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Testimony of Brian Imus
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Before the Illinois Health Reform Implementation Council
September 22, 2010

Good afternoon. My name is Brian Imus and I'm the director of the Illinois Public Interest Research Group. Illinois PIRG is a citizen-supported, non-profit consumer advocacy organization with more than 5,000 citizen members from across the state.

I want to thank Governor Quinn and members of the Council for taking the time to hear and consider the voices of consumers.

Setting up a strong health insurance exchange by 2014 is one of the most important things Illinois will do to ensure health care reform delivers lower costs and higher quality for consumers. A well-designed exchange will offer a clear array of health coverage options, with helpful quality and customer service rankings and useful tools that allow consumers to estimate potential out-of-pocket costs.

But an exchange should be much more than "Expedia for health care." In giving consumers better choices and offering the help they need in navigating the insurance market, it can act like the human resources department of a large employer. And as a purchasing pool, it can use its purchasing power to drive better quality for patients, and rein in costs—both by cutting waste and by focusing on prevention and proven treatments.

The extent to which the exchange helps rein in costs, provide better choices and improve quality depends on how it's designed. With thoughtful design and strong implementation, an exchange has the potential to be a critical tool to pull many elements of reform together, and do so in ways that are visible and accountable. It can simplify consumers' experience signing up for coverage; free small businesses from the burden of administering health benefits; cut waste and boost efficiency in the insurance system; and help control the underlying drivers of unnecessary costs in the health care delivery system.

We have recently put together a report that goes over detailed recommendations for how to build a strong exchange, but there are five key features:

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First, the exchange must be transparent, accountable, and responsive to consumers' interests, not those of the insurance industry. It should have a strong legislative mandate and mission statement focusing its efforts on delivering lower costs for consumers and small businesses. Consumers and business representatives should have input into the exchange's decisions, through appointments to decision-making bodies. Conflict of interest and revolving-door policies should be adopted, to prevent industry representatives from taking control of the exchange.

Second, the more enrollees the exchange has, the more power it will have to negotiate lower rates, lower costs through economies of scale, and spread risk over a larger pool. Illinois should operate a single exchange for both individuals and small businesses, and open the exchange to small businesses with up to 100 employees as soon as possible.

Third, the exchange should be an active purchaser, negotiating with plans to ensure low premiums and high quality. That means it must have the power to say no to low-performing insurers and refuse to list their products if they do not provide a good value to consumers. In addition, the exchange should set standards that encourage payment reforms that deliver better care and lower costs. By pushing insurers to adopt reforms like bundled payments and increased support of primary care, the exchange can be a powerful tool to leverage these important reforms across the health care system.

Fourth, the exchange should help consumers choose the plan that's right for them. It should offer a powerful, easy-to-use set of tools, including clear comparisons between plans, and quality and cost ratings. If consumers can make apples-to-apples price and benefit comparisons, they'll be better able to push plans to compete on cost and quality. The exchange should also ensure there are a range of clear, distinct choices, rather than an endless, confusing array of products with slightly different benefits.

Finally, the exchange must be stable. Insurers may try to cherry-pick healthy people outside the exchange, which would drive up exchange premiums. To prevent the exchange from being undermined, insurers should be required to offer the same products inside and outside the exchange, and use the same risk pool for both segments of the market. They should also be prohibited from steering customers outside the exchange – Illinois should carefully monitor marketing efforts and the way broker commissions are set to prevent this from happening.

The new federal health reform law gives us an opportunity to deliver better care at lower costs for all Illinoisans. The exchange is one place where we can put our own stamp on reform, and make sure it serves our state's needs. By adopting these five principles for our exchange, we can make sure Illinois' consumers get the affordable premiums and quality care they deserve.

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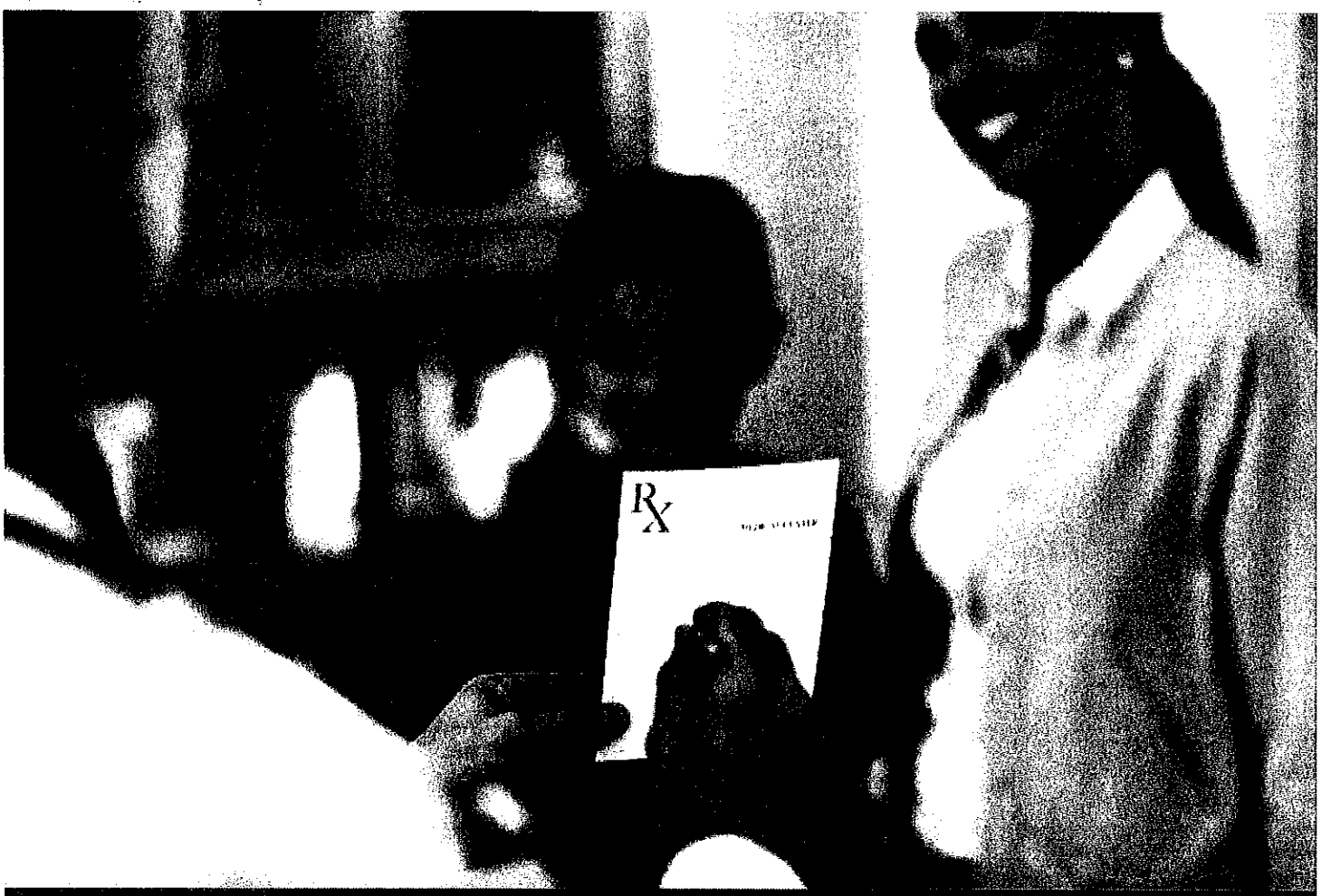

Delivering on the Promise

A State Guide to the Next Steps for Health Care Reform

Delivering on the Promise: A State Guide to the Next Steps for Health Care Reform

Illinois PIRG Education Fund

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Executive Summary

The recently passed federal health care reform law will make significant changes in how health insurance and health care work for consumers, businesses, and local and state governments, as well as how insurers and providers operate. But whether Americans experience improved care, lower costs and greater access depends largely on what happens next.

The federal bill provides powerful tools. Many of its provisions go into effect automatically or are enforced through federal agencies. But several of the most important decisions are left up to states. Unless state leaders take advantage of this opportunity and put reform into action, consumers and businesses will continue to face soaring premiums and out-of-pocket costs. While there are federal backstops for state inaction, these are an inadequate substitute for the active engagement of on-the-ground policymakers who are able to adapt the law's requirements to the unique policy and political landscape of their states.

Beyond formulating laws and regulations, states share responsibility for educating the public about health reform. Some of the new law's changes take effect this year, and many consumers will not be aware of what new benefits are available to them.

This guide has been written to assist state policymakers and advocates as they engage with the numerous issues and opportunities presented by the new law.

State Exchanges

States will have the opportunity to create new health insurance exchanges where individuals and small businesses will be able to pool their bargaining power and get information allowing them to choose the best health plan for them. But an exchange should be more than "Expedia for health care." In giving consumers better choices and offering the help they need in buying coverage, it can act much like the human resources department of a large employer. As a purchasing pool, it can use its purchasing power to drive better quality for patients, and rein in costs.

Key recommendations for states as they create the exchanges include:

- Studying the state's coverage landscape to ensure the exchange meets its unique needs

- Offering a powerful, easy-to-use set of tools for consumers, including clear comparisons between plans, quality and cost ratings, and ensuring there are a range of clear, distinct choices, rather than an endless array of confusing products. The exchange should help consumers easily sign up for a plan, and get the benefits to which they are entitled;

- Improving care quality and lowering costs by encouraging reforms that deliver better care for consumers. This may be accomplished by actively negotiating with plans on behalf of consumers, stopping excessive premium hikes, setting strong standards and ratings for quality care, and opening eligibility to as many individuals and businesses as possible, allowing them to pool their bargaining power on a single exchange;

- Protecting against the risk of insurers cherry-picking healthy people outside the exchange, which would drive up exchange premiums;

- Ensuring that the exchange's governance is transparent, accountable, and responsive to consumers' and businesses' interests, not those of the insurance industry.

Lowering Costs and Improving Quality

The new law offers a host of opportunities that will allow states to adopt groundbreaking reforms to make their health care systems more efficient and effective. Key strategies include prioritizing primary care via coordinated care teams called "medical homes," promoting the management of chronic diseases to help patients prevent acute flare-ups of their conditions, bundling payments to hospitals to reward those who provide effective care, and encouraging integrated care models called Accountable Care Organizations.

The specific steps states should take include:

- Adopting these transformative changes in state Medicaid programs;

- Pursuing the grant funding the federal law offers to support these programs;

- Directly implementing these reforms in state employee benefit programs.

Consumer Protections

New protections extended by the reform law will end many of the worst insurance industry abuses. But many of these protections will require a state role to ensure that they are enforced and deliver the maximum benefit to consumers:

- Young people up to age 26 will now be able to stay on their parents' coverage. States should encourage insurers to extend this benefit immediately, so that graduating seniors do not lose their coverage, and should ensure that young people applying to rejoin family plans can do so without being discriminated against if they are sick.

- The practice of insurers' retroactive

cancellation of sick enrollees' coverage will soon be ended. States should further require insurers to get regulatory approval before a patient is dropped.

- The law offers states grant funding to create or strengthen programs to review insurers' premium increases. States should use these funds to make sure that their programs look at all aspects of an insurers' business, including the steps they are taking to lower costs and improve quality. They should also make rate filings publically available.

- There is also funding to help states set up new temporary high-risk pools helping those with pre-existing conditions get coverage. States should make sure consumers are informed about these options, ensure the pools are not used as a dumping ground by insurers and employers, and finance them in an equitable fashion.

- Insurers will have to meet new standards for how much they devote to care, as against administrative costs. States should analyze these new standards to see how they mesh with their existing protections, potentially strengthening the federal rules if they would otherwise weaken current state law.

Beyond the Federal Reform

For all the strides taken by the new law, there are many important reforms it does not enact. States should take the opportunity to improve on the law by engaging with these unaddressed issues:

- Promoting greater administrative streamlining and reducing health care paperwork can lower costs for consumers, providers, and insurers.

- Limiting the worst marketing practices of the drug and medical device industries can deliver more affordable medical treatments.

