

State and Other Healthcare Reform Initiatives

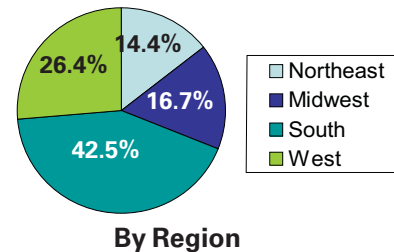
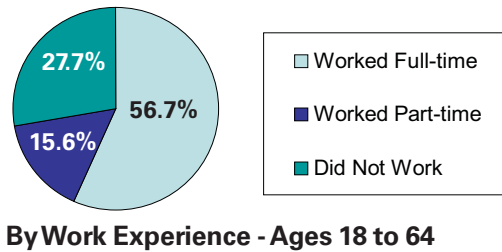
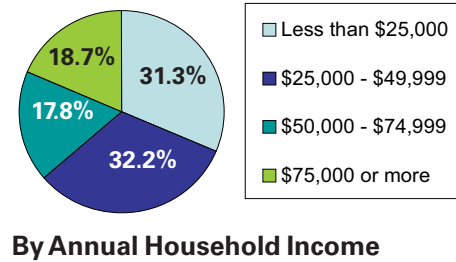
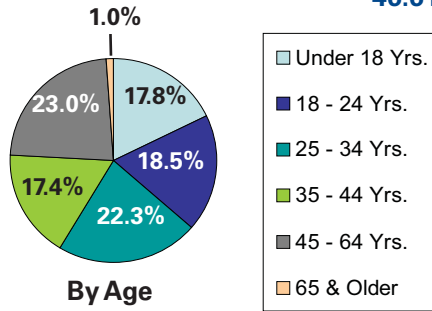
The United States spends more for healthcare than any other country on earth, yet today approximately 47 million of its population are uninsured. The Centers for Medicare & Medicaid Services (CMS) estimates that in 2007 annual U.S. healthcare spending will approach \$2.03 trillion (\$1.9 trillion in 2005), or 16+ percent of gross domestic product (GDP), compared with \$1.7 trillion, or 15 percent of GDP, in 2003 and a 2003 median 8.5 percent of GDP in other economically developed nations around the globe.

In addition, by 2016, assuming no major changes in our system, annual U.S. healthcare spending is projected to reach just over \$4.1 trillion, or 19.6 percent of GDP, and by 2030 the United States could spend 25 percent of its GDP on healthcare. In the next six years, the number of uninsured could reach 56 million, a 19 percent increase.

According to the Center on Budget and Policy Priorities, the percentage of residents who were uninsured was significantly higher in 2004–05 than in 2000–01, before the current economic recovery began, in 31 states: Arkansas, Colorado, Connecticut, Delaware, Florida, Georgia, Indiana, Maryland, Massachusetts, Michigan, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New York, North Carolina, Oregon, Pennsylvania, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, Utah, Vermont, Virginia, West Virginia, and Wisconsin.

A study by Jack Hadley at the Urban Institute indicates that the main reason adults' private insurance coverage has faded (employer-provided coverage was 59.5 percent of total coverage in 2005 vs. 62.6 percent in 2001) is due to climbing insurance premiums, making coverage less affordable for employers and employees alike.

Healthcare Uninsured in the United States in 2005 46.6 Million People in Total



Source: US Census Bureau

This report provides a brief description of some of the healthcare reform initiatives and activities that are beginning to occur at the state level and in coalitions around the country and addresses how the Employee Retirement and Income Security Act of 1974 (ERISA) could affect some of these activities. We include recent comments by Moody's Investors Service regarding state initiatives and not-for-profit hospitals.

Some 14 years after the Clinton healthcare plan was not supported by the Congress and a subsequent lack of other federal action, various state and local governments as well as healthcare coalitions have begun initiatives to change the system, to address the uninsured issue and to determine whether and how the health insurance system should be changed. In essence, according to the Commonwealth Fund, based in Washington, D.C., many state policy leaders, frustrated by the lack of federal action on the problem of the uninsured, have taken matters into their own hands, and the result is a trend toward healthcare reform at the state level.

Coalitions

Private coalitions are beginning to play an increasingly active role in seeking change. For example, The Health Coverage Coalition for the Uninsured, consisting of sixteen organizations and firms, such as the American Hospital Association, the American Medical Association, Johnson & Johnson, Kaiser Permanente, the Catholic Health Association, the Federation of American Hospitals, The U.S. Chamber of Commerce, Pfizer Inc., the United Health Foundation, and the Blue Cross and Blue Shield Association, has unveiled a two-phase proposal to cover half of the uninsured by boosting enrollment in public programs and providing tax credits.

