NATIONAL ACADEMY
for STATE HEALTH POLICY

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"Implementation of Federal Health Care Reform"
Presented by Alan Weil
Executive Director, National Academy for State Health Policy
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Mr. Chairman and members of the committee, thank you for the opportunity to be here today. My name is Alan Weil, and I am the executive director of the National Academy for State Health Policy, a non-profit, non-partisan organization dedicated to improving state health policy and practice.

The federal health reform law contains many of the elements states need to achieve major improvements in their health care systems. While states will face significant challenges implementing the new law—in part due to the many tasks they must complete, and in part due to the extremely constrained financial and staff resources available to them—states that rise to the occasion will find that they are rewarded for their efforts. In that vein, I applaud the Schwarzenegger Administration for publicly announcing their commitment to implementing health reform.

There is a natural tendency to focus the implementation discussion on the most immediate issues—for example the state's choice regarding the high risk pool. Indeed, you must tackle these issues, but it is equally important that you begin thinking about and

planning for the many aspects of implementation that occur in later years, particularly in 2014 when many of the law's provisions take effect.

In our analysis of the legislation, and in conjunction with our executive committee—of which both Secretary Kim Belshé and Deputy Cabinet Secretary Richard Figueroa are members—we have identified 10 critical components of successful state health reform implementation. I will begin my testimony by describing these elements, and will then turn to the steps you will need to take to achieve them.

First, Be Strategic With the Insurance Exchange

The insurance exchange presents each state with the opportunity to organize the chaotic and inefficient small group and individual insurance markets. A better-functioning market can improve choice and value for individuals, families, and small businesses, all of which are struggling to afford health insurance.

As Jon Kingsdale will no doubt describe later in this hearing, these outcomes do not arise naturally or automatically from the creation of an exchange. The state must be active and at times aggressive in administering the exchange. Critical exchange functions include standardized presentation of information on benefits so people can make informed choices, standardized data collection across plans and holding plans to high standards in providing access to services and achieving health outcomes, and an effective risk adjustment mechanism to avoid incentives for risk selection and to assure that plans have sufficient resources to provide services to enrollees with high health needs.

As the exclusive distribution vehicle for income-based subsidies, the exchange must be easy for the consumer to use. It must be able to offer potential enrollees a choice of plans, with post-subsidy prices and benefits readily available for comparison.

An effective exchange will give meaning to the affordability standards in the federal law, and will be a force for efficiency and an orientation toward quality in the insurance and health delivery sectors.

Second, Regulate the Commercial Health Insurance Market Effectively

While the federal law creates many new standards for insurance underwriting and rating practices, the enforcement of most of those standards falls to the states. And, as has become abundantly clear over the past few months, these standards do not enforce themselves. Effective regulation is essential to assure availability of affordable coverage, to enable the exchange to achieve its potential, and to place pressure on the health insurance industry to focus on delivery system improvements.

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

While health insurance regulation is not a new function for states, how it takes place will be under additional scrutiny because it is critical to the success of the overall reform endeavor.

Third, Simplify and Integrate Eligibility Systems

Dramatic simplification of eligibility is the only way to achieve the promise of near-universal coverage embodied in the federal law. To put it bluntly, you cannot extend MediCal or exchange-based coverage to what has been estimated to be 6.5 million Californians relying upon a county-based eligibility platform designed around the cumbersome and intrusive processes enshrined in the welfare eligibility system. That system will crumble.

The good news is that the federal law effects a tremendous simplification in Medicaid eligibility—moving to standards based on modified adjusted gross income as in the tax code. This simplification meshes nicely—at least in theory—with the simplified income tests for exchange-based subsidies. We also know a great deal about effective outreach, enrollment, and retention of people eligible for coverage—but part of what we know is that those tools are only effective in the context of an improved eligibility system.

With guidance from the federal government, states must completely redesign their eligibility systems and processes to assure seamless transitions as families' incomes rise and fall, families are formed, grow, or dissolve, as part time, seasonal, and migrant workers change status, and as people move from one part of the state to another—or to another state entirely. This is a massive undertaking, with the promise of incredible efficiencies and dramatic

improvements in customer service and, ultimately, access to care, if done well.

