Universal Health Coverage –
Research on States and Unresolved Issues

Liz Stefanics, PhD, Director

Kristine Jacobus, Deputy Director

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STAFF

Pollyanna Baca, Financial Specialist

Martina C'de Baca, Special Assistant

Marietta Esquibel, IT Database Administrator

Vicky Lee Groskinsky, IT Manager

Kristine Jacobus, Deputy Director

Tom Kauley, Management Analyst

Elisha Leyba-Tercero, Economist

David Martinez, IT Database Administrator

Kevin McMullan, Line Manager

Lisa Medina-Lujan, Management Analyst

Irma Montoya, IT Database Administrator

Don Ortega, Management Analyst

Peggy Schummers, Business Operations Specialist

Liz Stefanics, PhD, Director

Sheryl Zeigler, Management Analyst

INTRODUCTION

The New Mexico Health Policy Commission management and staff is pleased to provide a summary of various state laws, legislative bills and proposals, and reform initiatives regarding universal coverage. This document entails a compendium of researched topic areas that are being considered in many different states as they relate to universal coverage. Those states include laws in Maine, Massachusetts, and Vermont as well as pending legislation or initiatives in California, Colorado, Illinois, Maryland, Minnesota, New York, Ohio, Oregon, Pennsylvania, Washington, and Wisconsin.

Topics that have been researched include the shared role of insurance carriers, mandatory enrollment, purchasing consolidation, health care authorities, cost controls, payroll percentages, pay for performance, indigent funds and uses, difference in urban/rural areas, electronic medical records, electronic deposits
and telehealth.

The research is current as of early-to-mid August 2007. Given the fluid nature of the efforts in many states, the researched information may be not current as of the date this document is read.

TOPIC: ROLE OF INSURANCE CARRIERS

Maine

An Act to Make Health Care Affordable, Accessible and Effective for All

DirigoChoice™ is health care coverage designed to give Maine businesses with 50 or fewer employees, the self-employed, and individuals an affordable, high-quality option for health coverage. With DirigoChoice, employees of small businesses can now afford to participate. Enrollees receive discounts on monthly payments and reductions in deductibles and out-of-pocket expenses based on their income and family size. Discounts can be as high as 100%.

Under Maine law there is a section dedicated to shared responsibility. There exists a shared role of responsibility between employers and individual health care responsibility which must be contributed to provide a sharing of costs for the uninsured and employers who do not offer insurance. A carrier must provide the comprehensive health services and benefits as determined by the board established under this act. There are three requirements carriers must comply with.

Dirigo Health is governed by a board of directors. Five voting members must be appointed by the Governor and confirmed by the Legislature. Dirigo Health must contract with health insurance carriers to offer health insurance to eligible small businesses and individuals through Dirigo Health Insurance. The health insurance benefits must be determined by the board and must comply with all statutory requirements of the Maine Insurance Code, including mandated benefits.

In the first year of operation, funding for Dirigo Health is provided through the General Fund. After July 1, 2005, funding for subsidies and the Maine Quality Forum must be provided through savings offset payments paid by health insurance carriers, employee benefit excess insurance carriers and third-party administrators. The board of directors is required to establish the savings offset amount, not to exceed 4% of annual premium revenue or its equivalent, on an annual basis and those savings offset payments may not exceed the aggregate cost savings attributable to reductions in bad debt and charity care costs as a result of the operation of Dirigo Health and the expansion in MaineCare. 1

Massachusetts

The Massachusetts Health Care Reform Plan (Commonwealth Care)

The law creates the Commonwealth Health Insurance Connector, to connect individuals and small businesses with health insurance products. The Connector certifies and offers products of high value and good quality. Individuals who are employed are able to purchase insurance using pre-tax dollars. The Connector allows for portability of insurance as individuals move from job to job, and permits more than one employer to contribute to an employee's health insurance premium. The Connector is to be operated as an authority under the Department of Administration and Finance and overseen by a separate, appointed Board of private and public representatives.

The law merges the non- and small-group markets in July 2007. An actuarial study of the merging of the two insurance markets will be completed before the merger to assist insurers in planning for the transition. The bill also enables HMOs to offer coverage plans that are linked to Health Savings Accounts, reducing costs for those who enroll in such plans. Young adults will be able to stay on their parents' insurance plans for two years past the loss of their dependent status, or until they turn 25 (whichever occurs first), and 19-26 year-olds will be eligible for lower-cost, specially designed products offered through the Connector. The bill expands eligibility for employee participation in the current Insurance Partnership program from 200% to 300% FPL, in order to provide another option for small businesses who want to offer health care to their employees. The law would impose a moratorium on the creation of new health insurance mandated benefits through 2008.2

Vermont

Health Care Affordability Act

The Health Care Affordability Act creates Catamount Health which will provide affordable, comprehensive coverage for uninsured Vermonters.

Part of the principles of the bill is to provide financing of health care to be "fair, equitable, and sufficient. In the Legislative intent, there is a portion of the bill that mentions the "cost shift" to private insurers and how it is to be dealt with through consumers and the public sector. By 2009 private insurers must be involved. If there is not full participation by this time the commissioner, to be appointed, will reevaluate the program.

In §903, the intent of the general assembly is to request RFP's from carriers and insurers in the private market to provide Catamount Health and assume risk. However, there is a process that if these parts of the private sector do not submit RFP's there is a process to go through the commission to reevaluate the process and begin a second process of going through the same process but not having the private market assume risk.

The current language in 8 V.S.A. §4080f(m)(1) states that "A carrier shall notify the department that it intends to offer Catamount Health by filing written notice of that intent no later than 30 days after the effective date of the expedited adoption of Catamount Health rules."

This technically prohibits a new carrier from being able to offer Catamount health in future years. The language must be revised to allow future carriers to offer the Catamount Health Plan.

Statutory clarification is needed regarding legislative intent to prohibit balance billing. retire to immediately enroll in Catamount Health Plans. The Administration proposes language to clarify this intent.3

California

HB 840

HB 840 Creates the California Healthcare System (CHS), a single payer health care system administered by the California Healthcare Agency, to provide health insurance coverage to all California residents. States that CHS would become operative when the Secretary of Health and Human Services determines the Healthcare Fund has sufficient revenues to implement this bill.

This bill establishes CHS in state government, to be administered by the California Healthcare Agency, an independent agency under the control of the Healthcare Commissioner. The bill prohibits any health care service plan or health insurance policy, except for CHS, from being sold in California for services provided by CHS.

The bill provides that the transition to CHS be funded from a loan from the General Fund and from other sources, including private sources, identified by the Commissioner.

AB 8

AB 8 establishes a comprehensive package of health care reforms, including expansion of eligibility for the Medi-Cal and Healthy Families Programs (HFP), creation of a statewide health care purchasing program (California Health Insurance Purchasing Program or Cal-CHIPP), and modifications to the rules governing private individual and group health insurance.

The bill establishes the California Cooperative Health Insurance Purchasing Program (Cal-CHIPP) as a state purchasing pool administered by MRMIB, to negotiate and contract with carriers to offer health coverage to eligible persons.

The bill requires, on or after July 1, 2008, health plans and health insurers (carriers) selling group coverage to offer a benchmark benefit plan developed and approved by MRMIB, and subject to rate negotiation and approval by MRMIB and available only to employees and their dependents eligible under the Medi-Cal Program or HFP.

AB 8 requires MRMIB to develop and offer at least three uniform benefit designs, as specified, and requires all carriers to offer all of the uniform benefit designs developed by MRMIB in all individual and group markets in which the plan or insurer sells health coverage, but stipulates that this requirement does not preclude plans and insurers from offering other benefit plan designs.

AB 8 requires the Department of Managed Health Care and California Department of Insurance to adopt regulations by July 1, 2009, defining and limiting administrative costs such that at least 85% of revenues received by carriers must be spent on health care services rather than administration or profit, establishing a minimum "medical loss ratio." The bill requires, in addition, carriers to disclose to all prospective purchasers the medical loss ratio for the carrier's preceding fiscal year, as specified.

Effective July 1, 2008, AB 8 requires carriers to use a standard form, developed by MRMIB, in screening applicants for individual health coverage, requires MRMIB to develop a list of serious health conditions or diagnoses making an individual applicant automatically eligible for the state's high risk health insurance program, the Major Risk Medical Insurance Program (MRMIP), and prohibits carriers from excluding any applicants from private individual coverage based on health status, except for those individuals with conditions on the list

The bill requires the California Health and Human Services Agency CHHSA) to consult with CalPERS, and affected health provider groups, to develop performance benchmarks for quality measurement and reporting into a common "pay for performance" model to be offered in every state-administered health care program, as specified, and advanced as a common statewide framework for quality measurement and improvement.4

Ilinois

SB 5

SB 5 replaces everything after the enacting clause. The bill creates the Illinois Covered Act. It creates the Illinois Covered Rebate Program Act. SB 5 provides that the Department of Healthcare and Family Services shall provide premium assistance to offset the cost of paying premiums to secure health insurance to eligible persons. It sets forth the criteria for eligibility. Creates the Illinois Covered Choices Act.

