

Testimony of Heather Howard

**Informational Hearing on Universal Coverage and
Cost Containment Efforts in the United States**

**Select Committee on Health Care Delivery Systems and Universal Coverage
California State Assembly**

“Universal Coverage Systems in Other State and Cities, Overview”

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Thank you co-chairs Arambula and Wood and the members of the select committee. I appreciate your invitation to today’s hearing and it is an honor to join this distinguished panel.

My name is Heather Howard and I am a lecturer and faculty affiliate in the Center for Health and Wellbeing at Princeton University’s Woodrow Wilson School of Public and International Affairs, where I teach courses on implementation of the Affordable Care Act, state and local health policy, and the social determinants of health. Additionally, I serve as the director of State Health and Value Strategies, a national program of the Robert Wood Johnson Foundation. Our program provides technical assistance to states as they seek to transform health and health care. Prior to coming to Princeton, I served as New Jersey’s Commissioner of Health and Senior Services. I should note that my testimony today represents my views alone and not those of Princeton University, the Woodrow Wilson School or the Robert Wood Johnson Foundation.

Today, I have been invited to provide a brief overview of state efforts to achieve universal health coverage. As a former state official, I find myself an enthusiastic supporter of states as laboratories of policy ideas and innovation. Health care has traditionally been a purview of the states and we truly have at least 50 different health care environments – probably more when you consider larger states like California. There is, however, a common thread for states as it relates to coverage. States need federal engagement, usually in the form of financial resources, support and policy flexibility, to make a meaningful difference. As this committee embarks on the effort to examine the experiences of other states, keep the need for federal partnership in mind.

I will focus the discussion on efforts over the past 50-plus years, starting with the passage of Medicare and Medicaid in 1965. It is important to start here, because although that landmark law is a federal law, Medicaid is now the nation’s main public health insurance program. As such, it is the scaffolding on which so many state coverage efforts depend. And, it was uniquely designed to provide states with discretion to opt-in to the Medicaid program, and thus provides an interesting test of state action.

I will then touch on Hawaii and Minnesota as examples of state-directed efforts that did not depend on federal assistance. I will discuss the impact the Children’s Health Insurance Program, otherwise known as CHIP, has had on children’s coverage, briefly highlight Massachusetts’

reforms, and then turn to the Affordable Care Act, and how states have leveraged the opportunities in the ACA to strive for universal coverage.

The state role in coverage is hard to overestimate. Like the recent national debate over Medicaid Expansion, the start of Medicaid in the 1960s was marked by states delaying entry into the program. The ACA attempted to end state variation on coverage at the lower end of the income spectrum by crafting a compulsory Medicaid Expansion that would standardize coverage for people with incomes below 138% of poverty, no matter where they live. Of course, that was overturned by the Supreme Court in NFIB v. Sebelius, and states found themselves again as the decision-makers on whether coverage levels would be expanded.

As you will note on this slide, the darker the shade, the later the state entered into the original Medicaid program. Comparing Medicaid to the ACA, after four years of coverage (which is comparable to where we are right now in the lifespan of the ACA), 9 states still had not entered Medicaid. Today, 19 states have not yet taken up the Medicaid Expansion (though there is an asterisk for Maine, where voters this Fall approved expansion but it has not yet been implemented). Thus it is important to understand that state actions and decisions have a critical impact on achieving universal coverage.

But these actions and decisions go beyond participation in federal programs. States can choose to run their own Health Insurance Marketplaces, which have tended to be more successful in signing people up for individual market coverage. States have regulatory oversight of the fully insured group market and the individual markets. Decisions made in statute or by regulating authorities can affect affordability, take-up rates and eligibility – all of which connect to the availability of coverage for employees, people purchasing on their own, and the insurance rate.

State decisions have a clear impact on the rates of insurance. Lower coverage rates in Texas, Florida and Georgia are directly related to decision not to expand Medicaid. However, it is important to note that state decisions on coverage programs are not the only factors for coverage rates. Alaska's lower coverage rate is more likely due to prices, given that the state expanded Medicaid. Alaska has the highest statewide premiums in the country, given its size and geographic configuration. So state policies to achieve universal coverage must contend with forces beyond the program itself. Another key trend that is not evident on this map is economic conditions. In an economic downturn, lost jobs directly correlate with lower rates of coverage.

CHIP – the Children's Health Insurance Program – made great strides in reducing the uninsured rate for kids across the country. As you know, it provides a higher federal match rate to states and has more flexibility built into its structure than Medicaid. It too is evidence of state variation – states have the flexibility to set eligibility levels and craft state-specific CHIP programs.

This map highlights the differences in eligibility levels for CHIP – with gray states having eligibility above 250% of poverty, and blue states having eligibility below 250%. There is a correlation between higher rates of CHIP eligibility and high rates of insurance as seen on the previous map. As I am sure you are aware, there is uncertainty right now on the federal level when it comes to continued funding for CHIP. Reductions in federal funding would result in

decreased coverage levels for kids – and the current uncertainty means that many states are faced with shutting down their program as early as next month.

Now I will turn to specific state examples of efforts to increase coverage levels. I will start with Hawaii, which represents an early effort to achieve greater coverage rates. In 1974, Hawaii passed legislation known as the Prepaid Health Care Act, creating an employer mandate for coverage. Paired with that mandate was the creation of standardized plans for employers and limits on employee premium payments. Since Hawaii's state-based program was more restrictive than the traditional employer market, Hawaii received an exemption from ERISA – a federal law that limits states' ability to regulate multi-state employer plans -- to allow Prepaid to function. More recently, Hawaii also received a Section 1332 waiver from the ACA, again to allow Prepaid to continue to operate without interplay from the ACA. Later in the hearing, I will provide more details on Hawaii's Prepaid Act.