- Encouraging research into the best treatments, and integrating this new knowledge into health IT systems, can reduce medical errors and help doctors.

- Ending the practice of billing consumers directly when hospitals are dissatisfied with the out-of-network reimbursements paid by insurers will protect patients.

- Empowering all payers to negotiate with hospitals en masse will take advantage of consumers' bargaining power to lower costs.

A State-Level Public Option

The federal reform ultimately did not include a national public option, which would be a strong policy for giving consumers more choices and driving competition in the insurance market. States may wish to pursue this policy within their own borders, but should be aware of issues of size and competitiveness that could affect its viability. They should also make sure that the public option is transparent and accountable, that it works to adopt the latest quality-enhancing and cost-lowering innovations, and that private insurers cannot game the system to weaken it.

i. Introduction

The recently-passed Patient Protection and Affordable Care Act will have a significant impact on how health insurance and health care work for consumers, businesses, and local and state governments, as well as how insurers and providers operate.

But whether Americans experience improved care, lower costs and greater access depends largely on what happens next.

All the contentious, polarizing debate over reform may have obscured the practical realities at the heart of this law: it is not policymakers in Washington, D.C., but those in statehouses across the country who will have the greatest impact on the success of reform.

The federal bill provides powerful tools. Many of its provisions go into effect automatically or are enforced through federal agencies. But several of the most important decisions are left up to states. Policymakers who may have been on the sidelines for much of the federal reform fight now have the opportunity to play a central role, as the focus shifts to fifty state capitals.

Unless state leaders take advantage of this opportunity and put reform into action, consumers and businesses will continue to face soaring premiums and out-of-pocket costs. While there are federal backstops for state inaction, these are an inadequate substitute for the active engagement of on-the-ground policymakers who are able to adapt the law's requirements to the unique policy and political landscape of their states. Further, policymakers will likely want to adjust state law in order to best fit their state's health care market and systems to the new law's changes. Even where a decision rests wholly with federal policymakers, states have an important role to play, providing guidance and comments based on their experience and needs, in order to shape forthcoming regulations.

Beyond formulating laws and regulations, states will also have critical responsibilities when it comes to educating the public about health reform. Some of the new law's changes take effect this year and will affect consumers across the nation, many of whom will not be aware of what new benefits are available to them.

To make the most of the new law, states can play a critical role in convening a campaign of community groups, nonprofits, and others to inform consumers of their new rights, and should consider dedicat-

ing substantial resources to this public information effort. Without consumer education, many of the benefits of health reform will not be fully realized. State and local authorities, working with community leaders, know how best to reach their unique populations and adjust their messages to the specific needs of their state's residents.

This guide has been written to assist state policymakers and advocates as they engage with the numerous issues and opportunities presented by the new law. Authored by a team of U.S. PIRG's state advocates and national experts, it builds on the experiences of professionals who have been working on these policies in state capitals throughout the country and in Washington, D.C.

In the sections to follow, we analyze the key areas where states must play a major role to make reform work for their residents. We detail the options facing the states, and make recommendations on how best to take advantage of these opportunities. It must be emphasized, however, that this is not a comprehensive analysis of the law—there are many significant changes that we discuss only in passing, because while they will have a large impact on many Americans, there is little scope for state involvement (we have listed some resources for those readers who do want such a comprehensive analysis in the following note).[1]

Whether states put reform into place through administrative rulemaking, executive order, or legislative action will depend on how each state is organized and distributes responsibility. Translating these recommendations into action will require grappling with the many complexities of the existing policy and political landscape in each state. But the bottom line is that now is the time for states to shine. It is up to them to build an affordable, efficient health care system that puts the needs of consumers and small businesses first.

Before turning to our recommendations, below is a brief summary of the architecture of the reform law. The sections that follow go into much greater detail on many of these policies; this summary is meant to provide an orientation for those discussions, rather than serve as a full reference for every provision in the bill.

The Federal Reform Bill: Main Provisions

When taking the measure of the crisis in our health care system, it is clear that there are many overlapping causes: consumers have to deal with the crisis of costs, the crisis of coverage, and the crisis of insurance abuses, not to mention problems of low-quality care, access to needed care, and health disparities. Accordingly, the federal reform law contains a host of policies and provisions. However, just as the problems fall into a few large categories, so too do the solutions, the most important of which are **bolded** in the summary below. The specific section of the new law pertaining to a policy is listed after its description.

Expanding Affordable Coverage

The reform law aims to greatly expand coverage by lowering the barriers that have too often been placed in the way: cost and pre-existing conditions. Perhaps the single most far-reaching reform in the law is its prohibition on insurers denying coverage for pre-existing conditions and charging different rates to sick and healthy enrollees. **Starting in 2014, insurers will need to take all comers, and offer everyone the same fair rate**—they can alter premiums based only on geography, family size, tobacco use, and an enrollee's age (though within limits—the oldest enrollee cannot pay more than three times the premium offered to the youngest

enrollee), but not for health or medical reasons (Sec. 1201, amending Secs. 2701, 2702, 2703, and 2704 of the Public Health Service Act).[2]

While consumers who get their coverage through their employers have long benefited from such protections, this is a sea change for those buying coverage on their own, in the individual market. In most states, the individual market is dominated by insurers who compete on the basis of risk—screening out or dropping the sick and covering the healthy—rather than on cost and quality. These practices have left millions of Americans unable to get coverage at any price. Thanks to the new federal law, Americans who lose their job or want to go into business for themselves will be able to get health coverage even if they have a high-risk medical history.

There are still many Americans who would be unable to afford coverage even with these health status-related barriers lowered. The new law provides assistance to them in three main ways, which will ultimately lead to 94% of Americans having coverage:

1) For the lowest-income Americans, **the law expands the Medicaid program.** This federal-state partnership will now provide low-cost, public coverage for those who make less than 133% of the federal poverty level—an annual income of $29,300 for a family of four in 2009. This change will go into effect in 2014 (Sec. 2001).

2) For those with higher incomes, **the law extends tax credits to help offset the price of health insurance.** These tax subsidies are available to those making between 133% and 400% of the federal poverty level (for a family of four, this translates to yearly income of between $29,300 and $88,200), and who do not have access to quality, affordable work-based coverage. Since those with higher incomes will need less assistance, the subsidies are lower for those higher up on the income ladder. The subsidies will be delivered through state-based purchasing pools called **exchanges,** which are discussed in more detail below. These provisions also go into effect in 2014 (Secs. 1401 and 1402).

3) **For small businesses who cover their employees, the law also offers new tax credits,** which are available starting in 2010 (Sec. 1421).

Because most of these provisions only go fully into effect in 2014, the law also provides immediate help to those who have a medical condition that renders them uninsurable. The law gives states money for **temporary high-risk pools,** which provide subsidized coverage to those who have been denied care for a pre-existing condition (Sec. 1101).

Two other requirements complete the coverage mosaic and guard against forces that could destabilize the insurance market. First, the new subsidies to lower-income Americans might tempt some employers that currently offer coverage to stop providing health benefits, which would increase costs to taxpayers. To reduce this risk, businesses who don't offer coverage and who have employees who receive assistance through the law will have to pay a modest fee. This **"free rider" surcharge** will also help level the competitive playing field between businesses that offer coverage and those that do not (Sec. 1513).

Finally, while ending insurance company discrimination against the sick is a boon to consumers, it also could create a perverse incentive. If a person is able to purchase coverage with full benefits at any time, it would be rational not to carry coverage when healthy, and only get insurance when diagnosed with some illness that will require costly treatments. The result

would be that only sick people would have coverage, which would drive up premiums as there would be no healthy people with whom to share the risk. Further, there would still be many uninsured who would not be receiving cost-saving, quality-enhancing preventive and primary care, and who would be surprised by unexpected illnesses and accidents.

To avoid this tendency—called "adverse selection"—the federal health reform requires Americans who can afford to purchase coverage to do so. Exemptions will be offered to those who cannot afford health insurance, even with the subsidies discussed above, and those who have religious objections. Those who do not satisfy this **individual coverage mandate** will be assessed a moderate fine, which will be administered through the federal income tax (Sec. 1501).

Improving Consumer Choices

Simply having an insurance policy is no guarantee that an enrollee will be able to access needed care at a fair price, however, as many victims of insurance industry abuses can attest. So the law includes key policies to give consumers more bargaining power and information, and protect them from unfair insurance practices.

The most important of these policies is **the exchange**. It's long been true that large businesses get a better deal on health insurance than small businesses, because of the increased bargaining power they bring to the table. The same is true when it comes to individual health insurance, since a single consumer does not have much ability to negotiate. This lack of negotiating power also means there is less competition among insurers on these markets. Finally, costs are higher on the individual market because of the lack of economies of scale: each plan contract must be individually sold and administered.

The reform law's solution to this problem is the exchange, which will be a state-created marketplace where individuals and small businesses can come together into a purchasing pool. If properly designed, the exchange will allow consumers to combine their bargaining power when buying private insurance. Its greater size will also help reduce administrative costs, since insurers will not need to process each individual coverage application.

But the exchange is more than just a purchasing pool. It can also help organize the health insurance marketplace, so that consumers will have more information about the plusses and minuses of different plans. Consumers will be able to use these easy-to-understand comparisons to make better choices, which will make insurers more competitive. It will deliver the subsidies discussed above, to make coverage more affordable. And by negotiating with insurers and setting strong standards for consumer protection and quality improvement, it can lower costs by driving reforms throughout the entire health care system (the central exchange provisions can be found in Secs. 1311 and 1312).

Beyond the exchange, the bill also institutes new policies to make insurance work better for consumers. These include **allowing young people to stay on their parents' plans until they reach age 26** (Sec. 1001, amending Sec. 2714 of the Public Health Service Act), **barring insurers from retroactively cancelling an enrollee's coverage** (Sec. 1001, amending Sec. 2712 of the Public Health ServiceAct), **ending lifetime and annual caps on benefits** (Sec. 1001, amending Sec. 2711 of the Public Health Service Act), **limiting the amount insurers spend on administrative costs and overhead** (Sec. 1001, amending Sec. 2718 of the Public Health Service Act), **supporting regulatory review of unreasonable premium increases** (Sec. 1003, amending Sec. 2794 of the Public Health Service Act) and **setting minimum standards for benefits to weed out 'junk' insurance** (Sec. 1302).

Lowering Costs While Improving Quality

The third central pillar of reform is to slow down the relentless drumbeat of rising health care costs—nothing is more important to making coverage more secure and sustainable. Again, the reform law takes a multi-pronged approach to lowering rising premiums.

Some of the most important policies will be first tested in Medicare. Pilot programs to expand **accountable care organizations, bundled payments, medical homes, and chronic disease management** are among the most important. These innovative approaches reward doctors and hospitals for providing effective, high-quality care, rather than simply continuing to pay for a high volume of treatments whether they are beneficial or not (these reforms are contained in a variety of provisions in Titles II-VI of the law).

An important new committee, the **Independent Payment Advisory Board,** has been created to make further recommendations on how to build on these pilot programs and other policies to realize even greater cost savings. The Board's recommendations will be fast-tracked through Congress, to reduce the ability of special interests to use procedural tricks to slow reform and maintain the broken status quo (Sec. 3403).

The law also contains provisions that will apply across the entire health care system, not just in Medicare and Medicaid. **Administrative simplification** policies will reduce the costly, time-consuming paperwork that frustrates doctors and hospitals and reduces their efficiency (Sec. 1104). The law institutionalizes support of **patient-centered research into what treatments work best,** to give doctors unbiased information about the effectiveness of treatments, drugs, and medical devices (Secs. 6301 and 6302). And it creates **transparency on the gifts drug and medical device companies give to doctors,** in order to reduce the impact of marketing on decisions that should be based on scientific research (Sec. 6002).

Lastly, the law invests in primary care, to help patients get the preventive and wellness care they need to stay healthy and manage their health conditions. High-value **preventive care will not be subject to insurance policy deductibles or copays** once the law goes into effect (Sec.2713). It also **improves educational aid programs for primary care doctors,** to help inject more of these much-needed practitioners into the health care workforce (Secs. 5201 and 5203, along with related provisions in Title V). And the law **improves payment rates for primary-care physicians in Medicare and Medicaid** (Sec. 5501, and Sec. 1202 of the Health Care and Education Reconciliation Act of 2010, H.R. 4872).

