

STATE EFFORTS TO CLOSE THE HEALTH COVERAGE GAP

This review examines prominent state efforts to expand health coverage to the remaining uninsured. It analyzes and compares efforts in Massachusetts, Vermont, Colorado, California, and Nevada and highlights insights and themes that emerge. It explores the context and climate for reform within the state, stakeholder involvement, political coalitions, financing, and possible opposition. As such, it serves as a case study in how different states build, or fail to build, the popular and political will towards health care coverage for all residents. This is the first in a series of reports that will monitor and analyze developments at the state level to expand coverage and improve access to care.

There is a health coverage gap in the United States, with nearly [28 million individuals lacking health insurance coverage](#). While health insurance is not a guarantee of affordable health care or better health outcomes, [recent evidence](#) indicates that expanding coverage increases patients' access to primary care, preventive care, chronic illness treatment, medications, and surgery. State and federal governments have grappled with their role in ensuring coverage, attempting to close the coverage gap with a mix of public and/or private programs.

The Affordable Care Act (ACA) of 2010 was the most recent federal attempt to fill gaps in health coverage, and it made significant progress in reducing the uninsured rate. It is notable that as a compromise agreement, the ACA focused on incremental improvements rather than large-scale overhaul, particularly in the expansion of Medicaid and changes to the individual insurance market. Even if the ACA had been implemented as originally written, the Congressional Budget Office (CBO) [projected](#) that it would have left 23 million nonelderly people uninsured in 2019.

Overall, the goal of expanding coverage to the remaining uninsured enjoys general [public support](#), but there is little consensus around

policies to get us there. Further federal movement in that direction is unlikely in the immediate future, given the recent gridlock of the federal government. However, there has been activity at the state level toward this goal in recent years.

This review focuses on prominent state efforts that have, or had, as their primary goal to close the coverage gap, and highlights insights and themes that emerge. Other states have targeted important and relevant issues such as controlling health care costs, stabilizing private markets, improving choice, and increasing price transparency, all of which may help to expand coverage, but these efforts are beyond the scope of this review.

Overall, this review serves as a case study in how different states build, or fail to build, the popular and political will towards health care coverage for all residents. What might we learn across the experience of very different states, proposing very different solutions? We explore the importance of the current coverage gap within the state, building public will, stakeholder involvement, political coalitions, financing, and possible opposition.

MASSACHUSETTS (2006)

Massachusetts passed a health care reform bill in 2006 that became a model for the national effort that resulted in the ACA. It achieved nearly universal coverage in the state, covering 97% of all residents as of 2009.

Elements of Reform. The [Massachusetts reform](#) expanded Medicaid coverage; created state-subsidized insurance for low-income people not eligible for Medicaid; merged the individual and small-group insurance markets; instituted an employer “fair share assessment” and an individual mandate; and created the Commonwealth Connector, an insurance marketplace that also set coverage and affordability standards.

Climate for Reform. It is important to realize that Massachusetts was building on prior reforms to the individual marketplace, including guaranteed issue and community rating, and that the state had already broadened Medicaid eligibility under an 1115 waiver. The uninsured rate among the non-elderly was relatively low before the reform (10.9%, about 532,000 people), which dropped to 5.5% in the year after implementation. Massachusetts had other characteristics conducive to successful reform: it had a relatively high per capita income and large rate of employer-sponsored coverage. Massachusetts had also created an uncompensated care pool in 1985, to help compensate hospitals for otherwise unpaid care.

A motivating factor in reform was [revenue shortfalls and projected state budget deficits](#) that confronted the newly elected Governor Romney in 2003. Medicaid provider payments were cut an average of 3%-5% for hospitals, nursing homes, physicians, pharmacists, and managed care organizations. Enrollment and eligibility cutbacks were in the works as well. The existing system seemed fiscally unsustainable. One other immediate motivation was the impending [expiration of the Medicaid waiver](#), which put more than \$385 million in federal funds at risk without further reforms.

