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Roundtable: Health Care Coverage

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**United States Senate, Committee on Finance,
Roundtable on Health Care Coverage**

May 5, 2009

Mr. Chairman and Distinguished Committee Members:

It is an honor to be part of this morning's national health reform roundtable, which explores three issues related to health care coverage: How can coverage be made more affordable and workable for individuals and small businesses? What are the roles and responsibilities of individuals, employers, and government in achieving health coverage for all Americans? What role should public programs play? I begin with a general observation and then turn to the specific questions.

General Observations

In my view, Congress should care deeply about the issue of coverage because the overarching goal of reform is a health system in which all persons, regardless of wealth, place of residence, or other factors unrelated to need, receive appropriate health care. As Chairman Baucus has underscored in his own report, *Call to Action*, coverage is integral to accessible and high quality health care. The need to focus on appropriate care as the end result is particularly important in the case of certain types of care that bear fundamentally on health, such as: pregnancy-related care, that is, preconception and interconception care that allows women to maintain optimal health during their reproductive years;¹ the care of children, whose healthy growth and development depends not only on primary preventive services but also on treatments to ameliorate physical and mental health conditions; effective clinical preventive treatments for people of all ages;² and the care and services to allow people living with chronic physical, mental, and behavioral health conditions to maintain optimal health and avoid loss of function.³

To be sure, coverage is not the only intervention essential to achieving this overarching goal. Foundational to success are direct investments to create health care access in medically

¹ Wendy Chavkin et al., *Women's Health and Health Care Reform* (Columbia University, New York, NY 2008).

² Sara Rosenbaum and Paul H. Wise, "Crossing The Medicaid-Private Insurance Divide: The Case Of EPSDT," *Health Affairs*, March/April 2007; 26(2): 382-393.

³ Richard Kronick et al., *The Faces of Medicaid: Recognizing the Care Needs of People with Multiple Chronic Conditions* (Center for Health Care Strategies, 2007)

http://www.chcs.org/publications3960/publications_show.htm?doc_id=540806 (accessed April 26, 2009).

underserved urban and rural communities, build a highly trained workforce, spur the adoption and use of information technology, incentivize system reforms to achieve greater efficiencies,⁴ generate and apply information on the comparative effectiveness of health care, and stimulate broader public health investments in families, communities, and populations.⁵

In truth, however, in a health care system that is market-based, reform begins with attaining and sustaining good health insurance coverage over time, since it is through insurance coverage that most Americans pay for care. Because health insurance is integral to health care use, our relationship with health insurance is fundamentally different from our interaction with other forms of insurance. For example, when people insure their homes or their cars, their greatest hope is that they will never need to use their coverage. But while good health and the avoidance of illness and disability certainly are universal aspirations, people need health insurance precisely because it *enables* the use of health care, particularly primary and preventive care that help attain and maintain health and avert deterioration in health. Thus, while some focus on the “moral hazard” associated with over-insurance, the current epidemic of under-insurance in the U.S. and its consequences⁶ suggest the nation suffers from the opposite problem,⁷ one driven by the cost of care as well as a systemic inability to effectively manage the health care risks associated with sickness. In my view, the true moral hazard has been the national failure to come to grips with these problems, and I applaud the Committee for its dedication to finding answers. Indeed, in a nation in which the simple act of immunizing one’s child cost more than \$1,600 in 2007,⁸ even care that is basic to health lies beyond the reach of uninsured and under-insured Americans.

How Can Health Insurance Be Made More Affordable and Workable for Individuals and Small Employers?

In my view, the approach set forth in the *Call to Action*, which involves the establishment of a health insurance exchange to serve individuals and small employers, would make a significant inroad on several fronts. First, if designed to operate nationally, an exchange would foster stability and portability of coverage (state administration is, of course, an option if carried out under uniform requirements). Second, a national exchange could, over time, enhance market power, pooling resources across millions to promote system reform, with more focused efforts to promote the right kind of care and payment.