SB 5 requires all managed care entities to offer one or more suitable group managed care plans and one or more suitable individual managed care plans. It allows managed care plans to receive reimbursement for a portion of claims paid. It provides for administration of the Illinois Covered Choices program by the Department of Healthcare and Family Services, in conjunction with the Division of Insurance within the Department of Financial and Professional Regulation. The bill establishes an Office of Patient Protection within the Division of Insurance to ensure that persons covered by accident and health insurance or health care plans are provided the benefits due them under the Illinois Insurance Code. It creates the Comprehensive Healthcare Workforce Planning Act.

SB 5 provides for the formation of common claims and procedures work group to recommend steps to achieve goals relating to claims processing. Creates the Illinois Covered Assessment Act.

The bill amends various Acts concerning insurance and Medicaid. It contains provisions concerning findings, emergency rulemaking, and severability. A baseline assessment is to be added to insurers to be determined by the “division”. Small insurers whose share is minimal may be exempt. Managed care entities will share in the cost of publishing a consumer shopping guide.

Maryland

HB 400

HB 400 establishes the Maryland Universal Health Care Plan (MUHCP) to provide universal health care coverage for all state residents. The bill establishes the Maryland Universal Health Care Plan; specifies the purposes of the Plan; establishes the State Board of Governors of the Maryland Universal Health Care Plan; specifies the membership of the Board of Governors and the terms, duties, and powers of the members of the Board of Governors; authorizing the Board of Governors to adopt specified regulations; requires the Board of Governors to appoint an executive director; specifies eligibility requirements for membership in the Plan; etc.

Each state resident is a member of MUHCP and is eligible to receive benefits for services covered under the plan. A health insurer, nonprofit health service plan, or HMO may offer benefits that do not duplicate services covered by MUHCP. 5

Minnesota

HB 1856

Article 2 of HB 1856 requires every Minnesotan to have health coverage that satisfies minimum coverage requirements, establishes the Minnesota Health Care Access Portal, requires employers to collect additional tax withholding from employees who do not maintain required coverage, and contains other provisions related to health care access.

All health providers under this bill are required to offer insurance to any individual requesting health insurance. Health insurance companies are required to offer a basic health plan to be approved under requirements of this bill. Health plans offered must include preventative services.

The bill provides that qualified minimum coverage plans are subject to the underwriting and rating requirements that apply to the small group market under section 62L.08. These include, but are not limited to: plus or minus 25% premium variation for health status, claims experience, industry, and duration of coverage; plus or minus 50% premium variation for age; a requirement that geographic rate regions be approved by the commissioner; and prohibition on gender-based rates. 6

TOPIC: MANDATORY ENROLLMENTS

Maine

Enrollment in Dirigo Choice is voluntary. As a policy issue, the state of Maine decided that it would be difficult for some employers to offer health coverage and would retain voluntary enrollment.

Self-employed and individuals are eligible to join DirigoChoice. The costs vary depending on individual economic circumstances. Individuals and the self-employed are able to enroll during an annual open enrollment period. In the first year, issuance of self-employed and individual policies was capped at 4,000 to prevent adverse selection.

Employer, employee, the self-employed and individual payments are pooled with other funds from a variety of sources to finance DirigoChoice and its discounts. Lowest wage employees and individuals will get the deepest discounts. Some individuals may have no deductibles and pay only nominal co-pays. Discounts on monthly payments, reductions on deductible, and out-of-pocket expenses for those under 300% of the Federal Poverty Level are based upon a $28,000/single adult and $56,500/family of four. This sliding scale provides discounts of up to 100%.

Monthly payment discount rebates and reductions in deductibles and out-of-pocket expenses will help individuals with incomes less than $28,000/year and families (e.g., a family of four with income less than $56,500) to afford to participate in DirigoChoice. A business that employs at least 2, but not more than 50 eligible employees where the majority of the employees are employed in the state, is eligible.

Consistent with current insurance practice, 75% of eligible employees will need to participate. An eligible employee of an eligible business is someone who works at least 20 hours per week. (Eligible employee does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually.)

On May 24, 2006, Maine Governor John Baldacci signed an executive order establishing the *Blue Ribbon Commission on Dirigo Health* in order to "make recommendations with respect to long-term funding and cost containment methods to continue the efforts of Dirigo Health in increasing the affordability, accessibility, and quality of health care" for the state's citizens.

The Blue Ribbon Commission endorsed the following initiative to make health care coverage more affordable overall-“Regarding employer and individual mandates, the Commission endorses the concept of an employer mandate along with a mandate for individuals with income over 400% FPL, and recommends that the Governor move forward to explore the parameters of how such mandates would work, including, but not limited to such issues as: what is considered credible coverage; what would be a reasonable payment for businesses who elect not to purchase coverage; and how the individual mandate would be enforced.” 7

<u>Unresolved Issues</u>

The number of uninsured Mainers under 65 years old actually rose from 130,000 in 2004 to 141,000 in 2005, according to the U.S. Census Bureau.

DirigoChoice sales are also 75 percent below projections, according to the Maine Heritage Policy Center. If the goal is to expand coverage to the uninsured, there are a number of key points that Dirigo failed to adequately address They are a complex benefit design deterred people from taking up benefits and may have raised the cost of switching from their current provider/insurer. Small businesses offering insurance for the first time found it to be a difficult and untried task. DirigoChoice suffered from an influx of unhealthy people who see the subsidized plans as affordable, given their health problems. Healthy people still find the insurance too expensive and did not join the risk pool.

Massachusetts

The Massachusetts Health Care Reform Plan (Commonwealth Care) requires the participation of both individuals and employers. It mandates everyone in the state to purchase health insurance by July 1, 2007, and would impose financial penalties of up to 50 percent of the cost of a health insurance plan on those who do not via income tax filings. It also includes a requirement that employers with more than 10 employees provide health insurance coverage or pay a "Fair Share" contribution of up to $295 annually per employee. The $295 assessment on employers who do not provide insurance to their workers is intended to serve as an incentive to increase employer-based offerings, but is much less than the cost of offering insurance to employees. The Fair Share Contribution requirement will only apply to employers with more than 10 employees who do not provide health insurance or contribute to it, as defined by the Division of Health Care Finance and Policy, and will be pro-rated for employers with seasonal or part-time employees.

The plan specifies that the individual mandate is only enforceable if affordable health plans are available. While the legislation did not define "affordable," legislators have indicated that premiums for low-cost products should range from $200-$250 per month.

In 2008, the penalty for those not insured will be a loss of state tax exemption, worth about $219; later the penalty will be up to half of a monthly insurance premium for each month a person is uninsured. Also, while any insurance is acceptable at first, by January 2009, everyone must have drug coverage.8

Unresolved Issues

One of the issues is with the insurance mandate is enrolling uninsured individuals who make too much money to receive any state subsidies. Roughly 200,000 uninsured residents are above 300 percent of the federal poverty level, making them ineligible for public subsidies. Motivating these individuals to buy health insurance will be a challenge because those with income below 400% of the Federal Poverty Level can currently receive "free care" through the State's Uncompensated Care Pool. To deter residents from using that pool, the state s considering increasing deductible, and co-pays for free care services and making tem comparable to the premiums paid in the Commonwealth Care plan.

Vermont

In Vermont the Health Care Affordability Act creates Catamount Health which will offer coverage for uninsured Vermonters in October, 2007. Under this plan, everyone who is uninsured for 12 months will have access to - and will help pay for - a comprehensive health insurance package. The benefits will be administered through the private market and premiums will be based on income.

Catamount Health will be offered by insurance companies and paid for with a hike of 60 cents per pack cigarette tax and a fee on employers who do not offer health insurance to their workers.
Non-offering employers will pay a quarterly assessment equaling $1 per day per total number of full-time equivalent (FTE) employees, if the employer does not offer health insurance, only offers health insurance to some employees (assessment is on those who are not eligible for an employer's insurance), or has uninsured employees. The employer may exempt a maximum of eight FTEs from the assessment in fiscal years (FY) 2007 & 2008; six in FY 2009; and four in FY 2010. If Vermont has less than 96% of the population insured in 2010, the legislature will consider implementing a requirement that every Vermonter have health insurance.

Unresolved Issues

Although the program remains voluntary, Vermont estimates that approximately 25,000 of the 60,000 uninsured persons in the state will take up the new product. If the state's set goal of 96 percent coverage is not reached by 2010, the state will consider imposing mandatory insurance requirements.9

TOPIC: IBAC-LIKE PURCHASING CONSOLIDATIONS

Maine
Contract negotiations occur annually between the Director of Employee Health and the four unit union representatives from State Employees, one from Administrative, maintenance, technical, and supervisory areas. Teachers have unions and bargain within areas, towns or district.