The Role of States

The summary above provides an outline of what the reform law sets out to accomplish. However, it does not address the fact that many, if not most, of these policies will require significant implementation work before they go into effect. Some of this will be done by the federal Department of Health and Human Services (HHS) and Centers for Medicare and Medicaid Services (CMS). But much of it will fall on the shoulders of policymakers and regulators at the state level. The sections that follow delve into the policies discussed above to lay out exactly what options and opportunities the new law affords.

Before turning to those discussions, however, there is one more aspect of the federal law to discuss: the **state innovation waiver** (Sec. 1332). Starting in 2017, states that wish to experiment with new ways to lower costs, improve quality, and expand coverage will be able to apply for

a waiver to alter the requirements of the federal law. This will allow them to push beyond the limits of what the law requires and tailor health reform even more closely to the needs of their particular state. States would be able to make their exchange universal, push for even more innovative quality-improvements, and even adopt a single-payer health insurance system. With that said, in some states there may be an attempt to use the waiver process to water down the consumer protections and cost-saving policies at the heart of reform. Advocates should stay vigilant to ensure that any waiver actually serve the goals of reform, and policymakers should ensure that there is an opportunity for the public and stakeholder groups to have a say in crafting it.

Ultimately, states are anything but silent partners in this new phase of health reform—they are truly leading the way. And it will be up to state-based advocates and policymakers to deliver on the promise of higher quality, lower costs, and expanded access.

ii. State Exchanges

Setting up a strong health insurance exchange by 2014 is one of the most important things a state will do to implement federal reform.

It will be one of the most visible aspects of reform that consumers and small businesses will experience. The day the exchange opens, people across the state will log onto the website. What will they see? At the very least, there should be a clear array of health coverage options, with helpful quality and customer service rankings and useful tools to estimate potential out-of-pocket costs.

But an exchange should be much more than "Expedia for health care." In giving consumers better choices and offering the help they need in navigating the insurance market, it can act like the human resources department of a large employer. And as a purchasing pool, it can use its purchasing power to drive better quality for patients, and rein in costs—both by cutting waste and by focusing on prevention and proven treatments.

Everyone who uses the exchange should be able to say that it helped them pick a plan that's right for them—one that helps them to stay their healthiest, that is there for them when they need it, and that doesn't break the bank.

The extent to which the exchange helps rein in costs, provide better choices and improve quality depends on how it's designed. With thoughtful design and strong implementation, an exchange has the potential to be a critical tool to pull many elements of reform together, and do so in ways that are visible and accountable:

- Simplifying the consumer's experience signing up for coverage;
- Freeing up small businesses from the burden of administering health benefits;
- Cutting waste and boosting efficiency in the insurance system;
- Controlling the underlying drivers of unnecessary costs in the health care delivery system.

In this chapter, we'll outline they key questions states must answer when setting up an exchange, and make recommendations about how to make sure exchanges

are designed to best serve consumers and small businesses. At the end of the chapter, we detail what the federal law says about the exchanges.

Four Questions for States to Answer as They Set Up an Exchange

The new health care law sets minimum requirements for the exchanges, but states can go beyond them, and have significant flexibility to design exchanges to best meet local needs.

Below, we outline four key questions states must answer as they design their own health insurance exchanges.

1. How do people get coverage now, and who isn't insured?

2. What should the exchange look like to consumers?

3. How can the exchange best save consumers and businesses money while improving care?

4. Who should run the exchange and how should we hold it accountable?

In each section, we make recommendations about how states can best serve the constituencies badly hit by soaring costs and who have the most to gain from a robust exchange—individual consumers, families, and small businesses.

1. How do people get coverage now, and who isn't insured?

Mapping out the state's current insurance situation is critical to identifying the specific problems an exchange can help solve. It also can lead to insights regarding how best to implement the exchange.

To conduct such an analysis, states should identify how many residents currently obtain coverage through individual coverage, small-group coverage and other employer-based insurance, and through public programs such as Medicaid and Medicare, and at what average cost. By tracking these proportions over previous years, states can also see which sources of coverage are shrinking and which are growing.

If the percentage of people gaining coverage through the small employer market has shrunk in recent years, for example, special attention may be warranted to ensure the exchange meets the needs of small businesses and their employees. In addition to looking at the insured population, states can also discover important information about the size, geography, age and other demographic characteristics of its uninsured population.

Conducting a baseline analysis was an important step that Massachusetts officials took before putting their exchange into place. For example, they found that a large proportion of the uninsured were young adults and men. This information influenced their decision to include special low-cost "Young Adult Plans" for 18-26 year olds not eligible for subsidies. It also prompted them to reach out to young people and men to encourage them to sign up for coverage by partnering with the Boston Red Sox.[3]

Once an exchange is launched, it will be important for states to conduct ongoing monitoring of market and insurance patterns, and prepare for possible changes. While some of this work may be done by state agencies, they should also partner with community and advocacy groups who have direct knowledge of what consumers are experiencing. The new law further encourages states to partner with ombudspersons and "navigators" to reach out to the public and help them solve

their problems—it will be helpful to create a feedback loop between the exchange and these critical roles, allowing them to identify problems and trends. States may also benefit from creating the capacity to forecast changes in coverage patterns and to model various policy and demographic scenarios. By doing so, state decision-makers will have the information they need to allow the exchange to meet the needs of consumers and businesses.

2. What should the exchange look like to consumers?

One of the key roles of an exchange is to foster healthy competition between insurance companies as a way to accelerate improvements in cost and quality and improve consumer choices. To better allow consumer choice to drive value in the marketplace, we recommend the exchanges include the following features:

Clear "apples to apples" comparisons between plans

Consumers should be able to compare plans with equivalent levels of covered services, and see which has the lowest premium. The federal health reform law helps in this regard, requiring each state exchange to group insurance options into levels—bronze, silver, gold and platinum –according to how strong the benefit package is regarding covered services and levels of out-of-pocket costs. It also has a special "catastrophic" plan level, with fewer benefits and lower costs, for young people under age 30.

But this year's costs and covered benefits are not the only factors that matter when choosing a health insurance plan. People also need clear information about how their options stack up when it comes to the provider and hospital networks, customer service user reviews, and track records for quality of care (for example, whether the plan encourages providers to deliver patient-centered care, and rewards positive outcomes). They also need to know what each plan is doing to keep costs under control and improve quality care for next year, and into the future.

The exchange can meet this need by creating prominent, easy to understand ratings for each plan in each of these areas. For example, it could adopt a one to five star system to allow consumers to quickly understand which plans have the most comprehensive provider networks, or have the best history of keeping premium increases to a reasonable level, and so on. Search tools should allow consumers select the criteria that are most important to them, and match these preferences to plans that perform well on the chosen measures.

Choices for employees of small businesses

Employees of small businesses rarely get a choice of health plans because most insurance companies refuse to sell insurance to a small business unless the insurer is the "sole source." This means that small employers cannot offer a menu of health options to employees the way that larger employers can. In the exchange, employees of small businesses that offer coverage should be able to pick from a variety of options in the exchange within the benefit category (bronze, silver, gold or platinum) subsidized by their employer.

In the Massachusetts exchange, this works by having the small employer select a coverage level and set up a way to send premium payments to the exchange. The exchange then gives the employer a code for employees to use when signing up for coverage to access those subsidies. We recommend states work closely with small businesses to determine the best way to establish these systems and to welcome employees to the exchange.

Lower prices

One of the first things consumers will

notice when they visit the exchange website and do their first search for coverage options is whether the prices—the premium, deductible and other out of pocket costs—are stable and affordable. People who make too much to qualify for Medicaid, but too little to afford coverage on their own, will pay on a sliding scale, qualifying for subsidies and lower out-of-pocket costs. But the exchange has a major role to play, not just in administering subsidies, but reining in costs overall. As we'll discuss later in this section, the exchange should use its buying power to negotiate a better deal for all enrollees, and drive down costs in the delivery system.

The exchange's work to reduce costs should be apparent to consumers using the exchange website. While the overall cost of premiums is unlikely to drop, we should expect the exchange to slow the rate of increase. States could add a feature to the website that compares average exchange premiums with what they otherwise were on track to be, or that allows consumers to track the growth of their own premium costs over time.

Real choices, not "distinctions without a difference"

Deciding among different insurance options can be made more difficult, not less, if consumers face a sea of options that have little meaningful difference between them. This can be the case when it comes to the near-infinite number of combinations of deductibles, co-insurance, co-pays and premium levels within each tier (gold, silver, bronze, and platinum). We recommend the exchange filter out unnecessary variation that doesn't add value, and focus on providing consumers with a reasonable range of clear options, such one or two standard benefit designs for each benefit level. Doing so will not only reduce confusion, it will also reduce needless administrative costs.

Massachusetts is currently pursuing this approach, moving from 27 standard plans to 9 to give consumers real choices, not myriad variations that only breed confusion.[4] Other states should consider following suit. As another way to focus consumer choice, exchanges could also establish a uniform, "plain vanilla" benchmark plan at each level, which insurers would be required to offer, so that consumers have a menu of standardized, easy-to-understand choices.

Help choosing a plan, signing up, accessing care, and resolving any problems

The clear marketplace of the exchange will go a long way toward making it easier to find and sign up for suitable coverage. But many consumers will need help finding out about the exchange, and assistance when using it for the first time.

Toward this end, exchanges must operate a toll-free hotline to help answer questions about signing up for coverage. The exchange must also establish a network of "navigators"—community-based groups and associations working to raise awareness of coverage options and providing impartial information to help people enroll and access the benefits to which they are entitled (Sec. 1311(i)). All of that is good news for consumers.

States should also make sure consumers can access help once they have enrolled in a policy. Some states already have a state insurance ombudsperson or insurance consumer protection section within an agency, or may partner with separate nonprofit groups to serve this function. Regardless of whether consumer protection is provided via an agency, a nonprofit, or both, funding and technical assistance are available through the federal health reform law as of federal fiscal year 2010. States may want to integrate this function into the exchange as it is developed. They will also want to ensure that data is systematically collected and analyzed to identify recurring problems—this may be accomplished via the ombudsperson

or through some other mechanism, but is essential to allowing the exchange to adapt to better serve consumers' needs over time (Secs. 1002 and 1004(a)).

Depending on the state, health insurance brokers may already play a role either in the individual market or in the group market, or both, in helping consumers and businesses make decisions about coverage and resolving problems that come up. States may want to explore coordinating with brokers on this important function, as outlined in the law in the role of "navigators." However, since in many states existing broker networks do not reach all residents, states should also consider partnering with community groups that have strong relationships with those groups that will need more aggressive outreach. (Sec. 1311(i)).

A no-wrong door model for getting coverage

Accessing coverage can often be confusing. Employees and individuals will come to the exchange looking for help getting access to the benefits for which they qualify. One of the most important functions that the exchange will serve is to administer federal and state assistance to qualifying consumers to help pay for coverage. In addition to these public subsidies, the exchange can also serve as the place where employees access subsidies from their employers to cover, or partially cover, insurance that the employee chooses. However, some of those who try to buy coverage through the exchange will inevitably be eligible for some other public program, such as Medicaid or CHIP.

In order to meet these challenges, the exchange must make it it simple for consumers to access help paying for coverage. Beyond the subsidies laid out in the federal law, the exchange should also make it easy for employers who wish to contribute to their employees' coverage to do so. In addition, employees should be able to combine subsidies from multiple sources, such as from multiple part-time employers, as they purchase coverage.

The exchange will also have to coordinate with public programs to catch whether an applicant for coverage is eligible for Medicaid or some other program. If so, they should forward the application to the relevant agency, so that the applicant can quickly and easily be covered through the appropriate program, without needing to submit duplicate paperwork. Similarly, states should make sure that if a consumer applies for a public program such as Medicaid, but does not qualify, he or she is immediately connected to the exchange and can access its subsidies. Whatever door a consumer enters through, they should quickly and easily receive the appropriate coverage.

