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Feature

The Prospects for Health Reform in 2009

On November 4, U.S. voters chose a president who made health care reform a central part of his campaign. But at this moment the issue of most concern to Americans is the economic crisis. As the new administration prepares to take office later this month, it is not yet clear whether the economy will push health reform and other priorities off the table, or whether the economy and the health care system will be viewed as intertwined elements that should be addressed together.

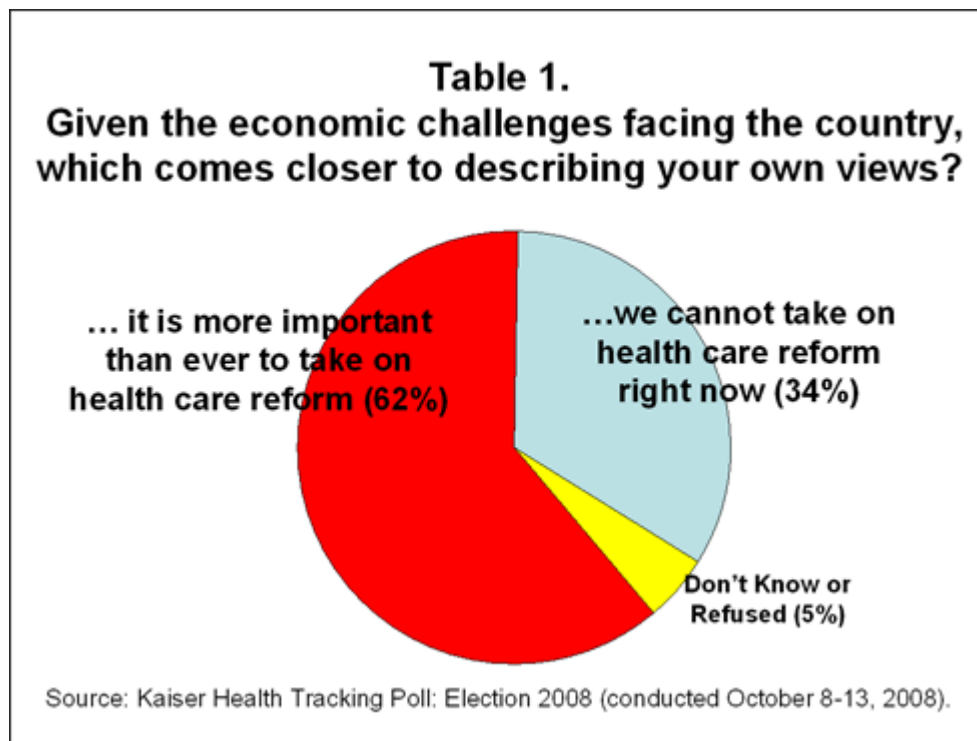
This issue of *States in Action* considers the prospects for a health care overhaul based on voters' opinions, President-elect Barack Obama's choices for a health care reform team, signals from incoming

Congressional leadership, and the specter of an ever-worsening economy.

Voters Want Change...But Not Necessarily for Themselves

Since 1988, health care has been one of the six most important issues to voters in each presidential election. In 1992, health care ranked among voters' top two priorities during an election that preceded the national debate over—and ultimate rejection of—the Clinton Administration's plan for health system reform.

