State leaders say health care is the most important challenge facing state governments today. And they’re ready to take action. Not only are states addressing the need to lower the number of uninsured residents, they are also developing initiatives that address poor diet and tobacco use.

By Sean Slone

Health care is the most important challenge facing state governments today, according to a recent state trends survey of state leaders by The Council of State Governments.

States, spurred by the urgency of rising health care costs, aren’t waiting for Washington to take action. Many states are serving as policy laboratories for innovative plans to reduce the number of uninsured. States are also developing initiatives to encourage healthier living by addressing poor diet and tobacco use, two factors that continue to threaten overall improvements in the nation’s health over the last two decades.

Insurance Coverage Innovations

On the health insurance reform front, a number of states have stepped forward with bold initiatives.

Massachusetts was the trailblazer in 2006, becoming the first state to require residents to buy health insurance or face tax penalties, and to fine firms that don’t offer health care benefits to employees.

“Massachusetts has a long history of health policy innovation,” said Michael Miller, policy director for Community Catalyst, a Boston-based health policy advocacy group. “That past record provided a substantive foundation for reform.”
Vermont was hot on the heels of its New England neighbor with a similar plan that provides premium assistance for the working uninsured.

Of course, a much larger state has also been making noise on this front. California Gov. Arnold Schwarzenegger has proposed a plan that would require all Californians to have insurance, require insurers to guarantee coverage, and encourage personal responsibility for health and wellness with an incentives and rewards program.

But big, comprehensive reforms aren’t the only innovations states are offering. Prior to the 2007 legislative sessions, seven states had experimented with public-private partnerships to help cover some individuals who have lost coverage and help small businesses offer coverage. Other states have instituted incremental reforms that seek to increase coverage for specific uninsured groups. Illinois and Pennsylvania, for example, have rolled out programs to provide health coverage to all children. Governors in states like New York, Wisconsin and New Hampshire promised to do the same in their State of the State addresses this year.

**Catalysts of State Action**

So what’s spurring this state action?

In Massachusetts’ case, the state stood to lose significant Medicaid funds if it did not pass a reform plan. But other motivation for states’ actions may include increases in the number of uninsured, declines in employer-sponsored health insurance, improved state economies with increased tax revenues, and greater political will in state capitals.

“In general there needs to be some kind of catalyst, but it can be political as well as financial or economic,” Miller said. “I think that the growing number of uninsured and the rising cost pressure from cost-shifting plays a role but political leadership and active organizing among the citizenry is crucial.”

It’s estimated that close to 46 million people nationwide are without health insurance. As a result, they’re unable to take advantage of preventive services such as health screenings. The uninsured often don’t receive early diagnoses and treatment of debilitating and preventable chronic diseases or get counseling about the unhealthy lifestyles that can cause these conditions. Delays in treatment can lead to poor health throughout their lifespans, costly emergency room visits and premature deaths.

The uninsured received about $41 billion in uncompensated care in 2004. Most of that care was provided by the so-called “safety net,” an informal network of health facilities supported by federal, state and local government funding. Funding levels have not kept pace with the rising number of uninsured and increasing medical costs, and safety net providers are unable to meet all the needs of the uninsured. Government spending available to pay for the care of the uninsured in 2004 was only $34.6 billion or about 85 percent of the total uncompensated care bill.

**One Size Doesn’t Fit All**

Although the states seem to be inspiring each other to take action, variations among the state plans may make transferability difficult, Miller said.

“There are some ideas from Massachusetts that are in play in other states,” he said. “Any state that moves forward is going to have to grapple with the same concerns Massachusetts did and will use some of the same approaches, but each state will put the pieces together in own way in response to unique environmental and political circumstances.”

Generally though, analysts say such experimentation with increasing coverage is most possible for states like Massachusetts with existing uninsured populations of less than 15 percent—for Massachusetts it was 11 percent, according to the Kaiser Family Foundation.

A few states have uninsured populations that are close to a quarter of their population. Having fewer uninsured also makes mandating individual coverage more feasible, particularly if a state is able to provide subsidies to address the problem of affordability. Massachusetts would shift more than $600 million from its uncompensated care pool to subsidize premiums for low-income workers over time.

Miller said Massachusetts’ example shows that any state can become a leader on health care.

“It’s been somewhat surprising how much interest the Massachusetts law has generated, largely I think because it was a real ideological blend so the reflexive response that Massachusetts is too liberal to be a model for other states was avoided,” he said. “Having said that, I think that a significant move forward in California would have great significance, as much for what it would mean at the federal level as for any inspiration it would give other states.”

