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Three Perspectives on Health Care Reform: National Health Care Reform, Health Care Reforms in Other States, and Implications for Health Care Reform in Rhode Island

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Articles

Three Perspectives on Health Care Reform: National Health Care Reform, Health Care Reforms in Other States, and Implications for Health Care Reform in Rhode Island

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I. THE NEED FOR REFORM

By now, the number of uninsured Americans – approximately 45 million – has been splashed across our headlines with enough

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frequency that nearly everyone has it committed to memory. Actually, well over 45 million are uninsured today – and millions more are *underinsured.* Here in Rhode Island, nearly 28 percent of residents younger than sixty-five years of age were uninsured at some point between 2007 and 2008. What is particularly startling, however, is that just over three-quarters of the uninsured in Rhode Island are from working families, be they full or part-time.[1] Though it can be easy to let these numbers become abstract or intangible statistics, particularly when we see or hear them so often, what they reveal is undeniable: the health care system is functionally and fiscally broken. It has become a factor that holds our nation back in terms of global competitiveness and it has significant human costs for our citizens. In fact, in 2007, just over 62 percent of all bankruptcies across the country were medical in nature.[2] Again, it is telling that most filers were insured, well educated, and owned homes – three-quarters of those who filed for medical bankruptcy had middle-class occupations; therefore, this is a trend that is also affecting those that *had health insurance.*[3]

Without a doubt, the Obama Administration is responding to these symptoms of system breakdown and has made national health reform a top priority despite the substantial political risks that historically accompany such initiatives. With an eye for expediency, the Administration charged Congress with the task of crafting reform legislation on a tight timeline, but to date, such speedy progress has proven hard to come by. What *is* clear, however, is that in spite of pushback, delays and pitfalls, health reform is a necessary stepping stone for the United States on its return from recession. Nationally, health care costs have increased by 6 to 7 percent each year for the last decade and have consistently grown faster than the economy itself since the 1960s.[4]

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1. Families USA, New Report Finds 254,000 Rhode Islanders Were Uninsured at Some Point in 2007-2008, April 7, 2009, http://www.familiesusa.org/resources/newsroom/press-releases/new-report-finds-254000.html.

2. David U. Himmelstein et al., *Medical Bankruptcy in the United States, 2007: Results of a National Study*, 122 AM. J. MED. 741, 742-743 (2009).

3. *Id.* at 742-44.

4. Uwe E. Reinhardt, *Is Health Care Reform Worth $1.6 Trillion?*, N.Y. TIMES ECONOMIX BLOG (June 26, 2009),

In fact, given that the gross domestic product (G.D.P.) is expected to decline this year, health care costs are expected to account for 18 percent of the G.D.P.[5] If nothing else, this is definitive evidence of the fact that health care spending has become a real impediment to our status as a global competitor.

II. A DISJOINTED SYSTEM IS CONTRIBUTING TO THE ESCALATING COSTS OF HEALTH CARE

To allow the status quo to continue would fly in the face of the quest for national economic recovery. Accordingly, given the current economic challenges that policy makers face, any reform initiatives must also be cost-saving and fiscally responsible in both the short and long term. As various proposals for reform are considered, there are certain principles to keep in mind, including the reality that whether or not a person has health insurance inevitably affects where, when and what kind of health care they will receive. Further, it also affects the cost of that care for that individual – a cost that reverberates at the community, state and national levels on the aggregate.

Due to the fact that those without health insurance are less likely to access preventive and screening services and are less likely to receive outpatient care on a regular basis, the probability that these uninsured individuals will be hospitalized for conditions that could have been avoided is significantly increased.[6] In fact, if uninsured, a person is up to three times more likely to report obstacles getting needed medical care – even for serious conditions – than those with insurance.[7] Furthermore, about 20 percent of the uninsured report that the emergency room

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http://economix.blogs.nytimes.com/2009/06/26/is-health-care-reform-worth-16-trillion; *see also* KAISER FAMILY FOUNDATION, TRENDS IN HEALTH CARE COSTS AND SPENDING (Mar. 2009), http://www.kff.org/insurance/7692.cfm (Click on "Fact Sheet" to download .pdf file).

5. Uwe E. Reinhardt, *Reader Response: How Much do we Spend on Health Care?*, N.Y. TIMES ECONOMIX BLOG, (June 5, 2009), http://economix.blogs.nytimes.com/2009/06/05/reader-response-how-much-do-we-spend-on-health-care.

6. KAISER COMMISSION ON MEDICAID AND THE UNINSURED, THE UNINSURED: A PRIMER 7 (Oct 2008), http://www.kff.org/uninsured/7451.cfm (Click on "Issue Brief" to download .pdf file).

7. *Id.*

is their primary source of care.[8] In 2004, these types of preventable hospitalizations accounted for $29 billion in hospital costs.[9] When this care goes uncompensated, hospitals account for their expenses by charging other payers – insurance companies, employer plans, and individuals – higher prices. In 2005, researchers estimated the amount of uncompensated care added up to $43 billion nationally, two-thirds of which is paid for by higher premiums for those with private health insurance.[10] The remaining one-third is borne by Medicare and other governmental programs.[11]

The costs of providing needed health care to the uninsured place a burden on the overall cost structure of the health care system, but it is often the rising cost of premiums that prices individuals out of the market and drives employers' decision to drop employee coverage.[12] For health reform to truly make an impact on the number of uninsured Americans and improve the quality of care, near – if not total – universal coverage must be the goal. Without it, the cost shifting dynamic will continue to inflate the cost of coverage for those who are insured, and insurance will remain out of reach for many. However, experience has also shown that universal coverage alone is not enough to make quality care sufficiently affordable, and therefore a truly viable health care system will need to address both coverage and cost containment concerns simultaneously.

