State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals

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Executive Summary

The Patient Protection and Affordable Care Act (PPACA) gives states many new tools and resources with which to pursue longstanding health policy goals.

State officials seeking to maximize coverage and access to care can take advantage of PPACA's new options to establish eligibility for Medicaid and subsidies in the exchange. These options use highly streamlined methods to help the uninsured receive coverage while lowering state administrative costs. States could also implement the Basic Health Program option for residents who are ineligible for Medicaid (because of income or a recent grant of legal immigration status) but whose incomes do not exceed 200 percent of the federal poverty level (FPL). Such an option could make coverage and care much more affordable for low-income residents than under the standard subsidy system established by PPACA, while the federal government would still pay all subsidy costs. States could also consider supplementing PPACA's subsidies to improve affordability of coverage and care to low- and moderate-income residents.

States interested in reforming health insurance to function more like a traditional market can give consumers much improved information about the services offered by particular providers as well as health coverage options. If state officials decide to operate a health insurance exchange rather than to leave that function to the federal government, state policymakers can structure the exchange to make a wide range of health plan choices available to as many state residents and employers as possible. In such a system, the consumer, not the employer, selects his or her own health plan, and those who want more expensive coverage must pay the resulting increase in premiums. Private health plans will thus have an incentive to offer consumers the services they want at a price they can afford. Insurers' desire for market share will drive innovation that meets customers' needs, as occurs in smoothly functioning markets.

State officials who want to hold insurers accountable for providing consumers with high-quality, affordable health coverage could:

- Dramatically increase their capacity to detect insurance company misbehavior by carefully analyzing the new data that PPACA requires insurers to provide;
- Permit only insurers that comply with reasonable state requirements related to cost and consumer protection to offer plans in the exchange;
- Educate the public and health plans about insurers' potential liability for treble damages under the False Claims Act, empowering public agencies to pursue such claims and to use the proceeds to fund further enforcement efforts;
- Use available federal grants to fund independent consumer assistance programs to help consumers vindicate their individual rights and to bring systemic problems to the attention of the public and responsible state officials;
- Use new federal grants to support rate review as well as leverage the exchange to supply administrative resources needed for enforcement of PPACA's insurance market reforms; and
- Establish a publicly administered plan to compete in the exchange. Such a plan would include, as its core membership, Medicaid beneficiaries, enrollees in the Children's Health Insurance Program (CHIP), as well as public employees and retirees. This critical mass could make it feasible for a state's providers to implement delivery system reforms that slow cost growth while improving quality. The resulting plan could be offered in the exchange, increasing competition for private insurers.

Not all state officials share the same health policy goals. But most state health care leaders will find that they can use PPACA to make significant progress toward meeting objectives they have long viewed as important to the residents of their state.

State policymakers interested in restructuring health care delivery and financing to slow cost growth while improving quality have a host of opportunities under PPACA. States can:

- Implement Medicaid demonstration projects to test new reimbursement methods that reward value, rather than volume;
- For public employee coverage, use new Medicare methods to base payment on provider performance;
- Incorporate Medicare, Medicaid, and private coverage into multi-payor 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 payors 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.

States interested in reducing budget deficits could achieve savings on public employee health costs by participating in federal reinsurance subsidies for early retirees. Significant General Fund savings could also be achieved, in many states, by substituting federal Medicaid dollars for current state and local spending on adults' indigent care, mental health services, social services, and other state-funded programs that, for the first time, will potentially fit under Medicaid's umbrella. At the same time, states that now cover some adults with incomes above 138 percent FPL could shift such adults into programs where the subsidies are funded entirely by the federal government, either in the exchange or through the Basic Health Program option. Such a shift could end the need for states to subsidize these adults' coverage. Finally, Medicaid cost growth could be slowed by taking advantage of PPACA's new options to fully integrate Medicare and Medicaid financing and services for dual eligibles. Coordinated care that smoothly integrates the two funding streams, eliminating current incentives for cost-shifting and provider gaming of multiple payors, offers the possibility of significant health status gains for beneficiaries and cost savings for states.

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Overview of Report

The enactment of the Patient Protection and Affordable Care Act (PPACA) gives states new responsibilities and choices for reforming health care and health coverage. Even at this early date, scores of detailed reports have already analyzed many aspects of the legislation. Rather than itemize everything that PPACA requires or permits, this paper seeks to help state officials by synthesizing the details of federal reform into several broad themes:

- Maximizing residents' health coverage and access to care;
- Helping health insurance function more like a traditional market;
- Holding insurers accountable for providing high-quality coverage at 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.

This report excludes a number of important topics. For example, it does not examine the potential for using PPACA to facilitate reform of long-term care, which is a critically important issue that is a complex world unto itself.[1] Also outside this report are PPACA's workforce investments. This report cannot possibly do justice to these issues while simultaneously exploring the themes listed above.

This report primarily explores options that states can implement by 2014. Left for another day is a detailed examination of such issues as the implications for states of federal allotments under the Children's Health Insurance Program (CHIP) that expire after federal fiscal year (FY) 2015, unless Congress reauthorizes CHIP; states' option, beginning in 2017, to give large firms access to coverage sold through a health insurance exchange; and states' ability, starting in 2017, to obtain waivers that allow radically different reform approaches than those embodied in PPACA.[2]

Limits on administrative resources will make it difficult for many states to go beyond the minimum steps needed to comply with federal requirements. But in states where more than basic compliance is possible, this report encourages officials to be proactive and selective in identifying the additional policy priorities they seek to accomplish. A careful focus on the "big picture" policy goals that most matter to a state can help decision-makers sort through the mass of detail in the new federal law, focus on the elements that offer the greatest promise for accomplishing the state's priorities, and chart a course forward that is coherent and effective. By showing how particular policy approaches would use PPACA to achieve specified state goals, this report seeks to help state leaders take advantage of the new federal law to accomplish longstanding policy objectives, which vary from state to state.

Key Features of National Health Reform

A comprehensive explanation of PPACA is beyond the scope of this paper and is available elsewhere.[3] However, to place in context the key choices facing states, this section of the paper begins by describing the new law's basic structure. It then provides a detailed explanation of several parts of the new federal law that may be particularly important to states—namely, the federal rules governing health insurance exchanges; the interaction between Medicaid and coverage subsidies in the exchange; and a new Center for Medicare and Medicaid Innovation that will be housed at the Centers for Medicare and Medicaid Services (CMS).

A basic overview

Some provisions go into effect this calendar year:

- *Medicaid and CHIP*
  - States may expand Medicaid to cover childless adults up to 138[4] percent of the federal poverty level (FPL),[5] with income determined based on federal income tax rules. Before PPACA, such adults' coverage required federal waivers, which were subject to federal budget neutrality requirements. Now, an ordinary Medicaid State Plan Amendment suffices to make these adults eligible. Standard Medicaid matching percentages apply before 2014.
  - As a general rule, states may not cut back prior eligibility for Medicaid until exchanges become operational in 2014. CHIP eligibility must be maintained through 2019. However, if a state's federal CHIP allotment is exhausted, eligible children may be enrolled in subsidized coverage offered through the exchange.
  - PPACA continues CHIP funding through 2015. Beginning with federal fiscal year 2016, federal matching rates under CHIP increase by 23 percentage points, but no additional federal CHIP allotments are available without further federal legislation.
- *Other subsidies to facilitate coverage and access to care*
  - Until 2014, $5 billion is available for high-risk pools that cover previously uninsured individuals with preexisting conditions.
  - Small firms with 25 or fewer workers may qualify for tax credits helping them purchase coverage.
  - Community health centers receive an additional $11 billion in appropriated funding for program operations.
  - Federal grants are available for home visitation, school-based health centers, and other services.
- *Health care delivery system reforms*
  - To qualify for the above-described, federally-funded reinsurance for early retirees, an employer plan must implement reforms that generate savings on care provided to the chronically ill and enrollees with high-cost conditions.
  - Grants and other new federal initiatives encourage a broad range of innovations that seek to slow growth in health care costs while improving quality. Such innovations include patient-centered medical homes; reimbursement reforms to incentivize safe, effective, high-quality care; accountable care organizations; better integration of care for individuals who receive both Medicaid and Medicare; efforts to increase prevention, promote wellness, and improve public health; etc.
- *Insurance market reforms*
  - Insurers may not discriminate against children based on preexisting conditions.
  - Lifetime limits and unreasonable[6] annual limits on coverage are prohibited.
  - Health insurance policies cannot be cancelled because consumers get sick and use care, unless such policies were obtained through fraud or deception.
  - Private insurers offering dependent coverage must extend such offers to adult children through age 26.
  - State offices that provide health consumer assistance can qualify for federal grants to help individuals and document systemic problems.
  - HHS and states will establish and begin implementing a process for reviewing insurance premiums, identifying unreasonable increases, and providing public notice about the insurer's justification for such increases.
  - Applying a standard format for presenting information, HHS establishes a web portal that consumers may use to compare their health coverage options.

Between 2011 and 2014, other provisions become effective. For example:

- As of January 1, 2011, the percentage of premium used to pay for health care—the so-called "medical loss ratio"—must meet or exceed certain thresholds, which vary based on the applicable market. Plans that violate these requirements must refund their excess administrative costs to consumers.
- For calendar years 2013 and 2014, Medicaid reimbursement rates for certain primary care services rise to Medicare levels, and the federal government pays all the resulting cost increase.

As of January 1, 2014, most of PPACA's key architecture becomes operational:

- *Health insurance exchanges* in each state offer health plans to small firms and to individuals, as explained in much more detail below.

- *Subsidized coverage*
  - Medicaid expands to cover all[7] children and non-elderly adults with incomes at or below 138 percent FPL, defined in terms of "Modified Adjusted Gross Income" (MAGI), an eligibility methodology that is based on federal income tax law. The federal government pays 100 percent of the costs for newly eligible adults from 2014 through 2016. After that, the percentage of health care costs paid by the federal government gradually declines to 90 percent in 2020 and beyond.
  - To help consumers afford coverage in the exchange, fully refundable tax credits that can be advanced directly to insurers when premiums are due provide sliding-scale premium subsidies to households with incomes between 138 and 400 percent FPL. Additional subsidies reduce out-of-pocket costs for households with incomes up to 250 percent FPL. Both premium and cost-sharing subsidies are unavailable to individuals who qualify for other forms of public coverage and to people who are offered employer-sponsored insurance (ESI) that they can afford and that meets minimum standards of comprehensiveness.
- *Shared responsibility*
  - As a general rule, individuals must obtain health insurance or pay a tax penalty. Exempt from this mandate are people with incomes below the FPL or the tax filing threshold, individuals who would be required to spend more than 9.8 percent of income for coverage, others for whom purchasing coverage would constitute a hardship (under rules to be promulgated by the U.S. Department of Health and Human Services, or HHS), people with religiously-based conscientious objections to the purchase of health insurance, and certain others.
  - A firm with more than 50 full-time employees must likewise pay penalties if it fails to offer ESI and one or more of such employees use tax credits to enroll in coverage offered through the exchange.
- *Health insurance markets* for individuals and for firms with 100 or fewer employees are reformed in many ways. Although some of these reforms go into effect earlier, all of the following are in place by 2014:
  - Insurers are forbidden from discriminating against adults based on gender or health status, including preexisting conditions. (As noted above, this ban applies to children as of 2010.) Premiums can vary with age, but by no more than a 3 to 1 ratio.
  - Insurers are required to cover federally-specified minimum benefits, including preventive care services (which must be exempt from cost-sharing).
  - Reinsurance and risk adjustment mechanisms provide insurers with additional resources if they disproportionately attract high-cost enrollees.

A more detailed analysis of selected provisions

Three specific issues are so important to states that they warrant a more detailed analysis. These issues involve health insurance exchanges; the interface between Medicaid and the exchange in determining eligibility for Medicaid, CHIP, and the new subsidies created by PPACA; and the new Center for Medicare and Medicaid Innovation that PPACA established within CMS.

PPACA's rules for health insurance exchanges

Basic structure

Responsible entity. An exchange can be operated by a state agency or a state-established, non-profit entity. An exchange can either carry out its responsibilities directly or contract to have one or more functions performed by (a) private corporations that are not affiliated with any health insurers or (b) the state's Medicaid program. Alternatively, the federal government can administer the exchange (either directly or though contract with a non-profit entity) if the state requests that it do so[8] or if the federal government determines that the state will be unable to adequately perform the necessary functions.

Geographic scope. Based on the state's choice, a single exchange can operate statewide; different "subsidiary exchanges" can serve distinct geographic regions within the state; or several states can jointly operate a multi-state exchange.

Populations served. The exchange serves (a) individuals who are U.S. citizens or legally resident immigrants and (b) employees of small firms and their dependents, if such firms choose to use the exchange to provide their workers with health coverage. Before 2016, states decide whether companies using the exchange may have a maximum of 50 or 100 full-time employees. Beginning in 2016, all firms with 100 or fewer workers may use the exchange. Starting in 2017, states have the option of opening the exchange to larger companies. A state can either operate separate exchanges serving individuals and firms—the exchange serving small employers is called a Small Business Health Options Program (SHOP)—or a single exchange for both individual and small group markets.

Although PPACA permits states to combine their individual and small group markets, such a combination is not required to run a single exchange serving both markets. Rather, a state using a single exchange to serve separate group and individual markets would offer the same plans to all enrollees, individual and group.

Funding. The federal government provides grants to cover start-up and other administrative costs through the end of 2014. However, starting on January 1, 2015—the second year of exchange operation—exchanges must raise their own funds. This can be done through surcharging insurance premiums; assessing health plans, employers, or individuals; appropriating state General Fund dollars; or otherwise. Whether

federal or state in origin, administrative funds may not be used for "staff retreats, promotional giveaways, excessive executive compensation, or promotion of Federal or State legislative and regulatory modifications."[9]

Health plans

Qualified health plans. An exchange may offer only "qualified health plans" that it finds satisfy applicable federal requirements. Such requirements include state licensure, coverage of essential benefits, offering packages in the exchange with (at a minimum) silver and gold actuarial values (explained below), premium charges that do not vary based on whether coverage is offered inside exchanges, nondiscriminatory marketing and benefit design, provider participation, health care quality, enrollment procedures, consumer information, and efforts to reduce racial and ethnic disparities. In addition to state-specific plans, two nationwide plans arranged by the federal Office of Personnel Management[10] (at least one of which must be non-profit) will be offered in each state's exchange.[11]

Actuarial value. For both small group and individual enrollees, the exchange can offer plans at four levels of actuarial value (AV). AV is determined by calculating, for an average population, the percentage of health care costs that a plan is likely to pay. Many different combinations of covered benefits and cost-sharing requirements can yield the same actuarial value. AV provides a single number that indicates a general level of comprehensiveness while still leaving room for considerable variation in the details of coverage. The four AV levels in an exchange are as follows:[12]

- Platinum, with an AV of 90 percent. The typical, employer-sponsored Health Maintenance Organization (HMO) has an AV of 93 percent, according to the Congressional Research Service. Such an HMO might offer coverage with—
  - $20 office co-pays;
  - a $250 co-payment for inpatient hospitalization;
  - no deductible; and
  - prescription drug co-pays of $10, $25, and $45 for generics, preferred, and non-preferred name-brand drugs, respectively.[13]
- Gold, with an AV of 80 percent. For example, a typical employer-sponsored Preferred Provider Organization (PPO) would have an AV between 80 and 84 percent with:
  - an annual deductible of $400 per individual and $700 per family;
  - 20 percent co-insurance for in-network office visits, inpatient hospitalization, lab, and x-ray services (and higher co-insurance for out-of-network services);
  - an overall, out-of-pocket maximum of $2,000 per individual and $3,500 per family; and
  - prescription drug co-pays of $10, $25, and $45 for generics, preferred, and non-preferred name brand drugs, respectively.[14]

As another example, a PPO would have an 80 percent AV with:

- an annual deductible of $500 per individual;
- $20 co-pays for in-network office visits;
- 15 percent co-insurance for other in-network services;
- an overall, individual out-of-pocket maximum of $3,500;
- a $75 co-pay for an emergency room visit; and
- a $10 co-payment for generic medication and co-insurance of 25 and 30 percent for preferred and non-preferred name-brand drugs, respectively.[15]

- Silver, with an AV of 70 percent. At this level, a plan could have 20 percent co-insurance, an out-of-pocket maximum of $2,975, and an individual deductible of $1,900.[16]
- Bronze, with an AV of 60 percent. One example of a plan with AV at this level would have 20 percent co-insurance, an out-of-pocket maximum of $5,950, and an individual deductible of $3,000.[17]

For individual enrollees, the exchange may also offer catastrophic-only plans to young adults under age 30 and to people without affordable access to coverage at the bronze level or higher. Such catastrophic plans cover preventive services (free of cost-sharing) and at least three primary care visits but otherwise allow cost-sharing up to the out-of-pocket limit that applies to Health Savings Accounts (HSAs).[18]

In the small group market, deductibles in 2014 may not exceed $2,000 for self-only coverage and $4,000 for coverage that includes spouses and child dependents. These amounts are indexed to rise in later years.

Is there room in the exchange for high-deductible plans that qualify for HSAs?

Some policymakers favor such plans as increasing consumer's financial incentive to avoid unnecessary health care costs and giving consumers more control over health care decisions. Fortunately for these policymakers, most HSA-qualified, high-deductible health plans (HDHP) have sufficient AV to be offered in the exchange. For example, the average employer-sponsored, HSA-qualified HDHP has an AV of 76 percent with a $1,500 annual deductible, 20 percent co-insurance, and a $3,000 overall out-of-pocket maximum.[19] If HHS decides that HSA contributions count in determining such a plan's actuarial value, then adding the typical HSA contribution among employers who make such payments raises this high-deductible plan's AV to 93 percent.[20] Even in the much less generous individual market, the average HSA-qualified HDHP has an AV of 61 percent, without counting any HSA contributions.[21] Put simply, not all high-deductible plans will qualify for the exchange, but many will.

Excluding qualified plans from the exchange. An exchange may exclude a qualified health plan if it finds that doing so would be in the best interests of the state's residents or employers who use the exchange. In making this determination, the exchange can negotiate with insurers, take into account premiums, and exclude plans that, in the judgment of the exchange administrators, charge too much. However, an exchange may not impose premium price controls or exclude a plan based on its use of fee-for-service reimbursement.

Consumer choice. In the exchange, consumers purchasing individual coverage may choose any participating plan. However, when an employer provides group coverage through the exchange, the employer selects an actuarial value level, and the workers are limited to plans at that level. (It is not clear from the statutory language whether an employer may select more than one AV level at which its workers and dependents may use the employer's premium contributions to obtain coverage.[22]) Consumers may change plans during annual open seasons.[23] Consumers pay all of the increased premiums when a more expensive plan is selected, thus furnishing an incentive for cost-conscious choice of coverage. For example, premium subsidies are based on the second-lowest cost silver plan. When subsidy recipients choose a more expensive plan, they pay the extra premium cost.

Administrative functions

Following are the minimum required functions of an exchange under PPACA. If a state so chooses, an exchange could presumably undertake other activities as well.

General administrative functions. An exchange must certify, recertify, and decertify qualified health plans, operate a toll-free hotline, offer an internet website with standardized comparative information on participating health plans, rate qualified health plans in accordance with federal standards, present plan options in a standard format (including a uniform description of coverage consistent with federal standards), determine and inform individuals of their eligibility for Medicaid and CHIP, enroll eligible individuals in Medicaid and CHIP, provide an electronic calculator that consumers can use to determine plan costs (taking into account tax credits and cost-sharing subsidies), decide whether individuals meet the federal requirements for exemption from the individual mandate, provide the Treasury Department with names and identifying information for individuals who are exempt from the mandate or whose coverage or employment status changes during the year, and inform employers when their workers stop receiving coverage in the exchange.

Consumer assistance. In addition to the above functions, an exchange must operate a Navigator program through which private entities provide culturally and linguistically appropriate public education, facilitate enrollment in qualified health plans, and refer consumers with complaints or questions to appropriate agencies. Navigators must meet federal standards for competence, licensure, the absence of conflicts of interest, and the provision of accurate and impartial information. In addition, a state may let brokers and agents sell coverage offered in the exchange, consistent with standards to be promulgated by HHS.