Massachusetts
The Group Insurance Commission responsible for providing health and welfare benefits to over 265k state employees, retirees and their dependents and retired teachers from certain towns and districts. A law, passed this July, allows additional cities and towns to offer their employees this benefit. If elected, the involved Unions must approve by October 1. The effective entrance date, if selected is July of 2008. Obtains health insurance for this July, allows additional cities and towns to offer their employees this benefit. If so, the Unions involved must approve by October 1. The effective date for participation is July of 2008.

Vermont
Union representative indicated that law provides for the union negotiating on behalf of active state employees and retirees and that these two groups are covered by the same benefits and at the same rate structure. Teachers are in separate unions and negotiate on a district or city- by- city basis.

California
California Public Employees Retirement System is the third largest purchaser of healthcare in the nation with 1.2 million public employees, retirees and dependents. By law, state employees participate, with local public agencies and school employers having the choice to participate. Employer contributions established through collective bargaining.

Colorado
Division of Human Resources oversees administration of health insurance. State Employees, including legislators and judicial personnel are one group while another group consists of University personnel.

Illinois
State agency, Central Management Services seeks bids for statewide healthcare benefit packages, once benefits packages have been negotiated.

Maryland
Does not have public employees entities charged with consolidated purchasing of health care. State has authorized local government and businesses to buy into a pool with state employees for the purchase of prescription medications. Implementation of plan is pending a court ruling. Maryland does have a Maryland Health Care Commission, a public regulatory Commission with 13 members appointed by the Governor. The Commission releases annually a report on performances by Health Maintenance Organizations.

Minnesota
Does not have public employees entities charged with consolidated purchasing of all health care benefits. Governor has instituted a program to allow State employees to purchase prescription medications from Canada. Minnesota Care, a smart buy alliance, exists.

New York
Department of Civil Service, Employee Benefits Division represents the largest public employer health insurance program in the nation outside of the Federal government. Department protects 1.1 million state and local employees, retirees and dependents. The Taylor law allows “no pattern” bargaining. Participation in this program explicitly excludes any organization with one million or more members.

Oregon
State employees and Retirees, not yet eligible for Medicare, are in a Public Employees Benefit Board (PEEB) that designs and contracts on behalf of them for health care and other services.

Pennsylvania
Pennsylvania Employees Benefits Trust Fund created to be the health insurance fund for state employees and retirees until the age of 65. Separated from the Retirement plan. Health Care Cost Containment Council (PHC4) reports patient outcomes in 80 treatment outcomes involving physicians, hospitals and managed care plans and sells the data.

Washington
Health Care Authority created a Public Employees Benefits Board (PEBB). All public entities can only offer this product while other entities are allowed and encouraged to participate. PEBB approves the benefits of all health insurance plans. With 320,000 state employees, dependents and retirees and k-12 teachers, they have expanded the state employees' wellness programs.

Wisconsin
Department of Employee Trust Funds, Group Health section, has statutory authority to provide program administration and oversight of HMO plans that are offered. State employees, elected officials, university system employees, and local government employees must participate.

TOPIC: HEALTH CARE AUTHORITIES

Maine

The Dirigo Healthcare Plan will provide lifetime healthcare for every Maine resident. The Plan provides healthcare — not simply insurance. The Plan creates the Maine Healthcare Authority to oversee and administer the Plan, which will be funded by streamlining and simplifying the many ways Maine residents currently pay for healthcare.

The Maine Health Care Reform Commission (MHCRC) recommended that the Authority board be comprised of healthcare providers, government appointees, hospital administrators and representatives of the business community as well as private citizens. The Authority will oversee the healthcare program as well as steward the education of healthcare professionals.

Unresolved Issues

One possible obstacle to providing healthcare to Maine residents is ERISA (Employee Retirement Income Security Act). ERISA's original purpose was to regulate employee pension plans. ERISA also precludes state agencies and governments from regulating self-insured business insurance plans.11

Massachusetts

Commonwealth Health Insurance Connector Authority is run by an independent agency with a 10-member board. The Connector will make health insurance portable by allowing employees to keep the same plan even if they leave an employer. The Connector will also allow employees to aggregate the contributions of multiple employers, e.g. if they are part-time workers or work for multiple employers, and apply them to one insurance plan. The Connector is designed as a clearinghouse for insurance plans and payments. It performs the following functions- it runs the Commonwealth Care program for low-income residents (below 300% of the poverty level) who do not qualify for MassHealth; it offers for purchase health insurance plans for individuals who are not working, are employed by a small business (less than 50 employees) that uses the Connector to offer health insurance. are not qualified under their large employer plan, are self-employed, part-time workers, or work for multiple employers, it sets premium subsidy levels for Commonwealth Care, and it defines "affordability" for purposes of the individual mandate.

Unresolved Issues

The possibility exists that a legal challenge to the law may arise under the presumption that it is an attempt to preempt the federal Employee Retirement Income Security Act .12

Vermont

The administrative centerpiece of the law is the Vermont Health Care Authority (VHCA), which began its work in August 1992. The VHCA acts under the direction of a three-member administratively powerful board appointed by the governor and confirmed by the Senate. The board's responsibilities include program design (typically requiring legislative approval), data collection, advisory work with other agencies involved in implementing reform, and working with existing public organizations to encourage local and regional health plans and primary health care systems and to negotiate with provider groups. The board represents one of the nation's most highly centralized and potentially powerful health care agencies.13

Colorado

The Blue Ribbon Commission for Health Care Reform is studying health care reform models to expand health care coverage, especially for the underinsured and uninsured, and to decrease health care costs for Colorado residents. The Commission is charged with examining health coverage and reform models designed to ensure access to affordable coverage for all Colorado residents; soliciting comprehensive reform proposals from interested parties; selecting between three and five proposals for in-depth

technical assessment by an independent contractor; and completing a final report with recommendations to the General Assembly by January 31, 2008. 14

Maryland
There is a State Board of Governors of the within the Maryland Universal Health Care Plan. The Board is to administer, implement and monitor the operation of the plan; establish a global budget for the total amount that may be expended for the provision of health care under the plan each year; develop and recommend to the governor and the general assembly funding sources for the plan; set reimbursement rates for non-hospital outpatient services which are not regulated by the Health Services Cost Review Commission; administer the Maryland Universal Health Care Trust Fund; establish reasonable and effective means of cost containment, quality assurance and promotion of access to services; establish a system to promote continuity of care, including the use of case managers for plan members with multiple health care problems; establish a prescription drug formulary; and administer payments for the provision of covered services to participating health care providers.15

Minnesota
The Minnesota Universal Health Board is legislatively proposed to create for the purpose of providing a single, publicly financed, statewide program to provide comprehensive coverage for all necessary health care services for residents of Minnesota.

The board may implement and administer the Minnesota universal health program; estimate the current cost of universal coverage for all Minnesotan residents; establish statewide and regional budgets; approve budgets for each region, establish fee schedules, which may vary to reflect regional differences; approve budgets for institutional providers; approve capital expenditures for freestanding outpatient facilities; monitor compliance with all budgets and fee schedules and take action to achieve compliance to the extent authorized by law; issue requests for proposals for a contract to process claims submitted by individual providers; provide technical assistance to the regional boards; administer the Minnesota Health Care Trust Fund; monitor the operation of the Minnesota universal health program through consumer surveys and regular data collection and evaluation activities, including evaluations of the adequacy and quality of services furnished under the program, the need for changes in the benefit package, the cost of each type of service, and the effectiveness of cost containment measures under the program. 16

Oregon
The Oregon Health Fund program would be established under proposed legislation. The goals of the program would be to provide coverage of the defined set of essential health services for all residents; reduce unsustainable health care cost increases in Oregon; shift to a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the private market; use proven models of health care benefits, service delivery and payments that control costs and over-utilization, with emphasis on preventive care and chronic disease management within a primary care environment; provide services for humane and dignified end-of-life care; restructure the health care system so that payments for services are fair and proportionate among various populations and health care programs; and fund a high quality and transparent health care delivery system that allows users and purchasers to know what they are receiving for their money. The Boards will also manage the Oregon Health Fund; oversee the actuarial process to define the set of essential health conditions; conduct public hearings to determine the adequacy of the defined set of essential health conditions and report the findings to the Governor and the Legislative Assembly; and contract with privately and publicly sponsored health care organizations.17

Washington
The Washington State Health Care Authority would work with contracting health carriers and health care providers, and a nonproprietary public interest research group and/or university-based research group, to implement practical and usable models to demonstrate shared decision making in everyday clinical practice. The demonstrations would be conducted at one or more multi-specialty group practice sites providing state purchased health care in the state of Washington, and may include other practice sites providing state purchased health care. The Health Care Authority and the Department of Social and Health Services shall also develop a five-year plan to change reimbursement within state purchased

health care programs to reward quality health outcomes rather than simply paying for the receipt of particular services or procedures; pay for care that reflects patient preference and is of proven value; require the use of evidence-based standards of care where available; tie provider rate increases to measurable improvements in access to quality care; direct enrollees to quality care systems; better support primary care and provide a medical home to all enrollees; and pay for e-mail consultations, telemedicine, and tele-health where doing so reduces the overall cost of care.18

TOPIC: COST CONTROLS

Maine

Reduce Bad Debt and Charity Care: Currently the cost of bad debt and charity care is estimated to be $275 million per year. Dirigo Health will work to reduce this through greater access to health coverage. Strengthen the Certificate of Need (CON) process to ensure more rational development of health care services. Only 26% of all capital investments made by health care providers (and hospitals are the type of provider most often impacted by CON requirements) fall under CON.