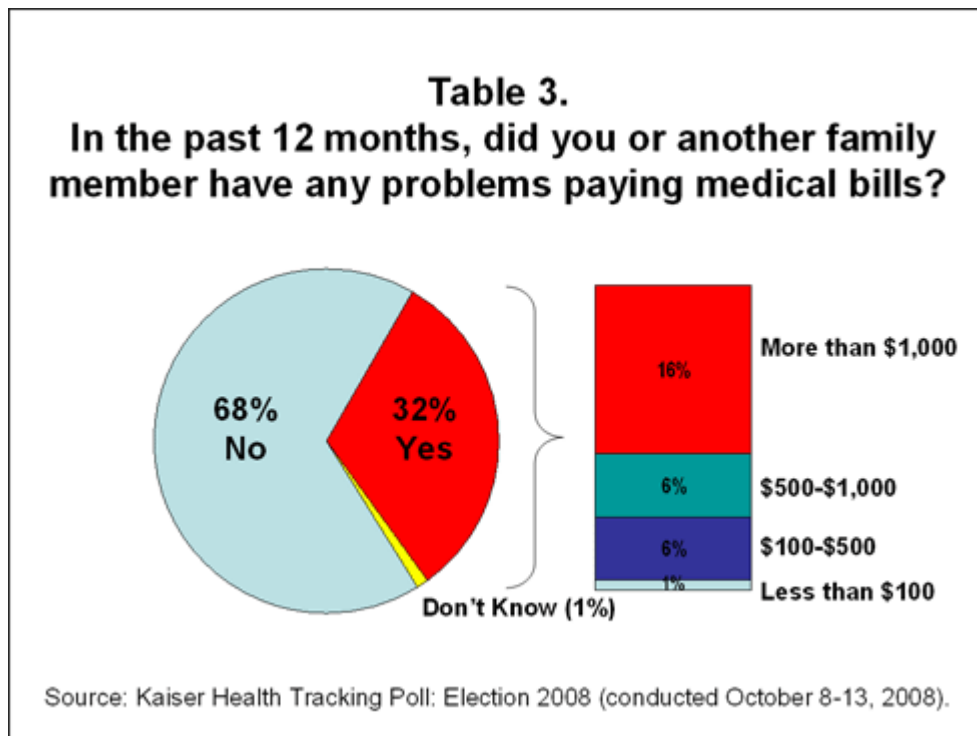
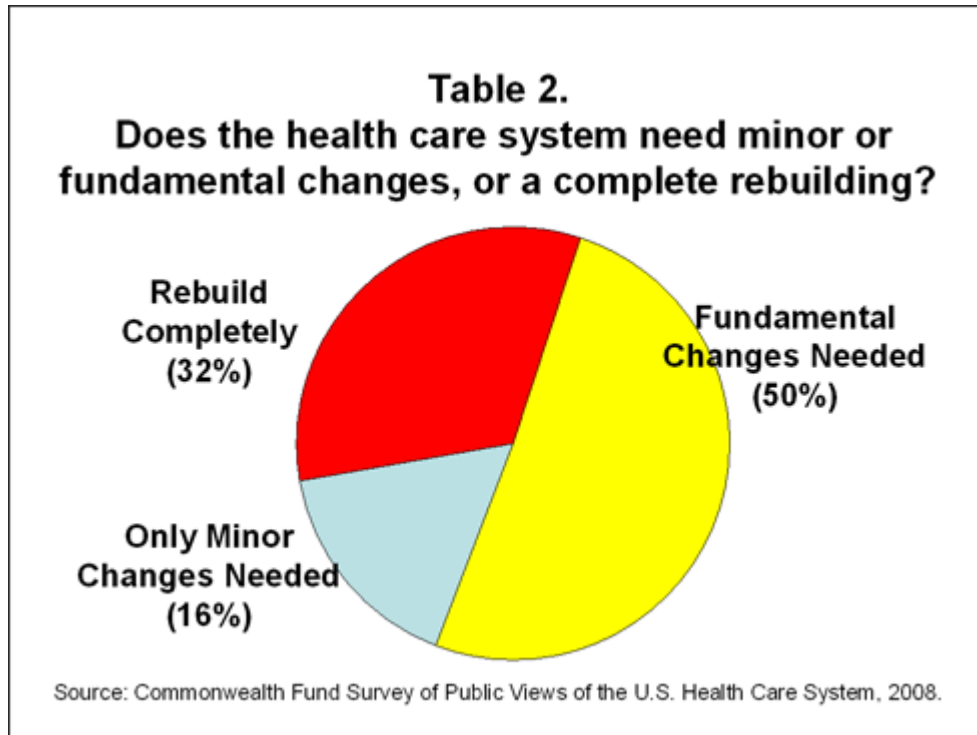
In 2008, registered voters ranked health care third as a stand-alone election issue, behind the economy/jobs and energy/gas prices. [1] However, most Americans see health care and the economy as related, and 62 percent believe it is more important than ever to take on health care reform (Table 1).



In a recent poll, the majority (77%) of respondents said that the new president should make major changes in the health care system (20% say he should not), and about half of respondents believe Obama should seek the changes immediately after he takes office. [2] Nearly three-fourths of respondents said that the new president should increase federal funds for health insurance for children.

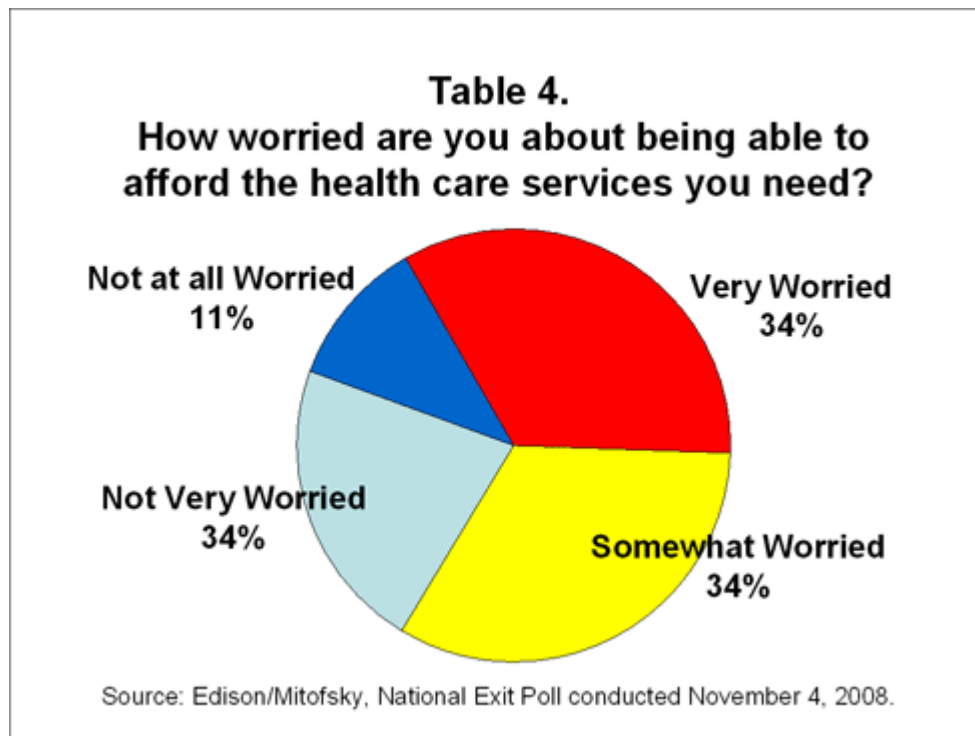
These responses mirror the results of surveys conducted earlier this year that indicated the vast majority of Americans believe the health care system needs fundamental changes or complete rebuilding (Table 2). About one of three Americans reported their family has had problems paying medical bills in the past year, up from about a quarter saying the same two years ago, and one of five report household problems with medical bills amounting to more than \$1,000 in the past year