Accountability

Consultation and stakeholder participation. Each exchange is required to consult with various stakeholders, including enrollees in qualified health plans, individuals and entities experienced in facilitating enrollment, representatives of small business and the self-employed, Medicaid offices, and advocates for enrolling hard-to-reach populations.[24]

Accountability to the federal government. Exchanges must keep an accurate accounting of all expenditures, submit annual accounting reports to HHS, cooperate with HHS investigations, and submit to federal audits. If HHS finds serious misconduct in a state's operation of the exchange, HHS may rescind up to 1 percent of all the money that HHS owes to the state under all programs HHS administers.

Transparency. On the Internet, the exchange must publish the average cost of all payments required by the exchange (including licensing and regulatory fees), the administrative costs incurred by the exchange, and an accounting of all funds lost to waste, fraud and abuse.

The interaction between Medicaid, the exchange, and external sources of data in determining eligibility

HHS will need to flesh out a clear vision of Medicaid's role in the determination of eligibility for subsidies in the exchange. But from PPACA's statutory language, the following seems clear:

- A single application form will be used for all three need-based health-coverage programs—Medicaid, CHIP, and subsidies in the exchange.[25] HHS will promulgate a national form, but a state can use its own version, if approved by HHS. A consumer can file the form with an agency administering one of these programs either in-person, on line, by phone, or by mail.
- Although the exchange takes applications from consumers, it is HHS that determines eligibility for advance payment of tax credits and for out-of-pocket cost-sharing subsidies in the exchange. IRS directly pays these credits and subsidies to health plans when premiums are due, and the plans bill individuals for the remainder of the premium.
- No matter how or where the application form is filed, all the relevant agencies work together "behind the scenes" to ascertain the appropriate program for the applicant. As a result, without completing any additional forms, the applicant learns about each program for which members of his or her family qualify.

- Data-matching systems must be established that let all health agencies exchange information from the application form and determine eligibility. These systems also gather information from a broad range of external sources to establish and to confirm eligibility, including the data currently used to verify income eligibility for Medicaid, federal income tax data, and information from eligibility files of need-based public benefit programs.
- Generally speaking, the same tax-based definitions of income eligibility apply to all programs, including Medicaid, CHIP, and subsidies in the exchange—namely, Modified Adjusted Gross Income (MAGI), which is defined as Adjusted Gross Income under federal income tax law, plus tax-exempt interest and certain tax-exempt income earned while living abroad. However, there are potential differences in the applicable time frame. Eligibility for subsidies in the exchange is based on prior-year federal income tax data, unless the applicant comes forward and shows a change in circumstances. If, at the end of the year, someone turns out to have received the incorrect amount of subsidies in the exchange, any differences are reconciled on the person's federal income tax return. The reconciliation process has one "safe harbor" limitation, however. If a consumer with income below 400 percent FPL, as shown on the tax return, received excessive subsidies during the year, the maximum amount that can be required for repayment is $250 or $400, for individual and joint tax filers, respectively.[26] By contrast, Medicaid eligibility is generally based on income at the time the application is processed. This issue is discussed in more detail below.

The Center for Medicare and Medicaid Innovation

PPACA Section 3021 establishes this 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.

The Center is empowered to test any promising model. However, among the models specifically approved by PPACA are the following:

- Promoting broad payment and practice reform in primary care, including the so-called "Patient Centered Medical Home," discussed in much more detail below;
- Policies that move away from fee-for-service reimbursement and toward comprehensive payment or salary-based payment;
- Supporting care coordination for chronically-ill individuals through methods that incorporate health information technology (HIT), a chronic disease registry, and home tele-health technology;
- Establishing community-based health teams to support small-practice medical homes by assisting the primary care practitioner in chronic care management, including patient self-management activities;
- Helping patients make informed health care choices by paying providers for using patient decision-support tools;
- Letting states test and evaluate fully integrating care for dual eligible individuals in the state, including the management and oversight of Medicare and Medicaid funds (see page 38);
- Letting states test and evaluate systems of all-payer payment reform for the medical care of their residents;
- Models that do not require a physician to be involved in establishing the plan of care for the service, when such service is furnished by another health professional authorized to do so under state law; and
- Establishing comprehensive payments to Healthcare Innovation Zones, consisting of a teaching hospital, physicians, and other clinical entities that deliver a full spectrum of integrated and comprehensive health care services to Medicare and Medicaid beneficiaries while providing innovative medical training.

Because of this Center, states can now propose to CMS policy approaches that incorporate Medicare and Medicaid within broader state initiatives that address health care transparency, quality, or value.

Maximizing Residents' Health Coverage and Access to Care

PPACA gives states an opportunity to dramatically reduce the number of uninsured, improving access to essential health care. As explained earlier:

- Medicaid expands to 138 percent FPL for children and adults, with income determined based on MAGI.
- For 2014 through 2016, the Federal Medical Assistance Percentage (FMAP) applicable to newly eligible adults pays 100 percent of all costs. After that, the percentage gradually declines to 90 percent in 2020 and later years. For purposes of claiming this greatly enhanced FMAP, newly eligible adults are defined as those who would have been ineligible for their state's Medicaid program on December 1, 2009. Other adults qualify for standard Medicaid matching rates.
- Tax credits subsidize premiums for individuals with incomes at or below 400 percent FPL who receive coverage through the exchange, provided that such individuals lack affordable access to minimally comprehensive employer-sponsored insurance (ESI). These credits seek to make it affordable for an individual to enroll in the second-lowest-cost "silver" plan. Additional subsidies reduce out-of-pocket costs for those with incomes at or below 250 percent FPL. The subsidies do this by raising the level of coverage to a higher actuarial value.
- In 2013 and 2014, Medicaid reimbursements rise to Medicare levels for certain primary care services. The federal government pays 100 percent of the resulting increased costs for these two years.

For these provisions to achieve their goals, state action in three areas described below may be particularly useful:

- Helping eligible individuals enroll in and retain subsidized coverage;
- Improving affordability and continuity of coverage for low-income adults who are ineligible for Medicaid; and
- Increasing access to care within Medicaid.

One preliminary caution is important. Many of the strategies discussed below will depend on how HHS interprets applicable statutory language. The analysis in this section is based on a careful reading of PPACA, but there is no guarantee that CMS will agree with the author on the meaning of many admittedly unclear provisions.

Helping eligible individuals enroll in and retain subsidized health coverage

Several state strategies will be important to maximizing eligible residents' enrollment and retention.

Public education and facilitated enrollment

The importance of public education and efforts to facilitate enrollment is illustrated by Massachusetts' experience expanding coverage following its 2006 enactment of reforms, which reduced the percentage of uninsured to the lowest level ever recorded in any state. The enactment of subsidies coupled with an individual mandate was not enough, by itself, to achieve that result. Additional important factors included:[27]

- A major public education campaign involving both earned and paid media, partnering with local foundations, the Boston Red Sox, and major local corporations;
- Several years of "mini-grants" (supplemented by foundation support) to trusted community-based organizations (CBOs), which played a critically important role educating hard-to-reach consumers about how to obtain coverage and which completed application forms on behalf of consumers; and
- State policies forbidding uncompensated care payments to safety net providers unless application forms for health coverage were completed by or on behalf of the providers' patients. This policy applies, among other things, to the state's payments to Disproportionate Share Hospitals (DSH).

Using a single application form for multiple programs (including for uncompensated care payments to safety net providers), the state created an on-line application portal for use by trained CBOs and provider staff. As an automatic part of the application process, consumers were invited to appoint these application assisters as their authorized representatives throughout the eligibility determination process. As a result, the application assisters received copies of state correspondence asking for additional eligibility information. This let them work with consumers to respond satisfactorily to the state's requests. More than half of all successful applications were completed, not by consumers, but by CBOs or health care providers acting on the consumers' behalf.

Other states have used different models for facilitated enrollment. For example, California's certified application assisters (CAA) have received payments of $60 (at initial enrollment) and $50 (at annual renewal) for each family whose children successfully enroll in Medicaid or CHIP thanks to the CAA's efforts;[28] and New York contracts with community agencies and safety net providers to act as Facilitated Enrollers helping consumers enroll and retain coverage.[29] Wisconsin has likewise developed

a noteworthy system for helping consumers complete the application process.[30] However a state establishes a system of facilitated enrollment and retention, it is critically important to maximizing eligible individuals' receipt of coverage.

Under PPACA, the principal vehicle for public education and facilitated enrollment is through the exchange. Perhaps the most important period for these functions will be through the end of 2014—that is, during preparation for and the first year of full implementation. Fortunately, the development and operation of exchanges will be supported by federal dollars until 2015.

States could use these federal resources, partnering with foundations and corporations, to conduct public education and to establish a program of enrollment facilitation. If a state implements Massachusetts' strategy of denying access to DSH funds except with patients for whom a hospital completes an application form, it would be important to work closely with community advocates to ensure that such forms do not deter use of emergency hospital care by immigrants and other consumers who will not qualify for or do not want subsidies.

A state could also implement the PPACA option of permitting hospitals to establish presumptive eligibility.[31] However, to establish ongoing eligibility, consumers must complete the full application process, a step that many have failed to take under previous presumptive eligibility procedures. Hospital-based presumptive eligibility could be an important policy tool that lets hospitals qualify their patients for Medicaid coverage of emergency hospital care, but for ongoing access to care, additional steps will be needed.

Public education and facilitated enrollment efforts may help to fulfill states' duty, under PPACA, to conduct outreach and enrollment for vulnerable populations, including racial and ethnic minorities, children, pregnant women, people with HIV/AIDS, etc.[32]

Application forms and procedures

PPACA provides that a single application form will be used for Medicaid, CHIP, and subsidies in the exchange. As explained above, federal authorities will develop a form, but a state can create and use a substitute form that meets federal standards.

Depending on how HHS interprets the relevant statutory provisions, following are state strategies involving application procedures that could eliminate potential enrollment barriers:

Application forms could be limited to questions that are relevant to determining eligibility, as provided in PPACA Section 1411(g)(1).[33] This seemingly straightforward rule-of-thumb may encounter some obstacles. The first involves states' need to identify "newly eligible" adults for whom the state can claim enhanced FMAP. For some beneficiaries, information irrelevant to eligibility will be needed to see whether they would have been ineligible for Medicaid under the state's 2009 rules and so can qualify as "newly eligible." For example, parents with incomes that may be[34] low enough to qualify for Medicaid under 2009 rules could nevertheless be newly eligible in 2014 because of assets that would have disqualified them in 2009. If states asked such parents about assets as part of the application process in 2014 and later years, the process of enrollment would become substantially more difficult. Many eligible consumers would not complete the application, and states would be forced to spend limited administrative resources verifying applicants' claims about assets.

States need not use application forms to request this information, which will be irrelevant to eligibility. Instead, states could claim enhanced federal match based on a statistically valid sample of the entire caseload of potentially income-eligible parents, using procedures like those used to determine Medicaid error rates. The HHS Departmental Appeals Board has repeatedly approved state claims for federal matching funds that were based on such sampling.[35]

A second obstacle to limiting application forms to questions relevant to eligibility[36] involves states' interest in identifying "newly eligible" adults to determine the appropriate benefit package. Rather than provide standard Medicaid benefits, PPACA limits newly eligible adults to "benchmark coverage described in [Social Security Act] section 1937(b)(1) or benchmark equivalent coverage described in section 1937(b)(2)."[37] On its face, this provision creates a need for states to distinguish between newly eligible adults, who receive "benchmark" benefits, and other adults, who receive standard coverage. For potentially income-eligible parents, this may create a need to assess factors like assets and deprivation of parental support, which will be irrelevant to eligibility in 2014 and later years.

To avoid this problem, a state could furnish newly eligible adults with the same benefits it provides to other adults. One category of benchmark coverage is "Secretary-approved coverage," defined as "[a]ny other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage."[38] Both before and after the passage of PPACA, states have received CMS approval to provide full Medicaid benefits as "Secretary approved" benchmark coverage under Section 1937.[39] If states provide the same benefits to all adults, they will not need to distinguish the newly eligible before deciding the benefits that particular adults receive. As a result, they will not need to gather and process information about assets and other facts that will ultimately be irrelevant to eligibility.[40]

Consumers could apply by authorizing disclosure of relevant data already in government hands, rather than by completing application forms that, in effect, tell the government what it already knows. PPACA Section 1413(c)(2)(B)(ii)(II) provides that, for Medicaid, CHIP, and subsidies in the exchange, eligibility is determined based on data when an individual applies "by requesting a determination of eligibility and authorizing

disclosure of … information [described in Social Security Act Sections 1137, 453(i), and 1942(a)] … to applicable State health coverage subsidy programs for purposes of determining and establishing eligibility."

Such disclosure and data-based eligibility determination is quite wide-ranging:

- Section 1137 describes information accessible through the Income and Eligibility Verification System, or IEVS, including information from the IRS, the Social Security Administration, state quarterly wage records and new hires data, and immigration status information available from the Department of Homeland Security through the Systematic Alien Verification for Entitlements (SAVE) Program.
- Section 453(i) describes the National Directory of New Hires. NDNH combines quarterly wage records and new hires data from all states and the federal government.[41]
- Section 1942(a) describes eligibility files maintained by public benefit programs, state income tax records, state records about private insurance coverage maintained for purposes of Medicaid Third Party Liability enforcement, and vital records data about births in any state.

Enrollment would be substantially simplified if, rather than complete an application form, a consumer could simply identify all uninsured members of his or her household, provide social security numbers to permit data matching, and sign a form that requests information disclosure to establish eligibility for subsidized coverage. Such a highly streamlined procedure would not end the need for more traditional application forms, since some people may be uncomfortable with the required disclosure or may need to provide information not available in government records. But it would provide an important route to subsidized coverage that could increase participation rates by greatly simplifying the application process.

Medicaid eligibility rules

Depending on how CMS interprets PPACA, two Medicaid eligibility policies could substantially streamline eligibility determination and enrollment.

Basing eligibility on receipt of other benefits. PPACA explicitly allows states to continue extending Express Lane Eligibility (ELE) to children.[42] ELE permits states to qualify children for Medicaid and CHIP based on the findings of other need-based programs or state income tax records, notwithstanding methodological differences in determining income. But another PPACA provision appears to give states an additional option to qualify children and adults for Medicaid based on the findings of other need-based programs. New Social Security Act Section 1902(e)(13)(D)(i)(I)[43] provides that MAGI is not used to determine eligibility for:

> "*[i]ndividuals who are eligible for medical assistance* … on a basis that does not require a determination of income by the State agency administering the State plan …, including *as a result of eligibility for, or receipt of, other Federal or State aid or assistance*, individuals who are eligible on the basis of receiving (or being treated as if receiving) supplemental security income benefits [SSI] … , and individuals who are eligible as a result of being or being deemed to be a child in foster care under the responsibility of the State." (Emphasis added.)

This language implies that a state can qualify someone for Medicaid based on their receipt of federal or state benefits other than SSI. CMS will need to rule on the meaning of this language, of course. But it would be logical, in view of Medicaid's increased eligibility to 138 percent FPL, to permit states to provide Medicaid to residents who have already qualified for benefits like the Supplemental Nutrition Assistance Program (SNAP, the program formerly known as "Food Stamps") or General Assistance, since recipients of the latter benefits almost certainly will be income-eligible for Medicaid.[44]

Basing eligibility on data. For subsidies in the exchange, prior-year income tax records determine eligibility. For Medicaid, by contrast, PPACA provides that the requirement to use MAGI in calculating eligibility "shall not be construed as affecting or limiting the application of the requirement under [federal Medicaid law] and under the State plan…to determine an individual's income as of the point in time at which an application for medical assistance…is processed."[45]

Clearly, this provision means that someone who qualifies for Medicaid based on current economic circumstances must be granted eligibility. But does it also mean that, unless an applicant documents current income levels by presenting, for example, pay stubs or unless the state accepts self-attestation of current income, Medicaid eligibility must be denied, even if all available data show income eligibility? After all, income data, by definition, describe household circumstances at some point in the past.

If this provision bars the establishment of Medicaid eligibility based on data, state administrative costs will rise, because manual procedures will be needed to determine eligibility. This is a significant consideration given the enormous expansion in Medicaid eligibility that will take place starting in 2014.

Such a statutory interpretation would also mandate a more cumbersome process of establishing eligibility for Medicaid than for subsidies in the exchange. In effect, while eligibility for exchange subsidies would be established on the proverbial information superhighway, eligibility for the poorest uninsured would be determined via the data equivalent of ox carts and horse-drawn carriages.

Fortunately, CMS could interpret this statute differently. A state could be allowed to qualify someone for Medicaid if eligibility is established based on **either** the most recent available data (including prior year income tax data, quarterly earnings records, and new hires data) **or** the applicant's

demonstration of income at the time the Medicaid application is processed. Under this approach, if the data-based methods used in the exchange establish that someone meets Medicaid's eligibility standards, the applicant receives Medicaid, without any need to take additional action. Only if such methods fail to establish Medicaid eligibility would an applicant need to come forward and demonstrate current income levels, with income verified by the state. Such an approach would be consistent with PPACA's requirement, "to the maximum extent practicable, to determine … eligibility on the basis of reliable, third party data."[46] It would also be consistent with states' current flexibility to use "less restrictive eligibility methodologies," which CMS has already found applicable to PPACA's new Medicaid category for childless adults.[47]

Eligibility determination infrastructure

As explained above, PPACA[48] envisions an integrated eligibility determination system. One application form is to be used to seek coverage through Medicaid, CHIP, and subsidies in the exchange. Wherever the application is filed, all agencies work together "behind the scenes" to assign each household member to the appropriate subsidy program, without any need for the applicant to provide additional information.

Such an approach has been an important factor in Massachusetts' accomplishment of high participation rates in Medicaid and other subsidy programs. That state's Medicaid agency contracts with several other agencies to determine eligibility for multiple programs, including the state's "free care pool," the state's new "Commonwealth Care" benefit, and a health coverage program for immigrant children. All programs use a common eligibility methodology and a single application form. A statewide Medicaid office uses computer-driven logic, rather than traditional caseworker discretion, to establish eligibility. Not only has this approach helped raise participation rates to high levels, it allowed the state to more than double its caseload with less than a 10 percent increase in staff, even before the 2006 reforms.[49] PPACA expressly permits states to replicate Massachusetts' approach by having state Medicaid agencies determine eligibility for tax credits and out-of-pocket cost-sharing subsidies that apply in the exchange.

To function effectively in the data-driven eligibility environment envisioned by PPACA, most states will need a substantial upgrade to the computer systems used to determine eligibility. Under regulations dating back to the 1970s, enhanced federal matching payments for "Medicaid Management Information Systems" are limited to computer systems that process provider claims; enhanced funding is not available for information technology used to establish eligibility.[50] For this reason, eligibility systems are typically outdated.

Fortunately, PPACA Section 1561 may provide a source of funding for states to establish eligibility systems that fit a data-driven eligibility model. This section requires HHS, within 6 months of statutory enactment, to promulgate standards and protocols that facilitate enrollment into Federal and State health and human services programs. It also provides grants to states and localities to upgrade their technology systems to implement those federally promulgated standards and protocols.

It is not yet clear precisely what requirements and matching rates will apply to these state and local grants. HHS' implementation of this section will thus be critically important to track, particularly given most states' severe budget constraints.

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

Some observers have expressed concerns that the new system of subsidies in the exchange will not be sufficient to make coverage and access to care affordable. For example, a single adult at 160 percent FPL earned $1,444 in monthly pre-tax income in 2009. Under PPACA, such an adult would be expected to pay 5.4 percent of income in premiums, or $64 a month.[51] Out-of-pocket cost-sharing subsidies would allow the adult to receive coverage that could have office visit copays between $25 and $30 and prescription drug copays between $10 and $40, depending on the prescription.[52] Many at this income level could have great difficulty paying such premiums. Others may scrape together the money to pay premiums but then have difficulty with co-payments and deductibles, which could lead them to delay seeking care until health problems became severe.