III. THE NECESSARY ELEMENTS OF COMPREHENSIVE REFORM

A. An Individual Mandate for the Purchase of Coverage Will Eliminate Two Drivers of Cost

In keeping with the goal of covering as many Americans as possible, an individual mandate for the purchase of health insurance will be an essential component of any national health

8. *Id.*

9. JANUARY ANGELES, CTR. ON BUDGET & POLICY PRIORITIES, INSURING ALL AMERICANS IS A CRITICAL COMPONENT OF AN EFFICIENT, HIGH QUALITY HEALTH CARE SYSTEM 2 (2009), http://www.cbpp.org/files/4-21-09health.pdf [hereinafter INSURING ALL AMERICANS].

10. *Id.*

11. *Id.*

12. *Id.*

care reform proposal. As noted in the New England Journal of Medicine, some of the most glaring deficiencies in the U.S. health insurance market can be attributed to the fact that it is voluntary.[13] Failing to require that every individual obtain coverage has inevitably led to a system less focused on prevention, health maintenance and coordination, and more focused on later and more costly treatment. There are two reasons for this problem which are largely intertwined. First, without being compelled to do so, the young and healthy typically will not seek out health insurance until they actually need it. Second, because the beneficiary pool thus tends to consist of those requiring immediate and often, more urgent care, insurers' costs go up. Consequently, insurance companies seek to avoid this trend by underwriting – employing policies that delay or even deny coverage based on factors such as age, lifestyle choices or pre-existing conditions – which creates a major obstacle for many who seek health insurance.[14] Massachusetts has led the nation in mandating coverage for everyone. Over the long term, this requirement will drive down the cost of premiums by "getting everyone in the pool" – but only if this mandate for participation is coupled with concurrent strategies to contain the underlying costs of care.[15]

An individual mandate for the purchase of health insurance also addresses the number of young adults who lack health insurance. Young adults aged nineteen to twenty-nine were the least likely of any age group to have health insurance in 2007, with over 30 percent lacking coverage.[16] Though cost is often cited as a barrier for this population, young adults are also apt to bet on their continued health and relative youth instead of purchasing insurance. In fact, of the 5 million adults aged nineteen to twenty-three in the United States without insurance

13. Linda J. Blumberg & John Holahan, *The Individual Mandate – An Affordable and Fair Approach to Achieving Universal Coverage*, 361 NEW ENG. J. MED. 6 (2009).

14. INSURING ALL AMERICANS, *supra* note 9, at 3.

15. *Id.*

16. NATIONAL COALITION ON HEALTH CARE, HEALTH CARE FACTS: YOUNG ADULTS, *available at* http://nchc.org/sites/default/files/resources/NCHC%20Fact%20Sheet%20-%20Young%20Adults.pdf (last visited Jan. 24, 2010).

in 2006, 30 percent reportedly said they did not believe it was worth the cost.[17] Consequently, more than two-thirds of this population did not see a doctor in the year they went without insurance.[18] Without reaching this sizeable portion of the market, reform will fail to attain the critical mass necessary to truly succeed.

B. Building on What is in Place: An Employer Mandate Keeps Employers in the Equation

Another key element to increasing coverage across the country is the employer mandate, which not only presents an opportunity to reduce the ranks of the uninsured, but also allocates the cost of doing so more equitably. A mandate in the form of a "pay or play" model would impose a fee on employers not currently offering insurance to their employees, while waiving that fee for those employers that do offer coverage. Historically, the primary source of health insurance for nonelderly people in the United States, employer-sponsored insurance, is a logical framework from which to expand health coverage.[19] Furthermore, 80 percent of the uninsured in the United States have a connection to the workforce, making employer sponsored insurance a practical and attractive way of reaching out to this population.[20] Perhaps most importantly, a "pay or play" requirement would also help to ensure that employers will not stop offering coverage once subsidies, another vital piece of the reform puzzle, are offered to low and moderate income families to make buy-in at the individual level affordable.[21] Not only will charging a fee to employers that do not offer employee plans act as a deterrent to those that might have otherwise dropped their

17. Press Release, Agency for Healthcare Research and Quality, For Many Young Adults, No Health Insurance, No Regular Doctor (June 24, 2009), *available at* http://www.ahrq.gov/news/nn/nn062409.htm.

18. *Id.*

19. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: WHAT IS AN EMPLOYER "PAY-OR-PLAY" REQUIREMENT?, 1 (May 2009), http://www.kff.org/healthreform/upload/7907.pdf [hereinafter EXPLAINING HEALTH CARE REFORM].

20. *Id.* (citing KAISER COMM'N ON MEDICAID AND THE UNINSURED, *The Uninsured: A Primer* 1, 16 (Oct. 2009), *available at* http://www.kff.org/uninsured/upload/7451-05.pdf).

