STATE HEALTH POLICY

Briefing

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STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

This *State Health Policy Briefing* identifies and describes ten aspects of federal health reform that states *must* get right if they are to be successful in implementation. These ten areas are:

1. Be Strategic with Insurance Exchange
2. Regulate the Commercial Health Insurance Market Effectively
3. Simplify and Integrate Eligibility Systems
4. Expand Provider and Health System Capacity
5. Attend to Benefit Design
6. Focus on the Dually Eligible
7. Use Your Data
8. Pursue Population Health Goals
9. Engage the Public in Policy Development and Implementation
10. Demand Quality and Efficiency from the Health Care System

This *State Health Policy Briefing* is a product of the State Consortium on Health Care Reform Implementation—a collaboration among the National Governors Association, the National Academy for State Health Policy, the National Association of Insurance Commissioners, and the National Association of State Medicaid Directors. This product has been reviewed by the Consortium and found to be consistent with its mission to add value to state policymakers and stakeholders in health reform implementation. Responsibility for the contents of this brief rests with the National Academy for State Health Policy.

NATIONAL ACADEMY *for* STATE HEALTH POLICY

State Policymakers' Priorities for Successful Implementation of Health Reform

BY ALAN WEIL

States that adopt a coordinated, strategic approach to implementing federal health reform will find that the new law contains many provisions that support significant improvements in their health care systems. At the same time, states will face significant challenges implementing the new law—in part due to the many tasks they must complete, and in part due to the extremely constrained financial and staff resources available to them.

There is a natural tendency to focus the implementation discussion on the most immediate issues—for example the state's choice regarding the high risk pool. Indeed, states must tackle these issues, but it is equally important that states begin thinking about and planning for the many aspects of implementation that occur in later years, particularly in 2014, when many of the law's provisions take effect.

At an April 26, 2010, meeting of the NASHP executive committee, the group identified ten aspects of federal health reform that states *must* get right if they are to be successful in their implementation. These ten areas are:

1. Be Strategic With the Insurance Exchange

The insurance exchange will be the exclusive vehicle for individuals and families to obtain subsidized insurance coverage, and it may also become a place where many individuals and firms purchase coverage without subsidies. As such, the insurance exchange presents each state with the opportunity to organize the chaotic and inefficient small group and individual insurance markets. A better-functioning market can improve choice and value for individuals, families, and small businesses, all of which are struggling to afford health insurance.

States have many choices with respect to the exchange. They may create separate exchanges for individuals and small businesses, or they may combine the two. They may create a statewide exchange, subdivide the state regionally, or join together with other states. States also may elect not to create an exchange at all, in which case the federal government will carry out these functions. Any one of these may be a reasonable choice for a state depending upon its own capacity and the nature of the insurance market. Beyond the number and size of the exchange(s), states must make choices about exchange governance, including whether the exchange is inside or outside state government, and, if inside, whether it resides in an existing agency, a new agency, or has an independent status.

Structural choices regarding the exchange will affect the state's ability to integrate the exchange into its overall implementation strategy. Critical exchange functions include selection of participating health plans and review of their rates, standardized presentation of information on benefits so people can make informed choices, standardized data collection across plans and holding plans to high standards in providing access to services and achieving health outcomes, and an effective risk adjustment mechanism to avoid incentives for risk selection and to assure that plans have sufficient resources to provide services to enrollees with high health needs. How the state approaches these functions—in particular how active or aggressive a role it plays in defining health insurance options within the exchange—will have a significant effect on the ultimate shape of the health insurance marketplace. An effective exchange will be a force for efficiency and an orientation toward quality in the insurance and health delivery sectors.

2. Regulate the Commercial Health Insurance Market Effectively

The federal law creates many new standards for health insurance underwriting and rating practices. Primary responsibility for enforcing most of those standards falls to the states. While insurance regulation is not a new state function, most states will be expected to dramatically increase their scrutiny of insurance rates and rate increases. Insurance regulation requires a significant number of resources, including highly technical skills. It also requires a range of enforcement tools.

