State Healthcare Reform Efforts

March 2017

Prepared by: Peter Renevitz

As the century began it was becoming increasingly evident that the issue of healthcare was going to be an issue which would have to be addressed. Between the ever growing costs, and the country's aging and sicker population, the old structures would strain under the additional costs. Efforts to address this issue began at the state level, as federal legislation permitted individual states to experiment with Medicaid expansion models through the adoption of waivers Section 1115.

State Efforts before the ACA

Section 1115 of the Social Security Act of 1962 gave the Secretary of Health and Human Services authority to approve experimental, pilot, or demonstration projects to promote the objectives of both the Medicaid and Children's Health Insurance Program (CHIP) programs. The purpose of these demonstrations, was to give states additional flexibility to design and improve service delivery to constituents. It was also hoped that these demonstrations would return valuable information to evaluate policy approaches going forward.[1]

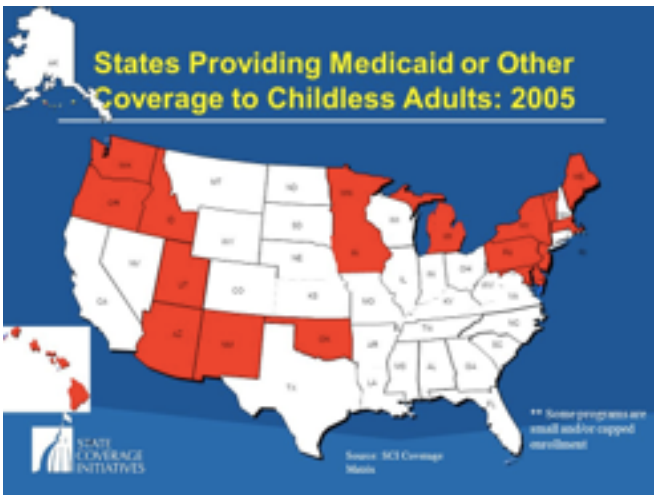
Medicaid Section 1115

Enabling states to apply for these waivers enabled the executive to promote innovation, improvement, and possible efficiencies in health care service delivery. States with 1115 waivers received federal matching funds to expand Medicaid services and eligibility requirements. The State Children's Health Insurance Program (S-CHIP, later known as CHIP) was enacted in 1997 and fully implemented by 2000. CHIP increased Medicaid enrollment, as families of children who responded to outreach efforts were also found to be eligible for Medicaid. Naturally, the overall health care spending trend began to increase at faster rates, particularly for prescription drugs. In 2001, the Bush (43) administration attempted to permit the use of CHIP funds to cover childless adults. However, Congress barred future CHIP waivers for childless adults under the Deficit Reduction Act. The Health Insurance Flexibility and Accountability (HIFA), provided a streamlined waiver approval process for states to demonstrate comprehensive approaches that would increase the number of individuals with health insurance coverage using then-current-level Medicaid and CHIP resources.[2]

States seeking to expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible, to provide services not typically covered by Medicaid, or use innovative service delivery systems, had to receive a federal waiver from Medicaid standards. To receive a Section 1115 wavier from the Centers for Medicare and Medicaid Services (CMS) states had to meet certain criteria, specifically that the proposal would:

- increase and strengthen overall coverage of low-income individuals in the state;
- increase access to, stabilize, and strengthen providers and provider networks available to serve Medicaid and low-income populations in the state;
- improve health outcomes for Medicaid and other low-income populations in the state; or
- increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.

Demonstrations had to be "budget neutral" to the Federal government, which means that during the course of the project Federal Medicaid expenditures will not be more than Federal spending without the demonstration.[3]



Utilizing these tools many states attempted to address healthcare reform on their own terms before passage of the ACA. The results of these experiments could be useful in addressing the issue at a federal level. By 2005, a total of 19 states had expanded their Medicaid programs to cover childless adults and make other modifications.[4]

Specific State Efforts

Several states attempted to address, what they perceived to be problems with the health care industry, prior to the federal government's concerted efforts. Worthy programs to note include the following.