21. *Id.*

insurance offerings, it may also persuade employers that have historically not offered employee insurance plans to begin doing so.[22]

The employer mandate is not, however, without potential pitfalls. In particular, with regard to the assessment of a fee or penalty for employers who fail to provide health insurance, there is a fine line to be walked. On the one hand, penalties must be large enough to discourage employers from dropping their existing coverage. Additionally, since the fees collected under "pay or play" schemes serve as a revenue flow to pay for the subsidy to make the individual purchase of insurance by the uninsured affordable, the larger the fee, the more resources will be available to use toward reducing the overall costs of covering the uninsured. On the other hand, reform attempts at the state level thus far have proven that too large a fee may provoke legal challenges rooted in the jurisdiction of the federal Employee Retirement Income Security Act of 1974 (ERISA).[23] Health reform at the federal level is likely to be necessary to finally address this problem of lining up the principles of federalism with state level attempts to create a scenario in which all employers have "skin in the game." The insecure status of several state-based "pay or play" laws will necessarily require a national solution. Indeed, given the principles of federal preemption, any federal solution that includes "pay or play" will likely resolve the ERISA dilemma in a way that no state, acting unilaterally, can definitively accomplish.

C. An Adequate Affordability Subsidy is Essential to the Feasibility of Any Individual Mandate

A federal subsidy will be critical to the success of an individual mandate, given the number of those without a connection to the workplace, or for whom employer-based coverage is not an option because it simply is not offered or is unaffordable. As health costs have risen steadily, employers have had to respond. Some have increased their employee cost-sharing while others have dropped their employee coverage altogether. In

22. *Id.*

23. OFFICE OF HEALTH POLICY, COST AND COVERAGE: THE IMPACT OF IMPLEMENTING VARIOUS STATE HEALTH CARE REFORM PROPOSALS NATIONALLY 15 (Summer 2008).

Rhode Island, a majority of employers continue to offer employee plans.[24] Those ranks have, however, decreased in Rhode Island from 79 percent in 1999, to 74 percent in 2005.[25] Notably, for the state's small employers (those that employ three to nine employees), that number dips down to 65 percent.[26]

The need for an affordability subsidy rings particularly true in Rhode Island, where health insurance premiums are among the highest in the country, a distinction which is also a likely contributor to the decreasing rate of enrollees in employer plans.[27] Among those in Rhode Island who were offered coverage, 69 percent were enrolled in full-time employer-sponsored plans in 2005, compared with 80 percent in 1999.[28] Consequently, if health insurance enrollment is going to be mandatory, it needs to be affordable in both the individual market and employer-sponsored market. A 2005 Commonwealth Fund Biennial Health Insurance Survey found that almost 90 percent of adults aged 19 to 64 who sought coverage in the individual market could not purchase insurance because of prohibitive costs or ineligibility.[29] Those who could afford it paid disproportionately high premiums and copays; over 40 percent spent at least one-tenth of their income on out-of-pocket expenses, compared with only 24 percent of those with employer-sponsored plans.[30]

Employer-sponsored insurance can almost as easily remain out of reach for many families. For example, a family of three with an income at 300 percent of the federal poverty level spends approximately 23 percent of its income on the average employer-

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24. *Id.* at 4.
25. *Id.*
26. *Id.*
27. *Id.* at 17, 27; *see also* DEB FAULKNER ET AL., CONSIDERING A HEALTH INSURANCE EXCHANGE: LESSONS FROM THE RHODE ISLAND EXPERIENCE 5, http://www.statecoverage.org/files/Considering%20a%20Health%20Insurance%20Exchange.pdf.
28. OFFICE OF THE HEALTH INS. COMM'R, 2005 RHODE ISLAND EMPLOYER SURVEY RESULT 4 (October 2006), http://www.dbr.state.ri.us/documents/divisions/healthinsurance/061024_FINAL_Employer_survey_REPORT.pdf.
29. SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, SQUEEZED: WHY RISING EXPOSURE TO HEALTH CARE COSTS THREATENS THE HEALTH AND FINANCIAL WELL-BEING OF AMERICAN FAMILIES 3 (2006), http://www.commonwealthfund.org/usr_doc/Collins_squeezedrisinghltcarecosts_953.pdf.
30. *Id.* at 12.

based policy.[31] Although the share of total premiums costs that workers are held responsible for has remained relatively stable over the years, the steep growth in overall premium levels has meant that over the past decade, workers are paying significantly higher amounts than they did a few years ago.[32]

The level at which the government should subsidize health insurance for individuals is a question that is far from settled. Although there is no universally recognized standard of affordability for health premiums, a report by the Urban Institute and the Blue Cross Blue Shield of Massachusetts Foundation used actual spending on health insurance premiums as a benchmark for affordability.[33] Actual spending was chosen as an indicator of what people are "willing and able to spend" on health care.[34] The analysis showed that those between 300 and 500 percent of the poverty line spend about 8 percent of their incomes on premiums in the non-group health-insurance market, and concluded that affordability standards would have to be lower than 8 percent of income for those making below 300 percent of the poverty line.[35] For those at the lowest income levels, the premium standard would necessarily reflect a larger share of income spent on housing, food and other basic needs.[36] Additionally, setting a hard and fast income level after which individuals or families would be solely responsible for either their premiums or a fee for noncompliance is not the most feasible option. Linking affordability standards to a percentage of income rather than expecting those at a certain level above the federal poverty line to "go it alone," regardless of actual cost, seems more likely to lead to the accomplishment of the "nearly" universal coverage goal. Without a well thought out affordability standard linked to any subsidy program, families sitting just above the poverty line would

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31. JUDITH SOLOMON, CTR. ON BUDGET & POLICY PRIORITIES, SENATE FINANCE COMMITTEE FACES DIFFICULT CHOICE IN LOWERING COST OF HEALTH BILL 8 (Jul. 1, 2009), http://www.cbpp.org/cms/index.cfm?fa=view&id=2854.