(Table 3). Yet, polls also indicate that the public fears major change from the status quo, particularly if it affects them and their families. [3]



When asked about specific health care reform priorities, voters in 2008 ranked affordability as their top priority and expanding health insurance coverage second. [4] In exit polls, 65 percent of voters were somewhat or very worried about being able to afford the health care services they need (Table 4). Yet, only one proposal was viewed "very favorably" by a majority of registered voters—requiring health insurance companies to cover anyone who applies, even if they have a previous illness.

The challenge for health reformers will be to respond to Americans' urgent call for significant reform in a way that places affordability front and center, does not significantly change coverage for people satisfied with what they have, and negotiates the devilish details without unleashing, as in the past, a firestorm of opposition.



Obama Health Care Team to Hit the Ground Running

On December 19, President-elect Barack Obama nominated former Senate Majority Leader Tom Daschle to lead the Department of Health and Human Services (HHS) and named him the Director of a new White House Office of Health Reform. The Daschle nomination is being taken as a sign that the administration plans to begin work on a health care overhaul early in 2009. In his recent book, *Critical: What We Can Do About the Health Care Crisis*, Daschle argues that the 1993 health care reform effort failed primarily because President Clinton waited too long to get started.

The Clinton reform plan met its end in Congress amid criticism that the administration had been naïve in believing it could simply hand off a full-blown proposal to Congress for enactment. Daschle's former colleagues on both sides of the aisle say he is a smart choice to avoid the mistakes of the past and work with Congress to craft and pass a health care plan. Daschle served three terms

as a senator from South Dakota and led Senate Democrats from 1995 until he lost his reelection in 2004. [5] Daschle is by all measures well-respected by the political leaders who hold the positions that will determine the outcome of any overhaul attempt in 2009.

In addition to reaching out to his friends in Congress, Daschle is also hoping to encourage a grassroots campaign for health care reform. Taking a page from the Obama campaign playbook and sending the message that the new administration will be listening to citizens' voices, Daschle invited Americans to sign up to lead a Health Care Community Discussion in their home or community over the holidays.

President-elect Obama's transition team has also created a [Health Care Policy Working Group](#) to help prepare the incoming administration to address "the urgent and long-run challenges in the health system." Working group members—whose resumes generally showcase experience on Capitol Hill and in the Clinton-era HHS—include Lauren Aronson of Rep. Rahm Emanuel's congressional office; Dora Hughes, M.D., who worked in Obama's U.S. Senate Office and at The Commonwealth Fund; and David Cutler, a Harvard economist and part-time Obama campaign advisor. Jeanne Lambrew, Ph.D., an associate professor of public affairs at the University of Texas and co-author of Daschle's book, will serve as Deputy Director of the White House Office of Health Reform.

Congressional Leadership Shows Interest

Most of the congressional leaders who are in a position to support or resist health care reform have signaled their eagerness to pursue health system change. House Speaker Nancy Pelosi (D-Calif.)—along with fellow influential California Democrats Rep. George Miller, chairman of the Education and Labor Committee, Rep. Pete Stark, chairman of the Ways and Means Health Subcommittee, and Rep. Henry Waxman, chairman of the Energy and Commerce Committee—is poised to follow the lead of the new administration.

The Senate is being watched carefully by proponents of a health system overhaul because the Democrat majority will likely need Republicans, as well as conservative Democrats, to achieve the 60 votes required to pass most legislation. Sen. Max Baucus (D-Mont.), chairman of the Senate Finance Committee, says that an overhaul aimed at providing insurance coverage to all or most Americans—and reducing the costs of health care—will be his committee's top priority in 2009. It is also the top priority of Sen. Edward Kennedy (D-Mass.), chairman of the Senate Health, Education, Labor and Pensions Committee. The two panels will share jurisdiction over any legislation that touches both private and public insurance programs. So far, Baucus and Kennedy are expressing support for each others' plans and say that they intend to unify the Senate around one proposal.

Weighing the Proposals

During the campaign, President-elect Obama outlined a [plan](#) for universal coverage that would build on the current system of mixed private and public group insurance. Some of its features are similar to the universal coverage law now being implemented in Massachusetts. All employers, other than small businesses, would be required to offer health insurance to their employees or contribute to the cost of coverage. Eligibility for Medicaid and the State Children's Health

Insurance Program (SCHIP) would be expanded. Small businesses, self-employed individuals, and people who do not have coverage through their employers, Medicaid, or SCHIP would be able to purchase a plan through a new insurance market called the National Health Insurance Exchange. Through this exchange, people could choose a private plan or a new public plan. All insurance carriers would be required to offer plans to all applicants and could not charge premiums based on health status. Small businesses would be eligible for tax credits to offset their premium costs and individuals would be eligible for income-based premium subsidies, though the size of eligible small businesses was never defined.