Political Support. The plan was introduced by a Republican governor, and endorsed by prominent Democrats, business leaders, consumer advocates, insurance executives, clergy, and hospital CEOs. The plan was three years in the making, beginning with a Blue Cross Blue Shield Foundation-funded initiative that developed a comprehensive “[Roadmap to Coverage](#).” Developed over two years with multi-stakeholder involvement, the Roadmap presented a plan that minimized 1) disruption to the employer market; 2) the need for new revenues; and 3) expansion of the government’s role. A central theme in the political debate was the need for “[shared responsibility](#)”—the idea that individuals, employers, and government would all need to contribute to achieving access to health care for all residents. A [survey](#) conducted six months after passage (but before implementation) found that 64% of Massachusetts residents were largely supportive of the new law.

Financing. In keeping with the theme of shared responsibility, the plan was financed by raising the level of funding from both the public and private sector. The [financing](#) of the plan “worked” because the new burden on taxpayers was presented as primarily a redirection of existing funding, with minimal impact on the state budget. After reform, with revenues redirected as shown in Figure 1, the net new spending was \$591 million, of which \$172 million — less than 1% of the state budget — came from the state’s general fund.

“Shared responsibility” was more than a slogan—a 2009 [report](#) found that the overall distribution of spending on health insurance by employers, individuals, and government remained essentially the same between 2005 and 2007. Only about half of the more than 400,000 residents who gained coverage by the end of 2008 were publicly subsidized. In 2009, two Massachusetts officials [noted](#) that “the individual mandate and employer incentives have provided good value for Massachusetts taxpayers, costing about \$1,060 in net new spending per newly covered resident in 2008. The state succeeded in enacting a government program that stimulated private parties to use private dollars to help fulfill a public good.”

Governing/Decisionmaking Body. The statute established the quasi-public Commonwealth Connector, an insurance-purchasing exchange, led by the Connector Board, composed of various stakeholders, including consumers, business, and labor. The board was charged with defining affordability, negotiating premium rates with health plans, developing consumers’ cost-sharing provisions, and defining the minimum benefits package. Significantly, Massachusetts did not include cost-control mechanisms such as rate setting or restrictions on cost growth.

KEY INSIGHTS:

- The Massachusetts reforms were built on pre-ACA scaffolding that included a low proportion of uninsured residents, a highly regulated insurance market, and significant state spending on an uncompensated care pool.
- Most of the residents that gained insurance did so through employers, thereby avoiding the political problems that a massive growth in government spending might produce.
- Bipartisanship—with support from a Democratic legislature and a Republican governor—reduced partisan divides and minimized entrenched opposition by party lines.
- The reform maintained the balance of funding across sectors, thereby minimizing narratives about “winners” and “losers.”

FIGURE 1
The Financing of Massachusetts Health Care Reform*

Source	Financing before Reform	Financing after Reform			Additional Financing, Fiscal Years 2006-2009
	Fiscal Year 2006, Actual	Fiscal Year 2007, Actual	Fiscal Year 2008, Actual	Fiscal Year 2009, Estimated	
<i>millions of dollars</i>					
Spending					
MassHealth	770	511	642	795	
Commonwealth Care	0	133	628	805	
UCP-HSTNF	656	665	416	417	
Total	1,426	1,309	1,686	2,017	
Additional, 2006-2009					591
Revenues					
UCP-HSNTF provider assessments and insurer surcharges	320	320	320	320	
Local contribution to MCO supplemental payments	385	0	0	0	
Federal financial participation	688	816	888	1,272	
Dedicated revenues	0	7	21	219	
Total	1,393	1,143	1,229	1,811	
Additional, 2006-2009					418
Difference					
General fund share	33	166	457	205	
General fund share of net new annual spending, 2006-2009					172

* Data are from the Massachusetts Executive Office of Health and Human Services. No enrollment increases besides those directly attributable to eligibility changes have been included in this analysis. Commonwealth Care spending is net of enrollee contributions. Dedicated revenues include new taxes and penalties dedicated to paying for health care reform. Some differences appear not to be exact, because of rounding. MCO denotes managed-care organization, and UCP-HSNTF uncompensated care pool—Health Safety Net Trust Fund (as the pool is called under health care reform).

SOURCE: Massachusetts Health Care Reform — Near-Universal Coverage at What Cost? [NEJM](#) 2009; 361:2012-2015

VERMONT (2011)

The most comprehensive state attempt to achieve universal health coverage in recent U.S. history occurred in Vermont. Its reform bill, Act 48, was enacted in 2011, with reformers wanting to improve upon the ACA to cover the entire population while simultaneously containing costs.