32. EXPLAINING HEALTH CARE REFORM, *supra* note 19.

33. Linda J. Blumberg et al., *Setting a Standard of Affordability for Health Insurance Coverage*, HEALTH AFFAIRS w465, June 4, 2007 (web exclusive).

34. *Id.*

35. *Id.* at w468, w471.

36. *Id.* at w471.

still struggle considerably to obtain coverage, or if they were unable to, they would face a penalty and remain uninsured.[37] These factors will be important to consider when designing the subsidy assistance policies necessary for effective comprehensive reform.

D. The Great Potential of Health Insurance Purchase Exchanges

Comprehensive federal health reform legislation that incorporates a subsidy to help the uninsured purchase insurance will also likely include new mechanisms for the purchase of insurance by those now without insurance – so called health insurance exchanges. At its simplest, an exchange can serve as a marketplace where people without health insurance can purchase their insurance. Using the latest online information resources, consumers can peruse information regarding available plans – most likely differentiated in tiers by cost and coverage – and choose the one that best fits their needs. The role for an exchange can extend beyond just an online marketplace, however. Because of the need to administer an affordable subsidy program, exchanges may be able to take on a more substantial and transformative role in health reform. Beyond serving as a marketplace where the uninsured, self-employed and those without a connection to employer-sponsored insurance can purchase health insurance, an exchange could become a vehicle for enacting larger market-based reforms. The frequently-cited goals of creating a more organized and transparent health insurance market – increasing competition among plans, and making price and benefits standards easily comparable for consumers – could potentially be executed via an exchange entity.[38]

The question of just how much authority should be given to an exchange remains a matter of contention across the various federal legislative proposals, as is the question of whether exchanges should operate at the state or national level. The result of this debate will undoubtedly affect the breadth and scope of

37. *Id.* at w464 (explaining the dangers of Massachusetts' system).

38. THE HENRY J. KAISER FAMILY FOUNDATION, EXPLAINING HEALTH CARE REFORM: WHAT ARE HEALTH INSURANCE EXCHANGES? 1-2 (2009), http://www.kff.org/healthreform/upload/7908.pdf.

health reform. But if the goal is indeed to cover as many people as possible, it is likely that exchanges will be necessary to accomplish this goal. In fact, analysts are observing that the purchase exchange in Massachusetts, referred to as the Health Insurance Connector, together with the individual mandate, has increased enrollment, which currently stands at 97 percent of residents.[39]

The Robert Wood Johnson Foundation and a group of stakeholders recently conducted a study in Rhode Island to identify and evaluate the best options for a state-based exchange and to define the goals of such an entity. What the study ultimately revealed can be replicated in many other states and likely, at the national level. First, the study defined three primary goals for an exchange: (1) to better organize the health insurance market, (2) to provide access to affordable health insurance for all Rhode Islanders, and (3) to drive system affordability and cost containment.[40] Next, it fleshed out four key factors in accomplishing those goals: (1) organizing the market (simplify purchasing, improve choice and portability), (2) establishing benefit standards and incentives (an individual mandate), (3) serving as a location for subsidies, and (4) containing costs by vigorously regulating the payment structures and benefits in plans offered through the exchange.[41]

Finally, the study laid out the core characteristics and functions of an exchange that would be necessary to achieving its goals.[42] First, including a public board with some analytic capacity within the exchange was recognized as a way to implement a subsidy program and enable a new purchasing model.[43] There was also a consensus that, in order to improve benefit standards and incentives to obtain coverage, an individual mandate and employer requirement were key elements for the success of an exchange.[44] Finally, while a more targeted approach

39. Lea Winerman, PBS Newshour, *In Legislation, New National Health Insurance Exchange Emerges*, http://www.pbs.org/newshour/updates/health/july-dec09/exchange_07-23.html (last visited Feb. 17, 2010).

40. FAULKNER ET AL., *supra* note 27, at 2.

41. *Id.* at 3.

42. *Id.* at 5.

43. *Id.*

44. *Id.*

to simplifying the small group market would be appropriate in Rhode Island, in order to contain costs and improve access, a more broadly applied strategy was deemed necessary.[45] Four exchange approaches were framed as possible ways to enact successful reform.[46] Specifically, these options included: (1) setting a minimum benefit standard, (2) establishing an "affordability" benchmark, (3) creating a new source of market information aimed at organizing all product options on a single website, and (4) establishing an administrative structure capable of handling enrollment, billing and customer services that would enable portability.[47]

IV. COMPREHENSIVE RATHER THAN PIECEMEAL REFORM IS NECESSARY

Working together, insurance exchanges, coverage mandates, and cost containment initiatives can make quality health care affordable for all while minimizing the amount of subsidy assistance needed to achieve universal coverage. Clearly, the financial success of the exchange model depends on sufficient enrollment.[48] Increasing enrollment and keeping the risk pool tenable can best be accomplished through an individual and employer mandate, which can be enforced through the exchange. For many, however, enrollment will remain impossible without an adequate subsidy. What is now clear is that these elements, considered independently, are incapable of achieving successful and affordable health care reform. Governmental reform can, however, only be accomplished within a historical context, not independent of the economic and political conditions of the moment. A health care system designed anew might have looked different, but in light of the constraints imposed by our the current national economic conditions and the many crippling budget crises across the country, comprehensive reform must be done in a way that attends carefully to the imperative to drive down health care costs overall and remain fiscally sustainable in the long term.