Fourth, Expand Provider and Health System Capacity

On average, people without health insurance use about 60% of the health care services as people with coverage. Therefore, expanding coverage will increase demand for services. This is a good thing, but it will strain the capacity of those parts of the health care system that are already under pressure. Particular challenges will arise in the areas of primary care, culturally competent and linguistically accessible care, and highly specialized care. Particular institutions will also face unusual strain—especially community clinics, health centers and public and other safety net hospitals.

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

time to revisit state scope of practice laws and the state's approach to training and credentialing medical professionals.

Health coverage expansions will not create a provider supply problem, but they will highlight the problems you already have. Support for health reform will suffer if the newly insured find that their coverage is a hollow promise, or those who are currently insured perceive that their access to care has been adversely affected by those who have gained coverage.

Fifth, Attend to Benefit Design

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

While the federal law establishes parameters for insurance coverage, and those standards may be further explicated through regulations, a significant number of benefit design issues remain with the states. For example, the new Medicaid coverage for people with incomes below 133% of the federal poverty level is for so-called "benchmark" coverage, which can be designed more akin to a commercial plan than to the traditional MediCal benefit structure. The

broad authority states have to select plans to participate in the insurance exchange could be used to affect benefit design. Many states operate premium assistance programs for workers who have access to employer-sponsored insurance, and the standards for those programs could include certain criteria regarding benefit design. States retain control over their benefit mandates in the individual and small group markets—although they must reimburse the federal government for some subsidy expenses associated with those benefits. And, of course, states continue to purchase coverage for their own workers and retirees.

From the perspective of the individual, benefit design affects the price of insurance, the financial risk he bears, and, ultimately, his access to services. The even greater power of benefit design, when used effectively across purchasers, is to push the entire health care system toward an emphasis on prevention and coordination and away from services and procedures that have limited value.

Sixth, Focus on the Dually Eligible

People eligible for both Medicare and MediCal account for 47% of total MediCal spending – a proportion that is higher than the national average. This group of frail elders and a subset of people with disabilities experiences poorly coordinated care and high costs. Improvements in care for the duals has long been a priority for states.

The federal law creates one new challenge and some important opportunities for states. On the challenge side, the changes to the Medicare Advantage program will have implications for existing Special Needs Plans, which, despite their limitations, have been one

source for coordination between Medicaid and Medicare. It is not yet clear how this will play out.

On the opportunity side, the law allows states to convert some home and community-based waiver services into state plan options, and it expands and extends the Money Follows the Person demonstration program to facilitate moving people from nursing homes back into the community. The federal law creates a new office within CMS that focuses exclusively on the duals, and the dually eligible are a target population for reforms that can be implemented by the new Center for Medicare and Medicaid Innovation. These two latter offices have not yet taken shape, but they offer unique vehicles for states to pursue models of integration between Medicaid and Medicare that have never before been available.

Seventh, Use Your Data

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

California, like other states, has developed health information exchange strategic and operational plans, but most of the work to develop those plans was completed prior to the enactment of the federal health reform law. There are myriad provisions in the law that call for the collection of new data. Data elements include race, ethnicity, and language, price and utilization, program enrollment, and

quality metrics. New data will be collected on, among other things, consumer complaints, wellness program, the prevalence of chronic diseases, and the health care workforce. Purchasers—individuals, employers, and the exchange—can use data to drive improvement in outcomes and quality. Doctors, hospitals, and health systems can use data to achieve the same ends. The state can aggregate data across systems to monitor population health, identify priorities for improvement, and track progress toward goals.

Effective use of data requires a commitment to collect it, a strategy to combine data that come from different sources, and selection of priority areas for analysis. The state must also have a strategy and plan to put appropriate subsets of the data in the public domain where it can become a force for improvement.

Eight, Pursue Population Health Goals

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

The prevention and public health components of the federal law represent a fundamental shift from public health as an afterthought, subject to annual appropriations in competition with the more visible personal health services, to a core, sustained investment. In addition to the creation of the National Prevention, Health Promotion, and Public Health Council, which will coordinate federal strategy, the law includes a large number of grants to address topics including

surveillance, public health laboratories, childhood obesity, and racial and ethnic disparities.

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

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

Ninth, Engage the Public in Policy Development and Implementation

The public remains confused about how health reform will affect them, and public attitudes toward reform remain as sharply divided as they were at the time of enactment. We know from the large number of people eligible for MediCal but not enrolled that simply creating opportunities for coverage does mean people will take them up. California is ahead of most of the country because you already had a very public conversation about a “culture of coverage.” Fundamentally, health reform can only succeed if it is more about culture and norms than it is about mandates and penalties.

