Practitioners of Change:
Regional Case Studies in State Health Care Reform and Cost Containment

A Report of
The Council of State Governments’
Midwestern Legislative Conference

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Foreword

One of the biggest issues we face as state policymakers is the pursuit of quality, affordable health care for our constituents.

In one way or another, every one of our Midwestern states has felt the pinch of higher health care costs. These rising expenditures have been outpacing state revenue growth while also straining the budgets of the individuals and families we serve.

Meanwhile, legislators from this region have time and again heard pleas to reform their state health systems in a way that insures more or all residents, improves efficiencies, empowers consumers and leads to better health outcomes.

In this report, the Midwestern Legislative Conference offers examples of how our region’s states and provinces are trying to reform their health systems, with a particular emphasis on cost containment.

The case studies in this report are based on interviews with Midwestern state officials, legislators and experts, as well as data from the nation’s top sources in health policy.

Our goal with this report is to highlight and share some of the promising policy ideas being explored and implemented in the Midwest.

Today, our nation’s health care system is ripe for transformation, innovation and reform, and as the case studies in this report show, this region and its policymakers can help lead the way.

Senator Thomas Dempster, South Dakota
2008 Chair of the Midwestern Legislative Conference
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INTRODUCTION: ROOM FOR REFORM

Amid concerns about rising costs and the uninsured, states in the Midwest step up efforts to meet health care challenge

Policymakers get heavy dose of fiscal realities

Few challenges confronting policymakers today are as daunting as those posed by the rising tide of health care costs and their impact on state spending, economic competitiveness, public health and family finances.

After decades of growth at rates in excess of rising gross domestic product, state spending on Medicaid now accounts for 21.5 percent of all state expenditures, making it the largest single piece of the total budget pie.

And with costs continuing to rise at robust rates, health care finance and reform are sure to remain at the top of legislative agendas for years to come.

According to the U.S. Centers for Medicare and Medicaid Services, national health care spending was projected to exceed $2.2 trillion, or 16.2 percent of GDP, in 2007. And both of those numbers are expected to grow sharply — to $4.1 trillion and nearly 20 percent of GDP — in the next eight years alone.

By any measure, the United States already outspends other developed countries on health care, without necessarily achieving better overall public health. Yet the cost trend lines continue to point up.

Per-capita health care spending, which jumped 57 percent in the last seven years to just under $7,500, could grow to as much as $12,782 by 2016. According to the U.S. Congressional Budget Office, total health care spending may account for a full quarter of U.S. GDP by 2025.

Higher costs for businesses, workers

Many observers contend that public health care spending will, at current growth rates, prove unsustainable in the long run. And the impact of rising costs on private insurers, employers and individuals is no less worrisome.

American manufacturers already spend more than twice as much on employee health care benefits as do foreign firms, a fact that threatens U.S. competitiveness abroad, according to the New America Foundation. And a recent study by PriceWaterhouseCoopers suggests that employer health care costs will continue to rise by almost 10 percent annually over the next two years.

But with average worker contributions for family health insurance coverage having more than doubled since 2000, shifting the burden of additional premium increases to employees potentially creates other problems.

With only a few exceptions, premium increases have steadily outpaced worker earnings growth in each of the last 20 years, and since the beginning of this decade, premiums have gone up at two to three times the rate of earnings.

These trends mean employees and their families have to spend more just to maintain their current coverage, even though the share of total health care costs paid directly by consumers has fallen sharply since 1970.

Not surprisingly, the share of family income consumed by health care has grown steadily in recent years, with 19 percent of all U.S. families spending at least 10 percent of their earnings on health in 2003 (up from 16 percent in 1996).

The impact of this squeeze was reflected in a recent study commissioned by the Kaiser Family Foundation, in which almost 25 percent of respondents reported that access to health care benefits had played a key role in the employment decisions made by family members within the past year. Seven percent of those surveyed said that they or someone in their household had married to gain insurance coverage for a spouse.

Future challenges ahead

Even with a strong economy, the factors contributing to rising health care costs (new technologies, demographic trends, chronic diseases, hospital construction, drug prices, etc.) will continue to pose challenges for state and provincial policymakers well into the future. One challenge among many is the aging population, including a dramatic growth
in the number of seniors as the baby boomer generation gradually retires.

Older Americans (those over the age of 65) already account for more health care spending than any other age group ($8,647 per person in 2004, 86 percent more than for those in the 45-64 age range), and their numbers will grow sharply in the years to come.

While the overall population in Midwestern states is projected to rise 9.5 percent by 2030, the number of seniors in the region is projected to grow at much higher rates — from 52 percent in Iowa to 108 percent in Minnesota — further fueling the demand for health care by the most expensive segment of consumers.

Potentially compounding such challenges are the problems flowing from an economic downturn, including higher unemployment, a growing number of uninsured, and increasing demand for public health coverage at a time when states are least likely to be able to afford it.

A recent study for the Kaiser Family Foundation concluded that a one-point increase in unemployment typically results in 1.1 million additional Americans without health insurance. The aggregate impact on Medicaid and the State Children’s Health Insurance Program comes to $3.4 billion, with $1.4 billion coming directly from the states.

But since a one-point increase in unemployment also typically means that state revenues decline by between 3 percent and 4 percent, the budgetary challenge to state lawmakers is even greater.

Controlling costs is one common refrain in the call for health care reform. Another is reducing the number of people without health insurance.

More than ever before, national health care expert and former U.S. senator David Durenberger says, those two objectives — cost containment and increased access — are inextricably linked.

“You’re not going to get to universal coverage in this country unless you bring down costs,” says Durenberger, founder of the Minnesota-based National Institute of Health Policy. “That’s what is different this time around compared to efforts in previous decades to achieve universal coverage.”

On the flip side, Kansas Sen. Jim Barnett says, states cannot adequately improve efficiencies and restrain expenses without a system that covers more people.

“Fundamentally, to control costs and improve health, we have to provide better access,” notes Barnett, a physician. “That gets into a deep discussion as to how to get there, but we have to find a way to take care of the uninsured.”

Expanding access leads to more patients being treated in a primary-care clinic instead of an emergency room, Minnesota Sen. Linda Berglin says, and means that costly chronic diseases are more likely to be prevented, detected early and managed more effectively.

But improving access to care also can require a greater investment of public dollars, at a time when fiscal conditions are tight and health care already is consuming more and more of state budgets.

Common concerns, solutions

Containing costs and expanding access aren’t all that many of the health reforms in the Midwest have in common.

Other recurring themes include an increased emphasis on prevention and wellness, changes in how care is delivered or providers are paid, and the push for a greater use of evidence-based health practices.

(continued on page 6)
In Minnesota, for example, Berglin says the centerpiece of her state’s 2008 legislative reforms was “cost containment through payment reform.”

“We needed to change the payment system so that providers could do a better job of treating people with chronic diseases,” she notes.

Rather than just pay for “10-minute office visits,” she says, the system is being altered to reimburse providers for better managing the care of high-risk, high-cost patients, reducing hospitalization rates and improving overall health outcomes.

The 2008 reforms in Minnesota also invest more in public health programs to curb smoking and obesity rates, seek to increase transparency and provider competition on price and quality, and expand the use of health information technology.

**Visions of a better system**

As a practicing physician and state lawmaker, Barnett is in a unique position to see some of the shortfalls in the current system and appreciate the impact that various health care reforms could have.

One notable example is health information technology.

At his medical office, Barnett is able to use an electronic medical system.

“I don’t like to touch a paper chart,” he notes.

But the system is not so advanced at the hospital where he works.

“We use a combination of the two, and it’s a duplication, it’s inefficient and it’s costly,” Barnett says.

The same can be said of the entire current system, he believes.

“With a statewide or community-based health record, what you do is avoid duplication of services or procedures and improve quality,” he says. “There are many patients harmed and lives lost, for instance, just from one doctor prescribing and another not knowing it.”

—Kansas Sen. Jim Barnett

Durenberger notes, too, that quality care in general needs to be a greater priority in the nation’s health system.

“We should be paying only for evidence-based value,” he believes.

According to Barnett, many of the inefficiencies and high costs in the current system can be traced back to the current lack of emphasis on evidence-based care.

“We waste enough health care money in this country to take care of all of the uninsured,” he says.

“Right now, we just assume everything that a doctor prescribes or a hospital provides will improve health. That’s not true. Americans think the more they pay, the better the result. That’s not true.”

**Case studies in reform**

Health information technology, quality and evidence-based medicine are among the issues that arise when states look to reform their health systems. Other issues include transparency, personal responsibility, wellness, and chronic disease prevention and management.

The case studies in this report focus on how some of these issues are being addressed in the Midwest, and how they relate to some of the fundamental goals of health care reform, including cost containment and improved access.

In 2008, health care reform, or “transformation,” captured headlines in states such as Iowa, Kansas and Minnesota. Over the past few years, either through highly publicized legislative initiatives or little-noticed bureaucratic changes, all states in the Midwest have been actively pursuing ways to improve their health care systems.

As Barnett notes, and this report underscores, states are rightfully seen as “incubators of change” in today’s health care system.

Combined, the different sections in this report of The Council of State Governments’ Midwestern Legislative Conference show how states are experimenting with various new policy approaches.

Two case studies, for example, look specifically at how Illinois and Indiana recently have expanded the reach of their public insurance programs.

Illinois is using savings from newly developed care-management initiatives to help expand coverage to all children. In Indiana, state policymakers are increasing health coverage under a program that emphasizes the importance of preventive care and personal responsibility in health care.

Other case studies in this report hone in on specific initiatives to improve efficiencies and control costs, such as efforts in Minnesota to promote health information technology, in Wisconsin to curb expenses.
Over the past few years, either through highly publicized legislative initiatives or little-noticed bureaucratic changes, all states in the Midwest have been actively pursuing ways to improve their health care systems.

related to state employee health benefits, and in Iowa to strengthen disease prevention and management.

This study also takes a look at how policymakers have tackled or are trying to address some of the major health care cost-drivers impacting state budgets.

Different case studies examine how Michigan became a national leader in controlling the cost of prescription drugs, where Medicaid reform may be headed in Nebraska, and why North Dakota will face significant challenges to its long-term care system in the years ahead.

In Kansas, the first step toward health reform was to change how the system is administered as well as how state policies are developed and implemented. This report’s case study for Kansas, then, looks at the formation and work of its new Health Policy Authority.

“It’s the best thing we’ve done in a while,” Barnett says of the authority, “because the level of discussion regarding reform has been at a higher level and has been more robust.”

The case studies for Ohio and South Dakota examine those states’ experiences with two other trends in health care reform. The Ohio section looks at how the state is increasingly incorporating managed care and “pay for performance” initiatives into its Medicaid program.

The South Dakota case study, meanwhile, focuses on a new Web-based initiative to improve the transparency of hospital pricing for the state’s health care consumers.

Organization of report

In choosing the subjects for the different case studies, our goal was not to highlight the “best” or even necessarily the most “significant” reforms in a particular state. Instead, we chose a mix of subjects that, when combined, provide a snapshot of some of the key policy issues and trends in health care.

The appendix in this report offers a perspective from the region’s provinces, with a look at how policymakers there are trying to address Canada’s health care challenges.

Information for the case studies was gathered by CSG Midwest staff through interviews with state legislators, governors’ staff, health agency officials and national health experts.

The case studies were written by Tim Anderson and Kathryn Schneider. The introduction was written by Mike McCabe and Tim Anderson. Mark Wyatt and Mark Goossens of Saskatchewan Health were the principal authors of the appendix article.
Caring for kids: Illinois uses costs savings to expand health coverage to all children

Lacking health insurance can take a financial, psychological and physical toll. Many note, too, that unemployment places a financial burden on the rest of the population.

In 2010, nearly 52 million Americans are expected to be without health insurance, according to Families USA. By then, says the nonprofit health advocacy organization, care for the uninsured is expected to account for more than $60 billion in uncompensated health costs.

