States Move Ahead Through Incremental Reforms

BY JANE H. WHITE

With no prospects for substantive national health reform this year, states' healthcare activities look increasingly significant. Every state has addressed some facet of health reform—from insurance reforms to embracing managed care for Medicaid. Although only a handful have moved forward with comprehensive health reforms to ensure universal coverage, all the states are looking at various incremental steps (see my October *Health Progress* column, pp. 14-16). As RAND economist Stephen Long recently put it, "I think states and incrementalism are where the action will be until the end of the decade. The feds couldn't get it together."

Ms. White is executive editor, Health Affairs.

STATE INSURANCE REFORMS

Community Rating One type of incremental reform that has captured attention nationwide is the use of community rating to restrict the rates private insurers can charge. The goal of many community rating proposals is to level the playing field for small businesses and sicker individuals who have been priced out of the market under the more widespread "experience rating" insurance strategy, where premiums are set based on healthcare cost experiences of particular groups and individuals.

Under "pure" community rating, insurers cannot charge different premium rates to different groups and individuals under the same insurance plan. They must not take health status or other risk and demographic factors into account. Most community rating plans, however, are "adjusted, or modified," and allow some variation of price for factors such as age, gender, and family size by creating "rating groups," or "bands." With different rating bands, the premiums charged for the same insurance plan can still vary by as much as four to one.

Virtually all the compromise reform bills debated in Congress included some community rating provisions. Twenty-one states have passed legislation introducing full or modified community rating, according to a report on state health reforms commissioned by the Henry J. Kaiser Family Foundation and conducted by the Intergovernmental Health Policy Project (IHPP) at George Washington University.[1]

New York State has undertaken one of the most controversial state efforts on this front. It is the only state to date to implement pure community rating. It is also one of only four states (including Maine, New Jersey, and Vermont) to have extended community rating to individuals, not just small businesses. In addition to community rating, New York's 1992 insurance reform law requires insurers to offer "open enrollment" where they may not reject applicants based on age, sex, health status, or occupation.

Both the community rating and open-enrollment provisions of New York's law went into effect April 1, 1993. This swift implementation has led to heated debate about its effects on insurance prices and on the number of insured. According to the IHPP report:

> Community rating is controversial because of concerns over how it will affect the current "winners," people now paying lower than average premiums. . . . To avoid "rate shock" due to sudden underwriting changes, implementation of community rating is typically phased in over several years by narrowing the amount of variation permitted and the types of factors that may be used. . . . New York has experienced problems due to abrupt implementation of full community rating.[2]

New York State Insurance Superintendent Salvatore R. Curiale reported that between March 31, 1993, and January 1, 1994, 25,477 insurance policies were dropped out of nearly 2.1 million, a decline of 1.2 percent.[3] A report conducted by Milliman & Robertson, however, estimated the drop-off at about 500,000 policies.[4]

Policy analysts question not only the difference between these numbers, but their interpretation

as well. A number of press accounts have focused on young, healthy New Yorkers whose previously low insurance rates skyrocketed under community rating and who consequently dropped their insurance. However, there may be more than simple cause and effect linking community rating to insurance drop-off. In a conversation, IHPP researcher Kala Ladenheim described the Milliman & Robertson data as "comparing apples and oranges." And RAND economist Long said, "The 1.2 percent drop could have been noise in the data. In addition, the Blues raised their rates [about 25 percent] at the same time, so how much of this [drop-off] is due to community rating" and how much is attributable to other unrelated factors in New York's insurance market? Blue Cross and Blue Shield already provided community-rated insurance before the new law.

Other states that have implemented community rating more gradually have shown more positive results. According to a new report on community rating by IHPP:

> [New Jersey's] risk sharing mechanism is credited with bringing more than 20 new carriers and 11,000 previously uninsured persons (20 percent of the newly sold policies) into the nongroup (individual) market. . . . In Vermont small group coverage shot up 15 percent in the first year of implementation. In Massachusetts and Maine, where phase-in of modified community rating has begun, . . . anecdotal evidence and state insurance regulators' reports . . . suggest that there have not been major problems to date.[5]

Health Alliances Another insurance reform debated at the federal level and actually under way in a number of states is the health insurance purchasing cooperative or alliance. Healthcare alliances were a centerpiece of President Bill Clinton's managed competition strategy. However, congressional bills soon dropped them after intense lobbying by insurers and business portrayed alliances as massive new mandated bureaucracies.

