



Health Policy, Health Reform, and Performance Improvement

States in Action: A Bimonthly Look at Innovations in Health Policy, September/October 2007

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Authors: Sharon Silow-Carroll, M.B.A., M.S.W., and Tanya Alteras, M.P.P., Health Management Associates

Editor(s): Rachel Nuzum, M.P.H, Program Officer, State Innovations, and Anne Gauthier, M.S., Senior Policy Director, The Commission on a High Performance Health System

Martha Hostetter, M.F.A., Managing Editor

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Please take a moment to answer this six-question survey to help us improve the *States in Action* newsletter. We appreciate and welcome your feedback.

Feature: Public Programs Are Using Incentives to Promote Healthy Behavior

Among states, there is growing interest in offering incentives to those enrolled in public health plans to promote healthy behaviors. A number of states are developing programs to motivate enrollees to curtail smoking, lose weight, and access timely child immunizations and prenatal care. By providing rewards for healthy behaviors, these states are trying to give members a greater stake in improving their health status, enhance prevention and health outcomes, and reduce program costs.

Focusing on behavioral change to improve health and control costs is a central concept of "patient engagement," which is being promoted by the U.S. Department of Health and Human Services. The premise is that the motivating power of financial rewards for practicing healthy behavior can make a significant impact on the efficiency and effectiveness of health care. Thus, many incentive programs focus on two major sources of morbidity and mortality—smoking and obesity. Using incentives to change unhealthy behaviors is also related to two other trends: value-driven purchasing, which involves providing consumers with information about health care quality and costs, and patient-centered care. Each of these movements encourages people to take a more active role in their care.

States are using a variety of incentives to encourage healthy behaviors, primarily among Medicaid populations but also in the State Children's Health Insurance Program (SCHIP) and state-funded programs. Incentives can take the form of reduced cost-sharing, or vouchers or coupons for health-related products such as over-the-counter medications, as in Florida. [1] As in Michigan (described below), the rewards can be clinical services such as dental care, which may not be part of the standard Medicaid benefit package. California's Medicaid program provides non-health-related incentives, such as movie tickets or gift certificates, to reward parents who keep up with scheduled well-child visits for their infants and adolescents. [2] Some states, including Wisconsin (described below), are seeking to link their incentive programs with efforts to improve health literacy.

Wisconsin

Wisconsin is incorporating incentives for healthy behaviors into BadgerCare Plus, an expansion of its SCHIP program, known as BadgerCare. [3] The goal of the expansion is to extend coverage to all of the states' uninsured children and to thousands of uninsured adults. [4] Implementation is scheduled to begin on January 1, 2008. Once BadgerCare Plus is fully implemented, state officials hope that it will significantly reduce the state's uninsured population (currently 272,000 individuals), bringing access to affordable coverage to 98 percent of all residents.

One unique feature of Wisconsin's strategy is its request of health plans to develop grant proposals for individual

incentive programs, through the new "Healthy Living" component of BadgerCare Plus. By piloting and evaluating at least five demonstration projects, Wisconsin hopes to identify creative, evidence-based approaches under the Healthy Living portfolio that could potentially be rolled out across the state. The programs are anticipated to begin in April 2008.

According to Donna Friedsam, health policy director at the University of Wisconsin Population Health Institute, "there are two goalposts here. The end goal of course is behavior change. We want to see appropriate body mass index among children, more children immunized on time and early prenatal care; and we want to see members stop smoking. . . . [but] until we understand what incentives can get people engaged in the programming, we will not achieve significant success with incentives for behavior change." [5]

In addition to the individual incentive programs, the state has developed a voluntary member pledge. By signing the pledge, families will promise to practice healthy behaviors; in turn, health plans will promise to support members in these efforts, in part through the incentive programs. The state is currently conducting focus groups with approximately 100 current BadgerCare members to learn what types of incentives might be effective, how they should be structured, and, perhaps even more important, what it would take to get people to participate in voluntary programs. The state envisions that health plans whose incentive strategies are chosen through the request-for-proposal process will work closely with providers and/or outreach workers to review the pledge with members, and to incorporate it into their overall strategy to improve patient health.

Finally, Wisconsin is developing a health literacy campaign to educate public plan members on how to ask providers appropriate questions to guide their health care treatment. It plans to use AskMe3 materials, developed by the Partnership for Clear Health Communication, which focus on three questions to facilitate discussion between patients and providers: "What is my main problem?," "What do I need to do?," and "Why is it important for me to do this?" The state is also considering working with providers in using the AskMe3 materials and, as with the member pledge, will ask health plans to incorporate the materials into their incentive program strategies.

