

Health Affairs

At the Intersection of Health, Health Care and Policy

Cite this article as:
Alan Weil and Raymond Scheppach
New Roles For States In Health Reform Implementation
Health Affairs, 29, no.6 (2010):1178-1182

doi: 10.1377/hlthaff.2010.0448

The online version of this article, along with updated information and services, is available at:

<http://content.healthaffairs.org/content/29/6/1178.full.html>

For Reprints, Links & Permissions:

http://healthaffairs.org/1340_reprints.php

E-mail Alerts : <http://content.healthaffairs.org/subscriptions/etoc.dtl>

To Subscribe: <http://content.healthaffairs.org/subscriptions/online.shtml>

Health Affairs is published monthly by Project HOPE at 7500 Old Georgetown Road, Suite 600, Bethesda, MD 20814-6133. Copyright © 2010 by Project HOPE - The People-to-People Health Foundation. As provided by United States copyright law (Title 17, U.S. Code), no part of *Health Affairs* may be reproduced, displayed, or transmitted in any form or by any means, electronic or mechanical, including photocopying or by information storage or retrieval systems, without prior written permission from the Publisher. All rights reserved.

Not for commercial use or unauthorized distribution

By Alan Weil and Raymond Scheppach

DOI: 10.1377/hlthaff.2010.0448
 HEALTH AFFAIRS 29,
 NO. 6 (2010): 1178–1182
 ©2010 Project HOPE—
 The People-to-People Health
 Foundation, Inc.

New Roles For States In Health Reform Implementation

Alan Weil (aweil@nashp.org) is the executive director of the National Academy for State Health Policy, in Portland, Maine, and Washington, D.C.

Raymond Scheppach is the executive director of the National Governors Association, in Washington, D.C.

ABSTRACT State policies and implementation practices will largely determine whether the new federal health reform law translates into more affordable coverage and access to health care services. States will play particularly important roles with respect to Medicaid expansion, the creation of insurance exchanges, and the new market rules for insurance. The decision of whether or not to create an exchange looms as the most important and consequential one for states. To achieve effective implementation, each state will need a coherent vision to guide its work. States will need help from the federal government and stakeholders and must learn from each other during implementation.

The Patient Protection and Affordable Care Act of 2010 creates a national structure for financing health insurance for low-income Americans. Its national rules eliminate various rating and underwriting practices in the small-group and individual insurance markets. However, state policies and implementation practices will largely determine whether the new federal law translates into meaningful, affordable coverage and access to services for the thirty-two million people who are expected to acquire insurance as a result of the law and the more than fifty million people currently covered by state-regulated insurance products.¹ States' choices will also have a major effect on whether the reforms lead to reduced growth in health care costs through changes in the health care delivery system.

In the course of implementation, states will need to make many decisions that reflect their own ambitions for health reform. The most important of these is whether or not to create one or more insurance exchanges. States that choose to play a larger role in implementation will face much greater challenges in the short run. Yet they also stand to gain long-term benefits through substantial health system efficiencies.

States have considerable expertise in adminis-

tering federal programs, but the health reform law arrives at a time of unusual challenges. State budgets are in their worst shape since World War II, and even though the national economy is recovering, states anticipate budget shortfalls of more than \$136 billion over the next several years.² Staff capacity at the state level is also limited as a result of hiring freezes, early retirements, and furloughs. Complicating matters further is the fact that at least twenty-four of the nation's governors will be new to their offices in January 2011.

The State To-Do List

The to-do list for states as they implement health reform is very long. Much attention has been paid to three core state functions.

MEDICAID ELIGIBILITY RULES First, states must create a new eligibility category within Medicaid that reaches everyone with incomes below 133 percent of the federal poverty level. This provision will bring sixteen million new people into the program,¹ increasing enrollment by 50 percent overall and by a much larger proportion in some states.³

INSURANCE REGULATIONS Second, states must modify how they regulate the small-group and individual insurance markets to, among other

things, eliminate exclusions for preexisting conditions; eliminate all rate variation by health status, industry sector, and sex, and permit variation only within a ratio of 3:1 with respect to age and 1.5:1 with respect to tobacco use; and provide greater oversight of proposed health insurance rate increases. These provisions represent a major change in regulatory standards for most states.