The first phase is a "Kids First Initiative" that calls on the federal government to increase funding for (1) greater enrollment in the State Children's Health Insurance Program (SCHIP) and Medicaid, (2) a new family tax credit to help families cover a significant portion of the cost of buying meaningful health insurance for their children, and (3) state grant initiatives.

The second phase would give states the option to expand Medicaid eligibility to cover all adults with incomes 100–300 percent of the poverty level to help them cover the cost of purchasing insurance and would provide federal funding to do so. Federal grants are also proposed to help states cover high-risk populations.

A private-sector initiative, The Better Health Care Tomorrow Campaign, is a coalition of the American Service Employees International Union, the Communications Workers of America, and four of the nation's largest employers—Wal-Mart, AT&T, Kelly Services, and Intel. Their initiative was introduced in February and is dedicated to achieving major healthcare reform in the country by 2012. The effort's guiding principles are:



- Every person in America must have quality, affordable health insurance coverage.
- Individuals have a responsibility to maintain and protect their health.
- America must dramatically improve the value it receives for every healthcare dollar.
- Businesses, governments, and individuals all should contribute to managing and financing a new American healthcare system

State Approaches and Plans

More than 50 percent of the states are now engaged in efforts to reform their healthcare systems and/or to expand coverage. These efforts now run from Maine to Florida, Massachusetts and Maryland to Illinois and Kansas and to California and Washington. Taking a longer-range view, one lesson from the erstwhile Clinton approach in the 1990s should be kept in mind: wholesale and rapid change to the healthcare system is not expected to be politically feasible since there is no apparent consensus in the country or in the Congress at this time on whether to or how to achieve universal coverage. As we mentioned in our Winter 2007 KPMG's Washington Healthcare Update, significant and quick healthcare system reform is unlikely in Washington so, for the time being, state and local governments are expected to fill a very important role serving as laboratories as the country experiments with various approaches.

According to the Commonwealth Fund, the primary strategies being used by the states to expand coverage are:

- Retain and expand employer participation
- Leverage federal matching funds
- Redesign programs
- Simplify and streamline program eligibility and re-determination
- Target special populations
- Generate new revenue

The McKinsey Global Institute's paper, *A Framework to Guide Health Care System Reform* describes the main function of national healthcare systems and seven reform principles. These should be considered now as states experiment as well as in the future for any national systemic reform.

- Main Function. To promote health among the country's citizens. In designing and operating any system, healthcare leaders aim to satisfy three competing

requirements: first, ensuring that all people have adequate access to the benefits of healthcare; second, making certain that the system delivers care of consistently high quality; and third, achieving all this at a sustainable level of cost

- Seven Reform Principles
 - Prevent illness and injury
 - Ensure value-conscious consumption
 - Promote sustainable financing mechanisms to collect and distribute funds
 - Promote efficient creation of capacity for labor, infrastructure, and innovation
 - Ensure quality among suppliers
 - Promote improvements to cost competitiveness
 - Provide an adequate organizational framework and deploy adequate approaches to allow the implementation of strategy levers

For more information, please go to

http://www.mckinsey.com/mgi/publications/Framework_Health_Care_System.asp

Adopted Plans

Three states in New England—Maine, Massachusetts, and Vermont—have adopted healthcare reform plans that could lead to nearly universal coverage when fully implemented, provided they can conform to ERISA, which is discussed later in this issue of FlashPoint. In summary:

- **Maine.** The plan and law encompasses three approaches: (1) a health plan offered by private insurers to small businesses, the self-employed, and the uninsured; (2) new systems to control healthcare costs; and (3) initiatives to ensure high-quality healthcare statewide. The goal is for all residents to have access to health coverage by 2009. More information is available at: <http://www.dirigohealth.maine.gov/dhsp01d.html>.
- **Massachusetts.** To date this law and plan has garnered the most national interest. It takes into account a number of approaches with the underlying principle that the government, employers, and individuals all share responsibility for contributing to the cost of coverage, i.e., “play or pay.”

The Massachusetts plan includes a mandate that every individual have health insurance, assuming that affordable plans are available. All but the smallest employers will pay penalties if they do not offer subsidized insurance to their employees. The law establishes a state agency to connect employers to affordable health insurance plans and also mandates market reforms to help insurers develop affordable insurance offerings.

A brief but excellent summary of the Massachusetts reform law can be found at: <http://www.kkf.org/uninsured/upload/7494.pdf>.
- **Vermont.** This plan and law was adopted in 2006 and provides comprehensive coverage for the uninsured. Under this plan, insurers are invited but not required to offer a standard plan that allows enrollees to receive free preventive care or recommended care for chronic illnesses. Persons whose income is below 300 percent of the federal poverty limit will receive state premium support. Persons without insurance and not eligible for coverage under their employer’s plan are eligible to purchase coverage through Catamount Health, a group of private insurers in the small group market that offers a comprehensive package covering primary and chronic care and hospital services. Persons uninsured but eligible for coverage through their employer may receive state financial assistance if certain conditions are met. More information is available at <http://hcr.vermont.gov/>.

