1/28/09 WHAT YOU NEED TO KNOW: HEALTH REFORM

Alaska State Legislature

Senator Bettye Davis, Chair
Senator Joe Paskvan, Vice Chair
State Capitol, Room 30
Juneau, Alaska 99801
Phone: (907) 465-3822
Fax: (907) 465-3756

Committee Members:
Senator Johnny Ellis
Senator Joe Thomas
Senator Fred Dyson

Senate Health & Social Services Committee

January 27, 2009

To: Sen. Davis, Sen. Paskvan, Sen Ellis, Sen.Thomas
Sen. Dyson, Rep. Keller, Rep. Herron

From: Lynda Zaugg, Aide Sen. Davis

Please find attached the back up information provided by The Primary Care Association in preparation for their presentation to the joint Senate and House H&SS meeting on Wednesday 1/28/09.

Alaska Behavioral Health Association
Alaska Center for Public Policy
Alaska Health Care Roundtable
Alaska Mental Health Trust Authority
Alaska Native Health Board
Alaska State Hospital and Nursing Home Association
American Cancer Society Cancer Action Network - Alaska
American Heart Association - Alaska
Anchorage Project Access

WHAT YOU NEED TO KNOW: HEALTH REFORM FOR ALASKA

BRIEFING AGENDA

Wednesday, January 28, 2009

Choice of Briefing Sessions: Morning Session 7:30 – 9:30 a.m.
Afternoon Session 1:15 – 3:15 p.m.

AFTERNOON SESSION – CAPITOL BUILDING Butrovich-Fahrenkamp Room 203 (refreshments served)

1:15 p.m.	Welcome	Wayne Stevens, Alaska State Chamber of Commerce
	Moderator	Rod Betit, Alaska State Hospital & Nursing Home Assn
1:25 p.m.	Picture of Alaska Development	Alice Rarig, PhD Health Planning & Systems
1:45 p.m.	What You Need to Know: Health Reform for Alaska - Lessons from Other States and Issues to Consider -	
	Keynote Speaker: Enrique Martinez-Vidal Vice President, AcademyHealth Director, State Coverage Initiatives	
2:45 p.m.	Questions & Answers	
	Panel: Bill Hogan, Commissioner, DHSS Linda Hall, Director, Division of Insurance, DCCED Enrique, Martinez-Vidal, Vice President, Academy Health Alice Rarig, PhD, Health Planning & Systems Development, HSS Rod Betit, CEO/President, ASHNHA	
3:15 p.m.	Adjournment	

Hosted by:
Senate President, Sen. Stevens; House Speaker, Rep. Chenault; Senate HSS Chair,
Sen. Davis; House HSS Co-Chairs, Rep. Keller and Rep. Herron

Sponsored by AHAAT, Alaska State Chamber of Commerce, Alaska Primary Care Association, Alaska State Hospital & Nursing Home Association and AARP-Alaska.

AHAAT ALASKA HEALTH ASSURANCE ADVOCACY TEAM

Co-Chairs:
Kip Knudson, Alaska State Chamber of Commerce

Shelley Hughes, Alaska Primary Care Association

Vice-Chair: Pat Luby, AARP-Alaska

Members:

AARP - Alaska
Alaska Association of Health Underwriters
All Alaska Pediatric Partnership
Alaska Behavioral Health Association
Alaska Center for Public Policy

Alaska Health Care Roundtable
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Alaska State Chamber of Commerce

Enrique Martinez-Vidal
Vice President, Academy Health
Washington, D.C.

Keynote Speaker *January, 28, 2008*
What You Need to Know: Health Reform for Alaska

Enrique Martinez-Vidal is a Vice President at AcademyHealth and the Director of the Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) program which works with state policy leaders to develop strategies to improve insurance coverage and foster broad health care reform. Enrique joined AcademyHealth in February 2005 as the deputy director of SCI.

He is currently the project director for the State Quality Improvement Institute, a project of the Commonwealth Fund to assist states that are ready to make substantial commitments to quality improvement and to facilitate development of concrete action plans for further progress. He also has worked on various projects under a contract with the federal Agency for Healthcare Research and Quality (AHRQ) including the oversight of a state-level environmental scan of quality initiatives to help determine how a partnership could be developed between AHRQ and states regarding quality improvement; and a pilot project that presented AHRQ's State Snapshots to four states in an effort to create an ongoing dialogue about how these reports can be used for state-level quality improvement.

Previously Mr. Martinez-Vidal was the deputy director for performance and benefits at the Maryland Health Care Commission, an independent state agency. There he was responsible for the oversight of Maryland's small group insurance market reforms; the annual evaluation of Maryland's mandated health insurance benefits; the collection and public dissemination of quality and performance information for hospitals, nursing homes and health plans; providing primary assistance on all legislative issues; and working on numerous other projects related to the affordability of health care, quality improvement, and patient safety.

Mr. Martinez-Vidal was formerly a policy analyst with the Maryland Department of Legislative Services for five years. During that time he staffed the House Economic Matters Committee and was involved with a number of health-care related issues. He has a B.A. in political science and international studies from Dickinson College and a master's degree in public policy from Georgetown University.

State Coverage Initiatives

Robert Wood Johnson Foundation

What You Need to Know: Health Reform for Alaska

Lessons Learned from Other States

A Briefing for Alaska Legislators and Staff

Juneau, AK
January 28, 2009

Enrique Martinez-Vidal
Vice President, AcademyHealth
Director, State Coverage Initiatives

AcademyHealth

Overview of Presentation

- Background
- What is driving state reform?
- State Reform Strategies
- States & the Health Workforce
- State Quality Reporting Activities
- State Health Policy Commissions and Authorities
- Lessons Learned from State Reforms
- Concluding Thoughts

State Coverage Initiatives (SCI)

- An Initiative of the Robert Wood Johnson Foundation

Community of State Officials

- Convening state officials

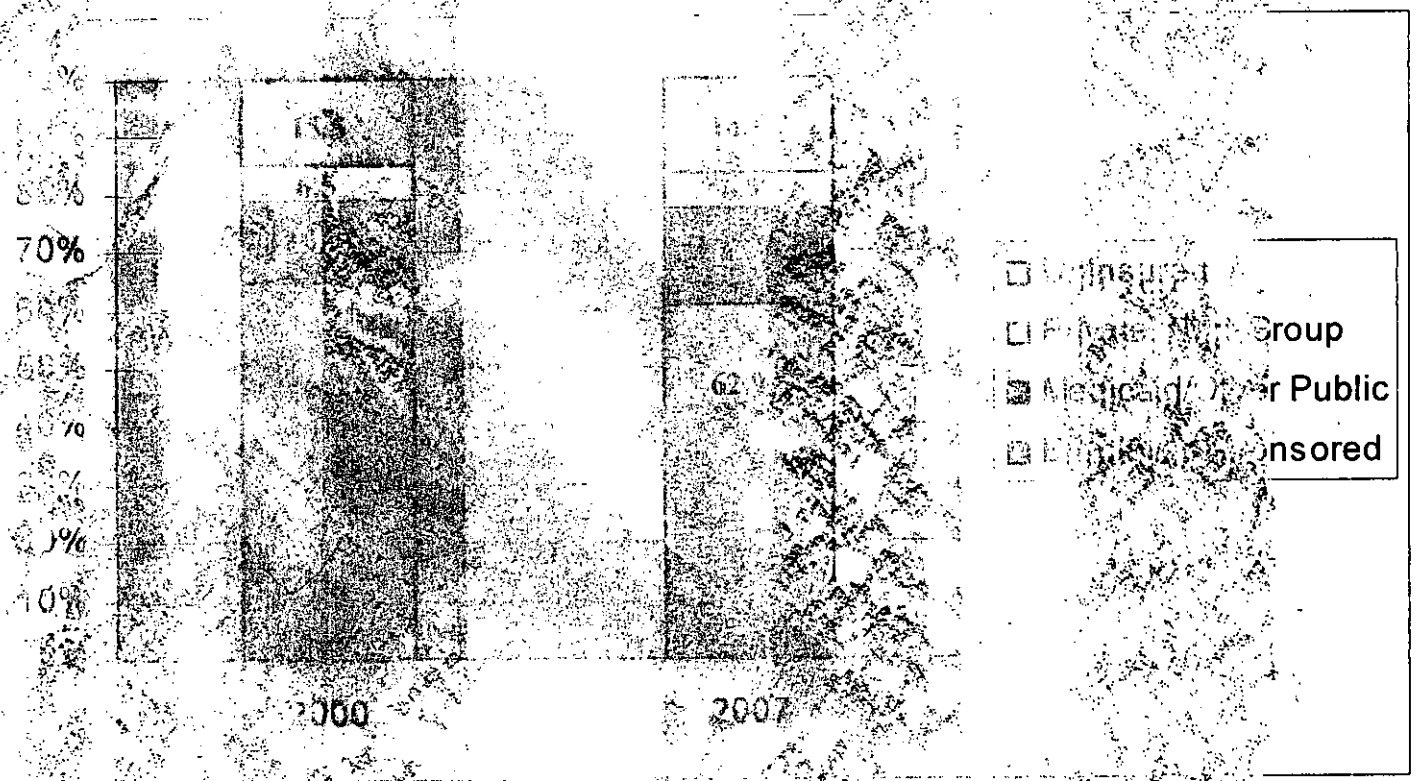
Resources and Information

- Web site: www.statecoverage.org
- State Profiles
- Publications/*State of the States*