Some of these costs will be absorbed by health providers, and state and federal budgets will take a hit as well. But the increased cost will also affect Americans who do have insurance in the form of higher premiums. By 2010, families who receive health benefits at work can expect to pay $1,500 more in premiums due to the unreimbursed costs of treating the uninsured. Average premiums for individuals will be more than $500 higher, according to Families USA.

Many policymakers argue that one of the most effective ways to reduce uncompensated care costs is to expand coverage to more uninsured residents.

In recent years, covering children has been a top policy priority for many states.

Illinois became a leader in this area in 2006 when policymakers successfully implemented the nation’s first universal coverage program for children. Legislation creating the All Kids program, HB 806, was approved by the General Assembly in 2005 and signed by Gov. Rod Blagojevich, who had championed the measure.

The All Kids program offers coverage to every child, regardless of income, health status or citizenship.

It builds upon the State Children’s Health Insurance Program (SCHIP) but is completely financed by state funds. Illinois’ expansion of SCHIP offers publicly financed coverage to families with incomes up to 200 percent of the federal poverty level.

For families above that threshold, All Kids offers a buy-in option, with premiums charged on a sliding scale based on income. Preventive care is free for all participants, regardless of income, and cost-sharing is designed to be affordable for low-income families.

In pushing for the plan, Blagojevich and other proponents frequently hailed its cost effectiveness. Instead of allowing 250,000 children to go without insurance, they said, All Kids would provide young people with preventive care, thus reducing the need to pay for costly medical care in the future. Supporters also said overall medical costs in the state would fall thanks to a decline in uncompensated care.

According to the Kaiser Family Foundation, the program reached its target enrollment goal in its first nine months.

Funding the program

The program’s cost was offset in its first year through a set of managed-care initiatives aimed at trimming the state’s health care budget.

Together, the Primary Care Case Management (PCCM) and Disease Management (DM) programs produced $34 million in net savings in fiscal year 2007, enough to cover the roughly $23 million needed to pay for the All Kids expansion, according to the governor’s office. The two managed-care programs were aimed at realizing per-beneficiary savings, including in costly adult populations, in order to free up funding for the children’s health expansion.

Illinois’ PCCM program, known as Illinois Health Connect, was launched in July 2006 and enrollment continued in phases through November 2007.

Program participants were asked to select a medical home, where ongoing care can be coordinated. As of spring 2008, about 1.7 million individuals statewide who receive their health care through state programs, including Medicaid, were participating.

Patients are encouraged to complete necessary preventive care through their regular physicians, who receive monthly electronic updates on services due for each patient. Claims histories, which include medical data such as medications, immunizations and procedures, are designed to help physicians make more informed treatment choices.

The state is also in the process of launching an outreach program aimed at improving children’s health. The new program will educate beneficiaries about the preventive health screenings that children should receive in order to assure health problems are addressed early in life.

Participants in Illinois Health Connect have access to a service that allows them to call a nurse for medical advice, including whether or not they need to visit the emergency room, where care can be costly.

Under the program, the state works with a network of 5,200 providers, which have the capacity to serve as medical homes to up to 5.3 million patients.

Your Healthcare Plus, the state’s disease-management initiative, takes primary care management a step further by providing more comprehensive support to patients with more extensive health care needs.

QUICK FACTS ON ILLINOIS HEALTH CARE

| Medicaid expenditures as % of total state spending (FY 2006): 26.2% |
| Health care spending as % of total Gross State Product (2004): 12.2% |
| Average annual growth in health care spending (1991-2004): 6.1% |

| Residents’ health insurance status/ coverage (2005-’06): Employer, 59%; Individual, 4%; Medicaid, 11%; Medicare, 12%; Other Public, 0%; and Uninsured, 14% |

Sources: National Association of State Budget Officers, U.S. Centers for Medicaid and Medicare Services and Kaiser Family Foundation’s statehealthfacts.org
Many states have made children’s health coverage a priority, and several have looked to Illinois as a model. Between July 2006 and January 2008, two-thirds of U.S. states expanded access to Medicaid and the State Children’s Health Insurance Program (SCHIP) for children and their families, according to the Kaiser Family Foundation. Below are some examples of recent children’s health expansions in the Midwest:

• Wisconsin’s BadgerCare Plus, launched in February 2008, aims to provide affordable access to all children through a major restructuring of the state’s health programs. Policymakers plan to pay for the program through streamlining the administration of several programs, moving beneficiaries to managed care and using the state’s buying power to provide insurance plans with affordable premiums for families of all incomes.

• During the 2008 session, Iowa legislators approved a measure that raises the income eligibility level to 300 percent of the federal poverty level for HAWK-I, the state’s health program for children in low- and moderate-income families. The legislation, HF 2539, is expected to provide coverage for 50,000 uninsured Iowa children.

• As part of the 2007 omnibus health and human services appropriations bill, Minnesota lawmakers passed a measure aimed at enrolling 30,000 additional children in publicly funded health programs. The additional enrollments, which will be achieved through eligibility changes and increased outreach, are expected to begin in October 2008.

The program serves about 220,000 patients, including disabled adult Medicaid beneficiaries, children with asthma and frequent emergency-room users.

Nurses and social workers work closely with patients and health care providers to assess and manage chronic health conditions in order to reduce the incidence of costly health emergencies. Program staff members work with patients on issues such as nutrition and housing to help manage factors that play into chronic conditions.

The governor’s office says that during the program’s first year, Your Healthcare Plus lowered inappropriate inpatient and emergency department admissions and improved key clinical indicators for clients, which helped result in savings.

The state saved $34 million in FY 2007, after accounting for the increased cost of care management. Cost savings are calculated by comparing the estimated average cost of a patient’s care before and after program implementation.

"Instead of just determining eligibility and paying medical bills, the state is now an active participant in the process, to make sure our clients are getting regular checkups and preventive care," Illinois Department of Healthcare and Family Services director Barry Maram says.

Because the state was able to realize such significant cost savings in health care, policymakers were able to make another goal a reality: helping provide more children with health insurance.

Other cost-containment/reform strategies in Illinois

Below are some examples of other cost-saving initiatives in Illinois:

• The state has achieved significant savings in its purchase of health care for state employees and retirees with reforms such as adopting managed-care programs and negotiating rates with insurance providers. According to the Office of Healthcare Purchasing, the state saved a total of $164 million in fiscal years 2007 and 2008 with these efforts.

• Through several cost-saving initiatives, the Department of Health Care and Family Services estimates it saved $452 million on Medicaid in FY 2005 and 2006. Efforts included limiting the types of over-the-counter medicines covered, requiring prior approval for brand-name prescriptions, adding co-pays to community health center visits and renegotiating rates in voluntary managed-care programs.

• In FY 2009, the department expects to save $78 million by adjusting fees paid to automated labs and offering incentives to pharmacies to dispense generic drugs when medically appropriate.
In the search for strategies that better control costs and reform health systems, policymakers in recent years have explored ways to encourage more personal responsibility through what often has been referred to as “consumer-driven health care.”

In particular, interest in health savings accounts has grown in recent years as insurance premiums skyrocket and consumers and employers look for ways to trim costs. Proponents say these accounts encourage the responsible use of health care because patients are paying for care directly out-of-pocket, unlike traditional insurance plans that take on the cost of most services after a deductible is met.

Indiana has become a national leader in consumer-driven health care, thanks to legislation passed in 2007 making it the first state to expand Medicaid through the use of health savings accounts.

**Expansion covers more low-income adults**

Since 2000, Indiana has seen steady increases in the rate of uninsured residents, and each year the rate of growth has exceeded the national average.

By 2007, approximately 561,000 state residents were without health insurance. Nearly two-thirds of them were working-age adults—a population not usually eligible for Medicaid or Medicare—with incomes at or below 200 percent of the federal poverty level.

The Healthy Indiana Plan (HIP), approved in 2007 by legislators and Gov. Mitch Daniels, combines state-subsidized health insurance with health savings accounts to help cover more uninsured Hoosiers. HB 1678 increased the tax on cigarettes by 44 cents to generate revenue to support the program as well as other health reforms.

To be eligible for the Medicaid expansion, residents must be between the ages of 19 and 64, uninsured for at least six months, and earning an income of no more than 200 percent of the federal poverty level.

Under HIP, enrollees are provided with up to $500 in free preventive care. If additional care is needed, patients can draw on funds in their Personal Wellness Responsibility (POWER) accounts.

Enrollees pay into the POWER accounts on a sliding scale based on income, and the state supplements their contributions to bring the balance to $1,100.

Enrollee contributions are capped at 5 percent of an individual’s or family’s gross income, with many participants paying less.

A single childless adult making $10,000 per year, for example, would contribute $17 per month to the POWER account, or about 2 percent of his or her annual income. A family of four with an income at 200 percent of the poverty level (about $40,000) would contribute $105 per month—about 4.5 percent of its annual income.

Thanks to various outreach efforts, the program has been greeted with unexpectedly high levels of interest from residents. While program administrators expected 4,500 applications in the first month, they received 20,000.

As of April 2008, about 4,700 residents were enrolled and the state had received a total of 36,000 applications.

Policymakers believe HIP will produce long-term cost savings by promoting personal responsibility and improving rates of preventive care. In addition, expanding coverage to more residents is expected to reduce the amount that individuals indirectly spend on uncompensated care for the uninsured.

In 2005, state officials say, Indiana families paid an additional $953 in annual premiums to cover the cost of caring for the uninsured.

**Incentives for better health decisions**

One of the goals of HIP is to provide an incentive for patients to complete preventive care, which can avoid potentially costly medical care in the future.

If enrollees have completed all of their necessary preventive care and screenings, their POWER account balances can be rolled over from year to year, which reduces their future premiums.

If funds in a patient’s POWER account are depleted, a traditional insurance plan kicks in to cover additional medical costs.

HIP proponents say that, unlike traditional entitlement programs, patients are encouraged to use medical services responsibly—and find the best prices—because their own money is partially at stake.

The program only charges co-pays for emergency-room visits that are deemed unnecessary—a measure that is expected to decrease the use of costly emergency care for issues that can be handled, for example, in a doctor’s office.

Indiana health officials expect to have enough funding to enroll 130,000 Hoosiers.

**Funding HIP, reducing smoking**

Funding for HIP was provided mostly through a 44-cent-per-pack increase in the state’s cigarette tax.

Most of the revenues generated by this new tax will go into a new state trust fund, which is expected to provide $129 million for HIP in 2008. The program will also

**Quick Facts on Indiana Health Care**

<table>
<thead>
<tr>
<th>Medicaid expenditures as % of total state spending (FY 2006):</th>
<th>21.6%</th>
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<tr>
<td>Health care spending as % of total Gross State Product (2004):</td>
<td>14.4%</td>
</tr>
<tr>
<td>Average annual growth in health care spending (1991-2004):</td>
<td>6.8%</td>
</tr>
<tr>
<td>Residents’ health insurance status/coverage (2005-06):</td>
<td>Employer, 60%; Individual, 4%; Medicaid, 11%; Medicare, 11%; Other Public, 0%; and Uninsured, 13%</td>
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</tbody>
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Sources: National Association of State Budget Officers; U.S. Centers for Medicaid and Medicare Services and Kaiser Family Foundation’s statehealthfacts.org.
Along with Indiana, a vast majority of other U.S. states have decided to raise cigarette taxes in recent years.

According to the Campaign for Tobacco-Free Kids, 43 states have raised their per-pack rates since 2002.

These tax increases have received widespread support because of their potential to raise state revenues and discourage smoking among residents.

The average per-pack state tax on cigarettes, as of April 2008, was $1.14. Here are some of the most recent examples of cigarette-tax increases from the Midwest:

- A year after Iowa legislators approved a $1-per-pack increase in the state's tobacco tax, sales dropped by 36 percent, according to state officials.
- Wisconsin's cigarette tax increased $1, to a total of $1.77, beginning July 1, 2008.
- In 2007, South Dakota's cigarette tax increased by $1, making the total state tax $1.53 per pack.

Along with making it more expensive to use cigarettes, state legislatures are enacting tighter restrictions on where people can smoke.

In 2008, Iowa and Nebraska became the latest states in the Midwest to pass indoor-smoking bans.