Proposed Plans

Various plans have also been proposed or are being considered in other states. A few examples:



- **California.** The vision of Governor Schwarzenegger is for healthcare reform to provide accessible, efficient, and affordable care under a system that promotes a healthier state using three building blocks: (1) prevention, health promotion, and wellness; (2) coverage for persons in the state; and (3) affordability and cost containment. The governor's proposal, among other things, will require every one of the state's 6.5 million uninsured to have health insurance with funds provided by individuals, employers, hospitals, other providers, and/or the state and federal governments.

All persons would be required to secure insurance coverage for themselves and their dependents at a level that protects them against catastrophic costs and cost shifting. The poorest persons would have access through expansion of the state's Medicaid and SCHIP programs. Among other provisions, employers of ten or more workers would be required to provide coverage to their workers or pay 4 percent of their payroll into the state's purchasing pool, i.e., "play or pay."

The governor's plan would also increase provider Medicaid payment rates in exchange for physicians and hospitals paying a "dividend" (2 percent of revenue by physicians and 4 percent of revenue by hospitals) to the state to help fund a state-run purchasing pool.

A detailed summary of the plan can be accessed at:
http://gov.ca.gov/pdf/press/Governors_HC_Proposal.pdf.

- **Illinois.** In July 2006, Illinois passed the "Covering All Kids Act," making insurance coverage available to all uninsured children as of January 1, 2007, with the cost to the family determined on a sliding-scale basis. And, as this brief is being prepared, Governor Blagojevich has announced that he intends to soon unveil a plan to offer health coverage for all of the state's uninsured. The proposal would expand the Illinois Medicaid program to cover 500,000 poor residents who currently do not qualify for assistance, and state subsidies from employers or from a state fund to be created under his plan would be used to help low income workers afford insurance.
- **Pennsylvania** has announced development of its "Cover All Kids" program,
- **Tennessee** has passed a "Kids Act," and others, such as Oregon, Wisconsin, New Mexico, and Washington, are considering similar proposals.
- **Kansas.** Governor Sebelius recently praised the Better Health Care Tomorrow Campaign: "The fact that business and labor have come together to issue a united call for change is remarkable, and it adds great momentum to the drive to reform our healthcare system."

A Kansas Senate Task Force has also recommended steps to improve the health of the state's residents and provide affordable and quality healthcare, including a market-based approach. The approach would, among other things, (1) increase the portability and ownership of individual health insurance policies, (2) use pre-tax dollars to purchase health insurance whenever possible, (3) expand the role of the consumer in healthcare decisions, and (4) use federal funds to subsidize premiums.

- **Maryland.** The state's newly elected governor Martin O'Malley is proposing the "Maryland Health Care Access Act of 2007." The Act's provisions include (1) expanding the SCHIP to cover children in families that earn up to 400 percent of the federal poverty limit, (2) requiring insurance companies to allow parents to cover dependent children up to the age of 25 on the parents' policy, (3) creating a



Maryland Health Insurance Exchange to enable small business owners to provide to their employees, on a pre-tax basis, access to a broad range of affordable policies, (4) creating an Institute for Health Quality to promote quality healthcare, and (5) creating a Task Force on Expanding Access to Affordable Health Care to examine issues such as the expansion of Medicaid to cover adults and incentives to small businesses to provide coverage and to individuals to secure coverage. Please see: <http://www.gov.stste.md.us/pressreleases/070122b.html>.

- **New York.** Another newly elected governor, Eliot Spitzer, announced at the end of January that the state should move toward a system of universal coverage as part of a multi-year strategy to fundamentally reform New York State's healthcare system. The key points in the plan are to expand the number of children covered under the state's health program; increase the number of people covered by Medicaid by easing the requirements for enrollment and re-enrollment; and increase efforts to combat Medicaid fraud. The governor will also look to reduce Medicaid spending on graduate medical education and freeze Medicaid reimbursement rates to hospitals and nursing homes.
- **Washington.** In mid-February 2007, Governor Gregoire lobbied lawmakers to support bills in the House and Senate aimed at expanding state residents' access to healthcare via universal health coverage for all by 2012. Among the provisions, the state would use its purchasing power to improve healthcare quality; emergency room visits would be reduced; better management of chronic care patients would be a priority; unmarried persons under age 25 would be covered; health insurance coverage would be portable from job to job; and premiums would be driven down by pooling public and private markets. Soon thereafter, and in concert with advancing the governor's broader plan, the Washington Senate passed legislation that would ensure that all children in the state would have health insurance by 2010. The governor's initiative is described more fully at: <http://www.governor.wa.gov>.

