State Initiatives on Health Care Access: Preserving the Fraying Safety Net

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In his 2002 article in the *New England Journal of Medicine*, Victor Fuchs asks, “Should health insurance be organized on the same principles as automobile or homeowner’s insurance?” Is health care a right or an entitlement or is it a commodity, a good, or a service? These questions must be asked to begin to explain why the United States is the only industrialized nation that does not have a system of access to health care services for all of its citizens. Over 16 percent of Americans are uninsured, with attendant problems that include: lack of or inadequate access to utilization of health care services, especially preventive services; avoiding or delaying seeking care, often leading to worse medical outcomes; and problems in terms of quality and continuity of care. With respect to children, despite a number of supportive programs, one child in eight lacks health coverage, including coverage offered by Medicaid and the State Children’s Health Insurance Program (SCHIP).

Further, for the two-thirds of Americans who rely on employer-based health insurance, businesses have employed cost-cutting measures at a time of globalization and increasing competitiveness. These measures include increasing the employee share of premiums; decreasing the benefit package; covering the employee but not family members; moving to defined contribution plans, medical savings accounts, and insurance coverage for catastrophic illness only; and cost shifting from employees who use little care to those who use more. These measures have resulted in declining numbers of people with access to employer-based health insurance. The problem really then is not just the uninsured but also those who are under- or inadequately insured.

According to Dubay and colleagues, in their 2006 article in *Health Affairs*, “[m]ore than half of the nation’s uninsured residents are ineligible for public programs such as Medicaid but do not have enough resources to purchase coverage themselves.” Their conclusion is that there is a need for assistance to enable them to be covered. At the federal level, attention to the increasing share of the budget devoted to Medicare and Medicaid is noted, bemoaned, and decried, but not truly addressed, at least not in a systematic fashion. However, increasingly, at the state level, responses to lack of insurance and under-insurance are being introduced and experiments implemented, both in terms of increasing the number of beneficiaries with at least some degree of health care coverage and in expanding the scope of covered services. These responses vary from comprehensive reform, to targeted initiatives, to legislatively mandated studies. Common to all, though, is an apparent recognition that the unaddressed health care needs of some state residents have effects on state coffers and on all state residents. These effects are due to such macro-level effects as increased state expenditures on emergency room visits, and higher hospital and other medical care charges made to individuals and private insurers to offset losses occasioned by caring for those who lack insurance.

This article will address state responses to increase access in health care. First, state Medicaid experiments are considered. Then state health insurance initiatives, whether for all populations or for children only, are reviewed. Concluding thoughts on health disparities, inequalities, and equity are then discussed.

**II. Medicaid Experiments**

Medicaid, a means-tested program tied to the Federal Poverty Level (FPL), provides a living laboratory for experimentation. This joint federal-state program includes both mandatory and optional beneficiaries as well as mandatory and optional services. For 2007, the FPL yearly income is $10,210 for an individual, with increments of $3,480 for each additional household member. Thus, for a family of four, the FPL is $20,650. Keep in mind two other numbers, for purposes of context and comparison. The first is that, in 2005, per capita spending on health care exceeded $6,600. Second, it no longer is unusual for the annual cost of a health insurance policy for a family to reach or exceed $10,000.

Medicaid’s income limits vary by eligibility category and by state. For example, one state may cover a service for those at the poverty level while a second may expand the reach by defining the beneficiaries as those earning up to 200 percent of the FPL. While primary populations at the onset of the program in 1965 were single parents with dependent children, pregnant women, the aged, blind, and disabled, some
states permit coverage for single adults other than those in these categories. Examples of optional services are prescription drugs, home health care services, and hospice care services.

The Congressional Budget Office displays the growing pressure on government spending. At the federal level, projections for fiscal year 2007 show that outlays for Social Security will account for 21 percent of all spending. For Medicare, 16 percent, and for Medicaid, 7 percent. SCHIP, a joint federal and state program to provide health care access to children of non-Medicaid-qualifying “working poor” or “near poor,” also is experiencing calls for increased growth. At the state level, Medicaid accounted for 17 percent of spending. With growing pressures from other sources of governmental spending, particularly defense at the federal level and education at the state level, governments have been struggling to maintain an adequate level of benefits to as many people as possible.

