Robert Wood Johnson Foundation

STATE OF THE STATES

February 2011

Laying the Foundation for Health Reform

AcademyHealth

STATE OF THE STATES

About SCI

The State Coverage Initiatives (SCI) program provides timely, experience-based information and assistance to state leaders in order to help them move health care reform forward at the state level. SCI offices an integrated array of policy and technical assistance services and products to help state leaders with coverage expansion efforts, as well as with broader health care reform.
Our team of policy experts tailors its approach to meeting state decision makers' needs within the context of each state's unique fiscal and political environment. SCI is a national program of the Robert Wood Johnson Foundation administered by AcademyHealth. For more information about SCI, please visit our website: www.statecoverage.org.

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Letter from the Director

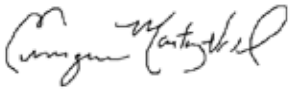
We are delighted to share this year's State of the States report, titled "Laying the Foundation for Health Reform." Following in the tradition of the State Coverage Initiatives (SCI) program, this year's report looks back at 2010, an extraordinary yet challenging year. With the passage of the Patient Protection and Affordable Care Act (ACA), the United States embarked on a historic course toward expanding coverage for the uninsured. The ACA has set an ambitious yet complex path for states to assume a major role in implementing many of the reforms envisioned in the new law. And, of course, all of this takes place in an extraordinarily difficult fiscal environment.

With the enactment of the ACA, states face an aggressive implementation timetable. There is no time to waste; for many, January 1, 2014 seems too near to accomplish so much. *State of the States* examines efforts to meet the requirements and responsibilities outlined by the ACA in order to build a new system maximizing residents' coverage and access to care, improving how private insurance markets function, holding insurers accountable, and reforming the health care delivery system.

As new administrations take the helm in 26 states, so begins a new era of health reform implementation. The learning curve will be steep but the opportunities are enormous.

The SCI program remains a supportive partner to states as they continue their implementation work. The majority of our technical assistance has been focused on the implementation of insurance exchanges and other insurance market reforms as defined in the ACA and we have a wealth of resources on our website www.statecoverage.org. We look forward to continuing to contribute to the research and experience-based knowledge states need as they lay the foundation for meaningful health reform.

Sincerely,



Enrique Martinez-Vidal

Executive Summary

The *2011 State of the States: Laying the Foundation for Health Reform* outlines the myriad health-related activities of states in 2010, which were primarily driven by the ongoing effects of the downturn in the American economy and the passage of the Patient Protection and Affordable Care Act (ACA).

BACKGROUND: FALLING REVENUES AND RISING NEEDS

The two major environmental trends that affected states were falling revenue and the rising need for state-based health coverage. New census numbers released in 2010 showed both a rise in the uninsurance rate to 16.7 percent from the previous 15.4 percent and an increase in the number of people covered by government-financed health insurance from 29.0 percent in 2008 to 30.6 percent in 2009.

As a result of these two trends, states had to close budget shortfalls in state fiscal year (SFY) 2011 that equaled $122.6 billion or 18.9 percent of state budgets on average. This was down from a 29 percent budget shortfall in SFY 2010. Making matters worse, budget stabilization, or rainy day, funds have been depleted across most states. In addition, a national workforce survey reported that 90 percent of respondents said their state government had implemented hiring freezes, with 65 percent instituting pay freezes, and about 46 percent furloughing employees.

Finally, the 2010 elections caused uncertainty and leadership change in many states. New governors were elected in 26 states; 17 of these governorships saw a change of party in control.

REFORM COMMITTEES AND TASK FORCES

The impact of the ACA cuts across many states agencies, requiring even greater coordination among state-level departments, including those responsible for Medicaid, public health, insurance regulation, and state employee and retiree health coverage. As a result, many governors established multi-agency task forces to coordinate their state's health reform efforts. They also considered ways to engage and include stakeholders through task forces or public committee processes. The *2011 State of the States* includes a chart of the various ways states organized their response to the ACA.

PRE-EXISTING CONDITION INSURANCE PLANS

One of the first major decisions facing states was whether or not to develop a state-run Pre-Existing Condition Insurance Plan (PCIP, also known as a high risk pool). The ACA's goal for these pools was to offer immediate access to coverage for those with health conditions that had previously prevented them from being able to access insurance. Ultimately, 27 states elected to run their own PCIP, while the remaining 23 states and the District of Columbia have federally-operated PCIPs.

By working with the federal government, states were able to help shape the coverage options available to their populations. This was especially important for states (mostly in New England) that already had insurance market rules that prevented plans from denying coverage based on health conditions. Those states were able to use federal funds to help make coverage more affordable for certain residents.

INCREASING CAPACITY FOR INSURANCE REGULATION

The ACA included $250 million over five years to increase the capacity of states to review the premium rates of health plans. The first round of grants has been distributed and states are using them to:

- Pursue additional legislative authority for rate review;
- Improve and expand the scope of existing health insurance premium review;
- Make information more transparent and accessible to the public; and
- Develop and upgrade technology.

In addition, the ACA includes a requirement that insurance companies spend at least 80 (in the individual market) to 85 percent (in the small group market) of premiums paid on medical costs. The Secretary of Health and Human Services (HHS) has the ability to allow some exceptions in the individual market if the application of the 80 percent medical loss ratio would destabilize that market in the state.

State insurance departments have been working with health plans and HHS to assess the current market and determine where this exception might be needed.

LAYING THE FOUNDATION FOR STATE-BASED EXCHANGES

Health benefit exchanges, which were established by the ACA and are required to be operational by January 1, 2014, will be the public face for health reform. Exchanges will be the place where consumers find out whether they are eligible for assistance in paying for insurance, and where they choose a health plan.

States are considering whether or not they will operate an exchange. In 2010, states applied for and received exchange planning grants, in part to help them make this important decision. In addition, states are using those resources to hire initial staff, host planning and stakeholder input meetings, assess current information technology infrastructure, and collect data on demographics and the insurance market that will inform future decisions.

In September, California became the first state to pass legislation to establish an exchange post-ACA. Other states are considering whether they will follow suit in their 2011 legislative session. States planning to seek legislation will need to make the key decision of how the exchange should be governed: through a state agency; an independent agency with a governing board; a non-profit; or a blended variation of those options. Many will follow California's lead of setting up a quasi-independent governing board with broad latitude to shape the policy decisions of the exchange.

MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM PRESENT OPPORTUNITIES AND CHALLENGES

State Medicaid Directors felt the pressure of the ongoing economic crisis from all sides. A rising number of people were eligible for Medicaid and CHIP, resulting in national enrollment growth of 8.5 percent in SFY 2010. There were also imperatives to cut spending in order to meet state budget targets even though the federal government prevented states from reducing eligibility levels. On the other hand, states continued to benefit from an increased Federal Medical Assistance Percentage (FMAP) throughout 2010.

Several trends were evident in the Medicaid program. Provider rate reductions or freezes were common. There has been growth in the utilization of managed care, even for groups that have been traditionally excluded, including those with disabilities and those eligible for long-term care. States have also utilized chronic disease management programs to improve care and restrain spending.

A few states took advantage of the new authority to cover childless adults in the Medicaid program under the ACA, by moving individuals in state-funded programs into the federally-matched Medicaid program. States also continued to take advantage of the performance bonuses in CHIP for states that simplified their eligibility and enrollment processes and increased the number of children both eligible and enrolled.

REFORMS IMPROVE QUALITY AND CONTAIN COSTS

Even as states work with the federal government to expand access to health care, the problem of growing costs and uneven quality remain. States have become active—both in their governing role and in their role as purchasers—in trying to work with consumers, payers, providers, businesses, and others to improve the health care system and, ultimately, to improve the health of the population. The strategies being employed are: medical homes and other investments in primary care, programs to improve transitions of care between hospitals and community-based settings, payment reform, health information exchanges and other investments in health information technology, development of all-payer claims databases and other key data infrastructure, and a renewed focus on population health. The *2011 State of the States* outlines numerous state activities in each of these areas.

CONCLUSION

Despite a challenging fiscal environment, states made considerable strides in 2010. In many cases, they used federal resources to accomplish tasks laid out in the ACA. In response to federal health reform, the majority of states are considering the big questions related to their goals for the health system. These conversations have already begun to yield innovative and interesting results with much more to come over the next several years.

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Chapter 1: Surveying the Landscape

The ongoing effects of the downturn in the American economy and the passage of the Patient Protection and Affordable Care Act (ACA) were the two major events affecting states in 2010. These two events sometimes worked at cross-purposes: states had to work to comprehend and absorb a major, transformative piece of legislation with staff who were swamped by rising needs as well as stagnant or falling revenue.

Work on implementation of the ACA began soon after passage of the legislation—states had 90 days to decide whether to manage a federally funded high risk pool (or Pre-existing Condition Insurance Plan). Ninety days after that, a number of insurance market reforms took effect. Many states also took an active role in communication about and enforcement of these reforms. States also applied for and received funding for insurance premium rate review and exchange planning grants. Many have either an executive order or legislation to support decision-making around implementation of the federal law.

At the same time, the United States has yet to recover from one of the worst national recessions in memory. As states prepared their state fiscal year (SFY) 2011 budgets (which generally run from July 2010 through June 2011), they faced an average shortfall of 19 percent.[1] Many states responded to that shortfall by enacting hiring freezes, travel restrictions, and furloughs.

States also saw increased Medicaid enrollment in 2010 due to persistently high levels of unemployment. The American Recovery and Reinvestment Act of 2009 (ARRA) helped ease some of that burden by increasing the federal matching rate for Medicaid. Along with the increased federal Medicaid funding came a requirement that states maintain their Medicaid eligibility levels, which limited how much states could programmatically decrease enrollment in their Medicaid programs.

Finally, the election cycle added another layer of uncertainty to the implementation process.

NUMBER OF UNINSURED INCREASES

In September 2010, the Census Bureau released its Current Population Survey data showing that the number of people without health insurance increased to 50.7 million in 2009, a significant increase from the 46.3 million reported in 2008. The uninsured rate increased to 16.7 percent from the previous 15.4 percent.[2] The increase in uninsurance reflects the sustained effects of the recession.

The number of people with health insurance decreased from 255.1 million in 2008 to 253.6 million in 2009. This marks the first time since 1987—the first year that comparable health insurance data were collected—that there was a real decline in the number of people with health insurance.[3] The breakdown of this figure includes a drop in the number of people covered by private health insurance (from 201.0 million, or 66.7 percent, in 2008 to 194.5 million, or 63.9 percent, in 2009) and an increase in the number of people covered by government health insurance (from 87.4 million, or 29.0 percent, in 2008 to 93.2 million, or 30.6 percent, in 2009).[4]

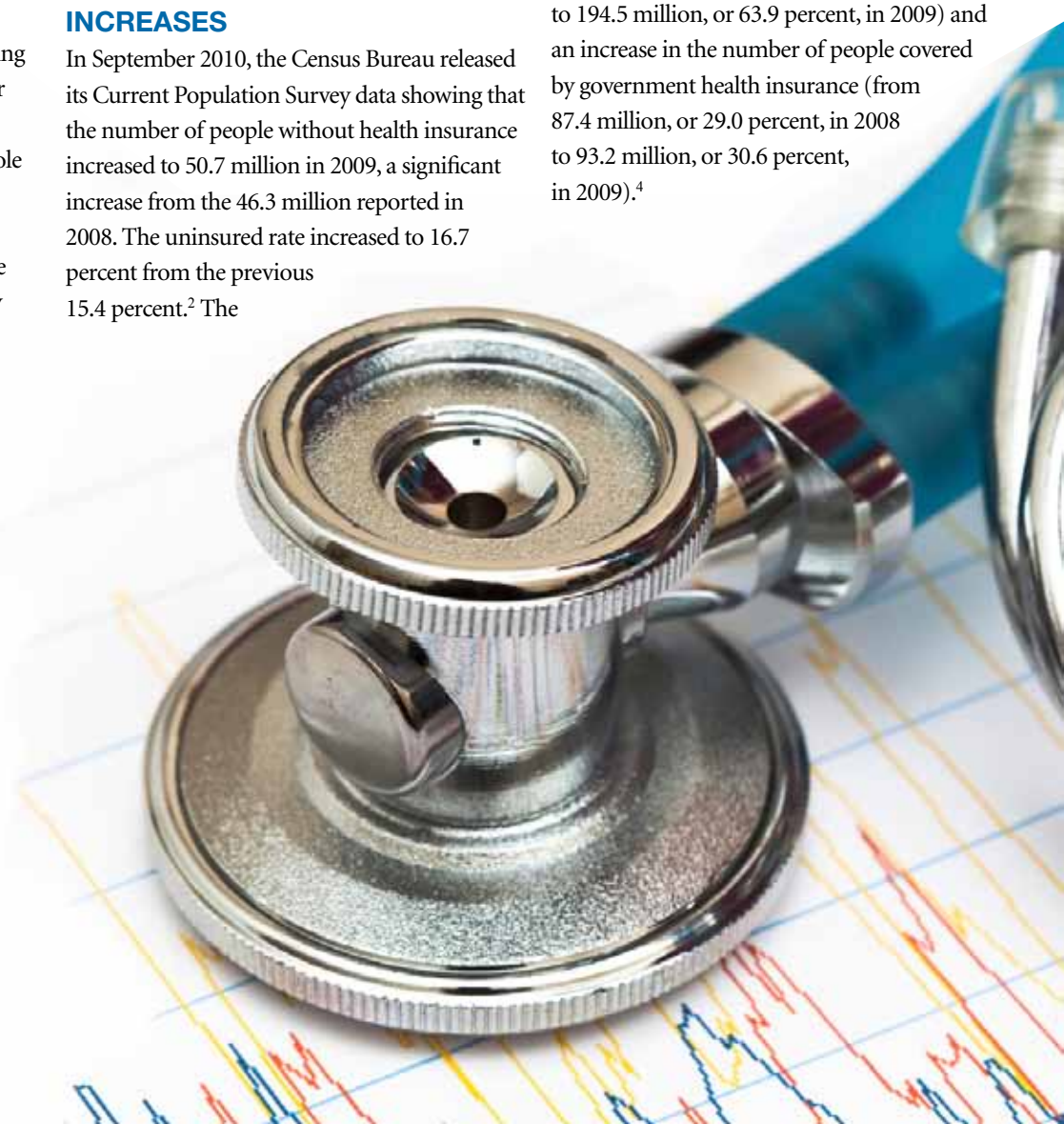
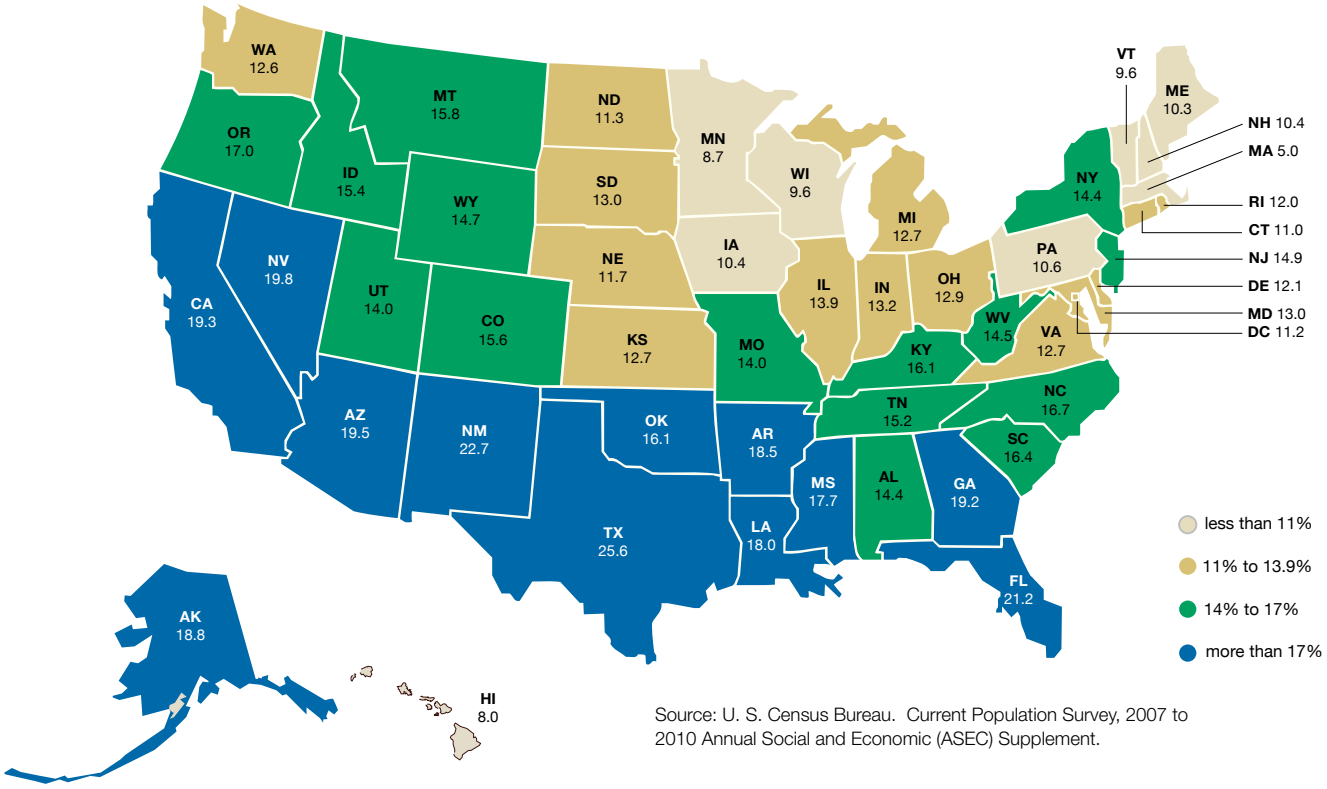


Fig. 1. **Two-Year Average Percentage of Uninsured by State: 2008-2009**



Source: U. S. Census Bureau. Current Population Survey, 2007 to 2010 Annual Social and Economic (ASEC) Supplement.

The 2009 uninsurance data are the first to reflect the toll of recession. (While the recession began in December 2007, significant declines in unemployment were not recorded until late in 2008.[5]) Unemployment went from 7.6 percent in January 2009 to 10.0 percent in December 2009. This increasing rate of unemployment accounted for a drop in the number of people covered by employer-based health insurance, which decreased to 55.8 percent in 2009 from the previous rate of 58.5 percent in 2008. In 2010, the rate of unemployment remained high, 9.3 percent in November after peaking at 9.9 percent in April, decreasing to 9.6 percent from August to October, and then rising again.[6] For comparison, the unemployment rate was only 4.9 percent in December 2007, before the onset of the recession. It should be noted that there is a significant variance in unemployment rates among states; as of November 2010, the rates ranged from 3.8 percent in North Dakota to 14.3 percent in Nevada.[7]

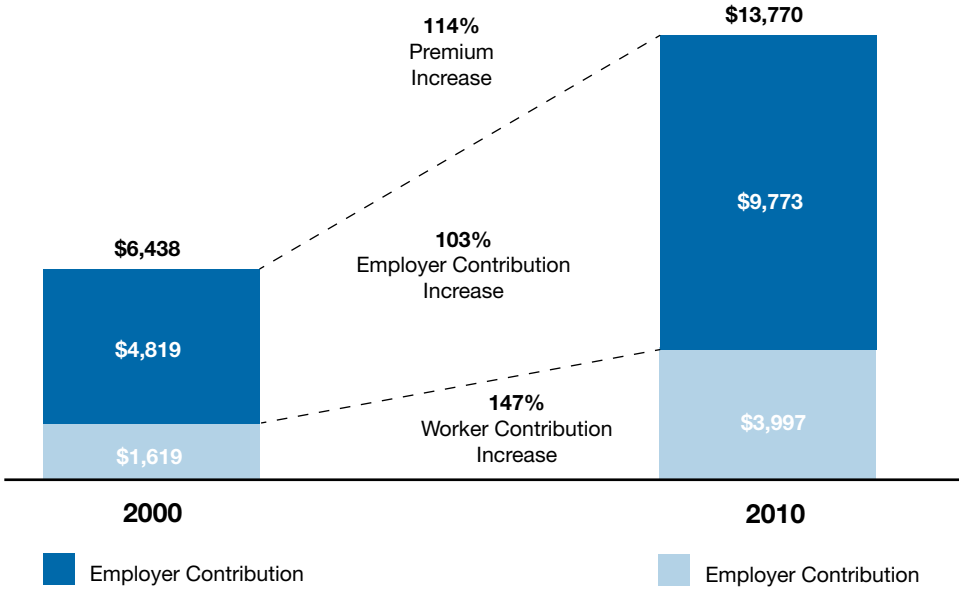
The census data also confirmed a trend of uninsurance among several population subgroups. While the uninsured rate for non-Hispanic whites increased from 10.8 percent to 12.0 percent, the rate increased from 19.1 percent to 21.0 percent among blacks, and from 30.7 percent to 32.4 percent among Hispanics.[8]

EMPLOYER COVERAGE

The Employer Health Benefits Survey found that annual health insurance premiums for single coverage increased by almost 5 percent from $4,824 in 2009 to $5,049 in 2010. Additionally, the premiums for family coverage rose 3 percent above the 2009 figures, increasing from $13,375 to $13,770. With the inclusion of this increase in 2010, premiums for family coverage have risen 114 percent in the past 10 years. In addition, workers with coverage also paid a larger portion of premiums in 2010. On average, covered workers contributed 19 percent of the total premium for single coverage, up from 17 percent in 2009. For family coverage, workers contributed 30 percent in 2010, up from 27 percent in 2009. It is important to note that the average figures disguise great variances; for instance, 28 percent of workers with single coverage pay more than 25 percent of the total premium, while 16 percent make no contribution. Similarly, 51 percent of workers with family coverage pay more than 25 percent of the total premium, while 5 percent make no contribution.[9]

Interestingly, there was an increase in the percent of employers offering health benefits, rising from the 60 percent reported in 2009 to 69 percent in 2010.[10] This change is primarily attributed to an increase in the offer rate of firms that employ three to nine workers, going from 46 percent in 2009 to 59 percent in 2010. This increase is significant but the specific reason for the jump is still unclear. Given the economic circumstances and the rate of unemployment, it is doubtful that more firms began offering coverage. The 2010 Employer Health Benefits Survey postulates that this change may be attributed to the attrition of non-offering firms (typically the smallest) during the recession, thereby skewing the numbers.

Fig. 2. **Average Annual Health Insurance Premiums and Worker Contributions for Family Coverage, 2000–2010**



Source: Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 2000-2010

STATE FISCAL CONDITIONS BLEAK, BUT STABILIZING

Although the worst of the recession seems to be over, states are still faced with difficult fiscal conditions. In SFY 2009, general fund revenues (consisting of state sales, personal income, and corporate income taxes) dropped a drastic 8.7 percent below the SFY 2008 figures.[11] On top of that, in SFY 2010, states experienced an additional 2.1 percent decrease from SFY 2009.[12]

As they developed their SFY 2011 budgets, states had to close a budget shortfall (referring to a deficit that must be addressed via spending cuts or revenue increases before a budget can be adopted) that equaled $122.6 billion or 18.9 percent of state budgets on average.[13] This was down from a 29 percent budget shortfall in SFY 2010. No relief is in sight for SFY 2012, with projected shortfalls that are similar to those felt in SFY 2011.[14] Making matters worse, budget stabilization, or "rainy day" funds, have been depleted across most states. These funds typically allow states to set aside excess revenue in order to close gaps in times of unforeseen shortfalls or budget deficits. The total state "rainy day" fund balance fell nearly half from a high of $69 billion in 2006 to $39.2 billion (6.4 percent of general fund expenditure) in 2010. It is projected to drop to $36.2 billion in 2011 (5.6 percent of general fund expenditure). However, these figures are somewhat deceiving: removing "rainy day" funds from Texas and Alaska reveals that the other 48 states possess funds matching only 2.8 percent of general fund expenditure.[15]

In 2009, Congress enacted the American Recovery and Reinvestment Act (ARRA) which temporarily increased the federal Medicaid matching rate (also known as Federal Medical Assistance Percentage, or FMAP) until December 2010. Given the expected SFY 2011 shortfalls, Congress also implemented a scaled back version (costing $16.1 billion rather than the $24.0 billion projected for a full extension) of this FMAP extension in August 2010, which is set to expire on June 30, 2011.[16] Because the majority of the SFY 2011 budgets were already passed when the FMAP increase was extended, many states needed to reexamine their SFY 2011 budgets.[17] Real concern lies ahead for states as they contemplate the loss of the FMAP increase in SFY 2012. While the FMAP extension can alleviate immediate financial burdens for SFY 2011, the loss of the FMAP extension in June 2011 will result in a dramatic increase in states' share of Medicaid spending of as much as 25 percent or more according to the Kaiser Commission on Medicaid and the Uninsured. This will have a substantial impact on states' SFY 2012 budgets.[18]

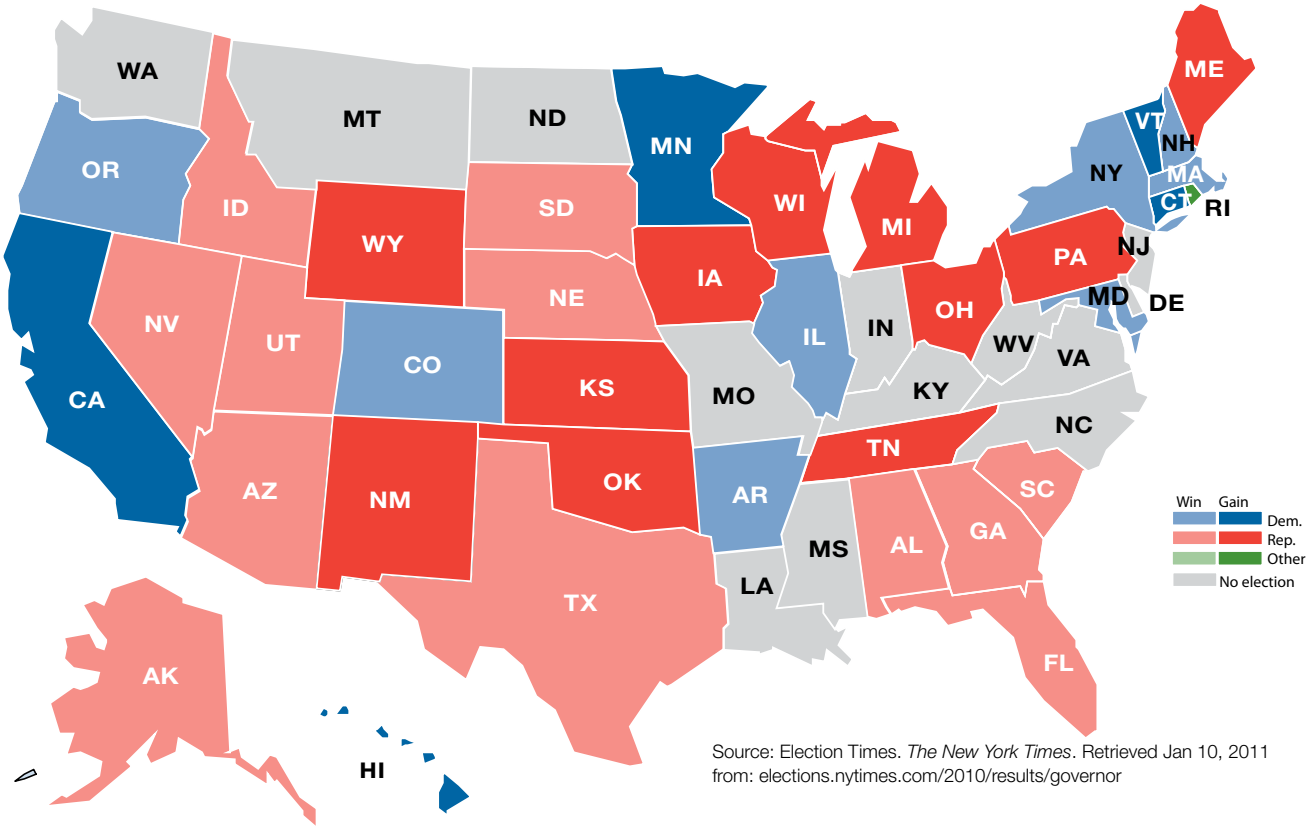
Despite the gloomy economic forecast, there are signs of slow stabilization. A Rockefeller Institute report in late November 2010 indicated that the July-September quarter of 2010 saw a 3.9 percent increase in revenue for states compared to the same quarter in 2009. Gains are likely to be limited; because personal income taxes collections are the largest source of revenue for many states, more substantial gains are unlikely while unemployment hovers around 10 percent.[19]

RECESSION RESULTS IN INCREASED MEDICAID ENROLLMENT AND SPENDING

The demand for Medicaid rose sharply in 2010, continuing the trend from the previous year. Projections for Medicaid spending growth at the beginning of SFY 2010 predicted a 6.3 percent growth through the 2010 fiscal year. However, the actual spending in SFY 2010 averaged 8.8 percent across all states, which is the highest rate of growth in eight years. Enrollment growth also outpaced the projections, averaging 8.5 percent—well above the projected 6.6 percent.[20]

The most oft-attributed factor for this increase in Medicaid spending and caseload is the recession. With the rise of unemployment (and subsequent loss of employer-based coverage), more individuals begin to rely on Medicaid. The ARRA-enhanced FMAP reduced the burden of Medicaid costs on states by 10.9 percent in 2009; in 2010, the relief equaled 7.1 percent. Despite this relief, nearly every state has had to implement at least one new policy to control Medicaid spending.[21]

Fig. 3. **Gubernatorial Election Map 2010**



Source: Election Times. *The New York Times*. Retrieved Jan 10, 2011 from: elections.nytimes.com/2010/results/governor

STATES FACE WORKFORCE WOES

As states grapple with implementing the Affordable Care Act, there are looming concerns related to the staff required for projects of the scale envisioned by federal reformers. Administrative cuts and workforce reductions will amplify the already considerable challenges associated with implementation of health care reform. On top of the recession causing workforce woes, many states are concerned about the amount of forthcoming retirements, the limitations of state hiring processes, and salary schedules. An astounding 33.3 percent of state government workers are eligible to retire in the next five years. This level of retirement eligibility occurring during a transition to new leadership (in those states where new governors were elected) may further increase states' loss of institutional knowledge. An online national workforce survey reported that 90 percent of respondents said their state government had implemented hiring freezes, with 65 percent instituting pay freezes and about 46 percent furloughing employees.[22] The diminishing workforce is of great consequence and bears troubling implications for the transitioning health policy environment.

