

POLICY AND REFORM

The Time for State-Based Healthcare Reform

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ABSTRACT

In this commentary, we discuss our thoughts on the future of healthcare reform in the United States. While public discourse on healthcare reform still focuses on the federal government and the Affordable Care Act, including the possibility of repeal, we argue that states are poised to continue the momentum started by the federal government. Implementation of Medicaid expansion, Delivery System Reform Incentive Payment waivers, State Innovation Waivers, and all-payer claims databases are examples of state-level opportunities to further the progress driven by the federal government on issues of cost, access, and quality. This shift in focus to state-based initiatives, bolstered by the recent elections and political appointments, raises important challenges, ranging from budget shortfalls to state-level political gridlock. Policymakers, researchers, and other stakeholders ought to recognize this trend and its implications for their work. We offer a few recommendations to help states successfully seize the opportunities available to them to drive reform and innovation. These include engaging in public-private partnerships, joining neighboring states in unified efforts, and creating infrastructure to borrow promising programs from other states.

INTRODUCTION

In the United States, healthcare reform at the federal level has been transformative over the past several years. From mandates to insurance reforms, the Affordable Care Act (ACA) and related executive actions changed our healthcare system in important ways. Decreased uninsured rates, increased access, and new innovations across the country are a few of the merits of these changes (Blumenthal, Abrams, & Nuzum, 2015). However, the future of the ACA is uncertain and there is mounting evidence that the country is still in need of bold, new reforms. While the ACA was never intended to solve all of the nation's healthcare ills, its impact has been hampered by an unfavorable Supreme Court decision on Medicaid expansion and several implementation challenges. Millions remain uninsured while increasing premiums burden the insured. Struggling to turn a profit, insurers have withdrawn from state exchanges, decreasing plan offerings for consumers in many markets. Meanwhile, according to the Congressional Budget Office (2015), costs continue to significantly outpace inflation and income growth, straining state and federal budgets. Prospects for federal efforts to build upon the progress of the ACA and address these remaining problems remain dim for the foreseeable future, due to political gridlock. Luckily, states have a number of opportunities to pick up the mantle from the federal government where the ACA and other federal efforts left off.

OPPORTUNITIES FOR STATES

Governors, state legislatures, and state agencies have several opportunities to drive the next wave of U.S. healthcare reform. A salient example of this new direction is Medicaid expansion, now a state-level issue. We expect to see significant Medicaid activity from the eighteen holdout states as evidence of the benefits of expansion, including improved access and reductions in uninsured hospital stays,

contributes to mounting public and fiscal pressure (Sommers, Blendon, & Orav, 2016; Nikpay, Buchmueller, & Levy, 2016). Earlier this year, Louisiana became the first state in the South to expand Medicaid while other red states, such as Oklahoma, also consider expansion (Table 1). President Obama's offer to non-expansion states of three years of full federal funding for new Medicaid beneficiaries further spurs this momentum. Some states have implemented expansion in unique ways, some of which are proving fruitful. Arkansas's private option approach, for instance, has been shown to reduce emergency department usage and improve health to the same extent as Kentucky's more traditional Medicaid expansion (Sommers, Blendon, Orav, & Epstein, 2016). However, innovative approaches such as these have potential downsides as well. Indiana's Medicaid coverage is significantly consumer-driven through the use of health savings accounts (HSAs), mitigating government burden (Kaiser Family Foundation, 2015). This approach, overseen by Vice President-elect Mike Pence, may decrease costs but also might discourage enrollment due to steep payment requirements for beneficiaries. While innovations like these should be thoroughly evaluated, those that are shown to improve coverage, affordability, and access, while containing cost growth, should translate across state boundaries.

Another often overlooked state-level reform is the Delivery System Reform Incentive Payment (DSRIP) waiver program, which is part of the Section 1115 Waiver program. These waivers, which enable states to reward innovative Medicaid providers, have increased collaboration and renewed focus on social services (Kaiser Family Foundation, 2015). California, Massachusetts, and Texas are seeking renewal of their waivers, while New York's experiment has just begun. Their success in partnering with providers and improving care for Medicaid beneficiaries has generated interest among other states. Alabama, Illinois, and others recently submitted DSRIP applications.