Third, and in some ways most significantly in the context of today’s roundtable, a national exchange, by pooling risk, would reduce the terrible tendency of today’s health

⁴ David Blumenthal et al., *Health Information Technology: The Information Base for Progress* (Robert Wood Johnson Foundation, 2006) <http://www.rwjf.org/pr/product.jsp?id=15895> (accessed April 26, 2009).

⁵ Robert Wood Johnson Foundation, Commission to Build a Healthier America, *Beyond Health Care: New Directions to a Healthier America*, (2009) <http://www.commissiononhealth.org/> (accessed April 26, 2009); Trust for America’s Health, *Blueprint for a Healthier America* (2008) <http://healthyamericans.org/report/55/blueprint-for-healthier-america> (accessed April 26, 2009).

⁶ Cathy Schoen et al., “How Many Are Underinsured? Trends Among U.S. Adults, 2003 and 2007,” *Health Affairs*, July/August 2008; 27(4): w298-w309.

⁷ See generally, Timothy Stoltzfus Jost, *Health Care at Risk: A Critique of the Consumer Driven Movement* (Duke University Press, Durham, NC, 2007).

⁸ Andrew Pollack, “Pediatricians Voice Anger over the Cost of Childhood Vaccines,” *New York Times* (March 24, 2007).

insurance market to discriminate against the sick.⁹ It is the need to ensure access to effective care when we are sick – something that is significantly less likely to happen appropriately in the U.S. than in other wealthy nations today¹⁰ – that makes resolving our crisis so urgent.

In order to achieve the power of pooling, I recommend making insurance available through a national exchange to individuals and small employers, defined as firms with fewer than 200 full-time-equivalent employees. This definition of “small” is used in major national surveys that assess employer-sponsored health insurance practices.¹¹ Although sixty percent of the 3 million U.S. firms that employ workers have nine or fewer workers,¹² the concept of “small” in the context of sickness should be substantially larger in my view, in order to position the nation for meaningful relief over time. Indeed, my own very large employer, The George Washington University, has found its premium rates affected by a handful of employees’ adverse health events.

The importance of a large purchasing pool is a direct outgrowth of the fundamental concepts on which the insurance market rests. In legal parlance, insurance sold in the marketplace is a contract of risk, with sellers operating on the basis of actuarial principles, one of whose core precepts is the concept of “fair discrimination,” meaning similar classification of like risks.¹³ In significantly unregulated health insurance markets, it has become virtually impossible for individuals or small groups to secure insurance at affordable rates. Furthermore, the problems created by inadequate risk-spreading mechanisms translate into more than coverage at a high cost; they also encourage the use of shielding techniques – *both prior to and following enrollment* – the purpose of which is to avoid individuals whose actual or perceived health creates a risk of health care use. The irony of course, is that the use of health care is precisely the behavior that health care experts typically want to encourage.

The first set of risk-shielding techniques, which has received a fair amount of attention in the literature and in the law, involves the use of enrollment exclusions to bar coverage of sick people – or people regarded as sick in accordance with actuarial principles – at the point of enrollment. Examples are the total exclusion of individuals with pre-existing conditions; medical underwriting at the point of enrollment to classify risks and set insurance rates; post-claims medical underwriting to eliminate sick people after the fact; imposition of excessively high premiums on people with certain health conditions; or the imposition of long waiting periods

⁹ Deborah Stone, “Protect the Sick: Health Insurance Reform in One Easy Lesson,” *Jour. Law, Medicine and Ethics: Health Reform* (Sara Rosenbaum and Jeanne Lambrew, ed.) (Winter, 2008) pp. 652-659.

¹⁰ Cathy Schoen et al., “In Chronic Condition: Experiences of Patients with Complex Health Care Needs in Eight Countries,” *Health Affairs*, 2008 w1-w16
<http://content.healthaffairs.org/cgi/reprint/28/1/w1?maxtoshow=&HITS=10&hits=10&RESULTFORMAT=&author=1=Schoen&andorexactfulltext=and&searchid=1&FIRSTINDEX=0&resourcetype=HWCIT> (accessed April 26, 2009).