Elements of Reform. Act 48 instructed the state to develop a single-payer, government-financed system, called Green Mountain Care, to provide universal coverage, replacing most health insurance in Vermont except for Medicare and Tricare. Employees could choose to keep employer-sponsored health insurance, with Green Mountain Care as secondary coverage, but the Act anticipated replacing most employer-sponsored coverage. Non-residents working for Vermont-based companies would also be covered. The plan offered a broad array of services, designed to mirror or improve upon existing coverage for most Vermonters. It required that hospitals and providers accept 105% of Medicare reimbursement rates for their privately insured populations, and set an overall cost growth cap of 4%.

Climate for Reform. In 2007, Vermont had enacted a package of health reforms, including a new program for covering the uninsured known as [Catamount Health](#). This earlier reform was a product of political compromise, with private, subsidized coverage offered to low-income uninsured people. Catamount Health experienced higher-than-expected costs, the state had less revenue because of the recession, and the ACA catalyzed advocates who had pushed for more radical reform in the earlier efforts. Before Act 48 was enacted, 7.6% of non-elderly residents were uninsured in 2009. After the ACA was implemented, the uninsured rate dropped to 6% (second lowest in the U.S.), about 31,200 people.

Political Support. In 2010, Peter Shumlin, a progressive Democrat with a close alliance with Senator Bernie Sanders, ran on a single-payer platform and won election as Governor. State legislators also wanted to go beyond the ACA, and push for radical reform. The plan was bolstered by a strong “Healthcare Is a Human Right” campaign, and the involvement of well-known health economists William Hsiao and Jonathan Gruber. Hsiao had experience developing universal health coverage programs in other countries.

FIGURE 2
Financial Estimates from Three Projections for a Vermont Single-Payer Health Plan*

Variable	2011, Harvard	2013, UMass	2014, State of Vermont
Estimated savings (%)	8-12% short term; 24-25% long term	1.5% over 3 yr	1.6% over 5 yr
Estimated new taxes			
Employers	9.4% of payroll	Not estimated	11.5% of payroll
Employees	3.1% of household income	Not estimated	Sliding scale up to 9.5% of household income
Cost gap to be state financed	NA	\$1.6 million	\$2.5 billion
New federal revenues from ACA Section 1332	\$420 million	\$267 million	\$106 million
Total cost of Green Mountain Care	NA	\$3.5 billion	\$4.3 million

* ACA denotes Affordable Care Act, NA not applicable, and UMass University of Massachusetts

SOURCE: The Demise of Vermont's Single-Payer Plan. [NEJM](#) 2015; 372:1584-1585

However, in 2014, Gov. Shumlin won re-election by a single percentage point margin, which left him without a strong mandate to implement the single-payer promise he had run on. In addition, the political will to enact the plan waned in the absence of a clear financing mechanism.

Political Opposition. “Partners for Health Care Reform,” a coalition of the Vermont Medical Society, Fletcher Allen Health Care, Blue Cross/Blue Shield, Vermont Association of Hospitals and Health Systems, Vermont Business Roundtable, Vermont Chamber of Commerce, and the Vermont Assembly of Home Health Agencies, did not come out explicitly against the plan, but challenged some of the assumptions regarding provider payments and administrative savings. The group commissioned a report that estimated the plan would amount to a 16% cut in payments to doctors and hospitals (something the state disputed). Public opinion [polling](#) in 2011 found that residents were divided in their support for the law, with 40% supporting it, 35% opposing it, and 25% unsure. In 2014, [polls](#) showed that the public remained divided, with 40% supporting the plan, 39% opposing it, and 21% undecided.