45. *Id.*
46. *Id.*
47. *Id.* at 5, 6.
48. *Id.* at 5.

V. REFORM EXPERIENCES IN OTHER STATES PROVIDE IMPORTANT INSIGHTS

In the past decade, lacking the support of a cohesive national framework for reform, state governments have taken it upon themselves to address the flaws of a broken health care system. The successes and failures of initiatives in states such as Massachusetts, Maine, Vermont, and California provide valuable lessons in crafting effective reform. Massachusetts, Maine, and Vermont have all demonstrated some degree of success with their versions of health care reform legislation. And while California's efforts ultimately failed, the attempt at reform remains an illuminating example for policy makers. All reinforce the point that cost containment initiatives, in tandem with coverage mandates, will be essential in achieving truly effective reform and making health care more affordable for all.

A. Massachusetts

The challenges Massachusetts has faced in reining in the costs of care underscore the necessity of directly addressing cost containment from the outset of any comprehensive reform effort. While the number of those without insurance was halved in Massachusetts in 2006, closing the last few percentage points for universal coverage has remained elusive, and costs have ballooned as the full need for subsidies became clear.[49] Generally speaking, this is because Massachusetts prioritized expanded access over dealing with the cost burden. As a result, the anticipated savings from an individual mandate have not come to fruition.[50] When Massachusetts' comprehensive health care reform law[51] was passed in 2006, the "assumptions were that the price of insurance premiums would fall as young, healthy uninsured people joined the ranks of the insured and that fewer people would use hospital emergency rooms for non-emergencies."[52] What has happened, however, is that many have chosen to purchase insurance only

49. Marilyn Werber Serafini, *The Lessons of Massachusetts*, NAT'L J., July 18, 2009, at 22.

50. *Id.* at 22-3.

51. Chapter 58 of the Massachusetts Acts of 2006, *An Act Providing Access to Affordable, Quality, Accountable Health Care.*

52. *Id.* at 24.

upon realizing they need it – and subsequently drop it once their immediate need has passed.[53] Massachusetts's $900 penalty for noncompliance has failed to serve as an adequate disincentive for this kind of behavior.[54] In fact, a Harvard-Pilgrim study estimated that between April 2008 and March 2009, approximately 40 percent of new enrollees remained enrolled for fewer than five months and incurred about $2,400 per person in medical expenses per month on average – about 600 percent above what the insurer would have otherwise anticipated.[55] It is becoming increasingly clear that coverage mandates will not work without the accompaniment of additional measures that directly address the costs of care. As a result, Massachusetts has aggressively pushed forward with a health care cost containment commission, and is in the process of implementing payment and benefit reforms to get costs under control. This remains a cautionary tale for both federal reformers and those who seek to implement state level reforms.

B. Maine

While the fact remains that cost containment initiatives will be an essential component to effective reform, the experience in Maine illustrates how such endeavors cannot, on their own, significantly reduce the uninsured population or succeed in making universal care affordable to all. Maine's Dirigo Health Reform Act (Maine Public Law 469) of 2003 took an ambitiously comprehensive three-pronged approach to reform, aiming to achieve universal access to quality and affordable health care for all Maine citizens within a five year timeframe by simultaneously addressing cost, quality, and access.[56] The Act established boards and commissions tasked with implementing research-based reform measures in all three areas.[57] To address quality concerns, the Reform Act established the Maine Quality Forum. This entity

53. *The Massachusetts Health Mess*, WALL ST. J., July 11, 2009, at A10.
54. *Id.*
55. *Id.*
56. Jill Rosenthal and Cynthia Pernice, *Dirigo Health Reform Act: Addressing Health Care Costs, Quality, and Access in Maine*, NAT'L ACAD. FOR STATE HEALTH POL'Y, at 1 (June 2004), *available at* http://www.commonwealthfund.org/usr_doc/Dirigo.pdf.
57. *Id.* at 4.

was tasked with releasing public reports on provider performance and quality outcomes, along with promoting evidence-based medicine and the consolidation of medical record databases.[58] The Reform Act also established the Dirigo Health Plan and DirigoChoice, an insurance package aimed at individuals without access to employer-sponsored plans.[59] Insurance, subsidized on a sliding scale tethered to income brackets, would be available as a low-cost alternative for eligible individuals and for those whose income falls below 300 percent of the Federal Poverty Level.[60] Under the original statute, the headwaters of the plan's revenue stream would be a combination of savings derived from two sources: the elimination of bad debt associated with the costs of the uninsured within the state, and funds channeled through the state's Medicaid organization, MaineCare. It would also rely on individual and employer contributions, and a one year initial injection of state funds.[61]

The Reform Act employed several strategies to contain the cost of care in Maine.[62] The Act encouraged greater transparency in the health care marketplace by requiring hospitals and providers to release cost averages on the fifteen most common in-patient and twenty most common out-patient services.[63] Additionally, the Act directed the state's Bureau of Insurance to review and publicly release the administrative costs and underwriting gain of carriers throughout the state. Bad debt and "charity" (free) care to the under and uninsured were cited as major contributing factors in increasing the cost of insurance.[64] By making affordable primary care accessible to the previously uninsured, it was expected that nearly $80 million could be saved annually as the population shifted to regular preventative care rather than resorting to the costly hospital procedures required by delayed medical attention.[65]