## Smoking target of new state taxes, laws

### Use of health savings accounts on the rise

While Indiana is the first state to use health savings accounts to expand its Medicaid program, HSAs have been available in the private market since 2004.

That year, federal legislation took effect to authorize tax-advantaged health savings plans to be used in conjunction with high-deductible health insurance plans.

Since then, HSAs have grown in popularity as consumers and employers look to reduce their health care costs.

The number of consumers using HSAs increased tenfold — from roughly 438,000 to 4.5 million — between September 2004 and January 2007, according to the U.S. Government Accountability Office.

Proponents say HSAs are an attractive option for some consumers because the premiums associated with them are lower than in traditional plans. HSAs also allow tax-free accumulation of funds for future health expenses.

In addition, some believe that the high-deductible plans force patients to be more educated health consumers because their initial expenses are paid out-of-pocket.

Critics point out that the plans are most attractive to the young and healthy. When these lower-cost consumers are drawn out of traditional health plans, critics say, those who remain in these plans face higher premiums.

Data show that HSAs also tend to attract wealthy health consumers. According to IRS data cited by the GAO, the average income of an HSA holder in 2005 was $139,000 — significantly higher than the average tax filer’s income of $57,000.

Therefore, some argue, these plans currently have little effect on decreasing the number of low-income, uninsured Americans.

To read the report, visit www.gao.gov/new.items/d08474r.pdf.

*Figures indicate only state cigarette taxes and do not count local taxes or the federal charge of 39 cents per pack. Source: Campaign for Tobacco-Free Kids

### Use federal matching dollars, according to the Kaiser Family Foundation.

Of the new tax, 3 cents on each pack is being used to provide a rate increase for primary-care physicians treating Medicaid patients. Proponents expect the measure to create an incentive for more physicians to participate in Medicaid and therefore increase access to preventive care.

About $11 million in new revenue from the cigarette tax is being directed toward programs to provide immunizations for children.

In addition to funding the Medicaid expansion and several other health reforms, proponents hope the cigarette-tax increase will discourage more Hoosiers from smoking, a habit that substantially increases the risk of many life-altering and costly diseases.

A portion of the tax increase will fund smoking-cessation programs. State officials also expect the increased cost of buying cigarettes to discourage more Hoosiers — especially young people — from starting the habit in the first place.

Indiana has one of the highest rates of cigarette use in the country. According to state officials, 27 percent of state residents smoked in 2005 — well above the national average of 20 percent.

Each year, medical costs related to smoking reach $1 billion in Indiana. Of that total, Medicaid takes on $400 million of the cost burden, according to state data.
When policymakers look for the source of rising health care costs, it doesn't take long for them to begin focusing on the fiscal impact of chronic diseases.

And conditions such as diabetes, heart disease, cancer and asthma take much more than a financial toll. They also adversely affect and, ultimately take, millions of lives.

Seven of every 10 Americans who die each year, or more than 1.7 million people, die of a chronic disease, according to the U.S. Centers for Disease Control and Prevention.

The leading cause of disability in this country, the CDC says, chronic disease significantly limits the daily activities of one in 10 Americans.

In all, more than 130 million U.S. citizens — nearly half the population — were living with some type of chronic condition in 2005.

All told, chronic diseases account for 75 percent of the $2 trillion spent on health care in the United States. Federal data estimate that the cost of heart disease and stroke alone will be $448 billion in 2008.

“The United States cannot effectively address escalating health care costs without addressing the problem of chronic diseases,” the CDC says.

These common health problems are often preventable, many health experts say, because they are frequently linked to obesity or unhealthy behaviors such as smoking.

Data show that investments in prevention have the potential to yield net cost savings. For example, for every $1 spent on preconception care for mothers with diabetes, more than $5 is saved in treatment for complications, the CDC has found.

In response, many states have ramped up efforts to promote healthy lifestyles and disease prevention. Iowa is a case in point.

Lawmakers there have made wellness a fundamental piece of their overall health care reforms.

**Steps toward a “healthy Iowa”**

Like policymakers in many other states, Iowa legislators have taken notice of the recent upward trends in health care spending.

Health insurance premiums more than doubled in Iowa between 2000 and 2008 — from $149 million to $316 million. By 2012, premiums are expected to total $420 million statewide.

State officials blame the increases in large part on the rise in unhealthy lifestyles, and they hope legislative actions taken in 2008 begin to tackle the problem.

In passing HF 2539 and other bills, legislators followed through on the work that had been done in the previous year by the Lieutenant Governor’s Commission on Wellness and Healthy Living. In an October 2007 report, the group identified five steps the state could take toward a “healthy Iowa.”

The reforms passed in 2008 aim to meet four of these objectives:

- removing unhealthy food from schools;
- improving the health of Iowa’s children;
- strengthening anti-smoking legislation; and
- promoting wellness and the use of preventive health services.

**Push for prevention**

The first two objectives were the focus of the Iowa Healthy Kids Act, which was included as part of the health and human services appropriation bill and targets a reduction in obesity rates among the state’s schoolchildren.

Under the legislation, a Nutrition Advisory Panel will be created and develop standards for the nutritional content of food sold in schools. The state’s Area Education Agencies must hire dieticians to help implement the panel’s new standards.

Also under the legislation, all students in kindergarten through 12th grade will be required to participate in at least 30 minutes of physical activity each school day.

Obesity wasn’t the only target of Iowa legislators in 2008; they also hope a new statewide smoking ban limits the adverse health effects of cigarette use. HF 2212 requires all bars and restaurants in Iowa to be smoke-free.

Most of the state’s other health reforms were included in HF 2539.

In part, the legislation created the Healthy Communities Initiative program, which will provide $900,000 in grants to support local efforts to encourage healthy lifestyles, promote wellness and reduce chronic disease rates.

In addition, the Iowa Department of Public Health has been directed to establish the Governor’s Council on Physical Fitness and Nutrition. The 12-member panel — which will be made up of health care and nutrition professionals, educators and other experts — will develop a statewide plan to increase physical activity, improve nutrition and promote healthy behaviors among state residents.

The council must deliver its recommendations to the legislature by December 2008. It also will partner with local communities to create the Governor’s Physical Fitness Challenge, an education and awards program encouraging Iowans to lead healthy lifestyles.

**CA S E S T U D Y: I O W A**

**Prevention as a cure: Iowa emphasizes wellness of citizens as part of overall health reforms**

**QUICK FACTS ON IOWA HEALTH CARE**

| Medicaid expenditures as % of total state spending (FY 2006): | 18.1% |
| Health care spending as % of total Gross State Product (2004): | 13.7% |
| Average annual growth in health care spending (1991-2004): | 6.4% |
| Residents’ health insurance status/coverage (2005-'06): | Employer, 59%; Individual, 6%; Medicaid, 13%; Medicare, 12%; Other Public, 1%; and Uninsured, 9% |

Sources: National Association of State Budget Officers, U.S. Centers for Medicaid and Medicare Services and Kaiser Family Foundation’s statehealthfacts.org
New measures to promote wellness and healthy lifestyles were only part of a major health care reform bill passed in 2008 by Iowa lawmakers. HF 2539 included numerous other provisions that aim to improve the system and expand access to care. Below are some of the specific measures included in the bill.

- Unmarried college students can now stay on their parents’ health insurance plans through age 25.
- HF 2539 eliminates barriers for individuals with pre-existing conditions wanting to move from a group health insurance plan to the individual market.
- Lawmakers established the goal of covering all children in the state by 2010 and authorized $25 million over three years to expand the state’s health insurance program. Pending federal approval, the program will include children in families with incomes up to 300 percent of the federal poverty level.
- The legislature expressed the goal of establishing universal health coverage for all adults by 2013.
- A Medical Home Advisory Council will be established and directed to coordinate the more widespread use of medical homes.
- The state Department of Health will form an advisory group to study the increased use of information technology and the creation of a statewide electronic health system.

Iowa already has a targeted disease-management program for state employees. The voluntary program is offered through the employees’ insurance plans and focuses on specific conditions, including diabetes, asthma and heart disease.

Patients are provided with individualized care, educated about their condition and given recommendations for improving their health.

For every dollar spent on the disease-management program in 2006, Iowa officials say, the state saved $3.14 in medical costs. The savings were realized through a decrease in hospital admissions, the lengths of hospital stays and emergency-room visits.

The governor’s office wants to expand the program so that it focuses not only on disease management, but also disease prevention among state employees.
By the middle of this decade, Kansas policymakers had compiled a long list of improvements that they thought should be made to the state’s health care system.

For starters, they wanted to reduce administrative costs, noting that up to 30 percent of the money spent by Kansans on health care went toward overhead expenses.

Policymakers also wanted to bolster the state’s purchasing power in the health care market, enhance the quality of care provided to Kansans, lower the number of uninsured residents, and strengthen wellness and prevention efforts.

The question for lawmakers was, Who should get the list and be charged with making the improvements?

Their search for an answer led to one of the most significant reorganizations in the history of Kansas state government.

Starting with structural changes ordered by Gov. Kathleen Sebelius and then culminating with the 2005 Legislature’s passage of SB 272, an independent state agency known as the Kansas Health Policy Authority (KHPA) was created.

The KHPA is unique in the scope of the duties it has been given, how it has been structured, and how its work is being overseen.

The agency now has responsibility for administering $2.5 billion in public programs — from Medicaid and children’s health insurance, to state employee benefits and workers’ compensation.

It also has been charged with

• developing policy strategies for lawmakers;
• collecting and analyzing health data for consumers, policymakers and providers; and
• transforming the health system in a way that increases efficiencies, improves quality of care and leads to better health outcomes.

The KHPA is guided by a nine-voting-member board, which is made up of health experts from outside of Kansas state government (some state agency heads are nonvoting, ex-officio members).

The board is appointed by the governor and legislative leaders, with all appointees subject to Senate confirmation. A joint legislative committee oversees the authority’s work, and the KHPA’s executive director must be confirmed by the Senate.

The state’s experiment with this new type of government structure is expected to last at least eight years. SB 272 calls for the KHPA to sunset on July 1, 2013, unless it is re-established by the Legislature.

Objective decision-making environment

On the administrative side, the KHPA points to several promising initiatives that already have been implemented as well as others in the planning stages (see sidebar story for some examples). It is too early to tell, KHPA officials say, exactly how much the state will save every year by combining its health purchasing power through the authority.

But the new agency’s ultimate success may rest on its ability to develop meaningful and workable health policy reforms.

Connie Hubbell, chair of the KHPA board, has noted that the authority’s unique structure was designed to encourage “decision-making and idea fostering … not affected by other political forces that commonly affect state agencies.”

“The authority plans to take advantage of this objective decision-making environment,” she said in 2006 testimony to the Legislature’s Joint Committee on Health Policy Oversight.

Three years after being established, the KHPA has emerged as a leading voice for change in state health policy.

However, in its short history, the authority has mixed success in getting its policy ideas through the Legislature.

New authority on health: Kansas using independent state agency to administer health programs, lead reform efforts

Back to the drawing board

In 2007, the Kansas Legislature passed SB 11, a measure that in part directed the KHPA to craft a comprehensive reform plan in time for the 2008 session.

To follow through on this directive, the authority conducted months of data analysis, held public hearings and coordinated meetings of various KHPA advisory councils.

In November 2007, the KHPA delivered a 21-point plan to lawmakers that focused on three areas of health reform, with specific policy proposals for each.

• Encourage greater personal responsibility — Proposals included 1) funding a health transparency project and 2) providing financial incentives to providers who adopt health-literacy practices.
• Promote medical homes and pay for prevention — Proposals included 1) increasing Medicaid reimbursement rates for primary care and prevention services; 2) increasing state support for cancer screenings and local wellness programs; 3) restricting access to unhealthy foods in schools and strengthening K-12 physical fitness requirements; 4) banning smoking in public places; and 5) helping small businesses develop workplace wellness programs.
• Provide and protect affordable health insurance — Proposals included 1) expanding eligibility in public insurance programs to cover more children and low-income Kansans; 2) developing “young adult” health plans, with limited benefit packages and lower premiums, to encourage this population of Kansans to become insured; and 3) increasing the state’s role in assisting small businesses secure health coverage for their employees.