Finally, consumers often change their source of coverage—they may become newly eligible or ineligible for a public program, or change employers, or move to the individual market. The exchange should put in place systems to allow it to seamlessly hand off and receive these transitioning consumers, with no gaps in coverage.

Tailoring the Exchange to Each State

Based on the needs and specifics of each state, officials are likely to think of additional features to help make the exchange a powerful tool. For example, states may want to include interactive maps of coverage areas, or add special rankings for the quality of treatment for prevalent chronic diseases in the region. They might also want to use the exchange to provide information to educate consumers about their health—for example, how best to manage a chronic disease, or listing key prevention treatments. We encourage states to approach the design of the exchange's consumer interface with the mindset that the exchange belongs to the consumers, and to think creatively and continually about how to make it as excellent as it can be.

3. How can the exchange best save consumers and businesses money while improving care?

One of the most critical functions of the exchange will be to organize the insurance marketplace to foster competition on costs and quality between insurers.

But if it's going meet the challenge of reining in rising costs while improving quality for consumers and businesses, it will need to do more than simply provide better information.

The exchange should play an active role in driving out waste, lowering costs and improving health care quality in a number of ways:

Negotiating a better deal on behalf of consumers and businesses

Much in the way that a large business operates when it negotiates with an insurance company, the exchange can act as an active purchaser on behalf of enrollees. If properly implemented, such an approach will allow consumers and small businesses to see the exchange not only as a transparent and fair marketplace, but as a much-needed advocate standing up for them and bargaining for the best value. In addition to getting a better deal for enrollees, the exchange's standards can help drive the insurance and health care markets toward high-value care—such as focusing on prevention and proven treatments, and cutting administrative waste (see sections III and V below for more details on these critical policies). The reform law explicitly empowers exchanges to pursue this kind of strategy to reward quality and improve patient safety (Secs. 1311 (g) and (h)).

We recommend states give the exchange the authority and the direction to act as an active purchaser, giving it the ability to set quality standards, negotiate on cost and engage in selective contracting. Some in the insurance industry may argue that plans should only be decertified for flagrant misconduct, and that state certification processes shouldn't be used as a tool in rate and benefit negotiations. But if the exchange is to deliver the maximum value for consumers and businesses, the state law must explicitly give the exchange the authority to decertify plans that repeatedly fail to deliver on consumer protections, care quality, and reasonable costs.

Working in coordination with other large health care purchasers

If an exchange has the power to set standards, negotiate, and do selective contracting, it will join the ranks of large employers as active purchasers in the marketplace. Depending on the state, there will be other powerful purchasers—such as public employee plans, the state Medicaid plan and union trusts—as well. By working together and aligning contracting standards wherever possible, these purchasers can even more effectively drive positive change in the health care market.

We recommend states consider building coordination mechanisms with other large purchasers to drive positive change in the marketplace into the design of the exchange. In the future, some of these large purchasers, particularly those using public dollars to purchase care—such as the state's public employee benefits plan—may want to explore merging with the exchange to further consolidate purchasing power.

Stopping excessive premium rate hikes

Through the federal health reform law, national officials will review the justification for unreasonable premium increases by health plans (Sec. 2794). Federal regulators will make recommendations that insurers with a history of violations be excluded from the exchange. But states retain their primary role as regulators of insurance, since they and they alone can decide whether the exchange will act on these recommendations and block unreasonable rate hikes. Further, the federal review only acts as a backstop to state-level rate review

systems. Various levels of rate review currently exist in 24 states, but consumers in the 26 others will require protection as well.

The exchange also has a significant role to play in policing unreasonable rate increases. First, the exchange should have the power to act on information from federal and state regulators and de-certify plans with a track record of exploitative premium increases. Second, working closely with the state's insurance commissioner or whichever entity is in charge of a state's rate review system, it should participate in the review of products sold in the exchange. The same standards should apply to insurance plans whether they are offered on or off the exchange, but the expertise of the exchange should be brought to bear on the plans sold in its marketplace.

We recommend that all states consider implementing a state-level rate review policy and integrate it with their exchange; Oregon and Rhode Island are states with relatively robust rate review laws and rules, and can offer potential models.[5] We discuss rate review outside of the exchange in Section IV, below.

Making sure the exchange helps as many people as possible

The bigger the exchange, the greater its negotiating power and ability to drive change in the health care system. The more people that are allowed into the exchange, the more people are served by it. And the larger it is, the greater its ability to achieve economies of scale to reduce administrative costs.

So who is in? Per the federal law, individuals without group coverage will be able to use the exchange, as will small businesses of up to 100 employees, once the law's full provisions go into effect in 2014. It allows states that currently define a "small group" as 50 or fewer to first offer the exchange to these smaller businesses and then expand to businesses up to 100 by 2016. Further, states are explicitly authorized to open the exchanges to larger employers starting in 2017.

Another Way to Bargain for Better Value in Coverage

Under the new law, states have the option of creating a Basic Health Insurance plan (Sec. 1331). Under this arrangement, which is similar to existing Medicaid managed care plans, the state offers access to a set of private plans to residents between 133% and 200% of the Federal Poverty Level. The state negotiates with the insurers to secure the best possible rates for these enrollees, reducing their cost sharing and providing coverage to a large swath of citizens at a lower cost. States that choose this option may dedicate the federal funds that this population would have received as tax credits in the exchanges to funding the program.

This option was included in reform legislation by Sen. Maria Cantwell (D-WA), whose home state has operated just such a program for over twenty years. It may be an attractive option, but policy-makers, particularly those in small states, must carefully evaluate the impact of such a program on the size of the risk pool left in the exchange, to avoid further fragmenting the market power of the citizens left in the exchange.

And while states are required to offer an exchange to individuals and to small businesses, these can be operated together as a single larger exchange instead of two smaller ones. The law also allows states to combine efforts with another state or states, and set up a joint exchange, and states have the option of setting up separate exchanges in different geographic regions.

For simplicity's sake, and for the reasons mentioned above regarding size and purchasing power, we recommend that states, or combinations of states working together, operate a single exchange that serves individuals and small businesses beginning as soon as possible, and open the exchange to employees of large groups in 2017. Note that this does not necessarily require merging the individual and small group risk pools and rating rules, which is a separate issue states may want to explore, but may not be required to operate a combined exchange.

Similarly, states should create a single, state-wide exchange, rather than splinter off its residents into separate exchanges depending on where they live. However, location is and continues to be a very important factor in how consumers receive their coverage. The exchange should make sure that consumers can easily see the most relevant coverage options by making it easy to search for plans that are active in a consumer's region of residence. It should also take steps to ensure that there are an adequate number of plan options at each coverage level in every important geographic area of the state.

In addition to allowing as many people as possible into the exchange, exchanges should actively reach out to enroll people in the plans. As mentioned previously, the law requires exchanges to establish grants for "navigators" to conduct fair and impartial outreach and education about the plan options and help people sign up (Sec. 1311(i)).

Is the exchange the sole market for health insurance?

A related issue to the exchange's size is whether it is the sole market where insurance may be sold to individuals and businesses, or whether there is also a secondary outside market.

If there is a dual market, states run the risk of insurers inadvertently or intentionally weakening the exchange, since they might be able to make higher profits away from the competition and negotiation it provides. Previous attempts to set up insurance buying pools have failed when insurers lured away the younger and healthier people to plans outside the purchasing pool, leaving only sicker people.[6] Termed "adverse risk selection," this leads to progressively higher premiums that are borne by fewer and fewer people, and ultimately the collapse of the exchange.

While rules outlined in the federal law should provide some limited protection against a full "death spiral" and collapse, without proper consideration, states may inadvertently allow an outside market to diminish the exchange's risk pool in size, and thereby limit its power to negotiate and drive better prices and quality in the market.

To prevent this, states have three main options. They may make the exchange the sole market where insurance may be sold, they may allow a dual market, while establishing additional rules preventing insurers from undermining the exchange via the outside market, or they may do a combination of the two and have the exchange be the sole market for most insurance, but allow a limited number of products to be sold both inside and outside the exchange.

It is important to note that while the federal law is clear that it does not require the exchange be the sole market in the states, it does nothing to pre-empt states from deciding to do so (Sec. 1312(d)).

A factor in a state's decision-making will be how it wants to approach the issue of

undocumented residents, and where they can buy insurance coverage. The law prohibits people without documentation from buying coverage in the exchange, even if they use their own funds (Sec.1312(f)(3)).[7] If the exchange is the sole market, that means that no one without proper documentation would be allowed to purchase individual insurance plans, throwing them into the ranks of the uninsured even if they could otherwise buy coverage. This will exacerbate the well-known problem of "cost shifting," prevalent in our-pre-reform system today— the uninsured will end up, receiving care in emergency rooms at high costs, which will be ultimately be absorbed into higher premiums and taxes for everyone.

To avoid the cost shift while keeping the exchange as large as possible, the third option listed above—moving most consumers to the exchange while leaving a residual market outside of it—may be the best for most states. In this scenario, states should be careful that the plans offered outside the exchange (which could include a state-level public option or other public programs, or some categories of private insurance) do not create destabilization in the market. One approach would be to require insurers to offer the same products outside the exchange as they do inside the exchange—since the federal rules require that such products use the same risk pool and charge the same premium both inside and outside the exchange, this would greatly reduce the risk of undermining the exchange.

If that approach is not possible, states could ensure that at least some products are available both inside and outside the exchange. For example, the exchange could use selective contracting to aggressively design and bargain for a plan at each benefit tier, which would have low premiums and benefits designed to promote high-quality, affordable care. This plan would be offered both inside and outside the exchange. Because the deal that would be negotiated by the exchange would likely be better than any individual consumers could get outside the exchange, it would be an attractive option. And again, since the risk pool would be the same regardless of whether the plan was bought inside or outside the exchange, this would make the exchange more stable.

In any case, to protect against adverse risk selection in a dual market or modified dual market as described above, the federal health reform law sets forth the following rules:

- Products sold inside and outside the exchange must be in the same risk pool (Sec. 1312);
- Products sold inside and outside the exchange must have the same premium rate (Sec. 1301(a)(1)(C));
- Products inside and outside the exchange must meet the same minimum benefit standard (Secs. 1302, 1311(d));
- Products inside and outside the exchange may not deny coverage, or coverage renewal, to people based on pre-existing conditions, and the same rating rules (how premiums vary based on age, geography and tobacco use) must apply inside and outside the exchange (Sec. 1201);
- All insurers will participate in reinsurance, risk adjustment, and risk corridor programs aimed at reducing the impact of differences in enrollee health, so that insurers who cover more sick people are not penalized (Secs. 1341, 1342, 1343).

States should further protect the exchange by prohibiting insurers or others from steering people outside of the exchange through different broker commissions, marketing or any other

way. This prohibition should be policed through adequate enforcement via the state Department of Insurance or other agency, and the exchange should engage in ongoing monitoring of the market to alert it to other enforcement measures that may need to be taken.

4. Who should run the exchange and how should we hold it accountable?

The exchange has the potential to affect the lives of many residents by helping to rein in the skyrocketing costs of their health care, while improving their choices and quality of care. As with any change, consumers as well as stakeholders in the health care and health insurance industry are bound to have concerns about what it means to their futures.

As states move ahead to answer these questions and establish and operate their exchange, we recommend that every step proceeds with the upmost public accountability and input, with consumers and businesses serving as the majority on decision-making and advisory bodies, and with the interests of the exchange's ultimate enrollees at the forefront.

According to the federal reform law, states have the freedom to establish their exchange as a state agency, a separate non-profit organization, or use other quasi-public models combining features of both (for example, a state might decide to use a governance structure based on a state agency, but have the exchange handle its money as if it were a private non-profit). Further guidance is expected in this area from the federal Department of Health and Human Services.

Whatever governance model states choose for their exchange, we recommend they consider the following principles:

1. The exchange should be operated for the benefit of individuals, businesses and their employees, not insurance companies and providers. This charge should be included in the exchange's legislative mandate and mission.