According to both Friedsam and Linda McCart of the Wisconsin Department of Health and Family Services, medical directors of some participating health plans have already expressed interest in the use of incentives and the health literacy campaign.

Plans in Other States

While Wisconsin is on track to embark on its incentive program next April, other states are in the planning stages, with some considering incentive programs as part of larger Medicaid reform efforts.

For example, in Michigan, both the executive and legislative branches are planning to incorporate incentives into the state's Medicaid program. Governor Granholm has introduced the Michigan First Health Care Plan, which would require Medicaid health plans to offer education, support, and financial incentives for lifestyle changes. Features of this plan include:

- asking enrollees to complete a health risk appraisal within 90 days of enrollment and having them follow up with a primary care physician;
- waiving copayments on important maintenance drugs for chronic diseases;
- offering incentives to members to use behavior change/wellness programs; and
- setting performance measures for participating health plans.

In February, the Michigan Senate approved SB-1—the "Authorize Medicaid Healthy Behavior Incentives" bill—which would require Medicaid to provide incentives to enrollees who participate in programs designed to assist in smoking cessation, weight loss, and compliance with doctors' visits, among other behaviors. The incentives would be used to motivate individuals to enroll in Medicaid, and to get those already involved to participate in healthy behavior programs. Some of the incentives that were proposed in the bill include expanded benefits (such as dental care), as well as reduced premiums and/or copayments. Included in the bill is a measure that would give the Department of Community Health the flexibility to create pay-for-performance programs for Medicaid managed care plans, providing incentives related to meeting outcomes for chronic disease and patient compliance.

Following a unanimous vote of 37–0 in favor, SB-1 was referred to the senate's Health Policy Committee, where it remains at this point. T. J. Bucholz, spokesperson for the state's Department of Community Health, says that Governor Granholm would like to see the bill passed, but it will likely need some amendments to ensure that it does not include any punitive measures. According to Bucholz, "giving people ownership into their own health care is important. We want to make sure the bill outlines proactive incentives for people to get healthier and not penalize people in reality or perception."

Texas is also working to incorporate healthy behavior incentives in Medicaid. Recently passed and signed into law, Senate Bill 10 outlines a package of Medicaid reforms. One component is a **pilot program** in which Medicaid beneficiaries who volunteer would receive expanded benefits if they participate in smoking cessation or weight loss programs, as well as credits in "individual health rewards accounts" that could be used to purchase additional health services. By the end of this year, the state's Health and Human Services Commission will submit a waiver request to the Centers for Medicare and Medicaid Services, which must grant approval in order for Texas to implement the proposed reforms.

Discussion

It remains to be seen whether incentives for promoting healthy behaviors among Medicaid and other public program populations will have a significant effect on health outcomes and costs. A review of the literature by the Center on Budget and Policy Priorities (CBPP) found that no rigorous studies have been conducted to determine whether incentive programs achieved their goals, and the few existing studies did not look specifically at the Medicaid population.

Developing and implementing incentive programs requires an investment on the part of a state's Medicaid program. With limited Medicaid budgets, there is some question as to whether the cost—both administrative costs and the incentives themselves—will result in significant returns in terms of cost savings and health outcomes. The CBPP report notes that states need to consider what might be more effective: an incentive program that provides financial rewards, or creating a benefit to cover comprehensive treatment for a certain condition. Smoking cessation, which forms the cornerstone of many incentive programs, offers a key example. The CBPP report highlights Idaho's Behavioral Preventive Health Assistance Program, which offers up to \$200 in financial rewards for individuals who get smoking cessation counseling, medication, and nicotine replacement products. However, the amount of the incentive does not cover a full protocol of care for smoking cessation, and some critics argue that it sets up participants for failure. [6]

What's more, environmental factors play a role in unhealthy behaviors—an issue not easily addressed by incentives or other efforts. Low-income individuals face considerable barriers to obtaining healthy foods and getting sufficient exercise and activity. Creating programs targeted not just at individuals' behavior but also at the unhealthy environments in which they reside will require enormous creativity and energy from states hoping to promote

healthy lifestyles.