State staffs working on health reform will also see a considerable amount of turnover as a result of the November 2010 state gubernatorial elections. New governors were elected in 26 states; 17 of these governorships saw a change of party in control.[23] A new team of senior level staff will need to get up to speed not only on state policies but the new decisions that will be required of them as a result of federal reform. In states where there is a lack of goodwill between the incoming and outgoing governors, it is possible that early planning efforts will be discarded and critical momentum will be lost.

LEGAL AND POLITICAL CHALLENGES TO FEDERAL HEALTH REFORM

A number of states have taken both political and legal steps to prevent the enactment of federal health reform. As of December 15, 2010 there were 24 lawsuits challenging the constitutionality of the ACA from a variety of types of jurisdictions (including states).[24] As of February 2011, the attorneys general of 26 states had joined a lawsuit in the federal court's Northern District of Florida against the U.S. Department of Health and Human Services, Department of Treasury, and Department of Labor, challenging the constitutionality of the ACA.[25] The attorneys general contend that mandating the purchase of insurance exceeds the powers authorized under Article I of the Constitution, and that the ACA infringes on the sovereignty of the states and the 10th Amendment to the Constitution. In November, legislators from 27 states responded with an amicus brief supporting federal health care reform. The brief contends that the ACA does not violate the principles of federalism due to the substantial amount of policy options offered as well as the level of control afforded to states for constructing mechanisms such as the health insurance exchanges.[26]

On December 13, 2010, Judge Henry E. Hudson, federal judge on the United States District Court for the Eastern District of Virginia, passed down a decision in another case filed by the attorney general of Virginia. The judge deemed the individual mandate piece of the ACA unconstitutional in the suit submitted by the attorney general of Virginia. Judge Hudson regarded this key provision of the ACA, requiring most Americans to purchase health insurance, as beyond the scope of congressional authority to regulate interstate commerce. Less than two weeks prior to this ruling against the mandate, U.S. District Judge Norman Moon of the Western District of Virginia had ruled in favor of the mandate in a case against the ACA brought forth by a university in Lynchburg, Va.[27] On January 31, 2011, Federal District Judge Roger Vinson of Florida went farther than Judge Hudson by not only finding that the individual mandate is unconstitutional, but that the entire law should be struck down because it is "inextricably bound" to the mandate.[28] The question of the constitutionality of the mandate is likely to be decided by the Supreme Court.

Forty states have also seen formal resolutions or bills that are intended to curtail federal health care reform from going forward.[29] While the majority of these motions did not pass or died in committee, there were some notable exceptions where states have signed laws or enacted statutes. In March 2010, shortly prior to the passage of the ACA, Virginia passed a law stating that no resident of the Commonwealth of Virginia would be "required to obtain or maintain a policy of individual insurance coverage" and that there would be no penalties associated with the failure to "procure or obtain health insurance coverage."[30] Idaho and Utah followed suit.

In June 2010, after passage of the bill, Georgia signed into law a statute stating "no law or rule or regulation shall compel any person, employer, or health care provider to participate in any health care system."[31] Louisiana enacted a similar statute a month later, stating that residents will be free from "governmental intrusion in choosing or declining to choose" health coverage.[32] In addition to an April law securing the right of Arizonans to accept or decline "any mode of securing lawful health care services" without penalty, Arizona's House and Senate has passed an amendment to the state constitution with similar language. This amendment received voter approval in the November 2010 election. Colorado and Oklahoma also passed ballot initiatives that allow residents of those states to opt out of the requirements of the federal law. While these state laws are evidence of the sentiment of the legislature and public in those states, they are unlikely to have an impact on the enforceability of the federal law.

Despite the political opposition and significant economic hurdles, most states are moving forward with, at the minimum, planning for federal health care reform. For instance, Virginia passed measures to block the individual mandate (as described above) and the state's attorney general was among the first to set into motion a case against the federal government in March 2010. Regardless, the governor's office established the Virginia Health Reform Initiative Council in August and appointed members to the council.[33] Virginia has also established six health care initiative task forces that are making recommendations to the council.[34] The story is a similar one in states such as Michigan and Texas, where steps to move forward in health reform have been taken despite challenges originating from the same state.

STATE AND FEDERAL INTERDEPENDENCY IN HEALTH CARE REFORM

It may be worth noting that 2010 marked a shift in the focus of national health reform efforts. After a multi-year process of crafting a federal bill, Congress finally passed legislation in March 2010 that gave states a central role in implementation. While all eyes had been on federal policymakers (and they will continue to play a strong role in funding and regulating reform), attention has now shifted to states. States are likely to face a higher level of scrutiny from stakeholders and advocacy groups going forward.

The sweeping changes envisioned by the bill at both the federal and the state levels will require a strong partnership between policymakers in each level of government. Relationships between state and federal policymakers regarding health care have sometimes been characterized by a lack of communication and trust. This is accentuated by embittered sentiments from those who feel they were not consulted enough during the formation of the ACA and who do not agree with the approach it envisions. For reform to work as planned, strong working relationships, characterized by two-way conversation, answers in real time to pressing questions, and mutual respect, must be developed.

The federal government will face important questions about when to set standards that states are required to meet and when to promote healthy experimentation and diversity of approaches. States will need their roles further defined while providing input into what those roles should be. There will be times when there is no right answer (and multiple approaches could be successful in different ways) and other times when the right answer is not yet clear. In the past, state experimentation has not always been connected to strong evaluation, which limits the ability of states to learn from each other and for the federal government to learn from successful states. Increased attention must be paid to determining what works and what does not so that all states can adapt policies appropriately. These evaluations can help prevent large disparities between states and will enable states to build on each other's successes.

Overall, the primary challenge is that states need federal guidance for a multitude of issues quickly, but that guidance will almost certainly be slow and gradual. This has created differences among states' reactions. Some have been proactive—moving forth with the requirements under the law despite ambiguities—while other states have opted

for a more conservative approach awaiting more legal and federal guidance before moving forward.

CONCLUSION

In general, 2010 was a transitional year for states. After a recession that resulted in some of the highest rates of uninsurance and unemployment in recent history, most states warily held off any plans for state health reforms and chose to see what would come of federal health reform legislation. When that reform legislation arrived in March, it led to more questions about state capacity to achieve meaningful reform. Fiscal stress compounded as state revenues ran low and budgetary demands increased. Many states had to rely on layoffs, furloughs, hiring freezes, and other budgetary cuts to balance their budgets. As a result, states must execute the provisions of the ACA with limited staff and financial resources.

Despite grim economic circumstances and daunting challenges, many states have taken the cue from the federal government to advance their health care initiatives using the tools and resources contained in the Affordable Care Act. The majority of states are considering big questions related to their goals for the health system and strategies for carrying out the ACA in ways that will work in their state's environment. These conversations have the potential to yield innovative and interesting results, particularly in the states that emerge as leaders in a national health reform movement.

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STATE OF THE STATES

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Chapter 2: Using Federal Reform to Accomplish State Goals

For states, 2010 was defined in many ways by the Patient Protection and Affordable Care Act (Affordable Care Act or ACA): debating its merits, watching its final passage, and then trying to absorb its many provisions. In some states, the legislation was met with cheers, as it was well-aligned with efforts already underway. For officials in other states, it looked like a federal imposition of a new set of priorities that may not have been similarly high on the state's agenda.

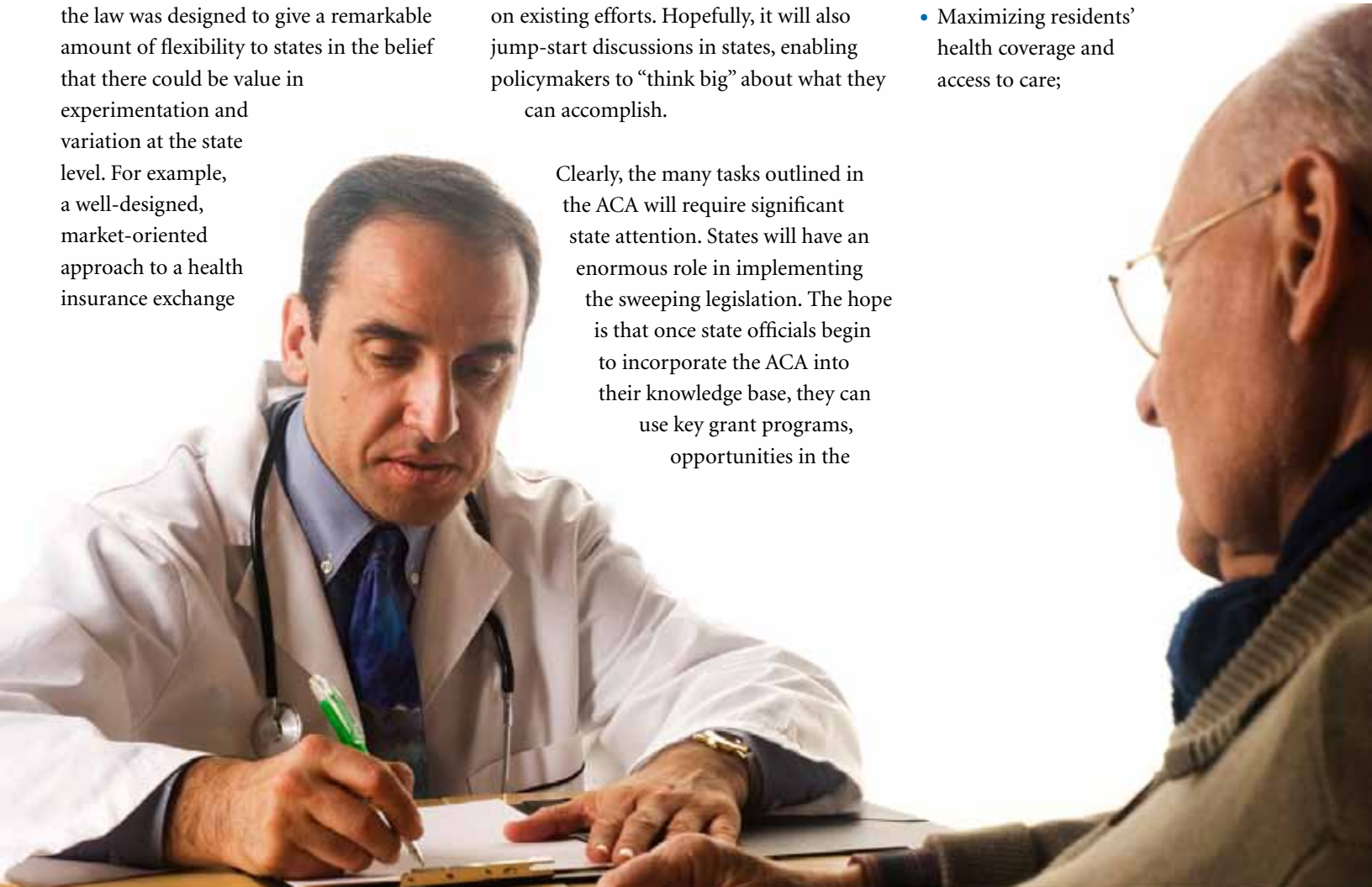
The challenge for states is to understand not only what is included in the federal law, but also how policymakers can use aspects of the law to accomplish their goals. Indeed, the law was designed to give a remarkable amount of flexibility to states in the belief that there could be value in experimentation and variation at the state level. For example, a well-designed, market-oriented approach to a health insurance exchange could teach us much about the merits of that approach, just as a well-executed regulatory approach could do the same. Community-based efforts to redesign the delivery and payment systems to provide better care and improve health will be the engine of reform across the country as successful strategies are incorporated across the system.

The key is for states to be active and engaged. Federal reform should not derail states from previous goals related to market reform, coverage expansion, or delivery system changes. In fact, the law can be a tool to help achieve those goals. It provides additional resources for states to build on existing efforts. Hopefully, it will also jump-start discussions in states, enabling policymakers to "think big" about what they can accomplish.

Clearly, the many tasks outlined in the ACA will require significant state attention. States will have an enormous role in implementing the sweeping legislation. The hope is that once state officials begin to incorporate the ACA into their knowledge base, they can use key grant programs, opportunities in the law, and the new power they have been given to improve the health care system in ways that fit the economic, social, and political climates of their states.

In order to help state officials accomplish their goals, State Coverage Initiatives (SCI) worked with Stan Dorn of the Urban Institute to develop a report titled: *State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals.*[1] It was designed to help state officials understand how the federal law applies to them and how they can use it to accomplish the following goals:

- Maximizing residents' health coverage and access to care;



- Helping health care and coverage function more like a traditional, consumer-driven market;
- Holding insurers accountable for providing high-quality coverage at a reasonable cost to the consumer;
- Reforming the health care delivery system to slow cost growth while improving quality; and
- Limiting state general fund spending on health care.

STRATEGIES TO MAXIMIZE RESIDENTS' HEALTH COVERAGE AND ACCESS TO CARE

States can use three mechanisms to increase access to care, depending on income level:

- Help eligible individuals enroll in and retain subsidized health coverage;
- Improve affordability and continuity of coverage for low-income adults who are ineligible for Medicaid; and
- Increase access to care within Medicaid.

Help eligible individuals enroll in and retain subsidized health coverage

Several state strategies will be important to maximizing eligible residents' enrollment and retention in both the Medicaid program and the subsidized plans that may be part of an exchange. Among them are: 1) public education and facilitated enrollment; 2) streamlining application forms and procedures for Medicaid, the Children's Health Insurance Program (CHIP), and subsidies for private coverage purchased in the health insurance exchange; 3) streamlining the eligibility determination and enrollment process; and 4) creating an efficient eligibility determination infrastructure.

Improving affordability and continuity of coverage for low-income adults who are ineligible for Medicaid

Coverage may still be out of reach for certain low-income people, even after the new system of subsidies in the exchange is fully implemented. Not only may the subsidies be too low to make coverage fully affordable, but low-income people can end up shifting between Medicaid and the exchange as their income fluctuates.

To make coverage more affordable for residents with incomes too high for Medicaid, states have two options: 1) to implement the Basic Health (BH) program option outlined in the ACA; or 2) to supplement federal subsidies in the exchange. BH would be available for citizens and legally resident immigrants with incomes at or below 200 percent of the federal poverty level (FPL) who are ineligible for Medicaid and CHIP. Since per capita federal payments through this option will equal or exceed the average cost of Medicaid coverage for adults, beneficiaries could receive Medicaid- or CHIP-style coverage, with very low premiums and out-of-pocket costs. However, because Medicaid and CHIP provider payment rates are lower than those of private plans in many states, beneficiaries might not have access to the broader provider networks that are likely to be in the exchange. States could lessen this problem by using any excess of federal BH payments over current Medicaid or CHIP premiums to raise rates.

Alternatively, states could supplement federal subsidies in the exchange. This option would offer access to the provider networks in the exchange, but unlike with the BH option, state general fund dollars would be needed.

To help people whose incomes fluctuate and are being shifted between Medicaid and subsidized coverage in the exchange, states can learn from the Massachusetts experience and encourage Medicaid plans to participate in the exchange (or BH, if the state implements this option). In this way, as household income rises or falls, a family could stay in the same plan and continue to see the same doctors, even as the applicable premium payments and out-of-pocket cost-sharing rules change. The BH option would also help with continuity of coverage and care as incomes fluctuate below 200 percent FPL.

Increasing access to care within Medicaid

The ACA increases funding for Medicaid to raise payment rates to Medicare levels for primary care providers furnishing "evaluation and management" services in calendar years 2013 and 2014. To further increase low-income consumers' access to care, the law increases funding for community health centers, school-based health centers, and other infrastructure that can potentially serve Medicaid beneficiaries. Other options to help encourage provider participation (other than increasing Medicaid rates) include expediting Medicaid claims payment, increasing the use of tele-medicine to serve rural Medicaid beneficiaries, and changing state licensure laws to increase the range of services that non-physicians (and non-dentists) are allowed to provide within the Medicaid program (and potentially outside it as well, depending on state politics surrounding this issue).

HELPING HEALTH CARE AND COVERAGE FUNCTION MORE LIKE A TRADITIONAL, HEALTHY MARKET

One of the most important aspects of a healthy market is for consumers to understand their options so they can make informed decisions. Currently, consumers do not have access to a wide range of both price and quality information about providers and insurance plans, making it difficult for them to choose plans that meet their needs. To address these problems, the ACA provides new tools that state officials can use to move the health care system toward a more competitive market-based system.

To that end, state policymakers can focus on:

- Price transparency for both providers and plans;
- Quality information for both providers and plans; and
- Implementing health insurance exchanges in a manner that increases the role played by consumer choice.

Price transparency is an important first step in helping consumers make informed decisions. The exchange will offer—in many cases, for the first time—an ability for consumers to compare premium prices on products with similar actuarial values. Exchanges can also offer additional information about plan quality, along with price and quality information about providers.

Since Medicare already collects performance data on hospitals and to some extent on physicians,[2] and the ACA further strengthens the current system for evaluating quality and efficiency for these providers, states can work with the Department of Health and Human Services (HHS) to make quality reporting easily accessible to consumers. In addition, states can build an all-payer claims database (APCD) that gives consumers access to information about real prices paid to providers. The federal law opens the door for Medicare participation in state-based APCDs, and some states are already receiving those data. Since performance data need to be risk-adjusted to provide an accurate picture, rather than reinventing the wheel, states can apply methodologies that HHS is developing for Medicare to address this issue.

To present the information in a user-friendly manner, states may:

- Make all price and performance information available in a single place, such as a consumer health information website, perhaps as a part of the exchange web portal.
- Present basic information; additional information can be made available for those who want to dig deeper.
- Organize the information to show risk-adjusted costs and outcomes for provider teams' treatment of particular conditions, throughout the full cycle of care.
- Consider—if all qualified plans are allowed to offer coverage—(a) designating which plans are recommended by the exchange, so that consumers are not overwhelmed by available choices or (b) providing consumers with decision tools to help narrow options to those that best fit the particular consumer's needs.
- Provide other useful information about insurance options in the exchange, such as whether particular drugs are included in health plan formularies.

To increase competition in the market, states can employ the following strategies:

- Encourage insurers to offer a broad variety of plans in the exchange, at each available actuarial value.
- Encourage one or more insurers to offer plans with limited provider networks that allow lower premiums.
- Consider the creation of new carriers, such as a member-owned co-op or a state-administered plan that can operate in the exchange. The goal is to increase competition among carriers, especially in states where a small number of insurers dominate the market.
- Let brokers and agents sell exchange plans, and give medium-sized firms—those with 100 or fewer workers—access to the exchange to increase the number of residents using the exchange. Brokers would receive the same fee regardless of the health plan in which a consumer enrolls.
- Collaborate with employers to design an exchange that works well for them.

HOLDING INSURERS ACCOUNTABLE TO CONSUMERS

The ACA establishes a multitude of reforms for health insurance markets and provides states with tools they can employ to increase insurers' accountability to consumers. The strongest measures go into effect on January 1, 2014.

One of the most important tools in ensuring compliance with legal requirements is having access to data that can potentially flag violations. Until now, insurance commissioners have had limited access to such data. The ACA changed this by requiring insurers to provide substantial new amounts of data on such topics as claims payment and denial, enrollment, disenrollment, and provider participation. This information can help spot possible legal violations, such as failure to provide services included in the minimum benefits package, that could be detected if a plan has unusually high denial rates for certain claims. Along similar lines, a very low volume of paid claims in a particular geographic area and specialty could indicate a gap in a plan's provider network.

A state can take additional steps and require other data elements that could be useful to determine plan performance. For example, a state could require detailed information about the number and nature of complaints and appeals filed by consumers (if such information is not required by HHS). To provide an incentive to insurers to comply with the additional data requests, a state can make licensure or access to the exchange contingent upon compliance with the data request. Making insurer performance data publicly available and searchable would let journalists, purchasers, and nongovernmental organizations supplement the efforts of state regulators and identify potential problems.

State officials can authorize state agencies to bring claims under the False Claims Act and educate the public and insurers about the potential application of the Act to insurers that knowingly offer unqualified plans in the exchange. False Claims Act recoveries may be enormous, as they will be based on the volume of federal subsidies wrongfully received by an insurer. In addition, states can tap into the $30 million the ACA appropriates for the establishment of a consumer assistance program and partner with community-based legal services offices that already furnish similar services. These actions can increase consumer protection and further deter insurers from violating legal requirements, including those that apply to the exchange.

States can use several mechanisms to supplement current enforcement dollars. For example, a state insurance department can contract with the exchange to certify plans as qualified. Funds for the administrative activities for the exchanges do not require state general fund appropriations. Until 2015, they can come from federal grants. After that, exchanges must be self-supporting. (The Massachusetts exchange, for example, surcharges insurance premiums in the exchange, which allows federal subsidies to pay most administrative costs.)

Other funding mechanisms for insurance enforcement include using federal grants to build capacity for rate review, working with health consumer assistance programs, and using "whistleblower" awards obtained from pursuing False Claim Act claims.

Finally, states can increase insurers' accountability to consumers by introducing new competitors into the health insurance market. To recruit providers without paying exorbitant reimbursement rates, such an insurer would need a large number of enrollees. A publicly-administered health plan, such as SustiNet in Connecticut, could achieve a critical mass of enrollees by enrolling, at plan start-up, Medicaid and CHIP beneficiaries as well as public employees and retirees. An added benefit is that, with such a large number of enrollees, such a plan has the potential to galvanize a change in the state's health delivery system, to help implement the reforms described next.

REFORMING THE HEALTH CARE DELIVERY SYSTEM TO SLOW COST GROWTH WHILE IMPROVING QUALITY

The ACA includes a number of provisions aimed at reforming the health care delivery system to slow cost growth and improve quality. Those provisions offer a range of options for states to consider in restructuring care delivery and reimbursement. For example, states can:

- Implement Medicaid demonstration projects to test new reimbursement methods that reward value, rather than volume;
- Use new Medicare methods to base payment on provider performance for public employee coverage;
- Incorporate Medicare, Medicaid, and private coverage into multi-payer initiatives that implement reimbursement and delivery system reforms;
- Help high-cost, chronically-ill patients in Medicaid, public employees, and the privately insured participate in the "patient-centered medical home" model of coordinated care;
- Implement initiatives to prevent costly rehospitalization, improving health status and saving money for public and private payers alike;
- Use the results of comparative effectiveness research to encourage public employees to avoid costly procedures and treatments that do not contribute to patient health, while permitting private employers to give their covered employees similar incentives; and
- Apply for federal grants and participate in demonstration projects to combat obesity, smoking, and other risk factors among Medicaid beneficiaries, in low-income communities, and with other residents.

Implement Medicaid demonstration projects to test new reimbursement methods that reward value, rather than volume

The fee-for service payment system provides incentives for providers to increase the volume of services and perform high-cost procedures, rather than incenting the provision of high-quality care in an efficient manner that focuses on improving consumer health. Over the years, concerns about the pitfalls of the fee-for-service payment system have led policymakers to consider a variety of options including:

1) *Bundled Payment.* This is a payment methodology through which all hospitals, doctors, and post-acute care providers participating in an episode of care join together to receive a single payment for that episode, from three days before hospitalization through 30 days after discharge, for example.

2) *Accountable care organizations (ACOs).* ACOs allow teams of physicians (and potentially other providers, including hospitals) to share in the cost savings that result when these providers' patients incur fewer health care costs than is typical for similar patients while meeting certain quality standards. The analysis of cost savings takes into account all services, not just those furnished by the ACO.

3) *Global Payments.* Large safety-net hospitals or networks could be paid on a global or capitated basis rather than fee-for-service.

The first two models also offer the hope that, if implemented, they would achieve both cost savings as well as better care in the form of increased care coordination across all treatment settings. The ACA includes opportunities for Medicaid to test some of these innovative payment methodologies.[3]

Use new Medicare methods to base payment on provider performance for public employee coverage

The ACA includes a number of mechanisms aimed at reforming the Medicare reimbursement system. Some, such as pay-for-performance mechanisms, focus strictly on either hospitals or physicians. However, other provisions included in the ACA try to increase

coordination across all treatment settings—for example, through bundled payment or ACOs.

The health reform law also includes provisions that encourage Medicare beneficiaries to take a more active role with regard to the care they receive. Beneficiaries who select high-value providers would either experience lower costs or receive additional benefits.

States may want to apply some of these reforms to public employee coverage. However, state officials would need to monitor the implementation of these reforms, as they could lead to unintended consequences. While a pay-for-performance system could lead to better and more efficient care, there is some concern that it could worsen racial and ethnic disparities and change providers' behavior so that they focus primarily on the measures used to determine payment levels. States would also need to ensure that the ACO-provider groups would develop in a manner that increases care coordination without creating entities whose leverage in contract negotiations would extract excessive payment levels from private insurers.

Incorporate Medicare, Medicaid, and private coverage into multi-payer initiatives

Multi-payer initiatives could help ease providers' administrative burden resulting from getting different or contradictory messages about expectations related to quality, cost, and care coordination. Such initiatives could include Medicare, either by applying Medicare reimbursement reforms to other payers or by applying state payment innovations to Medicare. To take the latter approach, states would need to propose a demonstration project to the Center for Medicare and Medicaid Innovation (CMMI).[4]

Help high-cost, chronically-ill patients participate in the "patient-centered medical home" model

Another way to increase coordination across treatment settings is to create patient-centered medical homes (PCMHs). Beginning in January 2011, states can implement the new Medicaid option for PCMH services and use federal grants to provide PCMH services to certain chronically ill beneficiaries. During the first eight quarters of a state's implementation of this option, the federal government pays 90 percent of the cost of the PCMH services.

However, states are not limited to implementing PCMH services in Medicaid. They can implement these services with public employees and retirees and encourage (or even require) private insurers to do likewise, particularly in areas of the state that have an infrastructure suited for this model of care.

States can support the PCMH model with community health teams, health information technology (HIT) implementation plans tailored to meet the needs of the PCMH model, and primary care extension centers (or other mechanisms to help providers transition to new models of practice). To do so, states would need to seek funding from the CMMI in case federal grants authorized for these purposes do not become appropriated. This funding could also be used to evaluate the effects of the PCMH model on quality, clinical outcomes, cost, and patient and provider satisfaction.

Implement initiatives to prevent costly rehospitalization

States can also follow Medicare's lead, for example by implementing in Medicaid the Medicare ban on reimbursement for care related to health-care-acquired conditions. The ban can apply to both Medicaid fee-for-service and Medicaid managed care. Likewise, a state can apply to dual eligibles Medicare innovations such as the Community-Based Care Transitions and the Independence at Home demonstration project. The Community-Based Transitions Program involves hospitals furnishing evidence-based care transition services such as active post-discharge engagement to patients who might be at high risk for hospital readmission. The Independence at Home demonstration program is intended to improve care coordination for approximately 10,000 chronically ill Medicare beneficiaries nationwide both in the home and across treatment settings. There is no reason why these initiatives could not focus on dual eligibles, potentially yielding gains for states as well as the federal government and beneficiaries.

Use the results of comparative effectiveness (CE) research

The ACA increases funding for comparative effectiveness research, which can assess the strengths and weaknesses of possible treatments for particular health conditions. Public employee coverage could incorporate the results of CE research so that only the least costly service that provides known medical benefits would be covered. Two safeguards would need to be implemented to give consumers the opportunity to receive more expensive treatments when necessary: 1) allowing patients to pay the extra cost of more expensive treatments; and 2) paying for the more expensive procedure if the physician can show that the more costly service is more likely to achieve its therapeutic goal or avoid harmful side effects for a particular patient.

On the private market side, states could authorize health plans to implement similar policies. However, because one safeguard involves patients paying extra to obtain more expensive services, applying CE research to Medicaid, CHIP, or subsidized coverage in the exchange should be avoided, at least until this policy establishes a track record.

Apply for federal grants and participate in demonstration projects to combat obesity, smoking, and other risk factors

The ACA provides a variety of funding mechanisms to support both primary prevention and secondary prevention. Primary prevention refers to population-based efforts to prevent the development of health problems. Such efforts include eliminating environmental toxins, improving nutrition, increasing exercise, and reducing the use of tobacco and other addictive substances. Secondary prevention involves providing screenings and tests to spot potential health problems and allows for early diagnosis and treatment that prevents the development of serious illness. The health reform legislation appropriates funds to support grant programs and demonstration projects that promote healthy behaviors and wellness, such as smoking cessation and healthy eating to prevent obesity. The ACA also gives Medicaid a small increase in the applicable federal matching percentage if the state covers certain qualifying preventive services, free of cost-sharing. State officials can also take advantage of discounted rates to purchase adult vaccines.

LIMITING STATE GENERAL FUNDING SPENDING ON HEALTH CARE

While many state officials have voiced their concerns over how much the ACA will increase the burden on state budgets, much less emphasis has been placed on the potential savings it can generate. For example, states can achieve savings by:

- Implementing mechanisms to save on the health coverage for public employees and retirees;
- Substituting federal Medicaid dollars for state and local dollars;
- Moving Medicaid beneficiaries into subsidized coverage that is fully federally funded;
- Slowing health care cost growth within Medicaid; and
- Increasing state revenue.