Direct technical assistance to states

- State-specific help, research on state policymakers' questions
- Grant funding/Coverage Institute

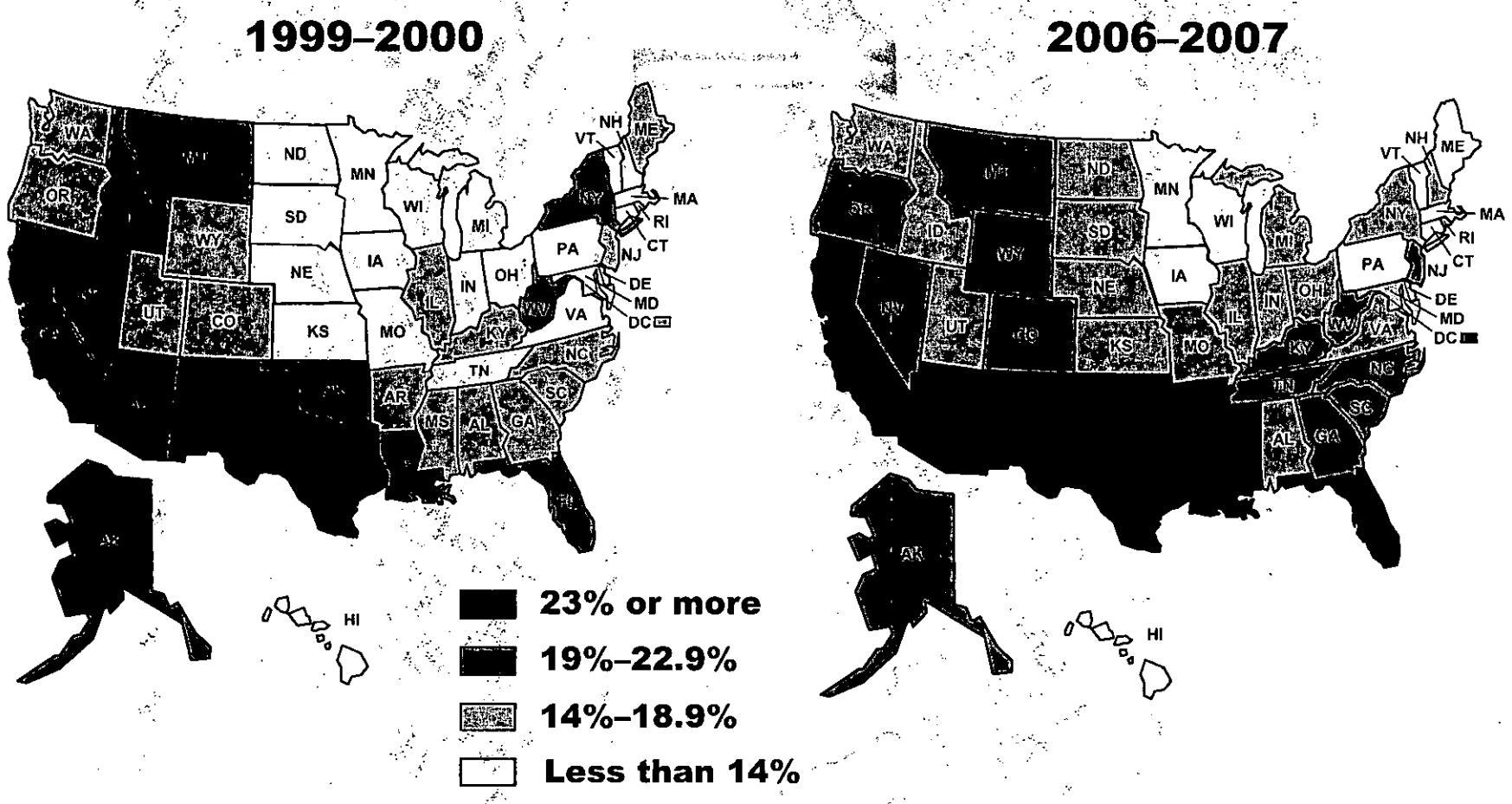
Health Insurance Coverage Changes for the Non-Elderly, 2000-2007



Source: Census Bureau, Current Population Survey, Annual Social and Economic Supplements, Historical Health Insurance Tables,. August 2008.

Percent of Uninsured Adults Ages 18–64

(Source: The Commonwealth Fund, 2008)



State Coverage Initiatives

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Data: Two-year averages 1999–2000, updated with 2008 CPS correction, and 2006–2007 from the Census Bureau's March 2000, 2001 and 2007, 2008 Current Population Surveys.

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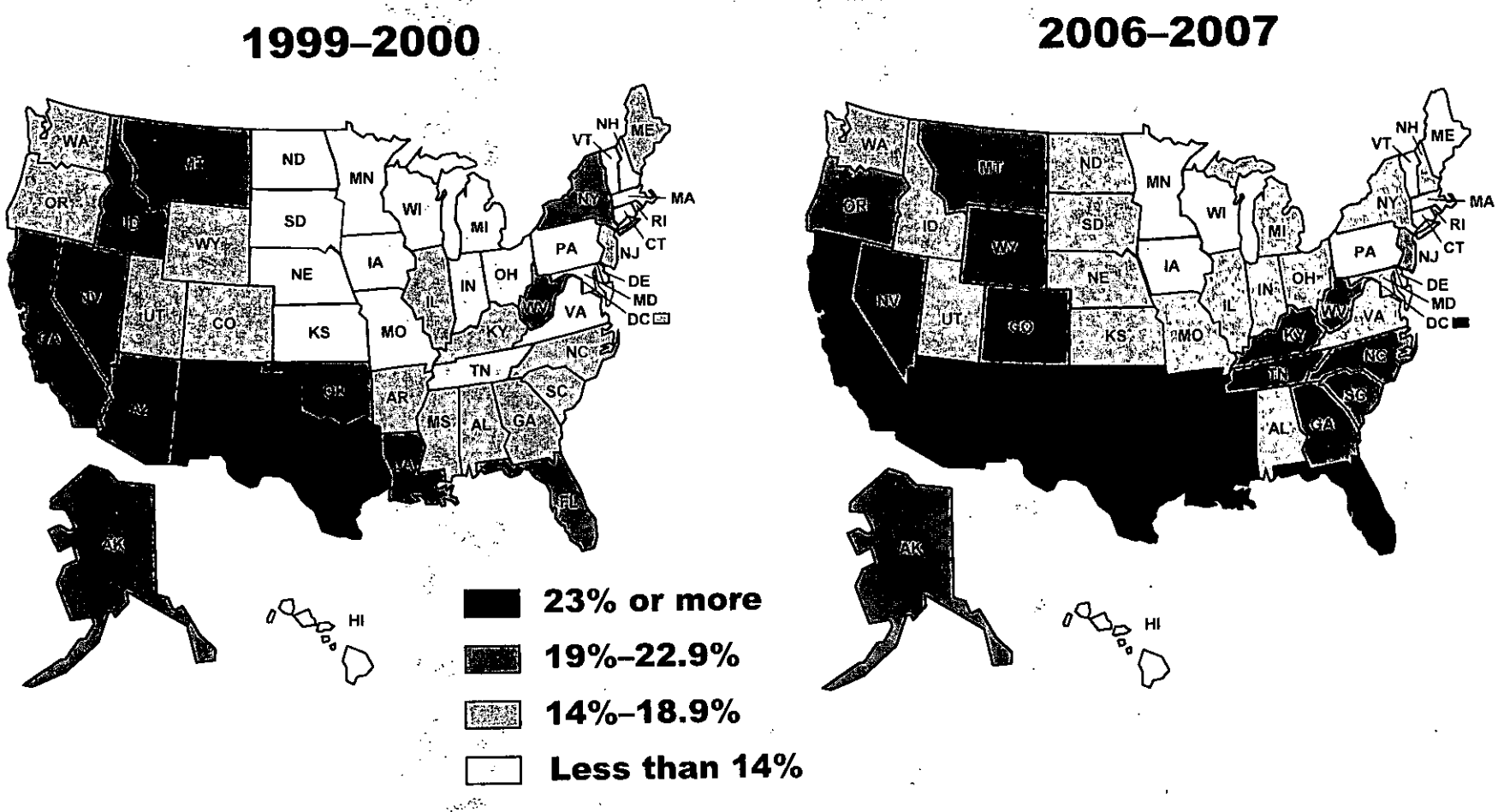

