

# STATE'S ROLE IN HEALTH CARE REFORM

By Andrew Allison

State health insurance exchanges represent the core of the insurance market reforms included in the federal health reform legislation signed into law earlier this year: the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010. Two of the best-understood insurance reforms in the ACA—requiring companies to offer insurance to all who seek it, and prohibiting discrimination in premiums based on health status—hinge on the market stability and managed competition that Congress is attempting to achieve in the new exchanges. Exchanges are also a lynchpin for the coverage expansions in health reform, since insurance is made “affordable” only within the exchange or through state Medicaid programs. A lot is riding on a timely and successful launch of these new marketplaces. This article describes the new exchanges, and lays out a core set of choices that state policymakers and administrators face as they begin the challenging process of implementing health reform.

### PRESUMED GOALS FOR HEALTH INSURANCE REFORM

The country has been through a long, and at times ill-informed, debate over comprehensive health insurance reform. Congress adopted—some might say defaulted to—the Senate’s version of the legislation, which calls for federally financed, state-level insurance reforms. To implement these reforms, state policymakers and officials will first need to consider—even if reluctantly—what Congress was trying to accomplish, and by extension, what states are to accomplish. Determining what Congress had in mind is a policy

debate if it is possible at all, but here for the sake of this discussion are four possible aims of the insurance reforms in the legislation:

- Define what it means to have basic health insurance coverage;
- Secure access to an offer of large group-like coverage for everyone;
- Get insurers to compete with each other rather than consumers; and
- Buy or subsidize minimum coverage to ensure affordability for all Americans.

It is not yet clear how successful Congress was in crafting legislation that can achieve all of this. States will play a key role in answering that question.

### NEW INSURANCE MARKETS INTENDED TO ACHIEVE BASIC GOALS

*Health insurance exchanges.* The ACA creates state-based American Health Benefit Exchanges and the Small Business Health Options Program, which I refer to here as simply “the exchange.” States can choose to let the federal government create and run the exchanges, or can establish and operate the exchanges themselves. States that operate them can determine their size and scope by choosing options such as:

- Combining exchanges for individuals and small businesses into a single, integrated market;
- Allowing larger businesses into the exchange beginning in 2017 (the exchange(s) must be available to businesses with up to 100 employees);
- Creating multiple exchanges within their borders, or combining their exchange with another state.

### *Basic functions of an exchange.*

Exchanges are structured web-based markets for health insurance, and the core purpose of the entity that runs the exchange will be to manage these markets. The exchange is to rate plans according to quality and cost, must group plans into four tiers (platinum, gold, silver and bronze) based on the overall level of benefits, and present health plan characteristics in an easily comparable format. The exchange will qualify health plans for participation based on minimum standards to be set by the HHS, but states will be free to add criteria as well. The exchange will need to enforce new and existing insurance regulations, including side-payments across plans that are intended to ensure that health risks are borne fairly by all competitors. The exchange is required to facilitate web-based determinations of eligibility for premium subsidies, as well as web-based selection and enrollment in health plans.

### *Subsidies available in the exchange.*

One aspect of the exchanges that will distinguish them from state experiments and market reforms to date are the large and comprehensive federal subsidies that will be available for the purchase of health insurance inside—and only inside—the exchange. In Kansas, these subsidies are estimated to



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exceed \$700 million per year. The subsidies are tied to the cost of basic health insurance coverage in the exchange, and vary with earnings to limit family costs to an increasing percentage of income. Subsidies limit the family share of premiums for those under 150 percent of the federal poverty level to between 2 percent to 4 percent of income. Family premium limits rise to 9.5 percent of income at 400 percent of FPL, the highest level of income protected in this way through tax subsidies. There are also income-related limits on cost-sharing within the exchange.

