Health Care for All of U.S.: Start with the States

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Different issues captivate our attention. For me, it was personal. The first child I cared for in the recovery room as a pediatric cardiology fellow was a five-year old who arrested three times that first night and with whom I instantly bonded; I followed her through childhood and adolescence. She died suddenly at the age of 19, presumably not by coincidence. She had not been able to refill a prescription for her vital heart rhythm drug because her Medicaid coverage had run out.

In the state of Virginia, there is a rural clinic that opens once a year to serve the uninsured. It was the line of patients waiting for care and stretching out of sight down a dirt road that captured the attention of Virginia policy makers. However, these officials disagreed about how to view the situation: one group thought the clinic was wonderful because it served the uninsured; the other thought it was terrible that it was needed at all.

The 43.5 million Americans who lack health insurance amount to more than the number covered by Medicare, more than the entire populations of Canada and Australia combined, and more than the aggregate population of 24 states. Since 85% of the population has health insurance, the impact of the 15% without health insurance is not felt on a day-to-day basis. More compelling to most Americans are issues of cost and, more recently, quality.

Therefore, for the US, health care is not likely to emerge as a compelling national issue and major point in a presidential campaign until a more significant proportion of the population demands a change in political will. Until that time, their constituents and their own sense of what is right may sufficiently move state officials, such as those in Virginia, to develop innovative approaches to improve the health of their citizens. As was seen between five and ten years ago, during the time of budget surpluses, states generally work to

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improve coverage policy. However, they currently lack money, and therefore, any state innovation in coverage policy will also require sufficient funds.

**State models for national policy**

The Institute of Medicine recommends that state models be used as “demonstrations” for national health policy, not only in coverage, but also in cost and quality.² The major reason for state experimentation is that a number of different approaches can be tried in several states, potentially allowing for comparison. Of course, the opponents of this approach are quick to point out that the politics and policies of many states are sufficiently different, and that what works in one state may not work in others. Furthermore, if states are to serve as models, the “experiment” should invoke a limited number of variables, as well as standardized data collection and analysis. However, this step has not yet been taken. If the various state models are enacted with high infrastructure expenses and several of them are successful, there is concern that adopting a single national approach would require the states to dismantle the expensive infrastructure and statutes supporting the system. Any prospective federal attempt to utilize state models must include consideration of these issues.

The major reason for suggesting state models is the will of states to participate at the present time. As these models are created, consideration must be given to each state’s collection of relatively standardized data and the pathway by which successful state models can be developed into a successful national model.²

### Considerations in State Coverage Models

In general, coverage is obtained through one of five ways: (1) Medicare, (2) the Veterans’ Administration system, (3) large employers, (4) small employers and (5) individuals.

Of the 43.5 million Americans without health insurance coverage, 75% are members of a family with at least one full-time worker. At the same time, firms with less than 50 people employ 34 million people.³ Therefore, it seems reasonable to attack the problem of the uninsured through those that work in small businesses or as individuals. A locus for coverage through employers has several benefits, including convenience for the employee. A large employer as a “sponsor” can select multiple plans for the employee to choose from, and has the clout to negotiate optimal rates on behalf of the employee in case of a dispute. However, the small-group and individual markets are dysfunctional due to the high turnover of employees in small firms, higher administrative costs, less clout of small groups and higher numbers of workers in at-risk populations. Therefore, the individual and small-group markets are characterized by risk segmentation, aggressive underwriting and a large variation in premiums based on health status.

The goals of any statewide coverage initiative should be:

1. To provide coverage for as many people as possible not covered by Medicare, the VA system or large businesses.
2. To make this coverage affordable. Public-private partnership for funding should be developed among individu-
als, employers and the state. Those in the 100% to 300% of poverty income range may be willing to spend one to two percent of their income on healthcare coverage, but not more. For example, for a family of four, 200% of the federal poverty level is $39,000 per year; two percent is $780 per year or $65 per month. Additionally, research has shown that small businesses may be willing to pay approximately $600 per year ($50 per month). The state needs to make up the difference between this total of $1380 per year and the current premium of $2,000 for adults and $1,000 for children.

Other principles apply to all healthcare systems:

3. Administrative simplification with concomitant reduction in administrative costs and administrative burden for patients, practitioners and health systems;
4. Provision of the highest quality health care including elimination of waste, coverage of “what works” using evidence-based benefits, continuity of care and choice of practitioner;
5. “Portability,” meaning that individuals are not tied to a specific job to obtain their healthcare coverage.

Before proposing a possible model system, it will be important to answer two questions. First, if the state is to provide subsidies, how should this provision be done? For example, provisions could go directly to the small business through the creation of small-group purchasing risk pools, or through the creation of individual purchasing and risk pools with subsidies to the individual. Second, especially in times of budget deficits, it will be important to identify ways to generate these subsidies.