INSURANCE EXCHANGES Third, states must decide whether or not to establish insurance exchanges—one for small businesses and another that will serve as the exclusive vehicle for providing subsidized insurance coverage to individuals and families with incomes of 133–400 percent of poverty. Once operational, these exchanges are expected to be the source of coverage for twenty-four million people.¹

The exchanges will have to perform a broad range of tasks. These include providing standardized information about all products offered; coordinating eligibility determinations for income-related subsidies and Medicaid; developing risk-adjustment mechanisms; and overseeing health plans' practices with respect to benefit design, marketing, network adequacy, and quality. If states do not exercise the option of creating insurance exchanges, the federal government will step in, although how it will carry out these tasks is not at all clear.

OTHER STATE RESPONSIBILITIES Beyond these core tasks, states will also find dozens of options, grant opportunities, and requirements as they implement the federal health reform law. For example, states will have new options for moving their service delivery systems for long-term care in Medicaid even more toward home and community-based options. States may participate in a number of new initiatives designed to promote healthy living, provide health education, and expand community-based health improvement activities.

Up to eight states will be chosen to participate in a demonstration program that uses bundled payments to promote integration of care related to hospitalizations. There also will be a demonstration program to allow states to pay safety-net hospitals through a capitated payment structure—a fixed monthly payment per person, rather than payment for each service rendered. States also can seek grant funds to promote the development of medical homes through community health teams. And there are demonstration grants to states to develop alternatives to current tort litigation as the means of addressing medical harm. This is just a small subset of the myriad provisions that reach every aspect of state policy and practice affecting cost, coverage, access, and quality.

State Policy Context

As challenging as states will find these new requirements, the requirements should be viewed in the context of the leadership that states have demonstrated over the past few decades in pursuit of the same goals that are embodied in the federal health legislation. State leaders have identified five goals for health system improvement: connect people to needed services; promote coordination and integration in the health system; improve care for populations with complex needs; orient the health system toward results; and increase health system efficiencies.⁴

Long before federal reform, states were working to improve the health system. States have expanded coverage to certain populations, such as low-income children and working adults. They also have built effective systems for delivering services to vulnerable populations, such as children with special health care needs and people with developmental disabilities.

States have been simplifying and streamlining enrollment systems, so that people who are eligible for assistance can obtain coverage and states can reduce their administrative costs. States have been implementing the provisions of the American Recovery and Reinvestment Act of 2009 that are related to health information technology (IT), building state-specific strategic plans for how this technology can support efforts to improve the health system.

States have invested in patient-centered medical homes that provide coordinated and continuous care. States are starting to grapple with the details of payment reforms designed to reward prevention, health, and quality, rather than a high volume of services. Many state governments lead or participate in public-private partnerships designed to identify systemwide priorities for health system improvement and to develop strategies to attain agreed-upon goals.

States' Approaches To Implementation

To implement the Patient Protection and Affordable Care Act effectively, states will need to develop a coherent vision to guide their work, coordinate their many tasks so that everyone is working toward the same goals, and engage a broad range of stakeholders so that each state's choices reflect the realities of its own health sector and the values and preferences of its citizens. This translates into six concrete elements.

KNOWLEDGE State officials must have a clear understanding of the provisions of the law. This includes state requirements, options, and grant programs as well as the time line along which

the various provisions take effect. States need to monitor federal guidance and regulations in all areas where state action is required or optional—particularly with respect to the exchanges, Medicaid, and insurance regulation. States also need to monitor federal implementation as it affects states, such as how the federal government defines a medical home or designs its temporary high-risk insurance pool.

EXECUTIVE-BRANCH LEADERSHIP Each governor should appoint a coordinator to oversee state implementation and identify the staff responsible for the major tasks related to Medicaid, insurance regulation, and the exchanges. The coordinator’s team will need to develop a working relationship with legislative leaders, key figures in the state’s health sector, and representatives of constituent groups such as businesses and consumers. This team will also need to establish procedures for communicating its progress and decisions to the public.

STRATEGIC PLAN Each state’s approach should be guided by a strategic plan that reflects the priorities of the governor and state legislature and that captures the state’s goals for health reform. The federal law creates myriad new options for states in areas such as promoting health, reducing health disparities, achieving price transparency, pursuing liability reform, expanding care coordination, and reforming payment systems.