States will also have new opportunities this year beyond Medicaid, notably State Innovation Waivers (or 1332 Waivers), which allow states to pursue original ways of providing affordable health insurance (Centers for Medicare and Medicaid Services, 2016). They enable states to waive numerous provisions and reallocate federal subsidies as long as coverage meets ACA benchmarks without increasing the federal deficit. These waivers create tremendous opportunity to fine-tune or redesign healthcare systems in order to improve population health while eliminating costly inefficiencies. Some states have been looking to these innovation waivers for years, while others are only beginning to explore the numerous possibilities they offer. For instance, legislators in Colorado proposed using a 1332 waiver to create ColoradoCare, a statewide single-payer system (Miller, 2015). Vermont submitted a waiver application to avoid building a website for its small-business insurance exchange, hoping instead those employers will enroll directly through insurers (Dickson, 2016). Hawaii passed a law (SB 2774 Act 13) authorizing pursuit of a waiver to resolve conflicts between the ACA and its existing mandates while Arkansas considers a joint 1332 and DSRIP waiver to support its private option model. Most recently, California posted a draft waiver to allow undocumented immigrants to attain unsubsidized insurance through their state-based exchange, Covered California. Recognizing that these examples are only the tip of the iceberg, many other states (*e.g.* New Mexico, Minnesota) have created task forces to explore 1332 waivers. While the opportunities are many, states face important operational limitations, particularly if they use the federal marketplace. The federal enrollment platform cannot accommodate different rules for different states, so states looking to tailor their systems must transition to their own enrollment platform. Despite these technical challenges, both DSRIP and 1332 waivers enable states to chart a path forward that better fits their specific contexts and cares for their people. Thus far, there has been no indication of plans to specifically repeal either of these waiver programs. Given that these programs champion states' rights, they reflect Republican ideology and are unlikely to be cut by the next Congress, although implementation will be shaped by a new administration. In a time of uncertainty, these waivers may be safe investments for states seeking to drive reform.

Yet another area in which state-level efforts will take center stage is in the arena of All-Payer Claims Databases (APCD), statewide repositories of claims data from public and private payers. These databases, which have received significant government funding over the past few years, allow providers, policymakers, and patients to access rich datasets with diverse uses. Broadly, they are used to inform state health agencies, support payment reform initiatives, and to increase price transparency in healthcare. Maine, Kansas, Maryland, and Massachusetts led the way in building APCDs, and more states are recognizing their value in guiding reform. As states feel increased pressure to contain costs and improve health, and continue to see examples of APCDs aiding that process, we will see more state investment in APCDs. For instance, New Hampshire's efforts to shed light on payment variation among public and private payers have educated policymakers and produced a decision support tool for patients as they choose providers (Hodder, 2016). The resulting price transparency will help control healthcare costs system-wide and for individual consumers. Since a recent Supreme Court decision (*Gobeille v. Liberty Mutual*) will hinder efforts to collect claims data from private insurers, states will have to creatively engage stakeholders to ensure APCDs paint a full picture of healthcare costs, perhaps by demonstrating how APCDs can benefit insurers who are reluctant to hand over their data.

ELECTIONS

With so much of healthcare reform under the aegis of state governments, the outcomes of the 2016 elections will play a major role in shaping the healthcare landscape. In fact, it was the election of a Democratic governor that, in concert with the state legislature, led to Medicaid expansion in Louisiana. On the other hand, the election of Gov. Matt Bevin, a Republican, in Kentucky has led to a gradual dismantling of that state's successful state-based marketplace, potentially reducing coverage options for consumers. Although they garner less interest from the public, state-level elections clearly matter for constituents' healthcare access and financial security. As several state legislatures and gubernatorial offices are transitioning, the future of Medicaid expansion, waiver applications, and other initiatives is highly uncertain.

With respect to the presidential election, many of these state-level opportunities will continue to exist in spite of Republican plans to repeal parts of the ACA. Indeed, in the absence of a cohesive replacement plan, the onus of future healthcare reform will more likely fall on individual states. Even Republican proposals at the federal level emphasize state responsibility. For instance, Speaker Paul Ryan's healthcare proposal includes Medicaid block grants, which would provide a lump sum to states to manage their Medicaid programs however they choose. Seema Verma and Tom Price, President-elect Trump's picks to head the Centers for Medicare and Medicaid Services and the Department of Health and Human Services, respectively, have also strongly advocated for state-based approaches to health reform. Clearly, the Republican sweep of the elections last November make state-level opportunities even more important.