Create Capital Investment Fund: Contain costs by limiting capital investments in the health care industry to a specific annual dollar amount.

Transparency in prices: Providers are required to let Maine citizens know the prices of common procedures and other information so customers understand the costs of health care and make informed decisions.

One year moratorium on capital expenditures: The Governor imposed a moratorium on the Certificate of Need process, thereby limiting costly new construction and other capital expenditures in the health system.

Voluntary caps on costs and operating margins: Dirigo Health requested hospitals and other providers to limit their cost growth to 3% per year and their operating margins to 3.5%. Insurers are asked to limit their operating margin to 3.5%.

Financial Incentives for health care customers: Health insurance carriers were permitted to offer their enrollees financial incentives to travel further to undergo non-emergency surgical procedures if the carriers can demonstrate cost-effectiveness and that the quality of care is equal to or better in the more distant location(s).

Strengthened oversight of insurance rates: There was strengthened oversight, review and approval of small and large group insurance rate filings by the Superintendent of Insurance.

Accountability for all insurers: All health insurers doing business in Maine are required to comply with standardized annual reporting requirements. These requirements include prescribed definitions of items including administrative costs and medical costs, which will allow easier comparisons of loss ratios and profit across lines of business and across insurers. 19

Unresolved Issues

On June 27, 2007 the Maine governor signed into law a bill allowing the DirigoChoice program to be self-administered. With the new legislation, the DirigoChoice program can now self-insure. According to the bill's fiscal note, converting to a self-administered plan could result in any of the following:

- The General Fund losing insurance premium tax revenue of approximately $1.8 to $2 million per year annualized (based on Dirigo 2008-2009 proposed budget premium assumptions) if a conversion takes place. This loss may be partially offset by a minor increase (less than $50,000) in corporate income tax revenue paid by the third-party administrator Dirigo may use to administer the plan.
- A net savings to the Dirigo Health program of approximately $3.9 million per year on an annualized basis, mainly from savings in administrative costs, greater plan design flexibility, and not having to pay the insurance premium tax. 20

Massachusetts

A "Free Rider" surcharge will be imposed on employers who do not provide health insurance and whose employees use free care. Imposition of the surcharge will be triggered when an employee receives free

care more than three times, or a company has five or more instances of employees receiving free care in a year. The surcharge will range from 10% to 100% of the state's costs of services provided to the employees for the health care services (e.g. emergency department visit), with the first $50,000 per employer exempted. This could be a considerable sum per employee. Revenue gained from the surcharge will be deposited in the Commonwealth Care Trust Fund.

Mandatory Offer of Section 125 plans: Section 125 plans or "cafeteria plans" allow an employer to offer health insurance and other programs such as day care funding to employees on a pre-tax basis. Because of the significant savings which result from pre-tax insurance purchase, employers with 11 or more employees will be required to offer this pre-tax benefit to employees.

Performance Goals: In response to concern that Medicaid has underpaid many of its providers in recent years, the new law includes $90 million in rate relief for FY 2007, 2008 and 2009. The law also establishes a process of tying future rate increases to specific performance goals related to quality, efficiency, a reduction of racial disparities, and improved outcomes for patients.

Redirection of Funds: The financing of the bill is based on redirecting some of the public funds currently spent on "free care" provided through hospitals to provide subsidized health insurance to the uninsured. The mandate is another way to make sure people do not rely on "free care" for their health care, but that they get comprehensive insurance.

Insurance Standardization. Coverage offered through the Connector exchange is administered according to the principles of very large employer-group plans with multiple choices of carriers and products. The purchase of coverage through an exchange is "regularized" and limited to an annual open-season period, with a few exceptions. This standardization makes it possible for participants to annually switch coverage on a guaranteed-issue basis, at standard rates, and without new underwriting administrative costs.

Compatibility with federal law. The exchange is structured to be compatible with federal employer-group insurance law. The State law is drafted in such a way that an employer may voluntarily designate the exchange as its "employer-group health benefit plan" for purposes of federal law, and the exchange agrees to be the employer's "plan administrator" under federal law. The firm's workers then choose coverage from among the insurance products offered through the exchange. For the employer, the exchange essentially functions like a giant third-party administrator (TPA), offering a standard menu of insurance products. This design transfers most of the administrative burden of plan sponsorship from employers to the exchange. Participating employers are relieved of most of the costs associated with separately obtaining and administering group coverage for their workers.

Uniform payroll withholding system. The exchange acts as a "premium aggregator," collecting and distributing to carriers premium payments made by employers, individuals, and government premium subsidies. This reduces the employer's role to participation in a single, uniform payroll withholding system, much like existing employee tax-withholding systems. It also effectively transfers the "payment risk" from insurers to the exchange. Insurers need no longer build into their premiums a factor to account for the probability that some portion of their customers will drop coverage before the end of the contract period. The elimination of this "build in" should help moderate costs.21

Unresolved Issues

- Definition of "affordable". Self-employed individuals are pressing for changes in controversial aspects of the law, such as how much employers should contribute to health insurance and the most individuals should have to pay for coverage. In late June 2007, the Connector Board established the an affordability schedule for determining whether Massachusetts residents may be required to purchase affordable health insurance in calendar year 2007. Whether these income levels are realistic and achievable remains to be seen.
- ERISA. The $295 per year assessment if coverage is not provided is vulnerable to court ERISA challenges because a federal court recently struck down a similar Maryland law requiring employers in the state with more than 10,000 workers to spend at least 8 percent of wages on health care coverage saying it violated ERISA. The prohibition in the law against companies

offering different quality levels of health insurance coverage to different classes of employees may be an ERISA violation.

- Funding. Initial state funding for the Massachusetts initiative was targeted at $126 million, but increased to $276 million when it was approved by the Massachusetts Legislature and then Massachusetts Gov. Romney in 2006. There is discussion for legislation to require that businesses pay at least 50 percent of the premiums for employees' health insurance if they want to avoid a penalty of up to $295 per employee. Currently, the requirement is 33 percent.
- Loopholes. Businesses have found loopholes around mandates, in some cases spinning off into smaller companies to avoid the requirements. 22
- Workforce. Massachusetts has the highest number of physicians per capita in the nation. According to a Massachusetts Medical Society Report, "newly insured residents may find it difficult to get timely appointments with physicians due to these shortages." If these newly insured utilize emergency departments as a timelier source of primary care, the costs of this type of care could be considerable. New Mexico is 32nd in the nation with large a shortage of physicians and maldistribution. 23

Vermont

The new legislation codifies the Vermont "Blueprint for Health" prevention and chronic disease management plan and directs chronic care management in Medicaid and Catamount Health that will save an estimated 5-10 percent in health care costs. The Blueprint establishes a system of chronic care management, changes provider reimbursement system to encourage best practice delivery in chronic disease management, and waives co-pays for patients who seek appropriate care. An estimated50% of Vermonters with chronic conditions account for 70% of the total health care spending, but only 55% percent get the right care at the right time.

Individual Health Insurance Market Reform-provides assistance to carriers in the individual market of 5% in order to reduce premiums by 5%. There is also a study to determine feasibility of merging the individual and small group markets.

Cost Shift Review-Decreasing uncompensated care is believed to decrease the rate of increase in premiums. The law expands hospital reporting on cost shifting and creates a cost shift task force to determine methods of accounting for the cost shift and ensuring that reductions in the cost shift are passed on to private insurance consumers. The law establishes a process to create a uniform, statewide uncompensated care policy or set of policies for all hospitals.

Healthy Lifestyles Insurance Discounts – allows discounts of up to 15% of premium for compliance with health promotion program and limits total deviation from community rate to 30% (including these discounts) in the individual and small group insurance markets.

Common claims and procedures – establishes a work group to make recommendations.

Common Credentialing for Providers – The Department of Banking, Insurance, Securities and Health Care Administration (BISHCA) will require use of single, form for credentialing applications.

Multi-payer Database & Consumer Price and Quality Information - requires insurers and third party administrators to report data in order for BISHCA to provide price and quality information to consumers.