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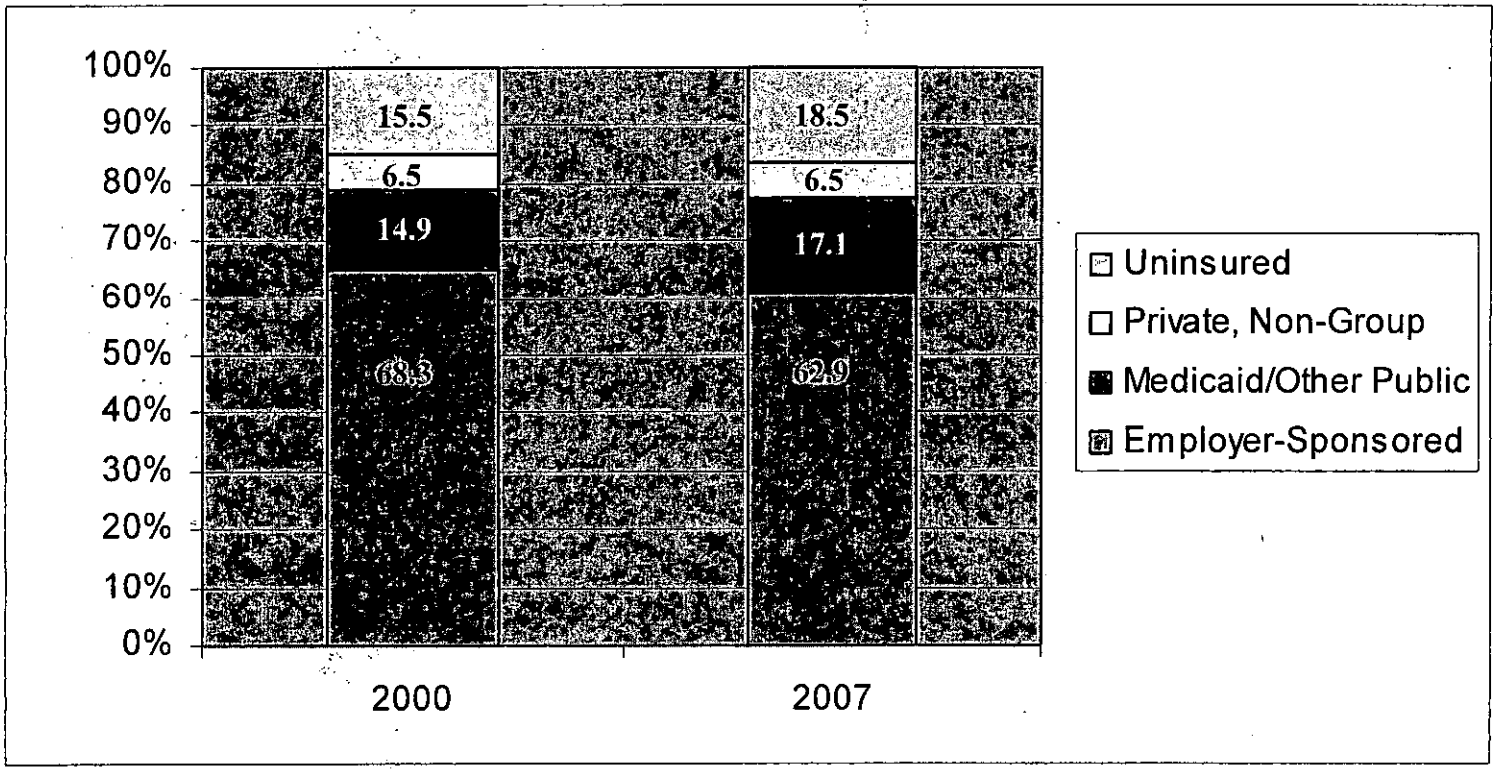
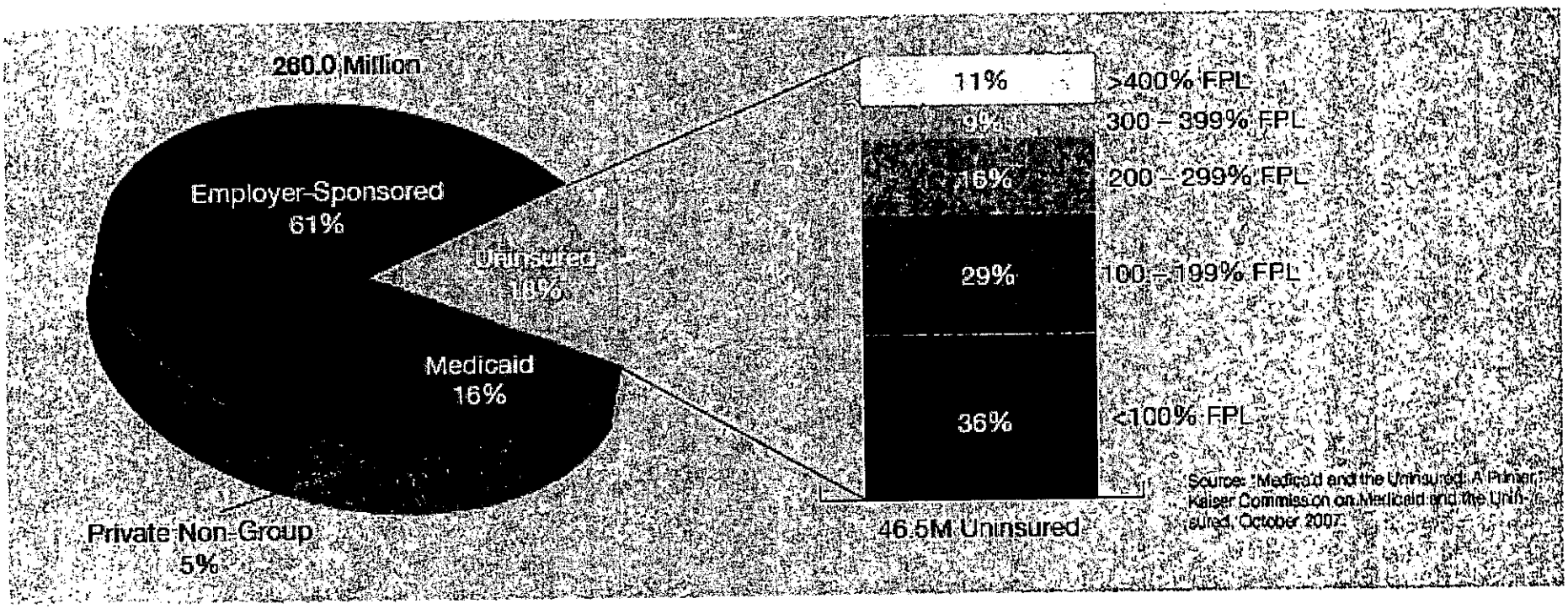
Health Insurance Coverage Changes Among Non-Elderly, 2000-2007