Implementing mechanisms to save on the health coverage for public employees and retirees

- Use federally funded reinsurance to cover claims incurred by early retirees available to employers who implement measures to reduce spending on the chronically ill.
- Implement delivery system reforms, which have the potential to slow cost growth. Particularly promising candidates for cost savings include home care for high-risk patients after hospital discharge, and exercise and diet interventions aimed at pre-diabetic individuals to delay or prevent the onset of full Type II diabetes.
- Lessen the need for local aid if local governments achieve savings by enrolling their employees and early retirees in the exchange.

Substituting federal Medicaid dollars for state and local dollars

Currently, states spend resources to provide physical and mental health care to adults with incomes at or below 138 percent FPL, including uncompensated care for the uninsured and mental health services. Federal matching funds through Medicaid can substitute for these state and local expenditures. With newly eligible adults, state savings will be particularly pronounced since the federal government will pay 100 percent of all costs during 2014-2016, then gradually scale back to cover 90 percent of costs in 2020 and beyond.

Moving Medicaid beneficiaries into subsidized coverage that is fully federally funded

Currently, Medicaid pays for the care of some adults whose income exceeds 138 percent FPL, including pregnant women. This coverage can be terminated, with the adults shifted to the exchange (or the Basic Health program, in states adopting that option). In addition, states can achieve savings on the medically needy, whether they receive coverage as newly eligible Medicaid adults (for whom the federal government pays enhanced match), Basic Health, or the exchange. The medically needy are people who have incurred, within a state-defined period between one and six months in length, medical bills that reduce their disposable income below medically needy income levels. When they receive full-scope coverage, their out-of-pocket costs will decline substantially, thus lowering the amount Medicaid must spend to cover their remaining expenses.

Slowing health care cost growth within Medicaid

Although many of the reforms included in the new law can save Medicaid dollars, the most promising may involve the establishment of the new Coordinated Health Care Office within CMS, which is tasked, among other things, with integrating both dollars and care for dual eligibles. Since these are the most frail and costly consumers—accounting for nearly half of all Medicaid costs nationally—coordinating care among these funding streams may be able to eliminate redundant and inconsistent care and result in savings while improving care.

Increasing state revenue

According to the CBO projections, once the exchanges are available, some small employers will drop coverage, resulting in a two-percent decline in employer-sponsored insurance (ESI). Labor economists believe that employers will share much of the resulting cost savings with workers in the form of higher wages. This, in turn, will lead to an increase in revenue from income taxes and (to a lesser extent) sales taxes. Also, in states with taxes on insurance premiums, revenues will increase as health coverage expands.

CONCLUSION

Health care reform remains a hotly debated issue. While state officials may not soon agree on every provision of the federal legislation, there is no question that they have been given considerable flexibility to put their stamp on the direction of the health care system under their jurisdiction. They can use the tools in the bill to accomplish long-held state goals and to foster conversations about new objectives for the future. States will not only have a role in determining the success or failure of the ACA, but, much more importantly, they will help decide if the larger goals of the health reform effort – higher quality and increased access to care while reducing costs – are achieved.

ENDNOTES

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2 Beginning in 2007, the Centers for Medicare and Medicaid Services (CMS) implemented a voluntary individual reporting program, called the Physician Quality Reporting Initiative (PQRI), which provides an incentive payment to physicians who satisfactorily report data on quality measures for covered Physician Fee Schedule (PFS) services furnished to Medicare Part B beneficiaries.

3 The ACA provides an opportunity for states to establish demonstration projects for pediatric ACOs.

4 PPACA Section 3021 establishes the new Center and appropriates $10 billion through 2019 to fund demonstration projects. Starting in 2011, the Center will test innovative payment and delivery arrangements to improve quality and slow cost growth in Medicaid, CHIP, and Medicare, without regard to normal budget neutrality requirements. HHS is authorized to expand successful models to nationwide scale, after appropriate certification by the CMS Actuary.

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STATE OF THE STATES

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Chapter 3: Policy and Politics: The Process of Implementation

The passage of the Patient Protection and Affordable Care Act (ACA) raised a broad range of policy issues for states to consider. While those policy questions are important (and are the subject of much of the *2011 State of the States*), states also spent time thinking about the *process* through which they would gather information and make decisions. They asked questions such as: Which state staff should be involved in major decisions? How public should the decision-making process be? Should we establish formal committees or task forces? Each state answered those questions in their own way, but they also learned from each other, particularly as they watched the information being developed in states that decided to have a more public process.

Decisions about process were impacted by the political landscape in the state. Many states had elections for governor in 2010, so many incumbent governors were uncertain whether they would be around to implement the decisions being made. For states where this uncertainty existed, there was even more impetus to involve outside stakeholders in the process, because those groups would outlast the term of the sitting governor. Some states moved quickly because a governor wanted to run on the issue of health care, while other governors shied away from the issue during their campaign.

The ACA gave states a central role in the implementation of health reform. The capacity and commitment to implementation within states was influenced by diverse factors, including their political environment, policy process, and the goals of their political leaders. Accordingly, state policymakers are reacting to the law's various components in different ways.

POLITICAL ENVIRONMENT

For the majority of states, 2010 was a year of significant political uncertainty and turnover. Thirty-seven gubernatorial races and numerous legislative races were determined in November. In a number of states, the campaign process slowed reform efforts throughout the summer and fall and dramatic changes in political leadership on election day added uncertainty to future efforts.

Prior to the election, 24 states had Republican governors, 26 were led by Democratic governors. Post-election, 29 states have Republican governors, 20 have Democratic governors, and one state has an independent.[1] Five states moved from Republican governors to Democratic governors: California, Connecticut, Hawaii, Minnesota, and Vermont. Rhode Island's outgoing Republican governor will be replaced by an Independent governor. Eleven states transitioned from Democratic to Republican governors: Iowa, Kansas, Maine, Michigan, New Mexico, Ohio, Oklahoma, Pennsylvania, Tennessee, Wisconsin, and Wyoming.[2]

Republicans picked up more than 675 legislative seats across the country, resulting in 11 states gaining Republican majorities in both houses: Alabama, Indiana, Maine, Michigan, Minnesota, Montana, New Hampshire, North Carolina, Ohio, Pennsylvania, and Wisconsin. Four states now have newly divided legislatures: Colorado, Iowa, Louisiana, and New York. Republicans will control both houses in 25 states, up from 14 before the election. The Oregon House of Representatives is evenly split with each party having 30 members.[3]

Table 1: **States with Legislation Related to ACA Compliance and/or Enforcement.**[4]

State	Legislation (2010)	Description
California	Senate Bill 900/Assembly Bill 1602	Enacts the California Patient Protection and Affordable Care Act to implement reforms under the federal ACA and establishes a health insurance exchange as an independent entity in California.
Maryland	Senate Bill 57	Gives the state authority to enforce the insurance market provisions of the ACA.
Massachusetts	Senate Bill 2585	Establishes a small group wellness incentive program and requires the commissioner of insurance to apply for and accept all available federal funding in the ACA.
New Hampshire	Senate Bill 455	Allows the insurance commissioner to implement insurance reforms and revise dependent coverage to comply with the ACA.
North Carolina	Senate Bill 897	Creates and allows a subdivision of the Department of Insurance to administer and enforce the provisions of the ACA to the extent that provisions apply to persons subject to the Insurance Commissioner's jurisdiction.

As of December 2010, the impact of these results on implementation of the ACA is still unclear. Several states, such as Iowa, Maine, Michigan, New Mexico, Ohio, Oklahoma, Pennsylvania, and Wisconsin, had out-going governors that were very supportive of the ACA, and governors-elect who are more critical of the law.

The implications of the elections will go beyond a change in party leadership, or legislative majority. In many states, experienced staff—in the governor's office, in gubernatorial appointee positions, and in the legislature—will likely resign or be replaced. The loss of their health care expertise and facility with the political and policy processes of their state will impact the speed with which the new administrations and legislatures can address the complex issues surrounding health reform implementation.

POLICY PROCESS

In 2010, in response to the passage of the ACA, many states created task forces or councils focused on health reform. Tables 1 and 2 show official state actions on health reform during the past year. Table 1 shows the states that have taken legislative action on reform, typically by creating authority within the states to implement sections of ACA such as exchanges and insurance premium rate review. As Table 2 shows, many governors used executive orders to address implementation challenges, the majority of which established health reform steering committees (typically made up of leaders in that governor's administration) tasked with developing initial recommendations or putting together work groups to get stakeholder input. In a small number of states, also included in the table, governors and policymakers took advantage of existing stakeholder engagement processes and workgroups, and simply expanded their purview to include ACA implementation strategies.

States' approaches to decision-making vary and each state's culture has influenced its responses to the passage of the ACA. In some states, decisions are typically made by a few top legislative leaders, the governor, and top advisors. In others, there is a culture of stakeholder engagement and an open and transparent process of decision-making. As a result, the amount of formal and informal engagement with outside stakeholders, the number of meetings to discuss reform implementation, and the public availability of documents and other resources have varied from state to state.

One nearly universal approach to information sharing has been the creation of state websites that include information on implementation efforts or on the ACA more broadly. These sites serve as portals for state stakeholders, and as a repository of resources created by the state. For example, in states that have a history of broad stakeholder involvement, a wide array of resources is available on newly established health reform implementation websites. States with a similarly established stakeholder process and information sharing include, among others, Colorado,[5] Maryland (see box on page 3.3 for more details), Minnesota,[6] Oregon,[7] and Washington.[8]

Other states, including Alabama,[9] Alaska,[10] Illinois,[11] and Michigan,[12] have used their websites to post information about the ACA, along with analyses of the law and implementation timelines.

South Carolina has established a unique policy process. The state is working in collaboration with two organizations—the South Carolina Public Health Institute and South Carolina Healthcare Voices—to engage nonprofit stakeholders to work with state agencies and design an implementation plan for the state. The goal of the effort is to create public-private partnerships that will build on "linkages with key state agencies to support collaborative decision-making and expand the collective capacity to address the

Case Study

MARYLAND

In July 2010, Governor Martin O'Malley established Maryland's Health Care Reform Coordinating Council via Executive Order.[1] The Council is co-chaired by the lieutenant governor and the secretary of the Department of Health and Mental Hygiene. The Governor's Office, the Department of Budget and Management, the Insurance Administration, the Attorney General, the Maryland Health Care Commission, the Health Services Cost Review Commission, the Department of Human Resources, and the State Senate and House of Delegates are all represented on the Council, supporting cross-agency and cross-branch engagement and collaboration.[2]

The Council's Interim Report, issued July 2010, outlines several characteristics that Maryland's ACA implementation must have:

- Serve the overarching goal of improving the health of all Marylanders, with particular focus on health equity.
- Develop a consumer-centric approach to both coverage and care.
- Use the tools provided by reform to improve quality and contain costs.
- Think broadly and creatively about strategies to promote access to affordable coverage and mitigate risk selection.
- Prepare and expand the health care workforce to meet new demands.
- Lead the nation in tapping the full potential of reform to improve health.[3]

The Council has had a series of public meetings since its creation in July, as have each of its more-targeted workgroups—Exchange and Insurance Markets, Entry into Coverage, Education and Outreach, Public Health, Safety Net and Special Populations, Health Care Workforce, and Health Care Delivery System. Each workgroup was tasked with addressing several key questions, which formed the basis of their reports to the full Council. The workgroups have all submitted final reports to the Council, with public input from the meetings contributing to the recommendations within each workgroup report. The Council issued its final report January 10, 2011, which identifies 16 recommendations for how to implement federal reform in Maryland.[4]

In addition to encouraging the public to participate in the various workgroup and Council meetings, Maryland posts all of its meeting information on its health reform website, and encourages individuals to offer their opinion through the site's "Comments and Questions" button, or via email. Additionally, individuals can sign up to receive email updates about the Council's activities. The low barrier to public feedback and the availability of information on the website contribute to a transparent and open process supported by public and stakeholder engagement.

Endnotes

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implementation of this legislation."[13] Several public-private workgroups have been created to examine specific components of the ACA, and all meeting materials and resources are accessible to the public online.

In many states, foundations and nonprofit groups have been highly engaged in the reform process, often performing analyses of the impact of reform on the state. They have also brought together stakeholders through statewide meetings or more informal meetings to inform the policy-development process. For example, in New York, the New York State Health Foundation funded an analysis of the ACA and its impact on the state.[14]

Other states are using internal staff to gather information and develop options. Those states are conducting their own analyses of the ACA and its implications in task forces or through other vehicles and will bring their recommendations to their governors and legislatures. They will then engage in a more public discussion with external stakeholders, who sometimes find it easier to respond to an existing document or white paper rather than to open-ended policy questions.

INTERPLAY OF POLICY AND POLITICAL ENVIRONMENT

Disagreement over the merits of the policies included in the ACA also affects how state governments have reacted to its passage. While some states have embraced federal reform and are moving forward as quickly as possible to determine how best to implement its provisions, other states are opposed to one or several provisions of the law and have taken to the federal courts to challenge its constitutionality. (See *Surveying the Landscape* for more information.)

However, even in those states that have filed suit against the federal government, efforts are still underway to examine the impacts of ACA and plan for its potential implementation. For example, while Virginia is pursuing a lawsuit to strike down key provisions in the federal bill, it is also one of 48 states and the District of Columbia that applied for a federal planning grant providing federal resources to states to help them determine whether to run their own health insurance exchange, partner with other states in a regional exchange, or have the federal government administer their exchange. Virginia state officials plan to use these funds to support a task force that is already meeting to discuss possible implementation of the federal law and to conduct research to support the policy decision-making process that lies ahead for the state. While the resources and goals of each state vary regardless of whether there is full support for implementing the ACA, most are beginning initial discussions about what the new law means for them.

While leadership changes and the uncertainty caused by ongoing litigation threatens to delay state efforts, the short timeline for implementation of the ACA means that states nevertheless need to have strategies in place for implementation. States have until January 1, 2013, to show they have the capacity to implement and operate a health insurance exchange by January 1, 2014. Many important and time-consuming tasks must be completed before those deadlines. (See *Laying the Foundation for State-Based Exchanges* for more information.)

Case Study

COLORADO

In 2010, Colorado had a very open planning and implementation process, focusing a considerable amount of effort on stakeholder and public engagement and establishing a transparent process that allows the public and interested parties to monitor the state's progress. Their health reform website contains a wide range of resources about the ACA and its potential impact on Colorado, as well as meeting announcements and notes, and the latest news updates. An implementation timeline of the ACA is also posted, so the public and other stakeholders can see when different provisions of the law go into effect and how those provisions will impact the state.[1]

Governor Bill Ritter created an Interagency Health Reform Implementation Board and designated an implementation director in April 2010, allowing individuals from across various state agencies impacted by ACA implementation to meet and communicate across agency silos. The Department of Health and Human Services, the Department of Health Care Policy and Financing, the Department of Public Health and the Environment, the Department of Revenue, the Acting State Chief Information Officer, the Director of National Health Reform Implementation, the Department of Personnel and Administration, the Division of Insurance, the Office of State Planning and Budgeting, the Office of the Governor's Policy and Initiatives, and the chief legal counsel for the governor are all represented on the Board.[2] The Board meets on a monthly basis and all meetings are open to the public. Meeting agendas and materials are posted online.

Even as the Governor's Interagency Health Reform Implementation Board moves forward, it is important to note that the independently elected attorney general has joined the case in federal district court in Florida challenging the constitutionality of the individual mandate.

In addition to efforts to coordinate the various government agencies, the state has conducted a series of health insurance exchange public forums across Colorado, seeking input from members of the public as the state begins its work planning for and designing an exchange. All of the information from those meetings is available on the state's website.[3] The state examined the feedback from these engagement sessions and included, in its final report, the following key points about successful exchange implementation that resulted from stakeholder perspectives:

"A successful health insurance exchange will:

- Successfully connect people to stable coverage.
- Organize the marketplace so that consumers and small businesses can find understandable and reliable information about health insurance products.
- Establish certification criteria for participating plans that ensure consumers and small businesses have meaningful choice between high quality, affordable plans.
- Ensure all plans sold in the exchange offer the federally defined essential benefits package.
- Maximize participation in the exchange to create a stable risk pool and minimize adverse selection.
- Enable consumers and small businesses to purchase coverage without assistance and ensure support for consumers and small businesses that want and need assistance navigating the exchange.
- Maximize continuity of coverage and seamless transitions between public and private health coverage.
- Not duplicate the current regulatory functions of the Division of Insurance.
- Include robust data collection mechanisms to support transparency and accountability.
- Operate efficiently and aim to minimize administrative costs."[4]

In addition to the substantive lessons learned over the course of these meetings, the state learned several key process lessons on stakeholder engagement. Lorez Meinhold, director of national health reform implementation, shared some of these lessons at a National Governors Association meeting in September 2010. Those lessons include:

- Having a professional facilitator at meetings gives the process credibility.
- Creating and making publicly available background information before the meeting allows everyone to have the same discussion.
- Figure out what strategies or topics will be addressed at each meeting: have five questions on the agenda (shared before the meeting so people can prepare).
- Do not let the discussion be just about the "volume" in the room; some groups are more organized than others, but that does not necessarily make their viewpoints more valid.
- Thinking about partners is really important to help get the word out and engage people; make sure to be clear about the roles of partner agencies.
- Consider what type of public process you want to create: what audience are you engaging?
- The audience you hope to reach will impact the schedule of the meetings. For example, physicians may not be able to attend meetings during normal business hours because they are seeing patients. Evening or weekend meetings may be the most effective way to engage that group.
- This is a learning process in addition to an engagement process. Meeting attendees will contribute important ideas and viewpoints, so the state needs to be prepared to use that information as appropriate.
- Transparency is very important. It will help build trust along the way with all of the stakeholders.
- Timing is important: when is the legislative session? In order for the public meetings to be meaningful, their timing needs to be such that they can impact the legislative session.

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Case Study

VIRGINIA

Virginia, like Colorado and Maryland, has used a transparent process for the discussion of federal health care reform. Despite the fact that the state elected to sue the federal government over certain provisions in the ACA, in August 2010, Governor Robert McDonnell commissioned a Health Reform Initiative Advisory Council to develop recommendations for a comprehensive strategy to implement health reform in Virginia. The Council, made up of leaders from the state legislature, health care systems, and business, was asked to recommend innovative health care solutions that meet the needs of Virginia's residents. In December 2010, the Council made 28 recommendations to the secretary of health and human resources. The recommendations focused on ways to improve health care delivery, reform the Medicaid program, and provide guidance to the development of a health benefit exchange.[1]

In an effort to encourage input across state agencies, the Department of Medical Assistance Services, the Department of Rehabilitative Services and Department for the Aging, the Bureau of Insurance, the Department of Health, the Department of Behavioral Health and Developmental Services, the Department of Health Professions, the Office of Health Information Technology, and the Department of Human Resources Management are all represented on the Advisory Council.[2]

In addition to the Advisory Council, the Governor also announced six task forces: Medicaid Reform, Insurance Reform, Capacity, Delivery and Payment Reform, Technology, and Purchasers. The task forces all include a wide array of stakeholders, including consumers, and are geared toward taking a broad view of issues. The Advisory Council held three two-day retreats and the six task forces met 18 times, all with the opportunity for public comment. The final report and summary reports from the Advisory Council and task force meetings are available for the public and other interested stakeholders to view on the state's website.[3]

Endnotes

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CONCLUSION

States varied in their approach to the implementation of health reform, but across states, some best practices emerged. These include:

- Establishment of a high profile health reform steering committee to make recommendations to the governor and legislature;
- The use of white papers or other discussion briefs to facilitate input and decision-making;
- Establishment of working groups to study difficult issues;
- Creation of a website with information about public meetings and decision points;
- Use of nonprofit groups and foundations to expand state capacity and facilitate stakeholder involvement;
- Passage of legislation to establish an exchange or to enforce insurance reform provisions; and
- Use of an open and transparent decision-making process.

Going forward, every state will need to establish a decision-making process that brings together key leaders and garners input from affected stakeholders including the general public. Once exchange governance has been decided, states will likely shift some of this work to that entity, whether it is within state government or under the auspices of a new governing board. (See the discussion within the Exchange section for more information about issues related to governing boards.)

States will likely achieve their process goals in different ways. Every state possesses an entity reviewing federal health care reform; Table 2 shows the states that have formed workgroups and committees specifically to plan for ACA implementation. In addition, some states may also be advancing their ACA implementation process through less formal channels. Regardless of the process used, however, the direction of reform in each state is likely to hinge on the political perspectives of those in leadership. 2010 was a year of significant changes in state political leadership; the impact of those changes will be felt in 2011 and beyond.

Table 2: **State Workgroups, Committees, and Task Forces Studying Impact of ACA**

State	Entity	Establishment Mechanism	Responsibilities
California	Health Exchange Executive Board	Senate Bill 900[15] and Assembly Bill 1602[16]	This board coordinates the development of the health exchange and is required to, at a minimum: • Implement procedures for certification, recertification, and decertification of health plans as exchange qualified health plans (per HHS guidelines). • Assign a rating to each qualified health plan offered through the exchange in accordance to HHS criteria. • Implement the crucial elements of the exchange: toll-free hotline, website up to HHS standards, standardized format for presenting health benefits plan options, eligibility informing mechanism (i.e., will inform individuals if they qualify for other forms of government support, such as the Medi-Cal Program).
Colorado	Interagency Health Reform Implementation Board	Executive Order B-2010-006[17]	The implementation board and the designated implementation director will coordinate all health reform efforts.[18] This includes the development of a strategic plan; coordination of state agencies; pursuit of federal and state grants; assuring compliance with federal law; and extensive engagement with stakeholders to assist in the improvement of the health care system in Colorado. Stakeholder activities are facilitated through mechanisms such as the Health Insurance Exchange Forums, which are open to the public.[19]
Connecticut	Health Care Reform Cabinet	Executive Order No. 43[20]	The cabinet consists of commissioners from various state health agencies. They also track reform progress via progress reports.Reports include status of temporary high risk pool, early retiree reinsurance program, rate review, long-term care, etc.[21]
	SustiNet	Public Act-09-148	Originally created in 2009 to establish a framework for comprehensive health reform in Connecticut, the SustiNet Health Partnership Board of Directors was additionally charged with making recommendations on how the provisions of the ACA fit with the SustiNet structure.
Delaware	Delaware Health Care Commission	Title 16, Chapter 99 of the Delaware Code[22]	The commission has been proactive in health care reform in Delaware since 1990, and has tasked itself with issues concerning health care reform since ACA passage. The commission has listed federal health reform implementation as an agenda item at each meeting it held in 2010.
District of Columbia	Mayor's Health Reform Implementation Committee	Established by former D.C. Mayor Adrian M. Fenty[23]	The goal outlined by the committee is to ensure the smooth implementation of the federal health care legislation in the District of Columbia.
Iowa	Iowa Legislative Health Care Coverage Commission	2009 Iowa Acts, S.F. 389	This commission is developing a health care reform strategic plan for Iowa. The commissioner of insurance, along with the commission, will develop a plan for operating an exchange. The commission also met with Department of Human Services and the Department of Public Health to incorporate changes resulting from federal health reform.
Illinois	Illinois Health Reform Implementation Council	Executive Order[24]	The council is responsible for making recommendations to the governor about implementing ACA health reform measures.[25]

Table 2: **State Workgroups, Committees, and Task Forces Studying Impact of ACA** *(Continued)*

State	Entity	Establishment Mechanism	Responsibilities
Maine	Health Reform Implementation Steering Committee	Executive Order to Implement National Health Reform in Maine, April 2010[26]	The Steering Committee is charged with developing plans to implement provisions of health care reform, including high risk pools, the state health exchange, and an overall plan with a timeline for implementation.[27]
	Joint Select Committee on Health Reform Opportunities and Implementation		Composed of 17 legislators appointed by the speaker of the House and the president of the Senate, this Joint Committee was established to study the federal law and determine the role of the state in implementing health reform and how the law will affect current state programs and laws such as MaineCare. [28] The Committee is also responsible for consulting with other stakeholders including the Governor's Office of Health Policy and the Department of Health and Human Services.
Maryland	Health Care Reform Coordinating Council	Executive Order 01.01.2010.07[29]	The council is charged with submitting a comprehensive document with recommendations and implementation strategies by January 2011.
Michigan	Health Insurance Reform Coordinating Council	Executive Order No. 2010-4[30]	The council will identify steps for implementing the ACA in Michigan.[31]
Minnesota	Health Care Reform Task Force	Minnesota State Legislature Session Law[32]	The task force was mandated to produce a report by December 15, 2010, with recommendations for state law, program changes, and implementation.
Mississippi	Health Insurance Exchange Study Committee	Senate Bill 2554	The committee is charged with studying the federal requests related to health insurance exchanges and make implementation recommendations.
Montana	Interim Committee	State Joint Resolution 35	The resolution allows for interim study and research on federal and state efforts related to health care reform and the provision of recommendations for state-level initiatives.
Nebraska	ACA Study Select Committee	Legislative Resolution 467	The resolution allows for a study to research and provide recommendations for implementing federal reform. Report from this committee was due December 31, 2010.
Nevada	Health Care Reform Policy Group and the Health Care Reform Implementation Working group	Created by the Nevada Department of Health and Human Services	These groups are tasked with gauging the impact of the ACA on state health care and Medicaid policies.[33]
New Hampshire	Commission on Health Care Cost Containment	Senate Bill 505 (2010)[34]	The commission is focused on the implementation of health care reform and payment reforms. It will also make recommendations to contain costs and improve quality, while examining the hospital services, ambulatory surgical facilities, and health insurance carriers, making recommendations for changes to the system for health care services financing. The recommendations will coordinate with the ACA.
New Mexico	Health Care Reform leadership team	Executive Order 2010-012[35]	The team is tasked with strategic planning around implementation.[36] They released a roadmap to reform that had been accepted by the former governor.[37]

Table 2: **State Workgroups, Committees, and Task Forces Studying Impact of ACA** *(Continued)*

State	Entity	Establishment Mechanism	Responsibilities
New York	Cabinet to Implement Federal Health Care Reform in New York	Established by former Governor David Paterson on May 13, 2010[38]	The cabinet will make recommendations to the governor on all aspects of health care reform and implementation.[39] The cabinet includes advisory groups that not only advise on policy and implementation, but stakeholder and public engagement.
North Carolina	Health Reform Overall Advisory Committee	Established by the North Carolina Institute of Medicine (NCIOM) [40]	The committee coordinates the efforts of eight health reform workgroups at NCIOM. These efforts include identifying decisions that need to be made to implement health reform and identifying and securing potential funding opportunities.
Ohio	Health Care Coverage and Quality Council and Health Care Reform Stakeholders Forum	Council originally established via Executive Order 2009-03S[41] Put into law via House Bill 1 (2009)[42]	The Ohio Health Care Coverage and Quality Council is part of the Forum. The Council has become the main driving force behind improving coverage, cost, and quality of Ohio's health care system, as well as stakeholder engagement.[43] The Council established an additional task force focused on health benefit exchanges.
Pennsylvania	Commonwealth Health Care Reform Implementation Committee; Commonwealth Health Care Reform Advisory Committee	Executive Order 2010-02[44]	The Implementation Committee will model high-risk pools and exchanges, identify technical assistance needs, prepare a strategic plan for implementation, and identify legislative action to enable full implementation. [45] The Advisory Committee will be briefed on the Implementation Committee's findings, and respond to them with feedback. Additionally, it will identify best practices for the Implementation Committee to review, and advise the Implementation Committee on the commonwealth's high risk pool, health insurance exchange, technological and other improvements needed to implement the obligations of the state under the ACA, and the strategic plan for implementation of the ACA in Pennsylvania.[46]
Tennessee	State Insurance Exchange Technical Advisory Groups	Established by the Tennessee Insurance Exchange Planning Initiative[47]	The two technical advisory groups (Actuarial/Underwriting and Agent/Broker) will provide expertise on specific analytical questions to help in Tennessee's exchange planning process.
Virginia	Virginia Health Reform Initiative Advisory Council	Formed as a part of Virginia Health Reform Initiative by the Virginia Secretary of Health and Human Resources[48]	The council is responsible for managing activities related to federal health care reform, serving as the liaison between governor's office, agencies, and other entities. It will also identify and coordinate to procure grants for mechanisms such as the health insurance exchange, as well as convene stakeholder workgroups, and submit recommendations to the governor.
Washington	Health Care Cabinet	Executive Order 10-01[49]	The cabinet is responsible for providing leadership and accountability for implementation of state and federal health reform. The cabinet was to have submitted a work plan by August 2010.[50]
Wisconsin	Office of Health Care Reform	Executive Order #312[51]	The office is responsible for developing a plan that utilizes national health care reform to update existing Wisconsin programs. It also provides public access to information and assesses insurance market reforms. In addition, this office also developed plans to pursue federal funding for health insurance exchanges.
Wyoming	State Agency Leadership Team on Health Care Reform	Established by former Governor Dave Freudenthal on May 14, 2010.[52]	This team was convened to determine how the federal law affects state programs and the people they serve. The team was required to draft a short-term work plan that sets out necessary considerations and actions through January 1, 2011.

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STATE OF THE STATES

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Chapter 4: First Hurdle: Pre-Existing Condition Insurance Plans

The Patient Protection and Affordable Care Act (Affordable Care Act or ACA) includes a provision that creates a temporary high-risk pool to provide coverage to people who have been unable to obtain health coverage because of a pre-existing condition. The plans offered through the new high-risk pool are called Pre-Existing Condition Insurance Plans (PCIPs) and can be administered by either a state or the Department of Health and Human Services (HHS). The pools will operate until 2014, when most of the broader coverage reforms of the legislation take effect.