Quick Facts on Kansas Health Care

Medicaid expenditures as % of total state spending (FY 2006): 18.9%

Health care spending as % of total Gross State Product (2004): 14.4%

Average annual growth in health care spending (1991-2004): 6.6%

Residents’ health insurance status/coverage (2005-06): Employer, 57%; Individual, 7%; Medicaid, 11%; Medicare, 13%; Other Public, 1%; and Uninsured, 11%

Sources: National Association of State Budget Officers, U.S. Centers for Medicaid and Medicare Services and Kaiser Family Foundation’s statehealthfacts.org
The Kansas Health Policy Authority is unique in the scope of the duties it has been given, how it has been structured, and how its work is being overseen.

The KHPA estimated that the entire plan would cost $85.7 million in state general-fund dollars.

But one of the recommendations that would have generated revenue — and paid for some of the other 20 policy options — ended up being one of the plan’s most controversial elements.

A proposal to raise tobacco-user fees, including a per-pack tax increase of 50 cents on cigarettes, was rejected by the Legislature. Lawmakers also were leery of making the fiscal commitment needed to enact many other parts of the plan.

Despite the KHPA’s contention that the initial state investment would result in long-term cost savings — by improving the health status of Kansans, increasing the use of health information technology and changing how consumers use the health system — most of the policy options did not pass or were not funded by the Legislature.

A handful of the recommendations, however, were approved this year in SB 81 and signed by the governor. The legislation, for example, defines “medical home” in state statute and directs the KHPA to employ a medical-home delivery system in public insurance programs.

Some parts of the KHPA reform plan — including the Health Care Quality and Transparency Project and the collection of health and fitness data on Kansas schoolchildren — did not require legislative approval and will be implemented by the state agency.

KHPA officials, too, will continue their work on overall health reform — and strive for greater legislative success in the years ahead.

Other cost-containment/ reform strategies in Kansas

Several new health policy strategies are being implemented as the result of recent legislative actions and various initiatives of the Kansas Health Policy Authority (KHPA).

Below is a list of some examples.

**Office of Inspector General** — SB 11 of 2007 created an independent Office of Inspector General within the KHPA to conduct performance reviews and investigations of the state’s medical assistance programs. Principal goals of the inspector general include improving program operations and deterring fraud and waste in the state health system.

**Redesigning system of long-term care** — With the 2008 Legislature’s passage of SB 365, the KHPA and other state agencies have been directed to implement a new system for long-term care services that, in part, emphasizes “self-direction, individual choice … and [the use of] home and community settings.”

SB 365 also establishes a new joint legislative committee that will review the number of individuals in Kansas being transferred from institutional care to home and community-based settings. This review will include a cost-benefit analysis.

**Help for small businesses** — One focus of legislators over the past few years has been finding ways to meet the health care needs of small businesses. SB 11 made grants and no-interest loans available to small businesses wanting to form associations that help them access affordable health insurance.

The same legislation also created a grant program to expand the use of “cafeteria benefit plans” by defraying the plans’ startup costs for small businesses (50 or fewer employees). This type of employee-benefit plan is popular among some businesses because it can reduce their payroll taxes.

**Advancing health information technology** — Early in 2008, the KHPA formed a 14-member advisory council that will coordinate public-private efforts to deploy health information technology throughout the state. Advancing the use of “e-health,” policymakers say, will improve efficiencies in the health care system by cutting administrative costs, reducing the duplication of services and improving patient outcomes.

One idea the panel will pursue is the creation of a “statewide community health record.”

Under a pilot program with Medicaid providers and an IT company, the state has implemented a community health record in a single county: Sedgwick. The system is built on administrative claims data, the KHPA says, and provides physicians with electronic access to patients’ demographic information, medical visits, dispensed medications and immunizations.

**Enhanced Care Management** — Sedgwick County also has been the home of another pilot program run by the state: Enhanced Care Management (ECM).

The goal of the initiative is to improve the care provided to Medicaid enrollees “experiencing multiple chronic conditions” and who have “probable or predictable high future health care costs.” Under ECM, the state takes an active role in connecting individuals to appropriate health care and social services in the community. A December 2007 evaluation of this disease-management program showed “positive changes in costs, utilization and clinical quality.”

**Health transparency** — Recommended by the KHPA, the Kansas Consumer Health Transparency Project aims to provide consumers with the information they need to make sound health decisions. The project has developed a Web site (www.kansashealthonline.org) where users can search for doctors, compare health plans and hospitals, and access information about health and wellness. Price information is expected to be added soon.
Few areas of health care policy have received more attention over the past decade than the rising cost of prescription drugs.

And few states in the Midwest — or the nation as a whole — have been more pioneering than Michigan in trying to control pharmaceutical spending.

From the use of a preferred drug list to the launch of a first-of-its-kind multi-state drug pool, Michigan often has marked a policy path eventually followed by many other states.

Data show that these efforts in Michigan have paid off — a welcome outcome in a state that has faced severe budget challenges. A 2008 report by the Michigan Senate Fiscal Agency underscores the impact that the state’s cost-containment actions have had.

“Before the adoption of these initiatives, Medicaid pharmaceutical expenditures had been increasing at rates in excess of 10.0 percent per year,” the report says about trends in the late 1990s and beginning of this decade.

“In contrast, prescription drug expenditures in FY 2006–07 were only about 0.6 percent higher than in FY 2005–06.”

Overall Medicaid spending in Michigan, meanwhile, rose by 6.1 percent between fiscal years 2005–06 and 2006–07.

While certain external factors have contributed to this controlled growth in drug spending, Michigan policymakers say the state’s cost-containment strategies have had a significant impact.

They also note that some newer initiatives have been implemented to get the most out of limited state dollars. For example, the Department of Community Health has strengthened coordination-of-benefits controls and enhanced its claim submission requirements.

It also continues to participate in the Pharmacy Quality Improvement Project (PQIP) — an educational program to ensure that evidence-based guidelines are used to treat mentally ill adults and children in the state’s Medicaid program.

Early results from this public–private partnership indicate it is improving quality of care and reducing costs, DCH officials say.

**Past cost-saving efforts continue**

Michigan, meanwhile, continues to reap savings from the initiatives it launched earlier in the decade.

In 2003, the state partnered with Vermont to create the groundbreaking Multistate Prescription Drug Pool. The idea behind this pool — and the others that have been established since then — is to combine states’ purchasing power to negotiate deeper discounts, known as “supplemental rebates,” on prescription drugs.

A pharmacy benefits manager negotiates prices with manufacturers based on a preferred drug list (PDL), which Michigan implemented for the first time in 2002. Drugs are chosen for the PDL based on factors such as efficacy, safety and cost-effectiveness. If a doctor wants to prescribe a drug not on the list, he or she must receive prior authorization.

As a result, the PDL helps the state negotiate supplemental rebates (with the manufacturers who want their products on the list) and encourage the use of generic drugs (when appropriate).

In FY 2004, the state’s total savings in pharmacy spending were estimated at $130 million. Not coincidentally, FY 2004 also was the first year in which both the PDL and the multi-state pool were in place.

Today, Michigan’s multi-state pool is known as the National Medicaid Pooling Initiative (NMPI).

The NMPI was impacted by federal implementation of Medicare Part D, which requires most “dual eligibles” (those enrolled in Medicaid and Medicare) to receive drug coverage from Medicare, not Medicaid.

Because many of Michigan’s fee-for-service Medicaid beneficiaries now get drugs under Medicare Part D, the state covers fewer drug products, resulting in a lower volume of claims with supplemental rebates.

Still, since implementation of Medicare Part D, the NMPI has saved Michigan between $12 million and $14 million annually, DCH officials say. In addition, Michigan’s various pharmaceutical-savings initiatives curbed the amount of state funds going to the federal government under Part D’s “clawback” provision (which requires states to reimburse the federal government for taking on the drug costs of Medicaid beneficiaries).

**PQIP’s details, early results**

Michigan’s PQIP initiative targets better quality care for a part of the Medicaid population still receiving prescription drugs via the state-federal health insurance program. Specific goals include improving continuity of care, eliminating redundant treatments, coordinating care among providers and decreasing the risks associated with the misuse of prescription drugs.

Another objective is to save state dollars.

The PQIP is modeled after Missouri’s Mental Health Medicaid Pharmacy Partnership Program. Both initiatives evaluate the prescribing practices of physicians caring for people suffering from mental illness and identify patterns that do not follow accepted evidence-based treatment guidelines.

**Quick Facts on Michigan Health Care**

| Medicaid expenditures as % of total state spending (FY 2006): | 20.1% |
| Health care spending as % of total Gross State Product (2004): | 13.5% |
| Average annual growth in health care spending (1991-2004): | 5.8% |

**Residents’ health insurance status/coverage (2005-06):**

| Employer, 59% | Individual, 4% | Medicaid, 13% | Medicare, 13% | Other Public, 0% | Uninsured, 10% |

Sources: National Association of State Budget Officers, U.S. Centers for Medicaid and Medicare Services and Kaiser Family Foundation’s statehealthfacts.org
Missouri officials say their program saved $7.7 million in Medicaid dollars in its first year (FY 2004). Specific results that caught the attention of Michigan health officials included:

• a 98 percent reduction of patients who were being prescribed the same medications from multiple doctors;

• a 64 percent reduction of patients who were on two or more medications of the same type;

• a 43 percent reduction of children on three or more psychotropic medications; and

• a 40 percent reduction of patients receiving an unusually high dosage of medication.

Like the Missouri program, Michigan’s PQIP has received funding support from Eli Lilly and Co.

Physicians participating in the voluntary program are provided with educational materials as well as opportunities for peer-to-peer consultations.

An initial analysis of the PQIP showed it was having a positive impact. The evaluation, which examined the prescribing habits of about 600 physicians before and after a PQIP “intervention,” reported a 22 percent reduction in pharmaceutical claims and a 21 percent decline in costs. During the six-month intervention period studied, the DCH estimates the program saved approximately $1.7 million, according to the Michigan Senate Fiscal Agency.

Buying in bulk, saving together

The idea of states combining their purchasing power to save money on prescription drugs has spread since Michigan and Vermont launched the first multi-state pool in 2003.

According to a report by the National Conference of State Legislatures (available at www.ncsl.org/programs/health/bulkrx.htm), five different pools were operating as of early 2008. Iowa, Michigan and Minnesota are among the Midwestern states participating in one of these plans. This year, Nebraska legislators passed LB 830, which in part calls on the state to maintain a preferred drug list and enter into a multi-state purchasing pool.

Even before Michigan and Vermont began their pool, Minnesota was operating MMCAP, the Minnesota Multistate Contracting Alliance for Pharmacy, a voluntary group-purchasing organization serving government-based health care facilities.

More information on MMCAP is available at www.mncapadmin.state.mn.us/mmcap.

More recently, Oregon and Washington formed the Northwest Prescription Drug Consortium. Unlike other multi-state initiatives, which focus on savings in government purchasing, the consortium aims to find discounts for uninsured or underinsured residents.

Single states also have used their purchasing power and set up buying clubs to provide drug discounts to residents. Examples in the Midwest include Illinois’ Rx Buying Club, Community Rx Kansas, Michigan MiRx, Ohio Best Rx and Wisconsin’s Badger Rx Gold.

Other cost-containment/reform strategies in Michigan

Along with efforts to rein in state expenditures related to prescription drugs, Michigan policymakers have pursued various other health care cost-containment and reform strategies. Below is a brief description of some of those initiatives.

• Healthy behaviors — In 2007, the Legislature passed SB 1, which directs the state Department of Community Health (DCH) to create incentives (related to copayments, premiums and benefits) for Medicaid recipients to practice positive health behaviors. The legislation also calls on the DCH to create performance incentives for Medicaid HMOs to meet chronic-disease compliance targets, with priority given to the 10 most prevalent and costly conditions. For more than 10 years, too, the state has had a Healthy Michigan Fund, which allocates tobacco revenues to promote wellness, disease prevention and family-planning activities at the local level.