### Options for Subsidies and Risk-Pooling

1. **Provide subsidies directly to small businesses**

   The rationale for a subsidy to small business is sound: 48% of those in small businesses, usually defined as those with less than 50 employees, are not offered health insurance. The approach of giving a subsidy to businesses (publicly organized and subsidized through health insurance, where the employers of all workers select insurers and pay premiums) has been tried in Massachusetts and Michigan with limited success. The estimate has been made that even with a 30% subsidy, there will be an increase of only 15% in small businesses that would offer health insurance coverage, an improvement in the rate of uninsured of just 1.5%. In short, 30% appears to be an insufficient subsidy when the added administrative burden on the small businesses is taken into consideration.

2. **Small business purchasing pools**

   Pooling of small businesses as purchasing pools without a premium subsidy has been attempted in New York (HealthPass). Advantages of such a system are that each employer can choose among a number of health plans and that the system is administratively simple. This approach uses a “defined contribution” approach, in which the employee sets the amount contributed for health care for a specific benefits package, and the individual may choose to add to this package for greater benefits. The disadvantages include the insurers’ desire...
to keep the functions of premium collection and enrollment, as these are the relatively profitable parts of their businesses. They also would prefer not to stimulate large purchasing groups with clout that could successfully negotiate lower prices.

The HealthPass initiative created a private purchasing alliance (a subsidiary of the New York Business Group on Health) for businesses ranging from two to fifty employees. There was an initial $2.7 million investment from New York City, and the alliance contracted with four insurers. Initially each insurer had five benefits packages that were consistent among the four insurers, and the employer completed an enrollment form and received a single invoice. After three years, there had been a 19% decrease in average employer contribution. Additionally, only 1,000 employers (with a total of 9,000 employees) had enrolled. The lack of success in reaching significant numbers has been partially blamed on a lack of consistent communication between employers, employees and insurance agents, and also on a lack of premium subsidy.

3. Creation of individual purchasing pools

Two proposals have been made in the area of creating individual purchasing pools. The first is a public program, the “Extended Federal Employees Health Benefits Program (E-FEHBPs).” The states would administer this program, and if a state declines, the program would be administered through the Office of Personnel Management. It would be available to all individuals not covered by an employer or public program and to employees of small businesses. A tax credit would be given to individuals, and those who receive the tax credit must participate in the pool. The premiums would be community rated, but they would form a separate pool with a premium different from the current FEHB. High-risk individuals would be covered in a separate pool subsidized by the federal government.

The second approach is the creation of “private purchasing pools.” The stated advantages are that there is no welfare stigma to the employee and no government stigma to the employer. The purchasing pool could negotiate as a private entity, and therefore avoid “any willing health plan” difficulties. If the pool were large enough, it could have the same economies of scale and potential for risk pooling, choice of plans and sponsorship with purchasing expertise, and clout as plans of large employers.

A detailed outline of how this could work at the federal level has been provided by Curtis, Neuschler and Forland. The population that could be covered would include all individuals, except those with access to public programs or coverage through a large employer. Alternatively, small businesses with less than 25 employees and a high proportion of low wage earners could apply as an entity for a federal subsidy on behalf of their employees. The funding for the plan would use advanceable, refundable federal tax credits ($2,000 for an individual and $4,000 for a family) for up to 200% of the federal poverty level, with a phase out above 200%.

Other public subsidies, such as the State Children’s Health Insurance Program, could also be applied to the pool. The federal seed money could be used for 80% of the infrastructure, not to exceed $2 million with at least 20% from the state and/
or foundations. Any individual or small business receiving a tax credit would have to use the pool. This requirement would enhance the size of the pool, as well as reduce adverse selection. The state would regulate coverage.

The pool would contract with at least three plans, unless this is not geographically feasible. Each of the plans must have comparable packages — benefits, services and cost sharing. The basic package can cost no more than the tax credit for the lowest income group. This package is set by national standards as a “national minimum benefits package,” similar to those that could be developed with public and private input by a group such as the National Association of Insurance Commissioners. If plans choose not to participate, the state could require those who have state employee contracts or FEHBP contracts to participate. The rates would be adjusted community rated by age only. The pool may risk adjust premiums paid to health plans, depending on the risk of their employees. Where enrollment volume would be large enough to realize administrative economies of scale, there would be multiple competing pools in the same geographic area, which would permit selected contracting and reduce the likelihood of plans forcing “any willing plan” regulations. Pool costs would be approximately three to four percent of premiums (exclusive of agent commissions and advertising). The pools would require electronic submission, allowing premium costs to be 5% to 10% less than comparable individual premiums. Small employers would provide the administrative support for payroll deductions if the employee has an added premium.

Principles for a New State Model for Small Group Insurance

Based on these proposals, certain principles for a state-based small group insurance model can be proposed.

1. A state private-public partnership could be formed for administration of a purchasing pool similar to the Federal Employee Health Benefits Program. State funds would be required for the start up of each pool, not exceeding $3 million per pool. Creation of regulations for the pools, as well as an information infrastructure, could be developed.

2. With regard to purchasing pools, the focus would be on covering individuals and families between 100% and 300% of the Federal Poverty Level with sliding scale subsidies. Small businesses with greater than 50% low wage earners could also qualify to be part of the pool, and a subsidy would be paid to the individual. A mechanism would need to be developed for educating each individual on the appropriate choice of a health plan, given their specific health circumstances. Participation in the pool would be mandatory for an individual receiving a subsidy, thus partially addressing the issue of adverse selection. Of note, individuals and families at 100% or less of the Federal Poverty Level would be covered by a state Medicaid expansion, if at the time such expansion could be covered by state revenue.