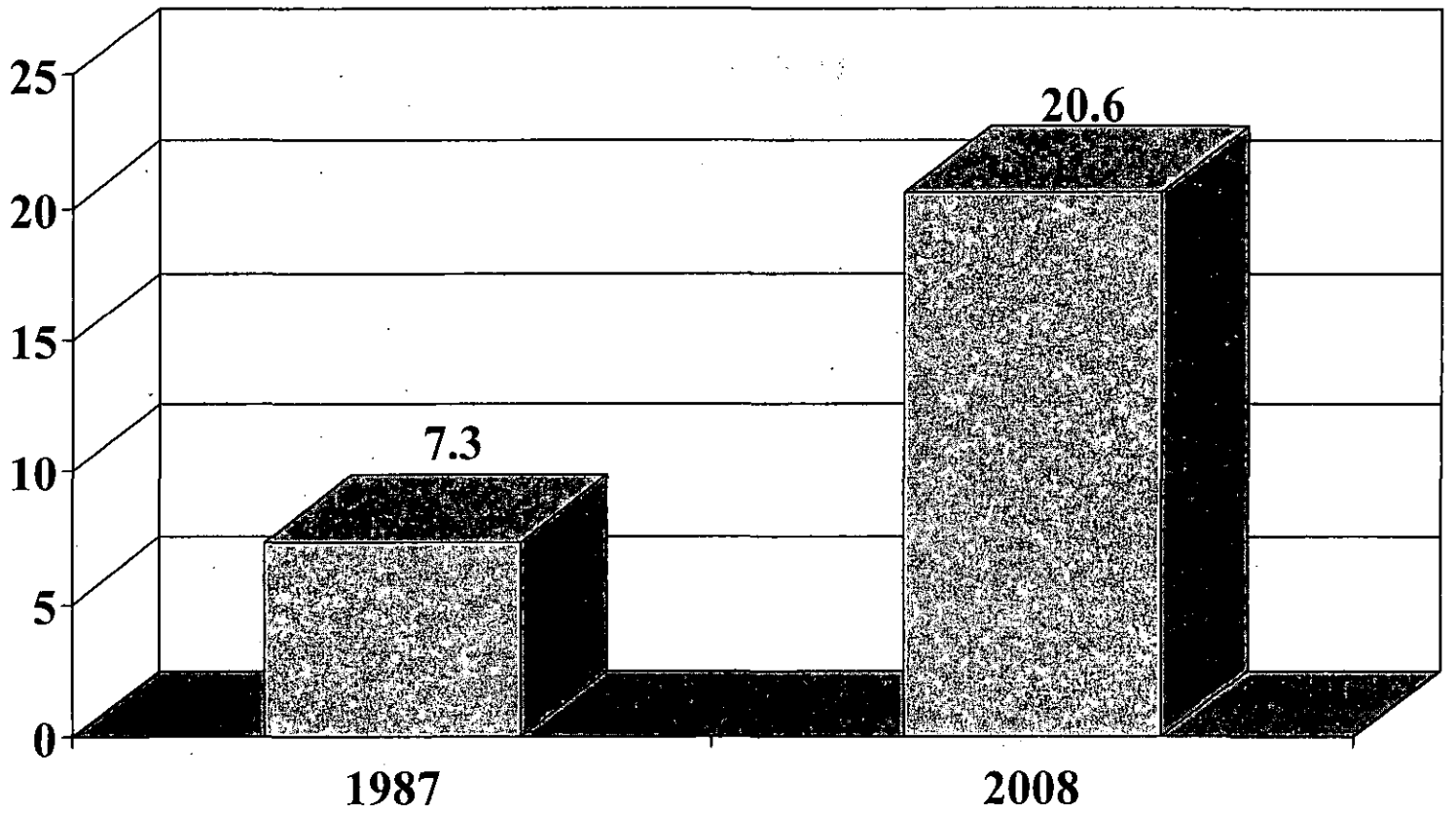
State Coverage Initiatives
Robert Wood Johnson Foundation

Note: Data from Current Population Survey, Census Bureau, Historical Health Insurance Tables,. August 2008.

The Non-Elderly as a Share of the Population and by Poverty Level, 2006



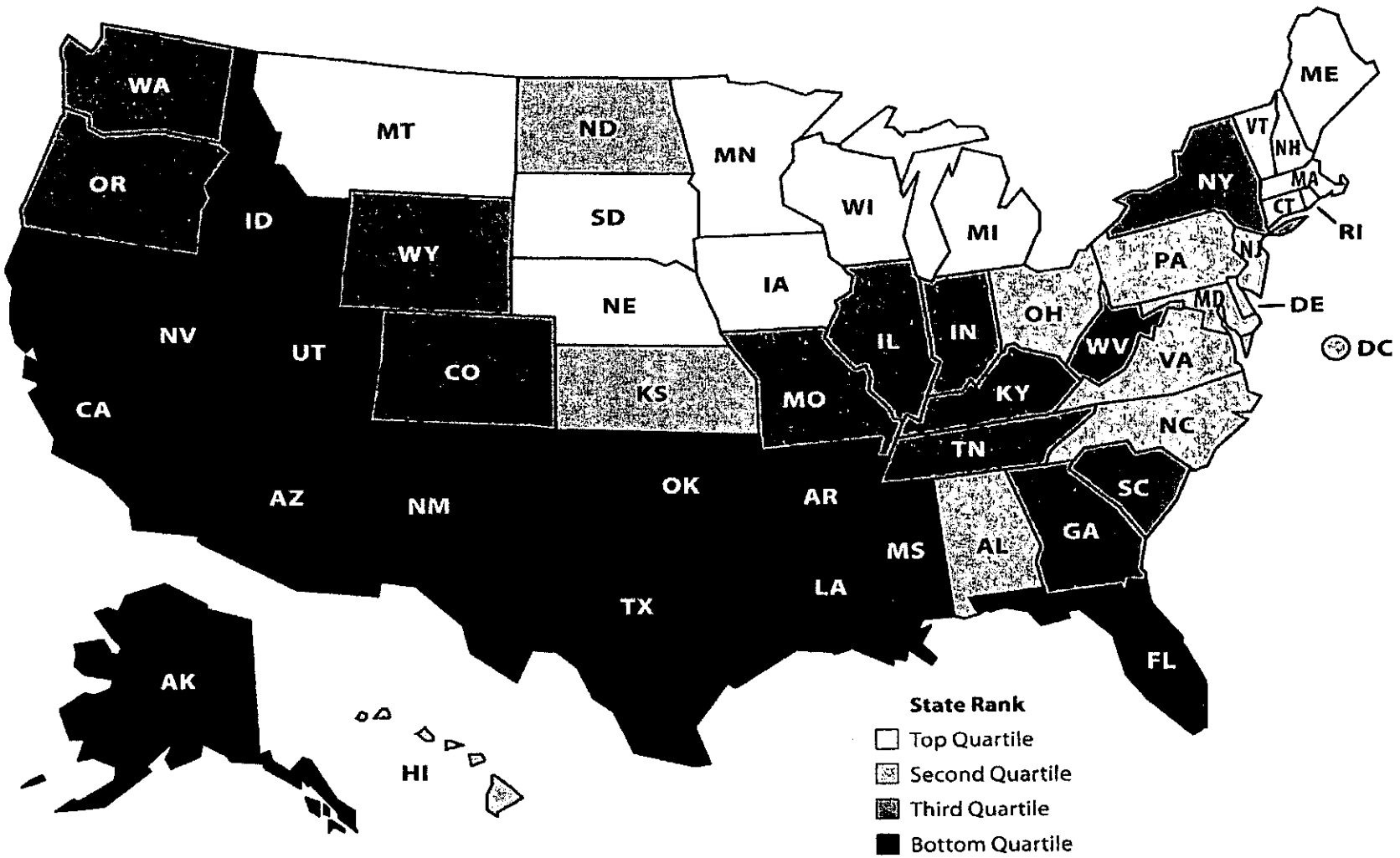
Percent of Median Family Income Needed to Buy Family Health Insurance



State Coverage Initiatives
Robert Wood Johnson Foundation

Source: Calculations by Len Nichols (1987) and AcademyHealth (2008), using KFF and AHRQ premium data, CPS income data.

State Ranking on Quality Dimension



SOURCE: Commonwealth Fund State Scorecard on Health System Performance, 2007

Drivers of State Health Reform Efforts

- Uninsured still high
- Employer-sponsored insurance down
- Costs/premiums increasingly unaffordable – Indiv; Families; Govt
- Coverage needed for effective and efficient health care system
- Lack of national consensus – future?
- Greater political will at state level

Key Policy and Design Issues

- Different Populations Require Different Solutions
- Subsidies and Financing: Who will pay? Who will benefit?
- Should Health Insurance Coverage Be Required?
- What is Affordable Coverage?
- What is the Most Appropriate Benefit Design?
- Do Insurance Markets Need to be Reformed/Reorganized?
- Best Mechanisms for Cost Containment/Systems Improvement

"One size fits all" approach won't work

- Those with few resources to bring to private insurance market
  - Ceiling = eligibility for public programs
  - Children: 100-300% FPL
  - SCHIP Parents/Childless Adults: Vary from 12-275% FPL
- Those with some resources but cannot bear the full cost of insurance premiums
  - Subsidies and other methods to reduce premiums
- Those who have sufficient incomes to participate in market on their own
  - Encourage voluntary participation or mandate coverage

No Free Solutions: Who Will Pay? Who Will Benefit?

- Shared responsibility – Who will help cover the costs?
  - Individuals; Employers; Federal government; State government; Health plans/insurers; Providers
- Enough money in current system?
  - If yes, then – Redistribution (Who will pay? Who will get paid?)
  - If not, then need new forms of revenue: Sin taxes; Provider taxes; Payroll taxes; Lease the lottery; Slots revenues; Gross Receipts Tax

Should Health Insurance Coverage Be Required?

- Unenforceable? Impingement on individual freedom?
- Does your state have money for subsidies to help lower-income uninsured (or an exemption process)?

What is Affordable Coverage?