To date, more than 20 states are testing this approach. According to the IHPP state profile report:

> These experiments are attractive to states, because they may produce substantial change without a major financial investment by government. . . . Three approaches to alliances are common: (1) creation of alliances for state-funded coverage, such as Medicaid and state employee health plans; (2) creation of voluntary alliances for business (and sometimes individuals); and (3) definition and regulation of integrated health plans . . . that combine delivery system and insurance elements.[6]

"Community rating is controversial because of concerns over how it will affect the current 'winners,' people now paying lower than average premiums," according to the IHPP report.

California is a leader in the development of healthcare alliances. The state's employees, including county, municipal, and school workers, purchase health insurance through an alliance called the California Public Employees Retirement System (CalPERS), which began in the late 1960s. Nearly 1 million Californians and more than 750 public agencies use CalPERS to arrange their healthcare coverage and manage competition among various health insurance plans.

More recently, in August 1992, the California legislature passed new regulations for the small group–health insurance market, which included the establishment of a purchasing pool called the Health Insurance Plan of California (HIPC). This purchasing alliance, which is voluntary for small businesses in the state, began operating in July 1993. In its first six months, the HIPC enrolled 1,900 groups for a total of 33,000 beneficiaries. Its negotiated premium rates averaged 10 percent to 15 percent below comparable plans in the state.[7] Other alliances in California are operated by the Bay Area Business Group on Health and the University of California school system.

Across states, alliance experiments vary widely "in governance, geographical boundaries and authority to negotiate with health plans," notes the IHPP state profile report. "Florida's alliances are quasi-governmental agencies with state-appointed boards and exclusive territories, while Iowa's are voluntary nonprofit organizations with either exclusive or overlapping territories. Texas approved the formation of both private and government-sponsored alliances."

State Medicaid Reforms

Another area where health reform is proliferating at the state level is in Medicaid, the state-federal insurance program for some categories of the nation's poorest citizens. The states' share of Medicaid costs has jumped from $12.1 billion in

1981 to $48.2 billion in 1992. The federal share rose even more, from $15.6 billion in 1981 to $64.7 billion in 1992.[8] States, however, are required to balance their budgets each year, and Medicaid has eaten away a major portion of these budgets, leaving states with fewer resources to address other priorities.

To help control burgeoning Medicaid costs, some 41 states are experimenting with Medicaid managed care programs. In the 10 years between 1983 and June 30, 1993, Medicaid managed care enrollment has grown from 1 percent to 15 percent of beneficiaries (4.8 million). The Health Care Financing Administration projects that figure will rise to 8 million in 1994.[9]

Congress authorized Section 1115 Medicaid waivers in 1981 to allow states to set up demonstration experiments on Medicaid financing and delivery. Arizona was the first state to set up a Medicaid managed care demonstration—the Arizona Health Care Cost Containment System (AHCCCS). Before 1982, Arizona did not participate in the Medicaid program but provided indigent care through the counties. A recent evaluation of AHCCCS finds that the program "yielded $100 million in savings over estimates of what a traditional Medicaid program would have cost in Arizona from 1983 to 1991."[10]

Hoping for similar results, a number of states have recently embraced managed care as the cure for their budget woes. Tennessee, for instance, passed legislation in 1993 to enroll 100 percent of its Medicaid population and up to 500,000 uninsured state residents in managed care plans in just a few months. The new plan, TennCare, went into effect January 1, 1994. A little more than four months later, enrollment reached 903,911, of which 174,696 were formerly uninsured.[11] Critics question, however, the state's ability to adequately serve this rapidly enrolled population. Most other states that are moving forward with Medicaid managed care programs—Illinois, Missouri, and Ohio—"have much more developed HMO networks and have done much more advance work than did Tennessee, which made its move quickly to head off a budget crisis," reports *State Health Notes.*[12]

One leading healthcare advocate in Congress who has concerns about the proliferation of Medicaid managed care is Rep. Henry Waxman, D-CA. He has asked the General Accounting Office to review the programs in both his home state and in Tennessee. The GAO report is due later this fall.

A number of states have recently embraced managed care as the cure for their budget woes.

OTHER STATE HEALTH REFORMS

The reforms described above are just some of the more widely debated incremental health reforms taking place at the state level. Additional insurance market reforms, according to the IHPP report, include:

- Medical high-risk pools to insure those individuals most likely to be denied healthcare coverage or unable to afford it because of medical conditions such as cancer and AIDS (27 states)
- Basic benefit or "bare bones" plans for small groups that provide only minimum healthcare benefits at a lower and presumably more attractive price (40 states)
- Small group insurance reforms (44 states), such as "guaranteed issue" where insurers must offer coverage to all businesses at some point in the year (35 states), and "portability," which ensures that people will receive continuous coverage without waiting periods when they move between health plans.