Effective regulation is essential to assure availability of affordable coverage, to avoid risk selection between the exchange and the external market, and to focus the health insurance industry on delivery system improvements. The transition to new rating rules for small group and individual insurance must be handled carefully, as the existing market is fragile and subject to instability, and the amount of change in this market that will occur over a short period involves significant uncertainty.

States will also have a significant new role regarding review of health insurance premium increases. States must scrutinize rating and marketing practices carefully inside and outside the exchange. States must monitor the status of grandfathered plans to assure that they do not become an opportunity for risk selection or risk segmentation. Regulation will also be necessary to determine if new benefits such as preventive services are being delivered.

Effective commercial health insurance regulation will be critical to the success of the overall reform endeavor.

3. Simplify and Integrate Eligibility Systems

Dramatic simplification of eligibility is the only way to achieve the promise of near-universal coverage embodied in the federal law. To put it bluntly, 36 million Americans cannot be enrolled in Medicaid or the new exchanges by relying upon what in most states is a county-based eligibility platform designed around the cumbersome and intrusive processes of the welfare eligibility system. Eligibility systems in most states rely upon outdated technology and are expensive and slow to modify.

The federal law effects a tremendous simplification in Medicaid eligibility—moving to standards based on modified adjusted gross income as defined in the tax code. This simplification meshes nicely—at least in theory—with the simplified income tests for exchange-based subsidies. To make this work in practice, states must work out myriad issues that coordinate the flow of eligibility and enrollment information among Medicaid, CHIP, and the exchange. They must develop and refine data sharing between these entities and the federal government for information on income and citizenship. These information streams must come together in real time to provide potential enrollees with clear choices regarding their coverage options.

States have learned a great deal about effective outreach, enrollment, and retention of people eligible for coverage—but part of what they have learned is that those tools are only effective in the context of an improved eligibility system.

With guidance from the federal government, states must completely redesign their eligibility systems and processes to assure seamless transitions as families' incomes rise and fall; families are formed, grow, or dissolve; part time, seasonal, and migrant workers change status; and people move from one part of the state to another—or to another state entirely. This redesign must account for the need to continue administering fairly complex eligibility standards for some categories, such as people with disabilities, and for the efforts many states have made in recent years to offer single entry points for access to a broad range of social services, including the Supplemental Nutrition Assistance Program (SNAP, formerly Food Stamps) and child care subsidies. This is a massive undertaking. If done well, it holds the promise of incredible efficiencies and dramatic improvements in customer service and, ultimately, access to care.

4. Expand Provider and Health System Capacity

On average, people without health insurance use about 60 percent of the health care services as people with coverage. Expanding coverage will increase demand for services, which will strain the capacity of those parts of the health care system that are already under pressure. Particular challenges will arise in the areas of primary care, culturally competent and linguistically accessible care, and highly specialized care. Coverage expansions will occur at the same time as some institutions—community clinics, health centers and public and other safety net hospitals—are experiencing significant changes in their financing.

Expanding capacity is a long-term endeavor, so states must start now. The federal law provides some important opportunities. There are grant funds to support community health workers. There are opportunities for innovative payment and delivery models associated with telehealth in the areas of behavioral health and treatment of people with chronic illnesses, in particular by non-medical providers. There are significant changes in the allocation of graduate medical education training slots to emphasize primary care and outpatient settings and increased requirements on nonprofit hospitals to identify and meet community needs. There are a number of new funding streams designed to expand provider supply in underserved areas, promote a more diverse workforce, expand the number of oral health professionals and expand nursing capacity in federally qualified health centers. Federal grants to states to support alternatives to the current medical liability system may affect supply. And, while the new federal law does not make any changes in this area, now would be an excellent time to revisit state scope of practice laws and the state's approach to training and credentialing medical professionals.

Health coverage expansions will not create a provider supply problem, but they will highlight the problems states already have. The goals of health reform will not be met if the newly insured find that their coverage is a hollow promise.

5. Attend to Benefit Design

Benefit design has a powerful effect on access to and utilization of services—particularly for the low and moderate-income people most affected by health reform. Traditional design features such as copayments, deductibles, and benefit limits are blunt instruments. Newer concepts of evidence-based benefit design are more sophisticated. For example, some plans have eliminated cost sharing for medications designed to treat chronic conditions on the basis that use of these drugs should be encouraged, not discouraged through copayments. At the same time, new benefit designs under development increase cost-sharing for procedures that do not have an evidence base to support their effectiveness.