• Health information technology — Two bills were passed in 2006 to expand the use of health information technology in the state. HB 5336 created the Health Information Technology Commission and set aside funds to create regional health information exchanges. HB 6039 created a separate HIT development fund. In addition, SB 1 of 2007 calls on the DCH to further the use of electronic health records.

• Long-term care — HB 5389, which became law in early 2007, established four point-of-entry demonstration sites to help people as they enter the state’s long-term care system. The sites help individuals make informed decisions on their best options of care, which sometimes can be community-based rather than more-costly institutional care.

• Move to managed care — According to the DCH, moving more Medicaid beneficiaries to managed care has been a significant cost-saver for the state over the last decade. Most of Michigan’s eligible Medicaid beneficiaries are now enrolled in managed care. Between fiscal years 1995 and 2007, the DCH reports, the average annual cost increase per managed-care beneficiary was 3.2 percent, compared to 7.8 percent per fee-for-service beneficiary.

• Third-party liability — The DCH also reports an increase in third-party-liability (TPL) recoveries and cost avoidance (almost $400 million in FY 2007). TPL refers to the legal obligation of health plans to pay for health coverage before Medicaid does.
Throughout history, new medical technology has been an important tool in the advancement of clinical care.

Today, many policymakers are stressing the role that technology can play in reforming our nation’s health system.

Health information technology (HIT) encompasses a wide range of methods that use networks of computers to allow patients, insurers and physicians to exchange information electronically.

Electronic health records, for example, allow health care providers to do away with paper files and keep a patient’s medical information – such as past procedures, allergies and health history – in a computerized format. Proponents say these records help doctors keep more accurate health records and make more-informed treatment decisions.

In addition, the records can be more easily shared among several physicians to coordinate specialized care.

More physicians are using e-prescribing, which allows them to submit prescriptions electronically to a patient’s pharmacy. Proponents say e-prescribing improves upon paper prescriptions by reducing fraud and decreasing the chance of errors due, for example, to illegible handwriting. In addition, prescribing a patient’s medications electronically can help doctors and pharmacists screen for harmful drug interactions.

Another emerging trend in HIT is telemedicine, which allows patients to submit vital signs and other medical information electronically to their physicians, sometimes eliminating the need to schedule an in-office appointment. Other uses for HIT include electronic ordering of medical tests and online communication with a patient’s doctors and nurses.

Many states have used health information technology as a component of overall health care reforms. A notable example from the Midwest is Minnesota.

**Saving on costs**

Along with improving the quality of medical care, proponents say, HIT can reduce costs for states and the overall health system.

They point out, for example, that electronic health records reduce administrative costs by eliminating the need to update and store paper files, as well as making it easier for providers to file claims with insurers.

Electronic records also ensure that past test results are gathered in one place, decreasing the need to duplicate procedures and providing reminders for routine preventive care.

E-prescribing is regarded by many as a cost-saving measure for making it more difficult for patients to fill the same prescription from multiple doctors.

In addition, electronic prescribing systems could reduce the number of drug interactions and the medical care associated with treating them. Medication errors injure 1.5 million people at a cost of at least $3.5 billion each year, according to the Institute of Medicine of the National Academies.

Experts differ in their assessment of how much money could be saved through a greater use of health HIT. One study conducted by the RAND Corporation estimated that the widespread use of HIT on a national scale could save $77 billion per year.

But there are up-front costs associated with implementing HIT, including the purchase of computer equipment and software. One study cited by the Alliance for Health Reform found that the initial cost to establish an electronic health record system is about $44,000 — plus $8,500 per year in operating costs — for a small, full-time medical practice.

Policymakers, then, are often faced with a fundamental question: Who will or should pay to advance the use of HIT?

**Minnesota addresses key issues**

Critics point out that small practices and those in rural areas often don’t have access to the technologies needed to employ HIT.

Others raise questions about security and privacy, looking to policymakers to strengthen laws that protect personal information.

Proponents of HIT are also calling for the federal government and states to adopt standards that ensure “interoperability,” the capacity for electronic systems in different hospitals and doctors’ offices to work together.

These challenges were among the many issues faced by Minnesota lawmakers when they passed legislation in 2007 making their state a national leader in HIT policy.

That year’s health and human services appropriations bill mandated that all hospitals and health care providers have an electronic health records system in place by 2015.

The measure directed a state advisory committee to develop a statewide plan to meet the goal, including uniform standards to ensure interoperability of systems throughout the state.

The bill also provided $14 million to help small rural health providers and community clinics meet the goal.

The Minnesota e-Health Initiative, a collaboration of members of the public and private sectors, is working to meet the 2015 deadline. The group has four main goals: empowering consumers, informing and connecting health care providers, protecting communities and improving public health, and enhancing infrastructure.

The 2007 bill also required all health care payers and providers in Minnesota to use a uniform billing process to conduct eligibility transactions and submit claims electronically. As of Jan. 15, 2009, those transactions can no longer be submitted in paper form.

A study conducted by America’s Health Insurance Plans found that processing one paper health care claim costs $1.58, nearly double the cost for an electronic claim (85 cents).

In a 2006 study, the state concluded that between $15.5 million and $21.8 million

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**QUICK FACTS ON MINNESOTA HEALTH CARE**

| Medicaid expenditures as % of total state spending (FY 2006): | 21.5% |
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| Residents’ health insurance status/coverage (2005-06): |
| Employer, 61%; Individual, 7%; Medicaid, 11%; Medicare, 12%; Other Public, 1%; and Uninsured, 9% |

Sources: National Association of State Budget Officers, U.S. Centers for Medicaid and Medicare Services and Kaiser Family Foundation’s statehealthfacts.org
could be saved per year by reducing the number of follow-up telephone calls made to insurers and physicians regarding eligibility and claims.

Minnesota will be the first state to go completely electronic, according to the governor’s office.

A companion piece of legislation, HF 1078, updated medical privacy laws to make them compatible with the use of electronic records. The bill removes barriers to electronic sharing of information and aims to clarify requirements for the release of personal information.

**Greater use of e-prescribing**

In the 2008 session, Minnesota lawmakers passed a bill requiring all of the state's providers to use e-prescribing by 2011. The measure was part of HF 3780, a larger health care reform effort (see sidebar) aimed at reducing health care costs in the state.

Minnesota policymakers are also taking steps to use e-prescribing to increase efficiencies in the administration of state employee health benefits.

In 2007, the state announced that it would streamline prescription drug purchasing for employees and their dependents by hiring one pharmacy benefits manager instead of three.

One of the company’s top goals was to implement e-prescribing for all drug purchases, a measure that is expected to increase safety and reduce errors.

State officials project the new system will save $5 million annually, which will be rolled back into the health plan to help control rises in health care premiums.

**State, federal policymakers advance HIT policies**

Fostering a greater use of health information technology (HIT) has become a focus of state and federal reform efforts in recent years.

At the federal level, health officials released in 2008 a strategic plan to ensure that most Americans have access to electronic health records by 2014. The plan is available at [www.hhs.gov/healthit/resources/reports.html](http://www.hhs.gov/healthit/resources/reports.html).

According to a Commonwealth Fund study, 37 of the 42 states responding to a survey indicated that they are using some form of HIT in their Medicaid programs.

In the meantime, state policymakers are also exploring ways to encourage the more widespread use of HIT. Here are some recent examples from the Midwest.

- Partnering with Medicaid providers and an IT company, a Kansas pilot program has implemented a “community health record.” The system is built on administrative claims data and provides physicians with electronic access to patients’ demographic information, medical visits, dispensed medications and immunizations, according to the Kansas Health Policy Authority.

- Two Michigan bills were passed in 2006 to expand the use of health information technology in the state. HB 5336 created the Health Information Technology Commission and set aside funds to create regional health information exchanges. HB 6039 created a separate HIT development fund. In addition, SB 1 of 2007 calls on the Department of Community Health to further the use of electronic health records.

- As part of major health reforms in 2008, Iowa legislators approved the creation of an electronic health records advisory panel and set goals for the more widespread use of HIT.

**Minnesota passes landmark health reforms**

During their 2008 legislative session, Minnesota lawmakers passed one of the most comprehensive reforms of the state’s health care system in recent years.

Provisions in the reform legislation will be financed in the 2008-09 biennium with $13.5 million from the state’s Health Care Access Fund, a pool of money derived from taxes paid by physicians and hospitals.

Legislative proponents expect the bill to reduce state health care costs in the long term (12 percent by 2015).

Here are some of the provisions of SF 3780/HF 3924.

- Eligibility for MinnesotaCare, the state’s publicly subsidized health program, has been expanded to include an additional 12,000 beneficiaries.

- A two-year grant program will provide local communities with funding for programs aimed at curbing obesity and smoking.

- Over three years, $6 million will be used to compensate primary-care physicians that serve as medical homes. The measure is aimed at better managing chronic diseases by establishing standards for medical homes to improve care coordination.

- Small businesses will be offered grants to establish Section 125 plans, also known as “cafeteria plans,” which allow employees to pay for medical expenses with pre-tax dollars.

- By 2010, the state will begin providing financial incentives to medical providers that meet quality and value benchmarks.

- The health commissioner has been directed to develop a plan to provide consumers with comparative cost and quality data.

- Beginning in 2010, physicians will be able to offer one-price “baskets of care,” charging a flat fee for a package of health services. The legislation directs the state to come up with standards for baskets of care aimed at seven chronic conditions, including asthma, coronary artery disease and depression.
Controlling Medicaid costs: 2005 plan still driving efforts in Nebraska

In 2005, Nebraska legislators put in statute what state fiscal trends had been telling them for several years: A major reform of the Medicaid system was in order.

Without such an overhaul, LB 709 said, “the medical assistance program may become fiscally unsustainable.”

Between fiscal years 2000 and 2005, Nebraska’s general-fund spending for the public health program increased annually by 8.2 percent, compared to an average increase in state revenues of 3.5 percent.

In FY 2006, Medicaid accounted for 18.2 percent of total state spending in Nebraska, the National Association of State Budget Officers reports. The figure was even higher among the 50 U.S. states (21.5 percent).

LB 709 laid the groundwork to contain Medicaid costs in Nebraska. Three years later, state officials continue building on this legislation — and still have an admittedly long way to go.

In part, the bill called for a rewrite of the state’s Medicaid statutes, which was done the next year with passage of LB 1248. It also required the development of a Nebraska Medicaid Reform Plan, which was unveiled in December 2005 after months of cooperative work between the legislative and executive branches.

Ever since its release, this plan — a mix of short- and long-term policy strategies — has served as the state’s guide for containing Medicaid costs.

Some of the short-term strategies already have been implemented, while others will be employed soon. They all are being made within the confines of the state’s current Medicaid structure.

But the 2005 reform plan also calls for consideration of a long-term strategy that would overhaul the structure itself: moving from the current “defined benefit” model to a “defined contribution” system.

**Short-term strategies**

Authors of the reform plan estimate that their 28 “short-term” recommendations would save the state $74 million a year by FY 2015. Many of the ideas are based on cost-containment initiatives already tried — and proven to work — in other states.

Nebraska’s plan touches on numerous aspects of the Medicaid program, but it focuses on two major cost drivers: prescription drugs and long-term care.

**Prescription drugs** — As of FY 2005, prescription drugs accounted for 17 percent of all Nebraska Medicaid spending, with expenditures nearly doubling during the first part of the decade.

In response, the state has followed through on a recommendation that prior-authorization requirements be put in place for certain brand-name drugs. This year, too, the Legislature passed LB 830, which calls on the state to maintain a preferred drug list and enter into a multi-state purchasing pool (for combined general-fund savings of as much as $5.2 million a year).

Under another initiative, the state has launched a voluntary education program to improve standards of practice for providers using drugs to treat mental health conditions. The initiative is modeled after Missouri’s Mental Health Medicaid Pharmacy Partnership.

**Long-term care** — Long-term care services represent the single largest cost category in Nebraska’s Medicaid program. And with the number of elderly residents in the state projected to rise significantly over the next few decades, policymakers are looking to expand the use of lower-cost alternatives to institutional care.

