Grassroots Effort Stresses Equitable Reform

Leaders hope to expand their organization beyond Oregon, particularly to Washington and Montana.

BY DOUG BRUNK
San Diego Bureau

The way Dr. John A. Kitzhaber sees it, Americans can't afford to sit back and wait for the future of health care to unfold before them. Instead, they should assume an active role in shaping its future.

"If people are unable or unwilling to agree among themselves on a vision for the future, the political process cannot and will not do it for them—and we will be destined to continue to be shackled to the failed policies of the past," he warned at the November 2007 annual meeting of the Society of Clinical Surgery in Portland, Ore. "By default, we will be allowing our future to become a matter of chance rather than a matter of choice. I think we are better than that."

In January 2006, Dr. Kitzhaber, the former governor of Oregon, founded the Archimedes Movement, a grassroots organization that takes a "we can do better" approach to the governance and delivery of health care. The movement is "committed to providing a safe forum in which citizens and stakeholders alike can be brought together to create a shared vision of a new health care system, a space in which we can ask, 'If anything were possible, what would a better system look like?,' " he said.

The name refers to Archimedes, the Greek mathematician who invented the lever and is reputed to have said, "Give me a lever and a place to stand, and I can move the Earth."

A key strategy of the effort is to agree on what a new health care system should look like, and to expose the contradictions and inequities of the current system and create a "tension" between the status quo and a vision for a new system.

Dr. Kitzhaber, an emergency physician who governed Oregon from 1995 to 2003, said he believes there should be a different standard for the part of health care that is financed by public resources and the portion that is financed by private resources. "We must demand that we get an actual health benefit for the public dollars we allocate for health care, a positive return on investment, [and] the effective and efficient use of public tax dollars. And, since these are public resources—resources held in common—we must demand that their allocation benefits all of our citizens, not just some of them; that it does not leave 47 million people behind."

As an example, he said people who wish to buy an expensive brand name drug when a much cheaper generic is just as effective clinically, and just as safe, should be able to do so with their own personal resources. Public resources should not be used to subsidize the difference in cost. Similarly, he said, expectant parents who want an ultrasound to determine the sex of their unborn child when the procedure is not indicated clinically for a normal term pregnancy should be able to get that—but again, the cost should not be subsidized with public resources.

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DR. KITZHABER

To date, the Archimedes Movement has conducted public forums and vision-sharing meetings with more than 3,000 Oregonians in 30 chapters, 13 hospital CEOs, 11 insurer and health plan executives, dozens of physicians and nurses, leaders of national state and labor organizations, and representatives of more than 50 non–health-related businesses in the state.

The resulting consensus led to the Oregon Better Health Act, which was introduced in the 2007 Oregon legislature as Senate Bill 27. It proposes that Oregonians have access to a "core benefit" of essential health services, and seeks to realign financial incentives to ensure fair and reasonable payment to providers, value-based cost sharing for consumers, and a transition to a more efficient delivery system.

Although SB 27 did not pass in the 2007 session, the enthusiasm it generated from citizens and stakeholders propelled the Archimedes Movement into the limelight. It also produced three documents that offer a conceptual framework for a new system in the state and that may serve as a foundation for bringing about national reform. The documents—a Statement of Intent, Principles, and a Framework—are available at www.wecandobetter.org.

Nowadays, Dr. Kitzhaber and his associates are working to expand the movement to other states, especially Washington and Montana. This strategy stems from the fact that the committee that has jurisdiction over health care in the U.S. Senate is the Senate Finance Committee. Both of Oregon's senators (Democrat Ron Wyden and Republican Gordon Smith) are members of this committee, as is Sen. Maria Cantwell (D-Wash.). The committee is chaired by Sen. Max Baucus (D-Mont.).

Dr. Kitzhaber pointed out that the discourse on health care reform he has heard from the 2008 presidential candidates convinces him that the Archimedes Movement is peaking at the right time.

He said that although each of the 2008 presidential candidates has proposals for health care reform, they are all defining the challenge narrowly as just a financing problem related to insurance.