While the federal law establishes parameters for insurance coverage, and those standards may be further explicated through regulations, a significant number of benefit design

issues remain with the states. For example, the new Medicaid coverage for people with incomes below 133 percent of the federal poverty level is for so-called "benchmark" coverage, which can be designed more akin to a commercial plan than to the traditional Medicaid benefit structure. The broad authority states have to select plans to participate in the insurance exchange could be used to affect benefit design. Many states operate premium assistance programs for workers who have access to employer-sponsored insurance, and the standards for those programs could include certain criteria regarding benefit design. States retain control over their benefit mandates in the individual and small group markets—although they must reimburse the federal government for some subsidy expenses associated with those benefits. And, of course, states continue to purchase coverage for their own workers and retirees.

While benefit design initially affects how the enrollee interacts with the health care system, when considered across purchasers, effective benefit design can push the entire health care system toward an emphasis on prevention and coordination and away from services and procedures that have limited value.

6. Focus on the Dually Eligible

People eligible for both Medicare and Medicaid account for 42 percent of total Medicaid spending. This group of frail elders and a subset of people with disabilities experiences poorly coordinated care and high costs. Improvements in care for those who are dually eligible has long been a priority for states.

The federal law creates new challenges and opportunities for states. On the challenge side, the changes to the Medicare Advantage program will have implications for existing Special Needs Plans, which, despite their limitations, have been one source for coordination between Medicaid and Medicare. It is not yet clear how this will play out. States will also need to figure out how to integrate the new CLASS Act—a voluntary long-term care insurance program—into their overall strategy for meeting the long-term care needs of their citizens.

On the opportunity side, the law extends and expands the Money Follows the Person demonstration program to provide enhanced matching funds to help residents of institutions move back into the community, and creates new options for supports for people with disabilities. The law also establishes a competitive rebalancing incentive program that provides enhanced Medicaid matching payments for home and community-based services if states adopt certain delivery system reforms. The federal law creates a new office within CMS that focuses exclusively on the dually eligible, and the dually eligible are a target population for reforms that can be implemented by the new Center for Medicare and Medicaid Innovation. These two offices have not yet taken shape, but they offer unique vehicles for states to pursue models of integration between Medicaid and Medicare that have never before been available.

7. Use Your Data

Data is the engine of improvement. The American health care system stands out relative to other sectors of the economy and relative to the health systems of other nations as operating with limited data. Its roots are paper medical records, payment methods that are treated as trade secrets, and fragmented delivery systems and payers, each of which owns its own data.

There are myriad provisions in the health reform law that call for the collection of new data. Data elements include race, ethnicity and language, price and utilization, program enrollment, and quality metrics. New data will be collected on, among other things, consumer complaints, wellness programs, the prevalence of chronic diseases, and the health care workforce.

Effective use of data requires a commitment to collect it, a strategy to combine data that come from different sources, and selection of priority areas for analysis. Under the provisions of the American Recovery and Reinvestment Act, each state has already developed health information exchange strategic and operational plans. These plans should be updated to reflect the new data provisions and to refine the approach to placing appropriate subsets of the data in the public domain where it can become a force for improvement. Purchasers—individuals, employers, public purchasers and the exchange—can use data to drive improvement in outcomes and quality. Doctors, hospitals, and health systems can use data to achieve the same ends. The state can aggregate data across systems to monitor population health, identify priorities for improvement, and track progress toward improvement goals.

8. Pursue Population Health Goals

The ultimate goal of the health care system is to improve and maintain people's health and functional status. Population health goals create a bridge between public health and personal health, because population health goals are only attainable through the coordinated efforts of both systems.

The prevention and public health components of the federal law represent a fundamental shift from public health as an afterthought, subject to annual appropriations in competition with the more visible personal health services, to a core, sustained investment. In addition to the creation of the National Prevention, Health Promotion, and Public Health Council, which will coordinate federal strategy, the law includes a large number of grants to address topics including surveillance, public health laboratories, childhood obesity, and racial and ethnic disparities. States will need to consider how closely the criteria for these grants match the priorities and programs in the state.