Medical Event Reporting-There will be established a program for the purpose of improving patient safety, eliminating adverse events in hospitals, and supporting hospital quality improvement efforts. Hospitals must track adverse events and analyze the causes. Infection rate reporting is added to community hospital reports.24

Unresolved Issues

- Cost Shift Task Force The task force was to make recommendations to the commission on health care reform by December 1, 2006 regarding statutory or administrative changes needed to

ensure that a reduction in the cost shift is reflected in a reduction or slower rate of growth in hospital charges and health insurance premiums.

- Uncompensated Care/Bad Debt Policy The state government in consultation with representatives of the Vermont hospital association, insurers, and consumers, was to review the uncompensated care and bad debt policies of Vermont's hospitals and recommend to the legislature by Jan 15, 2007 a standard statewide uniform uncompensated care and bad debt policy. The policy will include criteria for payment forgiveness for the cost of health services received by low income patients, criteria for a sliding scale payment amount for patients under certain income levels, a method for calculating the amount of services received by the patient, and other criteria necessary for ensuring that the care received by the uninsured and underinsured patients is billed in a uniform and consistent manner.
- Individual insurance market consolidation. The department of insurance in consultation with insurers that participate in the nongroup market was to recommend to the legislature no later than January 15, 2007 the best method to consolidate the nongroup market into a single risk pool of insured Vermonters with access to health plans equivalent to or better than that offered by Catamount Health. Also, the administration will report on options for treating seasonal employees.
- Voluntary Take Up- Although the program remains voluntary, Vermont estimates that approximately 25,000 of the 60,000 uninsured persons in the state will take up the new product. If the state's set goal of 96 percent coverage is not reached by 2010, the state will consider imposing mandatory insurance requirements. 25

California

AB8 has a uniform benefit packages to include coverage for primary and preventive care with minimal cost sharing. California will "adopt and encourage" healthy lifestyles through workplace and individual efforts to improve health. It adopts an employee mandated pay-for-performance program for state funded healthy coverage programs. It requires plans and providers to participate in the implementation of a personal health records system. It has a centralized assessment of new technology and a cap on health plan administrative costs and profits (must spend 85% of premiums on patient care).

The Governor's individual mandate proposal has subsidized insurance products that incorporate "Health Action Incentive/Rewards Program," which all healthy plans are required to offer; state-sponsored public health efforts to reverse obesity trends and continue smoking cessations efforts. It reduces regulatory requirements on health plans and in other areas in order to promote certain retail delivery models such retail health clinics. The proposal has a pilot to combine worker's compensation benefits with traditional health coverage. It also has a cap on health plan administrative costs and profits (must spend 85% of premiums on patient care).26

Unresolved Issues

There are conflicting views on pay or play laws. Opponents of state pay or play laws would argue that such approaches mandate employers to offer health coverage in violation of ERISA and would be preempted.

Colorado

Colorado has a Blue Ribbon Commission looking at four and possibly five different plans. No legislative action has been taken on any of the plans.

Cost controls in the Colorado Health Services plan are through a single payer. Because the burden of administration and bureaucracy is greatly reduced by dealing with only one system, the monetary savings are generated according to the proposal.

The Plan for Covering Colorado controls costs through creating incentives to further integrate care, promoting rapid development of health information technology, aligning incentives for and rewarding quality, standardizing forms and billing and payment systems, utilizing a Preferred Drug List for Medicaid

and Capture 340b drug pricing, creating a comprehensive benefit package as the minimum for coverage, making targeted changes in patient-centered care, and addressing the prevalence of chronic disease. The Better Health Care for Colorado controls costs through developing a more efficient and cost-effective system to provide care to the uninsured with a focus on care management, primary care and prevention, and benefits tailored to the target population, leveraging market competition and choice to reduce costs, reducing uncompensated care costs and cost shifting to employer plans and other payers, creating incentives for quality, cost-effective care in the most appropriate and least restrictive settings, and implementing targeted reforms in Colorado's Medicaid and SCHIP programs to incorporate strategies that contain costs. Also noted is greater use of capitated managed care and primary care case management to ensure access, quality and more cost-effective care through initiatives to manage care, implementation of pay for performance, incorporate evidence-based care, promote health and wellness and improve health and health care outcomes through performance benchmarks, more robust disease management for chronic conditions to incorporate best practices and evidence-based medicine in the delivery of care, reporting, monitoring and transparency to improve health and health care outcomes and to allow consumers to make cost-effective choices for plans and providers, hospital payments linked to quality of care performance benchmarks to contain hospital costs for hospital-acquired infections, readmissions for chronic diseases and pharmacy errors, and improved pharmacy purchasing strategies to garner savings through a preferred drug list, a multi-state purchasing pool, and a specialty pharmacy program.

The Solutions for a Healthy Colorado plan controls costs through reporting and transparency, creating effective pay for performance programs for managed care organizations which requires significant reporting systems. Also included is hospital Pay for Performance which ties future increases in Medicaid hospital payments to key quality performance measures, including hospital acquired infections, re-admission rates for chronic disease, initiatives that address workforce issues, and pharmacy error reduction.

There is the creation of a Health Insurance Exchange to serve as a clearinghouse and a vehicle to offer high-quality basic health plans that would be uniform across the market.

Noted is better management of key Medicaid cost drivers like chronic disease and the introduction of effective prenatal programs and an emphasis on preventative care.27

Illinois
A statewide consensus plan was to be developed for promoting wellness and managing chronic conditions. Illinois was to build upon recent efforts to improve patient safety, promote electronic medical records, improve access to information on quality of care and reduce administrative costs. 28

Unresolved Issues
The bill itself is being revived and will now cost about $1 billion a year and would be paid for with a 3 percent payroll tax on employers who cover few, if any, medical costs for workers. The revised proposal meets the governor's goal of providing free insurance to 300,000 individuals living below the poverty line, but it tightens eligibility rules and potential benefits for everyone else. As a result, the total costs have dropped from about $3 billion a year to $1 billion.

The governor's original health-care plan depended heavily on a major new tax on business revenues. The scaled-back version would be paid for entirely with a payroll tax on companies.

Maryland
Maryland already has in place and has had for years a regulatory body (Maryland Health Services Cost Review Commission) that regulates hospital rates. The bill goes further than the current cost control by adding all non-hospital outpatient health care services with the plan reimbursing providers in accordance with a fee schedule established by the trust board of governors. The plan does not allow balance billing with the rates established by the trust to be considered payment in full. The bill also calls for the establishment of a system to promote continuity of care including the use of case managers for plan members with multiple health care problems, and the establishment of a prescription drug formulary.29

Unresolved Issues
The plan is being redone to a much scaled down version with a joint committee of state senators and delegates pushing to develop a consensus behind a health care expansion within the next four months.

Minnesota
The major cost controls in the proposed legislation are provider payment rates and methods for paying for health care services, drugs, devices, supplies, and equipment in order to reward the provision of cost-effective primary and preventive care. It includes the rewarding of the use of evidence-based care; discouraging underutilization, overuse, and misuse; rewarding the use of the most cost-effective settings, drugs, devices, providers, and treatments; and encouraging consumers to maintain good health and use the health care system appropriately.30

Unresolved Issues
Budget issues are driving any consideration of universal coverage in Minnesota.

New York
Future cost premium increases are tied to the growth of New Yorker's incomes. Hospitals and other institutional providers are on global budgets, which include all their operating costs. Expenditures for new buildings or equipment are approved separately by an 18 member board of governors made up of representatives of consumers, business, labor, hospitals, doctors and non-physician health care professionals.

Individual practitioners would be able to choose fee-for-service, capitation or be salaried by a global budget institution. There would be no out-of-pocket charges for individuals, and no balance billing. Providers could also choose a set payment for each patient or be a salaried employee of a hospital or clinic.31

Unresolved Issues
In July, 2007 the Governor of New York directed the health commissioner and the insurance superintendent to draw up a plan by next summer for providing universal coverage that would take several years to carry out. The administration has cited a recent study saying universal coverage could cost the state $3 billion to $6.2 billion annually, but could also reduce costs for employers.

Ohio
Under the proposed legislation bill, the Ohio Health Care Board must limit administrative costs to 5% of the health system budget and must annually evaluate methods designed to reduce administrative costs. Under the bill, mandatory cost control measures may include, but are not limited to, the following: postponement of the introduction of new benefits or benefit improvements; postponement of new capital investment; adjustment of provider budgets to correct for inappropriate provider utilization; establishment of a limit on provider reimbursement above a specified amount of aggregate billing; any deferred funding of any reserve accounts; establishment of a limit on aggregate reimbursements to pharmaceutical manufacturers; imposition of an eligibility waiting period in the event of substantial influx of individuals into Ohio for the purpose of obtaining health care from the Ohio Health Care Plan. The bill requires the Ohio Health Care Board to prepare an annual operating budget for all care provided by facilities, group practices, and integrated health care systems, including the labor costs of providing care. All facilities, group practices, and integrated health care systems must submit annual operating budget requests to the Ohio Health Care Board and may choose to be reimbursed through a global facility budget or on a capitated basis. The Ohio Health Care Board is required to adjust the budgets on the basis of the health risk of enrollees; the scope of services provided; proposed innovative programs that improve quality, workplace safety, or consumer, provider, or employee satisfaction; costs of providing care for nonmembers; and an appropriate operating margin. 32

Oregon
The goal of the plan is to reduce unsustainable health care cost increases by shifting to a system of public and private health care partnerships that integrate public involvement and oversight, consumer choice and competition within the private market. The plan will use proven models of health care benefits,

service delivery and payments that control costs and over utilization, with emphasis on preventive care and chronic disease management within a primary care environment, and restructure the health care system so that payments for services are fair and proportionate among various populations and health care programs, and fund a high quality and transparent health care delivery system that allows users and purchasers to know what they are receiving for their money. The plan will be ensuring transparency of the costs of and charges by accountable health plans and providers, and by ensuring that the costs of health care are shared proportionately and equitably by the state, employers, health care providers and individuals. 33

Unresolved Issues
The commissions' and committee reports are pending.