Oregon: "OHP"

Among the first states to attempt to expand coverage with Medicaid under this provision was Oregon, through its Oregon Health Plan (OHP). In 1989 Oregon enacted a series of health reforms with the goal of securing universal coverage in the state, including an employer mandate.[5] However, the mandate never went into effect, and the state's health reform efforts instead focused primarily on the Medicaid-expansion component of OHP.[6] Put simply, Oregon intended to expand Medicaid to more people by covering fewer services. Expanding coverage for the poor—all Oregonians with incomes below 100 percent of the federal poverty level were made eligible for Medicaid—would be made affordable by offering recipients a basic health benefit package, one more limited than traditional Medicaid. A prioritized list that ranked medical conditions and treatments based on clinical effectiveness and "net benefit" was developed. Depending on how much it decided to spend on Medicaid, every two years the state legislature would literally draw a line in the list, with Oregon Medicaid paying for all services above the line and no services below it. In addition, the state sought to improve access and control costs by enrolling Medicaid recipients in capitated managed care organizations.[7]

Maine: "Dirigo Care"

In 2002, Maine received approval to expand their Medicaid program. Maine's approved waiver allows the state to use allocated but previously unspent disproportionate share hospital (DSH) funds to expand Medicaid eligibility to childless adults with incomes at or below poverty 100% federal poverty level (FPL) who were previously ineligible for Medicaid or SCHIP. The program was capped at 20,000 individuals with a maximum DSH total diversion of $90 million.

After one year of operation, the state will assess whether there is sufficient state funding to further increase childless adult eligibility to 125% of poverty.[8]

Massachusetts: "MassCare"

In 2006, Massachusetts passed and implemented its Health Care Reform bill (Chapter 58 of the Acts of 2006) to provide health care coverage to nearly all state residents. Legislation called for an individual mandate requiring residents to obtain health insurance coverage. It further placed responsibility for financing the coverage on: Medicaid expansions and subsidies; re-direction of Uncompensated Care Pool and Disproportionate Share Hospital funds; employers, through a "fair share contribution"; and a "free rider surcharge" for certain employers with employees receiving substantial free care services (focusing on preventive care).

The Medicaid expansion included, expanding eligibility for children to those up to 300% FPL. Increased the case load cap from 44,000 to 60,000. Restored previously suspended benefits for adults to include dental, vision, level IIIB detox, prosthetics and chiropractic care.

Established a healthcare exchange (called a "Connector") to be administered by the Medicaid office and CHIP program, to provide subsidized private health insurance for Massachusetts residents, including qualified non-citizens, with household incomes less than 300% FPL. Required a 6-month prior residency to qualify. Applicants only eligible if employer coverage was unavailable for prior 6 months (min. employer contribution of 33% individual / 20% family), to help discourage employers dropping coverage. Employees were able to purchase Connector coverage as long as the employer paid the Connector an amount equal to the employer's median contribution for its full-time employees (in order to off-set CHIP subsidy premiums).

Required Health insurers with 5,000 or more small-group enrollees as of December 31, 2006, to file a plan with the Connector each October, for approval by Connector. Requires Connector plans to meet certain coverage requirements, prohibited deductibles greater than the maximum annual contribution to a Health Savings Account (HSA) permitted by the IRS ($2,700 for an individual, $5,450 for a family). High deductible plans must also include a companion HSA.

Within two years of implementation the state's uninsured rate was cut in half.[9]

Vermont: "Global Commitment"

In 2005, Vermont obtained it's Global Commitment waiver, capping all of its federal funded for acute care services under a cap.[10] The waiver allowed the state to use Medicaid funds to refinance a broad array of non-Medicaid health programs and gave the state flexibility to reduce benefits, increase cost-sharing, and cap program enrollment.[11] A second waiver that capped federal funding for long-term care services. These placed a fixed dollar limit on the total Medicaid funds available to the state. While capping costs is generally cause for concern, the cap received under Global Commitment was very generous, and according to the General Accountability Office (GAO), higher than supported by the state's historical spend.[12] Due to this generosity, the state was allowed to refinance existing programs, waiver to expand coverage as part of its broader health reform efforts, in addition to its refinancing efforts.[13]

Also in 2006, Vermont passed comprehensive health care reform also aiming for near-universal coverage. In addition to creating the Catamount Health Plan for uninsured residents, the plan focused on improving overall quality of care and the management of chronic conditions through the Blueprint for Health.

While all states previously expanded eligibility for children to higher levels than adults through Medicaid and the Children's Health Insurance Program (CHIP), in Vermont, children with family incomes up to 318% of poverty (about $74,900 for a family of four) were eligible for Medicaid or CHIP under their waiver.

In addition, the state's Choices for Care program created an entitlement to Home and Community-Based Services (HCBS) for individuals with the highest need for services and also implemented a person-centered assessment and options counseling process to identify what services would be needed to enable individuals to remain in their own homes.[14]

Rhode Island: "Global Consumer Choice"
Rhode Island's global waiver, called the Global Consumer Choice Compact, merged a number of waivers the state already had received from the federal government (such as to help Medicaid-eligible people enroll in employer-based coverage and to expand the use of home- and community-based services for people needing long-term care) with new waiver initiatives. The new initiatives include allowing the state to establish a waiting list for long-term care services and supports while according priority to people with the highest need for such care, and allowing the state to contract on a competitive basis with a limited number of suppliers of medical equipment and other services in order to lower costs.