Another concern about coverage in the exchange is that, as household income fluctuates, beneficiaries could be shifted between Medicaid and subsidies in the exchange. Households could be changed, involuntarily, from one plan to another, and potentially from one doctor to another.

Fortunately, states can take effective action to address these two problems.

Making coverage affordable for residents with incomes too high for Medicaid

PPACA gives states the option to implement the Basic Health Program (BHP) for citizens and legally resident immigrants with incomes at or below 200 percent FPL who are ineligible for Medicaid and CHIP. This includes adults with incomes between 138 and 200 percent FPL. It also includes legally resident immigrants who are ineligible for Medicaid because their legalization took place within the past five years.[53]

A state implementing the BHP option contracts with health plans to provide consumers with coverage at least as affordable and comprehensive as subsidized coverage in the exchange. To fund these contracts, such a state receives 95 percent of what the federal government would have spent in tax credits and other subsidies for BHP enrollees.

This gives states the ability to provide Medicaid-style coverage to adults up to 200 percent FPL, with no more than nominal premiums and out-of-pocket costs. In most states, per capita federal payments through this option will equal or exceed the average cost of Medicaid coverage for adults.[54]

Medicaid can achieve this efficiency in part because of provider payment rates far below private levels. The disadvantage of the BHP option is thus that beneficiaries will not gain access to the broader provider networks likely to characterize private plans offered in the exchange. States can lessen this problem by setting BHP cost-sharing between Medicaid and private levels. In this way, provider payments could be raised above Medicaid rates while keeping net per member per month costs at standard Medicaid levels. If federal payments exceed per capita Medicaid costs, states could also use the extra federal dollars to further raise reimbursement rates for BHP enrollees. But at the end of the day, policymakers may need to decide whether, for this particular low-income population, the access problems that result from commercial-style cost-sharing in the exchange are more severe than the access problems that result from limited provider participation in a Medicaid-style plan.

As an alternative method of making coverage more affordable, states could supplement federal subsidies in the exchange. Such supplements would lower premium costs, deductibles, and copayments for low-income adults ineligible for Medicaid. To limit the resulting cost, a state could focus its resources on the very lowest-income exchange participants, rather than extend aid all the way to 400 percent FPL. Compared to the BHP alternative, this strategy would have the advantage of offering access to greater provider networks in the exchange. However, the countervailing disadvantage is that, unlike with the BHP option, state General Fund dollars would be needed.

On balance, for most states, the BHP option may prove the most feasible strategy to improve access to care for the very lowest-income residents who are ineligible for Medicaid.

Improving continuity of coverage and care

PPACA contains an important tool to lessen disruptions in coverage when household incomes change—namely, adults with incomes between 100 and 138 percent FPL have the option to receive coverage either through Medicaid or the exchange. If income falls from 140 to 125 percent FPL, for example, the affected family can stay in the same plan. But the same is not true if income falls still farther, to 90 percent FPL.

Massachusetts avoided this problem by using the same plans to serve Medicaid beneficiaries and recipients of the state's new "Commonwealth Care" subsidies, available up to 300 percent FPL. A state could take a similar approach under PPACA, encouraging Medicaid plans to participate in the exchange (and BHP, if the state elects that option). In that 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. Such plans need not be the only option in the exchange, but as long as they are available, families have the ability to maintain continuous coverage throughout the full spectrum of subsidy eligibility.

Increasing access to care within Medicaid

As noted previously, low provider reimbursement rates often translate into reduced provider participation and diminished access to care for Medicaid beneficiaries. To address this problem, PPACA provides full federal funding, in 2013 and 2014, to increase Medicaid payments to Medicare levels for primary care providers furnishing "evaluation and management" services. While a very helpful start, this provision does not address access problems outside primary care, including dentistry, mental health, and specialty services. In addition, states would find it costly to sustain PPACA's reimbursement rate increases if Congress fails to continue enhanced federal matching rates beyond 2014.

To some degree, PPACA lessens the extent of this problem by increasing funding for community health centers, school-based health centers, and other infrastructure that can potentially serve Medicaid beneficiaries.[55] But states could take additional steps to improve access to care.

The most straightforward such step would increase Medicaid rates—a costly proposition, if applied across-the-board. Another strategy would encourage provider participation by expediting claims payment. Providers' concerns about Medicaid's delays and "hassles" may be less costly to address than the underlying fees. States could also increase the use of tele-medicine to serve rural Medicaid beneficiaries, who often experience the greatest difficulty finding providers. In addition, states could change their licensure laws to increase the range of services that non-physicians are allowed to provide within Medicaid and potentially outside it as well.

Finally, it is worth noting that PPACA Section 2801 increases the purview of the Medicaid and CHIP Payment and Access Commission (MACPAC) and authorizes FY 2010 funding. MACPAC's charter now includes an ongoing analysis of access to care by children and adults in Medicaid and CHIP. MACPAC could thus play an important role in raising the visibility of Medicaid access issues nationally, as could the significant increase in Medicaid enrollment resulting from PPACA. This may create a climate that facilitates a helpful federal response that gives states additional resources to improve Medicaid beneficiaries' access to care.

A Quick Recap
How states can use PPACA to increase coverage and access to care

- Fund trusted community-based organizations to help low-income consumers apply for coverage and to provide effective public education. Federal dollars that support the establishment of health insurance exchanges can provide this assistance. States may also be able to leverage philanthropic contributions to supplement public dollars.
- Implement PPACA's option for hospital-based presumptive eligibility, while establishing procedures to ensure the follow-through needed for ongoing coverage.
- Limit application forms to questions that are relevant to eligibility, which means that such forms do not gather information needed to distinguish newly eligible adults from other eligible adults. To claim the enhanced FMAP that is limited to newly eligible adults, states can sample a statistically representative group of beneficiaries. And, by giving all adults the same covered benefits, states can eliminate the need to identify "newly eligible" adults before they complete their enrollment.
- Give consumers the option to apply for Medicaid and other subsidies by authorizing disclosure of personal information, rather than by completing a traditional form.
- Automatically grant Medicaid eligibility when individuals have already been found eligible for other need-based benefits with income-eligibility standards that are below Medicaid's new 138 percent FPL threshold.
- Automatically grant Medicaid eligibility whenever the income-determination method used in the exchange shows income at or below 138 percent FPL. If prior-year tax data (perhaps supplemented by recent quarterly earnings information) show Medicaid eligibility, a consumer would not be required to present pay stubs or other proof of current income.
- Take advantage of new federal resources to upgrade eligibility systems. Such systems will help Medicaid work with the exchange seamlessly, "behind the scenes," to decide applicants' eligibility for all subsidy programs, based on available data.
- Implement the Basic Health Program option to make coverage much more affordable for low-wage workers and their families with incomes below 200 percent FPL—without imposing costs on the state.
- Encourage Medicaid plans to offer coverage in the exchange, making it possible for low-income families to retain continuity of coverage and care when their incomes change and they shift between Medicaid and the exchange.
- Improve Medicaid beneficiaries' access to care by streamlining processing of provider claims, using tele-medicine to improve access to care in rural locations, increasing the range of services that non-physicians are allowed to provide, and (if future state budget conditions permit) raising Medicaid reimbursement rates.

Fundamental Questions About Health Insurance Exchanges

The next three parts of this report include an exploration of how a state could structure its health insurance exchange to achieve various policy goals—namely, making health care and health insurance more like consumer-driven markets, increasing health insurers' accountability, and reforming health care delivery to slow cost growth while improving or maintaining quality.

That analysis presumes, of course, that the state operates the exchange. This section of the paper briefly discusses the advantages and disadvantages of a state running the exchange, rather than letting the federal government play that role. It also analyzes several basic approaches that a state could take to running an exchange, basic approaches that play out in how a state seeks to accomplish its policy goals.

Should a state run its own exchange or allow the federal government to do so?

Much depends on whether a state chooses to operate the exchange that serves its residents. The advantage of such a choice is simple: the exchange can be a powerful tool for accomplishing state objectives. By contrast, if the federal government performs this function, decisions about the structure of the exchange might not fit optimally with state policy priorities. At the same time, a state operating its own exchange may be better positioned to coordinate eligibility determination with Medicaid than if the exchange is federally administered.

On the other hand, running an exchange carries risks. These will be new institutions charged with difficult tasks. Further, exchanges must be self-financing starting in 2015. The federal government will be defining the requirements exchanges must meet, without directly providing any of the necessary funding beyond the start-up phase.[56] Whoever administers the exchange may face a tension between demands to keep fees low and demands for high-quality customer service that meets federal standards.[57]

Without doubt, states will resolve this issue differently. And even within states, officials will have varying perspectives on how to weigh the risks and benefits of taking charge of an exchange.

Basic approaches to administering an exchange

A critical feature of PPACA's exchange provisions is that a state can either (a) permit all qualified plans to offer coverage or (b) exclude qualified plans based on the state's view of the best interests of individuals and firms using the exchange. This leaves room for very different approaches. One useful source[58] uses three categories to describe how exchanges can be run:

> "Market organizer:[59] under this model, the exchange acts as an impartial source of information on health plans that are available in the market; [and] provides structure to the market to enable consumers to compare health plans and purchase coverage… Although not yet fully developed, the Utah Exchange provides an example of this kind of model."
>
> "Selective contracting agent: this model includes many of the same functions noted above, but also attempts to influence the market and enhance competition by contracting with a select group of carriers and offering a limited number of health plans. The exchange solicits health plans based on plan design parameters established by the administrators of the exchange. However, the exchange does not necessarily negotiate premiums with the health carriers...The Massachusetts Connector … uses a selective contracting approach for its commercial offerings..."
>
> "Active purchaser: an exchange might also play a more active role in the market by establishing plan designs and purchasing health insurance much like a large employer procures health benefits on behalf of its employees.…Many of the health purchasing cooperatives that were established in the 1990s, such as California's PacAdvantage … and the Texas Insurance Purchasing Alliance (TIPA), are examples of active purchaser models."

Developed before the passage of PPACA, this typology still applies:

- An exchange that offered all qualified plans would be a market organizer;
- If qualified plans were required to meet specified design parameters before they could be offered in the exchange, the exchange would be a selective contracting agent; and
- If the exchange went beyond a statement of design parameters to negotiate with qualified plans seeking to offer coverage, the exchange would be an active purchaser.

Restructuring Health Insurance to Function More Like a Traditional Market

Basic perspective

Some observers believe that a central flaw of the present system central is its failure to embody two characteristics of a healthy market:[60] buyers choose between goods and services with clearly understood costs and benefits; and the individual or entity making the purchasing decision experiences all of the resulting costs and benefits. With those two conditions in place, sellers increase their market share by giving purchasers the products they want at a price they can afford. From this perspective, nimble private innovation, rather than government fiat, meets consumers' needs while holding down cost.[61]

One reason why these conditions rarely apply to American health care is that consumers usually lack essential information. Most Americans receive insurance through their employers, with the firm covering a significant share of costs; many consumers don't even know how much their employers pay. A consumer buying coverage on the individual market typically cannot obtain a copy of the insurance policy document before enrolling. When consumers seek care, they will eventually learn the copayment they are charged but almost never know the full cost of the service paid by the insurer. And even if a consumer enrolls in a high-deductible plan and so bears the full and direct expense of much care, it may be impossible to get advance price quotes from providers or to reliably compare their past performance. Put simply, much better information about the cost and benefits of potential options is available when consumers choose a microwave oven than when they make much more consequential decisions about a health plan, a hospital, or a health care procedure.

Further, the entity or individual deciding about health coverage rarely experiences the resulting costs and benefits. With ESI, the employer chooses the health plan, but it is the employee who reaps the benefits and, according to most labor economists, pays the cost in the form of lower wages.[62] Further, with health plans that have low deductibles and limited copayments, consumers obtain all the benefits of the services they choose but consumers pay out of pocket only a small fraction of the resulting health care cost.

To address these fundamental flaws, PPACA provides new tools that help state officials move toward a system that empowers each consumer with accurate, useful information and the authority to make health care choices that reflect the individual consumer's preferred balance between costs and benefits.

State policy options

State leaders interested in pursuing this basic approach can focus on (a) improving information about price and quality, so individuals can more effectively make decisions about care and coverage; and (b) implementing health insurance exchanges in a fashion that increases the role played by consumer choice. As noted in the Introduction, one additional strategy not discussed here involves the option, beginning in 2016, for states to enter into interstate compacts permitting the sale of health insurance across state lines.[63]

Public information about price and performance

PPACA's provisions

Following are examples of PPACA's provisions that increase the public availability of reliable information about the performance of insurers and providers:

- *Performance measures for both providers and plans.* Sections 3013 through 3015 of PPACA 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.* PPACA Sections 3002, 10327, 10331, and 10332 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 payors 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 PPACA Section 10101(f), requires hospitals to inform the public about their standard charges, as defined by HHS.
- *Health plans.* PPACA 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 PPACA Section 10101(i), provide for the establishment of Medical Reimbursement Data Centers. Such Centers can be funded from PPACA's $250 million appropriation slated for building state capacity to analyze insurance premiums. These new data centers are either academic or non-profit institutions that collect, analyze, and report information about local payment rates, including information to help consumers understand the amounts that health care providers in their area charge for particular services.

Opportunities for state action

In implementing PPACA, states can leverage these national initiatives to make major improvements in consumer information. Critically important will be combining information about performance and price in one place—a consumer health information website, perhaps as part of the exchange web portal. This would permit consumers selecting a health plan, a hospital, a physician, or other health care provider to easily compare the potential costs and benefits of each choice. Such a comparison ideally includes information about results achieved (including health outcomes as well as other measures), price (that is, cost per service), and efficiency (the number and nature of services provided for a given condition). In one approach proposed by Harvard Business School professor Michael Porter, states might eventually provide consumers with information about competing provider teams' risk-adjusted outcomes and costs over the entire cycle of caring for patients with a particular diagnosis.[64]

PPACA could make it easier for states to provide consumers with good information about performance and cost. The federal legislation directs HHS to work with national stakeholder groups in tackling tough methodological issues that could otherwise obstruct state progress. One such issue involves adjusting performance data to compensate for patient risk, thereby avoiding unfair penalties when providers furnish good care but serve patients with prior conditions that make an adverse outcome more likely. A similar issue involves the need to avoid judging individual physicians and other providers based on outcomes with relatively small patient caseloads, where a few random events can skew performance metrics. If HHS develops sound approaches, states could simply use them, avoiding the need to reinvent these difficult wheels.

In addition to presenting information to consumers in a useful, integrated format, states could supplement the information made available through PPACA. For example:

- While PPACA creates new mechanisms for assessing and reporting physician performance, it does not couple those mechanisms with information about the cost of receiving services from a particular office. A state could encourage physicians to furnish information about standard charges for an office visit, along with information about the health plans in which they participate. The state would then make that information available on its health consumer information website. If state officials feel strongly about providing consumers with the information they need to make good decisions, physician participation in such an information system could be a precondition for (a) having malpractice liability capped; (b) gaining preferred reimbursement rates from health plans covering public employees; or (c) licensure.

- Many of PPACA's most far-reaching policies for gathering and reporting information about performance involve Medicare. States could build on this federal effort by collecting comparable data about quality and efficiency for other payors, public and private, using an All-Payer Claims Database.[65] Such states would then work with HHS to combine this additional information with Medicare data and present the results to consumers, providing a fuller picture of provider and plan performance. A state could either: (a) adopt Medicare information-gathering strategies; or (b) seek approval from the CMS Center for Medicare and Medicaid innovation for modifying Medicare policies to fit state policy initiatives.

- Even though a health plan has more leverage than consumers to obtain lower prices from providers,[66] a state may be interested in arming consumers with information about provider charges in particular localities so that, if they have high-deductible coverage, consumers can negotiate with providers around price. If so, state officials could prioritize establishment of a local Medical Reimbursement Data Center, which furnishes information about typical charges for particular services. To make such a Center most effective, a state could encourage or require insurers to furnish it with provider payment data.[67]

In providing the public with information about results, quality, and efficiency, states would build on an extensive track record of prior work in this area.[68] For example, the Pennsylvania Health Care Cost Containment Council publishes annual reports for each region of the state showing individual hospital performance with specific common diagnoses and procedures. As to each diagnosis and procedure, the Council provides risk-adjusted information about each hospital's average charges, length of stay, mortality, and likelihood of re-hospitalization.[69] Along similar lines, Florida's Agency for Health Care Administration provides comparative information about hospitals, health plans, and prescription drug prices via its floridahealthfinder.gov website.

Several caveats are important. First, price data are not easy to interpret. The above-described states, for example, display hospital charges, which far exceed what insurers typically pay. Health plans vary in payment amounts as well as consumer cost-sharing obligations, so a hospital's charges may not be a reliable guide to what either a consumer or the consumer's insurer will pay. At the same time, the distinction between a consumer's cost-sharing amount and the full price paid by the insurer complicates the issue that price information is intended to illustrate. While the individual consumer receiving the service directly pays only the cost-sharing amount, the full service cost paid by the insurer is ultimately borne by all of the insurer's customers in the form of higher premiums (and in the case of ESI, the likelihood of lower wages).

On a website listing common outpatient procedures as well as inpatient labor and delivery, the state of New Hampshire addresses these problems by showing the amounts paid by insurers, using an All-Payer Claims database, as well as helping consumers understand what they will directly pay. The state's website allows a consumer to identify his or her health plan and provide information about deductible and co-insurance levels, after which the consumer receives an estimated cost that he or she will pay for the procedure.[70]

More broadly, consumers often find information about health care price and performance confusing.[71] It can be very challenging to present these data in a way that is easy to assimilate by most consumers, not to mention those who face special communications challenges, including general literacy problems or limited English proficiency. Even common difficulties understanding numbers and percentages can prevent consumers from processing simple information effectively.[72] Put simply, state officials interested in giving consumers data they can use need to pay careful attention to the details of communication strategy.

Finally, as an empirical matter, it is not clear that presenting consumers with information about quality or efficiency changes consumer choices appreciably.[73] Making such information publicly available often improves provider behavior, however, because of feared embarrassment, desired recognition, or concern about health plan, employer, or public agency responses.[74]

Health insurance exchanges

Potential impact on market structure

Health insurance exchanges offer the potential to move health insurance purchasing decisions toward a classic market structure. Because consumers pay the increased cost of more generous insurance, they must trade off price and comprehensiveness, much as when they buy other goods and services. In such a system, plans seek market share by giving consumers what they want at a price they can afford. And it is the consumer, not the employer, who chooses the plan and experiences the benefits while paying the marginal costs. For these reasons, the health insurance exchange run by the Federal Employees Health Benefits Program (FEHBP)—the country's largest and oldest such exchange—has been described as involving "free market principles of real consumer choice," "genuine market competition," and "a serious consumer-driven market."[75]

Utah provides a second example of policymakers using exchanges to move toward a consumer-driven market for health insurance. Although Massachusetts' exchange has received more public attention and covers many more people, Utah's approach has been celebrated by some advocates of market-based reform strategies who have concerns about Massachusetts' general approach.[76]

In Utah, small firms can use the state's exchange to provide their workers with coverage. While state officials ensure the availability of high-deductible plans that qualify for health savings accounts, plans may also offer any other combination of covered benefits and out-of-pocket cost-sharing that is consistent with state law.

To participate, an employer decides how much money it will contribute, and the firm's workers pay the remainder of the premium when they select a plan offered in the exchange. Consumers must thus compare the cost of each plan with its appealing product features, making the kinds of choices and trade-offs that typify other markets. If several different firms employ a worker, each can make a contribution to the worker's premium costs.

The exchange began operating as a pilot in mid-2009. Because of various problems, such as a significant differential between premiums inside and outside the exchange, fewer than 500 state residents had obtained coverage by January 1, 2010.[77] In response, the state legislature modified the exchange during the 2010 legislative session to ensure (as under PPACA) that common rules, premiums, and risk-adjustment mechanisms apply to small group plans, whether sold in the exchange or elsewhere.[78]

While PPACA as a whole departs in important ways from Utah's approach—for example, the federal law requires all plans, whether sold within or outside the exchange, to meet certain minimum benefit standards, and the federal law requires most individuals to obtain coverage—PPACA's provisions that specifically address health insurance exchanges leave considerable room for state policymakers to move insurance markets toward a consumer-directed approach, as explained below.