On the personal health side, the law expands coverage for preventive services, promotes employee wellness programs, and increases payment levels to primary care providers through Medicaid.

The combination of expanded insurance coverage, appropriate benefit design, improved data collection and monitoring, and the increased investment in public health make it realistic for a state to pursue targeted and substantial improvements in the health of the population.

9. Engage the Public in Policy Development and Implementation

The public remains confused about how health reform will affect them. The large number of people eligible for Medicaid and CHIP but not enrolled demonstrates that simply creating opportunities for coverage does not mean people will take advantage of them. Fundamentally, health reform can only succeed if it is more about culture and norms than it is about mandates and penalties.

The public also includes the large health sector and employers, who will also face significant changes. The most successful efforts to improve the performance of the health system have been multi-sector, public and private initiatives that set goals and plans for concrete improvements. This framework is particularly essential when pursuing payment changes, which can only have their intended effect if they are adopted across purchasers.

The sheer number and scale of the tasks to be accomplished means the resources of each state's people and institutions must be brought into the implementation discussion. No amount of talent and goodwill in the state capitol can develop answers and policies that work for an entire state. States must develop a clear approach to achieving effective information flow between an engaged public and their elected representatives to weigh in on options before one is chosen, and to provide information back on how things are going so they can be improved.

10. Demand Quality and Efficiency from the Health Care System

The American health care system is the most expensive in the world. While delivering technically excellent care in many instances, it also has tremendous documented failures, including overuse of certain procedures, poor management of chronic conditions, excessive and duplicative use of diagnostic tests, avoidable errors that lead to harm and death, and expensive, wasteful administrative processes. In that context, it is imperative that all of the forces of health reform align to squeeze out waste so resources can go toward the unmet needs so many people have and back into the pockets of families and businesses that have far better uses for their limited funds.

Health reform provides states with a broad array of new tools for improving the quality and efficiency of the health care system. These tools include pilots for the establishment of pediatric accountable care organizations, the promotion of medical homes for people with chronic conditions, demonstrations on bundling payments for hospital, post-acute and physician services, and the broad authority embodied in the Center for Innovation.

Far beyond these specific demonstration programs, states have the ability to align the purchasing power they have within Medicaid, CHIP, public employees and retirees, and the new exchange. That leverage, used in conjunction with Medicare and private purchasers, can, through payment reform, benefit design, using data, and setting ambitious population health goals, yield changes in how health care is delivered. Leading states already have in place public and private partnerships that are using payment reform, transparency

with respect to price and quality, and other tools to achieve targeted improvements in health system performance.

Conclusion

States that pursue the ten critical elements identified in this brief will have the greatest chance of achieving the goals embodied in the federal health reform law. As discussed elsewhere, what states need to achieve effective implementation falls into five categories: information and analysis; strategic and implementation planning; topic-specific technical assistance; communications; and coordination across efforts and integration with existing efforts.[1] Among these needs, the most critical are clarity regarding the substantive provisions of the legislation, analysis of the fiscal and programmatic implications for states, full engagement with the public, and, ultimately, an overall strategy and set of goals, discussed publicly and adopted by the executive and legislative branches, that guides the work of all implementing agencies.

Now is the appropriate time for states to develop a set of overall strategic objectives to guide health reform implementation. This must be done now, even as states await additional federal guidance and many states anticipate new governors arriving in 2011. The specifics of implementation will change over time, but the guiding principles for successful implementation are likely to remain stable.

Endnotes

1 Alan Weil, Jackie Scott, Anne Gauthier and Sonya Schwartz, *Supporting State Policymakers' Implementation of Federal Health Reform,* (Portland, ME: National Academy for State Health Policy, November 2009).

NATIONAL ACADEMY *for* STATE HEALTH POLICY

About the National Academy for State Health Policy:
The National Academy for State Health Policy (NASHP) is an independent academy of state health policymakers working together to identify emerging issues, develop policy solutions, and improve state health policy and practice. As a non-profit, non-partisan organization dedicated to helping states achieve excellence in health policy and practice, NASHP provides a forum on critical health issues across branches and agencies of state government. NASHP resources are available at: www.nashp.org.

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