Fast forward 18 years to Minnesota. In 1992, Minnesota enacted MinnesotaCare, an effort to create an option for residents above the Medicaid income level but without access to employer sponsored insurance. Prior to the ACA, eligibility for MinnesotaCare was set to 275% of FPL. Participants were required to pay a premium on a sliding scale – with the maximum family premium reaching about \$125 per month in 2011. MinnesotaCare provided comprehensive benefits with some limitations – most notably, a \$10,000 annual limit on inpatient hospitalization. MinnesotaCare plans were procured by the Medicaid agency and all program administration was completed in tandem with Medicaid. Since 2000, Minnesota has maintained its uninsured rate at less than 10%, with MinnesotaCare seen as a key contributor to that success.

Obviously, the first question for a program like MinnesotaCare is “How does Minnesota pay for it?” Minnesota's Health Care Access Fund was created as part of the MinnesotaCare enabling legislation. The fund receives the majority of its revenue from a 2 percent gross provider tax. The provider tax includes all health care providers, hospitals, health systems, surgical centers and wholesale drug distributors. In 2016, this tax was projected to collect \$603 million. MinnesotaCare is funded from this source, but the Health Care Access Fund also provides the state match for Medicaid expenses and other health programs.

MinnesotaCare did undergo changes after the ACA. I will highlight those changes in a moment.

Moving ahead another 14 years, Massachusetts is the poster state for achieving near-universal coverage. The passage of the Massachusetts Health Reform in 2006 was a watershed moment in state health policy. The Massachusetts model of individual and employer mandate, along with subsidies and a mechanism for individual market purchase, set the stage for the ACA. Its coverage impacts were felt almost immediately, with the Massachusetts uninsured rate quickly dropping below 5%. I know we have another witness who will spend more time on Massachusetts, so I'll move on to the post-ACA world, but I believe it is important to note that the Massachusetts example reflects the need for a true partnership between state and federal authorities. Massachusetts relied on significant funding and flexibility through a waiver from the federal government to achieve their coverage expansion

The ACA represents the next step in efforts to achieve universal coverage. And while no one will defend the law as perfect, it affords states great opportunities to leverage federal investment to maximize health coverage. Two major decision points for states developed from the law. The first was the decision for a state to operate its own exchange. The second – and somewhat unexpected – decision point was the acceptance of Medicaid Expansion, a decision necessitated by the Supreme Court decision in 2012.

Generally, states that chose to operate their marketplace also chose to expand Medicaid – and this group of 12 states have a lower uninsured rate than those expansion states that did not run their own marketplace. States that chose to embrace the opportunities of the ACA have seen the biggest impact in coverage numbers. Kentucky is a commonly cited example, and the efforts in California have also been impressive. In just 6 years, California cut its insurance rate by more than half, and the efforts of the Marketplace, Covered California, have been hailed as a national example in creating a stable individual market.

Some states have also looked beyond the “standard” implementation of the ACA to achieve state goals. You will hear from Governor Shumlin about the efforts in Vermont to expand coverage to all. A number of other states have also engaged in what I might call “gap-filling” efforts.

Prior to the ACA, New York provided Medicaid-like coverage to immigrants under the 5-year federal bar, using all state dollars. This is because, as you may know, federal Medicaid is only available to citizens and persons with legal permanent resident status for 5 years. The ACA has allowed the state to leverage a federal program known as the Basic Health Program to extend that coverage and use federal dollars to provide comprehensive coverage for no more than \$20 per month.

Minnesota also used the Basic Health Program option to support its post-ACA version of MinnesotaCare. Because of the federal funding, MinnesotaCare provides a more comprehensive benefit at the same or lower premium levels. However, due to federal funding constraints, MinnesotaCare had to drop its eligibility from 275% of FPL to 200%. Minnesota has been investigating the option to use federal waiver authority to restore MinnesotaCare to 275%, but recent federal decisions may make that model unworkable.

Minnesota also used state dollars to account for rising premiums and the challenges that persons over the ACA subsidy level were finding in the purchase of insurance. ACA subsidies phase out at 400% of FPL, but earlier this year, Minnesota provided a state-funded rebate for persons from 400-500% of FPL that purchased through the exchange.

Nevada made news earlier this year with a proposal to allow for a Medicaid buy-in. While the proposal lacked specifics and was vetoed by the Governor, the idea has gained traction – enough that fellow witness Cindy Mann will dig into the options and considerations for a state looking at a Medicaid buy-in.

The wildcard for states at this point is whether the federal government is positioned to be a partner to achieve coverage goals. Medicaid buy-in programs would likely need federal approval of a waiver. Recent federal actions have put the future of the Basic Health Program in New York

and Minnesota at risk. Proposals to cap federal Medicaid funding, as well as systemic funding challenges that would be exacerbated by the deficits projected under the pending tax proposals, would starve states of the resources needed to extend coverage.

In closing, members of the Committee, thank you for this opportunity to discuss the options states have to increase health insurance coverage. Most require some level of state investment, federal cooperation, and represent varying degrees of political and policy complexity. While I am heartened by the energy at the state level for coverage expansions, we should not underestimate the challenges states face – including the limited ability to modify ERISA and Medicare, state boundary issues, annual balanced budget requirements, and the dynamic federal policy environment. I look forward to hearing from the other witnesses and to answering any questions you may have.