References

[1] The Florida Medicaid "Enhanced Benefits" demonstration program provides beneficiaries with \$15 to \$25 in credits that can be redeemed for such products.

[2] P. Redmond, J. Solomon, M. Lin, "Can Incentives for Healthy Behavior Improve Health and Hold Down Medicaid Costs?" Washington, D.C.: Center on Budget and Policy Priorities, June 1, 2007.

[3] Governor Doyle's health care agenda includes BadgerCare Plus, a cigarette tax, and an expansion of Medicaid to childless adults. For more information about BadgerCare Plus, see <http://dhfs.wisconsin.gov/badgercare/>.

[4] Adults to receive coverage include more pregnant women, self-employed parents, farm families, caretaker relatives, and youth aging out of foster care.

[5] The University's Population Health Institute is working closely with the state in the design, implementation, and plans for evaluation for BadgerCare Plus, serving as a representative on the BadgerCare Plus Advisor's Group and the Healthy Living workgroup; Body Mass Index is a tool used to measure the percentage of body fat based on a person's height and weight.

[6] The recommended duration of treatment using a generic nicotine replacement patch is six to 20 weeks. The recommended duration of treatment using other medication is seven to 12 weeks, followed by six months of maintenance treatment. In both cases, \$200 would only purchase eight weeks' worth of treatment products (CBPP, 2007).

For More Information

See: Wisconsin Department of Health and Family Services Web site
Texas Senate Bill 10
Michigan First Health Care Plan.

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Snapshots: Short Takes on Promising Programs

Illinois' All Kids: Progress Report

Illinois All Kids, the first state-level universal coverage program for children, has had considerable success in its first year. Begun in July 2006, the program offers coverage to all state residents through age 18—including undocumented children—who are either uninsured or who meet income requirements. [1] The All Kids umbrella includes children's coverage funded under Medicaid, SCHIP, and a new state-only expansion component, whereby families of uninsured children who are ineligible for Medicaid or SCHIP (due to income or citizenship requirements) may buy into the program for their children, with premium and copayment levels tied to income. Subsidies for this component are funded exclusively with state dollars. These state costs were projected to be \$31

million the first year, funded from an expected \$57 million in savings from shifting Medicaid enrollees into managed care arrangements.

As of September 2007, more than 160,000 additional children gained coverage under All Kids, exceeding expectations. About 60,000 are in the state-only expansion component. According to Teresa Kurtenbach, spokeswoman for the Illinois Department of Healthcare and Family Services, "We are thrilled at the success we've had at assuring our kids have health coverage. We hope to see quick action in Washington to reauthorize the State Children's Health Insurance Program to give states like Illinois the financial support we need to continue this success. It would be a travesty to see a cut-back in federal support . . . for our children."

The successful enrollment is attributed to the considerable and innovative outreach efforts put in place over the last year. Outreach strategies included a user-friendly, simple application (that applies to all programs under the All Kids umbrella, regardless of funding source) and an application agent initiative, whereby insurance agents, medical providers, and various community organizations assist individuals in completing the All Kids application. The program's universality—it is open to children of all income levels—is considered to help the marketing as well.

The All Kids program has been a model for children's buy-in programs passed in states such as Pennsylvania, Tennessee, and Washington. Additional states are considering or planning similar programs, but may be limited by recent changes in SCHIP rules and the terms of the upcoming SCHIP reauthorization.

Reference

[1] Children in families with income up to approximately 200 percent of the federal poverty level (i.e., Medicaid/SCHIP eligibility levels) are eligible even if they are currently insured.

For More Information

See: AllKids Web Site or contact All Kids Hotline, 1-866-255-5437 ,
TTY: 1-877-204-1012 , hfswebmaster@illinois.gov.

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Healthy San Francisco: Local Model for Universal Coverage

Healthy San Francisco (HSF) is a new program that provides medical homes to the city's uninsured adults. It was launched in July at two health centers, expanded to 20 additional clinics September 17, and is expected to go citywide on January 2, 2008. Early enrollment exceeded expectations—there were 1,900 members as of late September—and the program could eventually enroll all of the city's estimated 82,000 uninsured adults. [1]

Championed by San Francisco Mayor Gavin Newsom, HSF is based on recommendations by a Universal Healthcare Council comprised of local stakeholders including health care industry, business, labor, philanthropy, and research representatives. It is administered by the city's Department of Public Health. According to program director Tangerine Brigham, "In the absence of federal reform, we're looking at what works best given our local health

needs, public resources, and political will. But aspects of what we're doing are certainly replicable elsewhere."