For many years the states have been seeking greater control over how the Medicaid program is administered and under what rules. In 2005, the Federal Deficit Reduction Act accorded states greater flexibility in terms of program design, benefit structure, charges to Medicaid eligibles, and the role of private insurers. Specifically, state governments were permitted to impose higher health insurance deductibles and premiums and to institute co-payments. Already, different innovations have begun to be implemented in the various states. Despite these varying programs, there are common concerns, such as the tension between increasing the numbers of beneficiaries versus maintaining the level of services to existing beneficiaries. A general theme in state reform is to increase individual costs to some extent. A delicate balance must be struck: the costs imposed must not be so high as to be burdensome to eligibles, becoming disincentives to seeking health care services, yet be of a sufficient magnitude in the aggregate for the state to avoid eliminating categories of optional beneficiaries or optional services. Some ascribe to the philosophy that requiring some cost sharing makes the beneficiary of services a more active participant. Guiding some state innovations is the understanding that individuals who no longer qualify for Medicaid will be unable to receive needed and timely services and will later utilize emergency room and hospital services, at a higher cost to the health care system.

West Virginia, starting in July 2006, is asking beneficiaries to sign a member agreement. In this agreement, they commit to keeping their doctor appointments, taking medicines as prescribed, and not using hospital emergency rooms for medical needs other than emergencies. Those beneficiaries who do not sign the agreement or comport with the conditions will be eligible for lesser benefits. The assumption is that by taking responsibility costs will be controlled.

Florida, as of September 2006, began to privatize the Medicaid system on a pilot basis in one large city and one large county in the state. In these localities, eligible individuals have a choice of health plans, each offering a different menu of services. In addition, state health officials will evaluate the health status of every Medicaid eligible and reimburse only for the level of care consonant with these officials’ estimates.

Arkansas, like Florida, is looking at privatization as a way of saving money. It has received permission from the federal Medicaid program to use its Medicaid dollars to subsidize small businesses with low wage uninsured workers if these companies offer employees a basic, no frills health insurance benefit package that includes six physician office visits, seven days of inpatient hospitalization, and two outpatient hospital procedures or emergency room visits per year, and two prescription drugs per month.

Kentucky is creating four categories of Medicaid eligibles, based on health and age, with different benefits offered to each group.

Iowa (IowaCares) also is among those states that have expanded Medicaid eligibility.

In Rhode Island, the “Rite Share Health Insurance Premium Assistance Program” directs the state’s Department of Human Services to assist families in which parents earn incomes up to 185 percent of the FPL. The employee must enroll in the employer-based health insurance plan as a condition of state participation.

Rhode Island also has adopted a Medicaid buy-in program that permits individuals with disabilities the option to purchase Medicaid coverage. One of the stated legislative purposes is to “enable individuals with disabilities to enter and reenter the work force as soon as possible.”

III. Health Insurance Initiatives

With increasing recognition in recent years of the toll of inadequately or under-insured residents, a number of states have begun initiatives to expand services to populations previously not covered. These may be individuals who are employed but are not offered or who decline the offer of health insurance, and their families, or those who earn more than the FPL state cutoffs, yet still cannot afford to purchase insurance on their own. As some of these initiatives may be termed or referred to as universal health coverage, it is important to define this term. “Universal

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health coverage” does not necessitate that there has to be a single public payer. Instead, commonly there is reliance on multiple insurance plans from the private sector.

Massachusetts law enacted in April 2006 requires all uninsured adults to purchase a health insurance policy by July 1, 2007 or face a monetary penalty. The Massachusetts plan builds on the model common to this country, namely, reliance on the employer for employee health coverage, but it goes beyond how employer-based programs traditionally have been structured. As noted by Patricia Barry, “[t]he state has become the first to adopt an idea promoted by the Heritage Foundation.