Financing. The initial Act provided no financial details, but directed that a financing plan be produced by 2013. Initial estimates predicted immediate and longer term savings for the health system (see Figure 2), and concluded that a new payroll tax of 9.4% for employers and new income taxes of 3.1% for individuals would replace health insurance premiums. However, other estimates were not so optimistic, and Gov. Shumlin did not produce the report of how much the act would cost until long after it was introduced, which may have contributed to its failure. [Projections](#) kept changing because

anticipated federal revenues from Medicaid and the ACA declined in the interim, and because the new plan offered ‘platinum’ level insurance (94% actuarial value) rather than the 87% actuarial value of the initial estimate. Yet policymakers refused to reduce the offering to gold-tiered benefits because that would have been a downgrade in coverage for many Vermont citizens. The plan was also expensive because it tried to [replace](#) federally-subsidized insurance with state-subsidized insurance. In the final, official [analysis](#), the plan would require raising payroll taxes by 11.5% and income tax by up to 9%, with lower predicted savings to the health system of 1.6%.

Governing/Decisionmaking Body. Act 48 created the Green Mountain Care Board with unprecedented, centralized responsibility for benefits design, coverage, and premiums. It was tasked with controlling the rate of growth in health care costs and “improving the health of Vermonters” through a variety of regulatory and planning tools. These tools included all-payer rate setting and an explicit cost growth cap (4%). The Board consisted of five Vermonters, nominated by a broad-based committee and appointed by the Governor.

Outcome. Citing the risk of “economic shock,” Gov. Shumlin pulled the plan in December 2014, stating that it was not the time to move forward with a publicly-financed health care system in Vermont. “Our current way of paying for health care is inequitable. I wanted to fix this at the state level, and I thought we could. I have learned that the limitations of state-based financing – limitations of federal law, limitations of our tax capacity, and sensitivity of our economy – make that unwise and untenable at this time.”

KEY INSIGHTS:

- The public was divided in its support for radical health reform when it passed. Three years later, it was just as divided, in the [absence of any sustained effort to educate](#) the public about what the act did and how it would affect people’s lives. Thus, there was no groundswell of support when estimates were much higher than anticipated. Health reform needs significant time and energy devoted to educating the public about the plan and its financing.
- The state government did not produce a competing narrative to the complaint about big-government expansion.
- States must work with hospitals and providers at the table for buy-in and to develop all-payer rates and limits on cost growth. Vermont’s inability to bring these players together in support of the bill likely contributed to its failure.
- It is important to think about the behavioral economics of how a plan will be received. For example, workers might fail to notice their employer-based health insurance premiums, but would notice an increase in their tax bill.

COLORADO (2016)

Through a ballot initiative in 2016, Colorado was the next state to try to pass an ambitious, universal health coverage plan (ColoradoCare). The plan would have replaced most employer-sponsored insurance coverage, individual market plans, Medicaid, and CHIP with a single-payer system.

Elements of Reform. ColoradoCare was a taxpayer-financed system of universal health coverage for all Colorado residents. It would be created by the state constitution (through Amendment 69), but largely beyond the control of the governor and legislature. It would replace Medicaid (but not Medicare) and private insurance. It featured broad coverage, no restrictions on provider networks, no deductibles, and some copayments.

It would have also replaced the medical care portion of workers' compensation insurance. Beneficiaries that would have been eligible for Medicaid or the Children's Basic Health Plan would have received benefits required by federal law, in addition to ColoradoCare's standard benefits. The wording of Amendment 69, as presented to the voters on the [ballot](#), is below:

SHALL STATE TAXES BE INCREASED \$25 BILLION ANNUALLY IN THE FIRST FULL FISCAL YEAR, AND BY SUCH AMOUNTS THAT ARE RAISED THEREAFTER, BY AN AMENDMENT TO THE COLORADO CONSTITUTION ESTABLISHING A HEALTHCARE PAYMENT SYSTEM TO FUND HEALTHCARE FOR ALL INDIVIDUALS WHOSE PRIMARY RESIDENCE IS IN COLORADO, AND, IN CONNECTION THEREWITH, CREATING A GOVERNMENTAL ENTITY CALLED COLORADOCARE TO ADMINISTER THE HEALTHCARE PAYMENT SYSTEM; PROVIDING FOR THE GOVERNANCE OF COLORADOCARE BY AN INTERIM BOARD OF TRUSTEES UNTIL AN ELECTED BOARD OF TRUSTEES TAKES RESPONSIBILITY; EXEMPTING COLORADOCARE FROM THE TAXPAYER'S BILL OF RIGHTS; ASSESSING AN INITIAL TAX ON THE TOTAL PAYROLL FROM EMPLOYERS, PAYROLL INCOME FROM EMPLOYEES, AND NONPAYROLL INCOME AT VARYING RATES; INCREASING THESE TAX RATES WHEN COLORADOCARE BEGINS MAKING HEALTHCARE PAYMENTS FOR BENEFICIARIES; CAPPING THE TOTAL AMOUNT OF INCOME SUBJECT TO TAXATION; AUTHORIZING THE BOARD TO INCREASE THE TAXES IN SPECIFIED CIRCUMSTANCES UPON APPROVAL OF THE MEMBERS OF COLORADOCARE; REQUIRING COLORADOCARE TO CONTRACT WITH HEALTHCARE PROVIDERS TO PAY FOR SPECIFIC HEALTHCARE BENEFITS; TRANSFERRING ADMINISTRATION OF THE MEDICAID AND CHILDREN'S BASIC HEALTH PROGRAMS AND ALL OTHER STATE AND FEDERAL HEALTHCARE FUNDS FOR COLORADO TO COLORADOCARE; TRANSFERRING RESPONSIBILITY TO COLORADOCARE FOR MEDICAL CARE THAT WOULD OTHERWISE BE PAID FOR BY WORKERS' COMPENSATION INSURANCE; REQUIRING COLORADOCARE TO APPLY FOR A WAIVER FROM THE AFFORDABLE CARE ACT TO ESTABLISH A COLORADO HEALTHCARE PAYMENT SYSTEM; AND SUSPENDING THE OPERATIONS OF THE COLORADO HEALTH BENEFIT EXCHANGE AND TRANSFERRING ITS RESOURCES TO COLORADOCARE?

Climate for Reform. In 2013, 14% of Colorado's non-elderly residents, approximately 646,200 people, were uninsured. After implementation of the ACA, the uninsured rate decreased to 10% (469,600 people), but parts of Colorado (rural areas with few providers and little insurer competition) faced skyrocketing premiums and growing cost-sharing.

Political Support. The initiative was shepherded by physician and Colorado State Sen. Irene Aguilar, a Democrat, and had the support of slightly more than half of the Democratic-controlled legislature. It garnered the necessary 100,000 signatures to put it on the ballot by tapping into public frustrations over rising out-of-pocket costs and limited coverage. It was supported by ColoradoCareYES, a community-based organization.

Political Opposition. The Denver Metro Chamber of Commerce coordinated opposition through a campaign group called Coloradans for Coloradans. State Treasurer Walker Stapleton, a Republican, and former Governor Bill Ritter, a Democrat, co-chaired the group. Gov. John Hickenlooper, a Democrat, also opposed the proposal, stating, "Our reforms are just beginning to bear fruit...and it would be premature to dramatically remake our health care system at this time." Strong bipartisan political opposition included four U.S. representatives, more than a dozen state senators, and more than a dozen state representatives. Sen. Bennet and three former governors spoke out against it, while candidates up for re-election found it risky to support the plan. Additionally, influential industries including realtors, bankers, farmers, contractors, and especially health insurance companies opposed it.

The measure lost the support of important women's health groups due to a fear that because the Colorado state constitution bans the use of 'public funds' for abortion, women covered by ColoradoCare would not be covered for abortions. By August 2016, the liberal group ProgressNow Colorado announced its opposition to the measure.

Financing. Unlike Vermont, Colorado did propose a financing plan: a payroll tax of 10% (pre-tax payroll premiums of 3.33% for employees and 6.67% for employers), and 10% of all non-payroll income, such as self-employment and capital gains. The tax would apply to individual income below \$350,000 for a single person, or \$450,000 for married couples filing jointly. Business owners said the extra taxes would have been burdensome and unpopular, driving business from the state. When fully implemented, the plan would cost \$36 billion, more than the state's present budget. An independent, nonpartisan [analysis](#) concluded that the proposed revenue to pay for ColoradoCare would not keep up with increasing health care costs, resulting in growing deficits each year.