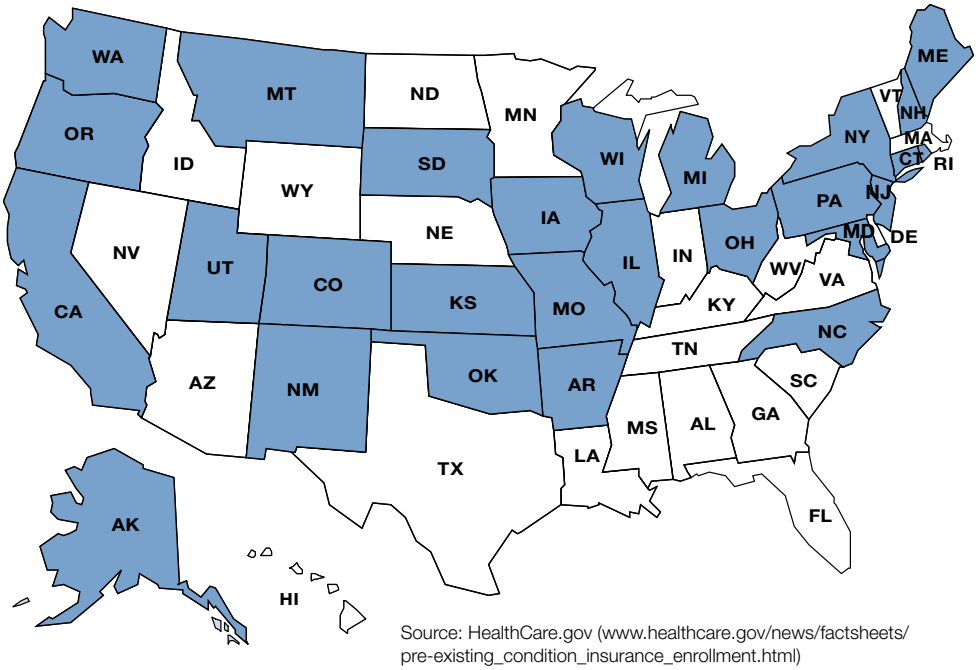
The PCIPs were required to be operational 90 days after the Affordable Care Act passed, so they became the first test of the ability of the federal government to work effectively with states to get a new program up and running. While there were understandable difficulties along the way, the whole process did proceed with unusual haste and the majority of states began taking applications in July or August. As of October 25, all PCIPs were operational. Twenty-three states and the District of Columbia (D.C.) chose to let the federal government run their PCIP and 27 states decided to govern their state-based PCIP (See Figure 1). Thirty-five states[1] operated state high-risk pools prior to the implementation of the Affordable Care Act. More than one-third (nine) of the states that opted out of running their own did not have an existing state high risk pool.

OVERVIEW OF PCIPS

States had the option to work with the federal program to design a state PCIP that generally met PCIP guidelines. The program rules of the new PCIPs include:

- In order to qualify for the program, individuals must have been uninsured for six months. In addition, they must meet one of two other requirements: have proof of being denied coverage by a health plan for a pre-existing condition; or have a condition that is on the state's official qualifying condition list. These requirements are waived (and replaced with proxy eligibility requirements) in a small number of states that already had guaranteed issue.
- Premiums must be set at or below standard market rates; they cannot vary by more than 4-to-1 based on age and insurers cannot use gender as a rating factor. These requirements generated lower premiums than were available in previous state-run high risk pools for which premium rates ranged from 125 percent to 250 percent of standard rates.
- The minimum actuarial value of a plan is 65 percent of medical costs. As a result, in 2010, for an individual, the deductible in all states with a federally-run PCIP is $2,500 and the out-of pocket maximum is $5,950. (Note: Deductibles and out-of-pocket maximums can vary and be lower in state-run PCIPs.)
- PCIPs may not impose a waiting period for coverage of pre-existing conditions.
- Eligibility for PCIP coverage is transferable between states.
- The programs will operate until December 31, 2013, or until the transition to exchange-based coverage (with subsidies and the guaranteed issue across the market) takes effect.

Fig. 1. **Distribution of Federally and State-Administered PCIPs**
(Note: Shaded states are state administered)



Source: HealthCare.gov (www.healthcare.gov/news/factsheets/pre-existing_condition_insurance_enrollment.html)

Most of the states that opted not to run their state's PCIP cited concerns that the $5 billion allocated to the program would not be sufficient, which could leave them to shoulder the cost of the program (or at least the moral responsibility to help those who had been receiving subsidies) if the funding ran out before 2014. Other states may have faced operational challenges getting a new program established in such a short timeframe. For example, some states felt that they needed legislative approval to start a PCIP and were not able to implement one by the deadline (because of the timing of their legislative session or other considerations). However, the ACA does not preclude a state that chose to allow the federal government to run the PCIP from establishing its own PCIP at a later date.

HHS intends to reallocate allotments[2] after a period of not more than two years, based on an assessment of state actual enrollment and expenditure experiences. The reallocation aims to ensure that federal dollars are distributed to states based on the initial formula as well as the actual use of services. On November 5, 2010, HHS announced the first premium and benefit level adjustment of the new program. The details are outlined below.

STATE IMPLEMENTATION OF PCIPS: CHALLENGES AND OPPORTUNITIES

States with Guaranteed Issue and Other Existing Market Reforms

States with the highest levels of insurance regulation already in place have experienced the greatest challenges in securing a portion of the $5 billion of federal funding for PCIPs. For example, five states—Maine, Massachusetts, New Jersey, New York, and Vermont—have a "guaranteed issue" requirement, barring insurers from denying coverage to people due to a health condition. In addition, all five states have some form of community rating, which also bars insurers from charging unreasonable rates based on gender, health, and other factors. These provisions make high-risk pools unnecessary, as high-risk individuals are pooled with the rest of the insurance market.

HHS worked with the five states to find a way to help them use the funding to expand coverage in a manner that is consistent with the goals of the PCIP program. In all of these states, the federal government worked with the state to find other eligibility criteria besides a denied application. These included: being offered coverage that is at least twice the standard rate (Vermont and Massachusetts); having a health condition that comports with a state-developed list (Maine and New York); and being offered a plan with a pre-existing condition exclusion (New Jersey). Three states elected to use the federal dollars to support a state-run plan (Maine, New Jersey, and New York), while the others (Massachusetts and Vermont) decided to let the federal government run the PCIP program.[3] In states with guaranteed issue, the federal government allowed other rate-setting mechanisms besides one based on standard rates.

Maine elected to sign an agreement with the federal government to use the federal funding to make its existing plan covering eligible small employers and individuals—DirigoChoice—more affordable to those who satisfy the ACA's PCIP requirements.

Premiums in New York also became more affordable as a result of the federal funding. According to Governor David Paterson,[4] the new enhanced plan—NY Bridge—will cost $362 per month in upstate New York counties and $421 per month in downstate counties, compared to the current guaranteed-issue product premiums which tend to cost around $1,000 per month.

While New Jersey's individual market insurance regulation does not allow insurers to deny coverage to people with pre-existing conditions, it does allow them to not cover those pre-existing conditions during the first 12 months after enrollment. Under the new PCIP called NJ Protect,[5] coverage for new enrollees with pre-existing conditions begins immediately after enrollment. Monthly premiums range between $212 and $768 per month, depending on a person's age and the plan selected. This is lower than the premiums of many of the plans available in the state's individual health insurance market. According to Ed Rogan, spokesman for the state Department of Banking and Insurance, the state expects to use $141 million in federal

Fig. 2. **Comparison of the State High-Risk Pool and PCIP in California and Wisconsin**

State		Premium	Deductible	Out-of-Pocket Limit In-network	Annual and Lifetime Benefit Limits
California[a]	High-Risk Pool (Major Risk Medical Insurance Program (MRMIP)[c]	125-137% of the standard market rate	$500	$2,500	$75,000 Maximum Annual Benfits $750,000 Maximum Lifetime Benefits
	PCIP	100% of the standard market rate	$1,500	$2,500	None
Wisconsin[b]	High-Risk Pool[d] (Premiums vary by gender)	Male/Female $781/$843 $408/$421 $258/$266 HSAs* $361/$374 $328/ $340	 $1,000 $2,500 $5,000 HSAs* $2,500 $3,500	 $2,000 $3,500 $6,000 HSAs*(medical and pharmacy) $4,600 $5,600	$2 million combined medical and pharmacy
	PCIP (Premiums are not allowed to vary by gender)	$559 $458 $330 $277	$500 $1,000 $2,500 $3,500	$1,500 $2,000 $3,500 $4,500	$2 million combined medical and pharmacy

Source: [a] California Managed Risk Medical Insurance Board: Facts about California's High Risk Pool and the Federal High Risk Pool (www.mrmib.ca.gov/MRMIB/Facts_About_California_HR_Pool.pdf).
[b] Wisconsin Health Insurance Risk-Sharing Plan (HIRSP): HIRSP State and Federal Plan Comparison (www.hirsp.org/pdfs/HIRSPvsHIRSP-Federal-Plan-Comparison.pdf).
[c] The MRMIP has an enrollment cap which limits the number of individuals that can be enrolled.
[d] In Wisconsin, individuals with incomes below $33,000 per year qualify for a subsidy.
* Health Savings Account Plans

money to cover an estimated 21,000 residents for three years.[6]

Funding and Enrollment Issues

One of the biggest concerns state officials have voiced is that, due to limited funding, they would not be able to enroll all the people who could qualify for enrollment in the PCIP. This apprehension was based on estimates by the Congressional Budget Office projecting that the costs for the program between inception and January 1, 2014, would range between $10 billion and $15 billion.[7] The amount that was appropriated is $5 billion. However, so far, most states have enrolled fewer than expected beneficiaries. According to statistics released by the Department of Health and Human Services, only 8,011 people had enrolled by November 1, 2010.[8] This was well below 10 percent of the capacity of these programs.

According to Amie Goldman, chair of the National Association of State Comprehensive Health Insurance Plans and CEO of the Wisconsin Health Insurance Risk-Sharing Plan (HIRSP), Wisconsin has received just over 450 applications[9] so far. They have capacity for more than 8,500 people in the program and the Government Accountability Office estimated that 63,504 people are potentially eligible.[10] As of October 18, California's Managed Risk Medical Insurance Board—the administrative entity responsible for the state's PCIP and other health care expansion efforts—mailed 6,300 enrollment forms, but received back only 768 (12 percent) applications.[11]

Several possible reasons may account for the current low enrollment in the PCIPs:

- Eligibility requirements that prevent people from applying. For instance, people who are HIPAA-eligible[12] are guaranteed immediate eligibility for coverage in the individual market or an existing state-based high risk pool. These individuals would likely not choose to go without coverage for six months in order to enroll in a PCIP when they can apply to the state high-risk pool and obtain immediate coverage.
- Premiums that—while lower than those in many state high risk pools—remain unaffordable for many potential applicants;
- Benefit levels and/or cost-sharing requirements that make the program unattractive; and
- Limited awareness of the program among health providers, community groups, and the general public.

As noted above, to qualify for a PCIP in the majority of states, people must have been denied coverage by a private insurer due to a pre-existing condition and must have been uninsured for at least six months.[13] If a person is not denied coverage, but the coverage is unaffordable either because the premium or other out-of-pocket expenses are too high—that person does not qualify for the PCIP in many states. For example, having a $411 per month premium coupled with a $25,000 deductible prevented a 64-year-old Virginia resident from obtaining PCIP coverage.[14] On the other hand, eligibility

criteria are less stringent in some of the states with already existing state-based high-risk pools. For example, in Wisconsin, people could qualify for enrollment in the state high-risk pool—Wisconsin HIRSP—if they have been rejected by one or more private insurers *or* if they satisfy other criteria such as showing that their plan was cancelled, reduced coverage or that they received at least one insurance offer with premiums at least 50 percent higher than a standard individual policy. In addition, families with incomes less than $33,000[15] qualify for a subsidy if they receive coverage in the state's risk pool. As a result, in September 2010, 674 people applied for the Wisconsin HIRSP as compared with 101 people for Wisconsin's PCIP.[16]

Another barrier to enrolling in a PCIP is related to the overall cost of a policy, which may surpass that of a policy under an already existing state high-risk pool. While premiums are generally higher in state risk pools than those in the PCIP, deductibles and out-of-pocket costs can be higher in the PCIP. The actuarial value of the PCIPs is set at a minimum of 65 percent. For example, in 2008, premiums in California's previously existing high-risk pool were approximately 125 percent of the standard market rates—25 percent higher than premiums in the PCIP plans, which are set at standard market rates. However the deductible in the California state high-risk plan is $500 while that in the PCIP is $1,500. The out-of-pocket limit is the same—$2,500 (see Figure 2). While not every state's high-risk pool has more generous benefits than the PCIP (and some have benefit levels that are more limited), the point remains that when premiums and cost-sharing are added together, these plans can be prohibitively expensive for many.

Not having enough information about the new PCIP program has also contributed to fewer than expected new enrollees. According to Richard Popper, deputy director for insurance programs at the Office of Consumer Information and Insurance Oversight at HHS, states that have more active outreach and referral mechanisms in place for their existing state-based high risk pools have seen stronger PCIP enrollment compared to those without an existing state high-risk pool.[17] This difference indicates that the number of people applying for coverage in the PCIP could substantially increase as more people become aware of the program.

State Variation

The federal government allowed a certain level of flexibility to states that agreed to manage their own PCIPs (see Figure 3). As a result, states have a variety of tools to make their PCIP more appealing and easier to access. These include:

- Offering enrollees choices of plans—Each plan design involves a trade-off between premium level and cost-sharing levels. States like New Hampshire, New Jersey, New Mexico, North Carolina, Ohio, Oregon, Utah, Washington, and Wisconsin have allowed enrollees to choose the plan design most appealing to them.
- Subsidies—A few states created a PCIP through an existing state-subsidized program (Maine and New Mexico) and enabled lower-income individuals to receive extra financial assistance. Wisconsin and Maryland have income-related subsidies for their state-sponsored pools, but not their PCIPs.
- Deductibles—In general, state-run PCIPs have lower deductibles than those found in the federally run pools. In the federally run plans, individuals have to meet their deductible ($2,500) before any prescription drug coverage is available, but many states offered first-dollar coverage for drugs that could include a tiered co-payment structure.
- Benefit Design—States could adapt the benefit design to be more accommodating to people with chronic conditions. Rhode Island, for example, required that enrollees choose a primary care physician and have a physical examination within six months of joining the plan. They also covered diabetic supplies and insulin, smoking cessation drugs, and generic drugs at no cost.

States vary in how they deal with co-insurance, prescription drug coverage, lifetime and annual limits, age bands, geographical variation in rates, and whether they have included a non-smoking differential in premiums, to name a few.

New Plan Options for Federally Administered PCIPS in 2011

On November 5, 2010, HHS announced[18] new plan choices for people enrolling in a PCIP in 2011. Beginning January 1, 2011, those who enroll in a federally administered PCIP will have the following three plan options. These plan changes are likely to make the program more affordable and attractive for potential enrollees.

- The Standard Plan—A plan with almost 20 percent lower premiums than the premiums of the plans offered in 2010, but with a $2,000 medical deductible and a separate $500 prescription drug deductible for in-network services.
- The Extended Plan—A plan with premiums slightly higher than the premiums of the plans offered in 2010, but with a $1,000 deductible for medical expenses and a separate $250 deductible for prescription drugs.
- A Health Savings Account—A plan with premiums that are 16 percent less than the premiums offered in 2010 and with a combined annual deductible of $2,500 for both medical and prescription drug coverage.

In addition, a lower child-only premium will be available for all of these plans starting in 2011 for children between 0-18 years of age.

CONCLUSION

While PCIPs have been slow to ramp up and they certainly are not for everyone, they have provided important health coverage for some of the individuals who need it most. The program has reflected an effective partnership between states and the federal government.

It has also shown the ways states can build on existing policy work to be advocates for their residents and bring stronger products to the market than what would otherwise have been available. Future success of the program will depend on the willingness of states and the federal government to continue to refine the program to make it more attractive and on the communication and outreach efforts that are undertaken.

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Figure 3. **PCIP Costs and Benefit Designs for All States**
(Note: Shaded states are federally administered)

State	Monthly Premium for a 50-year old	Deductible	Co-insurance In-network	Out-of-Pocket Limit In-network	Services Exempted from Deductible	
					Prescriptions	Office Visits
Federally Administered States	100% standard market rate	$2,500	20%	$5,950	No	No
Alabama	$518	$2,500	20%	$5,950	No	No
Alaska	$1,006	$1,500	20%, most services; 50% mental health	$3,000	No	No
Arizona	$495	$2,500	20%	$5,950	No	No
Arkansas	$395	$1,000	20%, most services; 50% mental health/drug dependency	$2,000	$10/$30/$70 copay	No
California	$445-494	$1,500	15%	$2,500	$5 copay, generic Rx before deductible; $500 separate deductible for brand-name drugs	$25 copay, physician visits
Colorado	$374-425	$2,500	20%	$5,950	$10 copay, generic Rx before deductible; $500 separate deductible for brand-name drugs	$30 copay, primary care; $45 copay, specialist
Connecticut	$507	$1,250	20%	$4,250	Separate $250 deductible	Prenatal office visits fully covered
Delaware	$513	$2,500	20%	$5,950	No	No
District of Columbia	$466	$2,500	20%	$5,950	No	No
Florida	$556	$2,500	20%	$5,950	No	No
Georgia	$495	$2,500	20%	$5,950	No	No
Hawaii	$330	$2,500	20%	$5,950	No	No
Idaho	$377	$2,500	20%	$5,950	No	No
Illinois	$253-338	$2,000	20%	$5,950	Yes	No
Indiana	$476	$2,500	20%	$5,950	No	No
Iowa	$385	$1,000	20%	$3,500	Yes	Yes, for in-network only
Kansas	$318-380	$2,500	30%	$5,950	No	No
Kentucky	$466	$2,500	20%	$5,950	No	No
Louisiana	$485	$2,500	20%	$5,950	No	No
Maine*	$609-657 $609-658	$1,750 $2,500	30%	$5,600	Yes	$25 copay
Maryland	$274	$1,500	0% for high-deductible plan	$1,500	No	No
Massachusetts	$513	$2,500	20%	$5,950	No	No
Michigan	$447	$1,000	20%	$5,950	Yes	No
Minnesota	$419	$2,500	20%	$5,950	No	No
Mississippi	$424	$2,500	20%	$5,950	No	No
Missouri	$680	$1,000	20%	$5,950	Separate $100 Rx deductible	No
Montana	$392	$2,500	30%	$5,950	Yes	No

* Premiums vary by region

Figure 3. **PCIP Costs and Benefit Designs for All States** *(Continued)*

State	Monthly Premium for a 50-year old	Deductible	Co-insurance In-network	Out-of-Pocket Limit In-network	Services exempted from Deductible	
					Prescriptions	Office Visits
Nebraska	$471	$2,500	20%	$5,950	No	No
Nevada	$513	$2,500	20%	$5,950	No	No
New Hampshire	$569 $738 $462	$1,000 $1,750 $2,500	20%	$3,500- $5,000	Separate $300 Rx deductible	No
New Jersey	$488 $363	$0 $2,500	0% or 20%	$5,000	Yes	$30 copay, primary care; $50 copay, specialist
New Mexico	$423 $379 $340	$500 $1,000 $2,000	20%	$5,450 -$5,950	Yes	No
New York	$362-421	$0	0%	$5,950	Yes	$20 copay, primary care and specialist
North Carolina	$469 $346 $316 $261	$1,000 $2,500 $3,500 $4,500	20%, PPO plans; 0%, high-deductible plan	$5,950, PPO plans; $4,500, high-deductible plan	Yes	$20 copay, primary care; $40 copay, specialist
North Dakota	$377	$2,500	20%	$5,950	No	No
Ohio	$323-378 $294-344	$1,500 $2,500	20%	$5,950	$15/$40/$60 copay for both plans; separate $150 Rx deductible for $2,500 deductible plan only	$30 copay, primary care; $50 copay, specialist; $40 copay, urgent care
Oklahoma	$327	$2,000	20%	$5,950	Separate $200 Rx deductible	No
Oregon	$593 $544	$500 $750	20%	$5,200- $5,450	Yes; $0 copay for diabetic supplies, insulin, and some evidence-based generic maintenance medications	No
Pennsylvania	$283	$1,000	20%	$5,000	Yes	$25 copay, primary care; $30 copay, specialist
Rhode Island	$430	$1,000	20%	$3,000	Yes	$20 copay, primary care; $40 copay, specialist; $75 copay, urgent care
South Carolina	$462	$2,500	20%	$5,950	No	No
South Dakota	$456	$2,000	25%	$5,750	Yes	No
Tennessee	$438	$2,500	20%	$5,950	No	No
Texas	$495	$2,500	20%	$5,950	No	No
Utah	$508 $431 $331 $240	$500 $1,000 $2,500 $5,000	20%	$5,000- $5,950; $5,000, high-deductible plan	Separate $150-$500 Rx deductible	No
Vermont	$419	$2,500	20%	$5,950	No	No
Virginia	$443	$2,500	20%	$5,950	No	No
Washington	$986 $476	$500 $2,500	20%	$1,500- $5,950	Yes	No
West Virginia	$401	$2,500	20%	$5,950	No	No
Wisconsin	$559 $458 $330 $277	$500 $1,000 $2,500 $3,500	20%	$3,500- $5,950	Yes	No
Wyoming	$358	$2,500	20%	$5,950	No	No

Source: Realizing Health Reform's Potential: Pre-Existing Condition Insurance Plans Created by the Affordable Care Act of 2010 (www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2010/Oct/1445_Hall_PCIPs_and_the_ACA_ib_FINAL.pdf)

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STATE OF THE STATES

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Chapter 5: Laying the Foundation for State-Based Exchanges

Health insurance exchanges (exchanges) were a huge topic of conversation in states in 2010. The Patient Protection and Affordable Care Act (ACA) requires the development of an entity—called an exchange—that would integrate many elements of health reform. The exchanges will be the public face of health reform, offering a new marketplace for health insurance and health information. They will also be charged with developing the seamless integration of multiple programs and data sources in order to determine who is eligible for which programs and subsidies and to help them enroll. The ACA gives each state the option to develop, implement, and run their own exchange; if a state chooses not to do so, the federal government will run one for that state.

As states begin to discuss how they might set up an exchange, a range of issues arise. These include adverse selection, cost containment, quality of care, transparency in the price and quality of health care services, the ongoing role of brokers and agents, and the playing field on which insurance plans will compete for business. The list quickly becomes long and overwhelming. While opinions vary on how much an exchange can and should accomplish, it is certain that states have many important policy and operational decisions ahead of them. State policymakers will not only need to decide *what* the exchange should achieve, but also *how* the goals can be achieved.

There are many excellent resources on policy issues related to exchanges. State Coverage Initiatives has set up an exchange website[1] that compiles our issue briefs and webinars, as well as reports, studies, and other working documents from states, research institutions, and from the federal government. Several other reputable organizations have done the same. This report does not go in-depth on every issue related to exchanges. It summarizes the exchange-related work of states in 2010, offers in-depth information about the two existing state-run exchanges in Massachusetts and Utah, and addresses some of the first-order policy choices states need to make including:

- Whether or not to have a state-based exchange?
- How should the exchange be governed?
- What types of data do states need to gather as they seek to make policy choices that will work in their health care markets?

Finally, this report offers a list of tactics (or lessons learned) for states as they move forward with exchange planning and implementation.

STATE WORK ON EXCHANGES IN 2010

The general work of states on exchanges was driven in part by the federal funding opportunities and requirements. On July 29, 2010, the Department of Health and Human Services (HHS) issued a Funding Opportunity Announcement (FOA) that

Timeline for Exchange Implementation in 2010

March 23:	The ACA is signed into law by President Obama.
July 29:	HHS issues a Funding Opportunity Announcement (FOA) that made $1 million available to every state for Exchange Planning and Establishment Grants.
September 1:	Exchange Planning and Establishment Grants applications due.
September 30:	HHS announces that $49 million was made available to 48 states and the District of Columbia for exchange planning.
September 30:	California becomes the first state in the nation (after the passage of the ACA) to enact exchange authorizing legislation.
October 4:	The deadline for comments on the proposed guidance for exchanges due to HHS.
October 29:	HHS announces a competitive grant program for "innovator states."
November 8:	HHS issues initial guidance on the IT expectations for exchanges.
November 8:	HHS announces that a 90 percent match will be available (once the rule becomes final) to develop new eligibility and enrollment systems and a 75 percent match for system improvements.
December 22:	Innovator grant applications due.

made $1 million available to every state (the funding was non-competitive) for Exchange Planning and Establishment Grants. The grant proposals were due September 1 and funding was announced on September 30; HHS announced that $49 million was made available to 48 states and the District of Columbia.[2] While a number of states had already begun discussions, once the grants were awarded to states, they began their planning efforts in earnest. Many states spent the fall developing requests for proposals (RFPs) for consultants and other experts to help them with their data collection and planning efforts.

States also spent time and resources preparing responses to the federal government in order to meet an October 4 deadline for comments on the proposed guidance for exchanges.

On October 29, HHS announced a competitive grant program for "innovator states." The funds are designed to help leading states make quick advancements in information technology that can then be shared with the rest of the states. On November 8, the Centers for Medicare & Medicaid Services (CMS) announced a notice in the Federal Register that proposes an increase in federal matching funds to states for designing and developing new information technology (IT) systems needed to support Medicaid eligibility systems that will interface with state insurance exchanges.[3] Once the rule becomes final, CMS will pay 90 percent of those costs rather than the previous 50 percent. In addition, they will pay 75 percent of costs for maintenance and operations of existing systems. In order to obtain these higher matching rates, the new IT systems will need to meet certain standards.

Many states also are preparing for the 2011 legislative session, hoping to get authorizing legislation passed to establish an exchange and set up a governance structure.

According to HHS, the state exchange planning grant applications requested funding for the following broad areas:

- Assessing current IT systems and infrastructure and determining new requirements;
- Developing partnerships with relevant stakeholders to gain public input into the exchange planning process;
- Planning for consumer call centers to answer reform-related questions from their residents;
- Determining what state statutory and administrative changes are needed, including changes that may be necessary to set up the governance structure, facilitate health plan contracting, consumer outreach, etc;
- Hiring key staff and determining ongoing staffing needs;
- Planning the coordination of eligibility and enrollment systems across Medicaid, CHIP, and the exchanges; and
- Developing performance metrics, milestones, and an ongoing evaluation process.[4]

In addition to performing the functions above, many states have already begun to collect the data they will need to inform decision-making. (See the box titled "Data States Will Need for Exchange Decision-Making" for more detail about the types of information states will need.)

The fact that the vast majority of states applied for the exchange planning grant funds can be taken as a positive sign of interest from the states. However, applying for the initial grant does not guarantee that states will ultimately choose to host an exchange (rather than letting the federal

Data States Will Need for Exchange Decision-Making

States will make many important decisions about the future of their health insurance markets over the next few years. They will need good data to make informed decisions. Some states will choose to collect and analyze those data on their own, while others will contract with consultants for the needed analytical work. Most states will combine these two strategies. Even when states work with outside firms, they will need to have clear sense of their own goals and the policy choices they need data to inform.

First, states will need to collect economic and demographic data—including information about the income distribution within their state and how individuals are currently getting health coverage. The ACA will cause people to move between coverage types and into the new subsidy programs; states will need to be able to predict this with some accuracy. They may also be interested in particular populations, like those who live in rural areas, minority groups, at-risk populations, and others.

Second, states will need to gain actuarial knowledge about their market. What benefits do current insurance products being sold in the state actually cover and what are typical cost-sharing arrangements? Are the uninsured in the state likely to be younger and healthier or older and sicker? What impact will any new rules likely have on premiums? Actuarial information will help state policymakers plan for premium changes and to guard against adverse selection in their exchange design.

Third, states will need to collect financial information so they can begin to develop a budget for the exchange. While a state has many options for funding their exchange, the model used in Massachusetts is a premium surcharge, which means that the revenue of the exchange is driven by the number of people enrolled in the exchange. As more people enroll, the funding that comes into the exchange will increase and there will be more people over which the expenses of an exchange can be spread. Some of the tasks of the exchange required under the ACA include:

- Providing for a toll-free telephone hotline;
- Developing a system for eligibility determination, verification, and enrollment;
- Certifying, recertifying, and decertifying health plans as qualified health plans (QHPs);
- Establishing a tier system for plans (based on actuarial value as required by the ACA) and any other rating mechanisms;
- Maintaining an internet website through which enrollees and prospective enrollees of QHPs may obtain standardized comparative information on those plans; and
- Making available an electronic calculator to determine the cost of health coverage after the application of any premium tax credit and cost-sharing reductions.

The goals, revenue, and expenses of an exchange are all inter-related. Finding the right balance will be especially important for states after 2015 when they will be responsible for funding the ongoing operations of the exchange. Ambitious goals will likely mean that the exchange has more expenses. Scaling back the goals could reduce the expense, but it may also reduce enrollment levels or customer satisfaction which could negatively impact revenue.

Finally, states will want to gain a sense of the impact of the ACA on their budgets. States will need to do an accounting of current state programs to see if any of them overlap with the federal legislation. Some states programs may be duplicative and funding could be re-programmed to supplement federal funds. In some cases, states may want to look at the resources that are currently allocated to covering uncompensated care and care for those without insurance. Some of that funding also could be re-allocated. Of course, states will also be asking questions about potential cost savings outside of the context of exchanges, as the budgets in all states are extremely tight. [5]

For more information on the data issues facing states, see "Health Insurance Exchanges: How Economic and Financial Modeling Can Support State Implementation," published by State Coverage Initiatives.[6]

government do it). The two states that did not apply for funding were Minnesota and Alaska. Each cited their opposition to the federal legislation as the reason they did not apply for the funding.

SOME STATES AHEAD OF THE CURVE

While the work of the majority of states was driven by the federal deadlines and availability of funding, a few states were ahead of the curve in their exchange planning. For the most part, states that acted quickly: 1) had governors who generally supported the ACA; and 2) had done some previous work related to exchanges (or at least related to reform of the small group market).