Where the global waiver differed dramatically from the state's earlier waivers, and from waivers granted to other states, was in its financing structure. The global waiver capped combined federal and state Medicaid spending at $12.075 billion for the waiver's five-year duration (2009-2013). The federal government would continue to pay a fixed percentage of Rhode Island's Medicaid costs up to the cap. The global waiver also allowed Rhode Island to claim millions of dollars in federal matching funds for health care services that previously had been provided entirely at state expense to certain groups of people who are not eligible for Medicaid under federal law; the state would not have received federal matching funds for those costs without the global waiver. Even before the waiver, Rhode Island spent more per Medicaid beneficiary than any other state in the nation.[15]

Other States
Healthcare reform was considered by other states, many using the Massachusetts model as their starting point. Those states included: Alaska, Kansas, Louisiana, Maryland, Michigan, New York, Oregon (reconsidered), and Washington, as well as the District of Columbia. None had passed, however, by the time Congress passed the Patient Assistance and Affordable Care Act (ACA).[16]

Even though California is typically a leader in public policy matters, it failed in its 2007 attempt to pass a health reform plan encompassing an individual mandate and shared responsibility for financing the costs. Even compromise legislation, supported by then-Governor Schwarzenegger, passed the Assembly, but fell short in the Senate.[17]

State Attempts Failing
While states harbored high expectations in covering their un/underinsured populations and containing healthcare costs, a variety of issues rose to derail these attempts. The Section 1115 provision was established and evolved to enable states to address coverage concerns, allowing each to explore their own solutions. States could act as test laboratories for various concepts and see whether or not they would succeed in a real-world scenario without interrupting the entire healthcare market. The high hopes of the states and the healthcare reform movement were quickly dashed as the economic models began to show a down-side of the implemented plans.[18]

Oregon: Capped Coverage and Over-reach
In 2002, the state undertook to expand OHP eligibility from 100% FPL to 185% FPL, to be phased in as budget conditions permitted. The change was based upon uncertain access to federal matching funds, and a downturn of the state's economy. As a result, benefits for existing enrollees were reduced to provide the funds to bring more uninsured into OHP. This led to bifurcation of the program into OHP Plus and OHP Standard. OHP Plus would cover those categorically eligible for Medicaid (such as pregnant women and children), its benefits remained based on the prioritized list. OHP Standard would cover the expansion of non-Medicaid (or CHIP) eligibles. OHP Standard population would receive a reduced benefit package estimated at 78% of OHP Plus's value. OHP increased rates on Plus enrollees, and attempted to cover fewer services. However, CMS had sharply constrained Oregon's ability to use the covered services list as a cost control instrument. As a result, the state was locked into a "very rich and fixed benefit." State policymakers had hoped that limiting services would give Oregon the necessary flexibility and tools to limit OHP spending.

Implementation of the OHP expansion triggered a meltdown in OHP Standard enrollment. In the year following its implementation, enrollment of the Medicaid-expansion population in the health plan fell 53%, dropping from 104,000 in January 2003 to 49,000 in December 2003.10 And in the ensuing eighteen months, OHP Standard enrollment fell by another 50 percent. Only about 24,000 enrollees remained in the state's Medicaid-expansion program by 2006, and it had been closed to new enrollment since 2004.[19]

Maine: High Cost and Lackluster Enrollment
While many hoped for the success of Maine's Dirigo Care plan when it was passed in 2003, it eventually

failed to realize the promises it made. The Dirigo Health initiative was initially heralded as the first state-based universal coverage program of the decade. Governor John Baldacci promised that Dirigo Health would (1) provide coverage for all of Maine's 128,000 uninsured by 2009; (2) not require any new taxes; (3) be paid for by savings created in the health care system in Maine; and (4) reduce health insurance and health care costs for all. The plan began to show fiscal strains within the first year, and most analysts determined that if it continued the program would have likely bankrupted the state.

The core element of the Dirigo initiative was the DirigoChoice "public option" insurance product – designed by state government, administered by a private insurer, subsidized by state tax dollars, and mainly marketed by state government to Maine small businesses and individuals.

As the initiative rolled out, it failed to realize its goals.