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58. *Id.* at 1.
59. *Id.* at 2.
60. *Id.* at 10, 13; *see also* NATIONAL CONFERENCE OF STATE LEGISLATORS (NCSL), COMPREHENSIVE HEALTH REFORMS: STATE EXAMPLES (November 2009), http://ncsl.org/?tabid=14496.
61. Rosenthal & Pernice, *supra* note 56, at 10.
62. *Id.* at 6.
63. *Id.* at 7.
64. *Id.* at 10.
65. *Id.*

Encouragingly, assessments of annual savings have increased steadily each year since the Act's passage, with one estimate placing the total amount saved through 2008 at $150 million.[66] Furthermore, hospital operational costs continue to decline.[67] However, while having demonstrated some success in reducing consumer costs,[68] the overall performance of the Dirigo plan has fallen short of expectations.[69] Originally aiming to expand coverage to nearly all of Maine's 128,000 uninsured citizens, as of August 2009 only about 9,000 were enrolled in Dirigo Choice.[70] Having failed to recoup the expected level of funds from savings offsets, Dirigo Health has been forced to scale back its operations in order to remain fiscally sound. It placed a cap on enrollment in September of 2007.[71] The experience in Maine yields an important lesson for those crafting federal reform: in order to fully deflate the ballooning costs of care, legislation like Maine's will need to be accompanied by a coverage mandate.

C. Vermont

Similar in design to DirigoChoice, Vermont's Catamount Health Plan has encountered the same problems with under enrollment.[72] Established in 2006 in the Health Care Affordability Act (H 861), Catamount Health was created as a standardized package to be provided in a new insurance market and offered by voluntarily participating insurers.[73] It was

66. In re: Review of Aggregate Measurable Cost Savings Determined by Dirigo Health for the Fourth Assessment Year, No. INS-08-900 (Sept. 28, 2008) (Maine Dept. of Professional and Financial Regulation, Bureau of Insurance).

67. DIRIGO HEALTH AGENCY, ANNUAL REPORT STATE FISCAL YEAR (2008) 1-2, *available at* http://www.dirigohealth.maine.gov/Documents/SFY%202008%20Annual%20Report%20012009.pdf [hereinafter DIRIGO ANNUAL REPORT].

68. *Id.*

69. DIRIGO HEALTH AGENCY, DIRIGO HEALTH MONTHLY NUMBERS (Aug. 2009), http://www.dirigo health.maine.gov/Documents/Numbers_August09.pdf.

70. *Id.*

71. DIRIGO ANNUAL REPORT, *supra* note 67, at 2.

72. Stefanie Sidortsova, Vermont Public Interest Research and Education Fund, Scoring Catamount Health: Examining Vermont's Progress Toward an Equitable Health System 3 (August 2008).

73. Health Care Affordability for Vermonters Act, 2006 Vt. Acts &

designed to be a first step in effectuating a shift away from acute (wrong time, wrong place) treatment and towards long term chronic disease and preventative medicine in Vermont, thereby slowing the growth of insurance premiums and reducing levels of medical bad debt.[74] Like Maine, Vermont would subsidize the purchase of Catamount Health for those with incomes below 300 percent of the Federal Poverty Level. Going one step further, Catamount Health would, by law, be forbidden from charging patients for preventative care as well as recommended protocols for treatment of chronic conditions such as asthma or diabetes. This focus on incentivizing preventative care is essential to achieving significant cost control. Funding for Catamount Health would come primarily from Medicaid dollars (about 60 percent of the plan's total cost). The rest would come from increases in the state's cigarette tax and from assessments on employers for employees who are not offered insurance or who are offered insurance yet decline to enroll.[75]

When the Catamount Health Plan was enacted in 2006, it was projected that 96 percent of all Vermonters could be covered by 2010. However based on early enrollment trends, this goal proved to be unrealistically optimistic. Rather than 4 percent, close to 26 percent of Vermonters under the age of 65 went without health insurance for all or part of the two-year period from 2007 to 2008.[76] By June of 2008, only 4,265 individuals were enrolled in Catamount Health, well under projected levels.[77]

In response to these sobering statistics, Vermont legislators have moved at an impressive pace to make the necessary modifications to their reform package. Act 71 of 2007 described in detail the state's objectives for reform and, in turn, provided a timeline within which they must be reached.[78] It also commissioned work groups to evaluate the efficacy of under-

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Resolves No. 191, §2.

74. *Id.*

75. NATIONAL CONFERENCE OF STATE LEGISLATORS, *supra* note 60; Health care Affordability for Vermonters Act, 2006 Vt. Acts & Resolves No. 191, §16.

76. FAMILIES USA, *The Uninsured: A Closer Look – Vermonters Without Health Insurance* (March 2009), http://www.familiesusa.org/assets/pdrs/americans-at-risk/vermont.pdf.

77. Sidortsova, *supra* note 72, at 3 n.8.

78. Act of June 5, 2007, 2007 Vt. Laws 71 (increasing access to affordable health care coverage).

performing programs, and to make recommendations on future systemic improvements.[79] Aiming to rectify under-enrollment issues, a 2008 act (Act 203) relaxed the eligibility requirements for Catamount Health plans and introduced a new public health initiative that incentivized healthy living by offering discounts for enrollees participating in smoking cessation programs, exercise routines, and other wellness oriented endeavors.[80] The rates of health care enrollment have increased at an encouraging pace since.