Following the reform plan’s recommendations, the state has expanded its Aged & Disabled Waiver program, which offers an array of services to support people in their homes and out of nursing homes.

Nebraska also is one of several states with a federal Money Follows the Person grant, which transitions individuals from institutional care to home and community-based settings.

Meanwhile, the state is rewriting regulations that govern home and community-based care, with an eye toward increasing the use of these services.

The reform plan also targeted a host of other cost-savings strategies that either have been implemented or are being considered, including:

• new limitations on certain state-optional health, vision or dental services for Medicaid recipients;

• more home visits for high-risk pregnant teens (the reform plan notes that every dollar spent on prenatal care yields savings of between $1.70 and $3.38); and

• an Enhanced Care Connection program designed to better manage the care and diseases of high-cost Medicaid clients, specifically those with multiple medical conditions.

**Long-term strategy**

By the end of this year, Nebraska officials will have in hand an outside analysis examining possible long-term structural changes to the Medicaid system.

**QUICK FACTS ON NEBRASKA HEALTH CARE**

- Medicaid expenditures as % of total state spending (FY 2006): 18.2%
- Health care spending as % of total Gross State Product (2004): 14.5%
- Average annual growth in health care spending (1991-2004): 7.6%
- Residents’ health insurance status/coverage (2005-06): Employer, 58%; Individual, 8%; Medicaid, 9%; Medicare, 12%; Other Public, 2%; and Uninsured, 11%

Sources: National Association of State Budget Officers, U.S. Centers for Medicaid and Medicare Services and Kaiser Family Foundation’s statehealthfacts.org
In particular, the analysis will explore the possibility of moving to the “defined contribution” model now being tried in states such as Florida and South Carolina.

Supporters of this model say it expands health care choices for Medicaid enrollees and improves management of their care. For states, they say, this model better controls per-enrollee costs and makes overall spending on Medicaid more predictable from year to year.

As Nebraska’s 2005 reform plan states: “Under a defined benefit program, eligibility and benefits are fixed, but costs are variable … Under a defined contribution program, eligibility and costs are fixed, but benefits are variable and targeted to meet individual needs.”

Critics of the defined contribution model have warned of several adverse consequences, including: declines in the number of providers serving the Medicaid population, overall gaps in coverage and access to care, and a loss of health benefits for enrollees.

Later this year, Nebraska health officials will begin to decide whether to move to a defined contribution model, or to make other fundamental changes to Medicaid.

As they have in the past, officials will rely on the experiences of other states to help guide them.

Evolving state trends in Medicaid policy

As the economy goes, so go many state decisions on Medicaid.

A fall 2007 report by The Kaiser Commission on Medicaid and the Uninsured illustrates this link between states’ fiscal environments and policy choices, and shows how much both have been changing over the past few years.

In the early part of this decade, driven by slumping state revenues and robust Medicaid spending growth, policymakers pursued aggressive cost-containment strategies.

According to the 2007 Kaiser study, a different trend in Medicaid policy has emerged during the latter part of this decade. States are increasingly focusing on program restorations or expansions, the authors say, and using Medicaid as a tool to expand coverage to the uninsured.

This trend has coincided with stronger revenue growth as well as modest increases in Medicaid enrollment and expenditures.

Still, the report notes, states face “ongoing pressures to control Medicaid spending.”

Many of the cost-control strategies enacted several years ago remain in place, particularly those related to prescription drugs, while policymakers look for new ways to get better value from the dollars spent on Medicaid.

“States are placing a high priority on measuring and improving quality of Medicaid-financed health care, often through enhancements in managed care or disease management,” the Kaiser study notes.

The Midwest is part of this policy trend, as recent state-by-state research done by CSG Midwest shows. This research found myriad examples of state efforts to control Medicaid spending, including initiatives related to quality, managed care and disease management.

Here are a few of the many examples from the region:

- Indiana has launched Care Select, a new managed-care program for the aged and disabled that seeks to improve disease management, care coordination and health outcomes.
- Kansas has created a county-wide pilot program (Enhanced Care Management) for Medicaid enrollees experiencing multiple chronic health conditions.
- With the 2007 passage of SB 1, Michigan legislators directed the Department of Community Health to establish pay-for-performance incentives for the state’s Medicaid managed-care providers, with priority given to “strategies that prevent and manage the 10 most prevalent and costly ailments affecting … [Medicaid] recipients.”
- In Minnesota, an initiative known as QCare (created through a 2006 governor’s executive order) has been established and is been applied to all state-purchased health insurance. QCare sets standards for quality of care and puts in place aggressive targets for health care providers. Providers are rewarded for delivering better care and producing better health outcomes.

According to the Kaiser report, policymakers also continue to seek changes to their long-term care systems. One example is the expanded use of home and community-based services, sometimes through the new options given to states under the federal Deficit Reduction Act (DRA) of 2005.

A handful of states also have used flexibility in the DRA to restructure their Medicaid programs.

West Virginia, for example, has begun offering enrollees a choice of two managed-care plans: basic or enhanced. To enroll in the enhanced benefit package, individuals must agree to comply with all medical treatment and wellness behaviors recommended by the state.

By the year 2020, nearly one in four North Dakotans will be 65 or older.

And this projected rise in the proportion of seniors (14.8 percent in 2005 vs. 23.0 percent in 2020) only tells part of the story of aging in North Dakota.

The state, which already has the nation’s highest proportion of people 85 or older (2.8 percent in 2005), is expected to see a significant increase in this demographic group as well.

Between 2005 and 2020, the number of North Dakotans 85 or older is projected to increase by nearly 9,000. Over this same time period, the state’s total population numbers will fall by more than 40,000, according to the North Dakota State Data Center.

These demographic trends will create myriad challenges for current and future state policymakers.

At or near the top of the list of challenges will be the effective financing and delivery of long-term care.

**High costs, new goals**

Long-term care already is a major source of U.S. states’ health care costs. In 2005, it accounted for 36.6 percent of the more than $300 billion spent on Medicaid, the Kaiser Family Foundation says.

The already-high costs of providing health services to the elderly and disabled, along with the aging of the nation’s baby boomers, have caused states across the nation to seek reforms of their long-term care systems, with two underlying goals:

- provide individuals with additional options regarding the use of long-term care services and help them make more-informed decisions; and
- curb overall state expenditures and reduce per-beneficiary costs (in part by better controlling the use of institutional care).

These objectives are behind ongoing initiatives and legislative studies in North Dakota.

**Plan to “rebalance” system**

In 2004, North Dakota secured a three-year grant from the federal government to improve its long-term care system.

One of the first steps in reforming the current system, leaders of the grant project have concluded, should be the creation of an Aging and Disability Resource Center (ADRC). Also referred to as a “single point of entry,” an ARDC is a one-stop shop of information and resources for individuals as they enter the long-term care system.

The goal of an ADRC is to help consumers make more-informed care decisions, at a time when they (or a loved one) are experiencing a disabling health crisis or deteriorating physical or mental abilities.

The best option sometimes is home or community-based care, but many people simply aren’t aware of the full range of long-term care services, according to Linda Wright, director of North Dakota’s aging services division.

In 2007, the Legislature passed SB 2070, which appropriates the state matching funds needed to apply for a federal ADRC grant (more than 40 states already have secured federal funding).

A final report on North Dakota’s Real Choice Rebalancing Grant spells out 21 essential components of any future ARDC in the state.

But making sure individuals are aware of their various long-term care options is only one step toward a more balanced system.

The services to provide those options also must be readily available.

The grant’s final report offers several strategies to bolster the state’s service infrastructure related to home and community-based services. They include pursuing more federal waivers to create new alternative-care services and developing an incentive program for “less viable” nursing homes to restructure.

North Dakota Rep. Gary Kreidt, a member of a 2007-08 interim legislative committee on long-term care, says the nursing home issue has been especially challenging.

In many of the state’s sparsely populated areas, he notes, these facilities are a vital source of jobs and local activity. At the same time, rural nursing homes often have empty bed space and struggle with adequate staffing, Kreidt said.

Since 1996, North Dakota has had a moratorium on adding nursing home beds. This cap has led to a reduction in beds per 1,000 elderly people, falling from 89 in 1996 to 65 in 2007.

But lawmakers have been examining the possibility of lifting the moratorium, because in urban areas, there have been calls for more bed space. Though the state does allow nursing homes in metropolitan areas to “purchase” beds from rural facilities, some say this process has been too slow to meet demand.

In future sessions, too, Kreidt expects the Legislature to explore new ways of encouraging institutional-care facilities to offer more alternative services such as home and community-based care.

“Instead of having to add thousands of nursing home beds, the hope is that alternative types of care can play a bigger part,” Kreidt says about how the state will help meet the challenge posed by the projected demographic changes.

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Sources: National Association of State Budget Officers, U.S. Centers for Medicaid and Medicare Services and Kaiser Family Foundation’s statehealthfacts.org
Partnership on long-term care insurance

Meanwhile, like many other states, North Dakota is hoping for positive results from its recently established Long Term Care Partnership Program (LTCP). The goal of this program is to encourage more residents to purchase an insurance plan that pays for their long-term care, thus preventing or delaying their need for state assistance.

North Dakota passed legislation in 2005 (HB 1217) and 2007 (SB 2124) to create the LTCP.

Under the partnership, residents who purchase long-term care insurance are able to protect more of their assets if the state ultimately has to pay for their care. Without the partnership policy, individuals must “spend down” all of their assets before relying on Medicaid for their long-term care needs.

Mike Fix of the North Dakota Department of Insurance says it is too early to tell how popular the LTCP will be with consumers. As of spring 2008, 16 companies had been certified to offer partnership policies in North Dakota.

Long-term care reforms seek more options for consumers, lower costs for state

One fundamental goal of reform efforts in long-term care is to reduce state systems’ reliance on institutional care.

“States are trying to get a better balance by offering more choices to consumers,” says Robert Mollica, senior program director for the National Academy for State Health Policy.

He points to a handful of states as pioneers.

• Wisconsin’s redesigned long-term care system (Family Care) has become a model for other states, particularly its groundbreaking use of local aging and disability resource centers. In part, these centers, or “single points of entry,” provide individuals with access to information on the home and community-based services available to them. Managed-care organizations are used to deliver the Family Care benefit. Originally a pilot initiative, Family Care was made a statewide program with legislation signed into law in 2006 (SB 653).

• A Vermont program known as Choices for Care is noteworthy for the entitlement it gives Medicaid-eligible residents to use home care. Along with expanding consumer options in long-term care, the initiative aims to reduce Vermont’s per-beneficiary costs by curbing the use of nursing homes.

• Washington and Oregon have long been leaders in the use of global budgeting, which puts various long-term care services and programs under a single spending authority. This practice gives state officials more flexibility in managing caseloads and offering various care options to consumers.

According to a February 2004 Governing magazine article, promising state policy trends around the country include:

• giving consumers more control over long-term care spending and hiring decisions,

• providing incentives to nursing facilities to develop home-care programs, and

• establishing statewide managed-care systems.

Aging population will demand more from states’ health care workforces

One ongoing challenge in North Dakota is finding and keeping the health care workers needed to provide services to the elderly and disabled.

While this problem may be particularly acute in a state like North Dakota, which is sparsely populated and has a high proportion of older residents, workforce shortages are being reported across the country.

An April 2008 report by the U.S. Institute of Medicine (www.iom.edu) concludes that these shortages, combined with a powerful demographic trend, add up to “an impending crisis” that requires a far-reaching response by policymakers.

The trend is the aging of the U.S. population. In three years, the first of the nation’s 78 million baby boomers will reach the age of 65.

While healthier compared to previous generations, today’s older adults often have complex health care needs. For example, the average 75-year-old has three chronic conditions and uses four or more prescription drugs.

The institute offers several reform ideas for policymakers, including:

• increasing Medicaid reimbursement rates and payments to boost the number of geriatric specialists and direct-care workers;

• requiring health care workers to demonstrate competence in basic geriatric care in order to maintain their licenses and certifications; and

• providing family members and other informal caregivers with more help and formal training.
Several years ago, a group of Ohio policy-makers was faced with a stark realization: health care spending was threatening to take over the state’s budget.