A strategic plan is necessary to ensure that the many specific implementation tasks work together to achieve these broad goals. For example, if a state has adopted reducing the incidence of obesity as a primary goal, it will want to pursue that goal through alignment of purchasing practices within Medicaid and the exchange (for example, holding health plans accountable for measurement and improvement), benefit design choices within those same programs (for example, requiring coverage of services such as dietary counseling), and pursuit of federal grant funds in this area (for example, community health grants). If implementation occurs piecemeal, efforts might not be coordinated.

OPERATIONAL PLAN Drawing on the strategic plan and knowledge of the federal law and state context, each state must develop an operational plan to implement the law’s many provisions. This plan must include state statutory and regulatory changes; applications to the federal government for grants; possible administrative reorganization, such as the creation of an entity to develop the exchanges; and specific implementation tasks. The plan must extend to at least 1 January 2014, when most of the provisions of the law go into effect. The plan needs to include specific mechanisms for engaging stakeholders

Each state must develop an operational plan to implement the law’s many provisions.

and communicating with the public.

NEEDS ASSESSMENT From the operational plan it should be possible to determine what resources the state will need to accomplish the critical tasks. These resources include general staffing levels and expertise in or knowledge about budgets and taxation, the insurance market, computer systems, and other specialized areas. As these needs are filled, or if they are not, it will be critical to revise the operational plan to reflect the state’s actual capacity.

SHORT-TERM PLAN There are a number of issues that each state must address immediately. Key early actions include establishing or modifying an existing high-risk pool, or deferring to a federal one; adopting a number of changes in insurance regulation; and working with the federal government on Web sites that give consumers information about their coverage options.

Conditions For Success

Given the many challenges that states face in implementing reform, to succeed each state must have a positive relationship with the federal government, active engagement with stakeholders, and effective means of learning from other states.

FEDERAL EXPERTISE In almost every area where state action is required, the federal government—often, but not always, the Department of Health and Human Services (HHS)—is authorized to promulgate regulations that define the parameters of state action and oversee or approve each state’s approach. The federal government should draw on its experience with the Children’s Health Insurance Program (CHIP). When that program was enacted, the relevant federal agencies involved the states in discussions of its regulations. After the program was reauthorized, the federal government issued informal guidance through documents such as lists of questions and answers and “Dear State Health Official” letters while it was developing formal regulations.

Success will require vision, leadership, commitment, and a willingness to take risks.

The biggest barrier to state action in response to the Patient Protection and Affordable Care Act will be uncertainty about whether state plans will fit within the guidelines that the federal government will ultimately adopt. Given the tight time lines and the many areas where guidance will be needed, the federal government needs to provide general direction as quickly as possible and adopt a posture of openness to state choices made in good faith before final regulations are in place.

ENGAGING STAKEHOLDERS Stakeholders have a great deal to offer in helping states design their approaches to implementation. Key stakeholders include health care providers, small and large employers, and consumer and patient advocates. Each of these groups brings a perspective that is critical to policy development, along with knowledge that will be essential as states begin implementation. The press of other work and limited staff make engaging stakeholders particularly challenging, but it is also particularly important.

LEARNING FROM OTHER STATES Despite the ways in which they vary, all states will be confronting many of the same issues and asking many of the same questions. An effective infrastructure for sharing ideas, approaches, and experiences across states will greatly improve the odds of successful implementation and will help address the resource limitations that states face.⁵ Four organizations—the National Academy for State Health Policy, the National Governors Association, the National Association of Insurance Commissioners, and the National Association of State Medicaid Directors—have formed a consortium to provide state officials with an efficient mechanism for obtaining the support they need.

The federal government has a critical role to play in supporting state implementation. We also anticipate that some of this infrastructure will be supported by health foundations that operate at the national level, while foundations that focus

on individual states will presumably assist with efforts in their target areas.

Opportunity And Obstacle

OPPORTUNITY FOR STATES Federal health reform creates an incredible opportunity for states. An expanded Medicaid population; an insurance exchange that will be sizable, because it will be the only place where individuals will receive income-based subsidies; a dramatic reduction in the uninsured population; and a broad range of payment and delivery system innovations being tested at the national level and supported at the state and local level all hold promise for the future. These changes will make possible significant reform in the way in which we deliver and pay for health care; a reorientation of the system toward health and prevention; and a level of transparency and accountability never before seen in the health care sector.