¹¹ Kaiser Family Foundation, *Employer Health Benefit Survey* (2008) <http://ehbs.kff.org/> (accessed April 25, 2009).

¹² Id. at <http://ehbs.kff.org/?page=charts&id=1&sn=1&p=3> (accessed April 26, 2009).

¹³ Rand Rosenblatt, Sylvia Law and Sara Rosenbaum, *Law and the American Health Care System* (Foundation Press, New York, NY 1997; 2001-2002 Supplement); Sara Rosenbaum, “Insurance Discrimination on the Basis of Health Status: An Overview of Discrimination Practices, Federal Law, and Reform Options,” *Georgetown University O’Neill Institute for National and Global Health Law* (2009).
<http://www.law.georgetown.edu/oneillinstitute/projects/reform/Discrimination.html> (accessed April 26, 2009).

prior to the commencement of coverage.¹⁴ Congress has taken preliminary steps, principally through the Health Insurance Portability and Accountability Act of 1996, to address these behaviors; further reforms are essential to ending enrollment-related insurance discrimination.

The second set of techniques that also bear directly on the questions posed today come into play post-enrollment and serve to further underscore the need for large pools. These techniques have received less attention in federal law; indeed, discrimination against the sick in the design of health insurance has been held to be exempt from the reach of the Americans with Disabilities Act (ADA); other laws aimed at lessening post-enrollment discrimination, such as the Paul Wellstone Mental Health Parity and Addiction Equity Act of 2008, while important first steps, are limited in scope.

Discriminatory coverage techniques that take place post-enrollment fall under the overall rubrics of *plan design* and *plan administration*; it is these techniques in my view that have helped create a 60% increase between 2003 and 2007 in the proportion of individuals who can be considered under-insured because their coverage falls seriously short of their health care needs.¹⁵ While the cost of health care is certainly a major cause of under-insurance, it is by no means the only cause. It is no coincidence, in my view, that as federal laws aimed at curbing discrimination at the point of enrollment have taken effect, the health benefits industry has focused increasing attention on the matter of coverage itself, developing mechanisms for curbing coverage, once attained, and thereby shifting financial risk back onto sick people. Indeed, these two types of discrimination – pre-enrollment and post-enrollment – are inextricably intertwined, and too-small risk pools offer fertile ground for both to flourish.

Post-enrollment discrimination against the sick can take many forms: very low annual or lifetime limits on certain aspects of coverage, such as behavioral disorders or HIV/AIDS; limited or no coverage of clinical preventive services that involve screening for costly conditions and whose use in the absence of health insurance is highly price-sensitive; the exclusion of certain conditions from coverage entirely, even though there are effective treatments; the refusal to pay for more than limited treatments for certain conditions; the use of restrictive prescription drug formularies; the use of restrictive practice guidelines that lack a reliable basis in evidence; medical necessity definitions that penalize and discriminate against children and adults whose conditions are developmental rather than the result of acute injury or illness from which “recovery” is possible (e.g., defining speech therapy as therapy needed to restore speech, thereby excluding speech therapy for children born with cerebral palsy and the developmentally delayed); excessive cost-sharing for certain conditions (e.g., very high copayments for expensive cancer drugs); excessively burdensome and virtually un-navigable utilization management techniques; restrictions on access to certain types of health care providers with expertise in management of certain conditions; and low provider payment standards that disincentivize participation in networks, thereby shrinking access to primary and specialty care.

¹⁴ See review of federal laws regulating insurance discrimination, as well as relevant judicial decisions, in Sara Rosenbaum, *Insurance Discrimination on the Basis of Health Status*, supra note 13. For an excellent analysis of insurance discrimination using cancer as the analytic framework, see Kaiser Family Foundation and American Cancer Society, *Spending to Survive: Cancer Patients Confront Holes in the Health Insurance System* <http://www.kff.org/insurance/upload/7851.pdf> (accessed April 26, 2009).

¹⁵ See Schoen, “How Many Are Underinsured?” Supra note 6.