. . . The law sets up a clearinghouse . . . intended to link uninsured individuals and companies having fewer than 50 employees to a choice of ‘affordable’ health plans designed by private insurers and regulated by the state. The [clearinghouse] aims to offer [employees and employers] the advantages that many people in large employer-sponsored groups now enjoy—deeper discounts, premiums paid out of pretax dollars and an opportunity to change plans every year.”

The policy benefits include doctor’s office visits, medications, and immunizations. Another benefit is that the plan is portable, meaning that individuals can keep their insurance plan when they move, switch jobs, or experience life changes.

Many details still need to be worked out, including the availability of new policies, their cost, employee premiums, and the amount of the co-payments. What is known is that uninsured adults who earn less than the FPL would pay no premium; the total cost of the premium would be subsidized by the Commonwealth of Massachusetts. Individuals earning up to three times the FPL can buy partially subsidized policies. There will be a sliding scale of premiums, based on earnings. Businesses with more than 10 employees must offer their employees a health insurance plan. If they do not, then they must provide the state with a per-employee monetary contribution to help defray the state’s anticipated costs in picking up the costs of health services.

In Vermont, effective October 2007, a new program will go into effect for uninsured persons. Unlike the plan in Massachusetts, the Vermont plan is voluntary, not mandatory. The state will provide the plan, offered by contracts with private insurers, for uninsured residents. Those insured will be subject to a deductible, make co-payments for office visits and prescription medications, and pay coinsurance for services and tests. There will be caps on out of pocket expenses: $800 per individual or $1,600 per family for use of in-network services. The premium is expected to be about $300 per month for an individual, with subsidized premiums on a sliding scale offered to those with incomes less than 300 percent of the FPL. Additional incentives are provided for enrollees with certain chronic conditions, such as chronic heart failure and diabetes. These individuals may participate in a disease management program that will offer certain tests and services with no deductible and at no cost.

As in the Massachusetts legislation, businesses - defined in Vermont as those with nine or more employees - will pay the state for each uninsured employee.

Of interest is the “base” upon which the Vermont plan will build. In Vermont, in 1989, a state financed program was initiated for women and their young children who did not qualify for Medicaid. This program was expanded in 1992 to include children up to age 18, living in families earning up to 300 percent of the FPL. Perhaps not surprisingly, Vermont leads the nation in terms of health care coverage for children, with only some 5 percent not covered.

An important caveat is that the Massachusetts law makes it a legal requirement that only uninsured adults must purchase health insurance. As Kowalczyk noted in the Boston Globe, “some advocates for the uninsured are worried that some of the state’s 40,000 to 78,000 uninsured children will remain uncovered if parents cannot afford health plans that cover their entire family.” For those families that qualify for Medicaid, coverage of children is not considered to be a burden. However, for those families that receive a partial subsidy, namely, those whose income approaches three times the FPL, the premium for health insurance for children could be prohibitive. The Commonwealth’s Secretary of Health and Human Services has sent to the Legislature so-called technical corrections to the law. One of these would expand the requirement to children.

The issue is particularly apposite as the number of uninsured children has been rising of late. Until recently this was not the case. In fact, even as the number of adults without health insurance has increased in recent years, the number of children without insurance was declining. Some experts posit that the recent increase for children may be attributable to a reduction in the number of employees who receive health insurance through their employer or who choose not to participate in employer-offered plans because of increased financial burden.

