incentive, the net of the employer payment is 25% of the employee premium. The employer will receive a monthly Premium Incentive Payment for each employee covered. The employees also become eligible for employee assistance payments. Each employee will receive a monthly Premium Assistance Payment (amounts will range from 20%-90% depending on family annual income). Both the employer premium incentive payment and the employee premium assistance payment are electronic funds transfer sent directly to the eligible individual.

Lessons to be Learned from Montana

1. Even though the Montana program has only a six month track record, the interest exhibited by small business is encouraging. The Montana results suggest that premium assistance models in combination with purchasing pools can lure previously uninsured small businesses

[5] Notes from the Wyoming Conversation with Montana indicated the small employer had been changed from 2 to 5 to 2 to 9. However, all of the written materials available on this program indicate that the program is for small employers with 2 to 5 employees. Possibly the information available on the web does not reflect this change.

to purchase insurance for their employees. When compared to the Utah premium assistance program (which is languishing for lack of interest), it is also clear that premium assistance must be large enough that an employee feels they can "afford" to participate.

2. The tax credit program based on a state income tax system would be difficult to implement in Wyoming. However, the tax credit program addresses one of the major questions raised when working on systemic access to health insurance. If the approach provides financial incentives to previously uninsured businesses to become insured, what message does this send to the "good citizen" employer who has provided insurance and had to build the insurance cost into his competitive cost previously?
3. This program has a dedicated funding stream distinct from general funds and not reliant on Medicaid funding in order to begin implementation. By establishing a dedicated funding stream, policy makers were allowed broad creativity in program design.
4. The authorizing legislation is clear that Medicaid funding is desired. Montana has a very expansive Medicaid program and has a national reputation for leading the way in encouraging Congress to expand Medicaid into new areas. The intent was to pursue waiver funding for all enrollees who are not currently eligible for Medicaid or CHIP, but meet the following criteria:[6]
   a. Uninsured adults ages 19 through 64 who have children under the age of 21, and have incomes under 200 % FPL; and
   b. Youths age 18 to 21 with incomes under 200% FPL
5. Montana also has a history of successful pursuit of federal funding for innovative expanded coverage. In the eighties, Montana Medicaid, working with Democratic Senator Max Bacus, long standing member of the Senate Finance Committee, became the first state to receive federal match to pilot the Critical Access Hospital (CHA) program. The success in Montana in sustaining small rural hospitals through federal/state support led to the approval of the program nationwide. Given the clear directive from the Montana legislature to pursue a waiver and the fact that one of the primary designers, Mr. Morrison is running for the U.S. Senate, I would assume that Montana will make every effort to be allowed to "pilot" this program for the nation and capture federal match for all low income (below 200% FPL) adults with or without children.
6. The program is capped in a similar manner to Utah, i.e. based on availability of funding. Enrollment is controlled in the same manner as Utah with a "first-come first-served approach". If funding grows, the cap works by keeping the program within annual appropriations and allowing orderly expansion. However, if the program is static, issues of how to address the pent up demand of the waiting list may arise. The program is too new to deal with any potential fall-out from a reduction in funding.

Personal Conclusion: *While Montana has not substantially expanded the number of insured individuals in comparison to Utah (hundreds versus thousands), the program is the first I've seen that has effectively drawn uninsured businesses (very small in size 2-5) into the insurance*

[6]The Legislative Services Office estimates that initially about 1200 enrollees will meet this criterion

market[7]*. The ability to stay within appropriations, the immediate appeal of the program to the small business community (based on initial registration) and ability to provide a standard benefit package comparable to other employer-based insurance at a reasonable price through pooled purchasing are all positive features of this approach. In addition, depending upon the outcome of the Montana Senate election, this model may soon be showcased on the national stage.*