Wisconsin. Wisconsin Governor Jim Doyle was a vocal proponent of health reform during the federal debate. In Wisconsin, he had already done considerable work to reduce uninsurance by expanding and simplifying coverage for children and families and offering new coverage options to childless adults. As a next phase of reform, the Doyle administration was considering options to improve the individual and small group insurance markets in the state. They hired a consultant to model options for a Wisconsin-based exchange. Ultimately, they did not pursue those reforms because Wisconsin did not have the resources for the level of subsidies that were eventually included in the federal reform.

Nevertheless, the prior effort in Wisconsin laid the groundwork for quick consideration of exchanges in a few important ways. First, there was already a growing consensus among officials in state government that the current insurance market was broken and needed serious overhaul. They had already identified many of the problems and possible solutions that could be applied to their market. Second, during previous coverage expansions, Wisconsin had begun to innovate by simplifying and improving their public program eligibility determination and enrollment structure. Their approach has been a model for other states around the country.[7] They are likely to build on that technology infrastructure to establish the web portal and back-end functionality of an exchange. Finally, Wisconsin has been experimenting with reforms throughout their health care system that could ultimately inform the work of the exchange. These include value-based purchasing strategies in their Medicaid program, a public-private

all-payer claims database that has goals for increasing transparency and quality reporting, and other cost-containment initiatives spurred by the recession in the state.

Building on that foundation, state officials in Wisconsin developed a white paper that outlines the main issues and policy questions Wisconsin will face.[8] It lays out recommendations for a governance and funding structure. It offers suggestions for how to make enrollment simple for consumers. It talks about how the state will work with the other groups in the Wisconsin Health Information Organization (WHIO) to improve payment and purchasing strategies.

Governor Doyle did not seek re-election and Scott Walker was elected governor in November. On November 10, 2010, Governor-elect Walker wrote a letter to the secretary of the Wisconsin Department of Administration that stated, "As you are no doubt aware, I have pledged that one of my first acts as governor will be to authorize the attorney general to join other states in suing the federal government to opt-out of the new federal health care law. Even as the lawsuit is considered by our judicial system, it is clear that the federal law will affect Wisconsin's management of our Medical Assistance programs. I ask that the Doyle administration temporarily freeze any new implementation of the federal health care law, including the establishment of exchanges, until after January 3."[9] Based on this statement and others by the governor-elect, it is likely that Wisconsin will change course in respect to its plans to implement an exchange.

The example of Wisconsin brings to light a challenge that many states face. There were 37 governor's races around the country in 2010. As a result, state officials did not know if their planning was laying the groundwork for future reform efforts or if it would be rejected by the incoming administration. Some state officials sought to preserve their efforts by broadening the conversation to include those who will outlast the administration—the public and other stakeholders. Other states delayed investing significant time in planning, preferring to leave the heavy lifting to the new administration. Still others spent their time gathering information and setting up a decision-making process while delaying major decisions until the political situation became clearer.

West Virginia. West Virginia is another example of a state with a head start on thinking about an exchange. They planned to set up an exchange prior to the passage of the ACA and received funding from the Health Resources and Services Administration under the State Health Access Program (SHAP) for that purpose. Using that funding (which is a five-year grant that started in 2009), West Virginia hopes to have an exchange functioning well before the federal deadline of 2014. West Virginia will issue requests for proposals and sign contracts through fall 2010 and spring 2011 to accomplish the following tasks:

- Conduct an insurance market survey;
- Craft an economic and actuarial assessment model;
- Create a planning and assessment model;
- Develop a business plan;
- Build an education and outreach plan;
- Assess their technology needs and develop a strategy for solving technical problems; and
- Facilitate all of the work listed above.

The planned West Virginia exchange will determine whether individuals are eligible for any state or federal assistance programs, and will enable individuals to comparison shop among available private insurance plans. The planning and stakeholder engagement process could also identify other objectives for the exchange.[10]

West Virginia has set up a process for gathering stakeholder input to help inform the structure of the West Virginia exchange. On November 15, the state issued a request for public comment that calls for that input. In addition, they have planned public meetings throughout the state from November 2010 through January 2011. The purpose of these meetings is to

> "inform the public about what is in the Affordable Care Act (ACA) concerning the exchange; educate the public about what the OIC [Office of the Insurance Commissioner] has accomplished to date on exchange planning; outline critical areas where stakeholder input is needed; receive stakeholder input and gather public ideas on the exchange; and, from the information gathered in these meetings and prior, develop community of interest policy groups to further develop exchange plans."[11]

While the planning work of state officials in West Virginia is ongoing as of the close of 2010, that state is also facing a change in leadership. West Virginia Governor Joe Manchin III launched an ultimately successful bid for the state's U.S. Senate seat in the middle of his second term as governor. As a result, the President of the West Virginia State Senate, Earl Ray Tomblin, a Democrat like Manchin, will become governor. Another election for governor will be held in 2012.

PLANNING FOR EXCHANGE AUTHORIZATION LEGISLATION

States have begun to consider whether they should seek legislation during the upcoming 2011 legislative session to authorize and establish an exchange. Many states will seek to pass basic legislation that sets up a governance structure (as California has already – see below) to handle incoming data (likely generated with planning grant funds), make recommendations and decisions based on that information, and ensure all of the

major functions of the exchange are carried out. That legislation would not decide major policy and operational questions; rather, it would determine who will be responsible for these decisions, whether that is a board, a nonprofit, or an existing agency or cabinet official.

Some states are making a political calculation as to whether 2011 is the right year to bring exchange legislation before their legislature. States are only just starting to spend their planning grant funds and much of the data that they expect to collect will not become available for several months. If the legislature is skeptical about the ACA and hesitant to implement an exchange, there may be more wisdom in waiting until 2012 when new governors and legislators have had more time to review pertinent state-based data that will be generated and consider all of the relevant issues.

Whether or not states elect to enact legislation in 2011, they do need to be aware that doing very little through the course of 2011 is a risky strategy, given the number of tasks that must be accomplished before January 1, 2013, when the federal government will certify whether or not a state will be ready to implement an exchange in 2014. For a full report on a suggested timeline for exchange implementation, see the SCI publication, *Health Benefit Exchanges: An Implementation Timeline for State Policymakers.*[12]

California Becomes First State in the Country to Authorize an Exchange Post-ACA

On September 30, 2010, California became the first state in the country to enact authorizing legislation for an exchange after the passage of the ACA. Like the other leading states, California had already spent significant time considering the possible role of an exchange in that state. In the case of California, this option was extensively discussed during their 2007-08 comprehensive health care reform debate.[13]

Table 1: **Should a State Run Its Own Exchange?**[14]

Pros	Cons
Allows a state to maximize its own goals.	Requires the allocation of staff resources and expertise.
Makes it easier to coordinate with state agencies.	Could carry more risk at the state level, both financially and politically.
Maintains maximum state regulatory authority over the market.	A federal exchange would allow for a consistent approach across states (or across those that do not host their own exchange).
More responsive to state stakeholders and the public; better positioned to engage in a dialogue with key state-based groups.	For small states, there might be questions related to economies of scale—will the exchange have enough people to justify the expenses of setting it up?
Better positioned to address adverse selection because policies inside and outside of the exchange can be aligned.	Susceptible to political changes at state level.
Better positioned to quickly modify the exchange based on changes in the state's market.	
Better positioned to build on a state's existing core competencies.	
Prevents the exchange from being susceptible to political changes at federal level.	
More control over how brokers and agents are treated under the exchange.	
A national definition of "qualified health plans" with no state-level modifications may not serve the needs or interests of local plans.	
Better positioned to understand the demographic and geographic issues that should inform network adequacy standards.	

The California legislation—Senate Bill 900 and Assembly Bill 1602—was designed to authorize the state to enforce the insurance market reform provisions of the ACA and to establish a health insurance exchange. The legislation stipulates that the exchange is to be governed by an independent, five-member board. This board will be charged with making a majority of the operational decisions for the exchange. Two of the members were appointed by the governor (in the case of this legislation, Governor Schwarzenegger had two days to make appointments between the enactment of the law and his final day in office) and another member will be the secretary of health and human services appointed by the incoming governor. The remaining two members will be appointed by the legislature, specifically the Senate Rules Committee and the assembly speaker, who will each get to appoint one member. The new law gives the board latitude to determine participation requirements, premium schedules, rates paid to plans, and cost-sharing provisions for qualified health plans.

Due to previous experience in California with adverse selection in an exchange (then called a purchasing pool), state officials were particularly concerned with setting up safeguards against that possibility. For that

Table 2: **Governance Models for State-based Exchanges**

Existing State Agency	
Strengths	Weaknesses
Builds off existing infrastructure thus curbing infrastructure costs.	Civil service and procurement rules could pose challenges (this could be addressed with legislation to exclude the exchange from certain rules).
Most accountable model to state policymakers and the public.	A risk of conflict of interest could arise, particularly for the insurance department which is charged with regulating all insurance.
Better positioned to work with constituent state agencies.	More susceptible to changes in political environment.
Better positioned to carry out public policies of governor's office.	The work of the exchange could get lost in the priorities of an existing agency.
Better positioned to work with federal regulatory agencies.	Diverse representation of a board could bring in multiple perspectives; this could be lost in an agency unless an advisory or governing board was also appointed.
Eliminates duplication of health insurance regulatory functions (if placed within the state insurance department).	Could carry stigma as a governmental agency.
Better positioned to mitigate risk of adverse selection, which is the number one threat to exchange success, because policies could be more easily aligned with insurance market regulations.	
Independent Quasi-Governmental Agency	
Strengths	Weaknesses
Most flexibility with hiring and procurement.	Less accountable to state policymakers/public.
Better positioned to insulate exchange from political environment.	Would have to create completely new infrastructure and cover resulting costs. (Note: this could be mitigated if the agency contracted with existing public and private entities for core exchange functions).
Less impacted by arguments of conflict of interest in facilitating purchase of coverage and regulating market.	Potential for duplicative regulatory functions for licensure, certification, market conduct, and enforcement.
This is an entirely new organization which could create its own culture and hire staff suited for achieving its goals.	Not as well-positioned to work with the essential state agencies (Note: this could be somewhat mitigated if existing state agency heads serve on the governing board).
Carries less of the stigma of being a government agency.	Because the exchange will be governed by an entity that is not accountable to the governor, it will be more difficult to align policies between the exchange and the larger insurance market, possibly leading to problems with adverse selection either into or out of the exchange.
A diverse board could ensure that multiple perspectives and areas of expertise are represented.	Does not have an existing structure for working with federal agencies.

Source: These strengths and weaknesses are taken from the lists compiled by West Virginia,[15] Maine,[16] Tennessee and other states.

reason, the legislation also requires all plans that offer coverage inside the exchange to offer a product at all five benefit levels. In addition, whatever products a plan sells inside the exchange must also be sold outside the exchange.[17]

NAIC Model Legislation

In order to help states develop authorizing legislation, a group of state health insurance commissioners drafted model exchange legislation under the auspices of the National Association of Insurance Commissioners (NAIC); it is available on their website.[18] The ACA charged the NAIC with helping the secretary of HHS develop regulations related to exchanges.

SHOULD A STATE RUN ITS OWN EXCHANGE?

Many states will quickly and easily decide to operate their own exchange. For others, the question of whether or not the state should take on this role could be a difficult one. States with small populations may wonder if the fixed costs of setting up an exchange can be recouped if only a limited number of people ultimately use it. Other states may be skeptical about the potential value of an exchange and prefer to let the federal government take the lead. Others may be stymied by limited staff capacity and expertise in this area.

One challenge for states that are debating whether or not they should attempt to operate an exchange is that they may need to make this decision in the absence of full information. It is currently not known, for example, how exactly the federal fall-back option would operate. States do not know how the federal government would fund the ongoing operation of a federally-led exchange. In addition, states have been given planning grant funds to collect data on their insurance market, expected demand for the services of the exchange, and other issues that could inform the decision of

whether it is feasible for a state to operate its own exchange. States that do not make that decision early risk falling behind in the planning process, but some may feel they do not yet have enough information to help them make the appropriate choice for them.

Table 1 lays out some issues related to whether a state should run its own exchange.

Whether a state's leaders support federal reform or not, it is clear that they will have more influence over the final impact of the ACA if they engage and seek to put their own unique stamp on reform. Strong coordination between those regulating the markets inside and outside the exchange needs to occur – most commentators have strongly recommended that states apply exactly the same rules in both markets – and this can be best accomplished when both markets are run at the state level.

GOVERNANCE AND ADMINISTRATION

For states that elect to establish an exchange, the next major question they face is how should it be governed? Three major options are available to states: 1) an independent, quasi-public board; 2) a state agency; or 3) a nonprofit. If a state agency is charged with governing the exchange, they could utilize an advisory board or a governing board. Multiple options for which state agency should get the job of governance also exist; options include: 1) the state health department or Medicaid agency; 2) the insurance department; 3) an overarching purchasing agency (in states where that exists); 4) the agency responsible for the state employees health plan; or 5) other options including a state budget agency or governor's office.

Related to governance is the question of how the exchange will be administered. For example, it is feasible that an exchange could be governed by an independent board, but that they would contract with the state Medicaid agency for the eligibility and enrollment functions. Likewise, a board could use the purchasing expertise of the state employees health plan staff to execute and monitor contracts with private plans. If the state elects to utilize a state agency to govern the exchange, they could adopt special hiring and procurement rules so that the public entity could operate in a manner more akin to a private entity or independent agency.

All states will be assessing their current capacity, including the strengths and weaknesses of existing agencies and the services that are available in the private market. A key to keeping costs low is to avoid duplicating existing expertise and functional tasks and to leverage aspects of the private market that are working well.

Many states—including Maine, Maryland, West Virginia, Wisconsin, and others—have already drafted "strengths and weaknesses" lists for various governance models. Table 2 shows some of the key considerations related to two of the most common governance models being proposed. The option of having a completely independent nonprofit entity run the exchange has not gained major traction with states. Most states want the exchange to have some public accountability that can be gained through public appointments or ex officio appointments to the governing board of key state officials. In addition, nonprofit governance raises several tax issues that states may be hesitant to tackle.[20]

Exchange Board Composition

For states that elect to use advisory and governing boards, the composition of those groups will be critical. States should consider several factors:

- **Size**. A governing board that goes above seven to nine people will quickly become unwieldy. In fact, California only appointed five members to their board. At the same time, states may want to make sure various types of expertise are represented, which could lead to pressure for a larger board.
- **State agency staff**. Because the exchange will need to be in-sync with the activities of a number of other state agencies—particularly a state's insurance regulator and its Medicaid agency—the exchange's governing board might include state officials ex-officio with expertise in those areas.
- **Commercial health plan experience**. Board representation from organizations with experience in the individual and/or small group markets could also be useful, providing the governing board with insight into those markets and firsthand knowledge of the types of plans consumers have selected in the past and the way those markets operate. Because the individual and small group markets operate under different rules than the large group market, states would be well served to include an individual with experience in those markets on the exchange board
- **Consumer representative**. The consumer perspective will be critical as the board plans outreach campaigns, sets up its website, and determines which plans will be available through the exchange.
- **Representation**. While it will be tempting to include a "representative" from all of the major stakeholder groups, it may be more advisable to seek people with the right expertise rather than those who come representing a certain interest group. In fact, it may be preferable to specifically require that individuals leave their advocacy hat at the door and seek to make decisions that are in the public interest.
- **Conflict of Interest**. States will want to consider compensation and conflict of interest rules. California put in place strong conflict of interest provisions, including some that prevent members from serving on the board of or staff to a health insurer or provider. Board members in that state will receive no compensation. For more details, see California Senate Bill 900 (2010).[19]

Getting the role of the board right will be important as well. Restrictive processes that require board approval for all activities of the exchange will not be conducive to effective and efficient operations. The exchange will need to be adaptive and flexible in order to respond to an ever-changing marketplace and an evolving set of federal rules and regulations.

Clearly, states have many issues to consider as they make their governance/administrative decisions. While West Virginia is strongly considering placing their exchange in their insurance department, other experts have advocated that states establish an independent agency. Timothy Stoltzfus Jost recommends an independent agency because, if placed within the insurance agency, health plan selection by an exchange would be "inconsistent with the impartiality that must be shown by an insurance commissioner"[21] in the agency's job of regulating all plans. He asserts that a Medicaid agency serves a fairly different population than the exchange would. An independent agency could be exempted from some state administrative rules and could develop a culture and a set of policies consistent with its unique role.

The Maryland Health Care Reform Coordinating Council has recommended that the legislature set up an independent public board to make initial decisions related to the exchange. They are leaving open the possibility that that board could recommend a different governance structure in future years.

The governance structure and administration of the exchange may determine, among other things:

- The management and extent to which the exchange will be allowed to operate outside the confines of state government;
- The level of transparency and public accountability;
- The manner by which goods and services will be procured;
- Staffing levels and hiring procedures;
- The criteria that may be used to select health plans; and
- The intersection between publicly-subsidized coverage and non-subsidized commercial insurance.[22]

However a state decides to govern their exchange, it will be critical that it is a nimble organization, able to react to the environment and learn from its mistakes. The work of the exchange will be new and states will need to learn as they go. They need a structure in place that allows them to operate – in some ways – more like a private-sector market participant than like a traditional government agency.[22]

CONCLUSION

Exchanges were a hot topic among states in 2010; they were discussed in their own right and as a centerpiece or organizing principle for overall state reform efforts. While all the health-related state agencies will have tasks related to the ACA, it is likely that the exchange planning process and, ultimately, the governing board and staff for the exchange will be a locus for discussing each state's reform goals and strategies.

Exchange planning was impacted by many of the larger trends discussed in this report, including the capacity challenges states are facing due to budget difficulties and the significant turn-over in state leadership (particularly governors). Once the political instability of 2010 has settled down, it is likely that most states will use 2011 to lay the groundwork for exchange planning and implementation.

Comparing the Small Group Component of the Massachusetts and Utah Exchanges

The existing state-based exchanges in Massachusetts and Utah have been characterized by many observers as representing the opposing ends of the political spectrum, with the Massachusetts Health Connector cast as the liberal, big government approach and the Utah model as the competition-oriented, conservative model. In fact, each state relies on the power of competition; they just have differing views on how to promote and enable consumer choice. While the programs have taken different approaches, much can be learned from each. In addition, each will need to adapt under the provisions of the Patient Protection and Affordable Care Act (ACA).

While the vast majority of the Massachusetts' Health Connector's resources are directed to implementing the individual subsidies and the state's individual mandate (because enrollment in its subsidized coverage program is currently much larger than in its unsubsidized program), the focus of this overview will be on the small group (i.e., the insurance market for small employers) component of their program. This will be compared with the Utah approach to this same market. Each will be examined in light of the requirements of the Small Business Health Options Program (SHOP) that passed as a part of the ACA.

TWO APPROACHES TO COMPETITION

The Utah Health Exchange was established to promote consumer choice in the small group market. In the Utah market outside the exchange (and in small group markets in most states), employers choose a health plan for their employees. However, the employer may not know the premium, cost-sharing, and benefit trade-offs that each individual employee might prefer. The Utah Health Exchange was set up to facilitate the ability of an employer to provide a defined contribution toward the overall premium and then allow its employees to choose a plan. Employees pay their share based on the additional cost (over and above what the employer is paying) of their chosen plan. The plans from which an employee is able to choose look very similar to the plans available outside of the exchange; the benefit designs are not standardized.

In 2010, the Massachusetts Health Connector launched a new small business product called Business Express. Similar to how individuals can access information and enroll through the Connector, Business Express enables employers to choose a specific health plan product for all their employees using the Health Connector's Web-based portal; employees then enroll in the product the employer has chosen. The Health Connector organizes its benefit plans tiers (Gold, Silver and Bronze) and each insurer offering coverage must meet basic benefit design specifications. The concept is that employers, like individuals, are more empowered to choose the coverage that best suits their needs if they have a venue where they can transparently view a reasonably representative sampling of health insurance options across a spectrum of standardized benefit designs and compare the prices of similarly designed plans—an "apples to apples" comparison.

Prior to Business Express, the Health Connector offered a different small group plan on a pilot basis that did allow some employee choice. It required that an employer choose a benefit tier and then employees could choose from various plans within the tier. Ultimately, they suspended that model for new business because it was perceived as more complicated to administer both for the Health Connector and for the small employer. It remains available for renewals of existing accounts. A major lesson learned was that employers want a plan that is *affordable* and *simple* to administer and explain to their employees.

The ACA requires that a state's small business exchange, at a minimum, gives employers the option of the employee choice model. It also requires the Health Connector's innovation of offering benefit tiers, though states will have significant flexibility in how many plans will be allowed in each tier. States could maximize the strengths of each state's model by allowing employee choice and then standardizing key benefit design options to ensure that plans are competing transparently on quality and price.

The details of how Utah makes the employee choice mechanism work could be particularly instructive to other states. Here are the steps that occur when an employer comes to the Exchange:

- An employer comes to the Exchange to express interest in purchasing a plan (this can be done through the employer's usual broker if that broker is certified to sell on the Exchange.)
- Information about the risk profile of each employee is provided to the Exchange.
- Two of the four plans in the Exchange assess the risk profile of the small employer's group, given the health history of all the employees. If these two plans calculate similar risk factors, all four plans agree to use the average risk factor. If the risk factors are significantly different, a third plan generates a deciding opinion.
- The employer decides on the amount of defined contribution for each employee.
- The employees each shop for a plan, using the amount the employer has elected to contribute for them, along with their own contributions. Premiums vary by the plan type or carrier selected but not by individual risk.

- Once each employee has selected a plan, the Exchange accepts a lump sum payment that includes the total premium from the employer and employees. On the back end, the Exchange risk adjusts the amount sent to each plan so that the plans with the higher-cost employees get a larger percentage of the overall premium.

FACILITATING GOOD CHOICES

The current insurance market is mostly opaque to both individuals and employers. This has required the use of brokers, who receive a commission from the insurance carrier. Utah required the use of brokers in their Health Exchange in 2010, though it will be optional in 2011. "The brokers provide a valuable service to many small businesses, and we believe that many employers will continue to want that human connection," says Patty Conner, the Director of the Utah Health Exchange. The use of a broker is optional in Massachusetts' Business Express. Further, the Health Connector has negotiated a small savings for "mini-group" employers, reducing the monthly administrative fee from $25 per month to $10 per month. As a result, these "mini-group" employers could save more than $300 annually by purchasing through the Health Connector. In Business Express, 92 percent of small businesses currently use a broker. Except for the small savings for mini-groups, the premium for the small employer is the same whether they use a broker or not.

The Massachusetts Health Connector provides comparative information directly to the consumer, reducing the need for a broker in the selection of coverage (although the broker may provide a range of other services that have value to the small employer). This type of comparative information will also be required by the ACA. The Utah Health Exchange is currently developing a mechanism to provide additional comparative information about health plans and providers using data from their all-payer claims database and other sources.

As states and the federal government consider the information technology solutions that will power the exchanges under ACA, additional search options and techniques currently utilized in Utah and Massachusetts will be worth considering. The Utah Health Exchange allows employees searching for a plan to know if that plan's network includes a preferred doctor, clinic, or hospital. The Massachusetts Health Connector has a provider search function for its subsidized coverage program and will soon implement one for its unsubsidized coverage program. In the future, exchange search engines could also include quality information about plans and providers. A search question could ask consumers which elements of a plan are most important to them: for example, low premiums; minimal cost-sharing; high quality rating; whether the plan's network includes a certain doctor; or whether the plan does a good job serving those with a particular chronic condition.

One element of choice is having a diversity of plans that offer different types of network options. This diversity was an important issue in Massachusetts, which generally has very high health care costs and also has a few providers who (because of their dominance in the Boston market) receive payments that are much higher than the average market rate. In order to promote limited networks, the Health Connector helped attract a new health insurer, CeltiCare, into the state's market. CeltiCare is a limited network option that is available at a lower price.

The Health Connector offers all of the state's seven major health plans. The Utah Health Exchange offers plans from four of the state's five major insurers in the small group market.

The choice model of the two exchanges is based on different theories on the type of environment that promotes good consumer decision-making. The Health Connector staff, based on focus groups and interviews with consumers, believes that consumers make the best choices when their options are simplified and somewhat constrained. They believe that consumers are best able to focus on the important differences between plans when key benefit design features and other specifications are standardized. For those shoppers who want a simplified, streamlined shopping experience, the Health Connector seeks to offer enough choice that consumers can make a meaningful decision, but not so much choice that they become overwhelmed or that important differences between the plans are hidden. The Utah Health Exchange is based on the idea that the market should decide the number and types of options available to consumers; the role of the Exchange is to facilitate competition and choice.[24]

INITIAL RESULTS

During 2010, the Utah Health Exchange completed a pilot phase and currently its service is available to all small employers seeking effective dates in 2011. The pilot phase enrollment includes 11 employee groups comprising 116 individuals. Early enrollment was limited in order to keep the development of the Exchange manageable. In addition, the Utah exchange had initial problems with health plans offering premiums that were significantly different from those being offered in the outside market. As a result, the state enacted legislation in 2010 to require the health plans to have a single risk pool for their products both inside and outside the exchange. Policymakers observed the importance of keeping a level playing field inside and outside the Exchange.

In the first few months of operation, Business Express has enrolled more than 5,500 members (a small number of these members are hold-overs from the previous small group plan). Their 2010 progress report includes a quote from one Massachusetts business owner who lays out many of the benefits that are available to small employers:

> "When our existing health plan provider announced a 23 percent increase in our health insurance rates, we wanted to explore our options. Business Express made it very easy for us to perform a side-by-side comparison of each of the health plans offered. Benefits are standardized on the website so you can really compare apples to apples to make the best choice. It saved us time, allowing us to get back to our business. . . But perhaps the best part of all is that our company and our employees saved a combined $9,300 compared to what we would have spent if we simply continued on with a very similar plan from another insurer."[25]

One interesting result of the Health Connector model (across individuals and small groups) is that it has led to some changes in consumer choices of plans. They are tending to choose smaller, lower-cost plans over the larger plans with higher name recognition, larger networks, and higher prices.

Evaluating the potential of employee choice based on the Utah model is more difficult. The small number of enrollees from the pilot program makes it unlikely that health plan behavior—in pricing and network and benefit design—has been impacted. There is hope among those in Utah and those who designed the federal SHOP model that the widespread ability of individual employees to choose plans could ultimately have a powerful effect on the market, making it more responsive to consumer demands. This remains to be seen.

ADMINISTRATIVE COSTS

Much has been made of the amount that the Health Connector spends on administration (about $30 million) versus what the Utah Health Exchange spends ($650,000), but a simple comparison of these numbers hides the larger reality of the goals and achievements of each model. The Connector provides coverage for 220,000 Massachusetts residents through the subsidized Commonwealth Care and unsubsidized Commonwealth Choice programs and determines the rules to implement the state's individual mandate. In addition, they invest in communications and outreach to educate Massachusetts residents about the requirements under the law and educate them about the coverage available through the Connector. The Utah Health Exchange uses its $650,000 annual allotment from the state to manage contracts and operations and to conduct policy planning for the state. In addition, they charge a $6 per employee per month fee that goes directly to the contractors for their role in operating the system. As stated above, 116 people are currently enrolled in the exchange in Utah. In addition, the Utah Health Exchange relies on brokers to facilitate employer and employee choice. That expense is exogenous to the state's cost to administer the Utah Health Exchange.[26]

LESSONS LEARNED

Both programs have learned important lessons during their first years of implementation that could be relevant to other states. Norman Thurston, Health Policy and Reform Initiatives Coordinator for the Utah Department of Health, shared the following insights:

- Involve stakeholders early and make sure insurers are heavily invested in the decisions and plans.
- Look for solutions that already exist in the private sector.
- Start with something concrete (it helped Utah to begin with a pilot).
- Make it a level playing field; keep the rules inside and outside the Exchange as similar as possible.[27]

Glen Shor, executive director of the Massachusetts Connector, notes:

- It is wise to pilot an experimental new product.
- For many small employers, less is more. Many prefer a shopping experience that is streamlined, simple, and facilitates informed comparisons among their options.
- The Health Connector hired staff that had both public and private sector experience. This diverse knowledge helps them serve their mission.
- Nurture relationships with providers, plans, advocacy groups, and legislators.
- Massachusetts benefited from having tight deadlines – it focused the work and kept reform efforts on track.
- Do not underestimate the power of a healthy, functioning market.[28]

CONCLUSION

Under the ACA, every state will need to develop a SHOP exchange (or defer to the federal government to run one in their state). In the first two years of this exchange, very small businesses with low-income employees will be eligible for tax credits within the exchange. After 2016, those credits will no longer be available. At that time, it will be important for these exchanges to show they can provide value to small employers as they look for a simple, cost-effective product.

ENDNOTES

1 The SCI health reform web page that highlights state, federal, and research work on exchanges can be found at: www.statecoverage.org/health-reform-resources/119/110.

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19 California Senate Bill 900. Retrieved December 23, 2010, from http://info.sen.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100819_amended_asm_v92.html.

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25 The Commonwealth Health Insurance Connector Authority. (2010, November). *Massachusetts Health Care Reform 2010 Progress Report.* Retrieved January 18, 2011, from www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/Connector%2520Progress%2520Report%252010.pdf.

26 For the most part, the Massachusetts Health Connector maintains the prevailing role of brokers in its health care market. Brokers had not typically been active in the individual market there and, thus, they are not used in the individual market portion of the Connector's business. This heightened the need for strong comparative information to be available on the Connector's website. Brokers have a stronger role in the small group market and this largely has been maintained through Business Express.

27 Based on phone interview and email correspondence with Norman Thurston, Health Policy and Reform Initiatives Coordinator, Utah Department of Health, October-December 2010.

28 Based on phone interview and email correspondence with Glen Shor, Executive Director of the Massachusetts Connector, October-December 2010.