"No candidate of either party has stepped up to honestly acknowledge the reality of fiscal limits," he said.

"The very fact that none of these issues are a central part of the national political debate is evidence of the underlying failure in our current governance structure, of the diminishing capacity of our political system to allocate and manage public resources in a way that serves the larger public interest.

"It is an affirmation of the fact that we cannot solve this crisis by relying solely on our current legislative institutions." ■

Evaluating Maine's Dirigo Health at the Halfway Mark

BY MARY ELLEN SCHNEIDER
New York Bureau

As more state policy makers consider their options for expanding health insurance coverage, the experience of Maine's Dirigo Health may offer a road map for avoiding potential missteps.

Under the Dirigo Health initiative, which began in 2005, the state offered subsidized health insurance for small businesses, self-employed workers, and low- and moderate-income individuals through a program called DirigoChoice. In addition, the state increased the annual income eligibility level for its Medicaid program, MaineCare, to include parents of children under age 19 years who were at or below 200% of the federal poverty level.

The goal behind the Dirigo Health initiative has been to provide access to affordable health coverage to every Maine resident by 2009.

The program has seen success in targeting subsidies to low-income individuals, but it also has run into problems meeting its financial goals and hitting enrollment targets, according to a report commissioned by the Commonwealth Fund. The report evaluated the program as of September 2006.

"The implementation can be just as difficult as actually passing the law," said Debra J. Lipson, the lead author of the report and a senior researcher at Mathematica Policy Research Inc., based in Washington, D.C.

When the Dirigo Health Reform Act was passed in 2003, the program was touted as a means to achieve universal access to health insurance and target the 136,000 uninsured Maine residents. The state estimated that in the first year of the program, it would enroll about 41,000 people.

But the program has fallen short of those expectations and as of September 2006, had enrolled about 11,100 people in DirigoChoice. About 5,000 people were enrolled in the MaineCare expansion. An additional 18,100 people were covered through an earlier MaineCare expansion that targeted low-income childless adults.

The higher total enrollments in the two MaineCare expansions indicates that states can have success in increasing enrollment when they offer fully subsidized insurance options, the researchers concluded. But, as is in the case in Maine, those expansions come with a large price tag.

Another problem for the Maine program is that DirigoChoice remains unaffordable for many small employers. About 700 small firms were enrolled in the program as of September 2006, comprising about 2.5% of all eligible small businesses. About 83% of firms that did not offer the program or any other health coverage said they failed to offer benefits because premiums were too high, according to the report.

Other states considering similar programs may need to offer stronger incentives to encourage employers to offer coverage and help with employee costs, the researchers wrote.

Paying for the program also has been difficult in Maine. Most of the cost was supposed to be offset by savings from lower uncompensated care. But how savings are measured has been controversial from the start and has not been able to generate enough revenue, according to the Commonwealth Fund report.

The savings offset payment formula even was challenged in court by insurers and the state's chamber of commerce. While the Maine Supreme Court sided with the state in May 2007, the formula is widely viewed as "politically unsustainable in its current form," the report says.

The type of enrollment in the Dirigo Health program also has created funding problems for Maine. For example, enrollment by previously uninsured people has been lower than expected, leading to a lower reduction in charity care costs and limiting the revenues that could be raised for the program. As a result of this and other revenue shortfalls, the state has had to institute periodic enrollment freezes.

Creating affordable health insurance options was a challenge in Maine because there was little provider competition and a highly concentrated insurance market, the report noted.

In many ways the Maine experience is a cautionary tale for other states, said Tarren Bragdon, CEO of the Maine Heritage Policy Center in Portland. The program missed the mark by not limiting benefits to only the uninsured, he said, and states with limited resources should consider a more targeted approach.

Mr. Bragdon also advised policy makers in other states not to try to fund coverage expansions with projected savings. Those savings generally are small and inadequate to fund these types of expansions, he said. ■

The full report is available at www.mathematica-mpr.com/health/dirigochoice.asp.