2. Consumer and business organizations and individuals should have robust input into the exchange's operations though direct appointments to oversight boards and other decision-making and advisory bodies, where they should comprise a majority.

3. Industry stakeholders should have opportunities for meaningful input into technical and workability decisions, but should not comprise a majority of those serving on decision-making bodies or oversight boards. Strong conflict of interest requirements should be in place to ensure that industry representatives do not make decisions that might financially benefit them.

4. Broad public input should be solicited and considered, both in the process to form the exchange and in its ongoing operation.

5. The exchange should be given clear authority to set rules, recommend legislation, and negotiate on behalf of enrollees, but should be ultimately accountable to the public, most likely through gubernatorial and/or legislative appointment of its leadership.

6. The work, budget, spending and any outside contracting of the exchange should be publicly reported and transparent, with the exception of any personally identifiable medical information. Meetings should be open, with transcripts publically available.

What the Federal Law Says About State Exchanges

Requirements regarding the exchange can mainly be found in Title 1, subtitles C and D of the federal reform law. Section 1311 sets out the basic structure of the exchange, but there are a number of other relevant provisions as well. The following summary should provide state policymakers with a quick sketch of the federal mandates surrounding the exchange—in short, while the law provides a few important guidelines and requires that the states act quickly to create an exchange, states have a large range of policy flexibility to adapt the exchange to their particular policy goals.

Timeline: Federal reform gives states the responsibility to establish exchanges for individuals and small businesses by 2014. If states do not establish an exchange by 2014, the law states that the federal government will establish one for them (Secs. 1311(b) and 1321 (c)).

Help for states: States can apply for federal grants to help set up exchanges. By 2015, however, exchanges must be self-sustaining (Sec. 1311(a) and (d)(5)).

Who can get insurance through the exchange: Individuals and small businesses are eligible, either in two separate exchanges, or one combined exchange. If the state so decides, larger businesses will also be eligible after 2017 (Secs. 1311(b)(2) and 1312(f)(2)).

How consumers connect to the exchange: The federal government will make a template internet portal available to states (Sec. 1311 (c)(5)). States are required to create a website to help consumers compare plans, and operate a toll-free hotline to answer questions (Sec. 1311 (d)(4)).

Helping consumers compare plans and sign up: The law directs the federal government to develop ranking systems on cost and quality, as well as an enrollee satisfaction survey tool, for states to use to help consumers compare plans in the exchange (Sec. 1311(c)(3) and (c)(4)). It also requires states to use a standardized format to present health plan options, enroll applicants eligible for Medicaid or other public programs into that program, and offer an electronic calculator to help consumers evaluate their actual cost after any tax credits or other benefits are factored in (Sec. 1311(d)(4)).

Benefit package: The federal government will establish an essential health benefits package and levels of coverage, from bronze (the lowest level) to platinum (the highest), and a "catastrophic" plan only available to people under 30 or people who are exempt from the requirement to have coverage (Sec. 1302(e)). States can require additional benefits, but must assume the cost for any subsidies for the additional benefits (Sec. 1311(d)(3)).

Subsidies: Consumers that make too much to qualify for Medicaid but cannot afford coverage are eligible for sliding scale assistance to pay for premiums, and limits on out-of-pocket costs (Secs. 1401 and 1402).

Criteria for health plans: The law directs the federal government to set criteria for an insurance plan to be "qualified health plan" and allowed into the exchange. Criteria will include having sufficient choice of providers and implementing a quality improvement program. The law delegates the enforcement of the certification of qualified health plans to the state exchange (Sec. 1311 (c)(1) and (d)). Aside from some narrow exceptions listed in Sec. 1311(e)(1)(B), states may develop and enforce additional criteria in the interest of enrollees for qualified health plans to meet. For example, the exchange may set quality standards, negotiate on costs, and do selective contracting. The exchange may also exclude plans with premium increases that are unjustified (Sec. 1311 (e)).

Reinsurance and risk adjustment: The law directs states to establish a reinsurance entity by 2014, to protect insurers in the individual and small group markets from having to raise rates because too many of their enrollees are sicker than average (Sec. 1341). For similar reasons, it also provides for risk corridor and risk adjustment programs (Secs. 1342 and 1343).

Process: The law requires state exchanges to consult with a range of interests, including health care consumers, small businesses and the self-employed, and requires the exchange to be transparent regarding its costs (Sec. 1311 (d)(6) and (7)).

Figure 1: Key policies will determine whether or not the exchange is a strong, pro-consumer force.

	Weak Exchange	Strong Exchange
Oversight	Doesn't set standards or fails to adjust them over time Takes prices as set by insurers Sets standards without consultation with stakeholders and experts Establishes standards without coordination with other large purchasers	Sets standards for benefit design, customer service, quality of care and costs Negotiates rates and benefits, and does selective contracting for some options Sets high, achievable standards that improve quality and reduce costs Coordinates contracting standards with other large purchasers
Size	Too small to drive changes in the market, no matter the strength of the standards Prohibits large employers from entering the exchange in 2017 Allows the outside market to draw away people and make the exchange smaller	Large enough to be a significant driver of quality improvements that cut costs Is open to individuals and small and large employers Spreads overhead costs over enough people to achieve lower prices
Sustainability	Allows the outside market to draw healthier people outside the exchange, leaving sicker people inside, leading to collapse of the exchange Fails to keep up with changes in the marketplace and in clinical advancements	Protects against adverse selection, including requiring the same rules, and that products be offered on the same terms inside and outside the exchange Continually reviews and adjusts to market dynamics and clinical breakthroughs
Usefulness	Consumers and businesses don't know about the exchange Too many options and no useful tools to compare their merits Lackluster customer service	Makes ongoing, robust outreach efforts to consumers and businesses Manageable number of meaningful options with easy cost and quality comparisons Oriented toward excellent service; a culture of problem solving
Governance	Inadequate public oversight and transparency Designed without public and stakeholder input Consumers and businesses are not a majority of the oversight body Wasteful spending	Fully transparent Stakeholders and the public have input into its design and function Businesses and consumers are a majority of the public oversight body Frugal

iii. Lowering Costs and Improving Quality

In health care, do you get what you pay for? While consumers and businesses pay plenty in premiums and out-of-pocket costs, our dollars are not necessarily going toward the results that we really want—healthier people.

That's largely because today's health care payment system rewards the number and complexity of tests and procedures that can be billed to insurance companies, not the quality of care provided or whether the patient gets healthy. Every state in the nation is confronting rising health care costs, in large part because how America pays for health care—the fee-for-service system—is inflating costs and shortchanging quality.

States have important opportunities to change that, and help make sure residents get the quality care they deserve at a cost that doesn't break the family budget or the state treasury.

To understand how states can best use the opportunities afforded by health reform to tackle the linked issues of cost and quality, it's helpful to first understand four major inter-related, game-changing solutions recognized by leading health experts:

Medical Homes: Under this approach to care, a patient's treatment is coordinated by a "medical home," composed of a team of health professionals. The patient's primary care provider is paid to work with other doctors and health care providers, to provide care that focuses on prevention and keeping chronic disease under control. Medical homes also ensure that the burden of keeping track of tests, prescriptions, and treatments doesn't fall entirely on a sick patient. With proper design, these programs can dramatically improve patient health and lower costs as well.[8]

Accountable Care Organizations: Best exemplified by providers like Intermountain Health in Utah or Geisinger Health in Pennsylvania, Accountable Care Organizations (ACOs) integrate the care patients receive across the medical system. Under this model, rather than hospitals, physicians and other providers each getting paid separately for individual services, they are all part of a single system which shares the payment for the patient's treatment and is accountable for the health and outcomes of the patient. In many cases, this allows

doctors to be paid by salary, rather than under fee-for-service rates, and creates additional incentives for improving patient health and reducing unnecessary costs.

Bundled Payments: This innovation replaces itemized fee-for-service payments with a single, bundled payment for all treatments. Hospitals, physicians, and even rehabilitative services together are reimbursed by a set amount for every patient admitted with a particular diagnosis (which can be adjusted upwards if the patient is especially high-risk and likely to require more extensive treatments). The recipients of the bundle share the payment, so that they are rewarded for delivering high-quality, effective care that ensures the patient will not be quickly readmitted for the same complaint. All the providers are thus rewarded for working together to treat the patient in the most coordinated, efficient way possible. Analysis from the Lewin Group and the Commonwealth Fund predicts that properly structured bundled payments can generate enormous cost savings.[10]

Chronic Disease Management: Chronic disease management is a systematic approach that focuses on promoting a combination of behavior changes and clinical treatments to prevent chronic conditions from flaring up into acute crises. For example, programs aimed at diabetes patients can closely monitor diet and other health indicators, to help the patient live a stable life rather than having to be rushed

Improving Quality by Ending Health Disparities

A serious response to the quality problems in America's health care system requires addressing racial and ethnic disparities in care. A 2002 report by the Institute of Medicine found that minorities are too-often ill-served by the health care system, being less likely to receive even routine medical treatments and suffering from lower care quality when they are able to access services.[12]

The new health reform law includes several important policies aimed at remedying these gaps. These include a provision calling for the systematic collection and analysis of data on health disparities (Sec. 4302); grants and other programs to expand the number of physicians and other health care providers in minority and medically underserved communities (Secs. 5203 and 5606); training to help medical professionals deliver culturally-appropriate care (Secs. 5301 and 5307); and substantial investments in the nation's Community Health Centers, which are an important source of primary care for many underserved communities (Health Care and Education Reconciliation Act of 2010, H.R. 4872, Sec. 2303).

States should look for opportunities to strengthen and build on these important new programs as they come on-line—for example by incorporating the new data into their own efforts to remedy disparities, and working with federal partners to ensure that cultural-competency programs meet the most pressing needs of a state's communities.

to the hospital for costly emergency surgery. While studies continue to evaluate these programs, research suggests that properly designed disease management programs can successfully reduce costs.[11]

The law takes several steps to promote further refinements and adoption of these exciting new solutions. The major approaches include one which for the most part bypasses the states—changes to Medicare—and three that emphatically do not: new programs in Medicaid, grants for pilot programs, and state employee benefit plans.

Cost and Quality in Medicare

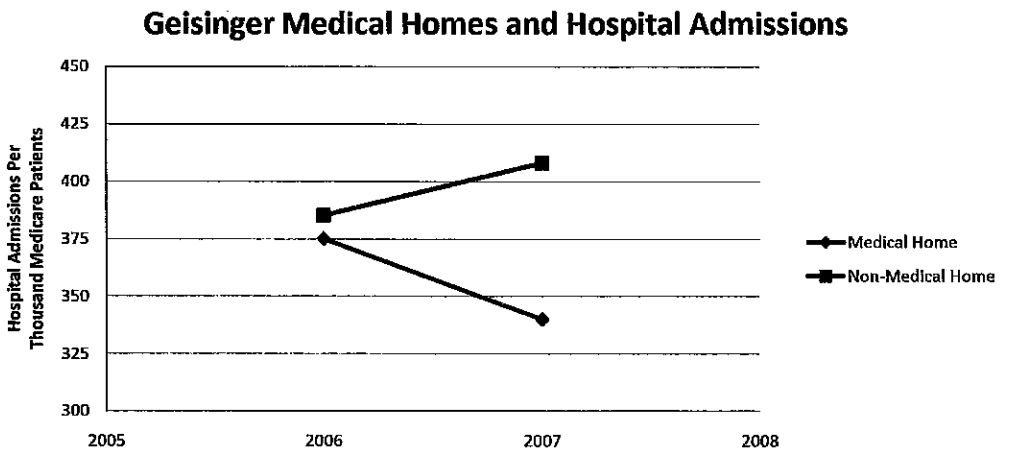
By restructuring how the federal Medicare program pays for care, the law lays the groundwork for replacing America's broken health care payment system with new models like those described above. Medicare is a large enough payer—accounting for over one in five health care dollars spent[13]—that changing the way it pays for care will generate changes in the practice of medicine across the entire health care system. To that end, the new law implements reforms to reward primary care and high performance on quality measures within Medicare over the next several years. The new law even boosts reimbursement for primary care within the Medicaid program for the years 2013 and 2014.