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Chapter 6: Insurance Regulation Reform

State insurance agencies had a busy and important year in 2010 as they were tasked with implementing and enforcing several technical provisions of the Patient Protection and Affordable Care Act (ACA) that were among the first to go into effect. State insurance regulators were asked to enforce a series of insurance reforms that took effect on September 23, 2010 (including mandatory dependent coverage and guaranteed issue for children, among others), to expand their role in reviewing premium increases, and to prepare for new medical loss ratio (MLR) requirements. In addition, a number of state insurance departments worked with the federal government in planning for federally funded high risk pools[1] and many of them took the lead on health insurance exchange planning.[2]

Many insurance agencies became much more engaged in broader health policy discussions at the state level in 2010. The ACA requires a stronger role for insurance regulators and a much higher level of coordination with health care agencies than has been typical in the past.

The traditional role of insurance departments (which, in all states except Rhode Island, regulate all types of insurance) has been to protect consumers and ensure the solvency of insurance carriers selling policies in the state. Some states have taken a more activist role and also review premiums to prevent unreasonable increases or to insure that the methods used to set premiums are actuarially sound. The ACA envisions an even stronger role for insurance regulators in this area, and it designated $250 million to fund efforts to strengthen state rate review processes over the next five years. This chapter outlines the baseline practices among states in the area of rate review, their efforts in 2010 to expand their work in this area, and their plans going forward (as expressed in their rate review applications).

BACKGROUND: THE RISING COST OF HEALTH CARE

The rising cost of health care can be measured in numerous ways but, by all measures, spiraling cost increases are alarming and unsustainable. New estimates from the Centers for Medicare & Medicaid Services (CMS) Office of the Actuary project that health care costs will increase from 17.3 percent of gross domestic product (GDP) in 2009 to 19.6 percent of GDP in 2019.[3] This is a significant increase from the 13.6 percent of GDP that health care consumed in 1999.[4]

Private health insurance premiums are rising precipitously. Average family premiums in the employer-sponsored market have more than doubled in 10 years from $6,438 in 2000 to $13,770 in 2010. At the same time, out-of-pocket costs have mounted as deductibles and other cost-sharing arrangements have increased. For example, the number of people with employer-sponsored single coverage that had a deductible of $1,000 or more increased from 6 percent in 2006 to 17 percent in 2010.[5]

In early 2010, the Department of Health and Human Services (HHS) put the spotlight on insurance carriers with the claim that they were charging "unreasonable" premium increases to consumers. The report published by the department cited examples of proposed premium increases for policies sold on the individual market ranging from 13-16 percent in Rhode Island to 56 percent in Michigan. The secretary's report concluded that carriers were increasing premiums in spite of large amounts of surplus held in reserve.[6]

The carriers countered with claims that the majority of premium increases are driven by rising medical costs, including rising prices being paid to doctors, hospitals, and pharmaceutical companies, as well as increasing volume in the services being provided.[7]

The causes of increasing premiums are complex, and vary depending upon the characteristics of the market. In many states, growing provider consolidation has given many providers increased bargaining power with insurance carriers. Some consolidated hospital groups or specialty practices are considered "must-haves" in insurance networks; they can set their prices and carriers have little leverage to negotiate with them. At the same time, many markets have seen a growing consolidation of insurance plans, which could help to counterbalance the power of providers, but could also lead to a non-competitive environment where insurance plans can raise premiums at will.[8]

STATES RESPOND TO EARLY INSURANCE REFORMS IN THE ACA

One significant way insurance companies have managed health care costs in the individual and small group market has been to attempt to avoid covering people with expensive health care needs. They have utilized unpopular techniques such as denying coverage to sick people, refusing to cover pre-existing conditions, and rescinding coverage to people with existing policies if they become sick and the insurer discovers that the policyholders incorrectly reported any aspect of their health condition on their initial application. These practices will be unlawful after 2014 when the individual mandate takes effect and the health insurance exchanges are in place; a few provisions took effect six months after enactment on September 23, 2010. The provisions that deal with risk selection practices include the following:

- Plans can no longer limit or deny benefits for children under 19, if they offer child-only policies.
- Plans can no longer rescind benefits for honest mistakes on applications; they must be able to prove fraud.
- Those with insurance have a right to both internal and external appeal of decisions to deny coverage for care.

Other insurance provisions that took effect on September 23 are:

- No "unreasonable" annual benefit limits are allowed.
- No lifetime benefit limits are allowed.
- Plans must cover dependents up to age 26 (if their policies cover any children dependents).
- Plans must include preventive services with no cost-sharing, an ability to see a pediatrician or OB/GYN without a referral, and the right to use the nearest emergency room without penalty.

Since the ACA passed in late March, many states were unable to enact legislation giving their insurance departments authority to enforce these provisions before the end of their legislative sessions. While few states had official legal authority to enforce the provisions, most state regulators took an activist role in educating and working with insurers to promote compliance with the law. In the meantime, state insurance commissioners have worked through the National Association of Insurance Commissioners (NAIC) to develop model laws that will give states authority to enforce these provisions.[9] Many state legislatures plan to pass these bills during their 2011 legislative sessions.

RATE REVIEW: CURRENT STATE LAW AND PRACTICE

Currently, a great deal of variation exists among states with regard to the rate review process. To address this variation and to contain the rapid increase in health insurance premiums, the ACA sets out to increase the transparency and scrutiny of proposed health insurance rate increases. The new law provides funding and includes provisions that will help states strengthen or create rate review processes. A pool of $250 million in grant funding will go to state insurance departments over five years to support enhanced rate review processes.

A recent report by the Kaiser Family Foundation sheds light on how current state laws and practices lead to such tremendous variation in the rate review process among states. Although regulatory authority is an important factor, enforcement, and the extent to which state laws actively encourage the input of consumers also play a key role in why some states effectively monitor and address insurance rate increases, while others do not.[10]

According to the study, state laws giving insurance agencies authority to review rates vary dramatically from state to state. At one end of the spectrum are states with "prior approval" authority over rates; they prospectively review and approve rates. At the other end are states that do not require health insurance carriers to file rates for their products at all. There are a range of options in between, including states that only require insurance companies to file an "actuarial certification" attesting that their rates are in compliance with state law, without providing any documentation to substantiate their claim. In addition, some states review rates retrospectively to determine whether the filed rates are found to be unreasonable; this is called "file and use." A file and use inquiry can be done on every filing or it could be instigated by consumer complaints.

The study finds that:

1. *A state's statutory authority often tells little about how rate review is actually conducted in the state.*

   How states exercise their review authority over rates varies widely and depends on motivation, resources, and staff capacity. While some states with "prior approval" authority put virtually no pressure on insurance carriers to

reduce their rates, others, with only "file and use" authority, may work behind the scenes to compel insurance companies to lower their proposed rates.

For example, Connecticut, a state with prior approval authority over all health insurance products in the individual market, recently resisted calls from the state's attorney general for a more aggressive review of insurance companies rate increases requests.[11] On the other hand, states with little to no authority to regulate rates have used their limited authority to put pressure on insurance carriers to lower their rates. Idaho and Ohio[12] have used their file and use authority to obtain lower rates or make additional changes to a filing to address their concerns.

2. *In many cases, statutory authority is limited, in that it does not extend to all market participants.*

Some states have limited statutory authority that only applies to certain market segments. In Pennsylvania, prior approval authority in the small group market extends to nonprofit Blue Cross Blue Shield and HMOs but not to commercial carriers. In Maine, due to an exception in the statute, small group carriers can bypass the traditional rate review depending on the pathway they choose for filing their rates. In South Carolina, a provision in the statute allows most individual market carriers to bypass rate review, even though the statute generally provides for prior approval authority. As a result of these limitations in statutory authority, the rates of many insurance companies in the individual or small group market are not reviewed at all.

3. *Most of the states interviewed use a subjective standard to guide the review and approval of rates.*

State rate review can be based on either objective or subjective standards. Subjective standards generally mean that rates cannot be "excessive, inadequate, or unfairly discriminatory," or that "benefits are reasonable in relation to premiums charged." An example of an objective standard is an MLR. Both types of approaches have advantages and disadvantages. The primary advantage of an objective standard is that it can be applied consistently and fairly across all plans. The disadvantage is that it is more rigid, leaving little room to address differences in circumstance and equity. While a subjective standard offers flexibility, it can lead to variability in its application, resulting in the perception of an arbitrary and opaque state determination.

Most of the states interviewed for the study use subjective standards, while some have a mix of subjective and objective standards.

4. *Most of the states interviewed have made little to no effort to make rate fillings transparent.*

The study found that much of the rate review process is conducted as an informal dialogue between the insurance department staff and insurance carriers. Consumers and policyholders have no means to participate in this discussion.

Although—according to the study—there is evidence that the simple ability to hold a hearing is enough to give state regulators leverage to negotiate lower rates, only three of the 10 states interviewed for the study (Colorado, Maine, and Wisconsin) allow policyholders to request a public hearing prior to rate approval.

Most states, in theory, allow public access to rate filings after they have been approved. However, the rate filing may not be easily accessible because consumers are required to physically visit the agency if they want to access the necessary documents. In addition, regardless of whether the public has access to the rate filing before or after rates have been approved, access may be limited because parts of, or in some cases, the entire filing is labeled "proprietary" or a "trade secret."

Most of the states interviewed indicated they were planning to use some portion of their federal grant to improve their website and enhance consumer access to information about the rate review process.

5. *Many states lack the capacity and resources to conduct an adequate review.*

A rate review is not just a mechanical function—an actuary makes assumptions and projections that involve nuanced judgment calls. An actuary being paid by the carrier may make a judgment in favor of the carrier. With a sound rate review process, a state may question the assumptions that underpin a carrier's rate increase. Without the authority, staff capacity, and expertise, a state may not be able to conduct adequate rate reviews.

Having only a relatively limited time available to conduct such a review may diminish a state's ability to perform an adequate rate review. This limited time is usually imposed by state statute which requires that insurance regulators review and make a decision to approve or disapprove rates during a specific time frame (usually 30-60 days). In some cases, however, states may have a degree of flexibility. For example, sometimes the time clock is halted while insurers respond to questions and requests for additional information from regulators. Carriers may also be willing to work with the regulators to delay using the proposed rates rather than risk a formal disapproval.

RATE REVIEW: FEDERAL LAW, REGULATION, AND FUNDING

The ACA requires HHS, in conjunction with the states, to establish a process for annual review of "unreasonable" rate increases for non-grandfathered health plans. However, the law does not define what constitutes "unreasonable" increases. On December 21, 2010, HHS

issued a proposed rule[13] that provides clarification as to how HHS is planning to implement the requirement for reviewing "unreasonable" rate increases. According to the regulations, HHS defines a rate increase as "unreasonable" if it is "unjustified," "excessive," or "unfairly discriminatory."[14] Also, the agency would only apply this definition to rate increases that HHS reviews. The agency would not create a federal standard for states to use. In other words, states that have an effective rate review program would be permitted to use any applicable standard based on state law and regulation. However, for states that do not have the resources or authority to do thorough actuarial rate reviews, HHS would conduct them and apply its regulatory definition of "unreasonable."

In addition, to increase transparency of the rate review process, the ACA requires insurance companies to publicly disclose and justify unreasonable rate increases.[15] To that end, for 2011 (i.e., rate increases filed in a state on or after July 1, 2011, or effective on or after July 1, 2011), the proposed rule would require all insurers seeking rate increases of 10 percent or more in the individual and small group markets to publicly disclose the proposed increases and the justification for them. HHS clarifies that increases above 10 percent should not be presumed unreasonable. The extent to which such increases are unreasonable would be analyzed and determined subsequently. For subsequent calendar years, the threshold for disclosure would be state-specific and based on data and trends that better reflect cost trends specific to that state.

States' Proposed Use of Grant Funding: To date, 45 states and the District of Columbia (D.C.) have been awarded $1 million in grant funding each. According to HHS's website, states are planning to use the funds in the following ways:[16]

- *Additional Legislative Authority*: Fifteen states and D.C. will pursue additional legislative authority to create a more robust program for reviewing or requiring advanced approval of proposed health insurance premium increases to ensure that they are justified.
- *Expand the Scope of Health Insurance Premium Review*: Twenty-one states and D.C. will expand the scope of their current health insurance review, for example by reviewing and pre-approving rate increases for additional health insurance products in their jurisdictions.
- *Improve the Health Insurance Premium Review Process*: All 46 grantees will require insurance companies to report more extensive information through a new, standardized process to better evaluate proposed premium increases and increase transparency across the marketplace.
- *Make More Information Publicly Available*: Forty-two states and D.C. will increase the transparency of the health insurance premium review process and provide easy-to-understand, consumer-friendly information to the public about changes to premiums.
- *Develop and Upgrade Technology*: All 46 grantees will develop and upgrade existing technology to streamline data sharing and put information in the hands of consumers more quickly.

To receive the grants, states are required to provide HHS with information about trends in premium increases in their state, both inside and outside of the new insurance exchanges. HHS will then assess the rate of premium growth inside and outside the exchange before allowing large businesses (more than 100 employees) to participate in the exchange.[17]

RATE REGULATION: NON-ACA-RELATED STATE EFFORTS

Even before the federal government made grants available to states to help them improve their rate review process, some states were already strengthening their legislative authority to improve their ability to control the rapid rate increases. Two states—Rhode Island and Massachusetts—have been at the forefront of this movement, instituting measures to help them control the cost of health insurance. The approaches taken, however, have been very different.

Rhode Island – Driving toward Payment Reform[18]

Rhode Island's unique approach is based on the belief that controlling health care costs cannot be addressed through rate review alone. Rather, rate review can be used as a tool to drive payment reform. Through a process that has included stakeholder input and partnership with existing quality improvement initiatives, Rhode Island has established rate review standards that promote increased spending on primary care, that restrict increases in payments to hospitals, and that work to promote care coordination and quality improvement. The rate review standards also restrict the administrative costs of the health plans.

Rhode Island's Office of the Health Insurance Commissioner (OHIC) has a unique mandate: to ensure overall health care system affordability and efficiency. To this end, in 2009, OHIC embarked on a project to strengthen primary care. In 2010, OHIC sought to expand its oversight into health plan contracts with hospitals.

Strengthening Primary Care: OHIC's decision to focus on primary care stems from a concern that payment policies have led to a shortage of primary care physicians. In addition, population-based quality and cost measures, both nationally and internationally, are positively correlated with the supply of primary care physicians.[19] Moreover, because primary care constitutes a small percent of overall health care costs, payment reform in this area seemed like a relatively easy place for OHIC to start. As a result, there has been wide acceptance from stakeholders of the idea that an investment in primary care is a worthwhile goal.

The priorities, established through the office's Advisory Council, seek to strengthen primary care without adding to the overall cost of care. They include:

- Expanding and improving the primary care infrastructure in the state;
- Promoting the adoption of medical homes based on the Chronic Care Model;
- Promoting the adoption of electronic health records by physicians; and
- Implementing more comprehensive payment reform.

Based on these priorities, the Advisory Council developed the following four regulatory standards aimed largely at increasing payment for primary care physicians and promoting delivery system reform through support for the medical home:

- "Health plans would increase the proportion of their medical expenses spent on primary care by five percentage points over the next five years. This money is to be an investment in improved capacity and care coordination, rather than a simple shift in fee schedules.
- As part of the increased primary care spending, health plans would promote the expansion of the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) project, or an alternative all-payer medical home model with a chronic care focus, by at least 25 physicians in the coming year.
- Health plans would promote the adoption of electronic medical records (EMR) programs that meet or exceed a minimum value.
- Health plans would commit to participation in a broader payment reform initiative as convened by public officials in the future."[20]

Importantly, these regulatory standards were linked to the rate review process—if carriers did NOT meet the primary care investment requirements outlined above, it would detrimentally affect their proposed rate increases.

Hospital Payment and Care Delivery: Since physician payment reform only addresses part of payment and delivery system reform, in 2010 OHIC included new insurer regulations aimed at altering payment to hospitals to provide incentives for efficient use of health services while increasing the quality of services.

According to OHIC, the impetus for hospital payment reform stems from concern over significant variations—up to 85 percent—in payment rates among hospitals for the same sets of services. In addition, data presented by health insurers in their most recent filings to OHIC indicate that a significant proportion—40 percent—of insurers' medical costs is spent on hospitals. In almost every case, inpatient and outpatient hospital expenses are growing faster than expenses in any other medical service category.[21]

To create incentives for hospitals to provide quality health care in a more efficient manner, on July 7, 2010, OHIC announced six new conditions with which health insurers must comply as part of the rate factor approval process effective in 2011. The six conditions that new contracts with hospitals must meet are:

1. Efficiency-based units of payment for both inpatient and outpatient services modeled on Medicare's payment system, which has moved away from fee-for-service and toward bundling certain services.
2. Annual maximum price increase for services based on a weighted amount equal or less than the CMS National Prospective Payment System Hospital Input Price Index. Currently, hospital price increases can exceed this index by a factor of multiple times.
3. Quality incentives whereby a hospital can increase its total annual revenue for enrollment under contract by at least two percent over the previous year if it attains performance levels for no less than three nationally accepted clinical quality, service quality, or efficiency-based measures. The measures and the required achievement levels should be subject to negotiation between the insurer and the hospital.
4. Administrative efficiency standards that would stave off the rapid increase in administrative costs, which are rising at rates of insurance premium inflation—several times the rate of general inflation.
5. Provider communications standards that would promote and measure improved clinical communications between the hospital and the patient's physician or other practitioners.
6. Carriers must provide public access to health plan payment terms and conditions with hospitals.

It should be noted, however, that these hospital contracting requirements are not without controversy as one large hospital system is contesting OHIC's authority in this area.

Rhode Island has been able to introduce regulations aimed at controlling costs and improving care, largely because its statutory authority goes beyond what most states currently allow. In addition, transparency of the process and continuous engagement of stakeholders in the development of the regulations have helped decrease resistance. Although it may take time for this approach to show results, its design includes features that can be incorporated by other states interested in achieving similar goals.

Massachusetts – Direct Rate Regulation

Massachusetts' variations in provider reimbursement rates mirror those in Rhode Island. According to a *Boston Globe* article published in late 2008, several high profile hospitals (particularly the two Partners Hospitals: Brigham and Women's Hospital and Massachusetts General, and Children's Hospital) were being paid 15-60 percent more than their competitors.[22] These

findings were confirmed by a subsequent report by the attorney general, which also found that price variations are not correlated to quality of care, the complexity of the patient population, the proportion of Medicare/Medicaid patients receiving services, or teaching status.[23] The report also indicated that price variations are correlated with market leverage of particular hospitals or provider groups and that the commercial health care market place has been distorted by contracting practices that reinforce and perpetuate disparities in pricing.

Although Massachusetts has seen similar variations among providers as Rhode Island, the state has chosen a different approach to address that variation and control costs. Massachusetts attempted to use its regulatory authority over the insurance carriers to indirectly pressure providers to reduce their reimbursement rates. The state also attempted to use the legislative process to hold down the cost of insurance for small businesses and individuals.[24] Specifically, the Massachusetts Senate approved a bill in May that would have required hospitals in the state to make one-time payments totaling $100 million to reduce premiums in the small group and individual markets; ultimately the bill was not enacted.[25]

The state took aggressive regulatory steps in February, when the Division of Insurance (DOI) issued emergency regulations triggering review of all premium increases at or above 150 percent of the New England medical consumer price index (5.1 percent in 2009)[26]—the equivalent of a 7.7 percent rate increase over the previous year—and required carriers to submit rate filings, which were subject to review and approval by the DOI, one month prior to their effective date. As a result of the regulations, in April, the DOI rejected 235 of the 274 rate filings by insurers in the small group and individual market, calling them "excessive and unreasonable."[27] Insurers had proposed rate increases ranging from 8 percent to 32 percent.[28]

In response, the insurance carriers appealed the rulings with the DOI and challenged the rejection of the proposed premium increases in court. In June, an appeals panel within the DOI rejected the denial of rate requests that had been filed by one insurer, Harvard Pilgrim Health Care. By the beginning of July, the insurer reached a compromise with the DOI, which allowed it to raise rates by slightly less than it had originally requested. The settlement also removed Harvard Pilgrim from the lawsuit filed in April by all of the state's other major carriers.

Since then, two of the six carriers—Tufts Health Plan and Blue Cross and Blue Shield of Massachusetts (BCBSMA)—have reached agreement with the DOI on rate increases, and one—Fallon Community Health Plan—was successful in its appeal of rate hike rejections by the DOI. Tufts Health Plan agreed to rate increases ranging from 5.8 percent to 12.8 percent [29] and BCBSMA agreed to increases below 13 percent compared to the original 23 percent increase requested.[30]

Another step toward containing rate increases for small employers is the passage of legislation in August, which was supported by some members of the business community—most notably small business advocacy organizations—as well as the Massachusetts Hospital Association. The new law includes:

- Authority for the state insurance commissioner to approve policies that do not cover some mandated benefits, for a period of up to five years, for small businesses that previously did not offer health insurance to their employees.
- A requirement that companies that insure at least 5,000 subscribers in the state offer in at least one geographic area, a plan with a reduced or selective network of providers, or with a tiered network of providers with cost sharing based on tier selection. The base premium for such plans must be at least 12 percent lower than the base premium for similar plans without reduced networks.
- Up to six "small business group purchasing cooperatives," consisting of member-employers with no more than 50 workers each may be formed under the new law. Total enrollment of the six groups may not exceed 85,000.
- A reduction in the number of enrollment periods to two in 2011, and one for each year thereafter, to limit the number of people who sign up for coverage, undergo expensive (typically elective) procedures, and subsequently drop coverage after the procedure has been completed.
- Allowing carriers to make age rate adjustments every year, instead of every five years.
- Prohibition of anti-competitive contract provisions linking rates to those charged by large providers.
- Promotion of wellness plans.

MEDICAL LOSS RATIO

As part of the effort to contain rising health care costs and provide better value for consumers, the ACA includes a requirement that insurance companies spend at least 80 to 85 percent of premiums paid on medical costs. In other words, administrative expenses and profits are limited to 20 percent in the small group and individual markets and 15 percent in the large group market. An exception is made for the individual market in that the secretary of HHS can adjust the MLR percentage if she determines that the application of the 80 percent MLR may destabilize that market in the state.

The legislation called for the National Association of Insurance Commissioners (NAIC) to develop draft MLR standards and submit them to HHS. In October, NAIC presented its recommendations along with a separate letter asking the secretary to be responsive to requests from state regulators for a phase-in period of the MLR standard if it is determined that meeting the standard may destabilize the individual market and result in fewer choices for consumers. HHS incorporated NAIC's recommendations and published an interim final rule on December 1, 2010.[31]

The MLR rule is expected to take effect in 2011. The ratios will be calculated annually at the state level. Insurers that spend less than these ratios must refund the difference to their policyholders starting in 2012.

To guard against destabilization of the individual market when insurance carriers cannot immediately comply with the new regulations, provisions in the rule allow for a phase-in period of the MLR standard requirement.[32] In other words, if a state can demonstrate that requiring insurers in its individual market to meet the 80 percent MLR has a likelihood of destabilizing the individual market and could result in fewer choices for consumers, the rule establishes a process for states to request an adjustment to the MLR standard for up to three years. This provision is consistent with NAIC's recommendations in its accompanying letter to HHS.[33]

The requests must be submitted by the state insurance commissioners on behalf of the state individual insurance market as a whole. The request may be made for one, two, or three MLR reporting years. The request must include the state's own assessment of how best to address any risk of destabilization through an adjustment to the MLR standard. To this end, the state must submit an appropriate alternative MLR standard for each year for which it is requesting an adjustment.

The regulations establish the following five criteria HHS will use to determine the risk of destabilization:

1. The number of carriers reasonably likely to exit the individual market or cease offering specific products in a state absent an adjustment.
2. The number of individual market enrollees covered by carriers that are reasonably likely to exit the state absent the adjustment.
3. Whether, absent an adjustment, carriers would reduce compensation to agents and brokers to the point where agents and brokers would leave the market and consumers would lose access to their services.
4. Alternate coverage options available within the state for enrollees of carriers that are reasonably likely to exit the market.
5. The impact on premiums charged, the benefits offered, and the cost-sharing provided to consumers by carriers remaining in the market in the event one or more withdraw from the market.

For more information about the MLR standard in the individual insurance market and provisions within the ACA for addressing any potential market destabilization, see *Recognizing Destabilization in the Individual Health Insurance Market,* an issue brief produced by the Changes in Health Care Financing and Organization (HCFO) initiative.[34]

CONCLUSION

Rapid and steep increases in private insurance rates are quite prevalent and there is growing concern that these rate increases will price more and more people out of the insurance market and make access to services increasingly more difficult. In addition, the need to find affordable products will increase once the ACA's requirement that everyone buy insurance takes effect in 2014. The federal government, in particular, will have a strong interest in containing the cost of health insurance premiums as they will be covering a portion of those costs for many Americans.

The interaction of the rate regulations outlined above with the advent of health insurance exchanges will be a significant issue for states going forward. They will need to consider how the insurance market restructuring contemplated by exchanges will interact with the work of the state's insurance department. Effective communication between the leadership of both entities will be critical to ensure that the right policy tool is being used for the job and that the work of rate regulators and exchange implementers does not conflict. Working in partnership, these two policy levers—rate regulation and a health insurance exchange—could be a powerful force for increasing access, containing costs, and improving quality in the health care market.

ENDNOTES

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STATE OF THE STATES

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Chapter 7: Medicaid and the Children's Health Insurance Program Present Opportunities and Challenges

Medicaid agencies have long pioneered cost-containment initiatives that became models across the health system. The extraordinary fiscal crisis in states, only partly offset by Recovery Act funding, placed new pressures on the ingenuity of Medicaid administrators. States have shown creativity in how they applied rate reductions to minimize negative impact on access to care. Medicaid agencies have significantly increased the scope of managed care to include more special needs populations, and they have developed new initiatives to work with providers to better manage chronic illness. In these and other respects, Medicaid continues to be an important area of innovation in cost containment and health care financing.

MEDICAID AND COST-CONTAINMENT

For the fourth consecutive fiscal year the state budget environment has been enormously difficult for states. General revenues declined in absolute terms in fiscal years 2008-2010, the first time states ever experienced even two years of back-to-back annual revenue drops.[1] However, with federal fiscal relief for states phasing out, most states anticipate ongoing significant budget shortfalls next year. As of December 2010, 40 states have projected gaps that total $113 billion for fiscal year 2012, a level almost as large as that for 2010.[2]

In August 2010, H.R. 1586 extended enhanced Medicaid funding through June 2011 in the form of a higher Federal Medical Assistance Percentage, or FMAP. Over the course of the final two quarters of the fiscal year (the first half of calendar year 2011), this enhanced FMAP is being phased out, and will no longer be available in FY 2012. Enhanced FMAP and the State Fiscal Stabilization Fund together covered about 35 percent of the state budget shortfall for FY 2011.[3] A significant proportion of this federal budget relief, however, was absorbed by increased Medicaid costs themselves. Enhanced federal match had a major impact on states' ability to deal with Medicaid enrollment growth during the recession. Despite overall Medicaid cost growth, enhanced FMAP reduced state expenditures for Medicaid, resulting in an average decline in state general fund spending for Medicaid of 7.1 percent in FY 2010 and 10.9 percent in FY 2009.[4]

States are now confronting the end of enhanced FMAP in their budgeting for 2012. Although FMAP began to be phased out in January 2011, the end of enhanced FMAP still represents a withdrawal of $40 billion of federal resources that were available to states in FY 2010, between the ARRA and the partial extension of enhanced FMAP for the last two quarters of the fiscal year. A preview of the potential impact of the end of enhanced FMAP was provided in the spring of 2010 by how states handled the possibility that enhanced match would end during FY 2011.[5] Most states had to adopt budgets for FY 2011 during the spring of 2010, when states did not know whether the enhanced FMAP would be extended beyond its original December 2010 ending date. States varied on whether they incorporated an extension into their budget projections. States that did not incorporate an ARRA extension had to project substantially higher rates of state Medicaid spending,

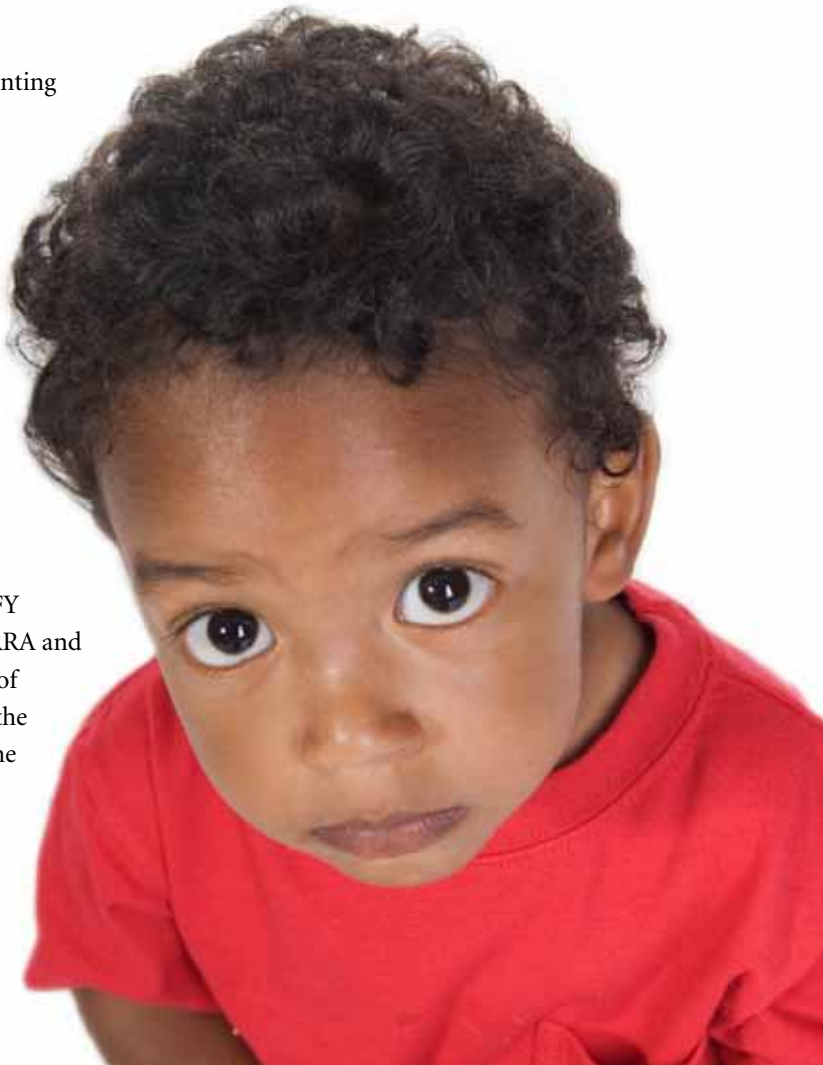
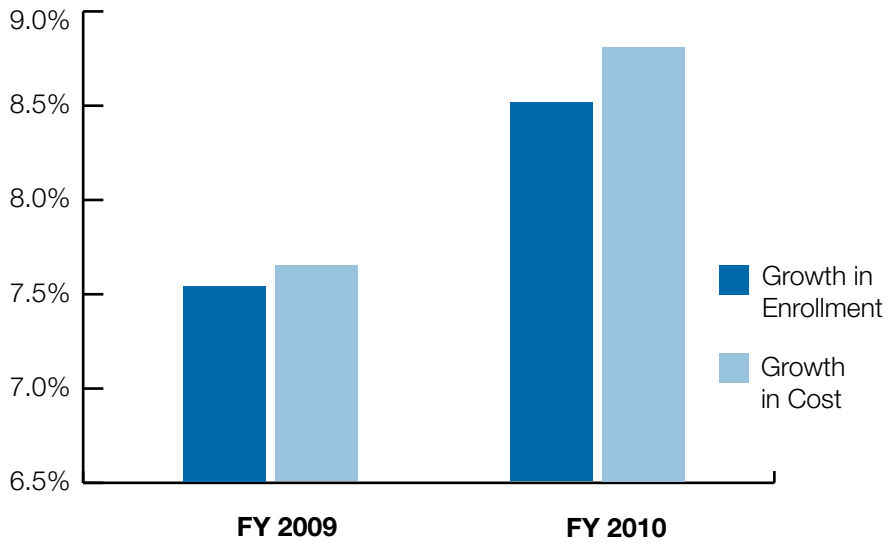


Figure 1: **Medicaid Enrollment and Cost Growth**



Source: Kaiser Commission on Medicaid and the Uninsured. Hoping for Economic Recovery, Preparing for Health Reform.

although total (federal and state) projected Medicaid spending was similar in the two groups of states. Those states that assumed an extension of the ARRA enhanced FMAP in their FY 2011 budgets budgeted for 5.3 percent state Medicaid spending growth on average. Those states that did not assume an extension of the enhanced FMAP budgeted for 25.6 percent spending growth on average.