Results of these insurance reforms have been mixed. As some states move toward community rating, they find less need for the risk pools. In 1993, for instance, Maine was the first state to drop its high-risk pool after phasing in community rating. IHPP reports that sales of bare bones plans have been "disappointing . . . perhaps due to the perceived inadequacy of the benefits they offer or perhaps due to the availability of other coverage in the same niche."

Sixteen states now offer tax incentives as a means of increasing access to healthcare; and five states have passed (but not implemented) laws to set up medical savings accounts. However, IHPP reports that changes in tax incentives in the state tax codes "without corresponding federal changes may not have much impact." Some 39 states have healthcare cost-containment programs. And 44 states are attempting to improve their data collection systems and standardize billing and reporting as key steps toward controlling costs.

State reforms that directly affect hospitals include legislation in 15 states to allow cooperative agreements between providers, thus paving the way for alliances and integrated delivery networks. These laws are fairly recent (most enacted over the past two years), according to IHPP, and some are

Continued on page 24

HEALTH POLICY

Continued from page 12

limited to a specific demonstration project.

Lesson for National Reformers

Taken together, these state actions provide a natural laboratory on healthcare reform that can offer many important lessons for national reformers. All this activity at the state level, however, should in no way let federal health reformers off the hook. States can take important steps forward, but, given their varying finances and capacities for implementing reforms, we must ultimately look for a national solution if true universal coverage is our goal. □

NOTES

1. Kala Ladenheim, Linda Lipson, and Anne R. Markus, *Health Care Reform: 50 State Profiles*, Intergovernmental Health Policy Project, Washington, DC, July 1994.
2. Ladenheim, Lipson, and Markus.
3. As reported in Kala Ladenheim and Anne R. Markus, *Community Rating: States' Experience*, Intergovernmental Health Policy Project, Washington, DC, July 1994.
4. Mark E. Litow and Drew S. Davidoff, *The Impact of Guaranteed Issue and Community Rating in the State of New York*, Milliman & Robertson, New York City, August 18, 1994.
5. Ladenheim, Lipson, and Markus.
6. Ladenheim, Lipson, and Markus.
7. Emery B. Dowell and Thomas R. Oliver, "Small-Employer Health Alliance in California," *Health Affairs*, Spring I 1994, pp. 350-351.
8. Teresa A. Coughlin, Leighton Ku, and John Holahan, *Medicaid Since 1980: Costs, Coverage, and the Shifting Alliance between the Federal Government and the States*, Urban Institute, Washington, DC, May 1994.
9. Linda Demkovich, "Medicaid Managed Care: Moving into the Mainstream," *State Health Notes*, August 8, 1994.
10. Nelda McCall et al., "Medicaid Managed Cost Savings: The Arizona Experience," *Health Affairs*, Spring II 1994, pp. 234-245.
11. Linda Demkovich, "Breakthrough or Blackmail? Emotions on TennCare Run High," *State Health Notes*, May 2, 1994.
12. Demkovich, "Medicaid Managed Care."

DETAILS.

Attention to detail has earned W.A. Baum Co., Inc. its reputation for designing and producing World Standard Blood Pressure Equipment for more than seventy-five years.

The details found in every Calibrated® V-Lok® Cuff assure correct fit, ease of application, accurate, repeatable blood pressure readings and long service life.

The Calibrated® V-Lok® system immediately and clearly indicates whether or not the correct size cuff is being used. Any of our six sizes can be applied with equal ease and effectiveness on either right or left limb.

The cuff has an additional flap of fabric to prevent bulging of the bladder as it is inflated and cuff seams are double stitched at critical points for long wear.

The cuff material is a special urethane coated, heat set, dacron polyester fabric *treated with an effective antimicrobial agent.* It is stain resistant and dimensionally stable.

Genuine Velcro® hook and loop fasteners, woven to our specifications, are precisely positioned and evenly matched in holding strength to provide the optimal number of open-close cycles.

The Calibrated® V-Lok® Cuff – a World Standard...in every detail.

Available through better-known medical equipment dealers worldwide.

W.A. Baum Co., Inc., 620 Oak Street
Copiague, NY 11726, U.S.A.