Maine's Dirigo Plan: *A Product for Businesses with 50 or fewer employees*

Background

Maine's Dirigos Health (DH) was enacted in 2003 (Public Law 469). DH is a major initiative of Democratic Governor John Elias Baldacci, who was elected in November 2002 on a platform of comprehensive health care reform-addressing cost, quality and access and the promise to develop a plan to "provide coverage to all Mainers". On the first day of his administration (January 2003), Governor Baldacci created by Executive Order the "Governor's Office of Health Policy and Finance" which is responsible for overseeing health reform efforts. DH won unanimous support from the Joint Select Committee on Health Care Reform and 2/3 majorities in both chambers of the Maine legislature. DH is intended to provide universal access to affordable and quality health care in 5 years.

The Dirigo Health centerpiece is DirigoChoice (DC) an insurance product offered through a private carrier(s) for businesses with 50 or fewer employees who work 15 hours or more a week, the self employed and individuals without access to employer coverage, and their dependents. The program offers sliding fee subsidies to qualifying enrollees up to 300% FPL. Employers must pay at least 60% of combined individuals/dependent premium costs. By creating a large pool, DC is intended to provide lower and more stable insurance rates to small business than they would be able to achieve by purchasing insurance as a small business on its own.

Maine's comprehensive approach to reform also includes reforms in the Maine Medicaid program (MaineCare). MaineCare was extended (without waivers) to parents with income up to 200% FPL and childless adults with income up to 125% FPL. MaineCare enrollees, whose employers participate in Dirigo Health, have the option of receiving coverage through their employer's plan with a MaineCare wrap-around or enrolling directly in MaineCare. Individuals not qualifying for MaineCare may receive sliding fee subsidies up to 300% FPL.

DH is a comprehensive reform effort and includes more than 18 separate components. The most notable of these reforms are requirements that a State Health Plan be developed by the Governor's Office to link expenditures and health outcomes; developing a Maine quality forum with a clearinghouse for best practices for wellness, disease prevention; enacting reforms in the insurance market: implementing cost control measures by expanding the existing certificate of

[7] In the eastern states, very small business (under 10) are excluded from many of the mandates and premiums because providing insurance for this cohort has proved so intractable.

need program; and imposing one year voluntary caps on hospitals and other health care providers.

The program was initially funded with contributions from enrolled individuals and small businesses, federal matching funds for low-income families (those below 200% FPL), and an upfront infusion of $53 million in state funds. Future expenses were to be paid by a "savings offset" billed to insurers and third party administrators. The offset was to accrue from the cost controls implemented as part of the reform. If there was no documented savings, there would be no required payments.

DH began enrollment January 1, 2005. In the 16 months since program launch, 15,400 Mainers have enrolled in MC and DC. Of that number, slightly over 10,111 adults and 2,321 businesses have enrolled in DC. While this figure is impressive, Maine had established benchmarks for 31,000 enrollees in the first year and 110,000 participants by 2009. The program has not attracted as many previously uninsured small businesses as the designers had hoped. Though the program has fallen below expectations, DirigoChoice is the fastest growing health insurance product ever launched in Maine. The Superintendent of Insurance has ruled that after the first year of operation the program has saved $44 million in insurance costs in the first year of operation. This amount will be paid by insurance companies and third party payers in future years to fund the program.

Program specifics include:

Participating small business are required to enroll 75% of eligible employees and pay up to 60% of premium. Employers are required to pay an annual participation fee ranging from $150 to $350 depending upon the size of the workforce.

DC is provided by Anthem Blue Cross and Blue Shield. Two plans are offered with tiers that reflect individual family financial circumstances. Both programs offer comprehensive coverage with no-cost preventive care and small co-pays for primary care. There is an 80% insurance/20% individual split on coverage after deductibles are met for in network providers. There is no life-time maximum. The two plans have a range of prices for deductibles and annual maximums based on individual/family income ranging from minimal amounts for participants with very low incomes to actual costs at 300% FPL. In Plan 1, the annual deductible for the individual at full cost is $1250, maximum out of pocket expense is $4000 and the individual employee cost is approximately $282. In Plan 2, the individual deductible at 300% FPL is $1750 and the annual individual outlay is capped at $5,600. The approximate monthly cost per employee for Plan 2 is $260.