States experienced the most rapid growth in their Medicaid spending in eight years in 2010.[6] This cost growth was almost entirely driven by growth in Medicaid enrollment. As indicated in Figure 1, in 2009 cost growth exceeded enrollment growth by only 0.1 percentage points, and in 2010 by 0.3 percentage points.[7] States projected continued modest per capita cost growth in their 2011 budgets.

These flat per capita cost trends reflect, in part, that Medicaid had a surge in enrollment of parents and children, relatively low-cost categories. Children alone accounted for 60 percent of the growth in Medicaid enrollment in calendar year 2009.[8] This surge was clearly driven by the recession and growth in unemployment among working-age parents.

State cost-containment actions were also instrumental in restraining the per capita growth of Medicaid spending. Maintenance of Effort requirements in the Recovery Act—continued in the ACA—prohibited states from reducing Medicaid eligibility. State cost-containment actions therefore focused on reducing per-enrollee spending. Cost containment was focused in the following areas, reviewed in more detail below:

- Reducing and freezing reimbursement rates;
- Increasing the scope of managed care;
- Implementing disease management programs;
- Maximizing the federal match; and
- Reducing benefits.

RATE REDUCTIONS AND FREEZES

Freezes or reductions in Medicaid rates were the most common form of cost containment adopted by states in 2010. During fiscal years 2010 and 2011, 41 states restricted provider reimbursement rates, with most of those states enacting cuts in both years.[9]

States employed a number of strategies to minimize the beneficiary and provider impact of these reductions, however. Medicaid rates for some categories of providers are generally adjusted for inflation every year. Typically hospitals and nursing homes both receive automatic inflation-based increases in base rates. For provider types who normally receive annual inflation-adjustments to rates, state rate "reductions" may in fact be increases or flat funding in absolute terms. Some states, seeking to minimize actual reductions in rates, focus rate adjustments on these providers. This tendency was reflected in the recent round of Medicaid cost actions, with hospitals the most common target for rate restriction and nursing homes the second most common. While three quarters of states restricted hospital rates and about half of states restricted nursing home rates during the fiscal crisis, most of these actions represented rate freezes rather than actual rate cuts.[10]

Physician services is another major cost center for Medicaid programs and physicians were the next most common target of rate reductions. A significant minority of states cut at least some physician rates in FY 2010 or FY 2011.[11] A number of states had increased physician rates in recent years, so these cuts were, in some cases, reversals of recent increases. It is also important to note that Federally Qualified Health Centers (FQHCs) are rapidly growing as a source of Medicaid physician services. Because FQHCs generally receive Medicaid payment based on a relatively high federal rate schedule, their growth represents an effective increase in average rates that Medicaid pays physicians.

State rate reduction actions in other major cost centers were less common. States are constrained from reducing managed care capitation rates by federal requirements for actuarially sound rates so those reductions were relatively rare.[12] State use of preferred drug lists and supplemental rebates to reduce pharmacy costs is well-established and robust, so state activity to add drugs to these mechanisms is routine and ongoing.[13]

The Affordable Care Act clawed back a portion of the supplemental rebates used in some states by increasing the minimum 50

percent state rebate amount and designating the increase as payable 100 percent to the federal government. However, the ACA also allows states for the first time to collect rebates on drugs purchased for Medicaid recipients by managed care organizations. State implementation of this provision is likely to be an important area for savings in states with managed care programs going forward.

An important legal challenge to Medicaid rate reductions has played out in the 9th U.S. Circuit Court of Appeals. The circuit court has made multiple decisions in 2009 and 2010 giving Medicaid providers legal standing to sue to stop Medicaid rate reductions. The Supreme Court has not ruled on whether this holding applies nationally, but unless and until the Supreme Court rules otherwise, states in the 9th Circuit (the largest in the nation including nine Western states) will face additional requirements to demonstrate that rate reductions will not damage quality and access in order to reduce rates.[14] California has appealed to the U.S. Supreme Court, and more than 20 states have filed papers supporting California's appeal.

INCREASED SHIFT TO MANAGED CARE

The last two years have seen a shift toward risk-based Medicaid managed care. The number of Medicaid enrollees in capitated, comprehensive, risk-based health plans nationally increased by over 12 percent over the year ending in June 2009.[15] Thirty-four states now have risk-based capitated Medicaid managed care.[16] Managed care growth in the last two years has involved multiple forms of expansion: expansion into new counties, the addition of new eligibility groups to managed care, a shift from voluntary enrollment into managed care to mandatory enrollment, or implementation of managed long-term care programs.

An important new aspect of the growth of managed care in Medicaid is a new emphasis on managed care for people with disabilities and dual eligibles. Enrollment of the Aged, Blind, and Disabled eligibility category into managed care has accelerated in the last three years.[17]

Managed long-term care, once an unusual strategy employed in a handful of states, has reached broader acceptance. Managed long-term care is now utilized in twelve states with a significant number of additional states actively planning to introduce it. Of these managed long-term care programs, six are mandatory for some or all long-term-care-eligible populations.

Almost half of state Medicaid agencies implemented new disease management or care coordination programs during State Fiscal Years 2010 and 2011.[18] Medically complex and/or disabled individuals represent an extraordinarily high share of costs in Medicaid programs, and a significant proportion of these costs are due to poorly managed chronic conditions. Unlike the early 2000s trend toward vendor-based disease management in both the public and private sector, however, recent Medicaid disease management and care management initiatives fall predominantly into two categories: provider-based initiatives, including both primary-care based programs and other provider-run initiatives; and managed care-based programs.

States Expanding Managed Care for Special Needs Populations: Two State Examples

Illinois created a new mandatory managed care system called the Integrated Care Delivery System in several counties in 2010 targeted at adults with disabilities and older adults in the Medicaid program. Rather than an expansion of existing managed care contracts, Illinois created a procurement for stand-alone plans for Aged, Blind, and Disabled eligibility categories. Illinois awarded contracts to Aetna and Centene in September 2010, with enrollment beginning in 2011. Expansion to managed long-term care is proposed as a next step.

Tennessee implemented mandatory managed long-term care in 2010, through its Choices in Long-Term Care program. Tennessee has historically had a long-term care system almost entirely dependent on institutions. In 2008, the legislature passed the Long-Term Care Community Choices Act calling for integration of long-term care services for the elderly and adults with physical disabilities into the existing TennCare managed care system. The state received approval for an amendment to its TennCare waiver in mid-2009. Tennessee rolled out managed long-term care unusually quickly, expediting this process by adding long-term care risk on to existing Tenncare contracts rather than conducting on new procurement process specific to long-term care.

BENEFIT REDUCTIONS

Despite the fiscal crisis, states prioritized maintenance of Medicaid benefits overall, and almost as many states reported increases to benefits as reductions or benefit limits.[19] Those reductions that did take place have focused on non-elderly adult beneficiaries.

Many states are now actively pursuing Medicaid Health Homes (aka medical homes) programs, created by Section 2703 of the Affordable Care Act and taking effect in January 2011 (See *State Efforts Improve Quality, Contain Costs and Improve Health* for more information). This new State Plan option has both short-term and long-term cost containment implications. In the short-term, because many states have existing care management and medical home programs for people with chronic physical and mental health conditions, these programs will be eligible, at least in part, for two years of 90 percent federal matching under the ACA. The Health Homes program also provides an opportunity for states to pursue long-term cost savings through medical home and care management programs for chronically ill Medicaid beneficiaries. For participating states, the 90 percent match provision of

the program is both a way to derive savings for existing activities and to pilot new care management programs for two years with limited financial exposure.

Growth in provider tax mechanisms has been a major source of revenue for states during the recent fiscal crisis. Many states employ provider taxes both as a mechanism for generating revenue directly and, in many cases, for generating additional federal match revenue. Over the past three years, the number of states with hospital taxes grew significantly, from 19 to 34.[20] Other provider taxes and taxes on managed care organizations have also grown significantly, and increases in provider tax rates have occurred as well. A significant minority of states have also increased the percentage of provider taxes retained by state rather than returned to providers in rate enhancements.[21]

States also have cost reduction opportunities related to Medicare Advantage (MA) changes. The Medicare Improvements for Patients and Providers Act (MIPPA) Act of 2008 imposed a requirement on Special Needs Plans (SNPs) for Dual Eligibles to contract with state Medicaid agencies, and the deadline for this requirement was extended to the end of 2012 by Section 3205 of the ACA. Many Medicare Advantage Duals SNPs were designed to shift costs onto Medicaid programs. That is, since non-SNP MA plans typically cover some Medicare premiums and cost-sharing (or other wrap-around benefits) that are also covered by Medicaid, MA plans created duals SNPs that did not cover those benefits and sought to make sure they were not paying anything for duals for which Medicaid would otherwise pay. The contracting requirement gives Medicaid programs an opportunity to work out a different arrangement with MA SNPs on Medicare cost-sharing, premiums and other wrap-around costs that is more favorable to the state Medicaid agency.

The end of enhanced FMAP and the ongoing economic challenges facing states will continue to pose profound fiscal challenges to state budgets in fiscal year 2012. At the same time, most states now have new governors who are going into their initial budgeting cycle. Together, these conditions are contributing to an environment in which major innovations in Medicaid cost-control are being actively discussed in many states.

STATES AND ACA ELIGIBILITY EXPANSIONS

State action to modify or expand eligibility in Medicaid or CHIP has been significantly constrained in 2010 by a combination of two factors. First, the maintenance of effort requirements of the ACA effectively prohibit states from reducing eligibility standards and processes until 2019. Meanwhile, the ongoing budget challenges states are dealing with have reduced activity to expand eligibility to large populations. However, some states have taken steps to increase eligibility for public programs because of the emergence of important new opportunities for states with state-funded coverage programs to convert those programs to federally matched Medicaid programs.

The ACA provided an option for states to cover adults without children, a primary population targeted by the 2014 Medicaid expansion, under the Medicaid state plan starting in 2010. Under the ACA, states are authorized to extend coverage without a waiver and therefore without demonstrating any offsetting savings to the federal government. Although this population will be covered with a significantly enhanced federal matching rate in 2014, states are required to finance any expansion using existing (lower than in 2014) federal matching rates. For this reason, it was most likely that states that exercised the option were doing so to receive federal match for an existing program that was funded with state money separately from the state Medicaid program.[22]

Connecticut was the first state to implement the ACA option. The expansion is expected to cover 47,000 individuals who had been receiving coverage under the state's Charter Oak insurance program. The expansion was announced in June 2010, but was made retroactive to April 1. The state estimated it would save $53 million by July 2011.[23] In July 2010, the District of Columbia became the second Medicaid program to exercise the option, moving a state-funded program known as the Alliance into Medicaid and covering 32,000 individuals. New Jersey also submitted a plan for approval of a similar expansion to adults without children.[24] A few other states have sought to expand coverage to this same group under an 1115 waiver, using the ACA option as an opportunity to use that financing vehicle more flexibly. Washington has sought authority under its existing waiver to cover individuals who are presently covered by the Basic Health Plan. California received approval in late 2010 of an 1115 waiver that authorized a phased-in (by county) expansion of coverage to this population. A number of other states are considering their options based on the ACA option—again, primarily to maximize federal funding opportunities for existing state programs.

The financing changes utilized by states typically had the effect of both enhancing the program for enrollees and creating net savings to the state. For example, in Connecticut and the District of Columbia, benefits were broadened to meet Medicaid minimum requirements.

STATES TAKE ADVANTAGE OF CHIPRA EXPANSIONS

A similar dynamic is taking place based on a new opportunity for states in CHIPRA. Enacted and signed into law in 2009, CHIPRA gives states the option to cover legal immigrant children and pregnant women, eliminating the five-year bar

created by the 1996 Personal Responsibility and Work Opportunity Reconciliation Act (PRWORA). Effective April 1, 2009, states that offered state-funded coverage for legal immigrants and pregnant women could use federal funds, and other states could expand eligibility and receive federal funds. In 2010, 23 states adopted or planned to adopt in 2011 this CHIPRA option. Most of these states previously covered the immigrants who qualify (pregnant women or children) using state-only funds.[25]

STATES, CHIPRA AND ENROLLMENT STRATEGIES

CHIPRA provides states with a significant set of tools to enhance and maximize enrollment and retention of children in CHIP and Medicaid coverage. Implementing these tools and incentives has been a high priority of the Obama administration and, in general, states were very active in this arena in 2010. A quote from an article published in *Health Affairs* by U.S. Health and Human Services Secretary Kathleen Sebelius portrays state activity under CHIPRA:

> *"Despite the economic downturn, in the year and a half since CHIPRA was enacted, more than half of the states have embraced these opportunities and used the new tools to enroll more children and improve their children's coverage programs. In particular: (1) Sixteen states have expanded income eligibility levels in their CHIP or Medicaid programs, or both. (2) Twenty-one states have taken steps to further streamline their enrollment and renewal processes. (3) Four states have received approval for the new Express Lane Eligibility option in Medicaid or CHIP, or both. (4) Twenty-nine states have elected to lift the five-year waiting period for eligible children or pregnant women who are lawfully residing in the United States. (5) Twenty-eight states are using, with the help of the Centers for Medicare and Medicaid Services (CMS) and the Social Security Administration, a data-matching process to verify citizenship for purposes of Medicaid and CHIP eligibility."*[26]

Table 1: CHIPRA Performance Bonus Enrollment and Retention Strategies

1. Continuous Eligibility
2. Liberalization of Asset or Resource Requirement
3. Elimination of In-person Interviews
4. The Same Application and Renewal Process for Medicaid and CHIP
5. Automatic/Administrative Renewal
6. Presumptive Eligibility for Children
7. Express Lane Eligibility
8. Premium Assistance

One of the powerful incentives in CHIPRA is the Performance Bonus Program for which states can qualify from 2009 to 2013. Intended to encourage states to improve their take-up rates for children in public programs, the performance bonuses provide added federal funding to states to offset the cost of increased Medicaid child enrollment. Children in Medicaid and in CHIP-funded Medicaid expansions are included in the program.[27] To qualify for a performance bonus, states must demonstrate in a given year implementation of at least five of eight specified enrollment and retention strategies. (See Table 1 for a full list of these strategies.)

The Performance Bonus program began in 2009. Nine states received performance bonuses totaling $73 million. In 2010, 15 states qualified for performance bonuses, and received a total of $206 million in bonus payments.

Alabama received by far the highest bonus because its relative enrollment increase – a 36 percent increase over the state 2010 baseline – was substantially higher than the next highest state, Wisconsin, which saw a 23 percent increase. In 2010, Alabama had the following strategies in place: 12-month continuous enrollment; liberalization of the state's asset test; elimination of in-person interview requirements; use of the same application forms for Medicaid and CHIP; and automatic or administrative renewal.[28] Alabama, along with 10 other states, received a "Tier Two" payment, a much higher bonus for states that exceed a 10 percent increase over the state-specific baseline.

STATES AND MEDICAID AGENCIES MOVE AHEAD ON HEALTH REFORM IMPLEMENTATION

Implementation of the provisions and requirements of the ACA is in full swing in many states, although progress has slowed slightly due to the 2010 elections and the need to get new administrations briefed on the issues. In particular, Medicaid agencies are deeply involved in planning efforts in most states, with a particular focus on planning for implementation of the new eligibility requirements of the ACA.

The ACA will require significant interaction between those developing state-based exchanges and staff in the Medicaid and CHIP programs, particularly in the area of eligibility systems and processes.[29] The ACA includes a series of requirements intended to simplify, streamline, and integrate eligibility for Medicaid, CHIP, and exchange-based subsidized insurance. Specifically, the law requires:

- The development of Web portals through which individuals can shop for and compare insurance options;

- The creation of a single application form that covers Medicaid, CHIP, and federal exchange-based subsidies, which can be utilized by applicants online, by mail, over the phone, or in-person; and
- The establishment of electronic data interfaces to exchange information with state and federal agencies.

State exchanges can contract with Medicaid agencies to determine eligibility for the new premium subsidies. Virtually every state is now engaged in a process, supported by the exchange planning grants, to assess technical infrastructure and capacity to meet these requirements and to understand how existing programs like Medicaid and CHIP will integrate with the exchange.[30]

To help pay for needed technology enhancements, HHS published a proposed regulation to make Medicaid eligibility system development eligible for the enhanced federal match (90 percent federal and 10 percent state, up from the previous 50 percent match rate). Taken together with the fact that exchange development will be 100 percent funded by the federal government, most of the development costs for ACA technology will be borne by the federal government.[31]

HHS also announced a competitive process for states to receive "innovator grants" for the design and development of the IT infrastructure necessary to operate exchanges. The grants are intended to reward states that demonstrate leadership in developing innovative components of IT infrastructure, and technology developed under the grants will be made available to other states. The grants will be awarded in early 2011.

In addition to these exchange-related technology challenges, state Medicaid agencies will need to implement a new income eligibility standard know as modified adjusted gross income (MAGI) in 2014. Planning for this change in combination with the Medicaid expansion in the ACA is a high priority for states.[32]

Louisiana's Experience with Express Lane Eligibility

Louisiana is an example of a state that has taken advantage of a new CHIPRA tool to support children's enrollment. CHIPRA authorizes an Express Lane Eligibility option (ELE) for states, through which a state can use information from a state-designated agency to determine whether a child satisfies an eligibility requirement of Medicaid or CHIP. In Louisiana, the Department of Social Services provides information from the State's Supplemental Nutrition Assistance Program (SNAP) that the Department of Health and Hospitals then uses to determine eligibility for Medicaid and CHIP.[33]

Using this process, more than 10,000 Louisiana children were automatically enrolled in the state's Medicaid program on one day in February 2010. Families received their Medicaid cards in the mail and were told that the first time they use the card, they would be asked to confirm that they want to enroll their child in Medicaid.[34]

Louisiana Medicaid and SNAP officials worked together to transfer information about all children receiving SNAP benefits to the Medicaid program. Specifically, the state was able to utilize data about income (as determined by food stamp rules), Social Security numbers, residency, and age to support eligibility determinations for Medicaid and CHIP.[35]

The practice of considering the use of the Medicaid card as legally-required affirmative consent for automatic enrollment into coverage will be replaced going forward. For new SNAP applicants, the state will provide a check-box through which applicants can agree to share their information and be automatically enrolled into Medicaid.[36]

Before the implementation of ELE, Louisiana had prioritized streamlining eligibility in public programs. It was one of nine states to receive CHIPRA performance bonuses in both 2009 and 2010. In 2009, the state had implemented the following strategies: continuous eligibility; liberalization of asset requirements; elimination of in-person interviews; common Medicaid/CHIP applications; and automatic or administrative renewal.

Optimizing eligibility processes in this way can create administrative efficiencies as well. While the volume of eligibility processing has not declined, the state was able to accomplish this innovation in enrollment despite a 12 percent reduction in the Medicaid workforce over the previous two years.[37]

Health reform also presents opportunities for states to improve outdated processes and systems and to undertake an efficient and thoughtful information-gathering process. A number of states have already contemplated that new systems and core functions will need to take into account new reform-related requirements. In Michigan, the state's procurement of a new enrollment vendor included language to authorize the state to use the selected vendor to perform health reform-related functions. Kansas has recently released a request for proposals to develop a new, integrated enrollment system that will be the operational base for enrollment into both Medicaid and the Exchange, and state policymakers are separately assessing how to maximize opportunities to simplify eligibility under the ACA, and how to construct Medicaid benefit packages for expansion populations that will integrate with existing Medicaid and with exchange plans.

CONCLUSION

States have been able to maintain and in some cases expand the availability of Medicaid as a critical source of access to medical care during a period of historically high unemployment. Without these efforts, uninsurance would have increased far more dramatically than it did through 2009 and 2010. As states move forward in to Health Reform implementation, they can build on long-standing efforts in many states.

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STATE OF THE STATES

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Chapter 8: State Efforts Improve Quality, Contain Costs and Improve Health

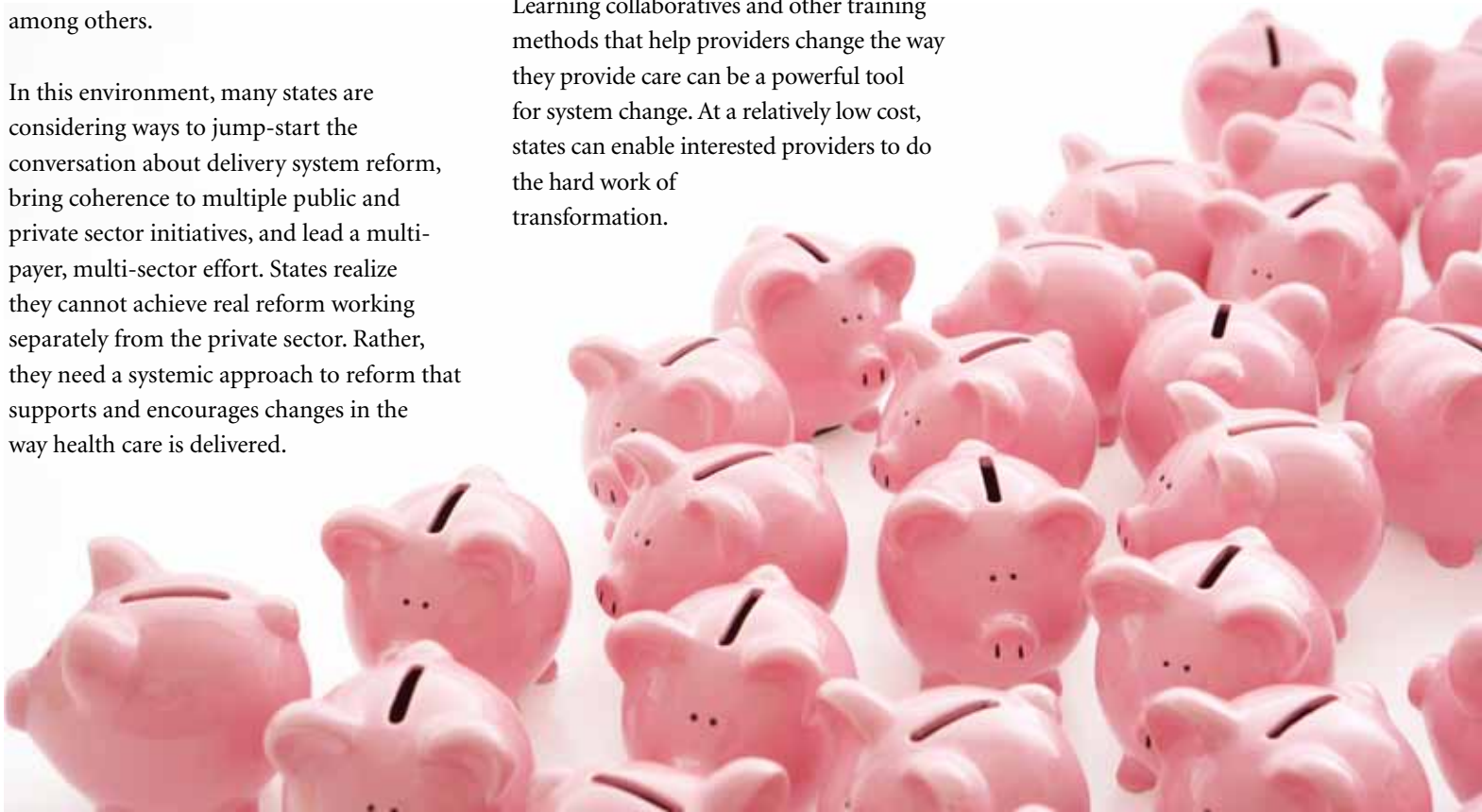
Health care costs continue to escalate in both the public and private sectors. In addition, more information is available showing that much of the health care system is not delivering high quality care in an efficient manner. Finally, there is growing recognition that not only should improved population health be a goal in and of itself, but can lead to a moderation in the overall health cost increase trend. As such, states are undertaking a set of strategies to redesign the delivery system, reform related payment structures, and improve the health of their populations. These efforts include patient-centered medical homes (PCMHs), accountable care organizations (ACOs), payment reform, increased transparency and reporting requirements, population health initiatives, and the adoption of health information technology and exchange, among others.

In this environment, many states are considering ways to jump-start the conversation about delivery system reform, bring coherence to multiple public and private sector initiatives, and lead a multi-payer, multi-sector effort. States realize they cannot achieve real reform working separately from the private sector. Rather, they need a systemic approach to reform that supports and encourages changes in the way health care is delivered.

There are several different roles that states can play in these efforts. They include:

- *Identifying Priorities:* Leadership from the governor's office, cabinet secretaries, or state legislature can send a strong signal to stakeholders about which issues are going to be areas of focus for the state.
- *Influence and Purchasing Power*: State agencies can bring powerful support to priority issues, lending staff and expertise. Their purchasing power can also be leveraged to bring strength and momentum to state-led initiatives.
- *Convening Stakeholders*: The state can bring different parties together, particularly for all-payer initiatives, and coordinate efforts.
- *Coordinating Learning Collaboratives*: Learning collaboratives and other training methods that help providers change the way they provide care can be a powerful tool for system change. At a relatively low cost, states can enable interested providers to do the hard work of transformation.
- *Integrating Different Initiatives*: Many states have a variety of public and private delivery system reform efforts underway at the same time. The state can serve a vital role in bringing these initiatives together, and coordinating their activities to reduce inefficiencies and administrative costs for both providers and plans.

The Patient Protection and Affordable Care Act (ACA) includes funding for many of the delivery system changes states were already contemplating. It also promotes increased data collection and a move to allow the Medicare program to be more innovative in its payment models (in some cases, Medicare will be able to participate



in state-led initiatives). The ACA creates a landscape where states can take the lead in implementation, designing initiatives that best account for their environments, while the federal government will provide support, financial incentives, and some regulation of these efforts.

STATE QUALITY IMPROVEMENT INSTITUTE

For the last several years, many states have been faced with budget difficulties due to the recession, and have been forced to look closely at their health care delivery system to find potential savings. Some of these states have made a commitment to increasing the quality of care delivered, with more coordination across delivery sites, in an effort to drive down costs, especially among the population suffering from chronic diseases. These individuals stand to benefit considerably from more coordinated care, which also can decrease the costs borne by the state.

Throughout 2009 and 2010, a number of states worked together to learn about, design, and implement systemic changes under the auspices of the State Quality Improvement Institute (SQII), a technical assistance partnership between The Commonwealth Fund and AcademyHealth. Eight states—Colorado, Kansas, Massachusetts, Minnesota, Ohio, Oregon, Vermont, and Washington—from a variety of geographic locations and with different levels of previous experience with system change participated.

Participating states developed, refined, and began implementing action plans around specific improvement strategies. The action plan process allowed states the opportunity to bring various stakeholders together and have candid discussions about a strategic vision for the state. States identified priority issues, and engaged stakeholders from various communities (e.g., providers, payers, patients) to establish a plan to address those issues.