The Tax Policy Center has projected that, in 2018, the Obama plan would reduce the number of uninsured by 33.9 million at a cost of \$237 billion and, over a 10-year period, the total federal cost could reach \$1.6 trillion. [6]

The health reform plan Daschle outlines in his book mostly reinforces the Obama approach, with some interesting exceptions. For example, Daschle proposes creating an independent "federal health board" to conduct research to determine which health procedures and treatments are most effective and to make recommendations about which ones should be covered under public and private insurance plans. He also endorses requiring all Americans to purchase health insurance, a measure that President-elect Obama has said isn't necessary to overhaul of the system.

Daschle's approach to health system reform is similar to a proposal recently unveiled by Senate Finance Committee Chairman Baucus. The chairman's [Call to Action: Health Reform 2009](#) expresses the same basic principles for reform outlined by Daschle—expanding health coverage and cutting costs by requiring all but the smallest companies to provide health insurance for their employees, providing tax breaks for people who cannot afford to buy coverage, and setting up a federally backed insurance system open to anyone. Obama, Daschle, and Baucus are all clear that they want people who are happy with their employer-provided insurance to be able to keep it.

All of these health care reform proposals envision a larger role for Medicaid and therefore states, which administer and partially fund the program. The proposals also address the need to get better value out of every health care dollar spent. States, which are constitutionally required to balance budgets, have been innovators in doing more with less and, in some cases, have been able to achieve gains in health outcomes without higher public program costs. Examples of promising [state innovations](#) that could become the basis for national health care reform include initiatives to improve prevention and primary care; paying for provider performance and not paying for mistakes; insisting on price and quality transparency from providers; improving care management for acute and long-term care; and establishing statewide purchasing pools or "connectors," combined with public subsidies and requirements, to extend coverage.

It's the Economy, Again

While some health care analysts have expressed concern that the nation's economic problems will hurt next year's chances for passage of major health care legislation, Baucus says a major overhaul of the nation's health care system is "central to restoring America's economy." And by appointing Tom Daschle to the health job, the President-elect seems to be defying the view that the state of the economy rules out such an expensive initiative. After all, the deepening recession is likely to have a devastating impact on coverage as companies lay off employees or scale back or abandon

the insurance packages they offer to their workers. (Jonathan Gruber, Ph.D., a professor of economics at the Massachusetts Institute of Technology, makes this case in a December 4 *New York Times* Op-Ed summarized in the box below.) Also, on the heels of unprecedented financial bailouts for American businesses and talk of additional stimulus spending, it might become politically easier to make the case that health care benefits for ordinary people are just as important as the welfare of corporations.

Leading up to the 1992 presidential election and the 1993 health reform debate, James Carville constantly reminded the Clinton campaign, "it's the economy, stupid." In 2008, the economy is again playing a central role in determining the future course of health reform. Will the incoming administration focus first on restoring the failing economy to the exclusion of other priorities? Or will a health system overhaul be seen as essential for economic recovery? The answer will likely emerge early in 2009 and set the course for reform. The new administration and Congress will do well to reflect on lessons learned from the failures of 1993, but also to think back further to 1965 when quick action and political tenacity delivered reforms that today provide health coverage through Medicare and Medicaid to one of three Americans.

Jonathan Gruber on Why Health Reform Is Good Medicine for the Job Market

One of the most effective ways to stimulate the economy would be to give states federal money to enroll more people in Medicaid and the State Children's Health Insurance Plan. This would free up state money for rebuilding roads and bridges and other public works projects.

Investing in computerized recordkeeping, and the improved sharing of information among doctors that it would enable, would improve the quality of patient care, perhaps also lower medical costs and, more immediately, create jobs in the technology sector.

Expanded insurance coverage would drive demand for high-paying, rewarding jobs in health services. Most reform proposals emphasize primary care, much of which can be provided by nurse practitioners, registered nurses, and physician's assistants. These jobs could provide a landing spot for workers who have lost jobs in other sectors of the economy.

Health care reform would also stimulate consumer spending, as previously uninsured families would no longer need to save every extra penny to cover a medical emergency. When the federal government expanded Medicaid in the 1990s, the newly insured significantly increased their spending on consumer goods.

Experts have yet to figure out how to restrain cost increases without sacrificing the quality of care that Americans demand, but cost control would be easier in an environment of universal coverage.

SOURCE: J. Gruber, "Medicine for the Job Market," *The New York Times*, December 4, 2008.

For More Information**See:**

- S. R. Collins, J. L. Nicholson, S. D. Rustgi, and K. Davis, [The 2008 Presidential Candidates' Health Reform Proposals: Choices for America](#), The Commonwealth Fund, October 2008.
- R. J. Blendon, D. E. Altman, J. M. Benson et al., [Voters and Health Reform in the 2008 Presidential Election](#), *The New England Journal of Medicine*, Nov. 6, 2008 359(19):2050-2061.
- C. Schoen, S. K. H. How, I. Weinbaum, J. E. Craig, Jr., and K. Davis, [Public Views on Shaping the Future of the U.S. Health Care System](#), The Commonwealth Fund, August 2008.

