KENNEBEC JOURNAL Morning Sentinel

The Kennebec Journal and Morning Sentinel, March 11, 2008

Universal health coverage? States will differ

By Courtney Burke

First of two parts

As voters nationwide focus on the 2008 presidential campaign, a basic reality about the American constitutional system is worth keeping in mind: the division of power between Washington and the states means the next president and Congress will not be alone in deciding major domestic policies.

Take what many Americans consider one of the most important issues right now: health care. States already play key roles in financing and administering publicly funded health insurance for over 60 million people in the Medicaid and State Children's Health Insurance Program (SCHIP).

The federal government shares in these program costs, but states make important decisions about coverage and costs. For example, Medicaid programs in New York and Illinois cover physical therapy, while those in Pennsylvania and New Jersey do not. In Vermont and Rhode Island, 16 percent of working-age women are covered by Medicaid; in Delaware, the figure is 9 percent.

As the presidential candidates debate whether and how to implement universal health coverage, states are moving forward. Massachusetts, Vermont, and Maine already have passed variations on such legislation; Colorado, Washington and several other states have considered or are developing plans for universal coverage.

The states' important role also creates differences in the cost of coverage, incentives for employers and insurers to provide health care coverage, and in regulation of insurers and the products they provide. Differences in state policies partially explain why the average annual premium for family coverage is $9,190 in Arkansas, and $11,835 in New Hampshire.

Given the rising cost of health care, governors and state legislators have been deciding how to control costs, restructure delivery systems and modernize care delivery. Most states already operate disease management programs to promote healthy behaviors, or use prescription drugs to improve care and control costs.

Pennsylvania has saved millions of dollars on prescription drug spending in recent years through a program that educates physicians about less expensive, equally effective generic drugs. States are also experimenting with financing systems that pay hospitals, doctors, and other providers more for better performance.

Massachusetts has received attention for its plan to achieve universal health coverage, including a still-unfolding provision that places responsibility for coverage on individuals. Other populous states such as California, Illinois and New York are exploring ways to achieve universal coverage. What is intriguing is that no state's plan for universal coverage is the same. If and when the next president and Congress create a national plan for universal coverage, state differences are likely to remain.

Leaving power in the hands of the states has both benefits and drawbacks. Innovation and consensus can be easier to achieve because there are fewer decision-makers than in a national program.

A system with variations among states can be more responsive because it is smaller and "closer to the ground" than a national system.

On the downside, a multiplicity of state-based systems is more complex to understand — for physicians and other providers, employers, insurers, and researchers — because there are so many differ-

ences. Quality and access can vary; a national plan must include decisions about how much of that variation Americans want. And 50 sets of rules and regulations become complicated for people who move from one state to another, as well as for caretakers who are monitoring care for someone in a different state.

Both Democratic and Republican candidates say the health care system needs to increase preventive care, use information technology to decrease costs, and give patients better information about providers and outcomes so they can make informed decisions. These are all good ideas.

Some voters will want to consider major differences among the candidates' proposals such as the level of financial responsibility and decision-making power assigned to individuals, employers and the government.

And while all the candidates would leave some decisions in the hands of state governors and legislatures, the amount of such power-sharing varies — generally speaking, the Republican candidates would concentrate less authority in Washington, while the Democratic candidates would ensure greater uniformity with stronger federal control.

Whoever wins the White House this year, important action in Washington seems likely. But that won't be the end of the story. Final decisions about the American health-care system will be made, as has always been the case, in the states.

Courtney Burke serves as director of the Rockefeller Institute's New York State Health Policy Research Center and is the project director for the Institute's current research on small group insurance markets. The institute is the public policy research arm of the State University of New York. Part two of this series appears tomorrow.