Governing Body/Decisionmaking. The Amendment proposed an interim board of 15 members appointed by the Governor and legislative leaders, followed by a permanent 21-person board of trustees elected from seven districts across the state. That board would set benefits and budgets. There was a great deal of fear that the board would have too much control over health care, and voters would not have been able to recall the elected board members. Detractors also said that health care providers could be inadequately reimbursed under the new system, causing them to stop providing care in Colorado and, thus, decreasing Coloradans' health care choices.

Outcome. When Colorado put single payer on the ballot as Amendment 69 in 2016, it failed badly, with 79% voting against it. Opponents (Coloradans for Coloradans) [outspent](#) supporters

(ColoradoCareYES) by more than five to one, with messages focused on the increased tax burden on employees and employers, and claiming that inadequate reimbursement would lead to a decrease in health choices.

KEY INSIGHTS:

- A ballot initiative, because the language is set early, does not lend itself well to the process of building support over time for large-scale reforms.
- It is clear that tax shock is a severe obstacle to such efforts. Support for single-payer dramatically drops if a tax hike is imposed. “Shall state taxes be increased \$25 billion annually...” is not likely to be positively received without a major initiative to educate the public about savings in the long-term.
- Fear of diminished or constrained choices in providers or coverage proved to be a powerful drawback. There was little appetite for delegating choices to a board, even an elected one; the public’s distrust of such governing bodies runs deep.
- Fractured coalitions with the loss of women’s health groups proved problematic.
- Without unified support from either party’s officials, building political will for large-scale reform is unlikely.

CALIFORNIA (2017)

The next state to attempt universal health coverage was California. In June 2017, the California State Senate passed a bill to create “Healthy California”—a program to create a single health care market in the state.

Elements of Reform. The bill would create the “Healthy California Trust Fund” in the State Treasury. Federal and state funds previously allocated to Medicaid, CHIP, Medicare, ACA subsidies, and others would be deposited in the trust fund. Under the Healthy California plan, individuals would not be subject to premiums, copayments, or deductibles. Medical, pharmaceutical, dental, vision, and long-term care would be provided to all residents—including undocumented immigrants—free of charge. Providers would be paid Medicare rates.

Climate for Reform. In 2013, 16% of California’s non-elderly residents, approximately 5.47 million people, were uninsured. After implementation of the ACA (and Medicaid expansion), the uninsured rate dropped to 10% (2.95 million people) in 2016. One in three of California’s remaining uninsured are non-citizens who are not eligible for any public program of coverage. California has a long [history](#) of campaigns and political leaders who have espoused universal coverage.

Financing. The bill required the legislature to develop a revenue plan for Healthy California. Experts [estimate](#) the program would

cost about \$400 billion per year—double California’s current budget. California could cover about \$200 billion from current federal and state spending—including Medicaid and Medicare. An additional \$100 to \$150 billion could be captured from what employers are already spending. The additional funding needed could involve a 15% payroll tax, a 2.3% sales tax, and/or a business tax increase.

Political Support. The powerful California Nurses Association led the campaign for the bill, with other support from labor unions and consumer groups. [Public support](#) in California for single payer is 65%, yet drops to 42% if such a plan requires an increase in taxes. Lt. Gov. Gavin Newsom supports single payer and is running for governor in 2018.

Political Opposition. A wide array of business groups opposed the measure, including health insurers, manufacturers and the [California Chamber of Commerce](#), which called the bill a “job killer” because of the tax burden it would impose on responsible employers. Opponents also pointed to the lack of cost containment measures that would lead to budget shortfalls, requiring drastic cuts in services or long waits for providers.

Governing Body/Decisionmaking. An independent public entity called the Healthy California Board would govern the program. The nine-member board would have representatives from the health care sector, labor, and the general public, and include individuals with health care experience. The Governor, Senate Committee on Rules, and Speaker of the Assembly would appoint the board members, and each member would serve four-year terms. The board would be responsible for negotiating contracts and payment methods with health care providers and health care systems, and for seeking necessary waivers and approvals to allow existing federal health-related payments to be made directly to the program.

Outcome. California Assembly Speaker Anthony Rendon shelved the plan in June 2017, citing a lack of a funding mechanism that would allow it to deliver the care and coverage that it promised. The measure is likely to be reconsidered in the 2018 legislative session.