Despite initial operational difficulties, there is considerable cause for hope in Vermont. The speed with which the State has been able to adapt has enabled it to overcome an initial barrier posed by minor flaws in its original design. This urgency is not accidental; since the passage of the first bill in 2006, legislators have been prompted to move quickly by "trigger mechanisms" installed in their reform proposals. If coverage goals are not met by the start of 2011, the General Assembly must consider implementing an individual mandate based on the operational recommendations of a reform commission.[81] With a contemporaneous focus on universal coverage, cost containment, and public health initiatives, Vermont may yet succeed where others have failed and provide a useful example for national reform.

D. California

In contrast, California lawmakers considered health care reform proposals in 2007, but failed to pass any into law. The bill that came closest, ABX1 1, was a bipartisan document endorsed by Governor Schwarzenegger and written by Assembly Speaker Fabian Nunez. Its explicit aim was to increase coverage to near universal levels without requiring major modifications to the existing insurance and delivery system frameworks – an objective that, perhaps unsurprisingly, revealed itself to be untenable. Various proposals addressing cost containment issues were indeed discussed, including pay-for-performance paradigms, health

79. *Id.* at § 8(b).

80. *See generally* An Act Relating to Health Care Reform, 2008 Vt. Acts & Resolves No. 203.

81. Health care Affordability for Vermonters Act, 2006 Vt. Acts & Resolves No. 191, §21.

technology upgrades, and expanded regulation and transparency in the insurance industry. Nevertheless, these options were eventually rejected.[82] Ultimately, the cost of achieving expanded coverage became an insurmountable barrier. The most common objection from state senators revolved around the fiscal implications of reform for a state burdened with budget problems and beleaguered by an economic recession.[83] Different proposals were estimated to carry a cost of $8 to $15 billion per year for the state, and a heated debate ensued over the source(s) of these funds. A proposed two percent physician revenue fee was dropped in light of objections from the California Medical Association.[84] A predecessor to ABX1 1, AB 8, which relied on employer fees to finance the package, was summarily rejected in response to bitter objections from the California Chamber of Commerce.[85] ABX1 1 itself was to be funded through a combination of sources including an employer payroll fee, a four percent hospital revenue fee, an increase on tobacco taxes ($1.75 per pack of cigarettes), federal matching funds, and resource reallocations from county budgets.[86] Spreading the source of revenue across several institutions and constituencies likely helped get ABX1 1 as far as it did. Nevertheless, these innovative options were not enough to get the bill passed into law. The California experience yields a clear takeaway: truly effective health care reform is impossible to achieve without specific attention paid to reining in the underlying costs of care.

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82. For a summary of the plans that were adopted, *see* Eliot K. Wicks, CALIFORNIA HEALTHCARE FOUNDATION, FRAMEWORK ASSESSMENT OF ABX1 1 (Feb. 2008), http://www.calhealthreform.org/pdf/FrameworkAssessmentABX11Jan2008.pdf.

83. *See* Marian R. Mulkey and Mark D. Smith, *The Long and Winding Road: Reflections on California's 'Year of Health Reform'*, HEALTH AFFAIRS (web exclusive), Mar. 24, 2009.

84. California Medical Association, What CMA is Doing for You: 2007 Accomplishments, *available at* http://www.cmanet.org/publicdoc.cfm?docid=11&parentid=1.

85. For a summary of the California Chamber of Commerce's objections, *see* California Chamber of Commerce, CalChamber Responds to Latest Health Care Proposal (Nov. 7, 2007), *available at* http://www.calchamber.com/headlines/humanresourceshealthsafety/pages/11072007ts.aspx.

86. Wicks, *supra* note 82, at 4.

VI. HEALTH CARE REFORM IN RHODE ISLAND

For the past two years, legislation has been introduced aimed at simultaneously covering more Rhode Islanders and reducing costs. As part of this initiative, the Mission: Healthy RI work group, which included over eighty Rhode Islanders, worked with health experts from outside Rhode Island and across the health care field to examine the nuts and bolts of achieving these objectives. The group concluded that the centerpiece of a successful reform would be an "exchange entity" – or as it was dubbed, "HealthHub RI." Under proposed legislation, 2009H-7910, the HealthHub would play a key role in aligning payments to priorities, setting minimum coverage standards, and emphasizing preventative care and chronic disease management. Additionally, pursuant to 2009S-2686, all individuals who could afford to purchase health insurance would be required to do so. Those residents whose income is below 400 percent of the poverty level would receive a subsidy. Furthermore, employers with more than ten employees would be assessed a health security fee if they do not provide insurance to their employees. Thus the legislation calls for both an individual mandate and an employer "pay or play." According to the Health Insurance Commission of Rhode Island, the individual mandate would have applied to close to 15,000 residents who are currently uninsured. Nevertheless, neither the Health Hub legislation nor the individual mandate/employer "pay or play" legislation were passed by the General Assembly in the 2009 legislative session, in large part due to uncertainties about how they might ultimately interact with then wholly undefined federal reform initiatives.

Two initiatives were passed into law. House bill 2009H7645 and Senate bill 2009S2481 created a Health Rhode Island Health Care Quality and Value Database which will collate data regarding the utilization, cost and quality of health care in the state. Companion legislation, House bill H7352 and Senate bill S2484, authorized and directed the Department of Health to develop a 5-year strategic plan to improve patient outcomes, focus on primary care and prevention, reward quality care and promote information technology, modeled on Vermont's public health and preventive medicine initiatives. This legislation also directs the department to develop best practice and care management plans

for patients with certain chronic conditions. As previously discussed, this kind of initiative has experienced some success in Vermont, where the focus on prevention, primary care and realigned reimbursement are viewed as some of the strongest elements of the state level reform.