Opportunities for state action

Offering a broad range of health plan options

States interested in maximizing the potential offered by exchanges to create a consumer-driven marketplace could take several steps to broaden offerings in the exchange:

1. Encourage insurers to offer plans at each of the actuarial value levels outlined in PPACA. That would permit consumers

to choose between high-deductible and more comprehensive plans, trading off the resulting cost differential against the importance of the additional protection offered by more generous coverage.

2. Encourage plans at each AV level to innovate by offering a range of covered benefits and out-of-pocket cost-sharing rules. It remains to be seen how much this range will be constrained by federal requirements that each plan must cover certain essential services. PPACA clearly permits plans to vary cost-sharing amounts that apply to essential benefits (except on certain preventive care services). HHS may also interpret the statute to allow plans to differentiate the amount, duration, and scope of coverage within mandatory service categories, much as occurs today with FEHBP.[79]

3. Permit all qualified plans to offer coverage in the exchange, thus maximizing consumer choices, rather than exclude qualified plans based on state decisions about the best interests of enrollees. Such an inclusive approach would leave it to the consumer (rather than the state) to decide, for example, whether premiums charged by a particular plan are too high.[80] A state taking this approach would use the exchange as a "market organizer," rather than a "selective contractor" or "active purchaser," under the typology described previously.

4. Intervene to increase the range of health insurance options by encouraging one or more existing insurers to fill important gaps in local health plan offerings. For example, officials in Massachusetts' exchange were initially concerned about premiums that were high because all insurers felt the need to contract with a small number of prestigious hospital systems that used their leverage to extract high reimbursement levels. To address this situation, the exchange encouraged insurers to offer plans that did not include those hospitals in their networks. Premiums for the resulting new plans were significantly lower than for older plans offering identical benefits.[81] With increasing market concentration of hospital systems and resulting upward pressure on hospital rates,[82] similar efforts in other states could be important to presenting consumers with options that lower health insurance costs by narrowing networks of participating providers.

5. Encourage or arrange the development of new insurers to increase competition among carriers. One such insurer could be a non-profit, consumer-owned health insurance "co-op," providing consumers with an additional choice of plan. Such a new insurance option could be particularly important in the many states where very few carriers dominate insurance markets.[83] PPACA provides $6 billion in grant and loan funds to assist in the development of such insurance co-ops. However, state officials should not be under the illusion that it will be easy for a new plan to get started, even with these federal resources. Without numerous covered lives, a new plan lacks the leverage to recruit numerous providers on favorable terms. As a result, the new plan can be forced to charge high premiums for a limited provider network that many consumers find unappealing. Another approach worth considering would have the state sponsor a publicly-administered health plan that begins with a large base of enrollment using Medicaid and CHIP beneficiaries, public employees, and public retirees. (see pages 26-27 for more detail)

One final comment in this area is important. Before pursuing policies that maximize the number of health insurance choices, policymakers may want to consider research findings showing that, both with health insurance and other goods and services, presenting consumers with a vast array of choices can cause confusion. When consumers feel overwhelmed by more options than they can easily process—particularly when the differences between options involve multiple variables—many consumers become less responsive to each option's costs and benefits, thus inhibiting the market's effective functioning.[84] Policymakers need to decide whether their vision of an ideal health insurance market includes the maximum possible number of qualified choices or a smaller number with fewer variables, which may be easier for many consumers to understand.

One possible middle ground would limit options in the exchange to a manageable number and variety while making clear, as provided by PPACA, that other plans are also available outside the exchange, perhaps directing consumers to websites with information about the latter plans.[85] Another possible middle ground approach would classify a subset of participating plans as "recommended," in the same way that websites offering information about consumer products frequently indicate that certain products are among the "editor's choices." Such an approach could help clarify consumers' decisions without eliminating options from the exchange.

Giving consumers useful information to guide health plan choices

A state could go beyond PPACA's minimum requirements to give consumers additional information about coverage offered through the exchange. For example, an exchange's website could provide information about the following features of each plan:

- Whether a consumer's preferred physician, nurse, or clinic is part of the plan's network and currently accepting new patients;
- The formulary and cost-sharing status of particular prescription drugs; and
- The risk-adjusted costs and results the plan achieves for consumers with particular medical diagnoses or conditions.

States could also empower private groups to educate consumers about available options, as exemplified by FEHBP. *Consumers Checkbook*, an independent, non-profit information source, furnishes federal employees and retirees with information about available plans. The

Checkbook is so well-established that many federal agencies subsidize access to the guidebook for their employees and retirees.[86] States could consider taking similar steps with the exchange, perhaps contracting with a private organization to present consumers with information about available health plans.

One final caution is that states may need to work very hard ensuring that information presented to consumers is clear and simple. Massachusetts' health exchange, for example, conducted extensive field research to determine the data most important to consumers. Clear, consistent displays of information in consumer-friendly ways proved critically important to shifting consumer purchases. Such displays, for the first time, allowed consumers to compare "apples to apples" and identify premium costs that did not yield commensurate increased value. As a result, consumers using the state's exchange are more likely than traditional health insurance purchasers to enroll in "generic," lower cost coverage[87]—a consumer-driven cost savings that other states could seek to facilitate.

Increasing the number of consumers with access to the exchange

One important strategy for increasing the number of firms and residents using the exchange involves insurance brokers and agents. Given the central role they currently play and the confidence they enjoy among many small firms and individuals, brokers and agents can be critically important to achieving high enrollment levels. Of course, states face a trade-off, as brokers must be paid a fee. Nevertheless, previous purchasing pools have found that, without brokers and agents actively participating in (rather than fighting against) a new purchasing arrangement, it can be very difficult for an exchange to gain traction.[88]

If states incorporate brokers and agents, it may be important to add rules ensuring that an agent receives the same fee, regardless of the health plan in which a consumer enrolls. Such a rule was adopted by both Utah and Massachusetts, where brokers receive a fixed fee per enrollee, regardless of plan choice. This lessens conflicts of interest by avoiding incentives to steer consumers to particular plans. In addition, states could lower fees below prior levels, since exchanges are likely to lower brokers' average costs.

States could also consider maximizing the number of firms allowed to buy coverage through the exchange by permitting firms with 100 or fewer workers to use the exchange, rather than limiting it to companies with 50 or fewer workers. As noted above, beginning in 2017, states could allow employers of any size to use the exchange. Such steps could increase the number of consumers who receive coverage through a more consumer-driven health insurance market than exists for most ESI today. Further, widespread employer participation in the exchange increases the likelihood that a worker can change jobs while retaining his or her preferred health plan. Such portability could yield important benefits, including incentives for health plans to invest in the long-term wellness of their members and an increased ability for workers to change jobs without disrupting continuity of coverage.[89]

Structuring employer involvement

PPACA does not address many key questions about employers' role in exchanges. This apparently gives states the flexibility to devise answers, subject to eventual regulations or guidance from HHS. Here are some important issues that may be left up to the states, along with some possible approaches and accompanying trade-offs:

- How must employers structure their premium contributions if they wish to participate in the exchange? Do they pay a percentage of the premium or a flat dollar amount? In addressing this issue, states need to be aware of an important trade-off. The former approach may lessen risk segmentation among health plans,[90] but the latter would give workers more of an incentive to select plans with lower premiums.[91]
- Must employers make a minimum level of contribution to premiums before they can offer coverage through the exchange?
- Are employers limited to a single actuarial value of coverage for their workers? Or can they give their workers a choice of AVs? (As noted previously, HHS may interpret PPACA to foreclose the latter option.) Giving workers access to more participating plans would, among other things, increase families' ability to keep the same health plan even if they move from job to job with employers who provide varying levels of support for ESI. On the other hand, Massachusetts required each firm using that state's exchange to select a single actuarial value that would apply to all of the firm's employees, thus avoiding potential income-based disparities in coverage generosity[92] and significant market distortions.[93]
- May employers offer their workers options both within and outside the exchange? If so, must a certain threshold percentage of employees agree to coverage through the exchange before the firm is allowed to use the exchange? In the past, such a threshold percentage has been important to preventing adverse selection. But this policy may not be needed under PPACA if risk adjustments function as intended to encompass small group plans both within and outside the exchange.
- When one worker has several jobs, how (if at all) can the various employers make small premium contributions, if they wish to help their part-time and contingent workers afford insurance? An exchange could (if permitted by HHS' interpretation of PPACA) accept contributions from multiple employers, as occurs with Utah's exchange.
- To access the exchange, may employers give their workers the option to use pre-tax dollars to pay their premium share? Must employers do so?[94]

A state's policymakers could seek to resolve these questions by working closely with the state's employer community to develop rules and procedures that make it simple and convenient for employers to participate while safeguarding the sound operation of the exchange according to market principles.

Final comments about exchanges

Several final comments about exchanges are important. First, states will need to structure an ongoing source of administrative funding that is stable and sufficient. Exemplifying one possible approach, the Massachusetts exchange charges a fee to participating insurers equal to 3 percent of premiums.[95] The insurers then pass on this cost to the purchasers of coverage.[96]

Second, exchanges under PPACA are likely to be much more durable and highly subscribed than has been the case for most health insurance purchasing pools in the past.[97] That is because PPACA limits the use of tax credits and other subsidies for low-income, individual consumers to people who buy coverage through the exchange. Small employer tax credits will likewise be limited to exchange-based coverage, beginning in 2014. Also, PPACA requires each individual to obtain coverage, thus increasing the demand for health insurance. In addition, PPACA enacts health insurance reforms that prevent discrimination against consumers with health problems and that equalize premiums for health insurance sold inside and outside the exchange, thus addressing the adverse selection problems that have plagued some health insurance purchasing pools. Similar policies adopted in Massachusetts resulted in an exchange that covers 157,000 subsidized consumers plus 31,000 unsubsidized enrollees.[98] CBO likewise anticipates that 24 million individuals, or 9 percent of non-elderly Americans, will receive coverage through exchanges under PPACA.[99]

Third, some observers have contrasted the small health insurance exchange that Utah began in 2009 with the much larger exchange that has operated in Massachusetts since 2006, suggesting that the Utah exchange involves a lighter public sector role than is present either in Massachusetts or under PPACA.[100] A clear analysis of this contrast, however, shows that PPACA gives states considerable flexibility to pursue a market-oriented approach to health insurance exchanges, incorporating many of the key features of Utah's exchange.

Some of the differences between Massachusetts and Utah involve policy questions that PPACA has definitively resolved. For example, PPACA includes an individual mandate and definition of minimum required benefits, roughly along Massachusetts lines—neither of which directly concerns the operation of the exchange—and risk adjustments among health plans, roughly along Utah lines, to include small group plans both inside and outside the exchange.

Other differences reflect choices that, in important ways, remain in state hands under PPACA. The federal law gives state the flexibility to run an exchange, not as a selective contractor or active purchaser, but as a market organizer—for example, by permitting all qualified plans to offer their products in the exchange, maximizing the number of consumers who use the exchange, encouraging the offering of diverse plan options, focusing state efforts on providing useful information to consumers, etc.

Of course, an exchange can also take a more interventionist approach in excluding qualified plans from the exchange. The administrator of the exchange thus has a significant role determining the degree to which the public sector controls the insurance sold in the exchange.

PPACA does impose regulatory constraints that go beyond those present in Utah—perhaps most important, the requirement that all qualified plans must offer what the federal government identifies as "essential benefits." That said, the use of actuarial value standards permits considerable variation and innovation by health insurers.[101] Moreover, most responsibilities that PPACA imposes on exchanges are intended to help meet the needs of consumers and firms choosing from among competing, qualified, private plans.

Put simply, market-oriented state policymakers can continue to pursue their policy goals to great effect as they implement this new federal legislation. But state policymakers who see exchanges as a policy lever to more aggressively transform health insurance and health care can pursue that goal as well, as described in the next section of this report.

A Quick Recap
How states can use PPACA to make health insurance more like a smoothly functioning, consumer-driven market

- Combine federally-generated and state-generated information about price and performance in a single place that is easy for consumers to find.
- Present basic consumer information that is simple and user-friendly while making additional information easily available for those who want to dig deeper.
- In presenting price information, help consumers learn the cost they must pay under their health plan, not just providers' generic charges.
- Consider organizing information to show risk-adjusted costs and outcomes for provider teams' treatment of particular conditions, throughout the full cycle of care.
- For state transparency initiatives, consider applying methodologies that HHS develops to address challenging issues, such as how to risk-adjust performance data.
- In providing consumers with information about physicians, consider combining federally-generated performance data with state-generated cost information.
- Work with HHS to build an all-payer database with Medicare information about provider performance along with state-generated information about performance under private insurance.
- Consider establishing a Medical Reimbursement Data Center to educate consumers about typical charges in their geographic area.
- Encourage insurers to offer a broad variety of plans in the exchange, at each available actuarial value.
- Permit all qualified plans to offer coverage in the exchange, potentially accompanied by a designation of which plans are recommended by the exchange.
- Encourage one or more insurers to offer plans with limited provider networks that allow lower premiums.
- Provide consumers with useful information about their insurance options in the exchange, such as whether particular drugs are included in health plan formularies.
- Increase the number of residents using the exchange by (a) letting brokers and agents sell exchange plans and (b) giving medium-sized firms access to the exchange. These steps would increase the number of residents receiving coverage where consumers (not employers) select their own health plan and pay the incremental difference in premium. In such a system, purchasers balance cost against desirable product features, as in other consumer-driven markets.
- Collaborate with employers to design the exchange so that it works well for them.
- Consider the creation of new carriers to operate in the exchange, particularly in states where a small number of insurers dominate existing markets. A new carrier could involve either (a) a member-owned "co-op" or (b) a state-administered plan that begins with a critical mass of covered lives consisting of Medicaid beneficiaries and public employees.

Holding Insurers Accountable to Consumers

Basic perspective

Some state policymakers believe that vigorous, public action is needed for private insurers to furnish consumers with high-quality, affordable coverage, for reasons that include the following:

- When enrollees use more care, a private insurer pays more in claims, and profits immediately drop. Even non-profit insurers have compelling financial reasons to maximize the proportion of premiums available to pay administrative costs, including executive salaries and the development of reserves. This creates an inherent short-term conflict of interest between insurer and consumer.
- In most states, insurance markets are dominated by a small number of carriers, weakening competitive pressures to improve customer service and slow cost growth.[102] In addition, recent years have seen tremendous consolidation of hospital and physician systems, making it increasingly difficult for insurers to negotiate aggressively over payment rates.[103]
- Insurers can realize enormous gains by avoiding the small percentage of consumers who generate the vast majority of health care costs.[104] As a result, plans often compete by avoiding risk, rather than by providing superior service at an affordable price. To shed or steer clear of high-cost patients, insurers have engaged in such actions as cancelling policies when members get sick; or raising premiums, denying enrollment, or limiting covered services for people with preexisting conditions, sometimes inflicting serious harm on the very consumers who most need health coverage.[105]
- Insurance policies are complex legal instruments. Consumers are rarely informed about these policies' details before enrolling in a health plan. And when information is provided—for example, in technical "explanation of benefit" boilerplate language that describes why claims have been denied and how consumers can appeal such denials—few consumers understand the information offered by insurers. Put simply, consumers and insurers do not engage on anything like a level playing field.
- Regardless of the cause, health insurers have a troubling track record. Many years of premium increases that far outstrip inflation and serious discrimination against people with health problems have engendered skepticism about health plan performance in the absence of strong regulatory intervention.

To address these and other concerns, PPACA extensively reforms health insurance markets, with many of the strongest measures going into effect on January 1, 2014. State governments are likely to play a central role in determining the extent to which these reforms succeed or fail.

Much of PPACA imposes new legal duties on insurers. Once a state has modified its insurance statutes to fit federal law, these requirements can be enforced by state insurance commissioners, using current mechanisms. Insurers' new duties have been discussed at length elsewhere,[106] including in the above summary of PPACA. And PPACA permits states to go beyond federal requirements in certain areas—for example, by increasing the percentage of premiums that must be spent on health care or by limiting the permissible extent of premium variation based on age.

What has received much less discussion, however, are the new tools PPACA provides to hold insurers accountable; and states' ability to increase competition in health insurance markets, including through offering state-based public plans.

New tools to hold insurers accountable

PPACA creates several promising new accountability mechanisms.

Data requirements

In the past, insurance commissioners have not always found it easy to determine whether insurers were abiding by applicable legal requirements. Often, access to hard data has proven essential to detecting violations. For example, year-end audits have frequently been useful in assessing whether insurers were complying with state laws regulating insurance premiums. According to the National Association of Insurance Commissioners (NAIC):

> "[NAIC's] uniform nationwide reporting and auditing standards … allow states to compare the information provided in rate filings by companies to the audited financial statement of those companies. State insurance regulators have found that oversight, reporting and verification of compliance with the law are critical to protecting the consumer."[107]

As noted earlier, PPACA now requires insurers to provide substantial new amounts of data concerning claims payment and denial, enrollment, disenrollment, provider participation, etc. Such data could prove critically important to spotting possible legal violations. For example, a plan with unusually high denial rates for certain claims could be targeted for investigation of potential failure to provide services included in the minimum benefits package. If a plan has high disenrollment rates involving consumers with high health care costs, that could signal potential discrimination based on health status.

A very low volume of paid claims in a particular geographic area and specialty may flag a gap in a plan's provider network.

Not only are data more abundant under PPACA, potential violations in charging premiums should be easier to detect than in the past. Most states have allowed premiums to vary based on many individual factors, with permitted ranges for each factor. The resulting complexity has made it very difficult to determine whether premiums are being charged consistently with state law. By contrast, under PPACA, the only factors that will affect premiums in the individual market are age, geography, and smoking, making it much easier to see whether premiums fit the rules.

Of course, nothing limits a state to the information required by PPACA. A state could require additional data from insurers, as a condition of licensure or access to the exchange.[108] 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 already required by HHS.

In gathering health plan performance information, whether mandated by federal or state law, a state needs to carefully structure its requests. For the data to be usable, a state would be well-advised to use the same, easy-to-compare forms for each health plan. Also, to lessen burdens on both health plans and regulators, state data requests need to be carefully targeted, seeking only relevant information.

Finally, a state could make these data publicly searchable and available (albeit in carefully redacted form that avoids any disclosure of patient identity).That would allow nongovernmental organizations, including consumer advocacy groups and researchers, to supplement the efforts of state regulators in identifying potential problems with health plan performance. It could also inform choice of health plan by employers and individuals.

The exchange

A state can bar qualified plans from participating in the exchange based on the best interests of the consumers and businesses who use the exchange to obtain coverage. Accordingly, access to the many covered lives in the exchange can be a reward for good behavior by insurers. A state could thus limit the exchange to health plans whose performance exceeds minimum requirements in terms of quality, consumer satisfaction, or affordable premiums. A state that articulated these requirements and allowed plans to meet them would be classified as a "selective contracting agent," under the typology described previously.

A state could be even more active by negotiating with insurers to arrange satisfactory terms. While Massachusetts is a "selective contracting agent" in the commercial market, it is an "active purchaser" when it comes to subsidized coverage in the exchange. Accordingly, that state's exchange saved an estimated $21 million in premium bids for subsidized coverage during state fiscal year 2011 through its careful process of review and negotiation with carriers.[109]

Of course, state regulators need to strike a balance. If the requirements for gaining access to the exchange are unduly onerous, the exchange may have difficulty attracting an adequate number of participating health plans.

The False Claims Act

PPACA Section 1313(a)(6)(A) applies the False Claims Act[110] to health plans' receipt of federal funds through the exchange. If a plan was not qualified to participate in the exchange but nevertheless did so, the insurer may be liable for three times the amount it collected in federal tax credits and subsidies for out-of-pocket costs, plus thousands of dollars in civil penalties for each wrongful federal payment. Such liability requires a showing that the insurer "knowingly submit[ted], or cause[d] another person or entity to submit, false claims for payment of government funds." "Deliberate ignorance" or "reckless disregard" of the facts can also give rise to a claim.[111] Put simply, liability may result if an insurance company participated in the exchange but knew or clearly should have known that it was not qualified to do so.