KEY INSIGHTS:

- The California plan is about as ambitious, and disruptive, as has been introduced.
- The plan faced significant hurdles both politically and practically. It would require a variety of federal waivers of existing Medicaid and Medicare regulations, and the financing mechanism would need to be developed.
- The lack of a defined financing mechanism for California’s proposal left even its supporters unable to proceed.
- Because the plan would create a true single-payer market (replacing all present insurance, both public and private) it faced predictable

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and well-funded opposition from those whose livelihoods were at stake (such as health insurers).

- California is one of the success stories in terms of implementing the ACA and creating a robust individual market. The fact that many of its remaining uninsured cannot obtain coverage through ACA-related provisions (due to citizenship status) provides incentive to pursue disruptive change.

NEVADA (2017)

In 2017, the Nevada legislature passed a plan to take the state closer to universal health coverage by building on the existing multi-payer model. It leverages the structure and negotiated rates of Medicaid to create a “public option” plan on the state exchange. It should be noted that although the plan would be available to all, it would not be subsidized—making it a vehicle for incremental progress, while unlikely to achieve universal coverage on its own.

Elements of Reform. The Medicaid-buy in model—known as “Sprinkle Care” after its namesake and champion, State Rep. Mike Sprinkle, a Democrat—would have been the first state program to allow individuals of all incomes to buy into Medicaid, at full cost; low-income people who qualify for tax credits under the ACA would have the option to use those credits to buy Medicaid-style coverage on the state’s Health Insurance Exchange. Employer-sponsored insurance and Medicare would have been maintained, but a commercial insurance product resembling the state’s Medicaid coverage would have provided consumers a new option and leveraged the state’s lower Medicaid reimbursement rates. The bill was only four pages long, and provided limited information on costs, premiums, and cost-sharing.

Climate for Reform. Prior to the implementation of the ACA, 22% of Nevada’s non-elderly population (522,200 people) were uninsured in 2013, one of the highest rates in the nation. A number of factors accounted for the high rate of uninsured, including Nevada’s high rate of service sector jobs and low-wage jobs without health benefits, as well as a high level of unemployment.

Under the ACA, that percentage was cut in half, primarily because of Nevada’s Medicaid expansion, in which enrollment grew by 90%. Nevada’s Gov. Brian Sandoval was the first Republican Governor to choose to expand Medicaid after the Supreme Court made it optional. According to Rep. Sprinkle, [the idea for the bill](#) sprung from two dynamics: first, the new Administration’s support for a greater state role in health reform decisions, and second, ambiguity and uncertainty around whether the ACA would continue to exist. A primary motive to move the bill was to give the Medicaid expansion population an option to buy-in if the ACA were repealed and the state lost the significant federal subsidy that enabled it to expand Medicaid in the first place.

Political Support. In 2017, Democrats controlled both chambers of the Nevada Legislature, which meets every other year. During floor votes on the House and Senate floors, there was no debate even as the bill passed along largely party lines. Nearly one in four Nevada residents is insured by Medicaid, which enjoys broad popular support.

Political Opposition. The Nevada Hospital Association, along with other health care providers, voiced concerns about the new plan reimbursing them at lower rates. However, they remained neutral, given the lack of detail about whether the plan might displace private payers or primarily be an option for people who were uninsured or at risk of losing their existing Medicaid coverage.

Financing. No details. According to Rep. Sprinkle, the state insurance commissioner was prepared to obtain an actuarial estimate of the premiums and costs once the bill was signed. The goal, he said, was to offer a premium that “is affordable, but that is also not going to cause such marketplace disruption that we lose a private insurance industry that we obviously need in the state.” Because the bill included no state subsidies for the plan, its effect on taxpayers would be minimal, with administrative costs built into the premium calculation.

Governing Body/Decisionmaking. The Nevada Medicaid Department would manage the new program, which would be separate from the Medicaid program. The department would have the option to contract with managed care organizations (MCOs), as it does with four MCOs in the Medicaid program in the more populous areas of Nevada.

Outcome. In June 2017, Gov. Sandoval, a Republican, vetoed the plan, writing that the legislation was “an undeveloped remedy to an undefined problem.” He also expressed concern that many people buying into the plan would be those with private insurance, rather than the uninsured. Proponents vowed to bring the plan back for consideration in the next legislative session in 2019.