- Related to overall benefit design
- Related to subsidies being considered
- Could be related to individual mandate
- General agreement that levels of both premium and out-of-pocket costs should somehow be related to income and ability to pay

Benefit Design

- Services included/excluded; cost-sharing; structure of access to providers
- Not just cost of coverage but value of the benefit plan – what set of services are purchased for specific amount of money
- Before – limit benefits; raise cost-sharing; limit networks (value issue)
- Levers within benefit design:
  - reduce premiums
  - encourage efficient/appropriate consumer behavior
  - change carrier and provider behavior
- Evidence-based benefit design? MN
- Consumer-driven health plans? IN
- First-dollar benefits? TN
- Direct consumer behavior change? RI

Don't Forget the Delivery System

- Prevention/primary care/wellness
- Chronic care management and coordination
- Public health initiatives
- Value-based purchasing/payment reforms
- Medical error reduction
- Health-acquired infection reduction/patient safety
- Price and quality transparency
- Heath information technology and exchange
- Administrative and regulatory efficiencies

What is a Medical Home?

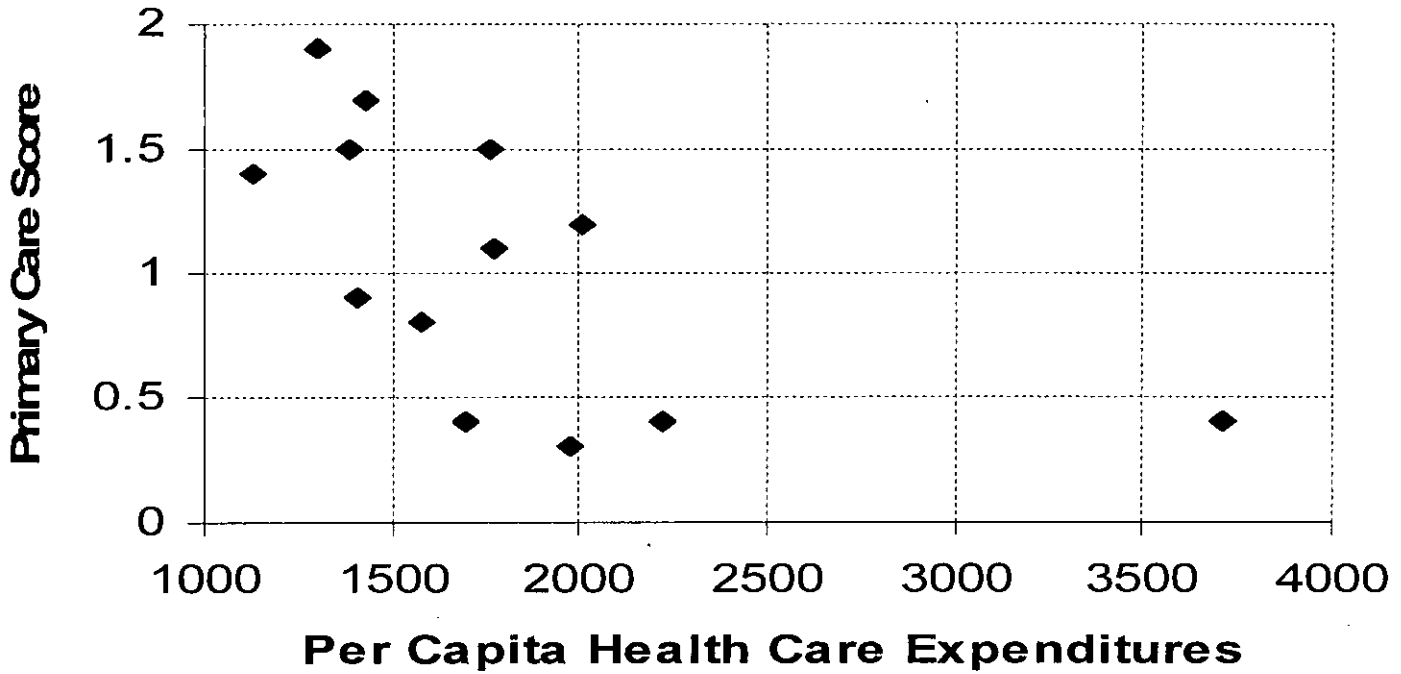
The Joint Principles of the Patient-Centered Medical Home, developed by the leading physician groups

- **Personal Relationship**
- **Team Approach**
- **Comprehensive**
- **Coordination**
- **Quality and Safety**
- **Expanded Access**
- **Payment for Added Value**

Other "Medical Home" Definitions

- NCQA – Has a 3-level standard being used or adopted by several states
  - Based on the Joint Principles
  - Utilized in Vermont, Rhode Island Medicaid and elsewhere
- Health Disparities Collaboratives, the "Wagner Model" or chronic disease management programs
  - A system change model that emphasizes:
    - Using best practice standards of care for specific chronic diseases
    - Use of quantitative process and outcome measures
    - Team approach to care
    - Patient education and self-management
  - Implemented in Community Health Centers around the country
  - Implemented in Washington, Rhode Island, Pennsylvania, and elsewhere
- Primary Care Case Management (PCCM)

High Access to Primary Care Correlates with Low Health Care Spending



Source: Based on The Commonwealth Fund 2006 International Health Policy Survey of Primary Care Physicians in Seven Countries

State Medical Home Programs

- 31 states have implemented programs to advance Medical Homes in Medicaid
- States working across payers on Medical Homes Programs include Colorado, Louisiana, Maine, New Hampshire, Pennsylvania, Rhode Island, and Vermont
- States with model Medical Homes programs include Vermont, North Carolina, Rhode Island and Pennsylvania

Comprehensive Efforts

Enacted

Maine ('03)

Massachusetts ('06)

Vermont ('06)

Significant Proposals

California – failed

Kansas – some pieces

New Mexico – very small pieces

Pennsylvania – in process

Strategies for Comprehensive Reform

	Maine	Massachusetts	Vermont
Individual Mandate	*No*	Yes	*No* *Will consider if coverage targets not met*
Purchasing Mechanism	DirigoChoice	Health Insurance Connector	Catamount Health
Subsidies for Low-Income	Up to 300% FPL	Up to 300% FPL	Up to 300% FPL
Public Program Expansion	Parents <200% FPL Childless Adults <125% FPL	Adults <100% FPL Children <300% FPL	*Builds upon previous expansions* *Children <300%* *Parents <185%* *Childless Adults <150% FPL*
Employer Requirements	*Voluntary* *Participating employers must pay 60% of premium*	$295/employee fee for non-offering. Must offer §125 Plan	$365/FTE fee for non-offering

Massachusetts Pillars of the Reform

- Employer Responsibilities
  - Section 125 Plan Requirement
  - Offer Coverage or Be Assessed
- Personal Responsibility/Individual Mandate
- Expansion of Publicly-subsidized Programs
- Major Changes to Insurance Market
  - Merged Small Group and Individual Markets
  - Raising age of dependents – up to 25
  - Connector

Current State of the Commonwealth

- More than 439,000 newly-insured between June 2006 and March 31, 2008
- 191,000 more in private coverage (no public $$) – more than 40% of all newly covered have no subsidies
- Employer-sponsored insurance remains predominant source of coverage (82% of non-elderly): no crowd-out
- Non-group premiums are down over 40% and membership has grown over 50%
- Approximately 1-2% of the MA population or 60,000 persons may be exempted from the mandate

Vermont - Blueprint Components

Public Policy	▪Blueprint legislation and funding ▪Executive Director at Governor's Office level ▪Integration with Public Health Disease Prevention Programs
Community	▪Community Grants ▪Environmental and Policy Strategies, Smart Planning ▪211 as statewide resource tool
Self-Management	▪Healthier Living Workshop—All conditions - Over 40 statewide; 500+ enrolled - +60% reduction in MD and ED visits post at one year ▪Patient portal planned
Information Systems	▪ Statewide RHIO, Health IT Plan ▪ Web-based chronic care information systems ▪ EMR
Physician Practices	▪Consensus treatment standards—7+ Diseases ▪Clinical Microsystems support in practices –training, coaching, peer support ▪75% participation in 6 Communities (HSAs)□200 practices
Health Systems	▪Required coordination across all payers in 3 pilots in 2008 ▪Contract with National Payment Reform Consultant

California Proposed Reforms

- **Shared Responsibility**
  - Individual mandate
  - Guaranteed issue
  - Financing: Government, Hospitals, Employers, Individuals
- **Prevention/Health Promotion/Wellness**
  - Tied to preventive health practices
  - Reducing medical errors (e-prescribing)
  - Obesity prevention
  - Tobacco cessation efforts
  - Health Care Cost and Quality Commission
- **Affordability & Cost Containment**
  - Subsidies for low-income adults and children
  - Section 125 plans/HSAs
  - Emphasis on HIT
  - Increase Medi-Cal reimbursement rates ('hidden tax')

Kansas – Summary of 2008 Legislative Action

Transforming Medical Care	Improving Public Health	Expanding Affordable Insurance
• Transparency project: Health care cost and quality (Kansas Health Online) • Health literacy • Medical home definition • Medicaid provider reimbursement • Community Health Record (HIE) • Insurance Form Standardization	→ Increase tobacco user fee → Statewide smoking ban → Partner with community organizations → Education Commissioner → Collect fitness data in schools → Promote healthy foods in schools → Promote fitness in schools → Wellness for small businesses → Healthier food for state employees → Dental care for pregnant women → Tobacco cessation in Medicaid (for pregnant women only) → Expand cancer screening	→ Aggressive outreach & enrollment of eligible children (target pop: 20,000) → Premium Assistance for low income adults without children (target population: 39,000) → Small Business Initiatives (target population: 15,000 young adults and 12,000 employees of small businesses)

Green – Passed with Funding, if Needed; Yellow – Passed with No Funding; Red – Did Not Pass

Health Solutions New Mexico Plan

What was Proposed:

- Insurance Reforms
- Phased-In Health Coverage Participation Reqmt
- Electronic Claims and Records
- Health Coverage Authority
- Evaluation

What Happened:

- Funding for eligible but not enrolled: $22.5 m.
- Treat developmentally disabled children: $10 m.