ERISA

At this time, many states, including Massachusetts and California, have or are contemplating healthcare legislation that includes "play or pay" provisions requiring employers to either provide health insurance coverage for their workers or pay into a state fund that covers the costs of the uninsured. These provisions and a likely myriad of regulations, as well as the provisions of the Employee Retirement and Income Security Act of 1974, could become a roadblock to the states achieving some of their healthcare reform goals. The key is whether these various state laws or proposed laws violate ERISA's federal framework for the administration and regulation of employee benefit plans or whether they regulate employers and insurance and not the ERISA plans. Multi-state employers are faced with the biggest problem since they could be faced with having to comply with a bevy of different rules and laws among the states in which they have employees, and some of the state plans could be preempted by ERISA.

A case has already been brought before and heard by a federal appeals court in Richmond, Virginia, involving Maryland's "Fair Share Health Care Act," a law that preceded governor O'Malley's plan referred to above, which would have employers spend at least 8 percent of the amount of their state payroll on health insurance costs beginning January 1, 2007. Covered employers who failed to do so would have been required to pay the difference to a public health fund to support the state's Medicaid and children's health programs.

ERISA contains expansive preemption provisions that seek to make the regulation of employee benefit plans exclusively a federal concern. In essence, Congress's intention was, with a few narrow exceptions, to create a uniform network of federal

law that would eliminate state law and regulation from plan design and administration. Congress particularly sought to eliminate the need for multi-state employers to administer their plans differently in each state. The federal court in Richmond relied on this fundamental tenet of ERISA when it overturned the Maryland Fair Share Health Care Act in January 2007.

Moody's Not-for-Profit Hospitals: 2007 State of the States

Statewide Initiatives to Play a Greater Role in Financial Performance

In its commentary released in February 2007, Moody's Investors Service writes that the role of individual states in not-for-profit healthcare promises to be more active than ever before as state initiatives are likely to be key factors in the performance of not-for-profit hospitals. As in the federal realm, state and local dynamics play a pivotal role in determining a hospital's ability to drive financial performance, especially as Medicaid programs are restructured and legislation is crafted to cover the uninsured and some states question the need for certain hospitals to exist as occupancy rates decline. In addition, some states are looking at the linkage between the provision of charity care and tax-exempt status. Due to these developments, activities below the federal level will play a greater role than ever before in affecting the near-term financial results of the not-for-profit sector.

The 14-page commentary addresses important credit issues facing not-for-profit hospitals in nine states and also provides ratings, both long- and short-term (as applicable), as well as an outlook evaluation of hospitals in those states. The states are: California, Florida, Illinois, Michigan, New Jersey, New York, Ohio, Pennsylvania, and Texas. In the summary opinion that begins the commentary, Moody's offers these observations:

- **California.** Significant capital needs in the state are exacerbated by excessive construction inflation, although many providers enjoy favorable fundraising capabilities, population growth, and continued managed care rate increases.
 - **Florida.** Steady population growth and financial stability are expected, although there are concerns about capital and staffing needs to meet demands, hurricane activity, and a strong for-profit presence. Medicare is particularly important due to the age of the state's population.
 - **Illinois.** Financial stability is expected since there is a fairly fragmented payor market and a provider tax program was recently reinstated. Capital spending, however, is on the rise and regulatory concerns exist.
 - **Michigan.** Relative stability is supported by a strong CON presence and the lack of a for-profit hospital presence, although negative outlooks versus positive outlooks in the state are a reflection of economic challenges in many markets.
 - **New Jersey.** Financial challenges are expected to continue as the state's charity care subsidies haven't kept pace with the provision of such care and this exacerbates the need for capital to replace aging plants.
- New York.** This is one of the most challenging healthcare environments in the United States due to the large number of competitors, a heavy union presence, high LOS, weak liquidity, a high concentration of payors, and a high level of Medicaid transactions.
- **Ohio.** There is relative stability as a result of recent consolidation, although negative outlooks exceed the positive. Financial performance is peaking as



hospitals face relatively flat patient volume, modest economic conditions, and increased competition.

- **Pennsylvania.** Future financial performance is expected to come under pressure due to capital needs, payor concentration in the Philadelphia and Pittsburgh markets, increasing for-profit presence, and modest demographics.
- **Texas.** Operating performance, favorable last year, benefited from tort reform and a lack of payor concentration in most markets, although physician and for-profit competition is fierce and the state has the highest percentage of uninsured in the country.

Please call Moody's at 1-212-553-4431 for more information.

In Conclusion

Whether it's the expansion of existing programs, creating small business and self-employed insurance pools, providing premium assistance for low-wage earners, or any number of other approaches, healthcare reform activities are taking place across the nation at the state level. What's more, bipartisan bills are emerging in the U.S. Congress to support states' efforts.

During the year, KPMG will periodically prepare follow-up briefs to keep you informed about significant matters and developments across the country in the areas of state healthcare reform, the uninsured, and related initiatives.

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