CHALLENGES AHEAD

States that seize the opportunities available to them will grapple with new and distinct challenges. Political gridlock at the state and local levels frequently hinders progress. But even when political will exists, states often face fiscal barriers. Some stakeholders worry, for example, about Louisiana's pursuit of Medicaid expansion in light of a three-quarter billion-dollar deficit (Patel, 2016). Over a dozen other states face budget shortfalls, with several lacking the financial means to invest in major state-driven improvements. This problem is compounded by the reluctance of governors and legislatures, especially in the South, to increase taxes to fund healthcare innovation. Many states also lack adequate expertise to redesign complex healthcare systems, while hiring contractors and consultants is costly. Further, policymakers face a lack of infrastructure for state-to-state transfer of innovation and reform. Although states sometimes learn from past or present experiences of other

states, the current level of cooperation falls short of producing nationwide improvements in access, quality, and cost. Multiple states are independently researching and developing APCDs similar to ones that other states have already built, a clear example of cost-inefficiency in a time of widespread budgetary distress. This type of collaboration is hindered by technical limitations as well as by immediate and competing priorities. Formal state-to-state transfer of marketplace innovations is often stalled by pressing, local demands that take precedence, particularly for public-facing reforms. Some states may choose to engineer their own post-ACA course in healthcare due to political reasons, such as a resistance to perceived federal overreach or interference. Other obstacles to collaboration are bureaucratic in nature. State insurance regulators, for instance, have varying roles and reach in their respective financing and delivery systems, complicating efforts to translate initiatives from other states.

IMPLICATIONS

Policymakers and researchers ought to pay attention to these challenges and adapt accordingly. At the state level, policymakers must prepare to develop their own solutions in collaboration with other states. Federal leaders should embrace state-level reforms as the next step in fulfilling the ACA's promises and support states by allowing flexibility and providing funding and oversight when needed. Considering joint 1332 and DSRIP waivers from states looking to waive both ACA and Medicaid requirements, and calculating budget neutrality across both waivers, gives states greater opportunity to innovate.

As states increasingly drive reform, research focused on state-level initiatives may be more fruitful, providing insight into best practices for governors and legislators. Analyses of the efficacy of specific initiatives and their translatability to other states will inform the next wave of healthcare reform. For example, states with substantial budget deficits eyeing Medicaid expansion (*e.g.* Georgia, Oklahoma) or other ambitious health reforms desperately need evidence-based strategies to accomplish their goals. Furthermore, ongoing evaluation of innovative state-based programs, such as Indiana's HSA approach to Medicaid coverage, can guide state governments in deciding which programs might be worth considering for their own state.

RECOMMENDATIONS

We propose a few strategies to help spur state-level innovation and reform in 2016 and the years to come.

Public-Private Partnerships

First and foremost, as states pursue these opportunities, they must incorporate stakeholder input from the private sector, including physicians, patients, insurers, hospitals, health IT companies, and others. Likewise, because the private sector plays a major role in healthcare innovation, public-private partnerships will be critical in efforts to produce and translate best practices, from system design to data structures. Looking to the private sector for leadership in execution and implementation, which will define the likelihood of success for most interventions, is one way to promote efficiency while minimizing investment from deficit-burdened governments. For instance, partnering with large employers, who remain committed to providing insurance, could facilitate efforts to improve coverage and health while containing costs. The profit motive of employers and others can be leveraged through shared savings models, easing strain on public funds. Partnering with insurers to drive further investment in targeted outreach and enrollment strategies would simultaneously improve coverage, advancing the public interest, and increase the size and diversity of state-based markets, advancing the private interest of insurers participating in exchanges. Certain segments of the population, such as the young and healthy, fit into this intersection particularly well. For instance, a greater enrollment rate among young, healthy adults would further diversify risk pools, expand access, and benefit insurance

providers. States should seek to take advantage of these areas of alignment between public and private interests, to the extent that they benefit consumers.

At the same time, states should be wary of over-reliance on private sector participation, which can impede progress in some cases. Stakeholders who will see revenues decline due to cost containment initiatives will obviously fight changes that could be beneficial to the overall system, and as such, relying on their full support in order to pursue change may be extremely limiting. For instance, continuing our previous example, insurers involved in enrollment efforts face a conflict of interest in that outreach could be biased to market a company's plans instead of the many options in the marketplace. Public-private partnerships should be carefully crafted to mitigate this risk while maximizing the positive contributions hospitals, physicians, and insurers can make to increase overall surplus. States can look to Europe and Center for Medicare and Medicaid Innovation Models for examples of productive partnerships (Barlow, Roehrich, & Wright, 2016).