3. Qualifying small businesses would provide minimal administrative support, such as payroll deduction and automated payment to the purchasing pool. A
payroll firm could be used for this administrative support and could be paid for by the pool.\textsuperscript{5}

4. Funding could be based on several assumptions: a premium of $2,000 for adults or $1,000 for children; 1.8 children per worker with worker plus children coverage of $317 per month or full family coverage for $484 per month. If an individual child is eligible, State Children's Health Insurance Program funding would be used to the maximum extent possible. In this model, the employer contribution of the qualifying small employer would be $50 per month; employee contribution would depend upon personal income, in general, not to exceed 5\% of income at 300\% of the Federal Poverty Level. New funding could be provided by the state (the model developed for the state of Virginia allows $21 per person per month), as an advanceable, refundable state income tax credit.\textsuperscript{11}

5. With regard to operation, the pools would be non-competitive and geographically distinct. The pool would perform risk adjustment across health plans with a state stop loss for high cost individuals.\textsuperscript{12} Premiums for subsidized individuals would be adjusted community rated with adjustment based on age, gender and geographic location. An evidence-based minimum benefits package would be developed. This could begin with a formulary that would extend over time to other benefits based on national guidelines, with a portion of reimbursements based on quality.\textsuperscript{10} Plans would be “incented” to participate, for example through loss of ability to access state employees for plans refusing to participate in the pool.\textsuperscript{3}

Electronic claims submission would be required, and over a two to three year period, these claims would be electronically tied to documentation. This would facilitate a 4\% administrative cost for the pool.\textsuperscript{10}

While not applying all of these principles, the most recent state attempt to develop comprehensive health system reform for this group of individuals has been done by the state of Maine and the Dirigo Health Program. The interested reader is referred to that outstanding program for details.\textsuperscript{13}

**First Steps To A State Model In Lean Times**

In this time of reduced state budgets, relatively low cost preliminary steps can be taken: (1) to charge a public-private group with recommending the mechanism for insurance pooling and initial implementation of the information infrastructure, leading to all-electronic claims submission, (2) to pilot methods for providing appropriate education to individuals and families on choosing health plans and (3) to initiate discussions with practitioners on a reimbursement system tied to evidence-based, national guidelines.\textsuperscript{10} These efforts can be initiated in lean times; ultimately, however, the complete infrastructure and subsidies required for coverage will require new funding.

**Increased state funding**

While it is beyond the scope of this essay to discuss all forms of funding that could provide state subsidies for health care, three approaches are worthy of mention: 1. Requirement of electronic claims sub-
mission and electronic documentation. Rapid application of the Health Insurance Portability and Accountability Act provision for uniform standards would reduce administrative costs and administrative burden. States could develop an “electronic clearinghouse,” where data regarding the insurance status of as many individuals as possible are available on the web. Ideally, these data would not only include the type of coverage, but also tie to individual coverage availability. If claim submission were electronic and tied automatically to documentation (e.g., the elements required for documentation with a specific code were contained and tied to the level the bill), the need for complex compliance programs could be reduced. If such procedures were in operation, this would enable a reduction in the billing costs from the current eight or nine percent to four percent.

2. Reduction of “waste.” As more data on what works and what does not work becomes available, the practice guidelines available through national specialty societies continue to improve. These guidelines should be tied increasingly to payment guidelines, using incentives aimed at “best practice” (e.g., use of beta blockers after myocardial infarction) or disincentives such as non-payment for services that are not indicated in the guidelines. Automated appeal mechanisms must be available when guidelines do not apply to individual patients. We are working on such a system in a public-private partnership of Medicaid and Anthem in Virginia. One further case of potential “waste” (defined as doing things that are of no value or that may even be harmful): little data exist on how often physicians need to follow patients after procedures. For example, after a hip replacement, should the patient be seen every six months, every year or every five years? Interestingly, one approach based on data has decreased the frequency of visits for prenatal care. Generation of such data would be extremely helpful, not because the price of an individual visit and its attendant tests is so high, but because there are so many of them each day.

3. New revenue generation. As the epidemic of obesity becomes more problematic in the United States, it seems likely that the cost of health care due to diabetes will increase considerably. An approach to obesity similar to that taken regarding smoking has been proposed, and is being considered in England. In one estimate, a 5% tax on fast food generated $46 billion per year in the United States. Other taxes and surcharges, whether on food or soft drinks, have also recently been proposed.

Why now?

As the 2004 presidential election unfolds, the prospects for significant federal legislation targeting the uninsured are dim. Yet, it seems reasonable to expect that some attention will be given to the issue, even if a national solution is not immediately reached. Each presidential candidate should propose federal legislation that would create a demonstration of funding for state models. Although it is too late to help the young patient unable to refill her heart rhythm medication, for the millions of uninsured Americans such as those waiting in line at the rural Virginia clinic, change is still possible. We must
learn how to improve the system, and help those most in need, until they develop a voice of their own.

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**References**