



Prescriptions

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With the enactment of the Patient Protection and Affordable Care Act, the national health policy debate has entered a new phase. Washington has embarked on an effort to exercise control over the entire health care sector of the economy, which now accounts for one out of every six dollars in American wallets. Washington's agenda is to transfer both private and state health policy decision-making to the federal government, particularly the U.S. Department of Health and Human Services (HHS).

In the wake of the enactment of this massive federal health care legislation, and over the next several years of its implementation, the debate on the future of this huge and growing sector of the American economy will continue and likely intensify. Ideally, individual states will continue to play a vital role, either in blocking, changing, or improving upon whatever Washington does or in seizing the initiative if Washington falters in trying to reform health care.

Historically, the states have had the primary responsibility for reforming health insurance markets. For the immediate future, they should not hesitate to forge ahead with their own best ideas for health reform and enact policies that can ensure that their citizens have the opportunity and ability to choose the health insurance and medical care that offers the best value for their health care dollars.

For too long, the doctor-patient relationship has been relegated to secondary in importance. Key health care decisions are being made for patients by someone other than their physician or health care provider; frequently it is their employer or the government. This current state of affairs is a direct result of the present third party health insurance system. It is only when individuals and families are able to choose *for themselves* among competing private insurance plans that health insurers and health care providers will have the right incentives to provide patients with better products and better results at better prices.

An essential characteristic of American health care reform must be that *any* reform respects the diversity and autonomy of the states. Significant variations exist among states not only in geography and demographics, but also in how their health insurance markets and medical delivery systems are organized and financed. The states must be prepared to fight for the right to retain and exercise their authority to enact and implement their own customized solutions that meet their citizens' particular circumstances and needs.

Washington still must play a crucial role. Federal action is needed to reform the tax treatment of health insurance so that people without access to adequate employment-based insurance and those who do have such coverage benefit from the same tax breaks. The current federal policy is profoundly unfair. At the

same time, the states, as the principal regulators of health insurance, need to undertake reforms in their markets that increase consumer choice, expand access to more coverage options, and create true portability of insurance that allows for greater continuity of care.

States license and regulate health care providers and are much better positioned than the federal government to promote value-focused competition in health insurance and medical care by fostering transparency of information about price, quality, and outcomes. States also administer two joint federal–state programs: Medicaid and the State Children’s Health Insurance Program (SCHIP). This means that they have the ability to manage those programs in ways that extend the benefits of patient empowerment and improved quality of care to their most disadvantaged residents.

As enactment of the massive Senate health bill demonstrates, Washington policymakers are inevitably drawn to top-down, old-fashioned centralized decision-making that vests concentrated authority in scores of bureaus, boards, councils, or commissions. The inevitable result of such an approach is the creation of a closed system that is characterized by a high degree of uniformity and restricted options with a limited capacity for innovation and change.

Such an approach is utterly incompatible with the reality that prevails in a large and diverse nation of 300 million persons, where health insurance markets and prevailing patterns of medical practice, as well as economic, social, and demographic patterns, are often radically different. Massachusetts, for example, has the highest health care costs in the nation, and Utah has the lowest, but both have embarked on consequential changes in their health insurance markets. State authorities are keenly aware of these differences and are best able to cope with their greatest challenges; especially the best ways to secure affordable, quality care for their poorest and most vulnerable citizens, who face the greatest difficulties in getting it.

There is no simple solution that is equally applicable to all states in the Union. For this reason, successful health care reform should encourage bottom-up solutions, allow for a diversity of approaches, and promote real innovation in the financing and delivery of care.

Imaginative state officials still have the authority to undertake historic reform and, in so doing, provide their fellow citizens in other states with fruitful examples of real progress and fulfill the states’ historical role as “laboratories of democracy.” There is no reason for state officials to delay real reform on the ground, waiting for Washington to implement its own agenda over the next few years with additional strings attached to federal dollars. Instead, they should force further public debate on the wisdom and constitutional limits of federal power.

Within the framework of that public debate, there are four initiatives upon which Delaware should act in order to lead and truly be the First State in health care reform. Those initiatives include using a patient-centered approach to reform, encouraging state innovation of health care insurance, creating defined contribution state insurance exchanges and a new way of thinking about Medicaid.