HSF does not offer insurance, but rather gives members a medical home that emphasizes preventive care. It also provides specialty care, urgent and emergency care, mental health care, substance abuse services, laboratory services, inpatient hospitalization, radiology, and pharmaceuticals. Members are given a HSF participant identification card, can select a primary care clinic as their medical home, and are encouraged to get regular screenings and check-ups. The services are provided by a network of local providers, primarily public health department providers and community health clinics as well as San Francisco General Hospital. The city plans to monitor the capacity of its provider network over the coming year.

Membership fees and copayments are based on a sliding scale. Those below the federal poverty level (FPL) pay nothing, while member contributions for those above the poverty level range from \$20/month to \$225/month (for those with income above 500 percent of the FPL). Copayments range from \$10 to \$20 per clinic visit, and \$200 to \$350 per inpatient stay.

To be eligible for HSF, a person must be 18 to 64 years old, uninsured, live within city limits, and be ineligible for other public coverage programs. Initially, enrollment is also limited to people with income under 100 percent of the FPL. In November, it will be expanded to include all residents, regardless of income or immigration status.

HSF will also be open to workers whose employers select the program as part of a minimum employer health care spending requirement. Beginning in 2008, employers with at least 20 employees must make required "Health Care Expenditures" to or on behalf of their local employees. [2] Employers who are not contributing to insurance, health savings accounts, or medical expenses must pay a fee of \$1.17 per hour per employee, equivalent to about \$200/month for a full-time worker. Employers with at least 100 workers must pay \$1.76/hour per worker, equivalent to about \$300/month. [3] If an employer selects HSF, their employees would then be given information about how to enroll, and would receive a discount on the participation fee. [4]

A local restaurant association is challenging the employer health care spending requirement, claiming that it violates ERISA, a law governing employer health benefits. A hearing is scheduled for November.

HSF is expected to cost about \$200 million the first year. This will be financed by redirecting some of the \$110 to \$115 million city funds currently spent on treatment and services for the uninsured, supplemented with federal funds of \$24 million per year for three years, together with members' fees and copayments and fees from participating businesses. [5]

References

[1] Nearly 70 percent (about 57,000 people) of the 82,000 are already in the county's safety net system receiving services through an existing network of providers.

[2] Based on the San Francisco Health Care Security Ordinance, passed in 2006. Beginning January 1, 2008, employers with at least 50 workers must comply; starting April 1, 2008, the spending requirement extends to firms with at least 20 workers. Firms with fewer than 20 workers are exempt. Employees working at least 10 hours per week are eligible. For more information, see http://www.sfgov.org/site/olse_index.asp?id=45168

[3] The required contribution will increase by 5 percent annually through 2009, and thereafter will be based on the average contribution for a full-time employee to the City Health Service System.

[4] Non-resident employees are not eligible for HSF; instead, they are given medical reimbursement accounts of value equivalent to their employer's contribution.

[5] San Francisco is one of 10 counties selected for federal funds under California's Health Care Coverage Initiative, a five-year 1115 Medicaid Demonstration waiver.

For More Information

See: Healthy San Francisco Web Site.

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Washington State: Cultural Competency Training

In an effort to reduce racial and ethnic disparities in health care, Washington State has joined New Jersey in requiring cultural competency training for certain health care professionals. The legislation, sponsored by Senate leader Rosa Franklin (D) and others and signed into law in 2006, calls for the establishment of an ongoing multicultural health awareness and education program "...to raise awareness and educate health care professionals regarding the knowledge, attitudes, and practice skills necessary to care for diverse populations to achieve a greater understanding of the relationship between culture and health." All professions regulated by the Washington State Department of Health (DOH) must integrate multicultural education into their basic curriculum by July 1, 2008.

To assist with this requirement, the DOH anticipates having a training tool available through its Web site for all health professionals by the July deadline. Use of this tool will be voluntary; training programs can develop their own educational approaches. In addition, the terms of the legislation can be met through a continuing multicultural education component for professions that already require continuing education.

According to Vickie Ybarra, chair of the Governor's Interagency Council on Health Disparities, "this legislation will importantly increase the availability of cultural competence training for health care professionals currently completing their education as well as those already in practice. Our state will learn much from this process that we are confident will help address health disparities in our increasingly diverse state."