But the truly transformative alternatives to today's fee-for-service system—including the four discussed above—will be tested through pilot and demonstration projects or voluntary programs. The pilots are often confined in scope. And the voluntary programs may not reach the necessary scale. For example, starting in 2012, ACOs can choose to participate in a Medicare program where they share in the savings they generate. That may be an important step, but it may take a while for this gradual implementation to yield the lower costs Americans need.

Under the law, the Secretary of HHS has the authority to apply many of these new models across Medicare, but the speed with which the models will be tested approved, and extended is unclear.

This gradual approach, if limited to a

Figure 2: Dramatic Progress on Cost and Quality: Geisinger Health System's medical home program has reduced the need for hospital admissions[9]



certain portion of Medicare, only begins to tap the potential of these game-changing reforms. To truly transform the broken status quo will take greater testing and refinement, including programs that extend to private insurers and other public programs, and it must happen more quickly.

Fortunately, states continuing to grapple with ongoing increases in health care costs need not wait for these Medicare reforms to translate into real cost savings in the rest of the health care system. For states willing to lead on cost containment and health care quality, the new law offers three significant opportunities. First, states will have the option of restructuring their Medicaid programs to improve quality and reduce the cost to taxpayers. Second, an array of grants will allow states to accelerate the transformation of their state's delivery and payment system. Third, states retain the ability to directly push for system-wide reforms through shaping the policies of the huge purchasing pools they already control—public employee benefit plans.

Transforming Medicaid

States can help accelerate the transformation of health care towards lower costs and higher quality by utilizing Medicaid reform options provided by the new federal health care law.[15] While these opportunities are

Health Reform and State Medicaid Programs: the Basics

Since 1965, states have been stewards of a crucial component of America's health care system. The federal government has set standards for Medicaid, and provided many of the resources, but states design and administer their programs and contribute a share of the funding. State programs vary widely regarding who they cover—children, parents, and childless adults—and whether that coverage is provided by private insurers or directly by the state, as well as the level of reimbursement offered to providers.

By far the most significant change in the new law occurs in 2014. Beginning in that year, every state Medicaid program will open up enrollment to all individuals with incomes under 133% of the federal poverty level. The federal government will pick up 100% of the costs of covering these new beneficiaries for the first three years. In subsequent years, the federal government will cover 90% of the cost, with the states responsible for the remainder. States will have to plan early to meet this new fiscal challenge, though it should be noted that the match is substantially better than the existing Medicaid rates.

To ensure that states do not slash their Medicaid rolls prior to 2014, so-called maintenance-of-effort provisions in the federal law require that states not further restrict enrollment in Medicaid. On the other hand, for those states who wish to expand their Medicaid program before 2014, regulators have clarified that the federal government will match state investments in this area, albeit at the state's usual match, not the enhanced post-2014 rates.[14]

generally less aggressive than the Medicare reforms in the new law, they do allow states to move towards a system of efficient, effective care.

- **Promoting Medical Homes:** States have the option to enroll Medicaid beneficiaries with chronic conditions into a medical home (Sec. 2703).

- **Testing Bundled Payments:** A demonstration project will examine the use of bundled payments for hospital and physicians services under Medicaid in up to eight states. States should consider participating in this project, and put safeguards in place to reward care quality (Sec. 2704).

- **Creating Pediatric Accountable Care Organizations:** Under a demonstration project, qualified pediatric providers may be recognized and receive Medicaid payments as Accountable Care Organizations. Pediatric ACOs that meet quality guidelines and provide services at a lower cost will share in a portion of the savings they generate (Sec. 2706).

- **Incentives for Healthy Lifestyles:** The law creates grant funding for states to provide incentives for Medicaid beneficiaries to adopt healthy lifestyles. These programs must have demonstrated success in helping individuals lower or control cholesterol and blood pressure, lose weight, quit smoking and manage or prevent diabetes. By helping Medicaid enrollees live healthier lives, this program can also lower costs (though states should be careful to make sure that these incentive programs do not unfairly punish those who are unable to meet wellness goals due to health and environmental factors) (Sec. 4108).

- **Flat Payments to Hospitals:** Up to five states are authorized to move safety net hospitals away from the fee-for-service model to one in which hospitals are paid a single fee for every individual under their care, according to the severity of their illness. For those states who wish to make a wholesale move away from today's broken fee-for-service system, this ultimate extension of bundled payment could provide the opportunity (Sec. 2705).

As we note in the sidebar above, in 2014, every state will face the responsibility of administering Medicaid programs with expanded enrollment, and after 2017 will have to shoulder some of the increased costs that go with this coverage expansion. Adopting these cost-saving innovations can improve the quality of Medicaid care, and also help reduce the program's impact on state budgets.

In pursuing these opportunities, states should be sure to create opportunities to engage the public, including enrollees, community groups, and advocates. Participation and input from such partners will help ensure that these reforms deliver higher quality care and lower costs for patients.

Grant Aid for System Transformation

The reform law authorizes dozens of new federal grant programs. Below, we outline five of the most significant in terms of their ability to help states transform their health care systems.

- **Team-based Health Care Delivery:** Similar to the approach taken in the Medicaid program, these grants will promote the use of medical homes by supporting community health teams.

The funds are available to states, Indian tribes, or entities designated by the state, to create teams of doctors and nurse practitioners who can provide comprehensive, community based, coordinated care. North Carolina's use of this model has been successful, reducing costs by 5-15% in the state's Medicaid program[16] (Sec. 3502).

- **Medication Management:** One of the most important ways to keep chronic diseases from flaring up into a crisis is to ensure that patients are taking their prescription drugs properly. The new law allows any entity or organization to apply for grants supporting medication management programs to ensure patients are receiving all their medication when they need it. Enlisting licensed pharmacists allows this approach to help patients manage chronic diseases, as well as reducing medical errors and lowering hospital readmissions[17] (Sec. 3503).

- **Lowering Costs for Pre-Medicare Seniors:** States or large local health departments can apply for grants to help control chronic disease in 55-to-64-year-old citizens. Because they are on average more prone to illness than younger people, this age group accounts for a significant percentage of non-Medicare health spending. Grant-funded pilot programs would evaluate chronic disease risk factors, conduct evidence-based public health interventions, and ensure that individuals diagnosed with or at risk for chronic disease receive preventive treatment (Sec. 4202).

- **Community Health Workers:** Community health workers offer interpretation and translation services, provide culturally appropriate health education and information, offer informal counseling and guidance on health behaviors, and advocate for individual and community health needs. By connecting patients more closely with their care, they promote adherence to treatment plans and improve healthy behaviors in medically underserved areas. States, public health departments, clinics, hospitals, Federally Qualified Health Centers, and other nonprofits are eligible for grants under this program (Sec. 5313).

- **Community Transformation Grants:** This program authorizes competitive grants for community-based programs that promote health and reduce chronic disease. States, local governments, nonprofits, and Indian tribes are eligible for the grants, whose goals include preventing and reducing the incidence of chronic diseases associated with being overweight and obese, tobacco use, or mental illness. Activities could include initiatives to improve nutrition in restaurants, smoking cessation classes and support programs, investments in parks or exercise trails to encourage physical activity, and community-wide workplace wellness programs. Twenty percent of the Community Transformation Grants will be awarded to rural areas (Sec. 4201).

These are only a few of the most significant grant opportunities the federal reform law makes available. As an aid to policymakers, we have compiled a comprehensive list of all the grant funding in the law, which is available on our website.[18]

When appropriate, states should take every opportunity to pursue these grants themselves. States can also play a leading role in facilitating localities' and organizations' own grant applications by providing information about these opportunities, and directly working with the provider

and public health communities. States should also consider offering matching funds to make these grants more appealing or longer-lasting, or develop their own grant programs to spread quality-increasing reforms more broadly.

State Employee Benefit Plans: Another Tool to Advance System Change

States have one more powerful tool available to accelerate system change: their public employee benefit funds. In most states, the state employee plans are among the largest payers for health care, with enough market power to leverage real change.

We recommend that state policy-makers demand that these programs move away from the traditional fee-for service approach, and adopt the reforms discussed above: medical homes, accountable care organizations, bundled payments, and chronic disease management. State employee benefit plans are the element of the health care system over which states have the most direct control, and states serious about reducing costs and improving quality should make use of that leverage.

Fig. 3: Additional grant programs in the federal reform law. The table lists the total sum available to states under existing appropriations, the years when each program is active, and the section of the health reform law authorizing the program.

Purpose of the Grant Program	Amount Appropriated	Time Frame	Relevant Section
Establish, expand or support health insurance consumer assistance or ombudsman programs	$30 million	Immediately	2793
State health insurance rate review programs	$250 million	2010-2014	2794
Promoting regional, coordinated emergency care systems	$24 million	Each year 2010-2014	3504
Expanding access to trauma care	$100 million	Immediately	3505
School-based health centers	$4 million	Per year	4101
Pilot project: public health community interventions, screenings, and referrals for 55-64 population	Up to $50 million	For the duration of the 5 yr pilot	4202
Strengthening capacity of public health laboratories	$190 million	Each year 2010-2014	2821
Childhood obesity demonstration project	$25 million	2010-2013	4306
Planning a statewide health care workforce strategy	$8 million	2010	5102
Training for mid career public and allied health workers	$60 million	2010	5206
Increased residencies for primary care physicians	$125 million	2010	5301
Direct care worker workforce	$10 million	2010-2013	5302

iv. Consumer Protections

The new law fundamentally reforms the marketplace for insurance by ending insurers' ability to refuse coverage or alter premiums on the basis of an enrollee's health or history of illness or other medical conditions. These twin policies will help make coverage as accessible for the sick as for the healthy, and begin the process of reorienting insurance competition towards cost and quality, rather than simply selecting for low-risk customers.

States will not need to take specific actions to implement these marquee policies, as they will go into effect nationwide in January of 2014. But the law also includes a host of smaller, though important, reforms to the insurance market, many of which will go into effect in 2010. Immediate action by state policymakers can help make the most of these reforms for consumers and businesses.

Dependent Coverage Up to Age 26

Young people are the age demographic least likely to have access to quality, affordable health coverage, with 29% of young people 18-24 going uninsured in 2005.[19] A major cause of this problem is the fact that many health plans throw children off of their parents' family coverage when they turn 19, or when they graduate from college. Fortunately, the health reform law addresses this issue by requiring insurers to allow children to stay on their parents' plans until age 26 (Sec. 1001, amending Sec. 2714 of the Public Health Service Act).

This strong policy will help hundreds of thousands of young people across the nation keep their coverage. However, it only goes into effect in September of 2010. Since most college students graduate in the spring, that means that members of the class of 2010 may still experience a gap in coverage. Some insurers, such as WellPoint, Kaiser, and UnitedHealth have promised that they will implement this provision early.[20] While this step represents a significant benefit for consumers, not all insurers have committed to early implementation, and even those extending dependent coverage early might allow some soon-to-graduate college seniors to lose their coverage. Further, even where

insurers make the option available, some employers are deciding not to offer the extended coverage to their employees until 2011.

States should take immediate executive or legislative action to require all insurers selling individual and group insurance in their state to implement this provision as soon as possible, and ensure that young people who do lose their coverage in the meantime are able to quickly re-enroll on their parents' plans without requiring extensive re-application and readjustment of premiums. In particular, young people whose coverage has lapsed should not have to face coverage denials or limitations due to pre-existing conditions, so long as they re-apply quickly once the new rules go into effect

Prohibition on Rescissions

One of the most pernicious practices of the insurance industry is retroactive cancellation of coverage, known as rescission. When an enrollee gets sick and requires the insurer to pay large medical bills, some insurers have pored through the enrollee's initial application, looking for any mistake or other excuse that would allow them to claim fraud and cancel the coverage contract.[21] The new law includes a blanket prohibition on this practice as of September 2010, allowing rescission only in cases of intentional deception or fraud (Sec. 1001, amending Sec. 2712 of the Public Health Service Act).