References

- [1] R.J. Blendon, D. E. Altman, J. M. Benson et al., [Voters and Health Reform in the 2008 Presidential Election](#), *The New England Journal of Medicine*, Nov. 6, 2008, 359(19):2050-2061.
- [2] *Washington Post*–ABC News Poll, conducted by telephone between Dec. 11 and Dec. 14, 2008; responses from a random sample of 1,003 adults, with a margin of error of plus or minus three percentage points (Cohen/Agiesta, *Washington Post*, 12/21).
- [3] M. Brodie, [Public Opinion, Election 2008 and Health Care Policy](#), Presentation, December 9, 2008.
- [4] Blendon et al., 2008.
- [5] After leaving Congress, Daschle has worked as an advisor for the lobbying firm Alston & Bird and has served as a senior fellow at the Center for American Progress, a Democratic think tank.
- [6] L. Burman, S. Khitatrakun, G. Leiserson et al., [An Updated Analysis of the 2008 Presidential Candidates' Tax Plans](#), Urban Institute–Brookings Institution Tax Policy Center, September 12, 2008.

Snapshots**State Ballot Initiatives**

On Election Day 2008, voters across the country voted for or against 153 ballot initiatives on issues specific to their states. Of the fewer than 20 ballot initiatives related to health care, three were related specifically to health system reform. (For information about other health-related ballot initiatives including those related to medical marijuana, abortion, long-term care, bonds for financing health care services, and other issues see: <http://www.ncsl.org/programs/legismgt/elect/dbintro.htm>.)

The three state ballot initiatives related to health system reform—in Montana, Arizona, and Maine—do not seem to indicate a national trend toward or away from any particular type of health reform strategy. Montana voters supported expansion and coordination of publicly funded children's health coverage, while Arizona voters narrowly rejected a state Constitutional amendment that would have prohibited an individual or employer mandate or a single-payer system. Both of these referenda suggest support for state initiatives to expand coverage. Maine voters, on the other hand, rejected replacing the current funding mechanism for the Dirigo Health Plan—which provides subsidized coverage to small firms and low-income workers and their families—with a new, potentially more stable financing method. It is likely, however, that the Maine vote expressed the public's rejection of new taxes during difficult economic times rather than support for or against the Dirigo health program.

Below we describe these three 2008 ballot initiatives in more detail.

Montana Passes Healthy Montana Kids Plan Act

In November, Montana residents overwhelmingly passed Initiative 155, which establishes the Healthy Montana Kids plan to expand and coordinate coverage for uninsured children under Medicaid and SCHIP. The plan calls for: 1) raising income eligibility levels for children under SCHIP and Medicaid; 2) simplifying transitions between the public coverage programs; and 3) enhancing the use of community-based organizations to enroll eligible children. The initiative is estimated to cost the state \$20 to \$22 million for the first year, which would bring in additional federal matching funds. The state portion would come from a share of Montana's insurance premium tax.

The Healthy Montana Kids plan is expected to extend Medicaid and SCHIP to about 30,000 Montana children through age 18. This could expand Medicaid/SCHIP for children by nearly 50 percent and cover the vast majority of uninsured children in the state. [1] Medicaid coverage would expand from current family income limits of 100 to 133 percent of the FPL to about 185 percent of the federal poverty level (FPL). [2] Income eligibility for the state's SCHIP would expand from 175 percent to 250 percent of the FPL. [3]

The plan also calls for a single point of access for members of both Medicaid and SCHIP, promoting easier movement between the programs. It provides presumptive eligibility, meaning that children would be covered while awaiting final eligibility determination. Further, the state will enhance use of 'enrollment partners' such as health care providers, schools, and community-based organizations to help identify and enroll eligible children in Medicaid and SCHIP.

According to CHIP Bureau Chief Jackie Forba and Mary Dalton, health resources division administrator for Montana's Department of Public Health and Human Services, the following steps must be taken before the Act can take effect in October 2009:

- Congress must reauthorize SCHIP to ensure federal matching funds.
- The Montana state legislature must vote to appropriate the state funds (already collected from a health insurance premium tax) needed for the first year.
- Montana must submit state plan amendments for Medicaid and SCHIP programs delineating the program changes to the federal government.
- Administrative rules and operational changes must be developed and communicated.
- The economic crisis did not dampen and may have enhanced Montana voters' willingness to expand public coverage. 'Perhaps because we're starting with minimal eligibility levels for Medicaid and SCHIP, the people of Montana have said they want to move ahead.' Dalton says.

For More Information

- **Contact Jackie Forba**, CHIP Bureau Chief, Montana Department of Public Health and Human Services, jforba@mt.gov.
- **Initiative 155:** <http://www.healthymontanakids.org/Healthy%20MT%20Kids%20Language.pdf>

Maine Rejects Beverage Tax for Replacing Dirigo's 'SOP' Funding

Maine voters rejected a beverage tax in November designed to replace the current funding mechanism that supports the Dirigo Health Program.

The Dirigo Health program was established in 2005 to offer an affordable health plan to small businesses and low-income uninsured workers and their families. Through a public-private collaboration between the state and Harvard Pilgrim Health Care, eligible enrollees receive discounts on the monthly premiums and reductions in deductibles and out-of-pocket expenses based on income and family size.