Pennsylvania
The proposed legislation includes measures such as aggressive infection control procedures for medical centers; bonus payments for exceptional care; restoration of the state's certificate of need program requiring healthcare providers to demonstrate a need and gain approval before adding new medical services; and a statewide electronic medical records system. The bill would provide what it calls "fast and fair" compensation for medical malpractice claims through a "no-fault" system that gives patients the option of an automatic settlement at three times their annual salary or the traditional lawsuit route. Patients would sue the state trust fund, not individual participating healthcare providers. The bill would prohibit insurance companies from using anything other than age, geography and marital status to set rates. This community rating approach may spread risk and increase the number of people who could buy insurance which may reduce the rate of increase of future premiums. The bill calls for a greatly expanded role for nurse practitioners who would possibly provide comprehensive primary care less expensively than physicians. The bill would prohibit consideration of preexisting medical conditions in rate-setting and require that at least 85 percent of premiums be spent on health care costs as opposed to administrative overhead. The bill calls for hospitals to annually prepare community needs report with fines to hospitals that do not meet their stated community benefits as defined in the bill such as the amount of uncompensated care. 34

Unresolved Issues
There is uncertainty that the plan could reduce Pennsylvania health care spending by $7.6 billion through savings including reductions in medical errors and hospital-acquired infections, and increases in preventive care.

Washington
Specific cost controls in the law are the provision of cost and quality information for consumers and providers; reduction of unnecessary emergency room visits; reduce health care administrative costs; support community organizations that promote cost-effective care; and organization of the insurance market via the connector to make it more accessible to consumers. The law will reward quality health outcomes rather than simply paying for the receipt of particular services or procedures. It will also pay for care that reflects patient preference and is of proven value. The law requires the use of evidence-based standards of care where available and there is a tie provider rate increases to measurable improvements in access to quality care. 35

Unresolved Issues
There are a number of projects and recommendations that must be completed by state agencies in order fro the law to be implemented. For example, the Department of Social and Health Services and the Health Care Authority must initiate a number of efforts focused on quality improvements, including: developing a five-year plan by September 1, 2007 to change reimbursement to reward quality and incorporate evidence-based standards; report on trends in unnecessary emergency room use by December 1, 2007, and design a pilot to reduce such visits; and, in conjunction with Department of Labor and Industries and Department of Health, develop a five-year plan by September 1, 2007, to integrate disease and accident prevention and health promotion into all state health programs, and implement demonstration projects and evaluations of the projects, with reports to the Legislature December 2008, 2009, and 2010.

Wisconsin

In the proposed legislation**,** “Health Care Networks” will submit per-person bids to the Health Wisconsin Board of Trustees. A “Health Care Network” is defined as “a provider- driven, coordinated group of health care providers comprised of primary care physicians, medical specialists, physician assistants, nurses, clinics, one or more hospitals, and other health care providers and facilities, including providers and facilities that specialize in mental health services and alcohol or other drug abuse treatment.”

On the basis of their bids, these Networks will be divided into categories: those that are lower cost and higher quality and those that are higher cost and lower quality. There is no additional cost if a person chooses the lower cost network option. If they choose the higher cost network, they must pay, on a monthly basis, the difference in cost between the plans. There is a yearly deductible of $300 for a single person and $600 for a family. There is a $20 co-pay for office visits and hospital admission, except that there are no co-pays for preventive care, children, or for office visits for those participating in a chronic disease management program. Prescription drug co-pays are $5 generic, $15 brand name, and $40 for non-formulary drugs. Out-of-pocket expenses are capped at $2000 per adult or $3000 per family. 36

Unresolved Issues

Some estimates about the plan show that it would cost an estimated $15.2 billion annually -- $3 billion more than the state collects in taxes. The proposal would impose an employment tax on wages and "includes a tax escalator clause allowing an additional 1.5 percentage payroll tax to finance higher outlays in the future.”

TOPIC: PAYROLL PERCENTAGES

Massachusetts

House Bill 4479/Senate Bill 2282

The bills will redeploy current public funds to more effectively cover currently uninsured low income populations and make health care coverage more affordable. Individuals who earn less than 300% of the FPL and are ineligible for MassHelath will qualify for coverage. Premiums will be set on a slide scale based on household income.37

Unresolved Issues

The legislature wants to force employers with 11 or more employees to pay $295 annual fine for any employee with no health insurance.

According to the Department of Revenue, a penalty will be enforced for not having health insurance coverage which will amount to a loss of the personal exemption. For tax year 2008 and later, the penalty will increase to a portion of what an individual would have paid toward an affordable premium.

Vermont

House Bill 861: Health Care Affordability Act

House Bill 861 created the Catamount Health, which will provide affordable, comprehensive coverage for the uninsured. Catamount Health premiums are proposed based on the size per family and income. Premiums would likely be paid on a per enrollee per month basis. It is based on the claims costs of those enrolling in the program. Assuming the state would purchase reinsurance so that the reinsurer would pay 75% of all individual claims expenses during a year above $30,000—about 10% of overall expected spending. A 10% administrative fee was added to this calculation.38

California

According to the Governor's proposal (not yet in legislative language), the key advantages are that the universal coverage could be achieved; build on the existing health insurance structure; broaden risk sharing. The key concerns are high budgetary cost to state; future costs may lead to state budget pressures; some disruption to existing system; significant element of compulsion in individual mandate to have coverage.

Unresolved Issues

Governor's proposal is seeking to achieve universal coverage by establishing an individual mandate, extending eligibility for MediCal and Healthy Families up the income scale, provide subsidies for other lower-income people, requiring employers who do not provide coverage for their employees to pay a fee to the state, 4% of their payroll, which would help fund the subsidies. Also, requiring doctors to pay a fee equal to 2% of gross receipts and hospitals to pay a fee equal to 4% of net patient revenue and establish a purchasing pool to serve as a source for cost-effective coverage.

AB8

The key advantage is that 69% of uninsured would be covered; little disruption to existing industry; purchasing pool improves affordability of health insurance. The key concerns are high budgetary costs to the state; unchanged reimbursement may lead to inadequate doctor participation; new rules for insurers; possible long-run increases in health care costs.

Employers that do not spend at least 7.5% of Social Security wages for health coverage for employees would be required to 7.5% of payroll to the state.

SB 840

Universal Comprehensive coverage; substantial increase in efficiency and cost-savings; much easier navigation for providers and consumers and full portability; eliminates problem of uncompensated care. The key concerns are very high budgetary cost to the state; highly disruptive to insurance industry; less autonomy for providers (limits on payment rates, investment, additional regulations); could attract

chronically ill from other states; dramatic departure from status quo and major new government administrative mechanisms.

SB 840 will establish a single payer health insurance system. Assessing the equity of the financing is difficult because it represents such a major departure from the status quo and because some important elements are not yet specified. Premiums, co-payment and out of pocket expenses would be replaced by the new tax on wages, paid by both the employee and employer and by some additional income taxes on high-income people.39

Illinois

HB 311

In the amendments to HB 311, the state shall establish the Illinois Health Services Trust (IHST). One item addressed in the bill is that IHST shall provide a progressive set of graduation income contributions, which is 20% paid by the individuals, 20% paid by a business and 60% to be paid by the government.40

Pennsylvania

HB 700

According to HB 700, the Pennsylvania Consolidated Statutes is reforming the health care system by providing for access to affordable health insurance coverage for previously uninsured individuals and for small businesses, strengthening Commonwealth oversight of health insurance rate increases. Individual and small group health insurance rates are volatile. The Commonwealth must do the following, in order to ensure that affordable individual and small group health insurance is available:

- Contain health care coverage premium increases for small employers.
- Spread the risks
- Ensure that affordable health care coverage is available to those who have lost their employer-based coverage.
- Ensure that a substantial portion of the premiums for small employers is used to pay medical claims
- Require justification for premium increases.