Other states have passed legislation involving cultural competency training, including California, which requires cultural competency curricula in continuing medical education courses, and Maryland, which encourages education about health disparities and is piloting cultural competency training for certain health care providers. Bills addressing this issue have been proposed in Arizona, New York, Illinois, and Ohio.

In addition to cultural competency training, states are attempting to reduce health disparities through their Medicaid programs. Strategies include: standardizing and collecting race and ethnicity information on enrollees; incorporating financial incentives and disparities reduction goals into health plan contracts; and requiring access to translators and culturally appropriate care. These approaches are summarized in a recent Center for Health Care Strategies, Inc., issue brief, *From Policy to Action: Addressing Racial and Ethnic Disparities at the Ground Level*.

For More Information

Contact: Karen Jensen, Policy Director, Washington State Department of Health,
360 236-4621 , Karen.jensen@doh.wa.gov.

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Census Data on Children's Coverage: What Do They Mean for States?

On August 28, the Census Bureau released new statistics showing that the number of uninsured children increased from 8 million in 2005 to 8.7 million in 2006. The percentage of uninsured children has increased two years in a row, after declining or holding steady thanks in large part to SCHIP, which preserved children's coverage rates even while adult rates were on the rise. A breakdown of the numbers indicates that 19.3 percent of children in families with annual incomes below 100 percent of FPL are uninsured. These findings are particularly ominous given the uncertainty surrounding federal funding levels in coming years for the State Children's Health Insurance Program (SCHIP).

With estimates that a majority of uninsured children—about 5 to 6 million—are actually eligible for but not enrolled in Medicaid or SCHIP, states are placing a greater emphasis on outreach. [1] A national assessment of state outreach strategies in the **Summer 2007 issue** of *Health Care Financing Review* describes how states have shifted from conducting outreach as a means of explaining and getting "name brand" recognition for their SCHIP programs, to adapting their campaigns specifically "to close the gaps in reaching hard-to-reach populations." [2] States seek to close enrollment gaps by identifying a target population, refining the message to best catch the attention of that population, and using strategies most likely to reach that population. For example, states are crafting messages promoting eligibility and the value of health coverage, and bringing those messages to schools, health care providers, employers, and community-based organizations. According to the article, they are also developing more formal arrangements with local entities to help reach members of communities, all the while placing a strong emphasis on "retaining existing SCHIP enrollees and encouraging use of services." Target populations include minorities, immigrants, working families, and those living in rural areas.

Also, as employment-based coverage has been steadily declining, states have been picking up some of the slack by expanding eligibility for children (and some adults) in Medicaid and SCHIP. As reported in a **recent issue** of *States in Action* and in this issue's Illinois All Kids Snapshot, a number of states are implementing or exploring eligibility expansions and options for families to buy in to public coverage, in order to achieve universal coverage for children.

States' efforts to expand children's coverage and make headway in outreach, enrollment, and retention may be stymied, depending on the outcome of the federal reauthorization of SCHIP. As of September 28, a compromise bill had been approved by the House and Senate that would provide an additional \$35 billion in funding over five years, resulting in a total of \$60 billion in funding for the program. On October 3, President Bush vetoed the bill, as was expected, given his stated preference for adding only \$5 billion to the current \$25 billion baseline of funding. The Congressional Budget Office has publicly stated that such a small increase in funding would not allow the program to continue at its current enrollment levels, let alone enable states to address the challenges posed by the latest estimates of uninsured. While there appear to be enough votes in the Senate to override the veto, the same does not

hold true in the House of Representatives, making the fate of the compromise bill uncertain as of publication.

References

- [1] Estimates of the Number of Uninsured Children who are Eligible for Medicaid or SCHIP, Letter from Peter Orszag to the Honorable Max Baucus, Congressional Budget Office, July 24, 2007.
- [2] S. R. Williams and M. L. Rosenbach, Evolution of State Outreach Efforts Under SCHIP, *Health Care Financing Review*, Summer 2007 28 (4).

For More Information

See: S. Dorn, *Eligible but Not Enrolled: How SCHIP Reauthorization Can Help*, The Urban Institute, September 2007.

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Federal Activity: Presidential Candidates' Health Care Reform Proposals

Following our previous *States in Action* descriptions of health care reform proposals by presidential candidates John Edwards (D), Barack Obama (D), and Rudolph Giuliani (R), in this issue we summarize health plans proposed by Mitt Romney (R) and Hillary Rodham Clinton (D).