**The Federal Role**

Indeed it may ultimately fall to the federal government to evaluate the various state models over a period of years, to learn from the implementation challenges they face, and to incorporate the best solutions into a federal universal health care initiative, Miller said.

“Although states have a role to play in reducing the number of uninsured, including acting as a laboratory and a spur to federal action, in the end federal support is needed because states have more revenue constraints and are also subject to federal law, such as the Employee Retirement Income Security Act, that makes state-level reform more difficult,” he said.

“Although universal or near universal coverage might be a competitive advantage for states, in some cases you could imagine cross-state challenges that wouldn’t occur if there was a federal solution or at least a federal framework and financial support for reform,” Miller added.

**Public Health Efforts: Trans Fat**

Insurance coverage reforms aren’t the only health care initiatives that states have been advancing. They have also been innovating on the public health front.

Inherent in these efforts is a desire to address the root causes of chronic diseases and the costs that result. Poor diet, lack of physical activity and tobacco use are risk factors for many chronic conditions. Seventy percent of all deaths in the U.S. annually are due to chronic diseases. Experts believe policymakers need to continue to adjust health care budgets to promote wellness and prevention and move away from focusing so heavily on treatment of acute illness.
Massachusetts is one of many states where legislators this year are following the lead of New York City in introducing legislation designed to give consumers healthier choices at restaurants.

New York City’s Board of Health voted late last year to require restaurants to print calorie information on menus and to phase in a ban on trans fats in all restaurants in the city. Trans fats raise levels of LDL (bad cholesterol) and lowers levels of HDL (good cholesterol), which can cause clogged arteries and increase the risk of heart attack and stroke.

State Rep. Peter Koutoujian sponsored the trans fat legislation in Massachusetts.

“When New York City announced it was banning trans fats in all its restaurants, I felt that the timing was finally right to try something similar in Massachusetts,” he said. “The reaction has been generally positive. The Massachusetts Restaurant Association, which represents many of the state’s 13,000 eating establishments, has said it supports a statewide policy as opposed to a patchwork system where different communities have different rules.”

Koutoujian pointed out that a lot of restaurants are already going trans fat free. Even McDonald’s recently announced its selection of a trans fat free oil.

“I feel that once the public is educated to the fact that eliminating trans fats will not adversely affect the taste of their food, there will not be concern over their absence,” he said.

And, Koutoujian said, the legislation can make a big difference in improving the health of his state’s citizens.

“I think we have an opportunity here to eliminate an extremely unhealthy substance without affecting the enjoyability of the food. Trans fats possess no nutritional value. The body cannot process them and essentially keeps them as part of the body,” he said.

There is also a disparities issue to consider with trans fat, Koutoujian said.

“A lot of poorer families rely heavily on less-expensive restaurant food. If these restaurants, such as fast food chains, are heavy on trans fats, then a significant portion of the population is more likely to be consuming more trans fats than individuals who have more access to healthier foods,” he said.

Efforts to improve the diets of Americans have become critically important in recent years. In 1994, no states reported obesity rates at or above 20 percent. In 2005, 46 states reported obesity rates of more than 20 percent, and three states reported obesity rates of more than 30 percent.

Obesity has been linked to increased risk for heart disease, stroke, diabetes, osteoarthritis and several types of cancer. In 2000, the total cost of obesity in the United States was estimated to be $117 billion, of which $61 billion was for direct medical costs and $56 billion was for indirect costs.

Tobacco Prevention Programs and Settlement Funding

Smoking bans and comprehensive tobacco prevention and cessation programs are two other ways states are trying to improve public health.

Smoking results in an estimated 438,000 deaths and $167 billion in health care costs and lost productivity each year, making it the leading preventable cause of death in the United States. Stopping tobacco use has been shown to be the most cost-effective method of preventing disease among adults.

Comprehensive state tobacco prevention and cessation programs, when properly funded, have been proven to reduce smoking, save lives and cut health care costs. Unfortunately only a handful of states this year are funding these programs at the level recommended by the Centers for Disease Control and Prevention.

Though states this year will collect more than $21 billion from tobacco taxes and the 1998 settlement with tobacco companies, only 2.8 percent of that money will be spent on tobacco-use pre-

—Michael Miller, policy director
Community Catalyst

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“I can remember the time in the hospital when I used to follow doctors around with an ashtray to catch their ashes as they made rounds. I think that the societal change that we’ve seen towards smoking is remarkable and that the bans are just the next step … Smoking is one of the easiest things we can tackle to work on health promotion.”

—Washington State Rep. Eileen Cody