Medicaid, an entitlement program that was spending $10.5 billion in federal, state and local dollars in Ohio, was consuming more and more of the state’s budget. In 2005, program costs were growing at twice the rate of state revenues.

“Ohio’s Medicaid program is swamping the state budget,” concluded a report issued by a nine-member panel assembled by the governor and legislature to address the problem.

The problem, the Ohio Commission to Reform Medicaid found, was that the program was riddled with inefficiencies and structural deficiencies that made it unable to appropriately address health needs in the state.

After studying the system, the commission presented a group of recommendations to then-Gov. Bob Taft and the legislature on how to improve quality and reduce costs in Medicaid. One of its top suggestions built upon an idea already being implemented in many states, including Ohio: managed care.

1 million Ohioans get new health plans

Managed-care programs, which gained popularity in the mid-1990s, seek to reduce health costs and improve quality by emphasizing prevention and wellness, thus cutting down on the need for costly medical care. The programs seek to reduce the need for lengthy inpatient hospital stays and emergency-room visits by encouraging patients to regularly visit their primary-care physicians.

The managed-care model differs from “fee-for-service” systems because it pays insurance carriers a set amount per patient, or a capitation payment. The agreements are deemed “full risk” because after the state has paid for a patient’s plan, the insurance carrier takes on responsibility for what can sometimes be unpredictable health costs.

When the Ohio commission suggested enrolling more than 1 million additional Medicaid beneficiaries into managed care, it estimated the measure could have saved as much as $634 million in fiscal year 2005.

In the next legislative session, lawmakers included language in the budget that paved the way for a major expansion of Medicaid managed care.

In July 2006, the state began enrolling two major groups of Medicaid recipients into a new managed-care system — low-income families and aged, blind or disabled adults.

Over the next year, the department helped sign up about a million Medicaid recipients statewide, requiring them to choose from two or three insurance plans (similar to those offered by health maintenance organizations, or HMOs) and pick a primary-care physician.

“From a consumer point of view, it’s been a very large success,” says Jon Barley, chief of the Ohio Department of Job and Family Services’ Bureau of Managed Health Care. He adds that there was mostly a positive response to outreach efforts and that the transition for many Medicaid recipients was smooth.

Prior to the roll-out, about 300,000 beneficiaries had been enrolled in managed care, according to Barley. Currently, 1.3 million of the state’s 1.8 million Medicaid recipients participate in managed care.

Beneficiaries not included in the managed-care system include “dual eligibles” (those who qualify for Medicare and Medicaid) and people receiving more specialized care, such as adults in institutions or children who are blind or disabled.

Paying for performance

The state contracts with insurance providers to offer a choice between two or three health plans in each of eight regions in Ohio.

In addition to providing a range of options for Medicaid patients, the plans are also expected to meet certain quality benchmarks designed to boost health and wellness and decrease the need for expensive medical care.

Under a pay-for-performance system, the insurance plans are responsible for ensuring that recipients receive complete and quality preventive care. The plans must, for instance, ensure that a certain percentage of pregnant mothers makes it to all of their prenatal visits. If the success rate falls below the benchmark, the plan stands to lose 1 percent of its capitation payment.

While different insurance plans use varying incentives to encourage patients to

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complete preventive care such as well-child visits and routine exams, they are all responsible for making sure the state’s quality benchmarks are met.

Programs in other states, for example, chart each managed-care plan’s success in stabilizing blood-sugar levels and reducing complications for patients with diabetes.

Barley stresses that Ohio’s model places responsibility on the insurance plan — not the state — to take steps to improve care.

The new managed-care program has been in full swing for just less than a year, and while it’s too soon to tell how much money is being saved, Barley expects the results to be positive.

“We do expect to have savings as the program matures,” he says.

Putting a price on quality:
National study examines states’ pay-for-performance initiatives

Through pay-for-performance initiatives, state policymakers are working to get the best possible value for the dollars invested in health care.

Also known as “value-based purchasing,” this model rewards providers — such as physicians, hospitals and insurance plans — for achieving positive health outcomes. States provide incentives (most commonly financial bonuses to managed-care organizations) to help encourage efficient care that yields positive results.

As of mid-2006, at least seven of the region’s 11 states had existing Medicaid pay-for-performance programs. In addition, seven Midwestern states were planning new programs, according to a Commonwealth Fund survey of state Medicaid directors. (Information was not available for South Dakota.)

Nationwide, more than half of state Medicaid programs were utilizing pay-for-performance systems to help ensure quality and reduce health care costs. More than two-thirds of these existing programs have been used in conjunction with managed-care or primary-care case management and were targeting children, adolescents and/or women.

But a different population is the focus of many of the pay-for-performance initiatives that states were set to begin in 2008, the Commonwealth Fund found.

Through these new programs, states will try to more effectively manage chronic diseases — a group of ailments that account for 75 percent of U.S. health care spending.

Carrots and sticks

The types of incentives for performance vary by state and by program. Most often, states provide incentives such as financial bonuses to managed-care organizations for achieving quality benchmarks.

In turn, to help ensure these goals are achieved, some of the managed-care organizations rely on public reporting of quality data, including medical errors.

Proponents say that physicians and hospitals have an incentive to provide quality care when their performance data are available to current and potential patients.

Other strategies sometimes used by insurers (such as managed-care organizations and government programs) include enforcing penalties for poor performance and refusing to pay for substandard medical care.

For example, the U.S. Centers for Medicare and Medicaid Services recently announced that, beginning in October 2008, it would no longer reimburse hospitals for care required to alleviate eight hospital-acquired conditions.

Patient access a concern

Concerns have been raised about states’ increased use of pay-for-performance initiatives, including their impact on patients’ access to care.

Some health experts worry that additional administrative burdens could cause physicians to drop out of Medicaid or limit the number of beneficiaries they treat.

To address this issue, pay-for-performance programs have employed an array of strategies. They include employing health information technology and providing incentives directly to physicians, the Commonwealth Fund report found.

Critics of pay-for-performance initiatives also point out that safety-net hospitals, which usually treat more low-income and uninsured residents, are often unable to improve quality because of a lack of funding. These hospitals are then more vulnerable to penalties and reduced payments under pay-for-performance systems, further limiting their ability to improve care and outcomes.

“While public reporting and pay for performance have the potential to improve quality of care … some have expressed concern that these incentives have the potential to worsen existing disparities among hospitals,” according to a 2008 study published in the Journal of the American Medical Association.

On any given day, most consumers can log onto the Internet and compare prices on everything from small appliances to automobiles. But searching for the best price for a routine hip replacement isn’t nearly as easy.

Most consumers can guess the price of a new automobile within $300. But when asked to estimate the average cost of a four-day hospital stay, they miss the mark by about $8,000, according to a 2005 Harris Interactive poll.

While more than two-thirds of respondents reported spending more than eight hours researching a new car purchase, about one-third spend that amount of time researching a physician or health plan.

What’s more, about 63 percent of consumers who had received medical care in the past two years stated that they didn’t know how much the procedure would cost until they received the bill, and 10 percent never learned the cost.

South Dakota policymakers are looking to change that by implementing a new Web-based tool aimed at helping patients track down the best prices for the most common medical procedures.

The price of medical care can be complicated by varying provider charges and the fact that insurers — including Medicaid and Medicare — negotiate their own prices with physicians and hospitals. Policymakers are now exploring ways to make cost data more widely available to patients in hopes that they will use this information to compare prices and “shop” for medical care as they do for just about everything in their areas for procedures such as Cesarean sections or joint replacements.

According to the Sioux Falls Argus-Leader, the Web site logged nearly 76,000 hits in 2007.

Under the law, each hospital in the state is required to report data on its 25 most-performed procedures to the state each year. Required information includes the number of procedures completed, the severity of each case treated and charges.

The data are compiled and then listed on the Web site, where patients can search for prices at hospitals by county.

The Legislature took transparency a step further in 2008 with the passage of SB 182, which directs the state to build upon its current efforts to provide more medical price information to residents.

The state will partner with the South Dakota Association of Healthcare Organizations (SDAHO), which will purchase software to make the state’s hospital-pricing Web site more user-friendly and complete. The SDAHO will purchase PricePoint software, which costs between $6,000 and $7,000, at no cost to the state.

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PricePoint, pioneered by the Wisconsin Hospital Association and used in several other states, collects data from insurance claims. The new Web site will make it easier to compare prices side-by-side at several hospitals, as well as see how the prices stack up against the state average.

The site will include information (such as the median age and the sex of patients, as well as their average length of stay) for every inpatient procedure a hospital has performed more than 10 times in a year. Along with the hospital’s customary charge, the site will also provide average discounts negotiated by different payers, such as Medicaid or private insurance companies.

The new Web site and data-collection program will help consumers choose medical care not only based on cost — but also on a physician’s or hospital’s experience in that field.

Experts stress that as the number of procedures a provider has performed increases, outcomes improve. The software will take the state a few steps closer to tracking quality of care, its supporters say, by logging, for instance, the number

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Proponents argue that transparency helps consumers make wiser decisions about the cost of their medical care. As more and more residents turn to health plans with higher out-of-pocket costs, the data 

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<td>Residents’ health insurance status/coverage (2005-’06): Employer, 53%; Individual, 9%; Medicaid, 11%; Medicare, 14%; Other Public, 2%; and Uninsured, 12%</td>
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Sources: National Association of State Budget Officers, U.S. Centers for Medicaid and Medicare Services and Kaiser Family Foundation’s statehealthfacts.org
The new Web site and data-collection program will help consumers choose medical care not only based on cost — but also on a physician's or hospital's experience in that field.

SB 182 contains a provision requiring the transparency Web site to include outpatient procedures by mid-2009. The challenge for both SDAHO and the state will be retrieving and formatting the data for these procedures, which is more difficult to obtain from the thousands of independent providers that perform them.

Transparency initiatives aim to help patients make informed decisions

In an effort to empower more patients to make informed decisions about the price of their medical care, several states in the Midwest have implemented transparency initiatives. Below are a few examples.

- Wisconsin's Health Care Transparency Act (AB 907) directs the state to contract with the Wisconsin Hospital Association to provide hospital pricing information. The WHA uses PricePoint, a software program designed to cull prices and other data from insurance claims. The software is also being used by a handful of other states, including Georgia, Iowa, New Hampshire, New Mexico, Oregon, South Dakota, Texas, Utah, Virginia and Washington.

- In 2006, the Ohio General Assembly passed HB 197. It requires hospitals to provide prices for inpatient procedures to the state Department of Health, which is directed to list the figures on the Web. A Web-based information warehouse provides data, such as the total number of discharges, average length of stay and mean charge, for common medical procedures at each of the state's hospitals.

- Kansas’ Consumer Health Transparency Project, recommended by the state’s Health Policy Authority, aims to empower residents with information to help them make choices about their health. At www.kansashealthonline.org, users can search for doctors, compare health plans and hospitals, and find answers to questions about health and wellness. Price information is expected to be added to the site soon.
As the cost of health care rises, some employers are reducing benefits for their employees and, in certain cases, discontinuing coverage altogether.

Between 2000 and 2006, the share of workers with employer-based health coverage declined by 4 percent, to 70.8 percent, according to the Economic Policy Institute. During that time period, every Midwestern state experienced a drop in the rate of employer-based insurance.

In their role as employers, state governments have also felt the pinch of higher employee-benefit costs.

Public employee health plans provide benefits to about 13 million people in the United States, the Commonwealth Fund says, and rank second only to Medicaid in the amount of state health dollars spent on them. Excluding federal dollars, spending on state employee and retiree health benefits made up more than 15 percent of total state health spending in fiscal year 2003, according to data from the Milbank Memorial Fund and the National Association of State Budget Officers.

**Putting a premium on savings**

Since 2000, health premiums for Wisconsin state employees and retirees have more than doubled, to $950 million, according to state data.

In the early part of the decade, state policymakers implemented major reforms in how the state purchases health care for its employees and retirees.