While this is an important step, the federal reform does not set up a clear enforcement mechanism to prevent insurers from violating the new requirement. And in fact, in many cases of rescission, insurers do claim that the consumer has engaged in intentional misrepresentation or fraud. To truly safeguard patients from rescission, states should take the additional step of requiring review by an impartial regulator before a rescission goes into effect. This would protect innocent consumers from having to fight to reinstate their coverage when they are most vulnerable, and deliver on the reform law's guarantee.

Rate Review

Unreasonably large premium increases are one of the most visible signs of the crisis in health care costs—notably Anthem Blue Cross of California's proposal to raise rates by up to 39% early in 2010.[22] Health care reform gives state policymakers additional tools to deal with this problem. First, it requires insurers to submit their proposed rate increases, along with a statement justifying the hikes, to federal regulators. The law also provides for $1 to $5 million grants to states to support their regulatory efforts to review and approve or deny proposed rate increases (Sec. 1003).

Several states already have strong rate review processes, and should pursue this grant funding to strengthen their existing capacity. Other states have no such policies in place, or have them only in weak form. The availability of these federal dollars is an opportunity for states to establish or improve this critical consumer protection. With the new individual mandate requiring consumers to buy coverage, it is critical to extend the protection of rate review so that insurers are not able to exploit their customers.

Not only can rate review rein in unreasonable premium increases, it can also be used to help drive quality-increasing, cost-saving innovations throughout the system. For example, Rhode Island recently revised its rate review law so that in addition to the customary criteria of fiscal soundness and consumer protection, the state would now

Federal Support for High Risk Pools

Because the prohibition on pre-existing condition denials does not go into effect until 2014, the reform law also supports temporary high risk pools that will offer coverage to individuals who otherwise couldn't get coverage (Sec. 1101). Because these higher-risk individuals will be expected to have high medical costs, premiums in the high-risk pool are generally subsidized by the state. As a free-standing policy, high-risk pools have been only of limited use, but for the next few years they can provide an important stopgap solution for patients who otherwise would be unable to obtain coverage.

The new law earmarks $5 billion for states to create or expand their pools; there is also a backstop provision ordering the federal Department of Health and Human Services to directly administer a high-risk pool in states that do not act. Many states already have their own high-risk pools, but since they do not precisely match the requirement of the federal law, most states are deciding to use the federal dollars to create a new, parallel high-risk pool.

This approach may create administrative challenges for agencies, and potentially confuse consumers. States that opt for this two-pool approach should ensure that enrollees and potential applicants have clear information about the differences between the programs. Regardless, in moving ahead with new high-risk pools, states should adopt the following policies:

Inform Consumers About Their Options: Insurers who deny an application or require an increased premium due to a consumer's pre-existing condition should be required to give information about the high-risk pool alongside the denial or offer. Similarly, informative materials should be developed for use by insurance brokers and agents.

Guard Against Dumping: The reform law empowers federal agencies to prevent insurers and employers from dumping unhealthy patients into the high-risk pool. States, with their on-the-ground perspective, should act either to lend their enforcement power to the federal effort, or set up their own complementary enforcement structure.

Financing: Additional funding beyond the federal dollars will be required to sustain the new pools. Most states finance their high-risk pools via an assessment on private health plans, since the plans reap the rewards of healthier enrollees and lower costs. Assessments should take into account the proportion of applications that an insurer denies due to a pre-existing condition, so that insurers more apt to reject the sick pay a larger share.

Transition in 2014: As of Jan. 1, 2014, enrollees in the high-risk pool will have to change coverage. Policymakers should develop a plan for this transition, so that enrollees are able to identify and secure alternative coverage well in advance of the changeover.

approve or disapprove premium increases based on whether insurers were adequately compensating providers and encouraging accessibility, quality and affordability. The state has used this new leverage to put in place a series of standards, released in 2009, that include increased payment for primary care providers, medical homes, and incentives for the adoption of health information technology.[23]

Oregon also strengthened its rate review process in 2009 to prohibit excessive rate increases. It required rates to be based on reasonable administrative costs and expanded the factors considered when determining if the rate meets the standards, as well as opening insurers' rate applications to public scrutiny by posting them on the Internet. New rules also give consumers and advocates a role in the rate review process, by allowing input through a 30-day public comment period and public hearings.[24]

Other states should follow their lead. In creating or expanding a rate review procedure, states should adopt the following key policies:

- Insurers should be required to make a full statement of their premium increase proposal, including the proportion of premiums they currently spend on care, as against administration and executive compensation; their full financial position including investment income; specific cost-saving, quality-enhancing reforms they have adopted to lower the cost of care; their history of legal violations, consumer lawsuits, and regulatory action; and their track record of premium increases. Further, all of this information should be made available in its entirety for consumers to inspect on the internet, with exclusions for "trade secrets" determined by regulators and kept to a minimum, if not eliminated entirely;
- In determining whether to approve or reject an application, regulators should take all of the foregoing considerations into account—for example, insurers who repeatedly fail to adopt innovative payment reforms (such as those described in Section III, above) should not be allowed to pass the costs of their inaction on to consumers;
- If one component of a proposed rate increase is a rise in administrative costs that outpaces the Consumer Price Index measure of inflation, it should be presumed unreasonable unless the insurer can offer a satisfactory explanation.

For a more detailed discussion of the successes many states have had in instituting rate review policies, and for fuller recommendations on how to create or strengthen such systems, see CALPIRG's *Keeping Insurers Honest* report.[25]

Insurer Efficiency

The new law sets a floor on the percentage of a premium dollar that an insurer devotes to medical care, as against administrative overhead, compensation, and similar costs. For large groups, at least 85% must go to medical care, while the standard is 80% in the small group and individual markets. As of 2011, if an insurer fails to meet these requirements, it must make up the difference to its customers in the form of rebates (Sec. 1001, amending Sec. 2718 of the Public Health Service Act, and Sec. 10101(f)).

Fourteen states already have similar standards, though the federal requirement is as strong or stronger than all currently existing state rules.[26] However, the definition of what expenditures qualify as medical costs may vary substantially—for example, in response to the passage of

reform, WellPoint recently attempted to reclassify a number of administrative costs as being medical in nature, including "medical management" expenses.[27] Thus, depending on the set of definitions the federal government adopts, the existing state-level standard might be stronger than this new requirement.

States should act to ensure that their standards mesh with the federal regulations, without compromising the protection currently afforded to consumers. Adoption of the federal definitions will likely be the simplest approach, in the interest of efficiency and uniformity of reporting. But if this would mean watering down the status-quo protections, states could move above the 80/85% floor.

Other Provisions

A number of other market reforms are also included in the law, and most states should not need to contemplate additional action to give them effect or avoid conflict with state laws. However, they should be sure to reach out to their citizens to inform them of their new rights, and charge their Attorney General, Insurance Commissioner, and other regulators with enforcing the new protections.

First, as of September 2010, children under age 19 will no longer be subject to coverage denials or exclusions due to a preexisting condition (Sec. 1001, amending Sec. 2704 of the Public Health Service Act, and Sec. 10103(e)).[28] Lifetime and annual limits on essential benefits will likewise be prohibited, meaning that no insured consumer will be exposed to potentially unlimited financial liability. These provisions are effective in September of 2010, except that plans may impose limited annual limits until 2014 when the full prohibition goes into effect (Sec. 1001, amending Sec. 2711 of the Public Health Service Act). Finally, also as of September of this year, to promote proven preventive care and wellness, insurers will be required to offer first-dollar coverage of certain preventive treatments and tests, without any deductible, co-pay, or other cost-sharing (Sec. 1001, amending Sec. 2713 of the Public Health Service Act).

v. Beyond the Federal Reform

While the new law contains sweeping reforms to our health care system, there are several pressing problems that demand even stronger action. States should develop strong policy approaches that move beyond the significant achievements won this year. Not only will such policy innovations benefit the citizens of the states that pursue them, but they also can inspire imitation in other states, or even eventual adoption at the federal level.

Administrative Streamlining and Simplification

Administrative costs are a necessary feature of our highly-complex, highly-interconnected health care system. But repeated studies have shown that our administrative spending is unnecessarily high, inflated by duplicative requirements, complex, error-prone systems, and paper-based inefficiency.[29] Nationally, billing and insurance-related costs alone come to over $80 billion every year.[30] And the slow speed of processing claims can leave consumers uncertain about how much they will have to pay, or whether a treatment has been approved.

The new law begins to take aim at these problems. In Section 1104, it directs federal regulators to set up uniform standards for several administrative transactions, including electronic fund transfers between insurers and providers, treatment authorizations, and health claims forms. Unfortunately, however, these standards are not slated for full implementation until 2016, and they do not address several important causes of high administrative costs.

States have an opportunity to go farther by adopting strong policy solutions that have already been field-tested in states across the nation:

- **Build Secure Connections Between Providers and Insurers:** Creating an integrated health information network, in which providers and insurers can communicate efficiently and securely, can improve efficiency and lower costs, as well as provide important benefits to consumers. Networks in Utah and New England have

increased processing speed by a factor of six, and significantly reduced transaction costs, saving millions of dollars. States should foster the development of these networks by convening stakeholders and providing start-up grants, if needed.

- **Streamline Health Care Paperwork:** The profusion of different application and claims forms can confuse consumers and providers, and lead to wasted time and money as valid claims are denied due to avoidable clerical errors. By standardizing these forms and ensuring that insurers use the same, simple coding systems, states can streamline billing systems and reap significant savings. Minnesota has led the way in this area, with other states, such as Oregon and Washington, also moving toward adopting standard electronic forms. A recent Oregon Administrative Simplification Workgroup report details a proposal for that state to phase-in adoption of Minnesota's standards, adjusted for Oregon.[31]

Interested policymakers and stakeholders should consult the CALPIRG report *Cutting Red Tape in Health Care* for more details on these solutions.[32]

Prescription Drug and Medical Device Marketing

A key driver of rising health care costs is increased spending on prescription drugs. While many medicines do much to improve patient care and prevent chronic diseases from turning into acute conditions, others are simply "me-too" products that are no more effective than proven, more affordable alternatives. Drug manufacturers push their products through heavy marketing efforts aimed at doctors, which can include expensive meals, lavish junkets, and other gifts that have nothing to do with the scientific merits of a drug—as well as peddling misleading studies that overstate the benefits and underplay the risks of new medicines.[33] In addition to inflating costs, these marketing practices can create troubling conflicts of interest when doctors are called upon to write treatment recommendations or create formularies for public programs.

In recognition of these risks, the new law exposes drug and medical device manufacturers' marketing practices to the best disinfectant, sunshine: section 6002 requires drug and medical device companies, starting in 2013, to disclose every gift, payment, or other thing of value they give to doctors. In addition to submitting this information to federal regulators, it will also be made publically available.[34]

This welcome dose of transparency falls short in not setting a firm limit on the gifts a drug company can offer. It should also be noted that outright gifts are only one arrow in the drug marketer's quiver of marketing strategies. States can improve on this transparency provision in the following ways:

- **Adopt a Firm Gift Ban:** Once the gift and payment database created by new law is online and publically available after 2013, states that have not already done so should act to limit the aggregate value of gifts a drug company may give to a single doctor in a single year.

- **Provide Doctors with Unbiased Drug Information:** The "detailing" visits in which drug representatives push doctors to use their products are often one of the few sources of information physicians get. Successful programs in Pennsylvania and other states have pushed back against drug

industry spin by sending unbiased professionals into doctors' offices to give them the full facts about the relative advantages of different treatments. Such programs can be funded through industry fees, and if they target prescribers who treat Medicaid patients, they can save public dollars.

- **Protect the Privacy of Prescription Data:** States should prohibit drug companies from using the prescriptions that doctors write for marketing purposes. With access to databases of every prescription a doctor writes, drug companies can look over the shoulders of prescribers, allowing them to identify some as potential "profit centers," and monitoring them to prevent them from switching to a competitor's products. One former drug rep called this technique "our greatest tool in planning our approach to manipulating doctors."[35] States that have yet to act should put an end to this practice by requiring prescription information to only be used for legitimate scientific and medical purposes, not for marketing.