- Dirigo Health cost taxpayers $155 million over the first five years in subsidies and administrative costs alone.
- By 2009, DirigoChoice covered just 3,400 uninsured (less than 3 percent of Maine's uninsured population).
- Incredibly, the DirigoChoice premiums for sole proprietors and individuals skyrocketed 74% in 4 years (4 times faster than the Maine State Employees health plan (17%) and 7 times faster than inflation (10%).[20]

Massachusetts: Artificial Market

In Massachusetts, the reform effort has also met with more than its share of problems. According to insurance industry insiders, the plans are too costly for the target market, and the potential customers — largely younger, healthy men — have resisted buying them. Those who have signed up have been disproportionately older and less healthy. This should come as no surprise since Massachusetts maintains a modified form of community rating, which forces younger and healthier individuals to pay higher premiums in order to subsidize premiums for the old and sick.

Thus, between half and two-thirds of those uninsured before the plan was implemented remain so. That's a far cry from universal coverage. In fact, whatever progress has been made toward reducing the ranks of the uninsured appears to be almost solely the result of the subsidies. The much ballyhooed mandate itself appears to have had almost no impact.

Interestingly, this is the effort that would create the framework for the Affordable Care Act - a concept called "managed competition," which leaves insurance privately owned but forces it to operate in an artificial and highly regulated marketplace similar to a public utility. That effort was built upon both analyses from the Harvard School of Business and claimed to have greater input from the private healthcare market - though neither were rousing fans of the result.[21]

Vermont: Unsustainable Costs

In the best political environment for the establishment of a single-payer healthcare model, Democratic Gov. Pete Shumlin was forced in 2014, to kill the state's Global Commitment program, in what was a surprise announcement. The reason: the final estimates indicated that the plan would have required the state to raise an extra $2.5 billion in revenue annually. This is in a state that typically only raises about $2.7 billion total each year. In other words, it would have cost nearly the the same as the entire state budget combined - and that presumed that those estimates were accurate, and that the program encountered no unexpected cost overruns. It was simply unsustainable.[22]

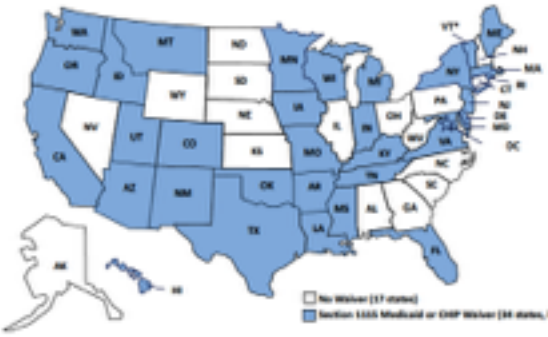
Transition to federal Affordable Care Act

When the Congress passed the Patient Assistance and Affordable Care Act in 2010, Medicaid expansion was a key component. In most states, however, this meant dismantling their prior healthcare expansion efforts under Section 1115. The waivers were then utilized to integrate the various state's Medicaid programs into the federal Affordable Care Act. As of May 2012, 34 states were operating at least one comprehensive Section 1115 Medicaid waiver.

In addition, according to data from the Office of Management and Budget (OMB), federal funds flowing through Section 1115 waivers will account for a third of total federal Medicaid expenditures in 2012.[23]

Figure 1

States with a Section 1115 Medicaid or CHIP Demonstration Waiver, February 2012



Note: Map denotes states with at least one comprehensive Section 1115 Medicaid or CHIP demonstration waiver program in operation. It does not include more narrowly drawn Section 1115 waivers, such as family planning waivers.
Source: Centers for Medicare and Medicaid Services, "Section 1115 Demonstration List," http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/Section-1115-Demonstrations.html, accessed May 7, 2012.

Conclusion

In the end, representatives many stakeholders across the spectrum agreed that some sort of healthcare reform was needed to address issues of cost, a growing uncovered population, and an aging and sicker population. Some states developed the political will to

attempt to address these issues, and Section 1115 of the Social Security Act of 1962 gave them the vehicle to adapt their Medicaid programs. The programs they

devised were instructive for future models of healthcare policy both in other states and at the federal level.

Some states were able to explore new methods of service delivery, however the pressures at the federal level to pass a comprehensive system, did not permit the states to deliver as much empirical data (both coverage and cost) to the public policy discussion. While there was little data derived, there were some lessons from these programs.

The future of the federal Patient Assistance and Affordable Care Act (ACA) remains uncertain. However, there is no doubt that both the initial passage of the ACA and any follow-on federal healthcare reform efforts will take lessons from the early medicaid expansion efforts (including the ones described above). Whether or not the ACA is modified, it will likely be many years before any system is devised without rancor among government, insurers, providers, covered populations, and other stakeholders in the states.