Wisconsin's Department of Employee Trust Funds (ETF) is the largest purchaser of health care in the state. In 2007, through the ETF, the state provided health insurance to about 240,000 active or retired state employees and their dependents, as well as employees of certain local governments that take part in Wisconsin's group health plan.

While insurance costs nationwide were seeing record-breaking growth, most premiums for employees receiving benefits through the ETF posted single-digit increases in 2004 through 2007. Meanwhile, the level of employee benefits remained unchanged.

The state credits its success in controlling costs to a new health-purchasing strategy.

Witcson has changed how it negotiates with insurers, is encouraging employees to purchase cost-effective plans, has restructured the administration of pharmacy benefits, is providing incentives for quality care and is publicly reporting the performance of health plans.

**Three-tiered plan for employees**

At the heart of this strategy is Wisconsin's “three-tiered” model, which was adopted in the 2003-2005 biennial budget.

Employees covered by ETF health benefits have the choice between 23 insurance plans, most of which are health-maintenance organizations, each with a uniform set of benefits.

When the department receives a yearly bid from an insurer, it analyzes utilization data to determine how efficiently the plan provided quality care to its subscribers. The plans are then placed into one of three tiers, with Tier I made up of the plans deemed most cost-effective.

Employees are given a financial incentive to choose Tier I plans, which provide the best care at the lowest cost to the state. Individuals enrolled in Tier I plans, for example, pay $27 per month for their health insurance. Individuals in Tier III pay $143. For families, monthly employee shares range from $68 in Tier I to $358 in Tier III.

The significant difference in cost is designed to affect how employees choose health coverage — and also which physician they visit. For example, if an employee’s doctor does not participate in a Tier 1 plan, the employee might be more likely to switch to a physician who contracts with a more cost-effective insurer.

This system also provides incentive for insurance companies to keep costs low in order to be included in Tier I.

Plans are given extra points for scoring well on measures of quality, patient safety and customer satisfaction.

The state then makes these performance data available to employees.

Wisconsin’s 2008 guide for beneficiaries includes extensive report cards on each of the available health plans, including how each fared in ratings of customer service, timely care, disease management and other measures.

In another effort to promote quality, the ETF provides enhanced premiums to health plans that make gains in patient safety, preventive care and the use of technology. According to a Commonwealth Fund study, the incentives for insurance companies range from .5 percent to 2 percent of total premiums.

**New drug program cuts costs**

The state is also using other strategies to contain costs and make the most of its purchasing power.

In 2004, the ETF carved the pharmacy benefit out of its health plans and transferred all drug purchasing to a single pharmacy benefits manager (PBM).

The state worked with a private company, Navitus Health Solutions, to shape the new PBM according to its desired specifications.

State officials say the agreement improves upon the previous system, in which the PBM kept revenue from rebates it negotiated with pharmaceutical companies. Under the new system, the state pays the PBM a flat administrative fee per beneficiary and then keeps any revenues generated through the rebates.

As an incentive to negotiate better rebates

**QUICK FACTS ON WISCONSIN HEALTH CARE**

- Medicaid expenditures as % of total state spending (FY 2006): 13.4%
- Health care spending as % of total Gross State Product (2004): 14.8%
- Average annual growth in health care spending (1991-2004): 7.2%
- Residents’ health insurance status/coverage (2005-’06): Employer, 60 %; Individual, 5%; Medicaid, 12%; Medicare, 13%; Other Public, 1%; and Uninsured, 9%

Sources: National Association of State Budget Officers, U.S. Centers for Medicaid and Medicare Services and Kaiser Family Foundation’s statehealthfacts.org
States throughout the Midwest have made recent policy changes to help reduce spending on public employee health care. Here are some examples.

- Minnesota’s Smart Buy Alliance, launched in 2004, brings together various public- and private-sector groups to pool their purchasing power in health care. While members continue to purchase health care individually, participating organizations agree to use common performance benchmarks, cost and quality reporting requirements, and technology standards when making their purchasing decisions. Combined, members of the Smart Buy Alliance purchase health care for about 70 percent of Minnesota residents, including state government employees.

- Employees participating in the online Healthy South Dakota program set personal fitness goals and receive $100 per year for achieving them. The money is deposited in an account that can be used to pay for out-of-pocket medical expenses, gym memberships, and entrance fees to state parks and recreation facilities.

- State employees in Indiana can decrease their health insurance deductible by $500 if they refrain from smoking.

- HealthQuest, a program for Kansas state employees, provides tobacco-cessation and weight-management programs, health coaching and other resources. Workers can also receive a gift certificate for completing a health-risk assessment.

Other cost-containment/reform strategies in Wisconsin

Wisconsin lawmakers have approved several health reforms in recent years. Here are a few of them.

- The Health Care Transparency Act of 2006 (AB 907) directs the state to contract with the Wisconsin Hospital Association to provide hospital-pricing information. The WHA uses PricePoint, a software program designed to cull prices and other data from insurance claims. The software also is being used by a handful of other states.

- Wisconsin’s redesigned long-term care system (Family Care) has become a model for other states, particularly its groundbreaking use of local aging and disability resource centers. In part, these centers, or “single points of entry,” provide individuals with access to information on the home and community-based services available to them.

- In 2008, the state carved drug purchasing out of its Medicaid managed-care programs. As a result, instead of 13 HMOs purchasing drugs separately, the state harnesses its purchasing power to negotiate better rates and rebates from drug companies. The Medicaid program has also saved about $80 million per year in drug costs since it implemented a preferred drug list in 2004, according to Medicaid officials.

- In February 2008, Wisconsin began enrolling beneficiaries in the BadgerCare Plus program, which is designed to provide affordable health coverage to every child in the state. Policymakers plan to pay for the program by streamlining the administration of the state’s health programs, moving more beneficiaries to managed care and using state buying power to negotiate low premiums.
The health care challenge in Canada: Provinces, territories seek to keep health systems sustainable

The rising cost of delivering health care is a challenge faced by all levels of government in Canada.

In its most recent report on health care expenditures, the Canadian Institute for Health Information (CIHI) reported that Canada’s health care spending was forecast to be an estimated $148 billion in 2006 and $160 billion in 2007.

In 2006, for the 10th consecutive year, total health care spending growth outpaced inflation and population growth. The CIHI study also forecast that health care spending would account for 10.3 percent of Canada’s gross domestic product (GDP), marking the highest level in more than 30 years.

The change in health spending from 2006 to 2007 represents an increase of an estimated 6.6 percent.

CIHI — a not-for-profit, independent organization created by the federal, provincial and territorial governments — has noted that Canada’s combined public and private health care bill has grown an estimated 300 percent in the last 23 years.

Despite ongoing efforts in health care reform and renewal, sustainability remains a serious challenge for Canada’s provinces and territories.

Funding sources, spending pressures

Private-sector financing, mainly through private health insurance and out-of-pocket payments, accounts for between 20 percent and 40 percent of health expenditures in most Organization for Economic Co-operation and Development (OECD) countries.

In Canada, private financing accounts for an estimated 30 percent of expenditures. This contrasts with the United States, where an estimated 55 percent of health financing is done privately.

Sustainability strategies

Health systems are complex, and the problem of health care sustainability is one that can not be met with a single solution.

The Canadian provinces and territories are using a variety of strategies to address the challenges of managing their health budgets while still trying to meet public expectations.

The following are examples of the types of approaches that provinces and territories are using to address health care sustainability:

- **Health promotion and chronic disease management** — Better manage and reduce the need for “downstream” services (acute care, for example), which generally cost more money.

- **Primary-care reform** — Promote the use of multidisciplinary teams to provide care to patients outside of the traditional hospital and physician’s-office settings.

- **Information technology** — Employ information technology to address workload issues, increase efficiency and enhance patient safety by providing higher quality and more timely information for patient care.

- **Quality improvement** — Improve quality across all of the different dimensions in the health system (for example, conducting studies to assess the quality and safety of services as well as developing tools and benchmarks aimed at achieving improved performance).

- **Pharmaceuticals** — Explore various ways to control drug costs (examples include the use of generics and bulk purchasing through jurisdictional cooperative arrangements).

Here are some specific examples of health reform initiatives being undertaken by the provinces of Saskatchewan, Manitoba and Ontario.

**Saskatchewan reforms**

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<th>Initiative</th>
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<td>The Saskatchewan Drug Plan’s “maximum allowable cost policy” obtains expert advice on which prescription...</td>
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In Canada, private financing accounts for an estimated 30 percent of expenditures. This contrasts with the United States, where an estimated 55 percent of health financing is done privately.
drug products within a group of similar medications are safe and beneficial, as well as the most cost-effective. The price of the most cost-effective drugs are used as a guide in setting the maximum price that the Drug Plan will cover for other similar drugs used to treat the same condition. The maximum allowable cost is not necessarily set at the price of the lowest-cost drug, and physicians can continue to prescribe whichever drug they choose. This Drug Plan policy, though, limits the amount that is reimbursed.

• The province’s Technical Efficiency Fund is used to conduct efficiency reviews within the health system. Its goals are to identify areas of health-system delivery that could benefit from the application of one or more approaches that improve productivity, the timeliness of care and health outcomes, and overall patient and provider satisfaction.

**Manitoba reforms**

• In March 2008, Manitoba Health and Healthy Living introduced an innovative pilot project to bridge general and specialist care. The aim of the new Manitoba program is to develop and test new ways of ensuring timely, seamless and appropriate care for patients. It particularly seeks to address a common concern among Canadian health consumers: the length of time between a referral by a doctor and the actual appointment with a specialist. As part of the pilot, guaranteed time frames for referral to specialists will be established in seven specific practice areas. The project also is expected to contribute to a more efficient health care system by reducing inappropriate referrals as well as preventing duplication and unnecessary lab and diagnostic tests.

• A major barrier to addressing health disparities among Aboriginal people in Canada is the ongoing jurisdictional question of whether the federal government or the provinces have primary responsibility for their health. Manitoba has adopted the principle that it will provide a particular service when required, even if it believes the service is a federal responsibility. Manitoba will not deny service, but will instead resolve the conflict afterward through a dispute-resolution mechanism. This is known as “Jordan’s Principle,” and it will help begin to provide a more coordinated, appropriate, effective and efficient delivery of services to Aboriginal people.

• Primary-care reform is crucial to improving the sustainability of the health care system. Recognizing this, Manitoba has introduced the Physician Integrated Network, which uses quality-based incentive funding (a Manitoba version of pay for performance) to help clinics improve their practices. One example is supporting the use of more advanced information-management systems. Clinics also have been encouraged to employ non-physician medical professionals, such as registered dieticians and nurses, to assist family physicians with different aspects of patient testing, screening, education and follow-up.

**Ontario reforms**

• Ontario passed legislation in 2006 to reform the provincial drug system in a way that saved taxpayers’ money. The system also was reworked to improve patient access through new conditional drug listings and rapid reviews of innovative drugs. To ensure better value, the province: 1) made changes to drug pricing and reimbursement, 2) strengthened transparency and accountability in the drug system by giving patients a role in drug listing, and 3) established an innovation research fund to study systems outcomes and evaluate the value of medicines in improving health outcomes. In 2007-08, Ontario was able to reinvest $260 million of savings from the new legislation into Ontario’s drug system to improve patient access to drugs.

• In August 2007, Ontario provided a $700 million investment over the next three years for the Aging at Home Strategy, which will provide seniors and their caregivers with an integrated continuum of community-based services. The goal of the program is to help seniors stay healthy and allow them to live more independently in their homes. The strategy marks a significant shift in emphasis away from long-term care home beds and toward providing a comprehensive mix of services. This new investment will allow the province to support non-traditional partnerships and new preventive and wellness services. One fundamental goal of Aging at Home is to better serve the province’s culturally diverse populations and increase equity and access for all of Ontario’s seniors.

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Mark Wyatt and Mark Goossens of Saskatchewan Health were principal authors of this article. Also contributing were Brian Falck and Ulrich Wendt of Manitoba Health and Tasneem Essaji of the Ontario Ministry of Health and Long-Term Care.
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