Qualifying individuals and families receive discounts on monthly premiums, and reductions on co-pays and other out of pocket expenditures based on a sliding fee scale. Discounts go directly to qualifying individuals accounts.

Lessons to be Learned from Maine

1. In DC, small business **does not** receive a payment incentive for participation. The incentive to participate is the development of a cost-effective product by creating the large pool. While there has been significant enrollment, enrollment has not met projections and suggests that effective models need to offer financial incentives to both small business and to employees.
2. There is not a direct cost savings between the expansion of health insurance and charity care and other health care costs.
3. After a year of operations, there is growing unrest in the provider and insurance community with DH. The Maine Hospital Association has begun lobbying against reducing DC payments to hospitals to Medicaid levels. Insurers protested the "savings offset" approved by the Superintendent of Insurance.
4. DH is administered separate from MC except where enrollee financing merges. Thus, DH has not corrected financial problems faced by the Maine Medicaid program. In January 2004, MC faced a short fall of $127 million leading to a series of cost reduction efforts independent from DH.
5. As part of their State Plan development process, Maine conducted innovative town hall meetings entitled "Tough Choices" for participants who were randomly selected using survey research methodology. The discussions were highly structured and provide an interesting model for pursuing public input. Results indicated that after 18 months of implementation further expansion of DC and MC was supported by 30% of the participants. An option not even offered when the groups where formed, single-payer system was supported by 48% of the participants. Similar to the country as a whole, no option enjoyed responding support.
6. DH has had an impact on the health care of Mainers. Maine has won national awards for innovation. Maine is one of 7 states, the only in New England, to reduce its uninsured population between 2000 and 2004. In contrast, New Hampshire increased its uninsured population by 48,000 during the same period.

Massachusetts: *Emphasis on "Shared" Responsibility and Mandates*

Background

Massachusetts, under the leadership of Republic Governor Milt Romney, made national headlines (April 2006) when the overwhelmingly Democratic state legislature passed Chapter 58. Chapter 58 requires all Massachusetts who are uninsured to buy health care coverage by July 1, 2007. The Massachusetts model is fundamentally different because it "delinks the longstanding relationship between employment and insurance coverage." In the Massachusetts model, insurance is portable with the individual from job to job because belongs to the individual and not the place of employment.

The Commonwealth Care Health Insurance Program was created to provide government subsidies to low income individuals to make the required insurance affordable. Sliding scale subsidies will be available to individuals with incomes up to 300% FPL. Individuals with incomes less than 100% FLP will not pay any premiums. In this carrot and stick approach, individuals who can "afford" insurance and do not purchase it will lose their personal tax exemption in 2007 and face fines of 50% of the monthly cost of health insurance for every month that they go without coverage afterwards.

The rules for health insurance and business are also changed in this model. There are two new requirements of businesses of 10 or more employees. The first requirement is that businesses provide insurance or pay a "fair share" contribution of up to $295 a year. The second requirement is businesses offer "Section 125" cafeteria plans to their employees <u>even if the business does not provide health insurance</u>. These plans permit workers to purchase health care with pre-tax dollars. Employers, who don't offer the cafeteria plans, face a "free rider surcharge". The surcharge is a hefty potential fine of being charged up to 100% of an employee's uncovered health care costs over $50,000. There is no charge to employers who offer the 125 plans but do not provide the insurance. Small businesses with 10 or fewer employees are excluded from all of these requirements and fines.