Another recent Rhode Island legislative proposal, 2009S-0188, is an example of a direct attempt at cost containment. This legislation targeted the medical loss ratio of insurers, a term defined within the bill as "the ratio between the amount that is spent for medical services covered by the insurer and the amount of revenue from health insurance premiums taken in by the insurer." If passed, insurers and health maintenance organizations would be required to maintain a minimum medical loss ratio of 88 percent, leaving the remaining 12 percent of their resources to be allocated to administrative costs, overhead, and profit. Insurers who do not comply would be taxed the lesser of 1 percent of their gross premiums on insurance contracts or the difference between their reported medical loss ratio and 88 percent. Their tax liability would be zero if they achieved a medical loss ratio greater than or equal to the bill's target amount.[87]

Under 2009S-0188, insurers' medical loss ratios would be evaluated by the Office of the Health Insurance Commissioner, an institution unique to Rhode Island that provides the state with a powerful tool to wield in bringing about health care reform. Unlike other states, the regulation of health insurance in Rhode Island falls under the purview of this specialized institution rather than being assigned to a regulatory body in charge of all types of insurance (auto, home, etc.). The Office of the Health Insurance Commissioner was established by 2004S-3101, one in a series of five bills referred to collectively as The Rhode Island Health Care Reform Act of 2004.[88] The Office is vested with the authority to review health insurance rate filings and conduct public hearings. In the past such reviews focused solely on insurer solvency but with the passage of the Rhode Island Health Care Reform Act of 2004, the health insurance commissioner is now empowered to weigh the affordability of health insurance for the public in

87. S.B. 188, 2009 Leg., Reg. Sess. (R.I. 2009).
88. 2004 R.I. Acts & Resolves S3101.

reviewing all rate changes. The legislation also enables the Office of the Health Insurance Commissioner to make recommendations to the director of Business Regulation and governor, propose legislation, establish a consumer/business/medical advisory group, propose caps on reserves, review administrative expenses, pursue quality improvement, review copays and deductibles, review competition in the marketplace, review reimbursement policies, review best practices for high-cost insurance enrollees, require a health insurance governance report, and assist in the developing standardized designs for billing.[89] With such a broad array of powers and a specific focus, the Office of the Health Insurance Commissioner gives Rhode Island a unique catalyst that can be used to rapidly bring about effective cost containment initiatives and progressive health care reform measures.

VII. RHODE ISLAND IS WELL POSITIONED TO IMPLEMENT PENDING FEDERAL HEALTH CARE REFORM

At the time of this writing, there is much uncertainty about the "when" and "what" of health care reform coming out of Washington. However these uncertainties are ultimately resolved, two basic principles remain: (1) a federal framework for comprehensive reform addressing mandates and subsidies will continue to be very important to support effective state level reform; and (2) the minimum necessary elements for comprehensive health care reform emerge from a careful examination of what has been done in other states. The first lesson from other New England states is that expanding access to coverage *must* be accompanied by simultaneous attention to cost containment of the underlying costs of care. The second lesson is that a comprehensive reform must be multi-layered and must contain, at a minimum, certain key elements. Those elements include some combination of (1) an individual mandate, (2) an employer "pay or play" provision, (3) a subsidy to make the purchase of health insurance affordable for those mandated to obtain it, and (4) a health insurance exchange through which to

89. Press Release, R.I. General Assembly, Health Care Reform Act Submitted to Address Health Care Concerns (May 11, 2004), http://www.rilin.state.ri.us/news/pr1.asp?prid=1160.

implement these other elements and, importantly, to serve as an essential locus from which to deploy key payment and benefit reforms that will address the underlying cost containment issue.

Further, attention must be paid to the drivers of health care cost. Beyond payment reform and benefit design reform, the actual structure of the health care delivery system must be addressed. Attention paid to incentivizing primary and preventive care, requiring adherence to best practices for chronic disease management, and rewarding well care rather than sick care will yield dividends in the long term sustainability of any comprehensive health care reform to be implemented in Rhode Island.

Federal reform, when it happens, will provide a platform from which to deploy meaningful change in Rhode Island. It is likely that any version of the federal reform under discussion will at least put in place the heretofore elusive individual mandate and employer "pay or play," thus fulfilling the goal of getting (nearly) everyone "in the pool." The federal reform will also likely provide the most basic framework and funding for the subsidy necessary to expand coverage – a goal unachievable for Rhode Island acting alone in the face of a serious state budget crisis.

However, there will be much for policy makers in Rhode Island to do, both before and after federal action is taken, in order to make a federal framework a reality. To date, we have done much of the work to be ready to implement an exchange or health insurance hub in Rhode Island. Indeed, we have in place the infrastructure of the Office of the Health Insurance Commissioner to facilitate the process of structuring the payment, delivery system and benefit reforms made possible by the existence of an exchange. Enabling legislation for the Cost and Quality Database and the statewide strategic plan for health, passed in 2009, created the tools necessary for market reforms and the implementation of best practices in chronic disease management and a primary care, wellness and prevention focus. Rhode Island is thus poised to act on federal health care reform and 2010 should prove to be a watershed year within which to make significant progress toward affordable, quality health care for all Rhode Islanders.