Governor Romney's Vision for Health Care Reform

On August 24, former Massachusetts governor and presidential candidate Mitt Romney **unveiled** a proposal for reforming the health care system without new spending or new taxes. It is a market-oriented approach intended to make private health insurance more affordable, accessible, and portable; enhance quality and innovation; and reduce overall health spending growth. Most of the specific strategies aim to create lower-cost health plans, and encourage the purchase of private insurance in the individual market.

Tax Reform and Deregulation

- Revise the federal tax code to allow U.S. residents who purchase a health insurance policy that at least covers catastrophic expenses to deduct the full amount of premiums, deductibles, and copayments from their annual incomes. This provision is meant to even the playing field between those with employer-sponsored coverage and those who purchase coverage through the non-group market.
- Promote health savings accounts (HSAs) by eliminating the minimum deductible requirement and implementing full deductibility for all qualified medical expenses (including premiums, out-of-pocket spending, deductibles, and copayments).
- Offer federal incentives to states (through access to federal funds) to reduce health insurance regulations, such as benefits mandates and restrictions on managed care plans, in order to reduce the cost of private coverage and expand choices for consumers.

Medicaid Reform

- Turn Medicaid into a block grant program with fewer federal regulations, allowing states to tailor programs and give subsidies to residents to purchase private insurance and containing federal Medicaid costs. This is intended to permit states to innovate and develop reforms that best meet their residents' needs.
- Allow states to redirect existing federal and state funds for "free care" for the uninsured to sliding-scale premium subsidies for low-income uninsured residents to purchase private insurance.

Quality and Health Information Technology

- Offer federal incentives (not yet specified) to states to promote information technology, electronic medical records, transparency in cost and quality, HSAs, and coinsurance products.

Medical Liability Reform

- Place federal caps on non-economic and punitive damages in medical malpractice lawsuits; encourage "health courts" run by judges who have experience in medical liability cases as well as alternative dispute resolution and sanctions for repeated filings of frivolous suits.

The Romney campaign estimates that the tax reforms alone would encourage two to six million middle-income uninsured residents to purchase private insurance, and lead to a 6.2 percent reduction in U.S. health care spending.

Senator Clinton's "American Health Choices" Reform Plan

On September 17, 2007, New York Senator and presidential candidate Hillary Rodham Clinton unveiled **American Health Choices**, a health care plan that would enable Americans to keep their current coverage or purchase new public or private coverage options. The plan builds on earlier proposals to contain health care costs and enhance value and quality. Key features of Clinton's proposed reforms are summarized below.

Coverage Expansion Strategies

- Establish "Health Choices Menu" as part of the Federal Employees Health Benefits Program (FEHBP), offering all Americans an efficient, Medicare-like public plan and private insurance options that emphasize proven and effective preventive care, as well as chronic care management.
- Offer a refundable, income-related tax credit to be used to purchase health coverage, designed to cap the percentage of income spent on premiums while maintaining consumer price consciousness.
- Impose an individual mandate to obtain affordable coverage.
- Require large employers to provide health insurance for their employees or contribute to the cost.
- Offer small businesses a tax credit to continue or begin offering coverage.
- Strengthen Medicaid and SCHIP, filling gaps such as lack of coverage for poor, childless adults (while also investing in public hospitals and community health centers).
- Offer a tax credit for retiree health plans to offset catastrophic costs, to help keep plans affordable.
- Reform private insurance rules: require insurers to guarantee issue and renewability, so that individuals are not denied coverage or renewals due to health conditions; limit rate variation based on age, gender, or occupation; and set a minimum stop-loss ratio to ensure that most premiums are used for the provision of care (versus profits and marketing).

Quality and Value Enhancement Strategies

The Clinton proposal emphasizes modernizing health systems, reducing waste, and promoting prevention and

high-quality care through the following policies:

- Offer financial incentives to physicians to adopt health information technology and to achieve better patient outcomes.
- Pressure pharmaceutical companies to offer "fair" prices and accurate information.
- Establish and fund a Best Practices Institute to link efforts by the Agency for Healthcare Research and Quality and the private sector to fund comparative effectiveness research and dissemination of information to patients and physicians.