CHALLENGES Yet the resources necessary to realize this opportunity are substantial, and mustering them is a daunting prospect for states. States must begin implementation during the worst fiscal crisis in decades and in the face of considerable uncertainty regarding the costs to states associated with an expanded Medicaid program. Adding millions of people to the Medicaid rolls will require revamping computer systems, securing administrative resources to process applications, and developing the capacity among providers and insurers to deliver services to this new group.

Rewriting insurance rules in the context of a very fragile market requires careful calibration of the transition, as well as significant resources to make sure the rules are applied fairly and accurately in what could be a much larger market. States that create exchanges must do so with very little in the way of a road map. States must decide on governance, understand the workings of the small-group and individual insurance markets, assume financial risk for the operations of exchanges, and—with health plans—work through myriad issues such as benefit design, quality standards, and risk adjustment. States must also decide whether to create a single exchange, substate exchanges, or multistate exchanges.

Then these pieces must be tied together, to ensure the coordination of subsidies between the new exchange and a greatly modified Medicaid eligibility system, as well as the coordination of funds from the U.S. Treasury for individual subsidies and from HHS for costs related to Medicaid.

WHAT IT WILL TAKE TO SUCCEED Success will require vision, leadership, commitment, and a

willingness to take risks. These requirements go beyond the many other resources that states will need, such as analytic skills related to the actuarial sciences—and some of those skills are in short supply within state governments and expensive to procure.

States also will need strong relationships with the organizations that provide health care services, which will be asked—in some instances pushed—to do things differently. States will need patients and their families, who are justifiably concerned about the implications of change within the health care system, to be engaged in implementation. Ultimately, each state's citizens must trust that their governments will use the resources at their disposal to be a force for good, and that their leaders will be accountable to the electorate for achieving health system goals that will be extremely difficult to attain.

ONGOING CONTROVERSY The political controversy that surrounded the enactment of the health reform law continues today. It is embodied in the lawsuits filed by twenty-one state attorneys general and in the probable role that efforts to repeal the law will play in the 2010 midterm election. However, it is impossible to tell at this early date whether these efforts will actually delay implementation in some states. Although some states might not want to implement reform, others could make a rational decision to defer to the federal government technically complex tasks such as building an insurance exchange. Such a decision should not be confused with unwillingness to implement reform.

Conclusion

The implementation of health reform in the states will be challenging because of their financial condition and limited staff capacity, and the high turnover of governors in January 2011. Despite these challenges, states have the ability to carry out the many tasks ahead. States will need to understand the legislation, establish leadership teams, develop strategic and operational plans, conduct needs assessments, and tackle a number of issues very quickly. States will need help from the federal government, a broad range of stakeholders, and an infrastructure of state-to-state learning that will happen only with financial support from the federal government and private foundations.

Although states have many options in their implementation of the Patient Protection and Affordable Care Act, the decision of whether or not to create an insurance exchange looms the largest. States that take on this responsibility will face major implementation challenges, potentially rewarded by unparalleled opportunities for coordination of the health care system.

States' choices will largely determine whether the federal reforms go beyond simply covering the uninsured to actually improving the health of the citizenry and reducing the cost burden on taxpayers and businesses associated with achieving our health system goals. Given the central role of the states, it is worth keeping in mind that despite many new federal standards, how health insurance coverage translates into access and improved health will still vary greatly across the country, even after full implementation. ■

The views expressed here are the authors' own and do not represent those of the National Academy for State Health Policy, the National Governors Association, or their members or sponsors.

NOTES

1 Congressional Budget Office. Cost estimate to Speaker Nancy Pelosi, U. S. House of Representatives. Washington (DC): CBO; 2010 Mar 20.

2 National Governors Association and National Association of State Budget Officers. State fiscal update. Washington (DC): NASBO; 2010 Feb.

3 Analysis of data from the Kaiser

Family Foundation's StateHealthFacts.org, as cited in Grovum J. Confusion in the capitols. Stateline.org [blog on the Internet]. 2010 Apr 8 [cited 2010 May 7]. Available from: <http://www.stateline.org/live/printable/story?contentId=475804>

4 Justice D, Hess C, Weil A. State policymakers' priorities for improving the health care system. Portland

(ME): National Academy for State Health Policy; 2009 Nov.

5 Weil A, Scott J, Gauthier A, Schwartz S. Supporting state policymakers' implementation of federal health reform. Washington (DC): National Academy for State Health Policy; 2009 Nov.