Market reforms, premium subsidies and cost-sharing protections interact to form an implicit and often complex definition of “affordable” care. Standardized benefits are richer than many current policies, which means that out-of-pocket costs will shift into premiums. Health care spending for healthy young adults could go up due to new limits on the price breaks they get for insurance now (i.e., due to favorable age rating). However, young adults are also most likely to qualify for premium subsidies and cost-sharing protections since they usually head the poorest families. On net, total insurance and medical costs for most young adults should be well under 10 percent of income.<sup>1</sup>

*Coordination between Medicaid and the exchange.* To make sure that everyone is covered and to create a clean dividing line between eligibility for federal subsidies in the exchange and eligibility for partially state-financed Medicaid coverage, the ACA synchronizes the definition of income used to determine eligibility for both using the tax-based concept of modified adjustable gross income. The MAGI allows a limited set of tax deductions, known in the language of public assistance as “disregards.” For Medicaid, reform offers the opportunity for simplicity and seamless transitions to private

health insurance. In Sections 1413 and 2201 of the ACA, Congress articulated a number of specific requirements to ensure this kind of integration in eligibility and enrollment between Medicaid and the exchange:

- States must make available a common web-based application for Medicaid, CHIP and the subsidies and cost-sharing protections available in the exchange.
- State exchanges must screen applicants for Medicaid and CHIP eligibility, and state Medicaid and CHIP programs must accept these referrals and enroll these individuals in the appropriate program without further review of eligibility.
- State Medicaid programs must ensure that ineligible applicants are screened for eligibility for subsidies in state exchanges, and that those found eligible are enrolled in a plan through the exchange.

Although not required, states may choose to contract with their state Medicaid agency to determine eligibility for premium subsidies and cost-sharing protections within the exchange. Given the potential duplication of effort and the financial disputes that could arise from two competing eligibility processes, I expect most states will take this option.

## KEY STATE CHALLENGES

Although the legislation is long and in some cases very specific, much is left to states. The expectation is that states will use the tools created in federal legislation—i.e., new insurance rules and federal funding—to initiate and implement reform and achieve its basic goals. States face a number of key choices in this process.

1. *States must decide whether to establish their own exchange.* The bill requires states to inform the HHS of their choice by January 2013.

Kansas Insurance Commissioner Sandy Praeger, a leader in the National Association of Insurance Commissioners, has indicated our state’s likely preference to operate an exchange. I expect most states will do the same to avoid ceding control to the federal government. Practically speaking, states need to be preparing now to implement state-run exchanges so that state legislators still have this choice available to them when deadlines for funding and authorization arrive.

2. *States need to define what kind of competition they want inside the exchange.* For good or ill, the new exchanges will reflect each state’s vision of a competitive insurance market. States might view competition in terms of the total number of carriers, health plans and benefit variations available to consumers. States might also view competition in terms of simplicity and comparability among health plans. Comparability will be greatly aided through creative software interfaces in the virtual stores that will make up the consumer’s experience in the exchange. But it is an open question how well these e-stores can be designed to help consumers filter through a complex maze of insurance options.<sup>2</sup> Some states may consider narrowing the range of approved health plan options in order to enhance head-to-head competition between carriers, while other states will want to emphasize innovation through a wider range of health plan choices.
3. *States must decide how to govern these new and potentially dominant health insurance markets.* Some states may assign the new responsibilities for overseeing the exchange to an existing governmental entity, i.e., state insurance agencies. Many will consider creating a new nonprofit

or quasi-governmental oversight agency, but this will entail a significant shift of responsibility for public oversight of health insurance products. States choosing to take a more aggressive role in these new markets may also look to combine these regulatory opportunities with the leverage of an expanded Medicaid program. This raises the question of whether new governmental structures are needed to coordinate state interests in health insurance markets. States' choices are likely to reflect the national diversity in opinion regarding the appropriate role for public policy in insurance markets. As with most states, this conversation has not yet begun in Kansas.

4. *States must coordinate enrollment of a significant percentage of their population in means-tested programs.* In Kansas, as much as 30 percent of the population could be enrolled in Medicaid or in a subsidized product in the new health insurance exchange in January 2014. Many of those 700,000–1,000,000 participants will enroll in the last months of 2013, a logistical nightmare if not a practical impossibility, using existing systems. The scale of this enrollment effort, and the required level of coordination between old and new programs, is unprecedented in health and human service programs in the vast majority of states. Kansas is going to meet this challenge with a grant it received prior to health reform to rebuild its Medicaid eligibility system and create a modern, web-based, decentralized and community-driven outreach and enrollment program. We expect the system to support the core eligibility functions of the new exchange, and are designing the system to be expanded and fully integrated with human service programs as soon as health reform deadlines are met. Each of

these steps is so large that they cannot be tackled simultaneously. If states are to meet the health reform deadlines, many will need to replace or upgrade their eligibility systems in stages, which could disrupt administrative workflow and coordination in the interim. Implementation is also likely to disrupt longstanding inter-agency relationships. Exchanges add a new entity representing a large new population, mostly un-served by state human service programs, into the decision process for designing, procuring and operating eligibility systems. States and the federal government should not underestimate this political and administrative challenge.