In 2004, the State of Illinois enacted the Health Care Justice Act. This legislation provides that “[i]t is a policy goal of the State of Illinois to ensure that all residents have access to quality health care at costs that are affordable.” According to the Campaign for Better Health Care, an Illinois advocacy group, the law “encourages [the state] to implement a health care plan that provides access to a full range of preventive, acute
and long-term health care services . . . “43 A concrete step in furtherance of this “policy goal” was the 2005 enactment of a proposal to subsidize health insurance for uninsured children who did not qualify for SCHIP.42 The program covers children who live in families that earn up to twice the poverty level, or $40,000 for a family of four.43 Now, a 2006 Illinois proposal would make eligible those children who live in families that earn between $40,000 and $59,000.44 According to this proposal, premiums would be $40 per month for each child in a family, and $10 co-payments would be required for each visit to a doctor’s office.45 The justification for this program was provided by the director of the state Department of Healthcare and Family Services: “Who is falling through the cracks? The people at poverty levels are often covered, and the people who are making a relatively substantial income are covered through their employer or health insurance they have obtained.”46

In Minnesota, the governor has established the “Smart Buy Alliance,” through which the state government and private employers, working in tandem, increase their leverage to reduce costs while improving the quality of health care and the efficiency of health care delivery.47 Maryland tried a different approach to increasing health insurance coverage.48 In 2006 it enacted a law that required all employers with more than 10,000 workers in the state to either provide health coverage to its employees or pay a penalty – the so-called “Wal-mart bill,” as Wal-mart was the only large employer to be covered by the legislation.49 In court action, a federal judge found the law unconstitutional.50 Montana is approaching the solution to the problem of insurance undercoverage in another way. It has established a health insurance pool that small businesses voluntarily may choose to join. The legislation provides for employer incentives such as tax credits for eligible small employers who provide health coverage for their employees.51 Further, it is expected that a small-business bill will be introduced in several states in the 2007 legislative session, including Iowa.

Rhode Island has adopted a number of targeted provisions to expand the safety net. In addition to the Medicaid buy-in program for working people with disabilities which was described earlier, in the discussion on Medicaid, the state has adopted the “Rhode Island Health Care Affordability Act of 2006.”52 Among other enhancements, this act expands health coverage to dependent children through group health insurance coverage.53 It also reduces the cost of health insurance for small businesses.54 For quite a number of years, Rhode Island has had a program of state community health centers that provide primary care services to underserved uninsured state residents. In addition, Rhode Island also has passed a law to establish, on a pilot basis, a state-subsidized, income-based primary health care program to provide health coverage for state residents who lack insurance.55 However, although the program exists in statute, no funding has been identified and tied to it. In the future, state dollars, including state and matching federal Medicaid dollars, could be among the funding sources for this program.

Through legislative action, health care reform committees have been established in Colorado and in New York. In Colorado, the “Blue Ribbon Commission for Health Care Reform” was established “for the purpose of studying and establishing health care reform models to expand health care coverage and to decrease health care costs . . . “56 Of interest, funding for the “development of the three to five proposals” and other study costs are made by “reducing the fiscal year 2005-06 general fund appropriation to the department of health care policy and financing, indigent care program in the children’s hospital, clinic based indigent care.”57 In New York, the “Commission on Health Care Facilities in the Twenty-First Century” was charged “with examining the system of general hospitals and nursing homes in New York State and recommending changes to that system.”58 The New York Commission’s report came out in the fall of 2006. The active response to its recommendations, particularly for large cutbacks in hospitals and hospital services, while not unexpected, served to highlight the accuracy of the legislative declaration in the Colorado Act: “Health care is the largest single industry in the United States, comprising multiple public and private interests, and these interests often have competing goals and values.”59

IV. Disparities and Inequalities
Disparities exist for children, for women, and for the elderly. Disparities and inequalities also exist for another group – recent legal immigrants. In the 1996 Welfare Reform Act, Congress made most legal immigrants ineligible for federal programs and cash assistance during their first five years in this country.60 More than twenty states restored health care coverage to at least some of these immigrants. These jurisdictions include Maryland, Virginia, and the District of Columbia.61 However, the Maryland budget for the fiscal year beginning July 2005 withdrew health coverage for 4,000 pregnant women and their children who had been in permanent legal residence for less than five years.62 Subsequently, the denial was mitigated somewhat when funds were restored for prenatal care for those pregnant women then receiving care.