Pennsylvania Proposed Reforms:

Prescription for Pennsylvania

Rx for Affordability	Rx for Access	Rx for Quality
Cover All Pennsylvanians (now Access to Basic Care)	Health Care Workforce	**Hospital-Acquired Infections**
Coverage for College Students and Young Adults	**Removing Practice Barriers – Scope of Practice**	Quality Outcomes
Community Benefit Requirements	Cost-Effective Sites	Pay for Performance
Uniform Admission Criteria	Co-Occurring Disorders	Chronic Care – Exec Order
Fair Billing and Collection Practices	Governor may consider individual mandate if number of uninsured does not decline over next few years	Health Disparities
Capital Expenditures		Child and Adult Wellness
Small Group Insurance Reform		Long Term Living
Health Information Exchange – Exec Order		End of Life and Palliative Care

State Coverage Initiatives

Robert Wood Johnson Foundation

Source: Presentation by Ann S. Torregrossa, Deputy Director & Director of Policy GOHCR. Alliance for Health Reform Briefing, October 26, 2007

Substantial Reforms

Enacted

Indiana - 2007

Iowa – 2008

Maryland - 2007

Minnesota - 2008

New Jersey - 2008

Washington - 2007

Wisconsin - 2007

Indiana: Healthy Indiana Plan (HB 1678)

- Increases tobacco taxes by $0.44 per pack; $0.33 will be used for:
  - Covering adults up to 200% FPL + Immunization programs

- The remaining $0.11 will be distributed as follows:
  - Three cents will increase physician/dentist Medicaid reimbursement rates;
  - Three cents will provide a tax credit to employers that establish Section 125 plans - for employers not offering a fully insured health plan that satisfies Section 125 of the IRS code, the state will provide the lesser of $50 per employee or $2,500 for 2 years if the employer establishes Section 125 plan; and
  - The remaining 5 cents will be used to increase tobacco prevention and cessation programs and for other health programs.

- **A key aspect of HIP is that it utilizes the HSA model combined with comprehensive insurance coverage above the deductible. Individuals will annually receive $500 of pre-deductible, free preventive care and have a $1,100 deductible.**

Iowa Reforms

- Coverage for children up to 300% of FPL (with a sliding scale premium between 200-300% FPL) + one-year continuous eligibility
- Directs an advisory group to develop a plan for full health coverage in five years
- A Medicaid buy-in option for those with disabilities
- A Medical Homes Initiative
- Healthy Communities Initiative, Quality improvement council, transparency, electronic health plan to be developed

Maryland Working Families and Small Business Health Coverage Act

- Provides subsidies to small employers (2-9 employees) and employees of small employers if the employer:
  - has not offered a health benefit plan within the prior 12 months;
  - meets certain low-wage requirements to be established through regulation;
  - establishes a Section 125 payroll deduction plan to allow for pre-tax premium contributions; and
  - agrees to offer a wellness benefit that is designed to prevent disease, reduce poor clinical outcomes, and promote health behaviors and lifestyle choices.
- Expands Medicaid eligibility up to 116% FPL for parents/caretaker relatives.
- Phase-in over four years of Medicaid eligibility up to 116% FPL for childless adults—enrollment may be capped and benefits may be limited based on available funding.
- Financing: combination of general funds, hospital uncompensated care savings, a one-time surplus from high risk pool, and federal funds.

Minnesota – Coverage and Cost

- Childless Adults to 250%
- Section 125 Plans
- "Essential Benefit Set"
- Easier enrollment and more seamless transitions
- Directs development of proposal to promote access to affordable employer-sponsored health care through tax credits and deductions

Children	275% FPL
Pregnant Women	275% FPL
Childless Adults	175% FPL
SSI Disabled	100% FPL

Minnesota Payment Reform and Quality Improvement

- Establishes a single statewide transparent system for quality-based incentive payments
  - Public reporting on risk-adjusted quality measures
- Establishes new payment system based on "baskets" of care and then allows consumers to compare prices across providers
- Establishes standards for state certification of health care homes (to receive care coordination payments)
- Administrative Efficiency
  - Requirement that all EHRs [Electronic Health Records] be consistent with federal interoperability standards and that all prescriptions are ordered electronically by 2011
  - Uniform methods of claims process
- Public health programs to reduce obesity and cut tobacco use

New Jersey: Phases of Reform

Phase I

- Familycare Buy-in
  - Passed Into Law – 12/1/07
- "Kids First" Mandate
- Familycare Expansion
- Market Reform
  - Signed by Governor 7/8/8
  - Implementation 9/1/08

Phase II

- Creation of Garden State AllCare
- Individual Mandate
- Sliding Scale Subsidies
- Section 125 Mandate
- Charity care/related hospital subsidies redirected over time to premium assistance
- Collaborative Care System Creation/Medical Homes

Washington State Reforms

- Provides access to coverage for all children by 2010 (SB 5093)
- Intensive education/outreach/admin simplification to enroll the currently eligible
- Expands SCHIP to children up to 300% FPL (now 250%) in 2009
- Children above 300% FPL – full cost buy-in
- Creates Washington Health Insurance Partnership (Connector) (SB 1569)
  - Targets small employers w/low-income workers
  - Sliding scale premium subsidies for those <200% FPL
- Provides high quality, affordable health care based on recommendations of the Blue Ribbon Commission in Health Care Costs and Access (SB 5930)
  - Reimbursement Changes
  - Chronic Care Projects/Medical Homes
  - Washington State Quality Forum
  - Health Information Technology
  - Appropriate Care Settings
  - Wellness Programs

Wisconsin Reforms

- BadgerCare Plus: Merge Family Medicaid, BadgerCare (SCHIP - covers children and parents to 185 percent FPL), and Healthy Start:
  - Cover all children (families above 200% FPL can purchase basic health coverage for their children for $10 to $68.53 per child per month, depending on income)
  - Provide coverage/enhanced benefits for pregnant women up to 300% FPL
  - Simplify the program
  - Promote prevention and healthy behaviors (member agreements; incentives for MCOs; incentives for individuals; health literacy/education)
  - Financed through increase by $1 per pack cigarette tax

- New Policy Goals (2008+)
  - Ensure 98% of Wisconsin's population has access to health insurance by expanding to childless adults through **BadgerConnect**, a new online gateway to health care
  - One-stop shop for health care access for low-income families
  - Increase business participation and health insurance portability
  - Use evidence-based medicine to design benefits and control costs

Wisconsin's BadgerCare Plus: Streamlining and Outreach

- Simplified & standardized eligibility rules
  - For example, the state reduced the number of earned income disregards and increased the income limit
  - The goal was to make the program easy to understand for both enrollees and staff

- Invested in outreach & focused on the community level
  - 42 agencies within the state received $25,000 to build the infrastructure needed to help people apply for the program
  - Statewide ad campaign—called the children's coverage expansion an "all kids" program

Wisconsin's BadgerCare Plus: Streamlining and Outreach

- Made online application process easier & more accessible
  - ➢Supported and promoted online applications
  - ➢Simplified the online application and trained community workers around the state to use it
  - ➢During the first few months of the program, online applications increased from about 25 to 50 percent of total applications

- Invested in more staff
  - ➢Increased size of staff statewide, especially in Milwaukee
  - ➢Developed a new processing center in Milwaukee to approve applications and send cards to enrollees within one week

Substantial Reforms

States with Recommendations for 2009 Session

Connecticut

Kansas

Ohio

Oklahoma

Oregon

Utah

HealthFirst Connecticut Authority Recommendations

- Expanded Medicaid/SCHIP eligibility for all residents with family incomes below 300 percent FPL, with sliding scale cost-sharing and premium assistance for those with ESI.
- Access to a restructured Charter Oak program - currently allows families to buy health insurance regardless of their health status at premiums tied to income.
- A Connecticut Health Partnership, using the state employee health benefit plan as a base, will be available to all residents and employers in order to improve employer offer rates and employee take-up rates, and to offer coverage to those in the non-group market.
- Multiple recommendations for containing costs and improving quality.
- Data collection and analysis to drive policy development, implementation, and evaluation.
- Public entity assigned or developed to oversee the proposed reforms and better coordinate state spending on health care.