For example, PPACA forbids qualified plans from "employ[ing] marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs."[112] If an insurer violated this requirement by developing a marketing plan or benefit structure that was intended to attract low-cost rather than high-cost members, the insurer could be liable for three times the amount of federal subsidies the plan collected through the exchange, plus civil penalties.

The False Claims Act Legal Center explains as follows this law's special provisions that allow private parties to share in the government's recovery when it is the private parties who brought false claims to the government's attention:

> "The False Claims Act contains qui tam, or whistleblower, provisions. Qui tam is a unique mechanism in the law that allows citizens with evidence of fraud against government contracts and programs to sue, on behalf of the government, in order to recover the stolen funds. In compensation for the risk and effort of filing a qui tam case, the citizen whistleblower or 'relator' may be awarded a portion of the funds recovered, typically between 15 and 25 percent. A qui tam suit initially remains under seal for at least 60 days during which the Department of Justice can investigate and decide whether to join the action."[113]

In recent years, the False Claims Act has become one of the country's most important tools for addressing Medicare and Medicaid fraud.[114] In 2006, for example, the health care industry was responsible for more than 70 percent of total False Claims Act recoveries.[115] PPACA's explicit invocation of this Civil-War era statute thus has strong precedent when it comes to publicly-funded health coverage.

At a minimum, state officials can educate the public and health plans about the False Claims Act. Such an effort can help deter insurers from violating legal requirements for participating in the exchange. In addition, a state agency, such as an insurance regulator, can bring False Claims Act violations to the attention of the U.S. Department of Justice, potentially qualifying for a *qui tam* award that could help defray future enforcement costs.[116] Such a state agency may be in an excellent position to spot health plan misbehavior that gives rise to a False Claims Act cause of action.

Health consumer assistance programs

For federal fiscal year 2010, PPACA Section 1002 appropriates $30 million for the establishment and operation of independent health consumer assistance programs that help consumers file complaints and appeals, educate consumers about their rights and responsibilities, help consumers enroll in health plans and qualify for tax credits, and gather data documenting consumer complaints and problems. Programs must report these data to HHS, which shares them with other federal agencies and with state insurance regulators. After FY 2010, funding is authorized but not yet appropriated.

Both to help consumers obtain coverage and care and to help policymakers learn about emerging problems, a state could prioritize the establishment of a consumer assistance program. If a state authorizes its consumer assistance program to pursue False Claims Act complaints, resulting *qui tam* recoveries could help provide future funding for consumer assistance, as explained above.

In structuring these efforts, states could learn from some of the best practices of existing consumer assistance programs. For example, programs could partner with community-based legal services programs that already provide consumer assistance and represent beneficiaries in appeals. Likewise, states could authorize programs to bring systemic problems to the attention of administrators, state legislators, and the general public.[117]

Additional administrative resources

Like most state agencies, insurance departments are strapped for resources, particularly in states facing serious budget problems. It may not be realistic to expect most state officials to increase their enforcement activities without an increase in administrative funding.

Fortunately, several mechanisms are available to supplement current enforcement dollars, including the role potentially played by the exchange. A state could structure the exchange to work closely with its insurance regulator to assist in monitoring and oversight of plans participating in the exchange, lifting some burdens from the regulatory agency.

Depending on HHS interpretations of PPACA, an exchange might pay the state insurance regulator to certify plans as qualified, pursuant to an interagency agreement. As explained above, resources for the administrative activities of exchanges do not require state General Fund appropriations. Instead, they come from federal grants until 2015, after which they may be raised through user fees, such as charges to participating insurers.

A second such mechanism involves federal grants to strengthen states' capacity to monitor and analyze insurance premiums. PPACA Section 1003 appropriates $250 million in funding from 2010 until 2014 to help states review premium increases and to provide HHS with information and recommendations, laying the groundwork for later annual recommendations to the exchange about whether particular plans have increased premiums so rapidly that they should be excluded from the exchange. These resources could be helpful in meeting states' new responsibility, under PPACA, to annually review unreasonable premium increases, along with HHS, as well as to help discharge any existing responsibilities pertaining to insurance rate review.

Third, the above-described funding for health consumer assistance programs could help meet some existing responsibilities of state insurance regulators, depending on the extent to which such state agencies currently furnish similar assistance.

Administrative appeals for consumers

Under Public Health Service Act Section 2719, added by PPACA Section 10101, health plans must provide for internal appeals of purported adverse actions taken by health plans and, if such appeals are unsuccessful, external appeals decided by independent entities.

These administrative appeal rights are important for several reasons. First, they can help consumers obtain necessary services. Second, effective appeals procedures make health plans less likely to arbitrarily deny covered services, since such action may lead to public embarrassment and consequent loss of market share. And third, appeals give regulators information about health insurers' conduct. If a carrier reports a high appeal rate for a particular issue, that may signal a problem warranting further investigation.

Introducing new public and private competitors into existing health insurance markets

One strategy for improving health insurers' performance is to sponsor a new market entrant capable of winning market share away from plans that fail to meet consumers' needs. Federal legislation provides substantial funding to help capitalize the initial development of consumer-owned, cooperative health plans, an effort that a state could encourage.

But even with federal resources for the start-up phase, it is not easy for a new health insurer to gain a foothold in local markets. A new plan faces a catch-22: to recruit providers without paying exorbitant reimbursement rates, the plan needs numerous enrollees; but to recruit

enrollees, a plan needs a large provider network and the kind of low premiums that are impossible if providers are being paid exorbitant reimbursement rates.

The Massachusetts exchange managed to recruit a new private insurer to serve Massachusetts residents—the first new entrant to the state's insurance market in two decades.[118] However, this new insurer has enrolled very few consumers to date, reaching only 1 percent of subsidized participants in the exchange.[119]

To escape this catch-22, existing state-sponsored populations could form the nucleus of a new, publicly-administered health plan that competes with private insurers. Such an approach is being pursued in Connecticut, following that state's enactment of health reform legislation in 2009. Although the final details of implementation await further action in the state's 2011 legislative session, following are some of the key features of the state's approach:[120]

- State employees and retirees, along with Medicaid and CHIP enrollees, will receive coverage through a new plan, dubbed "SustiNet." Administered by a public entity, SustiNet will seek to slow health care cost growth while improving quality by implementing health care delivery system reforms that represent best practices, including interoperable health information technology (HIT), patient-centered medical homes (at a minimum for patients with chronic illness), and incentives for evidence-based care.
- Although all of the plan's enrollees will share a common platform for implementing delivery system reforms, state employees and Medicaid beneficiaries will have different covered benefits, out-of-pocket cost-sharing rules, and provider payment rates. The purpose of this difference is to ensure that the shift to SustiNet will not reduce benefits or increase costs for any members. The latter objective also means that state employees and retirees will remain in a separate risk pool, so that the costs of new enrollees do not affect premiums charged for state workers.
- By July 2012, SustiNet will be offered for purchase by small firms, municipalities, and non-profits, consistent with the state's small group market rules. To compete effectively for business, SustiNet can offer coverage with benefits and out-of-pocket cost-sharing typical of small group ESI, using brokers, agents, and other existing channels of sale.
- Once a major Medicaid expansion becomes effective, along with other subsidies and new mechanisms for highly expedited, automatic enrollment, insurers will be forbidden from discriminating in the individual market based on health status, and SustiNet will be available for purchase by individuals.

In the wake of PPACA's enactment, officials are considering qualifying SustiNet as a plan offered in the exchange starting in 2014.[121] This will require SustiNet to be a state-licensed plan. If Connecticut moves in this direction, it will need to decide whether to amend its existing insurance statutes to make it easier for a new, publicly-administered plan to become licensed. In addition, state policymakers may need to administer SustiNet through a quasi-governmental agency or independent state authority, to avoid a conflict of interest with state agencies that administer the exchange.

Other states could take a similar approach. Using public employees and publicly subsidized consumers to establish critical mass not only surmounts the "catch-22" problem described above, it offers the potential to galvanize a change in a state's health care delivery system, implementing many of the reforms described in the next section of this paper. With a substantial percentage of the state population enrolled in the publicly administered plan that implements delivery system reforms, it would become more economically feasible for physicians, hospitals, nurses, and other providers to change how they do business. Further, the state could work with private insurers to implement multi-payor innovations that include but go beyond the public plan, such as reforms that implement HIT and patient-centered medical homes. If a public plan competing in the exchange implements reforms that slow cost growth, private insurers may need to adopt similar reforms to preserve market share. And if one large plan makes changes in how its members receive health care, other plans may find it easier to do the same.

Put simply, not only could a state-sponsored public plan give private insurers competition that many state markets currently lack, it could help bring about a transformation in the state's overall health care delivery system that makes an important contribution to slowing cost growth while maintaining or improving quality and safety. Such a state policy would seek to pull together the diverse strands of delivery system reforms supported by PPACA into an integrated strategy for improving how health care is organized, reimbursed, and delivered, along the lines explored in the next section.

A Quick Recap
How states can use PPACA to hold insurers accountable to consumers

- Analyze PPACA's new data sources to improve detection of insurance company violations.
- Consider supplementing PPACA's data requirements if additional information would strengthen the state's capacity to monitor insurer behavior.
- Carefully structure and limit data requests, targeting only relevant information and using similar forms for all plans, thus simplifying the process of comparison and analysis.
- Make insurer performance data publicly available and searchable, after careful redacting of information that could potentially identify individual consumers.
- Consider using access to the exchange as an incentive for strong performance.
- Educate the public and insurers about the potential application of the False Claims Act to insurers that knowingly offering unqualified plans in the exchange.
- Authorize state agencies to bring False Claim Act claims, potentially using the resulting "whistleblower" awards to fund future enforcement efforts.
- Prioritize implementation of federally-funded health consumer assistance programs, partnering with community-based legal services offices that already furnish similar services, and authorizing such programs to inform the public and policymakers about emerging problems.
- Leverage additional resources for state insurance departments by contracting with the exchange to certify plans as qualified, using federal grants to build capacity for rate review, and working with health consumer assistance programs.
- Ensure satisfactory implementation of consumer appeal procedures to help consumers obtain promised services, to give plans additional incentives to follow the law, and to flag the potential emergence of systemic problems.
- Introduce new competitors to the health insurance market by sponsoring a publicly-administered health plan that begins with a critical mass of enrollees consisting of Medicaid beneficiaries and public employees and retirees. Offered in the exchange to individuals and small firms, such a plan could implement best practices for reforming health care delivery to slow cost growth while improving or maintaining quality.

Reforming Health Care Delivery and Financing to Slow Cost Growth and Improve Quality

One of the most widely shared complaints about the country's health care system is the unsustainable, ongoing growth in spending. A remarkable variety of solutions have been proposed to slow cost increases while maintaining or improving quality.

This variety found its way into federal health reform legislation. As Jonathan Gruber of M.I.T. observed, "It's really hard to figure out how to bend the cost curve, but I can't think of a thing to try that [the legislation] didn't try… Everything is in here."[122] PPACA thus includes new methods for provider payment, new methods of organizing health care delivery, efforts to shift consumer behavior in healthier directions, increased provision of preventive health care services, initiatives to measure and improve quality, increased funding for comparative effectiveness research, and more. PPACA also follows on the heels of the American Recovery and Reinvestment Act of 2009 (ARRA), which made major investments in HIT.

Not only do PPACA's strands embody many different substantive approaches, the policy tools employed are remarkably varied. National policy changes and demonstration projects with Medicaid and Medicare, demonstration projects that operate outside Medicare and Medicaid, grants to states, grants to other entities, rules for insurance companies, and new public health initiatives overseen by HHS all play a role.

This gives state policymakers much to work with—perhaps too much. Selectivity and focus are likely to be especially important features of successful state PPACA implementation in this area. A careful analysis of the health care delivery system within the state and intensive consultation with local academic experts, employers, providers, insurers, and other stakeholders could be helpful. Such preliminary work can help identify the reform strategies that address important issues within the state and have the support needed for successful implementation.

To help with that process, this section of the paper analyzes PPACA's provisions and state policy options under several general headings:

- Reimbursement reforms;
- Delivery system reforms; and
- Encouraging healthy behaviors, wellness, and prevention.

One preliminary comment is important. Outside the four corners of PPACA, ARRA's investments in HIT may prove critically important for many PPACA efforts to change the country's health care delivery system. A smoothly functioning information system, carefully tailored to help accomplish the goals of reimbursement or delivery system reform, can greatly facilitate the effectiveness of those efforts, whether they involve increased care coordination, management of patient care over time, or provider accountability.

Reimbursement reforms

General approach

Current fee-for-service payment methods reward providers for volume and for high-cost procedures, rather than for improving health outcomes or adding value by enhancing quality relative to cost. To fix this problem, a range of strategies have been suggested, including the following:

- Using "bundled payments" when a patient is hospitalized, so that a single payment covers all costs (whether charged by physicians, hospitals, or others) both during hospitalization and for a limited period afterwards. Because a flat fee would cover post-discharge care, providers would lose money if patients are readmitted shortly after discharge. As a result, bundled payments would furnish an incentive to prevent costly re-hospitalization.[123] Bundled payments are also justified as encouraging providers to work together, reducing fragmentation and increasing care coordination, ultimately improving quality and reducing cost.[124]
- So-called "Accountable Care Organizations," or ACOs, can 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.[125] The analysis of cost savings takes into account all services, not just those furnished by the ACO. Among the goals of this effort are to encourage provider collaboration, reducing fragmentation, increasing care coordination, and ultimately improving quality while lowering cost. ACOs are among the care innovations that are strengthened when HIT is carefully structured to support reforms in health care delivery and reimbursement, as noted above.
- Hospital do not receive payment for so-called "never events"—that is, care so substandard that it should never take place.[126] Payment can also be denied for treatment of infections or other preventable health problems that begin during a hospital stay. Along similar lines, reimbursement penalties can apply to hospitals with high rates of preventable readmissions soon after discharge.
- More broadly, "pay-for-performance" initiatives seek to increase or lower payment based on the achievement of identified metrics for providing safe, high-quality, efficient care; and "global payment" strategies cover multiple services within a single payment, thus avoiding incentives to furnish excess care.

Many aspects of PPACA embody this approach to reform.

PPACA Provisions

Medicare. By far PPACA's most ambitious effort in this area involves Medicare:

- *Hospitals*
  - Section 3001 establishes a hospital value-based purchasing program, starting in FY 2013. Under this program, a percentage of hospital payment is tied to hospital performance on quality measures related to common and high-cost conditions, such as cardiac, surgical, and pneumonia care, but re-hospitalization rates are not included. Hospital performance is summarized into a single number. The highest ranking hospitals receive higher payments, which are funded by reducing payments to other hospitals.[127] Hospital results are adjusted to take into account patient risk.
  - Section 3008 imposes financial penalties, starting in FY 2015, on hospitals that are in the top 25 percent nationally in their rate of infections or other health problems that the patient acquired while in the hospital. Rates are adjusted to take into account patient risk. The identity of these hospitals is disclosed publicly.
  - Section 3025 lowers hospital payments based on the dollar value of each hospital's percentage of potentially preventable Medicare readmissions, starting in FY 2012. Readmission rates are adjusted to take into account patient risk. The section also creates a quality assistance program to help poor-performing hospitals address problematic readmission rates. HHS is directed to publish information about hospital readmission rates for both Medicare and for all payers.
- *Physicians*
  - Section 3007 creates a value-based modifier for physician payment. Doctors who furnish above-average care, defined based on quality and cost, receive extra Medicare reimbursement, which is funded by lowering Medicare payments for other doctors. This new modifier is phased in during calendar years 2015 and 2016. Results are modified to take into account patient risk as well as geographic factors that affect costs.
  - Section 3003 precedes the application of value-based modifiers with confidential feedback to physicians and physician groups about their performance, including (beginning in 2012) information about their resource utilization compared to other physicians.
  - Section 3022 rewards ACOs that meet quality-of-care standards and reduce the costs of their patients' care relative to a spending benchmark. Such ACOs receive a share of the savings they achieve for the Medicare program. Alternatively, HHS can use other methods, including partial capitation for highly integrated ACOs capable of bearing risk. HHS can give preference to ACOs that establish similar arrangements with private insurers. This new initiative begins in January 2012 and takes into account patient risk levels.
- *Bundling.* Section 3023 establishes a pilot program on payment bundling 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 3 days before hospitalization through 30 days after discharge. The program begins on January 1, 2013, and can be expanded if it improves quality and reduces costs.
- *Patient-centered incentives.* Section 10331(h) authorizes HHS to implement a demonstration project giving beneficiaries financial incentives to select physicians who furnish efficient, high-quality care. Such incentives may not increase costs above or reduce benefits below what Medicare would otherwise provide. Put differently, beneficiaries who select high-value providers would either experience lower costs or receive additional benefits.

Medicaid. PPACA includes both options and requirements for state Medicaid programs to move forward with reimbursement reforms:

- *Demonstration projects*
  - Section 2704 directs HHS to establish Medicaid demonstration projects in up to eight states to test the application of bundled payment methodologies. This effort runs from calendar years 2012 through 2016. The demonstration will focus on health conditions that offer the possibility of improving care while slowing cost growth.
  - During fiscal years 2010 through 2012, Section 2705 of PPACA[128] directs HHS to operate, in up to five states, Medicaid demonstration projects that pay large safety net hospitals or networks on a global or capitated basis, rather than fee-for-service.[129]
  - Section 2706 lets states establish demonstration projects for pediatric ACOs from calendar year 2012 through 2016, along the same general lines described above for Medicare.
- *Payment ban.* As of July 1, 2011, section 2702 forbids federal Medicaid dollars from being used to pay for hospital treatment of infections or other health problems that a patient acquired while in the hospital.

State policy options

Medicaid-specific approaches. State policymakers interested in pursuing this approach can implement the Medicaid demonstration provisions described above and vigorously implement the ban on using Medicaid dollars to pay for health-care-acquired conditions. The latter ban applies, not just to Medicaid fee-for-service payments, but also to managed care. State Medicaid programs accordingly could include in their contracts with Managed Care Organizations provisions requiring health plans to track health care-acquired conditions, to report such conditions to state and federal authorities, and to deny payment.

Building on Medicare's reimbursement innovations. As Medicare implements reimbursement reforms, a state could apply those same reforms to public employee coverage, Medicaid, and commercial coverage in the exchange. Alternatively, rather than follow Medicare's lead, some states in the vanguard on this issue may seek to include Medicare within state multi-payor efforts already under way. Such inclusion could be proposed to the Center on Medicare and Medicaid Innovation, described previously on page 9.

Whether a state follows the federal lead or incorporates Medicare within state efforts, giving providers the same targets and incentives through multiple payors would drive behavior more powerfully than with a single program, even one as large as Medicare. Such coordination could also simplify providers' lives since they would have one set of incentives rather than multiple incentive schemes to incorporate into their practice patterns. To further increase the number of covered lives affected by a single set of reimbursement reforms, a state could encourage self-insured large employers and other private plans that operate outside the exchange to participate. In addition to strengthening and coordinating incentives for strong performance, an aggregated approach that bases incentive payments on all-payor performance would encourage hospitals and physicians to furnish high-quality, efficient care to all patients, regardless of their source of coverage.

On the other hand, states considering movement towards Medicare-style "pay for performance" methods need to understand some of the challenges experienced to date with this approach. Some researchers question whether these payment methods have caused significant shifts in provider behavior; key design features, such as the measures used to assess performance and the nature of the incentive payment, can have a large impact on how reforms work out in practice; and some observers have expressed concerns about unanticipated consequences, including worsening racial and ethnic disparities, narrowing providers' focus to the measures that are used to determine payment levels, and unfairly disadvantaging hospitals in low-income communities.[130] State policymakers accordingly may wish to see how Medicare and other payment reforms work in practice before committing wholeheartedly to bring state residents more broadly within these efforts. Officials could also consider phasing-in these initiatives gradually, perhaps starting with particular geographic areas rather than moving to immediate statewide implementation.