Teaming Up

Several states share political, financial, and cultural commonalities with nearby states. Policymakers in healthcare should leverage those regional commonalities and pursue multi-state initiatives. Joint data collection efforts are one efficient way to engage neighboring states in a collaborative endeavor. Because more data would provide greater statistical rigor in evaluation and monitoring, joint efforts would also produce more value for all states involved than if they went it alone. Federal approval of joint 1332 or DSRIP waivers by multiple states could encourage this type of collaboration. For example, Vermont cited fiscal constraints for its failed attempt to establish a single-payer system. If other like-minded states, such as Massachusetts, joined Vermont as part of a joint effort to establish a multi-state system, the pooling of risk and funding across a larger population and multiple governments could make single-payer more financially viable. While any risk pool merger includes winners and losers, states could be incentivized to participate by neighboring states or by the federal government, through financial subsidies, regulatory flexibility, or through other means. In a similar fashion, struggling state-based exchanges in the same region could merge to improve their financial sustainability while maintaining and potentially increasing options for consumers. For instance, some states considered merging marketplace functions for the fourth open enrollment period but did not have enough time to achieve integration. Nevada engaged Connecticut, Massachusetts, Maryland, Oregon and Washington about the possibility of using another state's enrollment platform or call center while Vermont and Rhode Island discussed a merged call center. This is precisely the kind of cooperation that can produce cost efficiencies. While the returns from this type of collaboration could be substantial for some states, the bureaucratic, political, and legal barriers may be significant, as individual states have long had jurisdiction over health insurance plans sold within their borders. Still, they merit serious consideration, especially from states looking to reshape the health care landscape in novel and innovative ways.

Another way interstate cooperation could contain costs is through state insurance regulators, who approve or reject mergers, premium hikes, or other insurance-related actions. Proposed mergers between Aetna and Humana, as well as between Anthem and Cigna, would give the resulting mega-insurers monopoly power in some markets. Alone, one or even a few states cannot prevent national mergers. However, multiple state regulators in a region, such as in New England, could consolidate their authority to hinder mergers and prevent monopolistic practices that hurt consumers and government payers. Thus far, twelve states have signed on to a complaint filed against the Anthem/Cigna merger and nine have signed one against the Aetna/Humana merger. The more bargaining power states can build, the better rates they can negotiate with insurers. As states continue to hold hearings on these mergers, they should consider joining forces with their fellow states to combat rate hikes and exploitative profiteering by consolidating their authority rather than relying on antitrust

action by the Department of Justice. In this way, states can tackle the insurance industry in the same way a coalition of state attorneys general took on the fossil fuel industry: by teaming up and scaling up (Gibson, 2016). This strategy could also be employed to control select prescription drug prices by increasing state bargaining power.

Borrowing Innovations

In each area, some states move forward while others lag behind. Though each state is unique, these reform efforts are often scalable. Thus, developing infrastructure and providing more opportunities for states to borrow rigorously tested innovations from other states would be valuable. Increased flexibility in data sharing across states and across sectors, such as health and social services, within states is a first step. Requiring feasibility of scale assessments with DSRIP or 1332 waivers could also guide states evaluating the translatability of waiver-based initiatives. Policymakers must use economic realities to drive collaboration and standardize processes that produce cost-efficiencies. States should recognize and seize the financial benefits of borrowing proven models, such as a working APCD or an effective monitoring or oversight system, from states that have already invested in the research and development of these programs. Another method comes from the Blues of Tennessee (BlueCross BlueShield of Tennessee), which received so many requests from other states about how to manage their Medicaid patients that they set up a consulting arm. This is precisely the type of infrastructure that can facilitate the transfer of innovations across state boundaries, but is largely absent in the public sector. The National Governors Association and others are pursuing similar management and technical assistance efforts to bridge gaps between states. Indeed, governors, chiefs of staff, state legislators, state health officials, state insurance regulators, and state Medicaid officials have very active professional associations, which can be used as platforms for productive transfers. Given budget shortfalls and the complexity of American healthcare, borrowing best practices from other states is not just smart – it is necessary.

CONCLUSION

The U.S. healthcare system has made significant progress over the past six years in increasing access, reforming payment systems, and experimenting with new delivery systems. However, these efforts have been primarily driven by the federal government. States across the nation now face numerous opportunities to continue the transformation started by the Affordable Care Act. By working with the federal government, the private sector, and each other, they can seize these opportunities to drive system-wide innovation and create lasting improvements on issues of cost, access, and quality.

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Author Contributions: Mr. Gondi principally researched and drafted the manuscript. Dr. Patel and Dr. Peck provided guidance, revisions, and examples to improve the manuscript.