Patient-Centered Reform

Patient-centered health care reform requires introduction of the free-market principles of consumer choice and competition into a patient-centered system. Legislative changes should shift the responsibility of decision-making to *individuals and families*, and they, not insurers or the government or employers, should control the flow of health care dollars.

The fundamental objective of this shift is to maximize value for individuals and families so that they receive more benefit and better results for their health care dollars, both as patients and as consumers buying health insurance. Only when individuals choose and own their own health insurance will the other actors in the system, including health plans and providers, have the right incentives to deliver better value in the form of improved results at lower prices.

Patient-centered, consumer-driven health care reform legislation should embody six key principles:

Individuals are the key decision-makers in the health care system. Individuals should control the flow of health care dollars.

Individuals buy and own their own health insurance coverage. Most Americans do not own their health insurance; their employers or government officials own it. As a result, Americans lose coverage as they change between jobs or government assistance programs. In a reformed system, individuals would choose and own their own health insurance.

The role of government is limited. Government should make and enforce rules that create a level playing field for free-market forces and should avoid any actions that pick winners and losers.

Individuals have a wide range of coverage choices. Suppliers of medical goods and services, including health plans, should enter and exit the health care market freely.

Prices are transparent. Individuals should know the prices of the health insurance plan or the medical goods and services that they are buying so that they can compare the value that they receive for their money.

Individuals have the periodic opportunity to change health coverage. Individuals should have the ability to pick a new health plan on predictable terms. They should not be locked into past decisions and deprived of the opportunity to make future choices.

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State Innovation

The regulation of insurance and the administration of health care programs like Medicaid have been, and should remain, primarily state functions. It makes sense for Washington to set broad parameters and goals while allowing the states to develop and implement the best ways to arrange health care coverage. Even if it were possible to create an arrangement that had the same effect from Manhattan to rural Alabama, innovations and changing conditions would quickly render it ineffective in other parts of the country.

Several bipartisan bills before Congress use a federalist approach to advance state innovation in health care. State experimentation with health care reform should be encouraged as an important instrument for policy improvement. The following are a few basic elements of a state oriented approach to health care reform:

Congress should establish broad, measurable goals for increasing health care coverage while leaving it to the states to develop their own unique approaches.

Congress should enact a “policy toolbox” of federal reforms or programs that, while not required, would be available to states. The aim would be a package of federal initiatives and legislative waivers that represented the political spectrum on health care in Congress.

States should develop innovative proposals to achieve the agreed goals, utilizing selected federal toolbox items and state initiatives.

Congress could also extend grants or allow states to use funds more effectively to assist them in developing their proposals.

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Health Insurance Markets

State policymakers can redesign state health insurance markets to promote personal ownership of health plans and enable individuals and families to keep coverage regardless of employment changes, combine health premium payments from multiple employers, and benefit from federal tax advantages.

Americans get unlimited federal tax breaks for the purchase of health insurance if they receive that coverage through the workplace. Workers who buy health coverage outside of the employer-based system often have to pay for health insurance coverage with after-tax dollars and cope with high administrative costs and inflexible government mandates. With these extra costs, plans purchased outside of work can cost 40 percent to 50 percent more.

Another problem with the federal tax code is that it promotes health insurance that sticks to jobs and is not portable. The majority of America's uninsured are in and out of coverage, usually due to changes in their job situations, having access to insurance and then losing it.

Benefits of Defined-Contribution Health Insurance Markets

Short of federal reform of the tax treatment of health insurance, state establishment of a defined-contribution health insurance option for employers, administered through a state health insurance exchange, is a solution that gives individuals and families the opportunity to secure the health plans of their choice without losing tax benefits, even while changing jobs. Such innovative state health insurance reforms offer solutions to many problems commonly found in current health insurance markets.

They reduce bureaucracy and create one-stop shopping. A health insurance exchange serves as a market organizer and central clearinghouse, both for the buying and selling of health insurance and for managing related information and financial transactions.

They lower administrative burdens on business and increase employers' flexibility in offering health benefits. An exchange can perform the administrative functions associated with individuals choosing and paying for health insurance, can give employers greater options for providing access to health care for employees, and can give employees expanded plan choices.

They provide better coverage for more people. Like the current employer system, insurance would be guaranteed issued and would not be individually underwritten, and benefits would not diminish if health status declined.

They enable you to pick a plan and take it with you. Employees, not employers, would buy their health care coverage with pre-tax dollars, would own their own health plans, and would take their plans from job to job without losing the generous tax benefits of conventional employer-based coverage.