As one would expect, multi-payer initiatives can be challenging to manage. Each payor has its own priorities and management structure. Further, enrollees may have different characteristic profiles in Medicaid, Medicare, and private plans. An intervention that fits one setting may not fit another. A careful focus on these issues may help states devise effective plans to overcome the challenges inherent in using the leverage of multiple payors to transform reimbursement methods and provider incentives.

ACOs. PPACA's preference for Medicare ACOs that establish similar relationships with private insurers gives states an important opening. Using its regulatory powers and its role as a selective purchaser in the exchange, a state could develop ACO-type arrangements with both public employee coverage and exchange-based coverage. In addition, state officials could encourage private insurers operating outside the exchange and self-insured group plans to develop similar arrangements, on a voluntary basis. A strong degree of state involvement may be necessary to prevent ACO-provider groups from developing leverage that lets them extract excessive payment levels from private insurers.[131] But with that caveat, the ACO provisions of PPACA give states an opportunity to encourage the growth of integrated provider systems that take overall responsibility for the care of their patients on an ongoing basis, regardless of changes to the patients' sources of coverage.

Delivery system reforms

General approach

Many analysts describe most of American health care as fragmented and inconsistent, lacking the kinds of care coordination, evidentiary basis, and accountability that characterize high-performing health systems.[132] To remedy this state of affairs, numerous interventions have been proposed. Some of the largest scale approaches include the following:

- Interoperable HIT could allow the development of electronic health records (EHR) that a health care provider can access while seeing a patient. Health information exchange systems (HIE) would allow providers with diverse software to access and supplement a patient's EHR housed elsewhere. Implemented to support other delivery system reforms, HIT could stop the provision of redundant services and furnish decision support that prevents medical errors, improves adherence to clinical care recommendations, and potentially reduces health care costs.[133]
- Patient-centered medical homes (PCMH) add to primary care a combination of patient education, care coordination (including management of transitions from hospital to home), 24-7 availability for patient consultation, and a clear locus of accountability and patient contact.[134] Some applications of the PCMH model have resulted in cost savings with chronically ill patients, particularly when coupled with a robust HIT system.[135]
- Comparative effectiveness (CE) research could rigorously assess the strengths and weaknesses of possible treatments for particular health conditions. This would allow patients, providers, and health plans to make wiser choices between, for example, prescription drugs and surgery or between brand-name and generic drugs that seek to treat the same condition. While research alone is unlikely to change practice patterns,[136] incorporating the results of CE

research into health plan decisions about cost-sharing, covered services, and provider reimbursement methods could, according to the Congressional Budget Office, slow cost growth without harming health outcomes.[137]

Other strategies include providing services at home, immediately following hospital discharge, to prevent rehospitalization among patients at high risk of returning to the hospital if care goes unmanaged;[138] using pharmacists to manage multiple medications received by a single patient;[139] shared decision-making through which patients and their caretakers assume an active role deciding between possible courses of treatment;[140] and reforms that lessen the need to engage in defensive medicine to avoid malpractice liability.[141]

To summarize, many of these strategies seek improved care coordination and proactive management of patient care throughout the full continuum of settings and conditions. While such reforms frequently improve quality of care, achieving cost savings may depend on focusing innovations on high-cost, chronically ill patients and coupling delivery system changes with targeted information support, through either electronic health records (perhaps supported by resources made available under ARRA) or disease registries.

PPACA Provisions

PPACA approaches health care delivery system reform from many vantage points, in addition to the CMS Center for Medicare and Medicaid Innovation, described on page 9.

Patient-centered medical home. Provisions that promote patient-centered medical homes include 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 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. This new option is available to states beginning in January 2011.
- Section 3502 authorizes HHS grants to states to develop community health teams to support the PCMH model. Such teams support primary care physicians 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."[142]

Comparative effectiveness research. Sections 6301 and 10602 establish a Patient-Centered Outcomes Research Institute to conduct comparative clinical effectiveness research. Such research can include information obtained through accessing electronic health records for Medicare, Medicaid, and other coverage systems to analyze the effectiveness of various services with particular populations. This research is supported by an ongoing funding stream with fees from private insurers and the Medicare program, which are projected to equal $1.26 billion over 10 years. The findings announced by this Institute may not "include mandates for practice guidelines, coverage recommendations, payment, or policy recommendations."[143]

The exchange. To be a "qualified plan" capable of being offered in the exchange, a plan must implement a "quality improvement strategy," which includes[144] a payment structure that encourages:

- Improving health outcomes through quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, and the use of the medical home model;
- Preventing hospital readmissions, whenever possible, through a comprehensive program for hospital discharge;
- Improving patient safety and reducing medical errors through best clinical practices, evidence-based medicine, and HIT; and
- Wellness and health promotion (discussed below).

In addition, beginning in 2015, a qualified health plan is barred from contracting with a hospital that has more than 50 beds unless the hospital implements programs to promote patient safety and to prevent hospital readmissions soon after discharge.

Medicare. Several Medicare provisions implement delivery system reforms:

- Section 3026 appropriate $500 million for a Community-Based Care Transitions Program through which hospitals and community-based entities furnish evidence-based care transition services, including active post-discharge engagement, to Medicare beneficiaries at high risk for hospital readmission. The program is funded during calendar years 2011 through 2015, but the program may be extended and expanded if HHS determines that such steps would lessen Medicare spending without reducing quality of care.
- Section 3024 appropriates $30 million for FY 2010 through 2015 for an "Independence at Home" demonstration program for chronically ill Medicare beneficiaries. This program uses physician and nurse practitioners: (a) to provide—as part of a team that also includes physician assistants, pharmacists, and other health and social services staff—comprehensive,

coordinated, continuous, and accessible care to high-need populations at home; and (b) to coordinate health care across all treatment settings. The demonstration project is not intended to serve more than 10,000 beneficiaries, nationwide.

Additional specific reforms supported by PPACA include the following, each of which has funding authorized (but not yet appropriated):

- Sec. 3503 provides grants for medication treatment management (MTM) programs operated by pharmacists who serve the chronically ill, beginning in May 2010.
- Section 3506 establishes a program at HHS to facilitate shared decisionmaking, developing educational tools to help patients, caregivers, and authorized representatives understand their treatment options. This section authorizes grants to Shared Decisionmaking Resource Centers, which will provide technical assistance and training to physicians, who can also qualify for grants.
- Sec. 10607 funds state demonstration programs to evaluate alternatives to current medical tort litigation.

State policy options

Creative state policymakers can use these tools to pursue a number of promising options. Following are some approaches that illustrate a much broader range of possible strategies.

Patient-centered medical homes could be implemented with a focus on high-cost, chronically ill consumers, accompanied by the meaningful use of HIT to support medical homes and related efforts to improve quality and efficiency. Such a focused implementation of care reorganization supported by information technology increases the likelihood of cost savings through reduced hospitalization as well as improvements in quality of care that have an impact on patient morbidity and mortality. A comprehensive effort aimed at implementing PCMH could include the following elements:

- A state would implement the new Medicaid option for PCMH services, starting with a planning grant in 2011, and benefiting from eight quarters of enhanced federal matching funds.
- The state would also implement PCMH services with public employees and retirees. It could encourage (or even require) private insurers to do likewise in areas of the state that have a particularly strong provider infrastructure capable of moving forward quickly with this model of care.
- Once the exchange becomes operational in 2014, the state could require, as part of health plans' quality improvement strategies, that insurers wishing to sell coverage in the exchange must fulfill PCMH functions. (Such an approach has the exchange function as a "selective contracting agent.")
- The state would seek early funding from the CMS Center for Medicare and Medicaid Innovations to support the PCMH model with community health teams, 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). Such funding would be needed if, as some fear, the authorized grants described above do not become appropriated.[145] This funding could also support an intensive evaluation of effects on quality, clinical outcomes, cost, and patient and provider satisfaction. Given the need to slow health care cost growth by rapidly scaling up successful initiatives, such an evaluation could include early publication of interim results.

Other delivery system innovations, such as a home-based program to prevent hospital readmissions of high-risk patients, could likewise apply in Medicaid, to public employee coverage, and with health plans in the exchange. Such an effort could seek support from the CMS Center for Medicare and Medicaid Innovations, along the lines explained earlier, in connection with the PCMH model.

Comparative effectiveness research could be applied to encourage the provision of less costly care that is no less effective than more expensive alternatives. For example:

- At some point in the future, HIT systems could incorporate decision support that informs physicians when they are about to order a service that is more costly than an alternative that, according to CE research, is equally effective. Physicians could proceed with the more costly service, but that choice would need to be conscious and explicit, with the rationale recorded in the electronic health record. Such choices would be taken into account by systems of provider feedback and quality improvement.
- Public employee coverage could incorporate the results of CE research by paying only for the least costly service that provides known medical benefits. To address consumer concerns, states may need to include two safeguards. The first is a method for reimbursing more costly services based on a physician's showing that, given the particular patient, a more costly service is more likely to achieve its therapeutic goals or to avoid harmful side effects. Appeal rights would need to apply. And as a second safeguard, if the patient wants a more expensive service, he or she could obtain it by paying the extra cost.
- State law could authorize private health plans to implement policies in the commercial market like those described above for public employee coverage.
- Until this new policy has had several years in which to establish a track record, it would probably be unwise to apply it to subsidized coverage in the exchange, since low- and moderate-income consumers have less ability than others to pay for costly services out of pocket. This concern applies with even more force to Medicaid consumers. For these consumers, one of the two above-described safeguards would not exist.

All-payer payment systems. This promising reform is on the list of practices specifically authorized for testing by

the Center for Medicare and Medicaid Innovation. Under an all-payer system, fees can vary by hospital, but a facility must charge the same amount for a particular service whether the patient is uninsured or covered by Medicare, Medicaid, or private insurance. For many years, Maryland has operated such an all-payer system, which has slowed hospital cost growth, stabilized the state's hospital infrastructure by reducing the variability in hospital margins, and facilitated the provision of uncompensated care.[146] PPACA now opens the door for other states to replicate this successful approach, which can potentially benefit public and private payors alike.

Applying Medicare innovations to dual eligibles. A state could seek to apply to dual Medicare-Medicaid eligibles the above-described Medicare innovations involving Community-Based Care Transitions and the "Independence at Home" demonstration project. Dual eligibles are among the most costly and fragile of Medicare beneficiaries, so applying these innovations to this particular population could yield important gains, both financially and in terms of health status. A state pursuing this option would contribute its proportionate share of Medicaid resources, which would pay patient cost-sharing and cover Medicaid services outside the Medicare benefit package.

Prevention and wellness

General approach

Several dimensions of prevention are the subject of reform efforts. The first, sometimes called "primary prevention," involves population-based efforts to prevent the development of health problems. Such efforts may seek to eliminate environmental toxins, improve nutrition, increase exercise, reduce the use of tobacco and other addictive substances, alleviate stress, and otherwise encourage healthier behaviors. In particular, many observers now recommend vigorous efforts to address epidemic levels of obesity, which cause significant health care spending.[147]

A second dimension, often termed "secondary prevention," involves providing screenings and tests to spot potential health problems. The goal of such tests is to allow prompt diagnosis and early treatment that prevents the development of serious illness.[148]

PPACA Provisions

PPACA's approach to prevention has many dimensions.

HHS' fully funded health promotion initiatives outside Medicaid include the following provisions:

- Section 4001 establishes a National Prevention, Health Promotion and Public Health Council to develop a national strategy for prevention and health promotion.
- Section 4002 creates a Prevention and Public Health Investment Fund (Prevention Fund) to support initiatives to implement the national strategy for prevention and health promotion. PPACA appropriates ongoing resources to the fund, starting at $500 million in FY 2010 and gradually rising to $2 billion a year in 2015 and later years. HHS has broad discretion in the use of these funds.[149]
- Section 4201 creates a program of Community Transformation Grants, which can be supported through the Prevention Fund. These grants, which can go to state or local government as well as community-based organizations, support policy, environmental, programmatic, and infrastructure changes needed to promote healthy living and reduce racial and ethnic disparities. Among the potential uses of these grants are community-wide plans to reduce tobacco use, mental illness, or obesity. For example, such a grant could be used to build paths and restructure streets to make neighborhoods more walkable; to fund tax incentives and other initiatives to bring affordable, healthy food to low-income communities; to create afterschool programs that permit children and youth to exercise safely; etc.
- Section 4004 allocates up to $500 million for a national public education and outreach campaign aimed at promoting healthy behaviors and encouraging the use of available screenings and other preventive care services. This campaign includes development of a website allowing individuals to create personalized wellness plans.
- Section 2953 appropriates $75 million a year, during fiscal years 2010 through 2014, for "Personal Responsibility Education." These grants to states (or to local or community-based groups, if a state chooses not to apply) fund evidence-supported methods to teach adolescents about both abstinence and contraception, with the goal of lowering teen pregnancy rates. The grants are also used to teach adolescents about subjects that prepare them for adulthood, such as healthy relationships, parent-child communication, adolescent development, financial literacy, etc.
- New Public Health Service Act Section 2705, added by PPACA Sec. 1201, requires HHS, by July 2014, to establish a 10-state demonstration project testing wellness initiatives in the individual insurance market. Such initiatives can cut premiums by up to 30 percent when members participate in certain health promotion and disease prevention programs.

Medicaid health promotion provisions include the following:

- Section 4108 appropriates $100 million, for use beginning in January 2011, by states in giving Medicaid beneficiaries incentives to participate in programs that have demonstrated success in helping low-income people make improvements in their weight, cholesterol, blood pressure, smoking, diabetes, and (at state option) associated co-morbidities, such as depression. If a state chooses to participate in this effort, ordinary Medicaid statewideness requirements are waived as needed.
- Section 4107 requires Medicaid to cover tobacco cessation services for pregnant women, beginning on October 1, 2010.

- Section 4004's above-described public education campaign includes a requirement that states must educate beneficiaries about preventive and obesity-related services that are available to Medicaid enrollees, including obesity screening and counseling for children and adults.

Health promotion initiatives that are authorized without appropriations include the following:

- Section 4202 authorizes grants to states and localities to conduct pilot programs reducing chronic illness among 55-to-64 year olds.
- Section 4206 authorizes a demonstration project to furnish clients of community health centers with comprehensive risk-factor assessments and individualized wellness plans.
- Section 10408 authorizes $200 million in grants, from FY 2011 through 2014, to provide employees of small businesses with access to comprehensive workplace wellness programs. To qualify, a firm must have fewer than 100 full-time employees.

Initiatives focused on preventive health care services include the following:

- Under Sections 2713, 4104 and 4105, preventive services, without cost-sharing, are required of new health plans and guaranteed to Medicare beneficiaries.
- Section 4204 authorizes states to purchase adult vaccines at reduced rates under contracts between manufacturers and the Centers for Disease Control and Prevention.
- Section 4106 gives Medicaid programs the option, beginning in January 2013, to provide adults with (a) any clinical preventive service receiving an A or B grade from the U.S. Preventive Services Task Force and (b) immunizations recommended by the Advisory Committee on Immunization Practices. States that cover such services without copayments receive an extra percentage point in the federal matching rate for this care.

State policy options

Primary prevention. State policymakers interested in promoting healthy behaviors and wellness could seek federal grants and try to participate in the demonstration projects described above, including Community Transformation Grants; Medicaid grants to address obesity; smoking, and other risk factors; and any additional authorized grants that receive funding. States will also need to ensure that their Medicaid programs comply with federal Medicaid requirements for pregnant women's tobacco cessation services and public education about obesity screening and counseling.

Several of these initiatives may be controversial in particular states, including teen pregnancy prevention grants and demonstration projects involving wellness programs and premium discounts in the individual market. Some observers worry that the latter policies could discriminate against consumers with health problems and that employees may have differing access to and levels of participation in wellness programs based on their education, income level, and race or ethnicity.[150]

More generally, state policymakers need to understand that, while primary prevention yields many important benefits, not all such efforts save money. Positive results, both in terms of cost and health status, may be most likely if policymakers do two things: focus their efforts on the highest-risk populations and communities, among whom low-income people are disproportionately represented; and track the evolving science documenting the strategies that have the greatest impact, modifying interventions as necessary.

Secondary prevention. State public health officials could take advantage of discounted costs to purchase adult vaccines, including vaccines aimed at the flu and the human papillomavirus. State Medicaid programs could also consider covering, free of cost-sharing, preventive services that qualify for a small increase in the applicable federal matching percentage. While tests and screens for illnesses like cancer and high blood pressure may or may not save money, recommended screenings can improve health status by allowing the more rapid detection of illness and commencement of care.

A Quick Recap
How states can use PPACA to slow health care cost growth while improving quality

- Implement Medicaid demonstration projects that test reimbursement reforms.
- Consider applying the same reimbursement reforms to Medicare, Medicaid, public employee coverage, insurance sold in the exchange, state-licensed private insurance, and (on a voluntary basis) self-insured group plans. A multi-payor initiative can include Medicare either by applying Medicare reimbursement reforms to other payors or by applying state payment innovations to Medicare. The latter approach can be proposed as a demonstration project to the CMS Center for Medicare and Medicaid Innovation.
- Consider incorporating Accountable Care Organizations into private coverage, including public employee insurance, health plans offered in the exchange, and other private insurers. This approach may require active intervention to prevent ACOs from acquiring so much leverage with insurers that they can raise charges to unsustainable levels.
- Implement patient-centered medical homes (PCMH), supported by HIT investment, with an intensive focus on high-cost, chronically ill patients. A state could adopt the new Medicaid option for PCMH coverage, include PCMHs in public employee insurance, require plans in the exchange to cover PCMH functions, and encourage other private plans to do likewise. A state could seek funding from the CMS Center for Medicare and Medicaid Innovations for (a) community health teams that help one- and two-physician offices serve as a medical home and (b) evaluation, including rapid reporting of interim results.
- Implement other promising delivery system reforms. As with PCMH, such reforms can be included in Medicaid, public employee coverage, insurance offered in the exchange, and other private plans. One promising example is home-based monitoring and coaching for high-risk patients after hospital discharge, to prevent costly rehospitalization.
- Apply the results of comparative effectiveness research by furnishing HIT decision support that (a) tracks physicians' choices of high-cost care that furnishes no known clinical benefit and (b) asks physicians to justify those choices. States could also change public employee coverage to pay for the lowest-cost care that provides maximum clinical value, requiring consumers to pay the extra cost if they want alternative services that yield no additional clinical benefit. State statutes could permit private insurers to implement similar policies.
- Consider shifting hospital reimbursement to an all-payer system where a hospital's charges do not vary according to the patient's source of coverage.
- Apply promising Medicare innovations to dual eligibles. With duals as a target population, states could join Medicare demonstrations of delivery system reforms. These include community-based efforts to prevent rehospitalization of recently discharged patients; and home-based services for high-cost beneficiaries.
- Participate in federal grant programs and demonstration projects that promote healthy behaviors and wellness, including Community Transformation Grants and Medicaid grants to incentivize participation in programs that address obesity and smoking.
- Take advantage of new discounts for purchasing adult vaccines.
- For Medicaid adults, consider covering preventive services without co-pays.

Reducing State Budget Deficits

Many state officials have expressed concerns about the burdens PPACA will impose on state budgets. Receiving much less public attention is the potential PPACA offers to reduce state general funding spending on health care and health coverage. Such reductions can result from savings on health coverage for public employees and retirees; substituting federal Medicaid dollars for current state or local spending; moving Medicaid beneficiaries into coverage with subsidies that are funded entirely by the federal government; and slowing health care cost growth within Medicaid. In addition, the Congressional Budget Office (CBO) anticipates that ESI enrollment will drop by 2 percent.[151] Based on labor economics research, employers will pass on much of their resulting savings in the form of higher wages, which will increase state revenue.

The amount that specific strategies will save varies considerably by state. Accordingly, the goal of this section of the report is simply to flag potentially useful approaches for further, state-specific analysis.

Savings on health coverage for public employees and retirees

States can achieve savings through several approaches. First, PPACA provides $5 billion in federally-funded reinsurance to cover claims incurred by early retirees, provided that the employer furnishing coverage implements measures to reduce spending on the chronically ill. The statute specifically authorizes state and local government to claim these funds.