Cost Containment/Funding Sources

Funding for the above initiatives is expected to come from an estimated savings of \$110 billion from the following sources:

- Discontinue parts of the Bush Administration's tax cuts for Americans with income over \$250,000 (\$52 billion).
- Promote value and quality through information technology, prevention, chronic care coordination, and comparative effectiveness research (\$35 billion).
- Phase out excessive overpayments to Medicare managed care plans (\$10 billion).
- Reduce the Medicare/Medicaid disproportionate share hospital payments as the number of uninsured declines (\$7 billion).
- Allow Medicare to negotiate drug prices, promote generic drug competition and re-importation, increase Medicaid rebates, and enhance oversight of drug company relationships with providers (\$4 billion).
- Limit the current employer tax exclusion (whereby employer contributions to workers' premiums are excluded from taxable income) for very expensive health plans, for those with income over \$250,000/year (\$2 billion).

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Commission Corner

The Commonwealth Fund's Commission on a High Performance Health System continues to change the debate in health care reform.

Released in June, the Commission's state scorecard, **Aiming Higher: Results from a State Scorecard on Health System Performance**, is still generating a tremendous response from both policymakers and the public. Fund staff have traveled across the country to present the report's findings and methodology, state specific-results, and policy solutions to key, high-level stakeholders in an effort to impart Commission messages about the importance of universal coverage and a better organized health system to promote true high performance, as well as to develop a strategy for technical assistance to those states ready and willing to take action to improve their results. Most recently, the state scorecard was presented at the State Coverage Initiatives' Workshop for State Officials and Harvard University's Interfaculty Program for Health Systems Improvement.

The Commission is also shaping the debate over payment reform through the work of grantee Harold Miller at the

Pittsburgh Regional Health Initiative. The recently released Fund report, **Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform**, draws on the discussion at a one-day, invitation-only working meeting held in March and co-sponsored by the Commission. The report is designed to assist health care payers and policymakers to restructure payment systems in ways that will improve the quality of health care and reduce (or slow the growth in) the costs of health care.

For more information, please visit the [Commission page](#) on the Fund's Web site.

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Related Publications

S. Dorn, **Eligible But Not Enrolled: How SCHIP Reauthorization Can Help**, The Urban Institute, September 2007.

G. Kenney, A. Cook, and J. Pelletier, **SCHIP Reauthorization: How Will Low-Income Kids Benefit Under House and Senate Bills?**, The Urban Institute, September 2007.

S. Zuckerman and C. Perry, **Concerns about Parents Dropping Employer Coverage to Enroll in SCHIP Overlook Issues of Affordability**, The Urban Institute, September 2007.

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F. R. Vogenberg, J. P. Holland, D. Liebeskind, **Employer Benefit Design Considerations for the Era of Biotech Drugs**, *Journal of Occupational & Environmental Medicine*, June 2007 49(6):62–32.

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H. D. Miller, **Creating Payment Systems to Accelerate Value-Driven Health Care: Issues and Options for Policy Reform**, The Commonwealth Fund, September 2007.

C. S. Minkovitz, D. Strobino, K. B. Mistry et al., **Healthy Steps for Young Children: Sustained Results at 5.5 Years**, *Pediatrics* September 2007 120(3):e658–668.

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Upcoming Meetings

NASHP's Annual State Health Policy Conference

Denver, CO

October 14–16, 2007

<http://nashp.org/>

AcademyHealth's Health Policy Orientation

Washington, DC

October 22–25, 2007

www.academyhealth.org

American Board of Quality Assurance and Utilization Review Physicians' 30th Annual Health Care Quality and Patient Safety Conference

Las Vegas, NV

November 6–7, 2007

www.abqaurp.org

NCSL Fall Forum

Phoenix, AZ

November 28–30, 2007

www.ncsl.org

Institute for Healthcare Improvement's Annual National Forum on Quality Improvement in Healthcare

Orlando, FL

December 9–12, 2007

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The *States in Action* bimonthly newsletter describes innovative state health programs from across the country. It is intended to help policymakers, administrators, and researchers as they work to stretch health care dollars and meet the needs of their residents.

States in Action is part of a Commonwealth Fund program on state innovations. For more information, contact Rachel Nuzum, Program Officer, State Innovations at rn@cmwf.org

We welcome those involved in state efforts to expand coverage and improve care and efficiency to send an e-mail about their efforts to stateinnovations@cmwf.org.

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The Commonwealth Fund 1 East 75th Street, New York, NY 10021 Phone:

212.606.3800

Fax: 212.606.3500 E-mail:

cmwf@cmwf.org