In general, states changed their focus from more granular reforms to broader delivery system redesign efforts. This shift reflects the notion that in order to have a meaningful impact on costs and quality, the reforms pursued and put in place need to move beyond small-scale process measures and take a more holistic look at the delivery system, leveraging existing efficiencies, and using state leadership to identify and pursue strategies for meaningful, systemic reform. Important strategies under way in the eight participating states include implementation of medical homes and care coordination initiatives; adoption of population health programs to reduce chronic disease risk in the community; enhanced chronic disease management to improve outcomes and avoid costly hospitalization and avoidable re-hospitalization; and use of data for performance improvement, public reporting, and program evaluation.

PATIENT-CENTERED MEDICAL HOMES

All states participating in the SQII, in addition to a number of other states, have identified patient-centered medical homes (PCMHs) as one potential delivery system reform that can result in better coordinated, more efficient care. More than 30 states have engaged in efforts to implement programs to advance medical homes in Medicaid/CHIP programs, and states working across payers on these initiatives include Colorado, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, New Hampshire, New York, North Carolina, Pennsylvania, Rhode Island, Vermont, Washington, and West Virginia.

In 2008, the American Academy of Family Physicians (AAFP) defined a PCMH as a practice that "integrates patients as active participants in their own health and well-being. Patients are cared for by a physician who leads the medical team that coordinates all aspects of the preventive, acute, and chronic needs of patients using the best available evidence and appropriate technology."[1] While many states use this definition in their PCMH initiatives, some states, such as Maryland,[2] Minnesota,[3,4] New Mexico,[5] and Ohio[6] have moved beyond the AAFP definition to include other providers of primary care, including physicians assistants or nurse practitioners, as possible leaders of PCMHs.

While early iterations of medical homes rewarded providers for achieving various process measures (best exemplified by the NCQA standards),[7] there is a trend among states to move beyond process measures for medical homes and to focus on outcome measures. Often, outcome measures can be linked to overall cost reductions and reductions in preventable hospital and emergency room visits. Minnesota and Oregon both have defined medical homes beyond NCQA standards to focus on outcomes.

Federal Activities: The ACA builds on this state-led momentum in important ways: the law creates the Center for Medicare and Medicaid Innovation (CMMI), and offers several important grant opportunities to states in support of more widespread PCMH planning and implementation. CMMI will test different payment and delivery system reforms designed to reduce costs and increase the quality of care. It will have flexibility in the selection of pilot programs, and those pilots will not have to be budget-neutral during the initial phases. Congress has appropriated $10 billion through 2019 to pursue these projects.[8] Patient-centered medical homes have been designated by ACA as an area of innovation in which CMMI should invest.

An additional hurdle faced by state multi-payer pilots has been the lack of participation from Medicare. On September 16, 2009, Secretary Sebelius announced that the Centers for Medicare & Medicaid Services (CMS) will develop a demonstration project that will enable Medicare to participate in state-based "Advanced Primary Care (APC) models," also known as medical homes. On November 16, 2010, the eight states selected to participate in this demonstration project were announced: "Maine, Vermont, Rhode Island, New York, Pennsylvania, North Carolina, Michigan, and Minnesota will participate in the Multi-Payer Advanced Primary Care Practice Demonstration that will ultimately include up to approximately 1,200 medical homes serving up to one million Medicare beneficiaries."[9]

For the states selected to participate in the demonstration, Medicare will provide an enhanced payment to participating practices for their Medicare patients. In order to quality for the demonstration, the selected states had to have medical home programs underway that:

- Were conducted under state auspices;
- Had promotion of the APC model as its central purpose;
- Included Medicaid and substantial participation by private health plans;
- Had substantial support by primary care providers;
- Included mechanisms for community support of participating practices; and
- Were coordinated with state health promotion and disease prevention efforts.[10]

Additionally, the ACA has several provisions that specifically promote patient-centered medical homes, including the following:

- Section 2703 creates a new Medicaid option to provide certain chronically ill beneficiaries with PCMH services. Such services can include comprehensive care management, care coordination and health promotion, comprehensive transitional care, patient and family support, referral to community and social support services, and use of HIT. The section authorizes waivers of the statewideness and comparability requirements[11] that normally apply to Medicaid. Beginning in January 2011, HHS is directed to give states up to $25 million in planning grants. During the first eight quarters of a state's implementation of this option, the federal government pays 90 percent of the cost of PCMH services.
- Section 3502 authorizes HHS grants to states to develop community health teams to support the PCMH model. These teams support primary care physician practices who, by themselves, may not be equipped to perform the full set of PCMH functions.
- Section 5405 authorizes $120 million in annual funding, during 2011 and 2012, to establish a system of educating primary care providers about new models of practice, including the patient-centered medical home. This section creates a "Primary Care Extension" program that will operate through state and regional hubs, with local "extension agents."[12]

TRANSITIONS OF CARE

Within the process of care delivery, transitions of care—when a patient moves out of one care setting and into another—have been identified as a priority by the federal government and states. Well-functioning transitions of care can reduce preventable hospital readmissions, and lead to improved outcomes for patients.

The STate Action on Avoidable Rehospitalizations (STAAR) initiative is an Institute for Healthcare Improvement (IHI) technical assistance offering initially working in three states: Massachusetts, Michigan, and Washington.[13] In 2010, Ohio became the fourth state to participate in the initiative. STAAR engages clinicians and other providers across varied delivery sites (starting with a hospital-based team, individuals from nursing facilities, ambulatory practices, home health agencies, and patients and family caregivers) with the goal of improving quality of care, the patient experience, and reducing avoidable utilization through a multi-stakeholder process to reduce rehospitalizations. The initiative focuses on the following elements for improvement:

- Assessment of post-discharge needs;
- Teaching and learning;
- Communication at discharge; and
- Timely post-acute follow up.[14]

Using the state as the unit of intervention, STAAR's approach is to provide technical assistance to front-line teams of providers working to improve the transition out of the hospital, as well as improving the reception of the patient into the next setting of care. STAAR's focus on this component of the transition separates it from other interventions, which mainly seek to enhance transitional services offered by the hospital.

Amy Boutwell, director of health policy strategy at IHI and the co-principal investigator of the initiative, explains that STAAR's multi-tiered strategy requires working at the hospital, community, and state level. Dr. Boutwell notes that at the hospital level, elements of the STAAR initiative include: improving the transition out of the hospital for all patients, measuring and tracking 30-day readmission rates, and understanding the financial implications of reducing rehospitalizations. At the community-level, STAAR engages organizations across the continuum to collaborate on improving care, partners with non-clinical community-based services, addresses the lack of IT connectivity, clarifies who "owns" coordination, engages patient advocates, and ensures that post-acute providers are able to detect and manage clinical changes. STAAR also develops common communication and education tools. Finally, at the state level, STAAR works to develop population-based rehospitalization data, convene all-payer discussions to explore coordinated action, link with efforts to expand coverage, engage patients, improve HIT infrastructure, establish medical homes, contain costs, and establish a state strategy, using regulatory levers.[15]

While the STAAR initiative is just one example of an on-going care transition program, it provides a strong model for states to consider as they seek to improve transitions of care for patients. States can also learn from the ongoing Medicare demonstration, the Community-Based Care Transition Program,[16] and other leading care transitions programs.[17]

Federal Activities: As part of the ACA, Medicare will begin implementing its Community-Based Care Transitions Program in 2011, and the demonstration will run for five years. This program provides "$500 million to collaborative partnerships between hospitals and community-based organizations designed to meet the goal of implementing evidence-based care transitions services for Medicare beneficiaries at high risk for hospital readmission."[18]

HEALTH INFORMATION TECHNOLOGY AND HEALTH INFORMATION EXCHANGE

A considerable amount of energy and resources are focused on health information technology (HIT) and health information exchange (HIE) at both the state and federal level. The federal Office of the National Coordinator (ONC) has provided numerous opportunities to states through the American Recovery and Reinvestment Act (ARRA), which was signed into law February 17, 2009. The HITECH (Health Information Technology for Economic and Clinical Health) Act within ARRA provides states with substantial funding to support health information technology investment.

Some states, like Massachusetts, already had legislation or strategic plans in place to support the adoption of HIT before the passage of these federal provisions. In 2008, the state passed Chapter 305, a bill to promote "cost containment, transparency and efficiency in the delivery of quality health care, and include a goal to implement electronic health records (EHR) in all provider settings by the end of 2014."[19] This legislation positioned the state to begin the process of creating an organizational structure to support HIT. That structure includes the establishment of Massachusetts eHealth Initiative (MeHI) to coordinate HIT efforts in the commonwealth.

MeHI released its Health Information Technology Strategic Plan in 2010, which outlines Massachusetts' vision, goals, and strategies around HIT; the plan outlines four goals and the six strategies to achieve those goals. Through the use of HIT, Massachusetts hopes to improve access to comprehensive coordinated care, improve the quality and safety of care (using evidence-based decision support applications), slow the growth of spending by taking advantage of the efficiencies created by HIT and its use, and employ health information exchange to undertake population health efforts. Some of the strategies that will be used to achieve these goals include establishing a multi-stakeholder governance structure and a robust privacy framework, implementing interoperable EHRs in all types of clinical settings, developing and implementing a statewide HIE, creating and training a workforce capable of operating in an HIT environment, and monitoring success.[20]

In Oregon, the Health Information Technology Oversight Council (HITOC) was legislatively established in 2009. HITOC is the coordination body for Oregon's public and private efforts to support HIT and HIE statewide. "[HITOC] is charged with developing a statewide strategic plan for electronic health information exchange, coordinating public and private efforts to increase adoption of electronic health records, setting technology standards, ensuring privacy and security controls, and creating a sustainable business plan to support meaningful use of health information technology to lower costs and improve quality of care."[21] There are 11 members of HITOC, all appointed by the governor. Members come from across the state, both from the public and private sector. Additionally, HITOC has created three workgroups—Finance, Legal and Policy, and Technology—that will study these issues in-depth and deliver recommendations to the full Council in September 2011. The council has an active Consumer Advisory Panel, reflecting the state's recognition that, in order to have a successful HIE, the public has to be willing to consent to having their data shared.[22]

Rhode Island is another leading state in implementing a statewide HIE. The state received a $5 million demonstration contract from the Agency for Healthcare Research and Quality to design and implement a statewide HIE, called current*care*. Individuals voluntarily sign up for the program. At that time, their medical information—currently only lab results, although the system will expand to include more information—can be shared across authenticated providers in the state through a secure HIE network. Only providers involved in delivering ongoing care to specific patients can access their medical record, except for the case of emergencies, in which any doctor providing care will be allowed access. Patients can request to see the log of providers who have viewed their information, adding an extra layer of engagement and oversight to the system.[23]

While these are just a few of the states that have developed HIT and HIE infrastructures, all states are in the process of undertaking such work, and the federal government has awarded funding to the states to support these efforts. In February and March 2010, ONC announced funding to all 50 states, the District of Columbia, and eligible territories through the State HIE Cooperative Agreement Program. Some states elected for the funding to be awarded to a state-designated entity, as opposed to a state agency. This program is designed to support states as they develop the capacity necessary to exchange information within their state and across states.[24]

The application process required states to identify a state HIT coordinator, who will have a leadership role in the design and development of HIE in their state. Participating states will also be expected to use their authority and resources to:

- Develop and implement up-to-date privacy and security requirements for HIE within and across state borders;
- Develop state-level directories and technical services to enable interoperability within and across states;
- Coordinate with Medicaid and state public health programs to enable information exchange and support monitoring of provider participation in HIE;
- Remove barriers that may hinder effective HIE, particularly those related to interoperability across laboratories, hospitals, clinician offices, health plans and other health information exchange partners;
- Ensure an effective model for HIE governance and accountability is in place; and
- Convene health care stakeholders to build trust in and support for a statewide approach to HIE.[25]

States then developed and submitted strategic plans about the design, implementation, and evaluation of their HIEs to the ONC. ONC will work closely with the states over the coming years, offering "program direction and technical assistance to help recipients in advancing HIE across all providers, as well as in enhancing the effectiveness and relevance of the state HIE initiatives to local and national health improvement goals."[26]

For example, New York's eHealth Collaborative (NYeHC) works with the New York Department of Health to develop common policies, standards, and technical approaches for the state's HIT efforts. As of December 2010, New York has 12 regional health information organizations (RHIOs) across the state; the state has announced plans to link together these existing regional exchanges with some new infrastructure, creating the country's largest HIE. "The proposal was submitted to the Office of the National Coordinator for Health Information Technology (IT). It presented an outline for the use of $129 million in state and federal funds in building and implementing a statewide HIE network that could potentially serve hundreds of hospitals, thousands of providers and more than 20 million patients a year."[27]

HIEs are highly dependent upon the availability of patients' medical records in electronic form. In order to support the expansion of EHRs, Medicaid and Medicare providers are eligible for financial incentives to support their adoption and meaningful use. The incentives can be as high as $44,000 (through Medicare) and $63,750 (through Medicaid) per clinician. In order to qualify for these enhanced payments, clinicians must use EHRs to improve the quality of the care they deliver as evaluated by both process and outcome measures. They must incorporate the meaningful use elements at rates set by the federal government in order to qualify for the incentive payments, and will have to report data about their quality of care, which will eventually be available to the public. [28]

On July 13, 2010, ONC released its final regulations defining the meaningful use of electronic health records (EHRs). The meaningful use elements were classified into core objectives and additional tasks. This delineation was made in response to comments from stakeholders that the requirements in the initial rule were too difficult for providers to meet within the timeline provided. Core objectives are basic tasks and functions of an EHR that allow for its use to support improvements in the delivery of care.

"As a start, these include the tasks essential to creating any medical record:

- Entry of basic data including patients' vital signs and demographics, active medications and allergies, up-to-date problem lists of current and active diagnoses, and smoking status;
- Using clinical decision support software and tools designed to improve the safety, quality, and efficiency of care through better decision making by clinicians and avoidance of preventable errors;
- Using EHRs to enter clinical orders and medication prescriptions; and
- Providing patients with electronic versions of their health information."[29]

Beyond these core objectives are the additional tasks created by the final rule. Providers will choose five tasks from the list of 10 that they then will implement in 2011 – 2012. The hope is that this flexibility in implementation and "meaningful use" requirements will allow more providers to meet the requirements of the final rule within the required timeline.

VALUE MEASUREMENT AND TRANSPARENCY

For a many years, various states have been collecting data to measure health plan and provider (primarily hospital and nursing home) performance and disseminating that information to the public. The primary focus has been twofold: to educate consumers and employers in order to help them be more savvy purchasers and users of health care, and to encourage internal quality improvement on the part of health plans and providers. Increasingly, states are concentrating on transparency and reporting of health care cost and quality information as part of their delivery system reform efforts, including a focus on the use of all-payer claims databases (APCDs) to support broad data collection and analysis (see the box titled "All-Payer Claims Databases"). While the following information about several states comprises only a small number of examples of activities that states have underway, they illustrate how measurement is critical for quality improvement efforts.

All-Payer Claims Databases (APCDs)

While there is a wide range of ongoing efforts in states focusing on ways to increase transparency, an APCD is a data-collection tool that is increasingly gaining interest among state policymakers and has considerable potential to inform the health care delivery process.

The National Association of Health Data Organizations (NAHDO) and the APCD Council (formerly the Regional All Payer Healthcare Information Council) have defined APCDs as "databases, created by state mandate, that typically include data derived from medical, eligibility, provider, pharmacy, and/or dental files from private and public payers."[30] The information available through APCDs is valuable to an array of stakeholders, including policymakers, consumers, employers, providers, health plans/payers, and researchers.

Policymakers (Medicaid, public health agency, insurance department, etc.)

- Helps health care policymakers identify communities that provide cost-effective care and learn from their successes.
- Allows for targeted population health initiatives.
- Allows for assessment of health care disparities and for targeted interventions.
- Informs the design and evaluation of payment reform models, including medical homes and accountable care organizations.

Consumers

- Provides access to information, helping consumers and their health care providers make informed decisions about the cost and quality of care.

Employers

- Helps businesses know where they stand when compared with their peers, with respect to the cost and covered services of their health insurance policies, and to work with plans to improve the available options.

Providers

- Supports provider efforts to design targeted quality improvement initiatives.
- Enables providers to compare their own performance with those of their peers.

Health Plans/Payers

- Helps identify utilization patterns and determination of rates.
- Assists with benefit design and planning.

Researchers (public policy, academic, etc.)

- Fills the void of information from the most common setting of care (primary care) and for the majority of the population (those with commercial insurance).[31]

Eleven states had existing APCDs as of November 2010 (Kansas, Maine, Maryland, Massachusetts, Minnesota, New Hampshire, Tennessee, Utah, Vermont, Washington, and Wisconsin).[32] Two (Colorado and Oregon) are in the implementation stage, and a number of others have expressed a strong interest in the concept. One state, Rhode Island, has legislation enacted but no funding.[33]

There are several different governance structures states have used when creating APCDs. In Maine, an independent executive agency, the Maine Health Data Organization, was established to oversee and run the state's APCD. New Hampshire is an example of a state with shared authority between the Department of Health and Human Services and the Department of Insurance. In other states, like Massachusetts and Tennessee, the APCD resides in an existing government agency that is related to the state's hospital reporting process. Vermont houses its APCD in its Department of Banking, Insurance, Securities, and Health Care Administration—the agency that has oversight of carriers in the state.[34]

Colorado: Colorado has established the Center for Improving Value in Health Care (CIVHC) after recognizing the need for system-wide reforms to its health care system. It focuses on enhancing the consumer experience of the health care system, improving quality, containing costs, and improving overall population health. One of the specific goals recommended by its Data and Transparency Advisory Group is to "increase transparency and accountability in Colorado's health care system by making comparative cost, quality and safety data for all providers, health plans and medical facilities available to consumers and businesses statewide."[35]

CIVHC has been leading that state's efforts to develop an all-payer claims database which will allow the Center to meet one of its legislative charges to "… collect, aggregate, distribute, and publicly report performance data on quality, health outcomes, health disparities, cost, utilization, and pricing in a manner accessible for consumers, public and private purchasers, providers, and policymakers."[36]

Massachusetts: In its *Massachusetts Health Care Cost Trends 2010 Final Report*, the Division of Health Care Finance and Policy (DHCFP) presented both immediate and long-term strategies to address health care cost growth in that state. The long-term framework included five approaches:

- Oversight and direction provided by an independent public entity;
- Payment reform involving all payers;
- Support for health care delivery system redesign and system-wide adoption of health information technology;
- Transparency of cost and quality information; and
- Investment in evidence-based public health and wellness initiatives.[37]

In addition to efforts to implement an all-payer claims database, other examples of work in Massachusetts related to data transparency and performance measurement include the publication of a quarterly report presenting an overview of that state's health care landscape using information collected from providers, health plans, and government agencies and through individual and employer surveys as well as three new reports about preventable/avoidable emergency department use, potentially preventable hospitalizations, and primary care supply and access in Massachusetts.[38]

David Morales, Commissioner of DHCFP, notes that the Division's two key objectives this year are to "continue to produce reputable, transparent, high-quality work that demystifies the [Massachusetts] health care delivery system and informs discussions about health care costs and quality at all levels, and publish the Division's information in a manner that is easily accessible, readable, and understandable to a broader audience."[39]

Minnesota: For several years, Minnesota has been using data collection and reporting to support a variety of legislatively required activities including public reporting of a standardized set of quality measures for hospitals and physician clinics, payment for care coordination, developing the definitions of a variety of "baskets of care," consumer engagement strategies, and the creation of a provider peer grouping system.[40]

Minnesota is using its all-payer claims database to support its provider peer grouping initiative.[41] The state's goal is to have the information it obtains through this peer grouping program incent providers to improve their quality, for health insurance companies to create products that reward consumers for choosing providers that deliver high quality care at a low cost, and to allow consumers public access to the information, so they can choose high quality, low cost providers. Minnesota is providing information on total care as well as for care related to specific conditions (pneumonia, diabetes, asthma, coronary artery disease, total knee replacement, and heart failure). Using quality measures, utilization of health services data and pricing information are collected and analyzed. The state reviews the data, and initially releases it to provider practices, allowing them to review their data and grouping for accuracy. Practices will have the opportunity to appeal to the state, if they feel that the data are inaccurate. After this confidential review period, the information will become publicly available. Total care reports will be shared with providers in the summer of 2011, and will be public by the end of 2011. Condition-specific care reports will be shared with providers in the fall of 2011, and will also be publicly available by the end of 2011.[42]

Ohio: The Ohio Health Care Coverage and Quality Council was created initially by former Governor Ted Strickland through an executive order and subsequently was established legislatively in July 2009.[43] Its charge is to improve the coverage, cost, and quality of Ohio's health insurance and health care system. To accomplish those goals, it set up four task forces focused on payment reform; medical homes; consumer engagement, and health information technology. (Note: The Council added an additional task force on health benefit exchanges following the enactment of the ACA.) All of the consequent activities that underpin the delivery and payment system reforms envisioned by the Council are supported by performance measurement and the increased use of data. For example, at its recent Payment Reform Summit, participants agreed that "…payment reform should be accompanied by greater transparency and public reporting of data."[44] In addition, the Multi-Payer Enhanced Primary Care Work Group developed recommendations for the evaluation metrics to be used for measuring improved quality of care and for strategies to most appropriately engage consumers in their medical homes.[45]

Federal Activities: The ACA includes several provisions that will support additional efforts to increase transparency. The federal law has the potential to increase the amount of information publicly available that can be leveraged by states to improve quality and reform their delivery systems:

- *Performance measures for both providers and plans.* Sections 3013 through 3015 of the ACA direct HHS to establish performance measures of quality and efficiency for plans and providers, to collect such data, and to make them publicly available.
- *Physicians.* Sections 3002, 10327, 10331, and 10332 of the ACA strengthen the current system for evaluating quality and efficiency of physician performance under Medicare, giving physicians increased financial incentives to participate in that system, and making information available to consumers on a "Physician Compare" website operated by HHS. Information from other payers can be incorporated into this system, which HHS is authorized to extend to other providers.
- *Hospitals.* Section 3001 establishes a pay-for-performance system for Medicare hospitals, through which quality and efficiency are rewarded with higher payment levels and the public learns about hospital performance on HHS's "Hospital Compare" website. Section 3025 adds to this website information about the rate at which patients served by particular hospitals are re-hospitalized soon after discharge. In addition, the new Public Health Service Act §2718(e), added by ACA Section 10101(f), requires hospitals to inform the public about their standard charges, as defined by HHS.
- *Health Plans.* ACA Sections 2713(e)(3) (added by Section 10104), 2715A (added by Section 10101), 2717, and 2718 require health plans (including self-insured group plans) to provide a broad range

of public information. These provisions require disclosure, in plain language, of claims payment policies, enrollment and disenrollment statistics, claim denial rates, rating practices, in-network and out-of-network cost-sharing, medical loss ratios, and initiatives to reform health care delivery through care coordination, management of chronic illness, prevention, and other measures that improve health outcomes. Section 2715 requires health plans to describe covered benefits and out-of-pocket costs using an easily understood, readily-compared format developed by HHS.

- *Medical Reimbursement Data Centers.* New Public Health Service Act Section 2794(c)(1)(C) and Section 2794(d), added by ACA Section 10101(i), provide for the establishment of Medical Reimbursement Data Centers. Such Centers can be funded from the ACA's $250 million appropriation slated for building state capacity to analyze insurance premiums. These new data centers are either academic or nonprofit institutions that collect, analyze, and report information about local payment rates, including information to help consumers understand the amounts that health care providers charge for particular services.[46]

PUBLIC HEALTH

Many states are considering what the role of public health will be in a transformed health system. Likewise, particularly in light of health reform efforts, there is an acknowledgement that the public health system should leverage the ACA to effectively and strategically partner with the health care system to improve access to quality, affordable, and integrated care while also promoting chronic disease prevention and improving the population's health. The challenges presented by an unhealthy population with staggering levels of preventable chronic diseases such as diabetes and heart disease are prompting states to reconsider how public health systems should be structured to help individuals adopt healthier lifestyles. There is also a greater emphasis on encouraging policymakers to implement policies based on the best available evidence.

Colorado and Washington are examples of two states that are working toward transforming their public health efforts, approaching them from a more systemic perspective. The state of Washington has recently undertaken a new initiative—*The Agenda for Change*—focused on reshaping the governmental public health system in the state. The agenda has three primary pillars:

- Assure that the most effective and important elements of prevention, early detection, and swift responses are incorporated into the state's communicable disease capacity.
- Encourage policy and system efforts to foster communities and environments that promote healthy starts and ongoing wellness.
- Effectively and strategically partner with the health care system.

The *Agenda* is the state's strategic road map, showing how various agencies within the Department of Health unify and connect to local, state, and federal partners, as well as to private sector partners. The key elements guiding the new way in which the department conducts business include retraining the public health workforce, modifying and modernizing business practices, and developing long-term strategies for predictable and appropriate levels of financing. [47]

Colorado is one of four states across the country testing a chronic disease prevention integration model under a demonstration project through the Centers for Disease Control and Prevention (CDC). One of the most significant strategies that the state has pursued under this project is moving away from "categorical" approaches (e.g., tobacco; HIV). The Department of Health and Environment is structuring its Prevention Services Division around functions rather than disease categories to allow the flexibility to respond to emerging public health issues that cross categorical program boundaries. A new branch has been established to develop and implement policy and environmental change related to tobacco use and obesity. Additionally, a new Health Systems Unit was also developed to respond to ACA and the need to identify the public health role in the new environment of health reform. This unit is taking a comprehensive approach to health outcomes and incorporating similar practices that are used by private sector plans.[48]

Federal Activities: The ACA contains a wide array of provisions related to public health promotion, and many grant opportunities for states.[49] States will need to think strategically about applying for such grants, and closely monitor the dates associated with each opportunity, in order to ensure that they are well-positioned to apply for the available funding. Some of these opportunities include:

- *Medicaid Chronic Disease Incentive Payment Program*—HHS will award grants to states to test approaches that may encourage behavior modification for healthy lifestyles among Medicaid enrollees and to determine scalable solutions. HHS will develop program criteria and will conduct an education/outreach campaign to promote states' awareness of the grant program. $100 million has been appropriated for a five-year period beginning January 1, 2011 (ACA Section 4108).
- *Community Transformation Grants*—A program designed to promote evidence-based community preventive health activities is intended to reduce chronic disease rates and address health disparities (ACA Section 4201).
- *Healthy Aging, Living Well Public Health Grant Program*—Grants for pilot programs to provide public health

community interventions, referrals, and screenings for heart disease, stroke, and diabetes for individuals between ages 55 and 64 (ACA Section 4202).

CONCLUSION

The ACA includes many provisions to encourage local and regional experimentation and improvement in care delivery. Ultimately, these incentives will only be effective if state and local leaders are able to bring together multiple stakeholders in the health care market to promote positive change. This will require enormous effort. Not only do multiple groups need to be convinced of the need for change, but they must be convinced to move in a similar direction. Much greater coordination among the vast array of existing quality programs will be essential in addition to coming together around new ideas.

States are uniquely well-positioned to lead delivery system reform work. This report outlines several reasons for this, including the unique ability of state officials to take the lead and set priorities, a state's ability to get the attention of and convene stakeholders, its significant regulatory power and anti-trust exemption, and its substantial purchasing power as a buyer of health services. Many states have not taken on this mantel of leadership, letting the market guide the direction of the health care system. But with the new tools in the ACA and the growing sense of urgency caused by continued cost increases, a growing number of states will make use of their considerable power to influence to help achieve delivery system reform. Indeed—as this report shows—many states have done just that.

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STATE OF THE STATES

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Looking Forward

While Congress continues to debate the merits of the ACA, the real action will be at the state level. States will make critical decisions about the policy goals and strategies that will be carried out in the health care sector in 2011 and beyond. In doing so, they will lay the foundation not only for the immediate implementation of reform but for the direction of the health care system for years to come. Yet, states have many daunting tasks before them as they move into 2011 and how they deal with four key issues will be telling. The trends to watch in 2011 are:

New Governors and Top Policymakers—In the twenty-six states that have new governors, early 2011 will be marked by a spate of announcements of new state agency heads and key policy staff. Health policymakers will be watching the new state leaders, whose experience, perspective, and politics will have enormous influence over the way health reform is implemented. New governors will make their mark on state-based health reform in setting their own policy priorities, identifying their state leaders, and responding to federal timelines.

Difficult Budgetary Decisions—Budgets concerns will remain a key challenge for states. States used almost every budgetary tool available to them in 2010 to meet budget shortfalls averaging almost 20 percent, and similar shortfalls for 2011 are predicted due to slowly increasing revenues and the reduction of the federal matching rate in their Medicaid programs. Although states will receive some funding as a result of the Patient Protection and Affordable Care Act (ACA), additional new resources are unlikely to appear from a cash-strapped and increasingly conservative Congress.

Responding to Rising Costs—The rising cost of health care is an issue that affects not only state budgets, but the pocketbooks of American families and businesses. In response, some states may pass new laws regulating the increase of health insurance premiums and most will use federal funding to improve their rate review procedures. In addition, many will work with communities and key stakeholders to achieve delivery system and payment reforms that have the potential to restrain cost growth and improve the quality of care. States will also contemplate public health strategies and begin to consider how exchanges can be used as a tool for cost containment.

Reaction to ACA Implementation Deadlines — In early 2011, the eyes of the health policy world also will be on state legislatures. It will be a critical year for establishing and working on initial implementation of exchanges. Many will enact exchange authorizing legislation that will set those states on a path to hosting a state-based exchange. This legislation will likely establish the governance of the exchange and set a few basic policy ground rules. Most states will leave the specifics of implementation to the board or agency tasked with implementation. A few may decide not to establish an exchange and others may decide to wait until 2012 to raise the issue with the legislature. Those states will use 2011 to gather information and begin to map out a strategy for how to respond to reform. The states that simply wait, with minimal planning or only limited efforts to engage proactively with the federal reform legislation, may quickly find they are falling behind. It will be difficult for those states to catch up and successfully implement a state-based exchange.