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Do national policymakers have anything to learn from their counterparts at the state level as they struggle to identify and implement the right healthcare reform initiatives?

In recent years, individual states have been doing some of the heavy lifting, trying to find their own solutions to the issues of cost, access, quality, and prevention. State leaders and industry experts share their perspectives on how state-level successes and setbacks might influence national healthcare reform.

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ROUNDTABLE PARTICIPANTS:



STUART ALTMAN, PHD, is professor of National Health Policy at the Heller School for Social Policy and Management, Brandeis University. An economist whose research has focused primarily on federal and state health policy, Altman was chairman of the Prospective Payment Assessment Commission, predecessor to the Medicare Payment Advisory Commission.



JUDYANN BIGBY, MD, is secretary of the Massachusetts Department of Health and Human Services, where she oversees 17 state agencies and serves in the governor's cabinet. Bigby also chairs the Health Care Quality and Cost Council, which establishes statewide measures to improve quality, contain costs, and reduce racial and ethnic disparities in health care. Previously, Bigby was the medical director of Community Health Programs at Brigham & Women's Hospital, and was an associate professor of medicine at Harvard Medical School and director of the school's Center of Excellence in Women's Health.



RICHARD L. CLARKE, DHA, FHFMA, is president and CEO, Healthcare Financial Management Association (HFMA), headquartered in Westchester, Ill. Clarke has led HFMA's efforts to identify principles and elements of payment reform based on input from key stakeholders, including hospitals, physicians, payers, employers, and consumers.



TRICIA HUNTER, RN, MN, is a principal with Government Relations Group, Inc., a health-care consulting and lobbying firm, and executive director of the American Nurses Association/California. Hunter served in the California legislature from 1989 to 1992. She also served 11 years as a gubernatorial appointee, including as an appointee to the California Medical Assistance Commission; as a special assistant to the governor in the Office of Statewide Health Planning and Development; and as president of the Board of Registered Nursing.



LYNN NICHOLAS, FACHE, is president and CEO of the Massachusetts Hospital Association. Nicholas has more than 30 years of experience with hospitals and healthcare associations and previously headed the American Diabetes Association.



ALAN R. WEIL, JD, is executive director of the National Academy for State Health Policy, a not-for-profit, nonpartisan organization that guides states in identifying emerging issues and developing health policy solutions. Previously, Weil was director of the Assessing the New Federalism project at the Urban Institute, executive director of the Colorado Department of Health Care Policy and Financing, and a member of the Advisory Commission on Consumer Protection and Quality in the Health Care Industry, which drafted the patients' bill of rights under the Clinton Administration.

What seems to be working on the state level in terms of reducing the number of uninsured?

STUART ALTMAN: Massachusetts did several things. One, the state separated the issue of the uninsured from the issue of controlling costs, saying, "We're going to cover the uninsured first, and then we're going to develop a serious cost containment effort." Most people at the federal and state level believe we have to get these accomplished together. That is a big mistake because it's so hard to control costs, and you end up never covering the uninsured. You also make the uninsured responsible for all the serious cost containment problems. That's terribly unfair, and it makes the weakest elements in our system kind of the pawns for cost containment.

The second thing Massachusetts did was bring together all the constituent groups, some Republicans, some Democrats, without allowing anyone to place blame on the other.

LYNN NICHOLAS: Having a mandate for individual citizens is an absolute cornerstone of successful reform. It's

not sufficient to focus only on an employer mandate. If you require individuals to have coverage, and you offer many opportunities for those individuals to get that coverage—be it private insurance, employer insurance, or some form of subsidized insurance—then there's no reason for any one who is legally in this country not to have insurance. Also, everyone has to want this to work. In terms of Massachusetts, consumer groups, government, business groups, and healthcare providers have really worked hard to make this work. Everyone has given something up, and everyone has gained something. That kind of coalition is absolutely essential.

RICHARD CLARKE: The state reform efforts that made national news focused primarily on improving coverage through shared responsibility and approaches to reduce cost. Lesser known, but very important, are efforts to reform payment, such as in Minnesota, to properly align incentives among all players, which in turn reduces cost and provides for improved coverage. The desired endpoint is the same, but the focus of the effort is different.

What has been tested at the state level and is obviously not working?

ALTMAN: California tried to pass a plan that was similar to the Massachusetts plan, but it was much more extensive. Because the rate of uninsured was so large, the level of state subsidies for covering those uninsured had to be a lot more than in Massachusetts. California proposed a tax on both physicians and hospitals to help support the plan, claiming that these providers would be taking in more revenue via subsidies after the reform passed and that, therefore, they should pay back some of that revenue in the form of a tax. The backlash was great, so the plan didn't pass.

ALAN R. WEIL: Efforts to provide small subsidies or tax credits to small businesses so they can buy insurance coverage for their employees have largely failed. It's similar with bare bones packages, which strip insurance products down to the bare essentials. But no one wants to buy those plans.

One of the most common misperceptions that guide health policy is, "If we just do this—fill in the blank—all of our cost and coverage problems would go away." I think years and years of state experience show there is no silver bullet. A lot of the lessons from states are not that something fails, but really that something doesn't have the potential for as big a change as people might have hoped.

How have reform efforts affected patient care—in terms of improving quality or access—on a state level?