Conflict of Interests: The authors have completed and submitted the ICMJE Form for Disclosure of Potential Conflicts of Interest. No conflicts were noted.

REFERENCES

Barlow, J., Roehrich, J., Wright, S. (2013). Europe Sees Mixed Results From Public-Private Partnerships

- For Building And Managing Health Care Facilities And Services. *Health Affairs*, 32(1), 146-154.
- Blumenthal, D., Abrams, M., & Nuzum, R. (2015). The Affordable Care Act at 5 Years. *New England Journal of Medicine*, 372, 2451-2458.
- Dickson, V. Vermont first state to file waiver request to duck ACA regulations. *Modern Healthcare*. March 17, 2016. <http://www.modernhealthcare.com/article/20160317/NEWS/160319905>. Accessed April 30, 2016.
- Gibson, K. States team up to take on the fossil fuel industry. *CBS Moneywatch*. March 29, 2016. <http://www.cbsnews.com/news/states-team-up-to-take-on-the-fossil-fuel-industry/>. Accessed June 20, 2016.
- Hodder, L.C. Who Controls Health Cost Data? *New Hampshire Bar Association*. January 20, 2016. <https://www.nhbar.org/publications/display-news-issue.asp?id=8229>. Accessed May 2, 2016.
- Kaiser Family Foundation. (2015). Key Themes From Delivery System Reform Incentive Payment (DSRIP) Waivers in 4 States. <http://kff.org/medicaid/issue-brief/key-themes-from-delivery-system-reform-incentive-payment-dsrip-waivers-in-4-states/>. Accessed April 26, 2016.
- Kaiser Family Foundation. (2015). Medicaid Expansion in Indiana. <http://kff.org/medicaid/fact-sheet/medicaid-expansion-in-indiana/>. Accessed April 26, 2016.
- Miller, I.J. *ColoradoCare: How it would work*. Denver, CO: ColoradoCareYes; June 2015.
- Nikpay, S., Buchmueller, T., & Levy, H.G. (2016). Affordable Care Act Medicaid Expansion Reduced Uninsured Hospital Stays In 2014. *Health Affairs*, 35(1), 106-110.
- Patel, K. Louisiana makes great waves with Medicaid expansion. *Health360*. January 15, 2016. <http://www.brookings.edu/blogs/health360/posts/2016/01/15-worst-to-first-louisiana-medicaid-patel>. Accessed May 7, 2016.
- Section 1332: State Innovation Waivers. Centers for Medicare and Medicaid Services website. https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Section_1332_state_Innovation_Waivers-.html. Accessed April 25, 2016.
- Sommers, B., Blendon, R., & Orav, E. (2016). Both The 'Private Option' And Traditional Medicaid Expansions Improved Access To Care For Low-Income Adults. *Health Affairs*, 35(1), 96-105.
- Sommers, B., Blendon, R., Orav, E., & Epstein, A. Changes in Utilization and Health Among Low-Income Adults After Medicaid Expansion or Expanded Private Insurance. *JAMA Intern Med*. Published online August 08, 2016.
- The 2015 long-term budget outlook. Congressional Budget Office. June 2015. <https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/50250-LongTermBudgetOutlook-4.pdf>. Accessed May 23, 2016.

<i>State</i>	<i>Healthcare Reform Effort</i>
<i>Colorado</i>	Ballot Initiative to use 1332 waiver for single-payer was struck down in November 2016.
<i>Louisiana</i>	Medicaid expansion proceeds under \$750 million deficit
<i>Wyoming, South Dakota, Virginia, Oklahoma, Georgia</i>	Traditionally Republican states consider Medicaid expansion
<i>Hawaii</i>	Finalize & submit statute-authorized 1332 waiver application to retain pre-ACA employer mandates
<i>Arkansas</i>	Considers joint DSRIP & 1332 waivers to support “private option” Medicaid
<i>Vermont</i>	Adjusts its claims data collection efforts for APCD after Court decision; Awaits feedback on 1332 waiver application
<i>Kentucky</i>	Gov. Bevin seeks federal waiver to restructure Medicaid expansion
<i>Minnesota, New Mexico, Rhode Island</i>	Explore how 1332 waivers could help solve state-specific problems and potentially apply for waivers
<i>California</i>	Pursues a 1332 waiver to enable the state-based marketplace to extend coverage to undocumented immigrants

Table 1. Notable Healthcare Reform Efforts in Select States (expected in 2017 and beyond).