Dirigo has been funded by a controversial 'savings offset payment' (SOP), a fee on insurance carriers of up to 4 percent of paid health claims per year (on average 2.1%). The SOP is determined annually by the Dirigo Health Agency Board of Directors, based on a determination by the Superintendent of Insurance verifying the savings that have accrued from the wide array of Dirigo Health reform strategies. Such strategies include hospital voluntary targets on costs, rate regulation in the small group market, constraints on capital expenditures, and savings to the health care system resulting from fewer uninsured and underinsured residents. In December, the Dirigo Health Agency recommended the year four SOP to be \$42.1 million, which translates into a 2.14 percent assessment on paid claims; by law it cannot exceed the savings from Dirigo initiatives or 4 percent of paid claims, whichever is less. But Dirigo enrollment is frozen, and the SOP is regularly challenged in court by the insurance industry. [4]

The referendum rejects legislation that would have charged a tax on beer, wine and soft drinks and converted the SOP into a fixed 1.8 percent assessment on insurance claims. [5] As a result, Maine will retain its current 'contentious' SOP funding mechanism for Dirigo Health and the state cannot move forward with a planned reinsurance program for the individual insurance market, according to Trish Riley, director of the Maine Governor's Office of Health Policy and Finance.

Governor John Baldacci hopes, however, that under the incoming Obama administration, Maine could get federal Medicaid dollars to match Dirigo premiums paid by employers and individuals, which would help sustain and expand the program. This federal match was originally intended for the program but was rejected by the Centers for Medicare and Medicaid Service (CMS) and is now under appeal.

According to Riley, the November referendum rejecting the new beverage tax was less a message about health care than about taxes. 'After a \$4 million campaign by the beverage industry called 'Fed Up with Taxes,' and at a time when gas prices were at their highest and the economy was falling, the ballot was an opportunity to vote 'Yes, I'm fed up with taxes!' Riley says.

For More Information

See: http://www.dirigohealth.maine.gov/Pages/dirigo_choice.html
[Leading the Way? Maine's Initial Experience in Expanding Coverage Through Dirigo Health Reforms](#), The Commonwealth Fund, December 2007.
Cyber Seminar: http://www.commonwealthfund.org/topics/topics_show.htm?doc_id=668793

Arizona Narrowly Rejects Ban on Coverage Mandates and Choice Restrictions

Arizona voters narrowly rejected a state constitutional amendment that would have banned laws restricting choice of health plans or mandating that people obtain coverage. The amendment would have been at odds with certain elements of President-elect Obama's health care proposal. Of 1.8 million votes, 50.2 percent voted against, and 49.8 percent voted for, the amendment.

Sponsored by the group Medical Choice for Arizona, Proposition 101 was championed by two local physicians and conservative anti-tax groups and supported by some provider associations. Supporters claimed that Proposition 101, known by advocates as the 'Freedom of Choice in Health Care Act,' was needed to guard against a mandatory single-payer system and ensure patient freedom to make choices about their coverage.

Opposition was led by the Arizona Coalition for a State and National Health Plan, a group chaired by two Arizona physicians. It was also opposed by Governor Janet Napolitano, hospital and business groups, and some physician associations. They argued that the amendment could increase costs and the number of uninsured by putting the state's Medicaid managed care program at risk. The director of the Arizona Health Care Cost Containment System (AHCCCS), which runs the state's Medicaid and indigent programs, released a letter on September 17 saying that Proposition 101 could lead to requiring AHCCCS to switch from a managed care to fee-for-service model, increasing state costs by up to \$2 billion per year.

For More Information

See [http://ballotpedia.org/wiki/index.php/Arizona_Proposition_101_\(2008\)](http://ballotpedia.org/wiki/index.php/Arizona_Proposition_101_(2008))

References

- [1] Montana SCHIP enrollment was 17,240 and Medicaid enrollment for children was 46,645 in November 2008. Approximately 31,000 (14%) of all Montana children are uninsured according to the 2008 U.S. Census Bureau Current Population Survey, based on the three-year average (collected 2006-2008).
- [2] The eligibility cut-off between Medicaid and SCHIP will depend in part on the details of the SCHIP reauthorization by the U.S. Congress, expected in early 2009.
- [3] The SCHIP expansion applies only to children not covered by private insurance for at least three months, ineligible for Medicaid, and who are U.S. citizens or qualified aliens and state residents. The plan stipulates that eligibility may be reduced if funding is insufficient.
- [4] Enrollment is frozen, except for new dependents for existing members, new workers for currently participating employers, and applicants who do not need subsidies. About 11,000 members and 621 small groups are currently enrolled.
- [5] 64.3% of referendum voters chose "Yes" to veto Public Law 629, legislation enacted in June 2008 that amended the Dirigo Health Program statute to replace the Savings Offset Payment with funding from 1) a health access surcharge of 1.8% on paid insurance claims; 2) an increase in excise tax on malt beverages and wine; and 3) a new tax on syrup for soft drinks and bottled soft drinks. According to Riley, the legislation reflected a compromise developed over four years of negotiations.

Federal Activity

Unfinished Business—Economic Stimulus and SCHIP

Although the timing and outcome of comprehensive health care reform is uncertain, two health policy issues are likely to receive congressional action early in 2009: enhanced Medicaid payments as a component of economic stimulus and reauthorization of the State Children's Health Insurance Program (SCHIP).