TOPIC: PAY FOR PERFORMANCE

Maine

Maine Quality Forum

The Maine Quality Forum has been established as part of the Dirigo Health Agency to pursue initiatives to improve the quality of health care delivered in Maine. The Forum will collect and disseminate research, adopt quality and performance measures, coordinate quality data, issue quality reports in conjunction with the Maine Health Data Organization, conduct consumer education and technology assessment reviews, encourage the adoption of electronic technology, make recommendations for the State Health Plan and issue an annual report. The Forum works with an advisory group of health care providers, insurers, consumers and business representatives

Unresolved Issues

- Transition from current health care system to pay for performance system.
- Governance of new system
- Handling of budget for new system
- How will they be reimbursed? At what level? Can regional differences in the cost of health care technology and procedures, for example, between Maine and Massachusetts, be addressed?
- What mechanisms can be used to evaluate and ensure the quality of health care services provided under the plan?

Massachusetts

MassHealth

Under Chapter 58, MassHealth must begin a pay-for-performance program for hospitals beginning on October 1, 2007. An interagency workgroup has been working to develop a pay-for-performance model for hospitals and physicians. The workgroup has met with other payers in the Commonwealth to understand existing pay-for-performance initiatives. As provider involvement and input is critical to the success of pay-for-performance initiatives, the workgroup will begin meeting with hospital and physician representatives in January and February of 2007. MassHealth staff will also consult with the Quality and Cost Council and the MassHealth Payment Advisory Board before implementing the initiative.

Unresolved Issues

- Dedication and coordination efforts among Massachusetts state agencies, employers, insurers, and providers.

Vermont

Catamount Health

Catamount Health will tie Medical reimbursement for hospitals & health care professionals to Blueprint Standards and performance measures.

The plan will develop new payment recommendations to reward providers for high quality care and patient wellness.

Unresolved Issues

- A stable, sustainable funding structure with shared support from multiple sources
- Acceptable measures agreed upon by all parties involved.

TOPIC: INDIGENT FUNDS AND USES

Vermont
No later that October 1, 2007, subject to approval by CMS, the agency of human services will establish a premium assistance program to assist individuals eligible for or enrolled in the Vermont health access plan and uninsured individuals with incomes under 300 percent of the federal poverty guidelines and their dependents to purchase an approved employer-sponsored insurance plan if offered to those individuals by an employer. An otherwise ineligible person having a need arising out of a "catastrophe" may qualify for assistance. Emergency medical needs, including the repair of accidental injury, the diagnosis and relief of acute pain, the treatment of acute infection, the protection of public health, which if not immediately diagnosed and treated could lead to disability or death, qualifies as a medical catastrophe.41

Maine
Subsequent to the Dirigo Health Reform Act, municipalities in Maine had a statutory responsibility to provide medical care to the indigent under the state's general assistance statutes, and Maine had established an uncompensated care pool to provide hospital care to the state's poor.42

TOPIC: DIFFERENCE OF IMPACT ON URBAN/RURAL AREAS

Maine

Maine's Plan places a focus on strengthening Maine's local public health infrastructure. These considerations involve not only the infrastructure for health care delivery in rural areas, but on the systems aimed at promoting and preserving health. The health care delivery system continues to experience shifts in utilization patterns and a continuing trend in the movement of many types of services off of the hospital campus. This trend is unlikely to reverse itself and puts the future of the small, rural hospital into considerable flux. The impact of many of the changes already underway is being reflected in financial statements of many of these facilities. While Medicare and Medicaid payment policies at both the federal and state levels play a role in the financial health of small, rural institutions, the environment in which these organizations operate present the biggest challenge to their operating margins.
Hospitals facilities often provide critical services to their communities, providing, for example, 24-hour emergency department availability and local access to lab and imaging services. Local access to these kinds of services is vital to the integrity of a robust community. As the health care system continues to evolve, though, these facilities will find themselves serving more and more difficult or acutely ill patients, as healthier patients (and those less costly to care for) are diverted off campus to other sites of care. Patient volume will continue to decline and the fixed costs of operating a hospital – which are considerable – are left to be spread over a shrinking number of patients, contributing to the upward spike in the cost of care and leading to an increasing likelihood of patients passing by the local hospital for less expensive delivery sites.

The Governor's Office of Health Policy and Finance, in collaboration with the Maine Department of Health and Human Services, the Maine Hospital Association, the Maine Medical Association, the Maine Osteopathic Association and the Maine Primary Care Association will convene a study group to develop policy recommendations for addressing the challenges faced by Maine's small and rural hospitals and the infrastructure that interacts with those facilities to form the backbone of the rural delivery system. Participants in this group have to over-represent rural providers and consumers, although representatives of Maine's health care systems and insurers must also be included. The group will consider strategies that might be undertaken by communities, insurers, businesses, health systems, and health care professionals to meet the urgent and emergent health care needs of rural Mainers. Additionally, the group will develop recommendations regarding rural health policies, reimbursement policy, licensing policy and other related issues that might be undertaken by the state and/or federal governments with regard to this issue.43

TOPIC: ELECTRONIC MEDICAL RECORDS

Maine

Maine Quality Forum

The Maine Quality Forum is a part of Dirigo Health. It serves as a clearing house of best practices and information to improve health, and acts as an information resource for health care providers.

Purpose of the main quality forum is to consult with Main Quality Forum Advisory Council to:

- Promote and support systems of health care that use best clinical practices.
- Promote awareness of the need to use health care quality information as part of the decision making process for providers and patients.
- Provide information about health care quality so consumer can make informed decision about the care they receive.

Key initiatives are initial direction and seed funding for HealthInfoNet, a state wide electronic medical record (EMR) system.

Unresolved Issues

Computer Systems store medical records; they allow PCP providers to quickly and easily search records for information. Often, prescriptions are sent by computer or printed rather than hand written. Offices with EMR's may be better organized and more thorough than those without them. These systems are expensive and many physicians in small rural practices can not afford the electronic technology.

Vermont

VT H229 - Makes corrections and clarifications to the 2006 Health Care Affordability Act and related legislation.

- The Legislature requires that the state develop a loan and grant program to provide for the capitalization of electronic medical records systems at primary care practices. Health information technology acquired under a grant or loan authorized by this section shall comply with data standards for interoperability adopted by VITL and the state health information technology.
- As part of a collaborative effort, the RHIO will establish and manage electronic interfaces with a number of data sources as they become available (e.g., Electronic Medical Records (EMR's), Practice Management Systems (PMS), Labs, Payers, Pharmacies and Hospitals.

Unresolved Issues

The barrier is getting data into the system. This is a challenge because less than a quarter of the physician practices in the state currently have EMRs, and because other system have all been developed independently of one another.

For the effort to be cost effective, a common set of message standards need to be adopted by all electronic providers of information.

California

CA AB 53 would provide Universal Health Care coverage regardless of age, income employment or health statue.

- Section (e) "Establish electronic health records and personal health records that are compatible across system on statewide basis."

CA SB 320 would establish a Health Care Information Infrastructure to improve the quality of health and to reduce health care cost through advancement of health information technology.

Colorado

Co S 196 would create the Health Information Technology Advisory Committee to develop a long-range plan for health care information technology, including the use of electronic medical records and other methods of incorporating information technology in pursuit of greater cost-effectiveness and better patient outcomes in health care.

25-1-1401. - Section 3 (a) “On or before January 1, 2009, the committee shall develop a long-range plan for health care information technology, including the use of electronic records”.

Illinois
IL 1254 would create the Illinois Health Information Network Act. Requires the Department of Public Health to establish a not for profit corporation to plan the creation of state-level network for the electronic exchange among health care providers.

- Section 5 (a) “In order to advance the effective implementation and use of electronic health records through public-private partnerships, the Illinois Department of Public Health shall establish a not-for-profit corporation (ILHIN), by November 1, 2007. ILHIN shall plan for the creation of a state-level health information exchange using a federated model wherein complete patient electronic health records are stored, maintained, and updated by the treating health care provider, but access to key health data is provided to other providers of the patient, with patient consent, through secure interoperable record locator technology.”

Maryland
MD H 979 would alter the uses of the Community Health Resources Commission Fund to provide funding for a regional health data exchange; require the Health Service Cost Review Commission to provide funding of at least specific amount for regional health data exchange; establish eligibility requirements for an organization to receive funds.

- Provide funding for the development, support, and monitoring of Regional Health Data Exchange among primary and specialty care provider, hospitals and other providers of service to community health resources members. A regional health data exchange will carry forward the momentum created by the Task Force to study electronic health records.

Minnesota
MN S 2 - Implementation by January 1, 2015 all hospitals and health providers must have in place an interoperable electronic health records system. The Commissioner of Health, in consultation with the Health Information Technology and Infrastructure Advisory Committee, shall develop a statewide plan, including uniform standards.

MN H 297 - By January 1, 2015, all hospitals and health care providers must have interoperable electronic health record system. (Duplicate to MN S 2)

MN S 888 - The commissioner of health shall award grants to eligible community e-health collaborative project to improve the implementation and use of interoperable electronic health record.