Yet another disparity pertains to so-called mental health parity. The federal Mental Health Parity Act of 1996 attempted to regulate discriminatory industry practices limiting mental health coverage.63 However, the Act is limited in scope. It does not require that health insurance plans cover mental health services. It pertains only to those employers who choose to offer mental health coverage in the plans they provide. The law provides no uniform definition, but covers “mental illness” as it is defined by individual plans. Alcohol and drug abuse services are excluded. Despite hearings and proposed bills in Congress in the decade since adoption, the content of the federal law has not been expanded. Indeed, as noted by the advocacy group Faces and Voices of Recovery, in the past three Congresses, from 2001 to 2006, “ . . . the majority of U.S. representatives have tried to begin to address the discriminatory treatment of people seeking care for addiction. Despite bipartisan sponsorship by 230 members of the U.S. House of Representatives (in the last Congress), the House leadership has
refused to let the Paul Wellstone Mental Health Equitable Treatment Act...come up for an up-or-down vote. They have not even allowed a hearing on the bill or a vote in committee." However, of note, the federal law does not preempt state mental health parity laws. Perhaps the states, then, can become the new venue for potential expansion of the reach of mental health parity. For example, while the State of Maryland exempts from its parity legislation Medicare and Medicaid beneficiaries, as well as federal and state employees, it provides benefits for treatment of mental illnesses, emotional disorders, and drug and alcohol abuse. Different state experiments in incremental enhancements, such as those just enacted in New York and in Ohio at the very end of 2006, may offer a blueprint for turning the promise of parity into an actuality.

V. Concluding Thoughts

The lack of political will, coupled with the reluctance to reallocate funding, have resulted in a shift of health care policy leadership and responsibility from the federal to the state level. The states, through the multiple initiatives briefly noted in this article, as well as initiatives in other jurisdictions, including Maine, Oklahoma, Wisconsin, New Jersey, Oregon, Hawaii, and the City of San Francisco, are leading the way, and are doing this despite the limitation of mandated balanced budgets. It remains to be seen how these natural experiments will play out. Will states with more generous provisions experience a significant in-migration? What will be the effect on the millions of workers who reside in one state but are employed in another? What intended and unintended consequences will unfold? With the 2007 proposal by the governor of California, the most populous state, with an estimated 6.5 to 7 million uninsured persons, as well as the 2007 proposal by the governor of Pennsylvania, at least five states – Maine, Vermont, and Massachusetts, in addition to California and Pennsylvania – have enacted or proposed plans to cover the uninsured. As well, other states are covering uninsured children.

Will these 2007 developments prove to be decisive in tipping the scale? It is noteworthy that the President, in his 2007 State of the Union Address, spotlighted health insurance for the uninsured for federal legislative action. We soon will see whether there is a shift in political will or whether the underserved will continue to experience health care disparities and inequities.

Ultimately, as the late, eminent anthropologist Margaret Mead said, the measure of any society is how it treats the most vulnerable among them. In terms of this discussion, access to health services, quality of health services, cost of health care services, reimbursement for health services, and equity are intertwined and interrelated issues that transcend health, policy, politics, and ethics. How we respond to these challenges will provide the measure by which our society will be judged.

3 See id.
4 See id. at 22.
5 See id. at 28.
11 See id.
12 See id.
18 See id.
19 See R.I. GEN. LAWS § 40-8-7.3 (2004).
20 See id. at 40-8.7(1).
23 See id.
24 See id.
See id. at § 118H, § 2.
28 See id. at § 118H, § 188(b)(i).
29 See id. at § 118H, § 188(b)(ii).
31 See id. at § 1974(a).
32 See id. at § 702(c)(1)(A).
33 See id. § 4080f(c)(1)(A)-(D).
34 See id. § 4080f(c)(1)(E).
35 See id. § 1984(c).
36 See id. § 4080f(c)(1)(E).
37 See id.
38 See id. § 2003(a)(1).
43 See id.
44 See Peter Slevin, Illinois to Unveil Insurance Program, WASH. POST, Oct. 6, 2006, at A03.
45 See id.
46 See id.
49 See id. at § 8.5-102.
57 See id. at § 10-16-131(5)(b)-(c).

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