Economic Stimulus: A First Priority for Congress

On November 19, a panel of the nation's top economists testified before the U.S. Senate Budget Committee that government fiscal policy is the only engine of growth capable of preventing the country from sliding deeper into recession. Mark Zandi, chief economist at Moody's Economy.com, recommended that the stimulus package be at least \$400 billion (2.5 percent of gross domestic product). Some stimulus policies, he testified, result in a significant 'bang for the buck,' including extending unemployment insurance benefits, temporarily increasing Food Stamps, general aid to state governments, and increased infrastructure spending. Other options—including most tax cuts—are net losers in terms of economic stimulus and should be avoided, Zandi said. [1]

President-elect Obama has said he is willing to sign a stimulus package on his first day in office—congressional leaders are saying February is more likely—and his advisors have suggested it will include additional spending in the range of \$850 billion, primarily in infrastructure spending. In addition to traditional projects such as roads and bridges, the Obama plan is expected to invest in green technology and other non-traditional infrastructure projects, possibly including health information technology.

The National Governor's Association and National Conference of State Legislatures have requested direct relief for states, including a temporary increase in the federal medical assistance percentage (FMAP) totaling \$40 billion over two years. Two bills in Congress are the likely starting point for an FMAP negotiation. HR 7110 would increase current FMAP levels one to six percentage points, depending on each state's economy, for 14 months and cost \$14.7 billion. SB 3689 would provide an across-the-board eight percentage point increase for all states for 15 months and cost \$37.8 billion. Both bills ensure that no state's Medicaid FMAP will decrease, require states to maintain eligibility thresholds to receive the increase, and apply the stimulus-enhanced FMAP to Medicaid only, not SCHIP or disproportionate share hospital payments. President-elect Obama has said he supports FMAP relief in the stimulus bill, but has not yet committed to details.

SCHIP Reauthorization: Early Action Planned

House Speaker Nancy Pelosi has said SCHIP legislation "will probably be one of the first bills we would put on the President Obama's desk." [2] Although there has been speculation that SCHIP might be rolled into comprehensive health care reform as a strategy to encourage action on broader reform, child advocates and key congressional leaders say it is important to keep SCHIP separate. Rep. Pete Stark, who has jurisdiction over the SCHIP reauthorization as chairman of the House Ways and Means Health Subcommittee, has said SCHIP is his first priority, and that he

wants Congress to act soon to avoid the March 2009 expiration of the current program. [3] Chairman Stark has also cautioned that the terms of an SCHIP expansion previously approved by Congress and vetoed by the Bush Administration might have to be changed given the downturn in the economy. As written, the bill could result in more children becoming eligible for the program than Congress anticipated when the bill was originally approved—and cost significantly more than originally proposed. As a result, the income limits in the vetoed bill might have to be adjusted, Stark said. [4]

References

[1] M. Zandi, Chief Economist and Cofounder Moody's Economy.com, "The Economic Outlook and Stimulus Options," before the U.S. Senate Budget Committee (November 19, 2008).

[2] Nancy Pelosi, quoted in an interview on National Public Radio (November 5, 2008).

[3] Pete Stark, in an interview by John Reichard for CQ HealthBeat (November 17, 2008).

[4] Ibid.

Commission Corner

Gearing up for a new administration and Congress, The Commonwealth Fund Commission on a High Performance Health System released its call to action, [The Time Has Come for Comprehensive Health Reform](#). In this new statement, the Commission urges President-elect Obama and the 111th Congress to move quickly to ensure access to health care for all while at the same time take bold action to improve the quality and efficiency of care so that we may 'bend the curve' of health care spending. The Commission emphasized four key elements for comprehensive health reform:

- Providing all Americans with affordable health coverage.
- Organizing our care delivery systems by moving from our current fragmented system to one where physicians and other care providers are rewarded for banding together into traditional or virtual organizations.
- Reforming provider payment to drive innovations that save lives and improve the value of our health care dollars.
- Government leadership in purchasing, coordinating multiple payers, developing national improvement priorities and targets, creating a system for monitoring and reporting, and issuing recommendations.

In November, the Commission held its final meeting of 2008 in Washington, D.C. where it finalized recommendations for the new presidential administration and Congress and set priorities for work in 2009. In addition to this work, the Commission heard thought-provoking presentations from two outside guests. Liz Fowler, senior counsel to Senate Finance Committee Chairman Max Baucus, joined the group to talk about Congressional health reform efforts and how the Commission's recommendations can add value. Bill Roper, chairman of the National Quality Forum and chief executive officer of the University of North Carolina Health Care System, came to discuss the National Priorities Partnership's recently released recommendations for both public and private stakeholders on transforming the health system.

Also in November, the Commission and the Alliance for Health Reform hosted a briefing on Massachusetts' health reform efforts. The event featured Fund grantee Sharon Long's evaluations of the reforms and can be viewed on the Fund website as an [E-Forum](#).

In January, the Commission and the Alliance for Health Reform will host the 11th annual Bipartisan Congressional Health Policy Conference, which offers members of Congress the opportunity to learn from experts in health policy and delivery and collaborate with their colleagues in an off-the-record setting. In February, in partnership with the Catholic Health Association and the Alliance for Health Reform, the Commission will host a similar conference for Congressional staffers.

For more information, please visit the [Commission page](#) on the Fund's Web site.

Ohio Quality Improvement Summit

More than 180 health care leaders from various organizations and agencies throughout the state attended the Ohio Health Quality Improvement Summit from November 17-19, in Columbus. The summit resulted from Ohio's participation in the Commonwealth Fund/AcademyHealth [State Quality Improvement Initiative \(SQII\)](#), which aimed to develop 12 strategies and related tactics needed to transform Ohio's health care sector into a high-quality, cost-effective, high-performing system that will optimize the health of all Ohioans. Ohio was one of nine states to participate in SQII.