5. *States must decide how they will use the buying power and regulatory influence health reform gives them.* Although the ACA does not in every case create new regulatory authority for states, it does give them a new market and a great deal more “buying power.” To the extent states feel it is appropriate to do so, there will be new opportunities to regulate health plan design and either review or negotiate premiums in order to leverage savings, quality, and performance improvement. An extreme example is the “public option” health plan that would “compete” against private insurance inside the exchanges. Congress decided against creating a public option, but left this as an option for willing states. A more likely option is that states will create new links between Medicaid and the private exchanges.

Many states already operate a kind of health insurance exchange for health plans serving their Medicaid populations. These plans are now preparing for significant growth given the expansion of Medicaid to nearly everyone under 138 percent FPL in 2014. Medicaid-only health plans

## START NOW OR WAIT FOR THE COURTS?

This article focuses on states' roles in health reform bills as passed by Congress. A number of states have challenged the constitutionality of the new laws. Should these lawsuits prevail, the analysis here may be moot. Nevertheless, should the lawsuits or other forms of opposition fail, state and federal health program administrators need to be ready to meet reform's aggressive timeline. Moving forward under this cloud of uncertainty may prove to be the professional challenge of a lifetime, especially in this new era of fiscal austerity when contingency planning is a luxury.

are also considering ventures into the exchanges. Indeed, some states may use the leverage of the expanded Medicaid market to force plans to venture into the exchanges. Conversely, the expanded Medicaid market may attract some health plans that currently serve only the private market. Diversification would mean stronger competition for state Medicaid contracts, and has advantages for beneficiaries as well. Families earning their way out of Medicaid could keep their health plans, and parents with children in CHIP could share a health plan (while that program is still in operation).

With their buying power, state Medicaid programs seem likely to succeed in leveraging some level of integration with the exchange. This was the goal in a recent, year-long planning process for a now-abandoned expansion of Medicaid to poor adults in Kansas. The intensive discussions we held with insurance carriers in 2006 and 2007 foreshadowed a dilemma that some believe will be an Achilles'



heel in the Medicaid expansion: even with diversified health plans, it may be difficult to persuade providers to serve both Medicaid and private-pay patients. States will need to consider the full range of public policy tools—those created in the ACA as well as those states already possess—to prevent a two-tiered health care system.

### SUMMARY: REFORM PRESENTS STATES WITH HISTORIC CHOICES

Opinions differ as to the eventual size of the new insurance exchanges relative to the traditional, nonsubsidized private markets that are allowed to continue under the legislation. An overriding distinction between the ACA's insurance market reforms and those that have come before are the subsidies that

will be available inside the exchanges to families up to four times the poverty rate—a level of income that exceeds the median in Kansas and more than 30 other states. In this observer's opinion the attraction of huge federal subsidies for such a large percentage of the population is likely to draw most individuals and an even larger percentage of small businesses. If exchanges prove the dominant choice for consumers, then the challenge and opportunity states now face comes into focus: defining and implementing a new and much larger private health insurance market in less than three and a half years. The degree of choice available to states in creating these new markets is profound, and will tax states' capacity to understand, deliberate and select policy options that are both new and complex.

### ENDNOTES

- <sup>1</sup> Analysis based on earlier versions of health reform legislation. See Linda J. Blumberg, Matthew Buettgens and Bowen Garrett. 2010. "Update: Age Rating Under Comprehensive Health Care Reform." AARP Public Policy Institute, Insight on the Issues Series, <http://www.aarp.org/health/medicare-insurance/info-01-2010/i000-age-rating.html>.
- <sup>2</sup> For a more considered discussion of the nature of these new markets, see: Jon Kingsdale and John Bertko, "Insurance Exchanges Under Health Reform: Six Design Issues for the States," *Health Affairs* 29:6 (June 2010), pp. 1158-1163; and Jon Kingsdale, "Health Insurance Exchanges—Key Link in a Better-Value Chain," *New England Journal of Medicine* 362:23 (June 10, 2010), pp. 2147–2150. 

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