Evidence-Based Medicine and Health IT

Among the signal achievements of this year's health reform and the 2009 stimulus bill were the establishment and funding of initiatives focusing on health information technology (health IT) and research into which treatments work best. These programs can help spur the private sector to adopt productivity-enhancing technologies and promote effective treatments. But states can also seize the initiative and use them to set the stage for further systemic reform and billions in cost savings.

Today, drugs and devices must prove their safety and effectiveness in clinical trials prior to being approved. But they need not prove that they are more effective than alternative treatments. In fact, such studies are conducted only infrequently, which is a major reason why only half of medical interventions are supported by adequate evidence of clinical effectiveness.[36] Providers have little to rely on but the practice of other doctors in their area and the latest marketing push from pharmaceutical or device salespeople. To begin to remedy this gap, the 2009 stimulus law contained significant funding for this comparative research, and the federal health reform law establishes a new Center for Patient-Centered Outcomes Research, to study which treatments work best for various conditions.

The stimulus also invested $25 billion in federal funds to help wire America's health care delivery system. The need for these dollars is significant. The health care sector has fallen behind virtually every other American industry in integrating productivity-enhancing information technology systems. Patients typically receive care from multiple physicians, and frequently, physicians must see a patient whose test results or other relevant records are missing. If doctors' notes and test results are recorded in a single electronic file, coordinating care between different providers becomes much easier. And IT systems can help avoid an incorrect dosage or an overlooked drug interaction.

These health IT and comparative effectiveness provisions are important, positive reforms. Unfortunately, they stop short of integrating the two in order to reap the full potential benefit of these policies.

Some health researchers have proposed combining health IT and outcomes research to begin to encourage a truly evidence-based practice of medicine that includes electronic decision support systems. This health IT innovation prompts

providers with messages reporting the best standard of care at the very moment a provider is prescribing a particular course of treatment. Clinicians retain all decision-making authority, and still have the flexibility to actively choose another treatment—but they have the benefit of a comprehensive database of information and best practices. Integrating all of a patient's health care data into one system, along with supporting information, can reduce medical errors and promote high-quality care. Experts estimate that decision support systems, relying on evidence-based care guidelines, could save as much as $800 billion over ten years if adopted nationally as part of a fully realized health IT system.[37]

The new reform law does not mandate the creation or adoption of decision-support systems, but by promoting health IT and outcomes research, the building blocks are there. States have many options for fostering these systems, including offering grants to help health systems adopt decision-support programs, establishing higher Medicaid and public employee benefit fund payment rates for hospitals that use these systems, and even eventually requiring hospitals to implement decision support systems in order to win certification.

Ending Balance Billing

Receiving a hospital bill is often stressful for patients. It is much worse when they receive a bill purporting to charge them for services their insurer should be responsible for. This frequently occurs when a patient is treated for emergency services at a hospital that is not part of their insurer's provider network. Because the insurer and the hospital have not agreed on a reimbursement rate, hospitals frequently send bills directly to patients for the balance of charges an insurer does not pay, even after the patient has sent their copay to their insurer. Hospitals do this because they hope to be paid directly by the consumer, or to enlist their support in persuading the insurer to increase its reimbursement rate.

Unfortunately, this practice—known as balance billing—is very common, with one study finding that around 1.7 million Californians were balance billed over a two-year period, with an average charge of $300.[38] These charges are properly the responsibility of the insurer to cover, but estimates suggest that over over half of all balance-billed patients do pay at least some of what the hospital says they're owed. But when the patient rightly insists that they do not owe anything, they risk damage to their credit rating, making it that much harder to get a mortgage, make car payments, or keep up with credit card bills. Finally, large, unjustified bills can cause a huge amount of stress for a patient, just when they need to be resting and recovering from their illness.

And there's little a patient can do to stop balance billing. In an emergency, they can hardly be expected to take the time to determine which facilities are in-network for their insurance plan and which are not—indeed, if the emergency is serious enough, the best medical judgment is often to go to the closest available hospital. And of course, patients may be treated by non-contracting doctors even at an in-network hospital.

In states that do not regulate the practice of balance billing, the result is that consumers are left powerless to stop this unjust practice, and are at the mercy of a provider's decision to dragoon them into the reimbursement fray. State action is required to get consumers out of the crossfire between insurers and hospitals over payment rates.

In defending the practice, providers say they need patients' help to get a fair reimbursement rate from the health plans, because otherwise plans will systematically

underpay providers and manipulate their contracting networks to extract profit from doctors and hospitals. States should support efforts to create dispute resolution systems that quickly and effectively ensure that plans pay providers appropriately, as it is their legal obligation to do so.

But it is intolerable to use this as an excuse to allow providers to continue their practice of balance billing. Patients should not be held hostage to the plans' and providers' failure to reach a settlement. States that have not yet done so should therefore act, simply and decisively, to prevent hospitals from balance billing consumers for emergency services. They should closely monitor hospitals' complaints to ensure insurers are not taking unfair advantage and paying unsustainably low out-of-network reimbursement rates, and take further action as needed, but the key step is to get consumers out of the middle

All-Payer Rate Negotiation

A final option for lowering costs is to leverage the bargaining power of every patient in a state to negotiate better rates with hospitals. The state of Maryland has been a pioneer in this area, boasting a commission has set payment rates for hospitals across all payers, public and private, since 1974. Under this regime, rather than individual insurers negotiating the rates they will pay hospitals, the reimbursement is set based on evidence and argument before a commission. A waiver from the federal government would allow the state's regulation to apply to Medicaid and Medicare rates as well. Maryland's use of all-payer rate setting has resulted in hospital costs that have risen one percentage point slower than the national average, year in and year out since 1974. Of the seven states that have adopted some version of all-payer rate setting since the 1970s, five saw their hospital spending growth rate slow below the national average.[39]

Pursuing this policy will likely be politically difficult as well as novel in many states, but it has a proven track record of delivering lower costs for consumers. In states where even large insurers and employee benefit plans have been unable to negotiate affordable rates from hospitals, following Maryland's lead might be advisable.

vi. A State-Level Public Option

A major element of last year's health care reform debate was the public health insurance option—a publically-run insurance plan, available on the Exchange, which would increase consumer choice and strengthen the competitiveness of insurance markets. No public option was ultimately included in the final legislation, but for some states, creating their own public plan could allow them to realize significant benefits in lowering the cost of care and giving consumers better options.

A strong public plan would help to lower costs for consumers in several ways. First, if it had many enrollees throughout the state—or potentially in a multi-state region, if neighboring states decided to collaborate in offering a single public plan—it could use this negotiating power to leverage significant savings from providers. Second, if it were designed to do so, the public plan could employ the cost-saving, quality-improving policies discussed above (see Section III).

Third, additional savings would come from the effect that such a plan would have on the private insurance industry. By offering a low cost alternative to private insurance, insurers would have to innovate to bring their own costs down and so compete with the public plan. The adoption of these cost-saving, quality-enhancing approaches by private insurers would result in cost savings even for those who do not enroll in the public option.

If adopted nationwide, the best estimates were that a well-designed public plan could have saved $230-$320 billion in national health spending over its first decade.[40] Because a state-level public option would not have the same negotiating power or competitive strength as a full-fledged national plan, the potential savings for a state would be lower. But for some states, there could still be substantial benefits to creating a public plan.

As stated above, the new law does not include a national public option. Section 1322 does contain provisions relating to nonprofit health insurance co-ops, which were frequently discussed as a compromise or substitute version of the public plan in 2009's debate. But while some such co-ops have been successful in delivering quality care, notably Group Health in Seattle, many others have failed to even sustain themselves.[41] The reform legislation offers $6 billion in start-up loans in 2013 to

new, non-profit member-run insurers. But this funding is comparatively modest, and the law specifically disallows state or local governments from sponsoring such a co-op. As a result, this provision will do very little to allow interested states to realize the benefits of a true public plan.

However, there are some policies within the reform law that are significant for state public option efforts. In particular, it will be important to ensure that the public plan is designed such that it meets the standards for a "qualified health plan" under section 1301—this will allow coverage under the public option to satisfy the individual mandate requirement, and also allow enrollees who meet the eligibility standards access to affordability tax credits. Fortunately, there is nothing in section 1301 that requires that a qualified health plan be offered by a private company, meaning that a properly-designed public option should have little trouble meeting the definition.

Is a Public Option the Right Approach?

While there were several detailed public option proposals developed at the federal level, states should not simply try to import them wholesale. A policy that works for the nation as a whole might not be the best fit for a particular state, and several states have existing publically-run health plans that could be scaled up and adapted to meet many of the goals of the public option. Examples include locally run programs, such as California's county-organized health plans, and state-run plans like Maine's DirigoChoice and the Oregon Health Plan. Because these plans are already up and running, using them will reduce start-up costs, and will also allow reformers to build on a known foundation.

However, there are some states that might not be able to create a workable public option. This is because, for a public plan to survive, it needs to have enough enrollees to allow it to adequately spread risk. With a small number of customers, if only a few get sick it could substantially increase premiums for everyone. Also, without a critical mass of enrollees, some providers might be wary to enter into contracts with the unproven public plan, since with fewer potential customers it will be a less attractive partner (a further pitfall is that in states with low Medicaid reimbursement rates, some providers might fear that public plan reimbursements would likewise be low). That would hurt the public plan's ability to negotiate low provider rates and create a comprehensive provider network.

This will obviously be most difficult in smaller states, since there will be fewer potential enrollees. The degree of consolidation in a state's insurance market will also be a factor. In states with relatively uncompetitive markets dominated by a few large insurers, a new public plan might have a hard time carving out a toehold, limiting its ability to create much-needed choice and competition.

Ultimately, while there are many potential benefits to instituting a public plan, states should think carefully about whether to create one—and whether it is more advantageous to create one out of whole cloth or build on existing state programs. Smaller states might wish to partner with others in the region to ensure a sufficiently large enrollee population, and those worried about market consolidation might consider implementing other reforms to increase competitiveness before instituting a public plan (see Section II, above).

Key Considerations:

If state policymakers decide to move forward with the creation of a public option,

they should incorporate a number of key priorities in order to ensure it delivers on the promise of lowered costs and increased competition:

- **Governance**: As with the exchange, it will be important that the public plan have strong, independent leadership. While the public plan will need to draw on the expertise of actuaries and those with experience in the business of insurance, it must be accountable to its enrollees. Consumers, business, and labor representatives should play a significant role in all of the public plan's decisions.

- **Competition on the Exchange**: The public plan should be available on a state's exchange, where it will be best situated to enhance competition. If a state implements the strong consumer information provisions discussed above in Section II, consumers will know whether private insurers are measuring up to the standard the public option sets, and will be able to make their coverage decisions accordingly.

- **Driving Innovations Throughout the System**: As discussed in Section III, reforming the way we pay for care is one of the most powerful tools for increasing the quality and lowering the cost of coverage. The public plan can play a central role by incorporating these reforms and paying providers on the basis of quality and results, rather than simply volume. Not only will this benefit the public option's enrollees, but private insurers will also be pushed to adopt these reforms in order to remain competitive on cost and quality, leveraging reforms through a state's entire health care system.

- **Risk Adjustment and Reinsurance**: The potential weakness of a public plan is that it could have more than its share of unhealthy enrollees, since many consumers with health issues might distrust their private insurer and prefer to be covered through a publically accountable alternative. If this adverse selection occurs, premiums could quickly grow unaffordable. The risk adjustment and risk corridor programs set up in sections 1342 and 1343 offer one way to mitigate this danger by equalizing risk between plans. State policymakers should ensure that the public option participates in these two programs on an equal footing with private insurers, and should consider taking additional steps to guard against adverse selection if needed.

- **Independence**: As part of ensuring fair competition, the governance of the public plan should be completely independent of that of the exchange, and it should abide by the same regulations as private insurers. It should also eventually float its own boat via member premiums, though at first it will need start-up funding from the state. The public plan should repay any initial taxpayer investment.

Endnotes

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