Related Publications

A. B. Bindman, A. Chattopadhyay, and G. M. Auerback, [Interruptions in Medicaid Coverage and Risk for Hospitalization for Ambulatory Care-Sensitive Conditions](#), *Annals of Internal Medicine*, Dec. 16, 2008 149(12):854-60. (By subscription only.)

G. M. Kenney, L. J. Blumberg, and J. Pelletier, [State Buy-In Programs: Prospects and Challenges](#), The Urban Institute, November 24, 2008.

C. Schoen, R. Osborn, S. K. H. How, M. M. Doty et al., [In Chronic Condition: Experiences of Patients with Complex Health Care Needs, in Eight Countries, 2008](#), *Health Affairs* Web Exclusive, Nov. 13, 2008, w1-w16.

I. Hill, P. Barreto, B. Courtot, and E. Wada. [Growing Pains for the Los Angeles Healthy Kids Program](#), The Urban Institute, November 7, 2008.

[Tobacco Policy Trend Report: Helping Smokers Quit, State Cessation Coverage](#), The American Lung Association, November 2008.

S. K. Long and P. B. Masi, [How Have Employers Responded to Health Reform in Massachusetts? Employees' Views at the End of One Year](#), *Health Affairs* Web Exclusive, Oct. 28, 2008, w576-w583. (By subscription only.)

J. R. Gabel, H. Whitmore, J. Pickreign, W. Sellheim, S. KC, and V. Bassett, [After The Mandates: Massachusetts Employers Continue To Support Health Reform As More Firms Offer Coverage](#), *Health Affairs* Web Exclusive, Oct. 28, 2008, w566-w575. (By subscription only.)

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Fund Publications

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C. Bruner, C. Fitzgerald, and C. Plaza, [Improving Child Health Care Through Federal Policy: An Emerging Opportunity](#), The Commonwealth Fund, October 2008.

D. McCarthy and K. Mueller, [The New York City Health and Hospitals Corporation: Transforming a Public Safety Net Delivery System to Achieve Higher Performance](#), The Commonwealth Fund, October 2008.

Multimedia Resources

[Webcast—Ask the Experts: The Role of States in a National Health Reform Effort](#), Kaiser Family Foundation, December 4, 2008.

[E-forum—Massachusetts Health Reform: A Giant Step Toward Universal Coverage?](#) The Commonwealth Fund and the Alliance for Health Reform, November 7, 2008.

Upcoming Meetings

[American Public Human Services Association's Multi-State Collaboration Summit](#)
Tempe, Arizona
January 4–7, 2009

[Oregon Health Forum's The Role of States in Driving National Health Reform](#)
Portland, OR
January 7, 2009

[Families USA's Health Action 2009 Conference](#)
Washington, DC
January 29–31, 2009

[AcademyHealth's 2009 National Health Policy Conference](#)
Washington, DC
February 2–3, 2009

[Insure the Uninsured Project's Annual Conference](#)
Sacramento, CA
February 3–4, 2009

[National Association of County and City Health Officials' 2009 Public Health Preparedness Summit](#)
San Diego, CA
February 18–20, 2009

[National Governors Association 2009 Winter Meeting](#)
Washington, DC
February 21–23, 2009

State Health Research and Policy Breakfast

Washington, D.C.

Tuesday, February 3

**Registration is now open!*

The Commonwealth Fund's State Innovations program is cosponsoring the AcademyHealth State Health Research and Policy Interest Group to host a breakfast meeting called "[Breaking New Ground: State Strategies to Increase Value in the Health Care System](#)." This meeting is held in conjunction with AcademyHealth's National Health Policy Conference in Washington, D.C.

To register, please visit the meeting Web site: www.academyhealth.org/NHPC/adjunct.htm

Call for Papers

Showcase your state health policy research at the State Health Research and Policy Interest Group (SHRPIG) meeting to be held in conjunction with Academy Health's 2009 Annual Research Meeting on Saturday, June 27, 2009, in Washington, D.C. The State Health Research and Policy Interest Group meeting, sponsored in part by The Commonwealth Fund, offers researchers, policymakers, and practitioners the opportunity to share recent state-level research that emphasizes the unique challenges of working within a state policy and political environment. Papers that demonstrate innovative approaches to addressing state policy research needs, sound applied policy research methods, effective strategies for collaborating with state agencies and policy decision makers, and promising communication tools are being sought. Apply by Monday, February 16, 2009.

To apply, visit www.academyhealth.org/interestgroups/shrp/callforpapers.htm

About the Newsletter

The *States in Action* bimonthly newsletter describes innovative state health programs from across the country. It is intended to help policymakers, administrators, and researchers as they work to stretch health care dollars and meet the needs of their residents.

States in Action is part of a Commonwealth Fund [program on state innovations](#). For more information, contact Anne Gauthier, Assistant Vice President and Deputy Director, at ag@cmwf.org

We welcome those involved in state efforts to expand coverage and improve care and efficiency to send an e-mail about their efforts to stateinnovations@cmwf.org.

Editorial Advisory Board 2008

The *States in Action* Editorial Advisory Board includes experts from various aspects of state health policy. Members of the Editorial Advisory Board help to shape the newsletter by providing technical expertise, suggesting state innovations for inclusion, and assisting in the reviewing of each issue.

Special thanks to Editorial Advisory Board members Susan Besio and Scott Leitz for reviewing this issue.

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