The use of post-enrollment techniques to discriminate against the sick was best captured in a landmark 1999 federal appeals court decision, *Doe v Mutual of Omaha*,¹⁶ which held that the ADA's prohibition on disability discrimination does not reach the health insurance content. In its brief in support of its right to discriminate, the insurer expressly stipulated that it "has not shown and cannot show that its AIDS caps are or ever have been consistent with sound actuarial principles, actual or reasonably anticipated experience, bona fide risk classification, or state law."¹⁷ It is difficult to imagine a clearer admission that there is no basis in evidence for what can only be described as an intentional decision to limit the value of health insurance for certain groups of sick people and to push the financial risk back onto individual patients. I have no doubt that there are numerous individual health insurers today at the forefront of efforts to design and administer insurance products in ways that advance rather than impede health; by contrast, the problem I describe here is systemic.

Large pools can create the type of stable enrollment typical of large groups to help alleviate the potential profitability of short and frequently interrupted enrollment periods. But also essential are significant ground rules for defining coverage within health insurance products certified to be sold in an exchange. Whether these ground rules are shaped by Congress or delegated to an expert panel, they should cover certain dimensions of coverage and plan administration: a broad range of benefit classes and benefit definitions; a medical necessity definition that does not exclude children and adults with developmental conditions or those who will never "recover" but for whom health care can ameliorate the burden of illness; a definition of medical necessity for women's health that ensures their ability to develop and maintain good health during reproductive years and to age well, with a similar definition fashioned for men's health; coverage of clinical preventive interventions determined to be effective in identifying and managing health, such as immunizations recognized by the Advisory Committee on Immunization Practices and the U.S. Preventive Services Task Force; a requirement that treatment approval and coverage design employ practice guidelines (particularly those used to set across-the-board treatment limits such as those found in *Doe v Mutual of Omaha*) that rest on objective evidence rather than prejudice against certain people; fair payment and provider network practices; and fair and efficient utilization management.

What are the Roles and Responsibilities of Individuals, Employers, and Government in Achieving Greater Coverage?

Everyone has a role and a responsibility in supporting the cost of health insurance.

Individuals. In certain nations that have experienced national health reform, costs are borne through national tax policy;¹⁸ coverage is not conditioned on payment of premiums, cost-sharing at the point of care may be low, and overall financial exposure is controlled. The U.S. has elected to use premiums, as well as considerable levels of cost sharing (in the form of deductibles, coinsurance and copayments), restrictions of coverage design (which in turn create

¹⁶ *Doe v Mutual of Omaha Ins. Co.*, 179 F. 3d 557 (7th Cir., 1999), reh. and suggestion for reh. en banc. denied; *cert. den.*, *Doe v Mutual of Omaha Ins. Co.*, 528 U.S. 1106 (2000).

¹⁷ *Doe*, 179 F. 3d at 558.

¹⁸ Timothy Stoltzfus Jost, *Disentitlement: The Threats Facing our Public Health Programs and a Rights Based Response* (Oxford University Press, 2003).

cost-sharing liability), and annual and lifetime limits on coverage. As a result, when combined with shrinking benefits, the already high rate of under-insurance (measured by experts as financial exposure above 10% of family income or 5% of family income in the case of low income families) has shot up precipitously in recent years.¹⁹

All forms of financial responsibility should be considered when designing the individual responsibility component of health reform, particularly if the minimum benefit design is relatively modest. Under such a scenario, costs for sicker members will remain excessively high if cost-sharing protections are not included.

The first consideration is premiums. Affordability of premiums declines both relatively and in absolute terms as family income declines. For persons with monthly family incomes at or below twice the federal poverty level (approximately \$2,755.00 monthly gross income for a family of 4), premiums should set at a zero contribution level, with a gradual decline in subsidies for families with incomes between twice and four times the federal poverty level. Research has shown that premiums of more than 1% to 2% of family income are sufficient to deter enrollment among low income families,²⁰ whose economic circumstances place them in a position of subsistence, particularly in more urbanized areas. Indeed the National Governors Association (NGA) has reported that in 33 states and more than 1,200 cities and counties, the Fair Market Rent is more than twice the prevailing minimum wage.²¹