The public also includes the large health sector and employers, who will also face significant changes. The most successful efforts to improve the performance of the health system have been multi-sector, public and private initiatives that set goals and plans for concrete improvements. This framework is particularly essential

when pursuing payment changes, which can only have their intended effect if they are adopted across purchasers.

The sheer number and scale of the tasks to be accomplished, combined with the size and diversity of your state, means the talents and strengths of your people and institutions must be brought into the implementation discussion. No amount of talent and goodwill in Sacramento can develop answers and policies that work for the entire state. The answer lies in effective information flow between an engaged public and their elected representatives to weigh in on options before one is chosen, and to provide information back on how things are going so they can be improved.

Finally, Demand Quality and Efficiency from the Health Care System

The American health care system is the most expensive in the world. While delivering technically excellent care in many instances, we have tremendous documented failures. We do not effectively manage chronic conditions, we overdiagnose and overtreat, we make repeated, avoidable errors that lead to harm and death, and we are burdened by expensive, duplicative administrative processes. Reasonable estimates suggest that as much as one third of the medical services provided are of no demonstrated value to patients.

In that context, it is imperative that all of the forces of health reform align to squeeze out waste so our resources can go into the unmet needs so many people have and back into the pockets of families and businesses that have far better uses for their limited funds.

Health reform enables the State to align the purchasing power it has within MediCal, Healthy Families, and the new Exchange. That leverage, used in conjunction with private purchasers, can, through payment reform, benefit design, using data, and setting ambitious population health goals, yield a health care system that doctors, nurses and other health care providers want to practice in, patients want to receive care in, and that we can afford. New tools include pilots for the establishment of pediatric Accountable Care Organizations, the promotion of medical homes for people with chronic conditions, and the broad authority embodied in the Center for Innovations.

What will it take to develop these 10 elements of successful implementation?

First, you need knowledge of what is in the legislation – at a level of detail far beyond the typical bill summary, and organized in a manner that matches the policy choices states must make.

Second, you need executive branch leadership – while the legislature clearly has an important role to play, the administrative requirements of implementation are so significant that they can only be coordinated and carried out by a committed Governor and executive agencies. That leadership needs to bring in a long list of stakeholders—partly to help shape the substance, but also to provide continuity as term limits yield changes in executive branch and legislative branch leadership.

Third, you need a strategic plan. They key precursor to the plan is agreement on overall implementation goals. These goals should derive from what you know to be the most pressing health

needs of your citizens and the most critical challenges facing the health care delivery system. A goal-based plan is needed to give coherence to the disparate elements of implementation.

Fourth, you need to convert the strategic plan into an operational plan that gives specific guidance to each implementing body.

Fifth, you need to define the resources necessary to carry out the operational plan. Given the state's current fiscal situation, I can state with confidence that your administrative agencies do not have sufficient capacity to carry out such a plan within existing resources. The gap between the resources you have and the resources you have available define your unmet needs. At that point the State, the philanthropic community, and the health sector will face the significant challenge of meeting those needs. Necessary resources may also include relaxation or modification of traditional hiring, contracting, and salary practices that will impede the state's ability to get the job done. I should note that it is important not to squander resources in advance of reaching this stage, or you will find yourself devoting resources to areas that ultimately prove themselves to be of lesser importance.

As you undertake these activities, you need to keep one eye on the federal government. With that eye, you need to both advocate for federal policies that meet your state's needs, and monitor the choices the federal government makes to ascertain how they affect your plans. And, while additional federal guidance is forthcoming in many areas, try not to let uncertainty regarding federal policy impede your progress. You need to keep the other eye on the other states. While

California is certainly unique, many of the issues you will confront are identical to the ones other states are working through. Organizations like mine are devoted to the principle that there is a tremendous amount that states can learn from each other—and that seems more true now than ever.

Mr. Chairman, I congratulate you on your decision to hold these hearings as a vehicle for pursuing effective implementation of health reform. There is a great deal to do, but there is enough time to get this right. Leadership will be required, but those who lead will find that the federal law contains the elements that, when supplemented with appropriate, thoughtful, and strategic state choices, will yield a better performing health system, dramatically improved access to care and financial protection for those who are most vulnerable, and a health care system that we can afford. I thank you for the opportunity to offer this testimony.