NICHOLAS: Very positively in Massachusetts. Emergency department visits from those who can't pay has gone down. So those patients are receiving care in more appropriate settings. Organizations, such as The Commonwealth Fund, have surveyed consumers throughout the state and found that many people report better access to care, better access to physicians, higher satisfaction, and improved care. But challenges are beginning to emerge, such as inadequate primary care resources. And now the economy is raising concerns about people losing employer coverage again.

JUDYANN BIGBY: Most state reform efforts concentrate on coverage or access issues and don't necessarily address how these reforms affect patient care. Vermont is different from most states in that regard because it implemented a strategy for managing chronic illness, which I think is beginning to bear some fruit.

WEIL: Rhode Island is building around a medical home demonstration. Medical homes are essentially centralized

resources that attempt to coordinate care. The theory is that having one resource, say a primary care practice, that manages all aspects of a patient's care should, in effect, result in better care and lower healthcare costs.

TRICIA HUNTER: California has licensing laws for facilities—unit-based, minimum licensed nurse-to-patient ratios in acute care hospitals. Both national and state studies clearly show that the more registered nurses (RN) you have on the floor, the better the quality of health care, and the fewer patient safety incidents.

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How have those ratio reforms affected hospitals and nurses?

HUNTER: The ratio levels set by the reforms were pretty much where staffing was in California based on acuity. Statistics show that, for most hospitals especially the major institutions, staffing levels didn't change at all after the ratio law went into effect. But legislation is usually passed for outliers. Unfortunately, in this case, many of the hospitals that aren't staffing at appropriate levels made the decision to just pay fines rather than add staff, which I don't think is a good use of our healthcare dollars. Nor does it meet staffing concerns.

The part that has caused a hardship for hospitals is the rigidity of the "at all times" provision. There were hospitals that did not give nurses breaks or lunches. The law was changed to reflect the abuse of these hospitals. The consequence of this is that an RN on a medical-surgical floor cannot make a professional decision, based on the acuity of her patients and other issues, about whether she can take a 15-minute break without being relieved by another RN. It's that type of rigidity in the ratio laws that has really impacted many hospitals financially. They either have to hire someone

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to cover breaks or they have to pay the fines. I do know there are hospitals that have chosen to pay the fines, and are paying up to \$35,000 a day. It is also frustrating to a lot of nurses because they're not able to make appropriate decisions.

Ideally, how would you reform health care to benefit hospitals' business practices?

CLARKE: The relationships among patients, employers, payers (including government), and providers drives inefficiencies in so many ways. It is critical to focus on changing the methods of payment, such as aligning incentives, moving toward standardization, focusing on quality, encouraging innovative and effective approaches, and dealing fairly with issues such as uncompensated care, medical education, and research. So payment reform, which is driven by agreed upon principles and carefully implemented to reduce unintended consequences, will provide the right incentives to do the right things the right way. We have to fix the payment system for any reform effort to work.

NICHOLAS: One of the greatest challenges for hospitals is that, in the private health plan sector, there is so much variation. There are so many benefit designs and plan offerings that it is incredibly complicated. That variability is extremely costly because managing those plans leads to lots of administrative waste. Our new subsidized coverage in Massachusetts, which is administered through a connector authority, was relatively simple compared to what exists in the private sector. There were only so many plans, and it was very clear to hospitals what was covered and what wasn't. I think the big lesson to be learned is keep it simple.

BIGBY: I also think there's a lot of duplication and administrative complexity with the performance measures that hospitals are reporting on to payers, oversight agencies, and regulators. That whole process could be simplified, reducing the number of performance reports that hospitals have to generate. Also, if we had a way of aligning performance measurement standards and a standard for reporting quality measures, then

we would also have a better idea of what type of quality we are delivering. And when we launch interventions to improve quality, we would know what impact those interventions have.

How can payment reform address major health goals, including wellness, quality, access, and stability?

ALTMAN: Minnesota has passed some very interesting cost containment legislation, where all insurers are required to essentially pay the same rate to every provider. Of all the state projects, I think this has been the most interesting.

CLARKE: Current approaches to payment reform—pay for performance, never events, etc.—are fragmented distractions. An overall approach to payment reform is necessary, and must be guided by principles and effective implementation. The principles of payment reform must guide the design effort to focus on national health goals. The key is to have the payment system reflect desired outcomes. Several pilots are under way that will provide guidance on how successful reform can be implemented.

What successful efforts at the state level can realistically be replicated at the national level?

ALTMAN: I wish they would follow what Massachusetts has done at the federal level. Massachusetts now has the lowest uninsurance rate in the country. To be fair, Massachusetts was ahead of the game. It had one of the lowest numbers of uninsured in the country, a healthcare system that was very vibrant, and a community that supports health reform.

Now the uninsurance rate is going to be a lot higher in other parts of the country, and therefore, the subsidies are going to have to be different. Second, the federal government is going to have to provide most of the subsidies. It can't all come from the states.

WEIL: I'm not sure I would use the word replicate, but there surely are initiatives that have lessons to learn from. It's clear that national leaders view the Massachusetts plan as one that has a lot of lessons for national reform. But there are efforts around the country where payers have come together and are attempting to realign incentives in the system across different payment sources, such as the move toward patient-centered medical homes. Getting Medicare's participation has been one of the barriers to the movement.

National policy discussions are drawing upon lessons at the state level. It's hard to find an issue on the national agenda that doesn't have its roots in some state efforts. ■