MN H 842 - The commissioner of health shall award grants to eligible community e-health collaborative project to improve the implementation and us e of interoperable electronic health records. (Duplicate to MN S 888)

Electronic Health Records and Rural Health Care Grants - M.S.144.148, M.S.144.147, M.S. 144.1486, M.S.145.9268

As part of its initiative to speed the implementation of electronic health records and technology throughout the health care system, MDH is proposing a straightforward statutory change in several current programs to accentuate the department’s commitment to health information technology projects.

- The legislation adds specific language to these programs clarifying that electronic health records projects are eligible activities for state grant support and encourage and support the transition to electronic health records.

The legislation adds Electronic Health Records language to hospitals and clinics.
Hospitals:

- Rural Hospital Capital Improvement Grant Program (M.S.144.148)
- Rural Hospital Planning and Transition Grant Program (M.S. 144.147)

Clinics:

- Rural Community Health Center (M.S. 144.1486)
- Community Clinic Grant Programs (M.S.145.9268)

New York
Authorized the use of an electronic medical records system when dispensing certain schedule II controlled substances; defines electronic medical record system.

- Section 3335 - A physician may dispense directly to a pharmacy any controlled substance prescription pursuant to an electronic medical record system. Such physician shall be eligible and permitted to issue prescriptions through such electronic medical records system, including patients on Medicaid."

Washington
Chapter 114 - State health purchasing, reimbursement or pilot strategies, promote and increase the adoption of health information technology system, includes medical records, by hospitals as defined in RWC 70.41.020(4), integrated delivery system and providers facilitate diagnosis or treatment; (II) Reduce unnecessary duplication of medical tests.44

TOPIC: ELECTRONIC DEPOSITS

Minnesota

Uniform Electronic Transactions and Implementation Guide Standards

Minnesota is the first state in the nation to require all health care payers and providers to submit claims and eligibility transactions electronically using a common format starting in 2009. The new law was signed by Governor Pawlenty on May 25, 2007 as part of the state's Omnibus Health and Human Services funding bill (Minnesota Session Laws 2007 - Chapter 147). It adds a new section to the Minnesota Health Care Administrative Simplification Act, Minnesota Statutes, section 62J.536, entitled "Uniform Electronic Transactions and Implementation Guide Standards."

Minnesota Statute, section 62J.536, requires that beginning in 2009 all group purchasers and health care providers must electronically exchange the following four health care transactions: eligibility; claims; payment; and remittance advice. The electronic transactions must be in a standard format.

The new health care transactions rules will be developed by the Commissioner of Health, in consultation with the Minnesota Administrative Uniformity Committee (AUC), a voluntary, broad-based group representing Minnesota health care public and private payers, hospitals, health care providers and state agencies. The standards for the rules will be based on the Medicare program, with modifications the Commissioner deems appropriate after consulting with the AUC. The AUC has formed Technical Advisory Groups (TAGs) to reconcile diverse coding and conventions for health care transactions. Planning and initial work with the AUC and the appropriate TAGs is underway to develop the rules required by the new law by 2008, effective in 2009.

The rules for Uniform Electronic Transactions and Implementation Guide Standards must be developed at least one year prior to their effective dates.45

TOPIC: TELEHEALTH

Maine

After the Dirigo Health Reform Act was enacted into state law in June 2003, subsequent legislation, "An Act to Facilitate the Maine Quality Forum," established the state's requirements and organizational protocols for a statewide health information network and also specified the role of the Maine Quality Forum to support and assure the success and viability of the state's health information network. The Maine Quality Forum serves as a clearinghouse of best practices and information to improve health, and acts as an informational resource for health care providers and consumers. Additionally, the forum is responsible for creating quality standards and needs assessments for new medical technologies throughout the state.

The rapid growth and foundation of telemedicine in Maine, a rural and economically disadvantaged state, is largely attributable to the collaborative development efforts and service activities of the Maine Telemedicine Services (MTS). The mission of MTS is to improve community health and well-being in rural Maine by supporting health care, mental health, social service, government, and educational agencies to enhance access to their services through interactive videoconferencing (IVC) and other technologies. Working collaboratively, MTS, state government and other health care leaders are building an environment in Maine conducive to telemedicine, including favorable reimbursement and regulations.46

Massachusetts

The Massachusetts Health Care Reform Plan provided $5 million for the Massachusetts Technology Collaborative to spur the implementation of Computerized Physician Order Entry (CPOE) at community hospitals across the state. CPOE is a computer application that is used by physicians to enter diagnostic and therapeutic patient care orders. CPOE may reduce errors and adverse drug events, improves utilization of tests and medications, and possibly reduce the cost of care.47

Vermont

The Health Care Affordability Act established the premise for the Vermont information technology leaders (VITL), a broad-based health information technology advisory group that includes providers, payers, employers, patients, health care purchasers, information technology vendors, and other business leaders, to develop the health information technology plan, including applicable standards, protocols, and pilot programs. Two pilot programs, the medication history service, have been implemented at two Vermont hospitals. Patients in the emergency departments of the Rutland Regional Medical Center in Rutland and the Northeastern Vermont Regional Hospital in St. Johnsbury have the option of allowing their electronic medication history to be accessed. The opt-in rate at RRMC, the first hospital to go live on the service, is more than 99 percent.

The Blueprint for Chronic Care Information System is providing comprehensive data services to the Vermont Department of Health's Blueprint for Health Initiative, and its Chronic Care Information System. Physicians participating in the Blueprint for Health will record data about their patients with chronic conditions in a registry or an electronic medical record. The first condition being addressed is diabetes.48

<u>Unresolved Issues</u>

Vermont has identified here issues that are unresolved: funding for electronic medical records, incentives for physicians to adopt electronic medical records and train their staff, and balancing patient privacy issues with efficient data access.

California

The governor's proposal for a statewide health plan include a number of provisions to address cost containment issues including expanded and improved use of health care technology. As part of the governor's proposals, hospitals would be required to implement electronic prescribing of medications by 2010 and would be required to report data to reduce medical errors and hospital-acquired infections. California was one of the first states to allow Medicaid reimbursement for Telemedicine and eHealth services.

Colorado
Proposed legislation includes language to create a health information technology advisory committee to develop a long-range plan, on or before January 1, 2009, for health care information technology, including the use of electronic medical records, computerized clinical support systems, computerized physician order entry initiatives, regional data sharing interchanges for health care information, data privacy and security measures, and other methods of incorporating information technology in pursuit of greater cost-effectiveness and better patient outcomes in health care. It also requires the committee to pursue an interstate compact between (but not limited to): Arizona, Kansas, Montana, Oklahoma, New Mexico, North Dakota, South Dakota, Utah, and Wyoming, to create internal state HIT and HIE programs with the goal of connecting and exchanging information. Currently, there are not any specific health information technology components identified in the proposed legislation in operational status.

Illinois
Proposed legislation includes language regarding the establishment of an Illinois Health Information Network (ILHIN). The ILHIN's primary mission will be to establish a State-level health information exchange to facilitate the sharing of health information among health care providers within Illinois and other states and to foster the widespread adoption of electronic health records in the state's health care system.

Maryland
The proposed legislation to establish the "Maryland Universal Health Care Plan," does not include any provisions for telehealth or telemedicine in its proposed language. Another piece of proposed legislation, House Bill-979 entitled, "Health Information Exchange Pilot Project," provides language to establish a health information exchange pilot project; requiring the pilot project to be operated by the Maryland-DC Collaborative; requiring the pilot project to transmit specified information to participating health care providers in a specified manner and for specified purposes.

Ohio
Proposed legislation includes language to establish an Ohio Health Care Plan to provide universal health care coverage to all Ohio residents. The proposed legislation includes language to direct the Ohio Health Care Board to develop a centralized system of electronic claims and payments. There are not any additional provisions for telehealth initiatives contained in the proposed legislation.

Oregon
The "Healthy Oregon Act contains language to establish the Oregon Health Fund and Oregon Health Fund Board to create and administer a program to provide health care coverage for the state's residents. This specific bill contains limited language for the Fund and Board to develop health plan proposals focused on telehealth. Oregon Health Fund will develop proposals to use cost-effective information technology deliver efficient and quality health care and a voluntary program to provide every Oregonian with a personal, portable electronic health record.

Pennsylvania
Proposed legislation does not include specific provisions for health information technology components. Proposed language states, "Amending Title 40 (Insurance) of the Pennsylvania Consolidated Statutes, reforming the health care system by imposing certain health information technology requirements on health care providers." However, the proposed language does not specify any entities or initiatives to develop health information technology in the health care industry of the state.

Washington
Proposed legislation to provide affordable health care to Washingtonians is based on the recommendations of the State's Blue Ribbon Commission on Health Care Costs and Access. Proposed legislation includes recommendations to increase the adoption and use of information technology by the state's health care facilities and providers and with the goals to improve health outcomes, improve coordination of care, and decrease medical errors.49

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