Another new concept, which has been promoted by the Heritage Foundation, is the establishment of a clearinghouse, the "Commonwealth Health Insurance Connector" to connect individuals to affordable, quality insurance. Both uninsured individuals and small business under 50 employees can purchase insurance through the Connector. Workers who aren't offered insurance by their employer can identify policies on the Connector and purchase these policies with pretax dollars through the Connector. The Connector will also assist 19-26 years olds to identify lower-cost products.

Through insurance reforms, the individual and small-group insurance will be merged by July 2007. This change is anticipated to reduce costs to individuals by 24%.

The program designers anticipate that 515,000 residents of Massachusetts will be covered within 3 years at a cost of $1.2 billion dollars. Funding relies on redistribution of some Medicaid payments, general funds from the Free Care Pool, new funding from employer contributions and new general fund appropriation of $308 million over three years.

Questions over Specifics:

Unlike models that are currently operational, Massachusetts has yet to develop the specifics of their model. Key questions still remain around such issues as:

1. **Affordability**. The individual mandate is only enforceable if "affordable health plans are available". The legislation does not define "affordable". Legislative discussion suggested that $220-$250 per month was affordable. However, it remains to be seen

whether insurance companies will offer "affordable" policies and what affordability means in terms of implementation.

2. **Impact on the behaviors employers of the mandatory assessment**. The assessment on businesses ($295 annually) is much less than providing insurance to employees. The question remains if the mandate and fine approach will lead to more employer coverage or employers choosing to drop current coverage and pay the fine.
3. **Accuracy of cost projections**: In addition to the funding subsidies described in the Commonwealth Care Health Insurance Program, Massachusetts expanded Medicaid coverage to children living in families with incomes up to 330% FPL. There are enrollment caps on other Medicaid programs for adults. Projections are that these Medicaid expansions will cover an additional 92,500 people, mostly children. Historically, the costs of large Medicaid expansions in states have been drastically under estimated because of increasing health care costs.

Lessons to be Learned from Massachusetts

1. Massachusetts' efforts suggest that history matters and even failed efforts at reform can provide building blocks for future reform efforts. This is the third wave of reform in Massachusetts.[8] The legacy of reform provided Massachusetts has provided a strong foundation of insurance coverage through employer sponsored insurance and expansive Medicaid. As result about 10% of Massachusetts residents are uninsured compare to the national average of 16%.
2. The nation is watching Massachusetts carefully to determine if delinking insurance from employment and imposing a personal mandate for coverage will result in significant new enrollment. The big question mark is providing "affordable" coverage and if he cost of premium assistance program can be sustained by the state.

Vermont: *Linking universal health care and cost containment*

Background

After vetoing a reform bill in the previous legislature, Vermont's Republican Governor Jim Douglas worked with a bi-partisan legislature to pass the 2006 Health Care Affordability Act as a first step toward achieving the goal of quality, affordable health for all Vermonters. The main goal of the legislation was to control the steeply rising health care costs of all Vermonters. The cost control is accomplished by a two-pronged approach;

1. Encouraging uninsured individuals to come into the health insurance pool by providing access to a low cost product and providing sliding fee subsidies; and

[8] Other reform efforts date back to 1988: Universal Health Care Law that was never implemented and 1996: Chapter 203 MassHealth Bill. This was a broad Medicaid expansion increasing the number of Medicaid enrollees from 670.000 in 1995 to slightly over I million in 2006.

2. By undertaking a statewide chronic disease care management plan for all Vermonters who have chronic diseases.[9]

The premium assistance program (called Catamount Health) provides low-income uninsured Vermonters with subsidies to purchase the employer-sponsored insurance plan if offered. If the employer does not offer insurance, uninsured Vermonters can enroll in the Catamount Health Plan, a publicly subsidized plan administered by a private health insurer Blue Cross and Blue Shield of Vermont. It is estimated that as many as 60,000 Vermonters may be eligible for this program. Uninsured individuals are those who do not qualify for any other publicly funded program, have not had private or employer sponsored insurance for the past 12 months, have lost the private employer sponsored coverage because of loss of employment or other qualifying event, or have lost college or university sponsored health insurance. Catamount health is designed to be a voluntary program which offers an affordable and comprehensive benefit plan to every uninsured Vermonter. Benefits include primary care, preventive and chronic care, acute episodic care, and hospital services.

