

# The Critical Role of States in Transforming the Health Care System

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Governors and states can lead the transformation of the current health care system from the traditional fee-for-service model to a more integrated, coordinated, patient-centered system that delivers higher quality care at lower costs. The transformation must take place at the grassroots level, in individual hospitals, at individual clinics, and by individual physicians. It must be driven by those who pay for health care, both public and private payers, and by those who use it: the citizens in large cities, small towns, and rural areas across the nation. And this transformation must be led by state governments, as they have proven to be nimble and innovative, and the level of government that can work in close partnership with all key health care stakeholders in a state.

States can achieve meaningful change for several reasons. First, states possess major policy levers to drive reform, including the convening power of the governor; the purchasing power of the state-administered health care programs; and jurisdiction over malpractice, scope of practice, health insurance market places, and insurance regulations. Second, states also understand that the changes must be tailored to the local health care market and the insurance plans, payers, and providers that comprise it. Finally, states have a long history of demonstrating innovative governance and serving as models for national reforms in such areas as welfare policy, clean air laws, health coverage, and education. As Justice Brandeis said in his dissent to a 1932 Supreme Court decision, “It is one of the happy incidents of our federal system that a courageous state may, if its citizens choose, serve as a laboratory, and try novel social and economic experiments with no risk to the nation.” State policy levers include the following:

## State Purchasing Power

States are a major purchaser of health care, directing how dollars are spent in Medicaid, the Children’s Health Insurance Program (CHIP), and for state employees. States can use these investments to help steer the health care system toward organizational structures that are coordinated and integrated and make risk-based purchases.

Medicaid and SCHIP – There are currently about 60 million people in SCHIP and Medicaid, and in several years, the total will likely grow to more than 70 million due to the expansion under the Affordable Care Act (ACA). States are already driving the system away from fee-for-service toward more care coordination with the traditional Medicaid population of women and children and are beginning to do it with the disabled and dual-eligible populations.

State and Local Government Employees – States provide health insurance for about 3.4 million state government employees and retirees. There are also another 8.3 million local government workers who are covered by health insurance. Given that 73 percent of state and local government workers are in fee-for-service, this creates another opportunity for states working with local government to transform the delivery system.

Health Insurance Exchanges – The creation of health care exchanges—a requirement of the ACA—gives states another spending program to influence the quality and value of health plans. While the number of individuals who will be purchasing through exchanges will likely be only 8 million to 10 million at the beginning of the program in January 2014, it will likely grow to more than 25 million over the next decade. Essentially, states will be able to determine the requirements for plans to sell through these new marketplaces. Vermont, for example, authorized the exchange to selectively contract based on price, quality, coverage of preventive services, access, and other criteria that are deemed appropriate.

## **Health Care Regulation**

States have vast powers to regulate the current health care system. These run the spectrum from malpractice to scope of practice to setting rates.

Insurance Regulation – All states currently regulate health insurance to some extent, but the level of authority varies considerably. This regulation typically involves three activities: 1) reviewing premium rate increases, 2) overseeing solvency, and 3) determining if the plans include “mandated benefits” established by the state.

Scope-of-Practice – These rules define the clinical care a health care professional can and cannot administer to a patient and whether they can prescribe medicine, sign charts or death certificates, and practice independently. It can also affect reimbursement procedures. Scope-of-practice is particularly important as it establishes the rules for nurses, nurse practitioners, and physician assistants.

Malpractice – Most providers and many policymakers believe the systems are broken in most states and needs major reform. Today it is estimated that 75 percent of low-risk specialty doctors and 99 percent of high-risk doctors face a malpractice claim by age 65. In 2009, the Congressional Budget Office estimated that the direct cost of malpractice was \$25 billion. Indirect costs have been estimated to be between \$70 billion and \$ 125 billion.

Rate Setting – States, if they are inclined, can establish a process to set rates for hospitals and other providers. For more than two decades, Maryland has regulated its hospital costs by setting rates for particular episodes of care. From a cost standpoint, it has been quite successful as in 1976 the cost in a Maryland hospital

was 26 percent above the national average but has not exceeded the national average since 1980.

### **Encourage Competition and Choice**

The quality of care will be enhanced and the rate of price increases will be restrained over time by competition among both insurance plans and the consolidated provider groups due to purchasers making more cost-effective decisions.

Transparency on Price and Quality – As co-payments and deductibles increase over time, consumers will become more price-sensitive. To support good patient decision making, states can require providers to publish timely, consumer-friendly information on quality and prices.

Antitrust Powers – States can allow beneficial consolidation among providers and between providers and hospitals and even plans, but they can also limit those from exerting market power.

State-Spending Programs – While state-spending programs can be utilized to transform the delivery system, they can also be used to maintain and even enhance the level of competition in the state.

### **Lifestyle Decisions**

Virtually every state has launched at least one intervention to reduce obesity and promote healthy living. More research is needed to determine the effectiveness of these programs. However, research to date suggests that state policy to control obesity and promote healthier communities are a very important part of the arsenal to control overall health care spending.

School-Based Policies – These include setting nutrition standards for school meals, limiting unhealthy food and drink in school vending machines, conducting fitness screenings, and setting standards on physical activity or physical education in schools.

Healthy Community Design – These include state grants to local governments to expand bicycling and walking paths, and encouragement of transit development.

### **Engaging Stakeholders to Transform the System**

While you will not see it listed in the state constitution as one of the enumerated powers of the governor, the ability to convene is a powerful tool to generate change. As indicated above, states have a significant number of health care policy levers, but there is only so much that can be done by executive order and legislation. Far more

can be done with a strong consensus among key stakeholders. For example, if the governor is able to broker a consensus on payment reform, then it can be implemented on a voluntary basis.