KEY INSIGHTS:

- A Medicaid buy-in approach made sense in a state that saw its uninsured rate decline significantly through Medicaid expansion.
- The bill passed quickly in reaction to the threat of ACA repeal and particularly threats to federal Medicaid funding.
- The plan had a short timeline for start-up, with a target date of January 2019, with few details on how the plan would actually work. This likely contributed to its failure.
- The plan sought to build upon Nevada’s existing framework, which includes four managed care companies with Medicaid contracts. In so doing, it attempted to avoid severe pushback from the insurance industry.

EMERGING QUESTIONS AND THEMES

This review summarizes prominent recent attempts at the state level to adopt health reforms that could improve health care access through expanding coverage to all residents. As such, each state operates as a case study in building, or failing to build, the popular and political will towards reform. What might we learn across the experience of very different states, proposing very different solutions?

GETTING TO THE FINISH LINE

States that have pursued universal health coverage often have relatively low percentages of uninsured residents, meaning that the gaps in coverage they have to fill may be small. But paradoxically, it may be harder to build the support to pass a broad proposal when the coverage problem is limited. In the face of small coverage gaps, disruptive reforms may encounter majorities of the public fearful of changes to their existing coverage and thus more skeptical of change.

BUILDING PUBLIC SUPPORT

Educating the public about present health care costs and existing financing mechanisms is key. An understanding of this dynamic is essential to understanding the “problem” and countering the message of higher taxes. Financing through taxes leaves taxpayers (and the proposals) vulnerable to health care costs that grow at greater rates than revenue sources.

FINANCING

These proposals had varying levels of information as to the financing for the reforms. Some efforts floundered by either not offering information about how their policy would be fiscally sustainable, or by proposing drastic tax increases that faced backlash from the public and business community. Massachusetts found success by demonstrating the program could be paid for by reallocating existing funding sources and would require minimal new state funds, in the “shared responsibility” model.

STAKEHOLDER INVOLVEMENT

Building a broad stakeholder coalition in support of coverage expansion proposals is an important element of success in swaying public opinion and political support. Influential stakeholders who feel left out, or who feel their interests may be threatened, are likely to galvanize opposition to efforts to expand coverage. In particular, hospitals and other providers should be brought in early to address concerns about the long-term adequacy of payments.

BUILDING POLITICAL COALITIONS

Although universal health care is often considered a Democratic issue, the example of Massachusetts shows that it can be a Republican one as well. Conversely, the example of Colorado shows that health reform can cause intraparty division and bipartisan opposition, especially if it conflicts with other party priorities.

COUNTERING THE OPPOSITION

Single-payer proposals create the impression of larger government at the expense of the private sector, while an all-payer model raises the specter of price setting and price caps. In either case, getting the language right is essential, to avoid concepts that prompt immediate opposition. The example of Massachusetts shows that messaging such as “shared responsibility” can be used to counter these objections effectively.

DETAILS

One unanswered question is whether including details in an initial proposal is a help or hindrance to initial buy-in. It may be the case that when building upon existing frameworks, detailed plans are not needed for buy-in; but when planning for disruptive change, detailed financing and payment plans are essential in fully educating the public, or opponents may fill the void with scare tactics.

THE IMPORTANCE OF THE FEDERAL GOVERNMENT

Implementing universal coverage in a state, by almost any mechanism, must involve buy-in from the federal government in terms of waiver approvals. It is important for proponents to understand what the parameters of that approval might be, and to frame state debates within the context of the federal government’s likely reaction.

FUTURE STATE EFFORTS

Expanding health coverage to all people is a popular idea, but not a monolithic one. In the coming years, many states will consider a variety of approaches specific to their needs, population, economic characteristics, and political will for reform. Some state leaders are pursuing a single-payer model, and others are looking to find market-based solutions with a mix of public and private payers.

Our future analyses will examine and track developments at the state level to catalogue and share lessons learned, and inform state lawmakers as they consider alternatives. As they do, we will update this review and build on the foundation of both the successes and the failures.

This review was prepared by Janet Weiner, Rebecka Rosenquist, and Erin Hartman at Penn LDI. It was produced as part of a research partnership between United States of Care and Penn LDI, and we thank reviewers from both organizations for their valuable input.



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