Second, integrating several strategies to help the chronically ill offers the potential to slow cost growth, as noted above. The combination of medical home services, HIT, and interventions to prevent rehospitalization can potentially achieve net savings, provided that these efforts are carefully focused on high-cost employees and retirees.

Third, state officials can help local governments benefit from these strategies to limit health care costs. In addition, many localities may be small enough to offer their employees and retirees coverage in the exchange, which could result in modest administrative savings. (As noted above, even large employers can begin participating in the exchange in 2017, at state option.) Cutting local health care costs can benefit a state financially by lessening the need for local aid.

Substituting federal Medicaid dollars for state and local dollars

Under current law, much state and local spending provides physical or mental health care to adults with incomes at or below 138 percent FPL. Such residents will qualify for Medicaid under PPACA. Even undocumented immigrants will qualify for Medicaid coverage of emergency services, so long as their incomes fall below the threshold and they meet state residency requirements (which can be shown, e.g., by presence in the state with intent to remain indefinitely).[152]

This means that significant state and local spending in these areas can now be replaced by federal Medicaid funds. In the most straightforward example, programs to compensate hospitals for serving the uninsured can now be replaced, in whole or in part, by Medicaid, including federal matching funds. Medicaid can likewise substitute for health coverage programs serving childless adults at the state or local level, often provided in connection with General Assistance or General Relief cash assistance.

More broadly, states can examine their health and human services spending on behalf of low-income adults to see which services might qualify for federal Medicaid funds. For example, counseling provided to parents to prevent or stop child abuse may qualify for Medicaid reimbursement, potentially along with other social services. State mental health services are another candidate for federal Medicaid funding, with the exception of health services provided to adults age 21 to 64 who are patients of an institution for mental disease (IMD), which is defined as an "institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases."[153] Even IMD services might qualify for federal matching funds in a state that participates in a PPACA-authorized demonstration of Medicaid coverage for IMD services that stabilize an emergency psychiatric condition.[154]

When these state programs serve childless adults who previously were ineligible for federal Medicaid dollars, this substitution of federal for state dollars can begin without delay. That is because coverage of childless adults is now permitted through State Plan Amendment, with states receiving their normal Medicaid match. For example, Connecticut has already received approval for a State Plan Amendment to provide federally-matched Medicaid to childless adults who previously would have qualified for the state-funded General Assistance Medical Care program.[155]

However, these strategies will become particularly promising beginning in 2014. At that point, adults who would have been ineligible for Medicaid under 2009 rules—that is, the "newly eligible"—will qualify for an unusually high federal matching percentage, starting at 100 percent in 2014-2016, as explained previously. A state does not reduce its access to such highly enhanced match if, like Connecticut, it implements an interim expansion of Medicaid for childless adults.

Moving Medicaid beneficiaries into subsidized coverage that is fully federally funded

Most states have some adults who receive Medicaid even though their income exceeds 138 percent FPL (calculated based on MAGI). Eligibility for pregnant women typically exceeds that threshold, in some states by considerable margins. The medically needy can also qualify with incomes above 138 percent FPL by incurring, within a state-defined period between one and six months in length, medical bills that reduce their disposable income below medically needy income levels. (The required level of health care costs before a consumer qualifies as medically needy is sometimes termed a "share of cost" or "spend-down amount.") In a few states, parents currently qualify with incomes above 138 percent FPL.

Without Medicaid, these adults would receive either subsidized coverage in the exchange or Basic Health Program (BHP) coverage in a state electing that option (described above). In either case, the federal government would pay all subsidy costs, lifting from states the burden of paying for Medicaid.

PPACA's maintenance of effort requirements for adults end once exchanges come on line in 2014. At that point, a state could, at least in theory, terminate Medicaid for some or all adults with incomes above 138 percent FPL, shifting them into federally-subsidized exchange coverage and reducing state General Fund costs.

This general strategy needs to be pursued carefully. Mishandled, it could create serious access problems for some beneficiaries, including pregnant women and long-term care recipients. To avoid such problems, a state could consider the following approaches:

- To eliminate Medicaid coverage for pregnant women above 138 percent FPL without reducing access to care, a state could implement two policies.
  - As explained previously on page 13, a state could use the BHP option to provide Medicaid-level benefits and cost-sharing to pregnant women along with other adults up to 200 percent FPL, with the federal government paying all costs.
  - For pregnant women at higher income levels who would have qualified for Medicaid under prior law, the state could supplement subsidies in the exchange to eliminate out-of-pocket cost-sharing for pregnancy-related services. State costs for such supplements would be significantly less than what the state would have spent under current law for Medicaid-eligible pregnant women.
- A state might be able to greatly reduce its spending on medically needy beneficiaries above 138 percent FPL while improving their access to care. HHS and the U.S. Department of the Treasury may conclude that tax credit eligibility can extend to medically needy adults as long as they have not yet fulfilled their spend-down requirements and become fully eligible for Medicaid. If so, states can encourage their medically needy beneficiaries to apply for the BHP or tax credits in the exchange. By shifting their coverage, many such beneficiaries would improve their access to care, since they would receive ongoing health insurance rather than episodic coverage that becomes available during each spend-down period only after they have incurred the required amount of health care costs. And beneficiaries could still qualify for Medicaid coverage of long-term care by paying for nursing home services or home-based care not covered by BHP or health plans in the exchange. But because insurance in BHP or the exchange will delay the start of these beneficiaries' spend-down, state long-term care costs will decline.

Fortunately, states do not need to decide these complex issues in the next year or two. Federal authorities have time to provide guidance that will help state Medicaid programs reduce their spending on adults above 138 percent FPL without harming vulnerable residents' access to care.

Slowing health care cost growth within Medicaid

As noted above, PPACA's delivery system reforms can be applied to Medicaid; and potential cost savings may result if the medical home model's care management innovations are coupled with HIT investments and focused tightly on high-cost, chronically ill beneficiaries. Along similar lines, PPACA's opportunities to encourage healthy behaviors could prove useful in slowing Medicaid cost growth.

But the most promising strategy to slow Medicaid cost growth may involve PPACA's new options to integrate Medicaid and Medicare dollars and services in covering dual eligibles (people who qualify for both Medicare and full Medicaid). These seniors and people with disabilities are some of the country's frailest, highest-cost consumers. Currently, a single dual eligible may be covered by three different systems—Medicare Parts A and B for most physician and hospital care, a Medicare Part D prescription drug plan, and Medicaid for long-term care, Medicare cost-sharing, and Medicaid services outside the Medicare benefits package. Each of these coverage systems has an incentive to shift costs to the others. Under these programs as traditionally run, care is rarely coordinated among these funding streams, creating dangers of redundant or even dangerously inconsistent care. And some providers have an incentive to maximize their revenues by "gaming" these various coverage systems, even if those strategies increase total taxpayer-funded costs.[156]

To address this situation, PPACA, for the first time, allows the complete integration of both dollars and care for dual eligibles. Section 2081 creates a new Coordinated Health Care Office within CMS to encourage the integration of Medicare and Medicaid for dual eligibles. In some ways more important, one of the models that PPACA approves for testing by the CMS Center for Medicare and Medicaid Innovation involves "[a]llowing States to test and evaluate fully integrating care for dual eligible individuals in the State, including the management and oversight

of all funds under the applicable titles with respect to such individuals."[157] The precise parameters of this model are not defined, leaving room for states to propose creative initiatives that incorporate social services, intensive care coordination, nimble management of service provision in response to individual consumer need and the evolving scientific literature, and the use of home- and community-based alternatives to nursing home care.

Given the fragile condition of many dual eligibles, implementing such a major change needs to proceed slowly and carefully. State policymakers could thus consider pilot-testing this reform in part of the state, gradually expanding it to other state residents if careful evaluation of early experience shows positive results for both taxpayers and beneficiaries.

Another approach would use insurers rather than state officials to coordinate care in fully integrated systems of coverage for dual eligibles. Medicare Advantage, the private health insurance option for Medicare, allows Special Needs Plans, or SNPs, to specialize in meeting the needs of particular populations. SNPs that focus on dual eligibles must coordinate services with Medicaid, but they are not required to include both Medicaid and Medicare dollars within a single, integrated system that covers the full continuum of care. PPACA gives an incentive for such integration by providing higher capitated payment levels when SNPs combine all Medicare and Medicaid dollars and take full responsibility for furnishing all covered services.

Using the SNP model, a state could, in effect, pay a health plan to develop and operate an integrated system of coverage and care for dual eligibles. This would allow the state to guarantee a level of savings by, for example, making a 5 percent reduction (relative to projected levels under the status quo) in Medicaid's contribution to the SNP capitated payment.[158]

Such an approach would carry risks. Private plans may have an incentive to provide too little care. Intensive quality measurement, using electronic health records and other methods, would be essential to detect and address emerging problems, along with the proactive involvement of independent patient advocates.

A second danger is that a small number of high-cost outliers could significantly affect total costs. To address this concern, it may be important for plans to purchase reinsurance and to have a large number of enrollees in each SNP. On the other hand, such a large enrollment level involves a trade-off of making it difficult or impossible to slowly phase in this new approach, starting with a small, local area.

In the past, states have tried to integrate dual eligibles' care, but such integration was severely constrained by federal law. As a result of PPACA, states now have significant new opportunities to test strategies that offer the hope of controlling costs with dual eligibles while maintaining or improving their access to high-quality care. Whether public agencies or private insurers administer systems of care that fully integrate all Medicare and Medicaid dollars and services, careful and deliberate implementation will be essential to both safeguard beneficiary health and assure the long-term sustainability of these new systems.

Revenue effects of reduced ESI

One final point about revenue is important to make in the context of state budget deficits. If CBO projections prove accurate, PPACA will result in a net 2 percent reduction in employer-sponsored insurance (ESI), as coverage becomes slightly less common among small firms and companies with mostly low-wage workers who qualify for subsidies in the exchange.[159] Labor economists teach that employers will share much of the resulting cost savings with workers in the form of higher wages.[160] If this takes place, states can expect increased revenue from income taxes and (to a lesser extent) sales taxes.

A Quick Recap
How states can use PPACA to reduce state budget deficits

- For public employee coverage, claim federal reinsurance funds for early retirees.
- Apply PPACA's strategies for slowing cost growth through delivery system and reimbursement reforms to public employee coverage. High-cost enrollees and their employers can benefit from integrated reforms that include strong HIT support for proactive care management systems like patient-centered medical homes.
- Help localities save money on health coverage through those same approaches as well as through providing access to group coverage in the exchange. Local savings may reduce the need for state-funded local aid.
- Shift state- and locally-funded services into federally-funded Medicaid. This includes mental health and social services for low-income adults, payments to hospitals for uncompensated care, and "General Assistance" health care programs for childless adults.
- Consider shifting Medicaid adults with incomes above 138 percent FPL into the exchange or the Basic Health Program, both of which have subsidies that are funded entirely by the federal government.
- Slow cost growth within Medicaid by applying, to high-cost beneficiaries, PPACA's strategies for delivery system and reimbursement reforms, described above.
- Achieve savings while improving patient care for dual eligibles by combining Medicare and Medicaid dollars and services into either a state-administered care management program or a private health plan receiving a single capitated payment covering all care. To avoid problems in serving this very fragile population, it may be important to begin with local pilot projects and gradually scale up.

Conclusion

As this report goes to press, public discussion of health reform remains hotly contested. Some defend the new federal legislation with fierce ardor, while others advocate its rapid repeal.

Whether state officials oppose the new federal law, support it, or remain neutral, they now face the daunting task of rolling up their sleeves and implementing the legislation as effectively as possible to benefit the people of their state.

This report's goal is to help state officials understand options for implementing PPACA to achieve important state policy goals. For decades, state officials have sought to improve access to coverage and care, slow cost growth, and improve quality. The new federal law provides powerful new tools for making progress towards these longstanding state goals.

Without doubt, the challenges of implementation are immense. But the policy rewards could be even more significant. As they have so many times in the past, officials in states across the country will surely take full advantage of this new federal legislation, exercising creativity and diligence to secure major gains for their states' residents.

Endnotes

1 Long-term care reforms include new options for states to provide home- and community-based care, new spousal impoverishment protections, efforts to prevent elder abuse, transparency initiatives, a new "CLASS Act" to promote enrollment in long-term care insurance, and other measures. See, e.g., National Senior Citizens Law Center, *The Medicaid Long-Term Services and Supports Provisions in the Health Care Reform Law*, April 2010; Carol V. O'Shaughnessy, *The Community Living Assistance Services and Supports (CLASS) Act: Major Legislative Provisions.* National Health Policy Forum, June 9, 2010.

2 For example, this section could permit states to operate a single-payer health care system.

3 See Kaiser Family Foundation, Kaiser Health Reform Gateway: Health Care Reform and Health Insurance Reform Analysis, Data and Information, Accessed June 17, 2010, http://healthreform.kff.org/; National Association of Insurance Commissioners & The Center for Insurance Policy and Research, Special Section: Patient Protection and Affordable Care Act & State Insurance Regulation, Accessed June 17, 2010, www.naic.org/index_health_reform_section.htm; National Governors Association, Health Reform Implementation Resource Center, Accessed June 17, 2010, www.nga.org/portalsitengamenuitem.751b186f65e10b568a278110501010a0/?vgnextoid=7f8844ce25208210VgnVCM1000005e00100aRCRD&vgnextchannel=92ebc7df618a2010VgnVCM1000001a01010aRCRD.

4 Nominally, coverage extends to 133 percent FPL. However, in determining income for Medicaid purposes, 5 percentage points are subtracted from MAGI. As a result, the effective eligibility threshold is 138 percent FPL.

5 In 2009, the federal poverty level was $10,830 a year for a single individual, $14,570 for a 2-person household, $18,310 for a 3-person family, etc.

6 The meaning of these "unreasonable limits" is to be defined in regulation.

7 PPACA does not modify previous federal law concerning citizenship and immigration status requirements for eligibility.

8 The statute leaves it to HHS to define the time and manner through which a state notifies HHS that it does not plan to run an exchange.

9 PPACA Section 1311(d)(5)(B).

10 OPM is the federal government's "HR" office. Among its other duties, it offers health coverage to federal workers and retirees.

11 Over time, these national plans gradually phase up to participating in all exchanges. In 2014 and the first few years thereafter, many state exchanges are likely to lack access to national plans.

12 In addition to meeting AV standards, plans at each level may not exceed specified annual limits on members' out-of-pocket costs.

13 Chris L. Peterson, *Setting and Valuing Health Insurance Benefits,* Congressional Research Service, April 6, 2009.

14 Peterson, op cit.

15 Thomas D. Snook and Ronald G. Harris, "Understanding Healthcare Plan Costs and Complexities," *Milliman Healthcare Reform Briefing Paper*, June 2009.

16 Lynn Quincy, *What will an "Actuarial Value" Standard Mean for Consumers?* Consumers Union (citing findings of Watson Wyatt Worldwide), December 2009.

17 Quincy, op cit.

18 The Health Savings Account limit is $5,950 for individuals and $11,900 for families in 2010. See Kaiser Family Foundation, *Summary of New Health Reform Law,* April 21, 2010, www.kff.org/healthreform/upload/8061.pdf.

19 Peterson, op cit.

20 Peterson, op cit.

21 Ronald McDevitt, Jon Gabel, Ryan Lore, Jeremy Pickreign, Heidi Whitmore, and Tina Brust, "Group Insurance: A Better Deal for Most People Than Individual Plans," *Health Affairs,* January 2010, 29(1):156-164.

22 See PPACA Section1312(a)(2).

23 In addition, plans must accept new enrollees in response to certain life events such as birth of a new child, death, divorce, marriage, etc.

24 The extent of required consultation is not specified in statute and presumably will be made clear by HHS through regulations or other guidance. See PPACA Section 1311(d)(6).

25 Separate application forms can still be used for categories of Medicaid coverage that do not base eligibility on MAGI, such as medically needy eligibility, eligibility for certain adopted and foster-care children, etc.

26 These amounts are indexed after 2014.

27 Stan Dorn, Ian Hill, and Sara Hogan, *The Secrets of Massachusetts' Success: Why 97 Percent of State Residents Have Health Coverage*, November 2009, www.urban.org/UploadedPDF/411987_massachusetts_success.pdf.

28 Mireille Jacobson and Thomas C. Buchmueller, "Can Private Companies Contribute to Public Programs' Outreach Efforts? Evidence from California," *Health Affairs,* March/April 2007, 26(2):538-548; Ian Hill, Corinna Hawkes, Mary Harrington, Ruchika Bajaj, William Black, Nancy Fasciano, Embry Howell, Heidi Kapustka, and Amy Westpfahl Lutzky, "Chapter III: Outreach" in *Congressionally Mandated Evaluation of the State Children's Health Insurance Program: Final Cross-Cutting Report on the Findings from Ten State Site Visits,*" prepared by Mathematica Policy Research and the Urban Institute for the U.S. Department of Health and Human Services, Revised June 2004, www.urban.org/UploadedPDF/1001343_schip.pdf.

29 Ian Hill, et al., 2004, op cit.

30 Donna Friedsam, Lindsey Leininger, Alison Bergum, et al., *Wisconsin's BadgerCare Plus Coverage Expansion and Simplification: Early Data on Program Impact*, prepared by the University of Wisconsin School of Medicine & Public Health, Population Health Institute, for the State Health Access Reform Evaluation program of the Robert Wood Johnson Foundation, October 2009.

31 PPACA Section 2202.

32 Social Security Act Section 1943(f), added by PPACA Section 2201.

33 In a related provision, Section 1413(b)(1)(A)(iv) requires forms to be as simple as possible, "structured to maximize an applicant's ability to complete the form satisfactorily."

34 Because of differences between MAGI and traditional Medicaid income eligibility methodologies, a state may not always know whether a particular parent would have been income-eligible under the state's 2009 rules.

35 *New York State Dept. of Social Services*, DAB No. 1134 (1990), cited with approval in *Connecticut Department of Social Services*, DAB No. 1982 (2005). See also *Illinois Department of Public Aid*, DAB No. 1320 (1992); *New York State Department of Social Services*, DAB No. 1216 (1991); *Ohio Department of Human Services*, DAB No. 900 (1987).

36 A third obstacle, not discussed in the text, involves child support enforcement. States routinely use Medicaid application forms to collect information that is used for such enforcement rather than to determine eligibility for health coverage. Depending on how HHS interprets the applicable statutes, states may be able to (or may be required to) eliminate such questions from Medicaid application forms, in which case states could gather this information after granting eligibility. While such an approach would expedite the application process and raise Medicaid participation levels, some may object on the grounds that fewer parents would cooperate with child support enforcement procedures if states could not use health coverage as leverage to force cooperation.

37 Social Security Act Section 1902(k)(1), added by PPACA Section 2201(a)(2).

38 Social Security Act Section 1937(b)(1)(D).

39 See undated CMS posting of the State plans approved by the Secretary under Section 1937 authority, www.cms.gov/DeficitReductionAct/Downloads/070607benchmarkssection1937.pdf. The very first state receiving HHS approval to cover childless adults under PPACA, Connecticut, is providing such adults with standard Medicaid benefits. HHS Press Office, *Connecticut First in Nation to Expand Medicaid Coverage to New Groups Under the Affordable Care Act*, June 21, 2010, www.hhs.gov/news/press/2010pres/06/20100621a.html.

40 If a state instead decides to provide newly eligible adults with benchmark coverage that differs from standard Medicaid adult benefits, it could take two steps to prevent this decision from obstructing the application process: first, adults who would have clearly been ineligible for Medicaid under 2009 rules because of excess income or status as a childless adult can be enrolled in benchmark coverage without any need to request additional information; second, when additional information is required to determine whether someone is a newly eligible adult (that is, when someone is a parent who may have been income-eligible under the state's 2009 rules), the state could gather such additional information after eligibility has been established, thus keeping the application process simple and streamlined.

41 Among other benefits, the National Directory of New Hires provides access to information about earnings from multistate employers, which report wages and new hires to one state, including for workers employed in other locations. However, PPACA's cross-reference to this provision may or may not provide states with access to this data base. That is because Section 453(l)(1) forbids disclosure except where expressly permitted by Section 453. It is not clear how HHS and the courts will reconcile these provisions.