Kansas 2009 Health Reform Priorities – Kansas Health Policy Authority

- Statewide Clean Indoor Air
- Increased Tobacco User Fees
- Increased Access to Affordable Health Care and Health& Wellness
  - Medicaid Expansion to Parents up to 100% FPL
  - Convene panel to develop proposals to assist small employers and young adults afford health insurance
  - Tobacco Cessation for Medicaid
  - Expand Cancer Screening for Low-Income and Uninsured
  - HIT - Statewide Community Health Record
  - Workplace Wellness Grants for Small Businesses
  - Expand Kansas Coordinated School Health Program

Ohio State Coverage Initiatives Recommendations

- Requiring employers to establish §125 Plans
- Reinsurance for individuals and small businesses
- Extend group coverage to dependents up to age 29
- Premium assistance for low income workers
- Enrolling more Ohioans in Medicaid and expanding Ohio's Medicaid to high income levels
- Allowing non-Medicaid eligible adults to enroll in Medicaid managed care plans
- Reforms to the individual health insurance market (GI; Mandate; Subsidies; Admin Efficiencies)
- Connector

Blueprint for Oklahoma – Draft Report

- Maximizing enrollment in public programs for those eligible but not yet subscribed
- Developing an affordable basic health benefits plan
- Generating sufficient public revenue
- Encouraging the take-up of private coverage

Oregon Health Fund Board Report

- Improve access for children and low-income
- Cost containment and quality improvement mechanisms
- Purchasing strategies and insurance market reforms
- Encourage new models of care delivery
- Ensure health equity for all
- Train new health care workers
- Federal-state relationship

Utah Legislative Health System Reform Task Force Legislation

- Insurance market reforms:
  - Creates new basic benefit plan called the Utah NetCare Basic Health Care Plan
  - Allows mandate-free benefit plans to be offered in certain circumstances
  - Establishes Internet portal for the purchase of these new plans
  - Sole proprietors included in the small group market pool
  - Establishes a reinsurance pool
- Streamlines and standardizes various aspects of provider, insurer, and consumer interactions and communications.
- Framework for demonstration projects for delivery and payment systems reforms.
- Requires certain contractors who do business with the state to offer health insurance to their qualified employees.

Incremental Approaches

Cover All Children

Purchasing Pools/Mechanisms

Increasing Dependent Coverage

New Benefit Design

Reinsurance

Creative Uses of Medicaid (public/private)

Rhode Island ('07): HealthPact

- Includes coverage for physician visits, hospitalization, preventive services, and prescription drugs
- Design is intended to give incentives to enrollees to be more actively engaged in managing their own health care
- Proposes to achieve significant cost savings though financial incentives for enrollees who improve and maintain their health through **five key wellness initiatives**
- For enrollees who choose to participate in the wellness programs, it is proposed that deductibles, co-pays and co-insurance will be reduced to amounts normally seen in plans with much higher premiums

Cover Tennessee ('07)

- Affordable healthcare coverage
  - Premiums shared equally by employer, individual and state
  - Individual's monthly premium share ranges between $37 and $109
  - Premiums vary depending on age, tobacco use, and obesity
  - No deductibles; reasonable co-pays
  - Maximum Benefit amount: $25,000
- Portable – Individual Product
  - Owned by the individual
  - Individual can keep coverage even if they leave an employer
  - Provides continued coverage during brief periods of unemployment
- Basic – Provides most services most people need

States & the Health Workforce

State Coverage Initiatives
Robert Wood Johnson Foundation

States & the Health Workforce

- States have strong influence over the development and practice of the health workforce.
  - Education, financing and regulation
- State action is critical for current shortages & for the future.
- States are faced with current or imminent health workforce shortages due to multiple factors:
  - Aging population
  - Changing educational & practice environments
  - Limited pipeline of people entering health professions

State Action on Workforce Issues

- Data collection and analysis: State nursing centers, centers for health workforce studies, university centers
- Pipeline development: Health career websites, K-12 outreach programs, scholarships/loan repayment programs
- Retention (geared towards nurses): Career ladder programs, abolish mandatory overtime, pass minimum staffing ratios
- Licensure and Credentialing: Scope of practice changes, Nurse Licensure Compact (currently 23 states)
- Educational capacity building: Faculty scholarships and loan repayments, increasing educational capacity, innovation in educational delivery

Massachusetts (Enacted 8/08)

- Passed comprehensive plan to strengthen primary care infrastructure
  - Creates new Health Care Workforce Center within the Department of Public Health
  - State authority to establish a medical home demonstration project
  - Directs MassHealth Payment Policy Advisory Board to study methods to improve payments or bonuses for primary care providers
- For health care professionals who practice in underserved areas:
  - Loan forgiveness program
  - Affordable housing pilot
- Requires health insurers to recognize and reimburse nurse practitioners as primary care providers

Oregon (11/08 Recommendations)

- Released blueprint for comprehensive health care system reform - one key "building block" is to train a new health care workforce.
- Action steps include:
  - Collecting data through the licensure process to provide an on-going database about current workforce and analyze future workforce needs
  - Implementing strategies to train, attract and retain an appropriate supply of primary care providers in all areas of Oregon
  - Develop direct reimbursement and a certification system for Community Health Workers

Pennsylvania (Enacted 2008)

- Passed a series of measures over the last few years to expand the scope of practice for physician assistants, nurse practitioners, clinical nurse specialists, nurse midwives and dental hygienists
- Generally, the laws allow fewer doctors to oversee these health care providers and expand the types of settings where they can provide health care services

Iowa (Enacted 5/08)

- Requires that the Department of Public Health expand efforts to guarantee a stable & well-qualified workforce
- Creates a Direct Care Worker Advisory Council to continue work on education and certification issues
- Instructs the Department of Human Services (DHS) to maintain an ongoing report that measures direct care worker turnover in nursing facilities
- Directs DHS to design a premium assistance demonstration project to provide health coverage for up to 150 direct care workers and their dependents

Vermont (Enacted 2006)

Workforce measures to increase provider availability:

- Loan repayment program for health care providers & educators
  - Available to primary care doctors, nurses, dentists, and nurse educators/faculty
  - Must agree to serve patients enrolled in Medicare, Medicaid, or other state health benefit plans
- Loan forgiveness program for nurses and dental hygienists
- Tele-psychiatry pilot to fill the state's gap in available child psychiatrists
- Provider reimbursement surveys
  - Examine the adequacy of reimbursement rates and understand impact of rates on recruitment and retention of health care professionals
- Conduct Nurse Authority Study
  - Establish a work group to study and make recommendations on whether an advanced practice nurse need not be required to work in a collaborative practice with a physician

State Quality Reporting Activities

State Coverage Initiatives
Robert Wood Johnson Foundation

Using Performance Measurement to Improve Quality

- Public Reporting
  - Health Plans
  - Hospitals
  - Nursing Homes
  - Ambulatory Settings
- Purchasing to Improve Quality
  - Value-based purchasing/payment reform
  - Tiered networks
  - To drive delivery system reform
- To Drive Consumer Choice and Internal Quality Improvement

Public Reporting on Health Plan Performance

- Measures
  - HEDIS: Clinical Measures (Administrative/Medical Records)
  - CAHPS: Patient Satisfaction (Survey)
  - Complaints
  - NCQA Accreditation

- **26 States have public reports using HEDIS, CAHPS or both**

- Some Medicaid Programs publicly report as well

Public Reporting on Hospital Performance

- Descriptive Measures: Administrative
  - Volume/Utilization/LOS/Readmission
  - Number of beds; Services available; Financials; etc
- Process Measures: Clinical (CMS/JCAHO)
  - Heart Attack/Congestive Heart Failure/Pneumonia/SIP
- Outcome Measures: Clinical
  - Mortality (CABG/PCI) – risk adjustment
- Patient Satisfaction: Survey
- **15 States publicly report one or more of these measures**

Public Reporting on Nursing Homes

- Structural/Descriptive Measures: Administrative
  - Number of Beds
  - Staffing Info: Number of Nurses; Turnover; Wages
  - Financial/Cost
- Quality Measures: Clinical (CMS)
  - Quality Measures
  - Deficiency/Complaints
- Patient/Family Satisfaction
- **States generally publicly report deficiency/complaint information**

Public Reporting of Healthcare-Acquired Infections (HAI)