---

1. 42 U.S.C. 1315
2. Medicaid: A Timeline of Developments, 1965-2009, KaiserFamily Foundation, 2008. https://kaiserfamilyfoundation.files.wordpress.com/2008/04/5-02-13-medicaid-timeline.pdf
3. "About 1115 Demonstrations", medicaid.gov, accessed: March 2017. https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html
4. States Providing Medicaid or Other Coverage to Childless Adults: 2005, State Coverage initiatives.org
5. L.D. Brown, "The National Politics of Oregon's Rationing Plan," Health Affairs 10, no. 2 (1991): 28–51; M.A. Strosberg et al., eds., Rationing America's Medical Care: The Oregon Plan and Beyond (Washington: Brookings, 1992); and D.M. Fox and H.M. Leichter, "Rationing Care in Oregon: The New Accountability," Health Affairs 10, no. 2 (1991): 7–27.
6. OHP also encompassed a high-risk medical insurance pool and state-certified insurance packages for small businesses and the self-employed.
7. "Health Reform Interrupted: The Unraveling Of The Oregon Health Plan", Jonathan Oberlander, Health Affairs, December 2006.
8. *Fact Sheet, Maine Section 1115 Waiver, Kaiser Family Foundation, 2003,* https://kaiserfamilyfoundation.files.wordpress.com/2003/03/4098-maine-section-1115-waiver.pdf
9. Massachusetts Health Care Reform Bill Summary, Blue Cross Blue Shield Foundation of Massachusetts. http://bluecrossfoundation.org/resource-guide/overview-and-summary-results-2006-health-reform-law
10. Guyer, J., "Vermont's Global Commitment Waiver: Implications for the Medicaid Program," Kaiser Commission on Medicaid and the Uninsured, April 2006.
11. Ibid.
12. Government Accountability Office, "Medicaid Demonstration Waivers Recent HHS Approvals Continue to Raise Cost and Oversight Concerns," January 2008, GAO-08-87.
13. "Vermont Health Care Reform Plan," Kaiser Commission on Medicaid and the Uninsured, December 2007. 21 Artiga, S., "Florida Medicaid Reform: Early Findings and Current Status," Kaiser Commission on Medicaid and Medicare
14. Vermont Choices for Care: Fact Sheet, Proposal 11-W-00191/6, Updated January 2015.
15. Rhode Island's Global Waiver Not a Model For How States Would Fare Under a Medicaid Block Grant, Jesse Cross-Call & Judith Solomon, Center for Budget and Public Policy, March 22, 2011. http://www.cbpp.org/research/rhode-islands-global-waiver-not-a-model-for-how-states-would-fare-under-a-medicaid-block
16. "Lessons from the Fall of RomneyCare", Michael D. Tanner, January/February 2008, Cato Policy Report. https://www.cato.org/policy-report/januaryfebruary-2008/lessons-fall-romneycare
17. Timeline: History of Health Reform in the U.S., Kaiser Family Foundation. https://kaiserfamilyfoundation.files.wordpress.com/2011/03/5-02-13-history-of-health-reform.pdf
18. "Lessons from the Fall of RomneyCare", Michael D. Tanner, January/February 2008, Cato Policy Report. https://www.cato.org/policy-report/januaryfebruary-2008/lessons-fall-romneycare
19. "Health Reform Interrupted: The Unraveling Of The Oregon Health Plan", Jonathan Oberlander, Health Affairs, January 2007 vol. 26 no. 1 w96-w105. http://content.healthaffairs.org/content/26/1/w96.full
20. "A Series of Unfortunate Events: Dirigo – Maine's 'Public Option' Is a Costly Failure", The Maine Heritage Policy Center, June 30, 2009.
21. "Lessons from the Fall of RomneyCare", Michael D. Tanner, January/February 2008, Cato Policy Report. https://www.cato.org/policy-report/januaryfebruary-2008/lessons-fall-romneycare
22. "Vermont's Single Payer Health Care Plan Failed For One Big Reason: It Cost Too Much", Peter Suderman, Reason Foundation, Dec. 22, 2014. http://reason.com/blog/2014/12/22/vermonts-single-payer-health-care-plan-f
23. *Office of Management and Budget, Table 27-5: "Impact of Regulations, Expiring Authorizations, and Other Assumptions in the Baseline," Analytical Perspectives, Budget of the United States Government, Fiscal Year 2013, http://www.whitehouse.gov/omb/budget/Analytical_Perspectives .*