42 Social Security Act Section 1902(e)(14)(D)(ii), added by PPACA Section 2202(a).

43 Added by PPACA Section 2202(a).

44 Such a policy may already be permitted as a "less restrictive" eligibility methodology under Social Security Act Section 1931(b)(2)(c). That is, a state could define income as the lesser of (a) income as ordinary determined and (b) income as found by another, specified need-based program. Such a methodology would be "less restrictive" since it would not deny eligibility to anyone. See Social Security Act Section 1902(r)(2)(B). It would pass muster under CMS' interpretation of "comparability" required of eligibility standards, so long as any state resident could apply for the specified need-based program. See Social Security Act Section 1902(a)(17).

45 Social Security Act Section 1902(e)(14)(H)(i), added by PPACA Section 2202(a).

46 PPACA Section 1413(c)(3)(A)(ii).

47 Dear State Medicaid Director Letter SMDL# 10-005, PPACA # 1, *New Option for Coverage of Individuals under Medicaid*, April 9, 2010. Social Security Act Section 1902(e)(14)(H)(i) is framed as continuing current Medicaid policies, which include the option to use less restrictive methodologies.

48 See PPACA Section 1413.

49 Dorn, Hill, and Hogan, op cit.

50 42 CFR 433.112(c) and 42 CFR 433.111(b)(3).

51 Kaiser Family Foundation, *Health Reform Subsidy Calculator -- Premium Assistance for Coverage in Exchanges/Gateways*, Updated 3/26/10, http://healthreform.kff.org/SubsidyCalculator.aspx.

52 Such an individual would receive cost-sharing subsidies sufficient to raise actuarial value to 87 percent. The cost-sharing amounts in the text are taken from the above example of an HMO with AV of 89 percent. The actual costs imposed on such an adult could thus be slightly higher.

53 Under CHIPRA, states have the option to cover children during their first five years of legal residence in the U.S.

54 Average annual per capita costs for non-disabled Medicaid adults under age 65 were $2,142 in FY 2006. Kaiser Commission on Medicaid and the Uninsured and the Urban Institute, "Medicaid Payments per Enrollee, FY2006," *statehealthfacts.org*, 2009. This is the equivalent of $3,263 in 2015, or just 63 percent of the $5,200 that the Congressional Budget Office (CBO) projects as the average subsidy in the exchange. CBO, *Preliminary Estimate of the Direct Spending and Revenue Effects of an Amendment in the Nature of a Substitute to H.R. 4872*, March 18, 2010. For the lowest-income adults in the exchange, subsidies will be higher—and it is the higher amount that will be paid to states for the Basic Health Program. (Note: the translation of FY 2006 costs into 2015 dollars is based on projected per capita national health expenditures in CMS Office of the Actuary, *National Health Expenditure Projections 2009-2019*, released in January 2010.)

55 In addition, PPACA Section 10333 authorizes—but does not appropriate—funds for community-based collaborative care networks that provide comprehensive coordinated and integrated health care services.

56 As indicated earlier, if administrative costs are incorporated into insurance premiums, federal tax credits may help pay those costs, along with other premium payments on behalf of consumers obtaining coverage through the exchange.

57 On the other hand, if state officials run the exchange, they may gain credit for the federally-financed subsidies that are used to purchase exchange coverage.

58 Robert Carey, *Preparing for Health Reform: The Role of the Health Insurance Exchange,* State Coverage Initiatives, January 2010, www.statecoverage.org/node/2147.

59 In the original, this category was termed, "Market organizer and distribution channel."

60 Edmund F. Haislmaier, *Health Care Reform: Design Principles for a Patient-Centered, Consumer-Based Market*, Heritage Foundation, April 23, 2008.

61 Haislmaier, op cit.

62 See, e.g., Katherine Baicker and Amitabh Chandra, "The Labor Market Effects of Rising Health Insurance Premiums," *Journal of Labor Economics,* July 2006, 24(3):609-634.

63 See PPACA Section 1333.

64 Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results*, May 2006, Boston: Harvard Business Press.

65 Patrick B. Miller, Denise Love, Emily Sullivan, Jo Porter, and Amy Costello, *All-Payer Claims Databases: An Overview for Policymakers*, Prepared for State Coverage Initiatives by the National Association of Health Data Organizations and the Regional All-Payer Healthcare Information Council, May 2010, www.statecoverage.org/node/2380.

66 In a different model, plans, rather than consumers, negotiate prices with providers. That shifts the locus of consumer involvement from choice of provider to choice of plan, with incentives to select plans that pass on lower provider prices in the form of reduced premiums.

67 Insurers may be reluctant to disclose, as proprietary trade secrets, payment rates to providers. That concern could perhaps be addressed by requiring the Centers to keep the identity of each insurer confidential, providing the public and researchers with redacted data and syntheses that shield information about particular insurers' payments rates.

68 For a list of state initiatives, see National Conference of State Legislatures, *State Legislation Relating to Transparency and Disclosure of Health and Hospital Charges, Updated: April 6, 2009*; additions reposted January 2010, www.ncsl.org/default.aspx?tabid=14512.

69 For an example, see Pennsylvania Health Care Cost Containment Council, *Hospital Performance Report, 31 Common Medical Procedures and Treatments, FFY 2008: Western Pennsylvania,* September 2009, www.phc4.org/reports/hpr/08/docs/hpr2008west.pdf.

70 New Hampshire Insurance Department, "Health Costs by Procedure," *NH Health Cost* (based on actual patient experiences between July 2008 and September 2009, and increased to recognize price inflation) www.nhhealthcost.org/costByProcedure.aspx.

71 See, e.g., John M. Colmers, *Public Reporting and Transparency*, The Commonwealth Fund, January 2007; Deloitte Center for Health Solutions, *Health Care Price Transparency: A Strategic Perspective for State Government Leaders,* 2007.

72 Ellen Peters, Judith Hibbard, Paul Slovic, and Nathan Dieckmann, "Numeracy Skill And The Communication, Comprehension, And Use Of Risk-Benefit Information," *Health Affairs,* May/June 2007, 26(3): 741–748.

73 Arnold Epstein and Eric C. Schneider, "Use of public performance reports: a survey of patients undergoing cardiac surgery," *Journal of the American Medical Association*, May 27, 1998, 279(20):1638-42; Lisa M Schwartz, Steven Woloshin, and John D Birkmeyer, "How do elderly patients decide where to go for major surgery? Telephone interview survey," *British Medical Journal*, October 8, 2005, 331(7520):821-827.

74 Judith H. Hibbard, Jean Stockard, and Martin Tusler, "Does Publicizing Hospital Performance Stimulate Quality Improvement Efforts?" *Health Affairs*, March/April 2003, 22(2):84–94; Martin N. Marshall, Paul G. Shekelle, Sheila Leatherman, and Robert H. Brook, "The Public Release of Performance Data: What Do We Expect to Gain? A Review of the Evidence," *Journal of the American Medical Association*, April 12, 2000, 283(14):1866–74.

75 Andrew Grossman and Robert Moffit, *Health Savings Accounts and the FEHBP: Perfect Together*, Heritage Foundation, September 21, 2004, www.heritage.org/Research/Reports/2004/09/Health-Savings-Accounts-and-the-FEHBP-Perfect-Together.

76 Edmund Haislmaier, *State Health Care Reform: An Update on Utah's Reform,* Heritage Foundation Special Backgrounder, April 9, 2010, www.heritage.org/Research/Reports/2010/04/State-Health-Care-Reform-An-Update-on-Utahs-Reform.

77 Utah Health Exchange, *Health Exchange Update*, January 12, 2010, www.exchange.utah.gov/report1.html.

78 Haislmaier, 2010, op cit.

79 The FEHBP statute lists required benefits using general categories, but plans vary in the precise details of the coverage they offer within those categories.

80 As a practical matter, premiums are likely to be lower if the exchange retains the flexibility to exclude qualified plans, thus furnishing it with leverage to negotiate with plans for reduced premiums.

81 Amy M. Lischko, Sara S. Bachman, and Alyssa Vangeli, *The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions*, Prepared by Tufts University School of Medicine for The Commonwealth Fund, May 2009, www.commonwealthfund.org/Content/Publications/Issue-Briefs/2009/May/The-Massachusetts-Commonwealth-Health-Insurance-Connector.aspx.

82 Cory Capps and David Dranove, "Hospital Consolidation and Negotiated PPO Prices," *Health Affairs*, March/April 2004, 23(2):175-181; Leemore Dafny, *Estimation and Identification of Merger Effects: An Application to Hospital Mergers*. Mimeo, Northwestern University, September 2005.

83 James C. Robinson, "Consolidation and the Transformation of Competition in Health Insurance," *Health Affairs,* November/December 2004, 23(6):11–24.

84 For example, one study found that, in areas of Switzerland with more health plan options and more complex choices, consumers were less willing to change health plans, even when significant savings could have been achieved by such changes. Richard G. Frank and Karine Lamiraud,, "Choice, price competition and complexity in markets for health insurance," *Journal of Economic Behavior & Organization*, August 2009, 71(2)550-562. Another study found that, as the number of retirement savings options increased (either in a laboratory setting or in real-world choices among 401(k) plans), participants were more likely to select the simplest, easiest-to-understand option, even if other, less simple options would have been more advantageous. Sheena S. Iyengar and Emir Kamenica, "Choice proliferation, simplicity seeking, and asset allocation," *Journal of Public Economics* (2010): 530-539. Another study found that, facing an average of 40 choices, Medicare prescription drug beneficiaries rarely select the options that provide maximum protection at lowest premium cost, and that if the number of choices were substantially reduced, beneficiaries would be much more likely to make choices that optimize their welfare. Jason Abaluck and Jonathan Gruber, *Choice Inconsistencies Among the Elderly: Evidence from Plan Choice in the Medicare Part D Program*, February 2009, National Bureau of Economic Research Working Paper w14759 (Last revised: April 19, 2010). It thus is not surprising that Medicare beneficiaries, including those with the most education, express a preference for fewer rather than more health plan options for prescription drug coverage. Thomas Rice, Yaniv Hanocha, and Janet Cummings, "What factors influence seniors' desire for choice among health insurance options? Survey results on the Medicare prescription drug benefit," *Health Economics, Policy and Law,* October 2009.

85 One example of a website that currently provides information about options available in the individual market is ehealthinsurance.com. Post-PPACA, a similar website could be even more useful, as plans outside the exchange will be subject to federal requirements for information disclosure and presentation of plan information using consistent formats.

86 See Consumers Checkbook, *Agency and Association Access to CHECKBOOK's 2010 Guide to Health Plans for Federal Employees,* May 2010, www.checkbook.org/newhig2/more.cfm.

87 Jon Kingsdale, "Health Insurance Exchanges – Key Link in a Better Value Chain," *New England Journal of Medicine,* June 10, 2010, 362(23):2147-2150.

88 Ann Volpel, Asher Mikow, and Todd Eberly, *Marketing State Insurance Coverage Programs: Experiences from Four States*, State Coverage Initiatives, November 2007, www.statecoverage.org/node/164.

89 As explained by a researcher at the Heritage Foundation, "[E]mployee turnover and employers switching coverage in search of lower rates makes it difficult in traditional group coverage to maintain the continuity needed to successfully implement wellness or disease management programs that take more than one

year to show results. However, when workers, not employers, choose their coverage, they are more likely to renew coverage that satisfies their needs and expectations. This gives insurers an opportunity to experiment with offering long-term incentives, such as premium rebates for customers who stay with their plans over a number of years and successfully participate in wellness or disease management programs with measurable, personal outcome goals." Haislmaier 2010, op cit.

90 One study of FEHBP coverage found that, in areas of the country where the federal government paid a percentage of premiums for many plans, age (and the corresponding associated need for health care) did not affect employees' choice of health plan. Both young and old workers selected comprehensive benefits. By contrast, in areas of the country where, in effect, the federal government made a fixed dollar premium contribution, older and younger workers were much more likely to select different plans, with the older workers choosing more and younger tending to select less comprehensive coverage. Bradley M. Gray, Thomas M. Selden, "Adverse Selection and the Capped Premium Subsidy in the Federal Employees Health Benefits Program," *Journal of Risk & Insurance,* June 2002, 69(2): 209-224.

91 Linda J. Blumberg and Karen Pollitz, *Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals*, prepared by the Urban Institute and the Georgetown University Health Policy Institute for the Robert Wood Johnson Foundation, April 2009, www.urban.org/UploadedPDF/411875_health_insurance_marketplaces.pdf.

92 If an employer offered its workers multiple actuarial values and a single, uniform premium contribution, only the more affluent employees might have the income needed to buy the most comprehensive plans. Massachusetts' rule thus means that, if the most highly-compensated workers at a company want generous coverage while still gaining the labor market advantages of furnishing health coverage to other employees, everyone at the company must be offered that same coverage with employer subsidies that make the cost affordable.

93 Staff from the National Association of Insurance Commissioners (NAIC) explained this risk as follows:

"Some exchange proposals have suggested giving individual employees of small businesses receiving coverage through the exchange their choice of any plan offered in the exchange. While the portability of such coverage is extremely attractive, a number of technical difficulties make this a difficult task that must be approached carefully to avoid market distortions."

"If the group is rated as a whole, there is a potential for adverse selection as the individual employees select coverage from multiple insurers and become members of separate risk pools. Higher-risk employees would tend to gravitate toward more comprehensive coverage but would only carry with them a premium based upon the average risk of the group. Lower-risk employees, on the other hand, would tend toward less comprehensive coverage and would carry with them premiums that are higher than their individual risk would suggest. Furthermore, for an individual whose risk is average for a given group, the premium may not be sufficient to cover costs, even when selecting an identical plan from a different insurer if the risk pools of the two carriers are different." Josh Goldberg and Brian Webb, *Health Insurance Reforms (Discussion Draft)*, National Governors Association (NGA) Working Paper, updated March 5, 2010, prepared by the NAIC for the NGA, www.nga.org/Files/pdf/1003HEALTHSUMMITINSURANCEREFORMS.PDF.

94 The advantage of using pre-tax dollars, as is required of employers using exchanges in both Utah and Massachusetts, is that coverage becomes more affordable to the worker. On the other hand, consumers are less sensitive to premium differences if they pay their costs with pre-tax dollars. Walton Francis, *Putting Medicare Consumers in Charge: Lessons from the FEHBP*, presentation at American Enterprise Institute, December 16, 2009. As noted above, a heightened sensitivity to premium differences has the advantage of slowing cost growth but the disadvantage of worsening risk segmentation among health plans.

95 Kingsdale, op cit.

96 If such charges are ultimately reflected in premiums, federal subsidies may wind up paying most of these costs.

97 Elliot K. Wicks, *Building a National Insurance Exchange: Lessons from California*, California HealthCare Foundation, July 2009, www.chcf.org/publications/2009/07/building-a-national-insurance-exchange-lessons-from-california; Elliot K. Wicks, "The Insurance Exchange In Health Reform: Essential Characteristics," *Health Affairs* Blog, October 14, 2009, http://healthaffairs.org/blog/2009/10/14/the-insurance-exchange-in-health-reform-essential-characteristics/.

98 Massachusetts Connector, *Health Reform Facts and Figures,* May 2010, www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/News%2520and%2520Updates/Current/Week%2520Beginning%2520March%25209%252C%25202008/Facts%2520and%2520Figures%25203%252008.doc.

99 Reflecting the same basic pattern that emerged in Massachusetts, most participants in exchanges (19 out of 24 million) are projected to be subsidy recipients. CBO, *Preliminary Estimate of the Direct Spending and Revenue Effects of an Amendment in the Nature of a Substitute to H.R. 4872*, letter to the Honorable Nancy Pelosi, March 18, 2010.

100 E.g., Utah Office of Economic Development, Office of Consumer Health Services, *The Utah Health Exchange: A Utah Solution for Utah Businesses*, May 19, 2010, www.le.state.ut.us/interim/2010/pdf/SpecialBriefing/UtahHealthExchange.pdf.

101 Mark McClellan, *Rising to the Challenge of Real Health Care Reform*, Brookings Institution, October 2008, www.brookings.edu/opinions/2008/10_health_reform_mcclellan.aspx.

102 Robinson, op cit.

103 John Holahan and Linda J. Blumberg, *Is the Public Plan Option a Necessary Part of Health Reform?* prepared by the Urban Institute for the Robert Wood Johnson Foundation, June 2009, www.urban.org/UploadedPDF/411915_public_plan_option.pdf.

104 Blumberg and Pollitz, op cit.

105 Karen Pollitz, Richard Sorian, and Kathy Thomas, H*ow Accessible Is Individual Health Insurance for Consumers in Less-Than-Perfect Health?* prepared by the Georgetown University Institute for Health Care Research and Policy and K. A. Thomas and Associates for the Henry J. Kaiser Family Foundation, June 2001, www.kff.org/insurance/upload/How-Accessible-is-Individual-Health-Insurance-for-Consumer-in-Less-Than-Perfect-Health-Report.pdf.

106 For a good summary, see National Association of Insurance Commissioners (NAIC), *Patient Protection and Affordable Care Act of 2009: Health Insurance Market Reforms*, (undated) http://naic.org/documents/committees_b_Market_Reforms.pdf; and NAIC, *Patient Protection and Affordable Care Act: Selected Health Insurance Provisions*, (undated) http://naic.org/documents/index_health_reform_general_ppaca_selected_health_ins_provisions.pdf.

107 NAIC, *NAIC Response to Request for Information Regarding Section 2794 of the Public Health Service Act*, May 12, 2010.

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109 Massachusetts Health Connector, *Commonwealth Care FY 2011 MCO Procurement Results*, Board of Directors Meeting April 8, 2010, www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/Current/Connector%2520Board%2520Meeting%2520April%25208%252C%25202010/BOD%2520FY11%2520Procurement%2520Results%2520V3%25204-7-10%2520%25282%2529.ppt#571,1.

110 31 U.S.C. §§ 3729-3733.

111 Larry D. Lahman, "Bad Mules: A Primer on the Federal False Claims Act," *Oklahoma Bar Journal,* Vol 76:501 (2005), www.okbar.org/obj/articles_05/040905lahman.htm.

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113 False Claims Act Legal Center, *Why the False Claims Act?* [undated] www.taf.org/whyfca.htm.

114 Andy Schneider, *The Role of the False Claims Act in Combating Medicare and Medicaid Fraud by Drug Manufacturers: An Update*, Feb. 2007, prepared for Taxpayers Against Fraud Education Fund by Medicaid Policy, LLC, www.taf.org/schneider07drugreport.pdf.

115 Nathan Sturycz, "The King and I?: An Examination of the Interest Qui Tam Relators Represent and the Implications for Future False Claims Act Litigation," *St. Louis University Public Law Review*, Vol. 28, No. 459, 2009, http://papers.ssrn.com/sol3/Delivery.cfm/SSRN_ID1538393_code1241177.pdf?abstractid=1537749&mirid=1.

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121 The SustiNet Health Partnership Board of Directors, *Implementing SustiNet Following Federal Enactment of the Patient Protection and Affordable Care Act of 2010: A Preliminary Report to the Connecticut General Assembly*, May 30, 2010, www.ct.gov/sustinet/lib/sustinet/board_of_directors_files/reports/sustinet_60_day_report_05272010.pdf.

122 Ronald Brownstein, "A Milestone in the Health Care Journey," *The Atlantic,* November 21, 2009, www.theatlantic.com/politics/archive/2009/11/a-milestone-in-the-health-care-journey/30619/.

123 RAND Health COMPARE, *Overview of Bundled Payment*, Accessed June 20, 2010, www.randcompare.org/policy-options/bundled-payment.

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125 Kelly Devers and Robert Berenson, *Can Accountable Care Organizations Improve the Value of Health Care by Solving the Cost and Quality Quandaries?* prepared by the Urban Institute for the Robert Wood Johnson Foundation, October 2009, www.urban.org/UploadedPDF/411975_acountable_care_orgs.pdf.

126 Arnold Milstein, "Ending Extra Payment for 'Never Events'—Stronger Incentives for Patients' Safety," Health Care Reform Center, *New England Journal of Medicine*, June 4, 2009, http://healthcarereform.nejm.org/?p=455.

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