The second consideration is cost-sharing at the point of care, where too-high exposure can deter precisely the types of preventive and health maintenance treatments that national policy should seek to encourage. For low income and moderate income families (with monthly family incomes below 400% of the federal poverty level), deductibles and cost sharing must be kept low, with total exemptions for preventive services and chronic health management services. For all but the wealthiest families, the total financial out-of-pocket maximums in any year optimally should be allowed to climb to no more than 5% of family income. In the case of higher income families, presumably plans offered to them through an exchange would be much like product offerings today, with a tradeoff built into plan offerings between lower premiums and higher cost-sharing on the one hand, and higher premiums and lower cost sharing on the other.

Employers: The evidence suggests high variability – both within and across employers and by firm type and employee group size – in the proportion of premium that is borne by employers.²² The objective in designing policy where employer contributions are concerned should be an expectation of a fair, minimum employer contribution level by firm size and average payroll worker wage, so that the playing field is more level. Presumably many small private employers may continue to offer health benefit plans under ERISA and may continue to elect to subsidize worker premiums well beyond this minimum level. But the expectation should be that employers that do not do so will contribute to an exchange and at a minimum level

¹⁹ See Schoen, “How Many Are Underinsured?” Supra note 6.

²⁰ Leighton Ku and Teresa Coughlin, “Sliding Scale Premium Health Insurance Programs: Four States’ Experiences,” *Inquiry*, Winter 1999/2000.

²¹ NGA, Center for Best Practices, *Increasing Access to Housing for Low Income Families* (2002) <http://www.nga.org/Files/pdf/032902HOUSING.pdf> (accessed April 24, 2009).

²² Kaiser, *Employer Health Benefit Survey*, supra note 11.

considered fair. It is this sense of fairness, not high contributions, that currently is lacking. Failure to ensure a minimum level of employer responsibility undoubtedly will further erode the employer-sponsored market in years to come, as employers who have contributed to employee coverage out of a moral sense of obligation continue to pull back from doing so.

Government. The role of government is of course foundational. It is government that continues to sustain Medicare and (presumably) to support an expanded Medicaid program for eligible populations. It is government that establishes and operates the exchange system, government that sets minimum design and administration standards for health benefit services plans sold to both employers and individuals who purchase through an exchange, and the government that certifies plans as qualified to participate in the exchange and oversees and reports on all phases of plan and system performance. It is government that will provide the subsidies that will make coverage affordable to employers and individuals who purchase coverage through a health insurance exchange, and it is government that through tax policy makes health insurance affordable to employers and employees who elect to maintain coverage arrangements outside the exchange. Finally, it should be government that will set the coverage ground rules for health plans that elect to sell in an exchange and that concomitantly shield insurers from excessively high medical losses incurred by sick enrollees who have reached their own out-of-pocket maximums as well as what is considered to be the limits of insurability. In essence, where health reform is concerned, the role of government under the model now under extensive Congressional review is to create, foster, and stabilize a vibrant, stable, and effective health insurance market.

What is the Role of Public Health Insurance Programs?

The third question focuses on the role of public insurance, specifically Medicare, Medicaid and CHIP. I focus my remarks on Medicaid and CHIP.

CHIP. The Children's Health Insurance Program represents an important and prescient decision by Congress to utilize government to develop a stable and affordable health insurance market for children. Viewed in this context, the mission of CHIP is highly similar to the mission of a health insurance exchange. Presumably, as a subsidy system is extended to entire families, not only pregnant women and children, the need for a separate mechanism for creating stable and affordable coverage solely for people of certain ages or with certain health conditions will recede. My recommendation would be the absorption of CHIP into the exchange subsidy system at such a time that exchanges are fully functioning and able to offer families certified health plans that meet essential requirements for the coverage of children, as noted above. These requirements, at a minimum, consist of the benefits found in CHIP today, as well as a pediatric medical necessity standard that emphasizes both health care interventions aimed at promoting growth and development as well as interventions necessary to the amelioration of physical, developmental, and mental conditions in children.

