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The NEW ENGLAND JOURNAL of MEDICINE

Perspective

Can States Pick Up the Health Reform Torch?

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It is impossible to recall another time when a single incident — in this case, the off-cycle election of a U.S. senator — so thoroughly implicated the long-term direction of U.S. health policy. Washington is still taking the full measure of Senator Scott Brown's victory in Massachusetts, but among seasoned observers, the election's potential fallout for health reform was evident even before the first votes were cast.[1]

The political narrative of the Brown victory is the stuff of legend: the loss of a Senate seat held by an iconic figure who devoted his half-century political career to the very issue now at the center of events. The policy narrative is just as astounding, since Massachusetts' health care reform plan (for which Brown voted) provided the basic template for federal reform.

Even as the White House and Congress struggle to move forward, some observers have once again focused on the states. To be sure, the Senate bill, unlike its House counterpart, uses a state-based approach to the operation of health insurance exchanges, the purchasing marts through which eligible individuals and small businesses would gain access to affordable coverage. But unlike independent state reforms, the House and Senate bills offer a national solution for the residents of all states, not just those who live in jurisdictions with the political and financial means to pursue change.

Why Congress has reached a moment of national action is not hard to grasp. The insurance crisis has been with us a long time: only its magnitude has changed, with health care costs now exceeding 17% of the gross domestic product and with 17 states in which 15% or more of the nonelderly population is uninsured.[2] States have had decades to enact broad reforms, yet the record has been one of futility despite enormous effort. Massachusetts, the one standout in this regard, found itself in 2006 remarkably positioned to move. The state's social culture favored government involvement; its Republican governor and Democratic legislature aligned on a coverage mandate, greater insurance regulation, and strong Medicaid restructuring. A relatively low proportion of the population was uninsured, and the state enjoyed a seemingly healthy economy and the financial wherewithal to act (chiefly as a result of the Medicaid restructuring that was the basis of reform). As its financial

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picture continues to erode, Massachusetts now depends on a national solution to hold on to its gains, which makes particularly ironic the assertion of then-candidate Brown that national health care reform should be rejected because it would divert funds away from the state that it needs to maintain its program.

Massachusetts must be understood as the rarity rather than the norm. In the best of times, most states could not repeat the experience in Massachusetts. Today, between surging numbers of uninsured, collapsing state economies (see table), and a decided shift in the culture and politics of government intervention, another Massachusetts is out of the question. Putting aside the immediate financial crisis, proponents of state action overlook the vast legal, political, operational, and economic barriers to sweeping state reform.

The first hurdle is fiscal reality; health care reform rests on an infusion of federal resources, given the reduced income of most uninsured Americans. No matter how health insurance reform is structured (subsidized private coverage, a single payer, or a combination of approaches), insurance is astoundingly expensive. Cost estimates for employer group coverage (the most efficient market) in 2009 were $4,824 for an individual plan and $13,375 for a family plan.[3] Making coverage affordable means a real investment in the population. This is especially true in states whose unin-

State Budget Cuts Made during Fiscal Year 2009 and Proposed for Fiscal Year 2010.*

State	Fiscal Year 2009		Fiscal Year 2010	
	Size of Cuts (millions of $)	Cuts to Medicaid	Size of Cuts (millions of $)	Cuts to Medicaid
Alabama	697.4			
Alaska	11.7		1,053.4	
Arizona	554.0	X	111.0	X
Arkansas	64.9			
California	10,654.5	X	20,363.5	X
Colorado	144.0	X	926.5	X
Connecticut	341.4	X	52.8	X
Delaware	247.0		751.0	
Florida	887.4	X		
Georgia	2,262.2	X	2,596.0	X
Hawaii	86.2	X	315.4	X
Idaho	241.0		99.7	
Illinois	600.0		500.0	
Indiana	529.7		672.2	X
Iowa	108.8	X	564.4	X
Kansas	155.3		733.4	
Kentucky	163.2		273.8	
Louisiana	341.0	X		X
Maine	74.1	X	232.3	X
Maryland	470.9	X	448.0	X
Massachusetts	1,271.0		2,424.0	
Michigan	438.0	X	1,832.0	X
Minnesota	426.3	X	2,280.3	X
Mississippi	199.9	X		
Missouri	430.0		480.0	
Nebraska				X
Nevada	136.0	X	182.4	
New Hampshire	81.1			
New Jersey	2,000.0	X	3,284.0	X
New Mexico	282.1	X	539.1	X
New York	413.0	X	6,047.0	X
North Carolina	1,221.0	X		X
Ohio	1,093.0	X		
Oklahoma			471.7	
Oregon	764.0	X	988.0	X
Pennsylvania	470.4		1,172.8	
Rhode Island	214.0	X	415.6	X
South Carolina	1,106.4	X	328.3	X
South Dakota	0.4			
Tennessee	127.2		808.3	X
Utah	571.3		318.6	X
Vermont	68.0	X	98.0	X
Virginia	480.3	X	854.6	X
Washington	255.0	X	1,335.0	X
West Virginia			184.0	X
Wisconsin	635.0	X	1,917.7	X
Total	**31,318.1**	**27**	**55,654.8**	**28**

* Budgets for fiscal year 2010 are currently ongoing. Data are not available for Montana, North Dakota, Texas, and Wyoming. An X indicates cuts to Medicaid. Courtesy of the National Association of State Budget Officers.