- Public Disclosure:
  - 2003: IL (reworked in 2005)
  - 2004: FL, MO, PA
  - 2005: NY, VA
  - 2006: CO, CT, MD, NH, OH, OK, SC, TN, VT
  - 2007: DE, MN, NJ, TX, WA
  - 2008: CA, MA, OR, RI, WV
- Study Bills: TX (2005/public disclosure in 2007), GA (2006), AK (2006 - resolution)
- Pilot Project: NM (2007)
- Confidential Reporting: NE, NV (2005)

Report Card Authors Face Numerous Choices

Choice	Approach	Issues
Source of data	Claims	Easy and cheap to obtain, but less accurate
	Chart review	More accurate, but expensive
	Surveys	Consumers like, but expensive
Level of reporting	Hospital Level	Facility information, not care by specific practitioner
	Large groups of physicians	Heterogeneous, more valid statistically, less useful to patients
	Individual physician	Numbers of procedures too small, hard to do risk adjustment, most useful to patients
Display of data	Stars or bar graphs	Intuitive and familiar to consumers but can be misleading
	Statistical ranges	Closer to "truth," but more difficult to explain

Common Principles in Performance Reporting

- Steering committee of interested parties
- Pilot first then full implementation
- Reduce duplication of effort by carriers, facilities, and practitioners
- Continuous revision and improvement as measurement techniques advance
- Focus on the Positive
- Web-based application

State Health Policy Commissions and Authorities

State Coverage Initiatives
Robert Wood Johnson Foundation

Delaware Health Care Commission - 1990

- Independent public body reporting to the Governor and the Delaware General Assembly
- Policy-setting body rather than a service-delivery body
- **Mission**: To promote accessible, affordable, quality health care for all Delawareans.
  - **Access**- Promote access to health care for all Delawareans.
  - **Cost**- Promote a regulatory and financial framework to manage the affordability of health care.
  - **Quality**- Promote a comprehensive health care system assuring quality care for all Delawareans.
- Uninsured Action Plan
- Information & Technology
- Health Professional Workforce Development
- Research & Policy Development
- Specific Health Care Issues & Affiliated Groups

Delaware Health Care Commission

- Chair is Lt Gov
- Four government officials (ex officio)
  - Secretary of Finance
  - Secretary of Health & Social Services
  - Secretary of Children, Youth & Their Families
  - Insurance Commissioner
- Six private citizens appointed either by the Governor, the Speaker of the House or the President Pro Tempore of the Senate
  - Dean, College of Health and Public Policy, Delaware State Univ.
  - Senior VP for Government Relations, DE Chamber of Commerce
  - Chair, Dept of Family & Comm Med, Christiana Care Health Services
  - President, Maritime Exchange for the Delaware River and Bay
  - Two others

Maryland Health Care Commission

- Develop State Health Plan/administer Certificate of Need program
- Oversee certain aspects of small group market reforms
- Develop and publish consumer guides for health plans, hospitals, nursing homes and ambulatory surgical centers
- Establish and develop a medical care data base on health care services rendered by health care practitioners
- Establish standards for the operation and licensing of medical care electronic claims clearinghouses
- Determine the cost of mandated health insurance services
- Promote the availability of information to consumers on charges by practitioners and reimbursements from payors
- Oversee and administer the Maryland Trauma Physician Services Fund
- Other policy studies as requested: patient safety, affordability, etc

Maryland Health Care Commission

- 15 members appointed by Gov with advise/consent of Senate
  - Nine must be individuals with no connection to the management or policy of a health care provider or payor
  - Remaining six members:
    - Two physicians
    - Two payors
    - One nursing home administrator
    - One non-physician health care practitioner
- Also geographic representation requirements
- To the extent practicable, assure geographic balance and promote racial, ethnic, and gender diversity in the Commission's membership

Kansas Health Policy Authority - 2005

- Responsible for coordinating a statewide health policy agenda that incorporates effective purchasing and administration with health promotion strategies.
- All health insurance purchasing by the State is now combined under KPHA, including publicly funded programs (Medicaid, State Children's Health Insurance Program, and Medikan) and the State Employee Health Benefits Plan.
- Responsible for compiling and distributing uniform health care data in order to provide health care consumers, payers, providers and policy makers with information regarding trends in the use and cost of health care for improved decision making.
- 2007 Legislation: Directed KHPA to develop health reform options in collaboration with Kansas stakeholders.

Kansas Health Policy Authority

- Nine voting health care, business, and community leaders appointed by the Governor and the Legislature
  - President, Chief Executive Officer and General Counsel for Medicalodges, Inc.
  - Associate Professor, Dept of Public Administration, University of Kansas
  - Senior Vice President, Human Resources at EMBARQ Corporation
  - Chairman of the Board, Midway Wholesale of Topeka
  - Professor of Management Practice, Harvard Business School.
  - Retired Co-President and CEO, Center for Health and Wellness
  - Pediatrician
  - CEO of Pratt Regional Medical Center
  - Retired, Midwest Consortium Administrator, Centers for Medicare and Medicaid (CMS), HHS
- Ex-Officio Members
  - Dept of Health & Environment (Sec & Dir of Health); Dept of Social & Rehabilitation Services; Dept of Administration; Dept on Aging; Insurance Department; Department of Education; KHPA Executive Director

Connecticut Office of Health Care Access

- Headed by a Commissioner who is appointed by the Governor

- Mission: To ensure that the citizens of Connecticut have access to a quality health care delivery system:
  - By advising policy makers of health care issues
  - By informing the public and the industry of statewide and national trends
  - By designing and directing health care system development

- **Certificate of Need & Compliance Unit:**

- **Research & Planning Unit:**

Oregon Health Policy Commission - 2003

- Mission: To develop and promote policy recommendations to the Governor, the Legislature, and the Oregon Health Policy and Research (OHPR) that improve the health of all Oregonians by ensuring access to essential health care and support services, increasing quality and improving outcomes for individuals and society, controlling costs, and encouraging healthy lifestyles.

Oregon Health Policy Commission

- Ten voting members appointed by the Governor.
  - Exec VP, Corp Services & Chief Legal Officer,The Regence Group
  - Chair, AterWynne LLP (Strategic Legal Advisors)
  - Director, Integrated Clinical Services, Multnomah County Health Dept
  - Senior Consultant, Watson Wyatt Worldwide
  - President, SEIU Local 49
  - Health Care Consultant
  - Director, Oregon Ctr for Health Professions, Oregon Inst of Technology
  - CEO, The Lussier Center (Management Consulting Services)
  - Chairman, Triquint Semiconductor
  - Vice President and Chief Quality Officer, Samaritan Health Services
- Four legislators (one representing each legislative caucus) serve as non-voting advisory members to the Commission

Lessons Learned in State Reform Efforts

State Coverage Initiatives
Robert Wood Johnson Foundation

Lessons Learned in State Reform Efforts #1

- Successful comprehensive reforms are built on previous efforts, financing mechanisms
- Need ingredients: leadership, opportunity, readiness to act, persistence
- No free solutions
- Successful efforts to enact reforms often need shared financial responsibility
- State expansions in coverage often rely on private insurers to deliver care
- Voluntary strategies will not result in universal coverage - some states are beginning to recognize the need for mandatory participation

Lessons Learned in State Reform Efforts #2

- Hard to get agreement on what is covered (benefit design/affordability)
- Little success so far in addressing underlying cost of health care but a new focus on chronic care management/preventive care holds potential
- Address access, systems improvement, cost containment simultaneously—concern about long-term sustainability of coverage programs and improved population health
- New state reforms can be fairly judged only after several years, allowing a realistic length of time to work through implementation challenges.
- Comprehensive reforms need sequencing
  - Sequential = incremental with a vision

States Can Advance Reform Initiatives But Need Federal Support

- States face growing pressures for reform
  - Uninsurance continues to rise as employer sponsored coverage declines
  - Cost increases threaten state budgets and capacity to sustain Medicaid/SCHIP
- States play critical role in moving the conversations about coverage expansions
  - Testing new ideas (politically and practically)
  - Creating momentum for national policy solution
- States cannot achieve universal coverage without a federal framework and funding
  - Significant variation across states in resources, capacity, and landscape—including uninsured rates, available state funds to invest in coverage, insurance market structures, and other important factors

NCSL Health Committee Roster

Committee Officers & NCSL Staff // Committee Members // Committee Jurisdiction

Committee Description

This committee has jurisdiction over state and federal health programs, legislation, regulations and policies. The committee educates Congress and federal agencies about state concerns regarding developments in federal health initiatives and programs and grants to states. In addition, it serves as a forum for legislators and legislative staff to learn about and share information regarding health programs and health policy initiatives in other states. Recently, the committee has addressed the following issues:

- Medicare prescription drug coverage
- Medicaid
- Health care cost containment
- Health care access
- Public health and prevention

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