It is estimated that about 25,000 currently uninsured Vermonters will enroll.[10] Premium subsidies are projected to range from $60 a month for individuals with incomes above the Vermont Health Access Program (VHAP) but below 200% FPL to $135 a month for individuals with incomes between 275% FPL to 300% FPL. VHAP is the existing publicly funded insurance program for adults age 18 or older with incomes below 150% FPL. This program was created in April 1995 and funded with an increase on state cigarette taxes and an 1115(a) Medicaid Waiver. This program was designed to provide health services to very low income individuals who did not qualify for traditional Medicaid[11]. This program has been revised to have lower premiums and allow participants to purchase employer-sponsored insurance. The premiums for Dr. Dynosaur, Vermont's Children's Health Insurance Program, will also be reduced by 50%.

Employers who do not provide health insurance are required to make a premium contribution of $365 annually for each full time equivalent (FTE) in the first year. It is anticipated that this assessment will increase at the same projected rates as premiums in Catamount Health (estimated at 5% a year). An FTE is an employee who works 40 hours a week for 13 weeks.[12] Employers are allowed exemptions for 8 employees in fiscal years 2007 and 2008, six in FY 2009 and 4 beginning in FY 2010.

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[9] A chronic condition is denied as an established clinical condition that is expected to last a year or more and that requires ongoing clinical management. Examples include: diabetes, hypertension, cardiovascular disease, cancer, asthma, pulmonary disease, substance abuse, mental illness, hyperlipidemia, and spinal cord injury.

[10] The enrollment estimates were generated by Dr. Kenneth Thorpe's economic modeling. Dr. Thorp is the Robert woodruff professor and Chair of the Department of Health Policy and Management in the Rollins School of Public Health in Atlanta, Georgia. The Vermont Legislative Commission Health Care Reform engaged the services of Dr. Thorpe in identifying more affordable health models for Vermont. It should be noted that in reviewing materials on Vermont, agency officials representing Governor Douglas strongly disagreed with some of Dr. Thorpe's assumptions and modeling.

[11] VHAP also provide prescription drug benefits to low income elderly and disabled. VHAP was designed to provide initial access for the uninsured and then move recipients into a Managed Care program.

[12] There are partial calculations for part-time employees in which their actual hours work by 520 I40 hours X 13 weeks).

In his BluePrint for Health Initiative, Governor Douglas identified cost control as the centerpiece of his reform efforts. As part of the reform, a chronic care management system will be created for all Vermonters; The plan will provide early and coordinated screening for chronic conditions, better management of chronic care, emphasis on patient self-management, payment to providers that rewards quality and disease management not just quantity. Strong chronic care management programs have resulted in 5% to 10% per member savings for some insurance plans[13] The plan also directs chronic care management in the Catamount Health Plan, Medicaid, VHAP and Dr. Dynasaur. Primary care providers will be paid to coordinate the care of individuals with chronic conditions. The emphasis will be on delivering the right care at the right time through prevention and early treatment. It is the intent of the reform that the new chronic care model will be available to every Vermonter with any type of health plan not just individuals in the public programs. By redesigning the health care delivery system to provide better chronic care management, it is estimated that system-wide Vermont will save $550 million over the next ten years.[14]

The reform effort also included a series of activities identified as "common sense initiatives". These activities included community wellness grants, information technology coordination, loan repayment for health care professionals, health lifestyles insurance discounts, administrative simplification of claims and credentialing, multi-payer databases, medical event reporting and hospital infection reporting among others.

The program is funded with tobacco settlement funds, cigarette tax increases, and employer health care premium contributions. The program has cap on enrollment to limit the state's financial risk.