Recommended State Actions

Create a statewide health insurance market that allows defined contributions toward health care coverage.

Use the state's power to regulate commercial insurance to create a new hybrid insurance market for employer-sponsored coverage through plans that are individually chosen and owned by workers.

Charter a health insurance exchange as the market organizer for the new arrangement. Employers can then voluntarily sign up to designate the exchange (and all of the insurance products sold through it) as their employer group “plan” for their workers.

Administer premium support for public health assistance programs through the exchange for low-income residents.

Consider implementing non-subsidized health insurance risk-adjustment mechanisms to spread risk among insurers. While risk-adjustment arrangements do not directly reduce general health care costs, they can create a more smoothly functioning health insurance market by equitably redistributing the costs of a small number of expensive cases or individuals across a broader population.

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Improve Medicaid

Medicaid is crippling state budgets and squeezing out other state priorities, such as education and transportation. It typically provides less access and lower-quality care to those who depend on it for their health care needs and creates a two-tiered health care system, making the most vulnerable populations dependent on a broken health care program.

By reforming their Medicaid programs, state policymakers can do a great deal to control costs, improve coverage, and restructure the financing and delivery of health care in their states. For example, enabling Medicaid and State Children's Health Insurance Program (SCHIP) recipients to obtain private health plans of their own choosing can result in more appropriate care and reduced costs, both to the state and to the private sector. Often, the emergency department visit rate is greater for Medicaid and SCHIP patients than it is for patients with private health insurance or the uninsured. When more than one family member is eligible for assistance, private family coverage is likely to be less expensive than the cost of covering each member individually through Medicaid or SCHIP.

Enabling these families to purchase coverage in the private sector will lead to increased portability and, thus, greater continuity of care. Fewer gaps in coverage will help to reduce costs and reduce inappropriate and costly provision of care at hospital emergency departments. In addition, by moving the millions of healthy Medicaid and SCHIP beneficiaries back into the private health insurance pool, states can help to prevent further deterioration of private health insurance (the "crowd-out effect") and stabilize costs for everyone.

Recommended State Actions

Within current law, state policymakers can take several needed actions. Specifically, they can:

Create a premium-support system for Medicaid and SCHIP recipients. Premium-support systems direct government payment to a private health plan of the recipient's choice. States can administer premium support for private health insurance through mechanisms like a statewide health insurance exchange (as described in the previous section). In conjunction with reforms in the health insurance market, premium support will enable families to mainstream out of government-run health care and into the private insurance market.

Redirect government funds from institutions to individuals. Medicaid supplemental funding could also be used to help individuals and families buy their own health insurance by redirecting these funds proportionately from health care institutions that otherwise would receive the money to defray the costs of caring for the uninsured in emergency rooms.

Additionally, "cash and counseling" demonstration projects that provide long-term supportive services for the disabled and elderly have demonstrated that they provide increased access to services, improved patient care, and increased patient satisfaction, all without any increase in the risk of fraud. States can adopt such programs of self-direction as part of overall Medicaid reform through a simple state plan amendment process.

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Conclusion

State officials should not wait for Washington to act. Instead, they should search diligently to find ways within existing law to advance their own health policy agendas, using waivers or exceptions to federal rules. Within that framework, the nation's governors and state legislators should enact consequential reforms that expand health insurance coverage and improve the quality of health care while empowering individuals and families to control the flow of health care dollars.

The ultimate objective of a sound health policy should be reinforcement of the traditional doctor-patient relationship in which doctors control the delivery of care and patients control the financing of care. This can be done at the state level even if Washington fails to do it.

State officials should enact far-reaching reforms of the private health insurance markets within their borders and expand those markets with like-minded officials in other states through interstate compacts. These reforms should enable all residents to secure affordable coverage at competitive prices. At the same time, states should pursue significant reforms of their Medicaid and SCHIP programs that will enable beneficiaries of those programs to secure better care through health plans of their choice and reduce their dependence on hospital emergency rooms for routine care. By pursuing such serious reforms, states can become the centers of innovation in the financing and delivery of America's health care.

Americans will improve their health care system. They will do so largely because of the historical capacity for policy innovation that has been made possible through America's unique constitutional order; that is the Founding Fathers' wise division of authority between the states and the national government. All that is required is the political will and imagination to tackle the task.