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sured populations are staggeringly large. (Texas and California together accounted for 12.7 million uninsured persons in 2008, more than one quarter of the uninsured.)

A second hurdle is practical. If accessible private insurance is the goal, then states need to tackle the discriminatory tactics, such as price gouging and exclusion, that insurers use to deny enrollment or provide coverage that is grossly inadequate in relation to medical need. Even if individual states are willing to intervene, insurers are free to evade state regulation simply by pulling up stakes in any jurisdiction with an unappealing political and regulatory climate. State crackdowns make little headway; even California, the largest state, struggled to delay a proposed 39% rate increase by Anthem Blue Cross until the federal government intervened.

The law represents a third hurdle. Even states that are willing to intervene find themselves powerless to reach more than half the group market as a result of the Employee Retirement Income Security Act (ERISA), which exempts from state regulation self-funded employer plans that use large insurers only as plan administrators. Self-funding is not only for jumbo employers anymore; thousands of smaller firms now self-insure to avoid state insurance laws and liability for premium tax payments.

The final hurdle is the reality of health care today. The modern health care system is highly interdependent and operates across state boundaries. For example, health care providers in Washington, D.C., a place that has made a heroic effort to insure all residents, treat thousands of residents from Maryland and Virginia, whose public insurance programs are far less generous. Strategies for health care cost containment cannot be launched in individual states, because health care markets cross jurisdictional boundaries. Furthermore, in a modern economy, people need to be able to move interstate in order to pursue economic opportunities and participate in a changing labor market. Affordable health care is a national problem that demands a national solution.

The House and Senate bills recognize that to succeed, health insurance reform must be undertaken on a nationwide scale. Both measures foster local innovation in health care delivery, pumping billions of dollars into the development of local capacity and improvements in quality and efficiency. But the legislative proposals correctly frame health care as too large, complex, and essential to the nation's well-being to relegate adequate coverage levels to the individual states any longer. To this end, pending proposals aim to build a uniform foundation of affordable health insurance resting on combined federal and state oversight to ensure fair practices: fair enrollment and pricing that does not discriminate on the basis of sex, age, or health status; fairness in the quality of coverage; fair information and disclosure practices; and fair treatment of members, patients, and health care providers.

Despite the obvious need for national action, recent weeks have seen a revival of the notion of independent state action (even as more than half of all states either are considering or have enacted legislation to nullify federal reforms).[4] A few states, such as California and Missouri, have considered more ambitious state plans, although Missouri officials have been frank in admitting that they are unable to address the affordability problem. Indeed, every state is now trying simply to hold the line against deep erosion in Medicaid coverage, with nearly all states contemplating terrible reductions in the number of people insured, the range of essential services provided, and already desperately low provider payment rates.

Proposals from Congressional Republicans would considerably worsen matters for states. The most highly visible proposal can be found in *A Roadmap for America's Future*.[5] Mirroring the Democratic proposals in its framing of health care reform as part of a more extensive strategy to deal with "America's long-term economic and financial crisis," the *Roadmap* acknowledges the rising cost of health care, the financial burden that it places on families and businesses, and the economic consequences for the nation. With rhetorical flourish, the *Roadmap* characterizes the Democratic reform legislation as a "job-killing" government intrusion on the health care system, asserting that the Republican approach would play a key role in "rejuvenating America's vibrant market economy; and restoring an American character rooted in individual initiative, entrepreneurship, and opportunity."

But it does not take long to see the *Roadmap*'s real purpose: to shift the political and financial burdens of health care reform squarely back onto the states. A careful read of the *Roadmap* reveals a strategy in which a heavily deregulated insurance industry, operating with minimal federal

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oversight, would be free to market national plans aimed at the general population. Premium subsidies — financed by ending the favorable tax treatment given to employer-sponsored plans — would be limited to $2,300 for individual policies and $5,700 for family coverage, about 48% and 41%, respectively, of the 2009 cost of an employer group premium. This means, of course, that the products marketed interstate would be bare bones and targeted to low-volume, healthy users.

Under the plan, states would be expected to establish insurance exchanges, but since coverage of the young and healthy would be heavily tilted toward a stripped-down interstate insurance offering, the real purpose of the exchanges — made clear by the *Roadmap* — is to sponsor high-risk pools for uninsurable persons. As for subsidies for this enormously costly population, the *Roadmap* states outright that "states may offer direct assistance with health insurance premiums and cost-sharing" for this group, meaning that states are on their own. How the sponsors of the *Roadmap* think states will fund this is a mystery: the proposal would replace Medicaid for the poorest families with vouchers and cap federal payments for long-term care for the disabled and elderly at the general rate of inflation (although more than two thirds of state Medicaid budgets are spent on the sickest beneficiaries). Rather than position states for innovation, the proposal would drive their health care systems to the brink.

The United States has a strong tradition of federalism. Where health care is concerned, federalism has a central role to play, given the very local way in which health care is organized and delivered. But what does not vary — from town to town, metropolitan region to metropolitan region, or state to state — is the need for affordable, decent health care coverage, and it is a matter of vital national concern not to conflate the two. States may be health system innovators, but innovation in health care can happen only if it rests on a solid financial base. As in banking and other matters of national economic security, only the President and Congress — acting on behalf of an electorate possessed of the political will to move forward — can create the financial conditions on which a 21st-century health care system necessarily rests.

Disclosure forms provided by the author are available with the full text of this article at NEJM.org.

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This article (10.1056/NEJMp1001439) was published on February 24, 2010, at NEJM.org.

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