Program Specifics:

Similar to Massachusetts, Vermont is presently in the rule making stage. However, unlike most states the specific benefit package including costs and co-pays were written into the legislation. The legislature chose this specificity because of disagreements between the Republican Governor Douglas and the democratically controlled legislature on the scope of the benefit package. The benefit package is to be similar to one available to Vermont state employees. However, the costs as noted above will be much lower to enrollees because of the premium assistance program. Individuals with income above 300% FPL will pay full costs which are currently estimated to be about $340 per month.

Lessons to be Learned from Vermont

1. The Vermont model is premised on encouraging enrollment of all potential eligible's in publicly funded programs. Vermont estimates that there may be as many as 22,500 Vermonters eligible but not enrolled in public programs. In order to encourage enrollment, Vermont is reducing co-pays and premiums on existing Medicaid, Dr. Dynasaur and VHAP

[13] Dr. Kenneth Thorpe, health care consultant.
[14] Dr. Kenneth Thorpe, health care consultant.

programs. These changes further document the limited purchasing power of low income individuals and the nature in which costs negatively impact enrollment. It should be noted that these changes are being made when Vermont faces large cost overruns in other parts of its Medicaid program.

2. The Vermont model is an incremental phased-in approach to coverage. It begins with individuals who have traditionally been uninsured for at least 12 months. Groups such as the under-insured may be added at a later date but Vermont wants to verify the accuracy of its projections before expanding further. Verifying the accuracy of the projects to actual experience will be one of the lessons learned form Vermont. Dr. Thorpe's approach to modeling was new and quite well received by the legislature but not as well received by the Governor and his staff. Actual experience is the best evaluator of the predicting accuracy of any model.
3. The emphasis on chronic disease management is consistent with new directions in preventive/primary care. Assuming the cost savings can be realized, the redesign provides real promise for changing how we provide high quality medical care while reducing the trajectory of health care spending.
4. There is considerable discussion in Vermont about the Catamount Plan. One letter to the editor said: "it's a great policy if you can get it." The plan benefits are very comprehensive. Some of the discussion is whether the availability will actually lead employers to drop insurance in order to access better coverage at a lower cost to their employees. In these discussions, it is noted that the annual premium contribution of $365 is far below the cost of providing insurance. Actual experience will provide an excellent barometer of whether the plan serves as an incentive for uninsured to access health insurance as planned or if it instead provides as an incentive for those currently providing insurance to seek a more cost effective, compressive benefit package.
5. Similar to Massachusetts the big questions lie in the area of costs and take up. These questions are only finally answered through experience

CLOSING THOUGHTS

There are a number of new approaches to coverage on the horizon. If history is any predictor of the future, some will work better than others and some may not work at all. Some may work but far exceed budgetary estimates. One may provide the grand solution we are searching for.

The next two years will provide an excellent opportunity to evaluate which new approaches seem to be working the best. Given that many of these ideas are just beginning to be tested and given that I am a western pragmatist, I believe the Commission should approach reform incrementally. I would undertake (during the next fiscal year) a series of initiatives that have demonstrated success in other states, which provide visibility to the public that the Commission is taking concrete action and making progress. While implementing these initial first steps, I would carefully monitor the eastern states' experiences with implementation with the goal of identifying those components which work best for implementation in Wyoming in the next three to five years.