Medicaid. Medicaid is a far more complex question, and any thoughts offered to this Committee should be viewed as "opening gambits" in a lengthy process of knitting together a health care system that ultimately will consist of four major sponsors of health benefit plans for the population, virtually all of which are linked to "networked" service delivery arrangements – Medicaid, employer-sponsored coverage, coverage sponsored by a national exchange, and (to a

lesser extent, perhaps, where care through networks is concerned) Medicare. Since its 1965 enactment, Medicaid's evolution has been profound, as one might expect for a program that has been termed by one expert as the "Atlas" of the health care system.²³ Medicaid's functions are enormous, and its contribution to the health care system, incalculable. Aligning Medicaid and a health insurance exchange will take many years, but as the exchange becomes established and operational, certain possibilities come into clear view.

Medicaid plays five critical roles in my view. Its first is as a primary source of health insurance for millions of children and adults without access to coverage. This role increasingly takes the form of sponsored coverage through participating health plans (much as the exchange would sponsor enrollment into certified health benefit plans) as a result of the Medicaid managed care reforms that began in the 1980s.²⁴ Chairman Baucus' proposal to eliminate categorical restrictions on coverage of the low income population is a long-overdue and much heralded reform.

Medicaid's second role, as a result of its special rules on third party liability, is as a secondary payer for persons who have primary insurance through other sources (e.g., Medicare, employer-sponsored coverage, veterans' health care) but whose needs transcend the limits of even a generous plan. Mr. Grassley's leadership on the Family Opportunity Act is an example of the incredible importance of efforts to make Medicaid work in tandem with and a supplement to other forms of coverage.

Medicaid's third role is as a supporter of the public health infrastructure through its special relationships with public health agencies. Health care experts focus on the conduct of the health care system. Public health experts focus on the conduct of individuals, families, communities, and the population. It is often Medicaid that, through payment for public health nursing, the services of public health laboratories, home visitors, health departments, and other activities, serves as the bridge between changes in health care and changes in families, communities, and the population. This work is so integral to population health goals that Congress' highest aim should be its expansion.

Medicaid's fourth role is as an enabler of other critical social goals, such as child welfare, the education of children with disabilities, the treatment of serious mental illness and addiction disorders, the community integration of children and adults with disabilities, and long term care for the elderly. Medicaid enables these social goals by paying for health care (personal attendants, private nurses, long term therapies, case management, and alternatives to institutional care) that no ordinary insurer – not even a good insurer – would pay for, and paying for health care in settings (schools, public housing and homeless shelters, early intervention child care programs, homes) that no other insurer would recognize.

Medicaid's fifth role is as supporter of the health care safety net – federally qualified health centers, children's hospitals, rural health clinics, school health programs, and public hospitals – without which millions of low income and vulnerable children and adults (especially those living in medically underserved communities) would lack access to both primary and

²³ Alan Weill, "There's Something About Medicaid," *Health Affairs*, Jan./Feb. 2003, 22:1, 13-30.

²⁴ Sara Rosenbaum, "A Look Inside Medicaid Managed Care," *Health Affairs*, July/August 1997, 16:4, 266-271.

specialized care. Medicaid supports these providers in three important ways: through the recognition of the special costs that such providers incur (such as translation and patient support); through special payments such as the FQHC and RHC prospective payment system or disproportionate share payments to public hospitals and children's hospitals; and through the coverage of a high volume of patients served by these providers. Congress has long recognized the vital nature of this relationship between the health care safety net and Medicaid; indeed, the recent Medicaid HIT adoption amendments aimed at spurring adoption within the health care safety net represents the most recent evidence of Congress' desire that this relationship flourish. My school's own recent study of the role played by health centers in the wake of Massachusetts' landmark reform efforts underscores the importance of Congressional policy in this area.²⁵

The question is how to bring Medicaid and its multiple and special missions together with other reforms now unfolding in the earliest legislative process, particularly for families whose low or modest incomes will result in more frequent movement between Medicaid and an exchange. One important reform is to ensure that an application for Medicaid is also an application for subsidized health insurance through the exchange and to utilize techniques developed in CHIP to more clearly align enrollment and retention in order to virtually eliminate coverage breaks. Attention to this alignment effort will be particularly important in a world in which the exchange operates nationally while Medicaid remains state-operated, a lesson learned in the implementation of Medicare Part D.