Using the incremental approach, I would suggest the following steps this year:

1. An easy place to begin is with providing health insurance to the uninsured and underinsured between the ages of 19 and 26. Several states have addressed this group with fairly simple fixes. The first is to allow parents to carry dependents on their insurance policies until they are 25 or 26 (Utah and Vermont). Another approach is to mandate all students enrolled in state-funded higher education programs (University of Wyoming and community colleges) document that they have insurance as part of registration or accept coverage available through the higher education system (Idaho). A mandate for student health insurance coverage requires that the mandating body provide an affordable, low deductible comprehensive policy. At present, University of Wyoming full-time students can voluntarily opt out of coverage; part-time students can't get the coverage unless they are graduate students and the Wyoming Community College System does not provide universal access to a student insurance product. Possibly coverage could be linked to the new Hathaway scholarship to assist with affordability. If the Commission was interested in mandating that students carry health insurance, additional work would need to be done on numbers, affordability, access to products, and potential subsidies.
2. A second approach to this population is to use the Vermont approach of creating a low cost preventive care/primary care product for individuals between 19 and 26 which is tied to the individual not to work or school. This product could be offered through the private sector with premium subsidies available to the individual on a sliding fee basis.
3. Every state reviewed placed emphasis on enrolling eligible recipients in existing Medicaid programs. We discussed this at the meeting I attended in June and Commissioners seemed satisfied with outreach for Medicaid programs. However, this is a relentless task and new approaches are developed all the time. For example, Florida has developed a "smart application" which can be completed at computer kiosks in libraries and hospitals. Ongoing public education such as major events around "Cover the Uninsured Week" is part of this process. The Covering Kids and Families Outreach Program funded by Robert Wood Johnson have ended. Are there plans to continue aggressive outreach?
4. Wyoming is one of the smaller Medicaid programs in the nation in terms of covered services. I noticed in the minutes that some felt from verbal discussion that new initiatives are a move away from Medicaid. However, upon closer examine it is clear that all the reform states have utilized Medicaid as part of their funding engine, along with new sources of revenue. The reform states have redesigned and expanded target populations to meet identified needs. Given the role of Medicaid in reform, the Commission may want to ask the Health Department to review with them all possible expansions such as family and single coverage under the SCHIP program. The group may also want to look at the "Medically Needy" program to determine if the new flexibility available within federal law would allow the development of an insurance program which could be capped for adults up to 185% of poverty with "Chronic Diseases". This coverage would help with high costs of care for individuals with chronic diseases but unlike the Utah model would also pay the provider community (primary care, specialists and hospital) to manage this care. It has been

consistently documented that chronic diseases are a high cost to society and early intervention and ongoing management will result in better outcomes and lower costs. If this is an approach and the Commission is interested in significant time would need to be devoted to the design and address such issues as costs, caps, benefit, incentives for care management to providers, incentives to patients to complete care regimen.

5. Wyoming is state of small businesses and sole proprietors. Working on reform of the small business health insurance market might pay big dividends. Massachusetts is creating a single purchasing pool for small business and sole proprietors. A single pool in Wyoming might make a significant difference in access and cost particularly if high cost individuals could be directed to a publicly funded chronic disease management program.
6. The "Connector" concept in Massachusetts has great appeal. I frequently hear from individuals that they don't know where to go for insurance. The concept of "virtually linking" the individual with insurance both public and private options is worth investigating no matter which series of options the Commission chooses.
7. If the Commission is more interested in the "grand scale" approach, then the experience of the other states presented in this paper suggests that the design may not be as important as the decision by policy leaders of both parties with the Governor as the lead deciding to begin "something". The small business model in Montana is the easiest of the models reviewed to "test". By utilizing caps it is possible to pilot a small business model with very limited new dollars. However, mandating coverage for all individuals and then developing a subsidized model to assure affordability will be very expensive.
8. The long history of the eastern states suggests that the effort at reform even when it runs into problems, provides momentum for further reforms and information on how to improve. In the "grand scheme" methodology, the Commission should agree to some fundamental tenets such as focus on small business (Montana and Maine) or emphasis on preventive and primary care (Utah and Vermont), incentives versus mandates, timeline for implementation, possible funding (new tax, assessment on business) and then begin a dialogue with Governor about what is possible.

One Final Thought: I would not recommend putting substantial time and money into design features until the Commission and the Governor agree on a basic foundation for the design and amount of new funding that may be committed to a new effort.