Another important reform, and one that can only happen over time, will be the alignment of certification standards between health plans offered in an exchange (once the exchange system is operational) and Medicaid managed care. Through such alignment it will be possible eventually to reach a point at which both state Medicaid programs and a national exchange are able to purchase from a common set of health benefit plan offerings, with variable premium subsidies and cost sharing supports for families in different economic circumstances. This careful movement toward a more unified purchasing vision both preserves the Medicaid entitlement while also seeking to gain more coordinated improvements in health care quality, particularly for children and adults who depend on subsidized care.

At the point at which the coverage parameters of exchange products come fully into view and products actually begin to operate in the market, it will be possible to move forward with a more unified approach to health care purchasing. This positioning toward greater unification has two strengths in my view: the first is to strengthen coverage for special needs children and adults, and the second is to achieve a more coordinated approach to health care quality and efficiency in the case of sponsored health insurance products, whether purchased by Medicaid or through an exchange.

Since managed care was first introduced in Medicaid, state programs have purchased managed care products offering coverage that is more limited than the entire range of services and benefits offered under their state plans (or as part of Medicaid's early and periodic screening

²⁵ Leighton Ku et al., *How is the Primary Care Safety Net Faring in Massachusetts? Community Health Centers in the Midst of Health Reform* (Kaiser Commission on Medicaid and the Uninsured and RCHN Community Health Foundation, 2009)
<http://www.gwumc.edu/sphhs/departments/healthpolicy/CHPR/downloads/massReformHealthCenters.pdf> (accessed April 26, 2009).

and diagnosis and treatment benefits).²⁶ In essence, state Medicaid programs supplement their own sponsored products with additional coverage for children and adults with special needs, as well as with augmented and enriched “carved out” health care in a range of non-traditional settings. To the extent that exchange products ultimately offer comprehensive and affordable benefits so that coverage supplementation can be well defined, the integration of Medicaid and exchange purchasing becomes more feasible. Indeed, this goal of using Medicaid to strengthen and supplement commercial coverage was the principle that guided Mr. Grassley’s introduction of the Family Opportunity Act; in my opinion, the extension of Medicaid as supplemental coverage for all children and adults with special needs, as well as a financing mechanism for crucial health care and health related services not considered insurable, exists as a long term goal of reform generally.

The second goal – strengthening system efficiency and quality – is particularly critical for lower income populations, for whom the networked coverage arrangement in which they are enrolled, whether through Medicaid or through an exchange, represents virtually their entire health care system. For this population, there is no “point of service” option of the type enjoyed by more affluent families. The highest goal of insurance reform – high quality health care – thus becomes represented through stable and uninterrupted coverage (whether derived through Medicaid or the exchange system), a robust and accessible provider network that emphasizes high quality accessible primary care in a range of community settings as well as the full and necessary complement of specialty care, fair payment arrangements that reward quality and efficiency while emphasizing and incentivizing prevention and care management, the use of comprehensive health information linked to both health care quality and public health system improvement, and coordination with public health.

This goal of integrating Medicaid and exchange purchasing will take an extensive investment of time and creativity. The goal depends on a strengthened Medicaid program, expanded to serve all low income persons, implementation of a well-functioning exchange system, comprehensive coverage standards applied to exchange products, and a real commitment to system integration by plans and providers. But the end result may be the type of long term reform that enables high performance, while redesigning coverage to be less discriminatory against those who bear the greatest burden of illness and disability. It is a vision that lends itself well to an ultimate stage in health reform, the investment in community health and development projects that work in concert with communities that are disparately burdened by illness and the health care systems that serve them.

²⁶ Sara Rosenbaum et al., *Negotiating the New Health System: A Nationwide Study of Medicaid Managed Care Contracts* (The George Washington University, Washington D.C., 1997).