

The Next Health-Reform Campaign

The supporters of reform knew they had to battle to get it passed. Now they need to wage another campaign to implement it.

BY PAUL STARR

Carrying out health-care reform presents challenges far beyond those of ordinary legislation or even such landmarks as Social Security and Medicare. After a law establishes a new program, the next steps are usually a bureaucratic process of policy implementation. But the legislation passed by Congress last March, the Patient Protection and Affordable Care Act, will need to run a gauntlet of treacherous hurdles and be *politically* implemented.

The reforms will have to be defended in two national elections because the major provisions don't go into effect until January 2014. Assuming the law survives national efforts to reverse it, its implementation will also depend on complementary action in all 50 states, including many where Republican leaders have been hostile to the changes, questioned their constitutionality, and enacted measures to nullify the federal reforms. Although the federal courts are unlikely to uphold these challenges, the same states may resist fulfilling the substantial responsibilities that fall to them under the law. And even some supportive state governments may find it challenging to carry out their role despite the ample federal money they stand to receive.

In addition, the reforms need to win not just passive support but active cooperation from employers, insurers, and the public at large in the face of determined opposition to the law and widespread confusion about it. Confidence in the reforms will also have to survive continuing growth in health-care costs that the government has no power to control in the short run.

Under the best circumstances, health-care reform would need political implementation. Consider the experience of Massachusetts, which in 2006 passed the prototype for the federal reforms by requiring individuals to carry health insurance,

increasing subsidies for low-income people, and setting up an insurance exchange to make affordable coverage easily available. The Massachusetts program enjoyed overwhelming support from both the Democrats who controlled the state Legis-

lature and the state's leading Republicans. Mitt Romney was the governor who signed the bill, and Scott Brown, now a U.S. senator, voted for it when he was in the state Senate.

former lieutenant governor, who told him, "Jon, it's a political campaign from the day you start." And so it was: Winning the cooperation of interested parties and the general public was just like running a political campaign, Kingsdale recalled in his Boston office shortly before he stepped down in June.

THE IMPLEMENTATION CAMPAIGN

The prospect of a new campaign for health reform, this time to carry it out, may come as a surprise to some who thought the battle was over when Congress voted. The imperatives are clear enough, though, to leaders of the organizations that fought for enactment of the law and to key officials in the Obama administration. They are gearing up to defend the reforms and help realize their promise in all 50 states.

Just as they did during the legislative drive, the groups supporting the implementation campaign independently of the White House fall primarily into two overlapping coalitions. One consists of labor and grass-roots organizations brought together under the umbrella group Health Care for America Now. According to Ethan Rome, its executive director, HCAN will be continuing its local organizing to "explain and defend" reform, lobbying for it in the states, and supporting members of Congress who voted for it, particularly representatives from swing districts where the vote was not an easy choice.

The second coalition, organized by the progressive advocacy group Families USA, consists of proponents of expanded coverage and representatives of the leading health-care interest groups, including physicians' organizations, hospital associations, and the insurance and pharmaceutical industries. Before passage of the Affordable Care Act, these "strange bedfellows" (as they called themselves) met to hammer out a consensus on reform. Ron Pollack, the executive director of Families USA, has now brought together many of the same parties to create a new organization, Enroll America, which will try to ensure that the law's benefits reach as many people as possible. Like HCAN, Families USA is also preparing a public-information campaign of its own to defend the law and to influence the states' responses. AARP has already conducted a substantial campaign to explain the law to its 40 million members.

In yet another effort—this one closely tied to the White House—former White House communications director Anita Dunn and Democratic strategist Andrew Grossman have set up two organizations, the Health Information Center and Health Information Campaign, and hope to raise \$125 million over the next five years to promote the reforms.

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SUBSCRIPTION RATE **\$24.95**
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lature and the state's leading Republicans. Mitt Romney was the governor who signed the bill, and Scott Brown, now a U.S. senator, voted for it when he was in the state Senate.

Nonetheless, Jon Kingsdale, who was appointed to run the new insurance exchange in 2006, says that when he took the job, the best advice he received came from Tom O'Neill, the

Not least of all, through speeches and other events, the president promises to highlight the reforms as they go into effect.

Within the Obama administration, the immediate focus is on what Nancy-Ann DeParle, the president's top health-care adviser, refers to as "early deliverables": the short-term reforms aimed at creating a bridge to 2014. These include a number of changes to private insurance that the law made effective this year such as the elimination of lifetime limits on coverage, a ban on pre-existing-condition exclusions for children, and the extension of coverage up to age 26 of adult children under their parents' policies. In addition, the law calls for several forms of relief on insurance rates, including tax credits for small businesses, a reinsurance program for companies that cover early retirees, and a limited program to enable people deemed uninsurable to buy coverage through subsidized high-risk pools.

At the federal level, the primary responsibility for implementation rests with a new division of the Department of Health and Human Services: the Office of Consumer Information and Insurance Oversight, headed by Jay Angoff. The department now has more people in its leadership with relevant competence in insurance regulation than it has ever had. HHS Secretary Kathleen Sebelius is a former state insurance commissioner; so are Angoff and his deputy director, Steven Larsen. They are writing the new rules for the insurance market under the Affordable Care Act. "We know the insurance regulation business," Angoff told the *Prospect*.

In an interview in the West Wing, DeParle defended the Jan. 1, 2014, date for extending coverage through the new insurance exchanges. Nationwide, she insists, it was impossible to guarantee that implementation could meet an earlier deadline, though she says it might be practical for the federal government to support "demonstrations" by a few states (one of the Senate bills last year called for a "rolling start" by states as they were ready to proceed). Such demonstrations by states capable of moving earlier could help work out bugs before the program goes national.

The law gives states the first shot at running the exchanges and enforcing the insurance regulations, with the federal government stepping in only if a state fails to take up the opportunity. "We will not be waiting until January 2013," DeParle says, to determine whether states will act. Early in 2011 the administration will release a timeline that states will need to meet in order to run the exchanges and enforce the regulations themselves.

Under that timeline, state legislatures will likely face critical decisions in the period leading up to the 2012 elections. Ordinarily, conservatives might be expected to seize every opportunity to put the states rather than the federal government in charge. But in this case conservatives may continue preaching

defiance and resist putting the federal reforms into state law in the hope a new president in 2013 will abandon the program.

RED-STATE DEFIANCE?

Some Republican-dominated state governments have already refused to take up one option the law offers to the states: running the federally funded high-risk pools for people with pre-existing conditions who have been deemed uninsurable for at least six months. All but three of the 20 states that have left the pools to federal control have Republican governors, who apparently want nothing to do with what conservatives derisively refer to as "Obamacare" even though this particular element had Republican support.

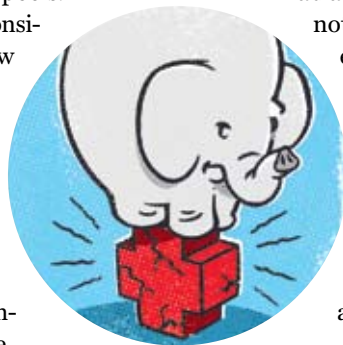
Since many of these states, particularly in the South, have had a record of lax regulation of health insurance, they would not necessarily deal a setback to reform by leaving the exchanges and enforcement of regulations to federal authorities. Red-state abdication would not reduce subsidies for the low- to moderate-income people getting insurance through the exchanges because the subsidies come in the form of federal tax credits.

An uncooperative governor and legislature could nonetheless make it hard to achieve the goal of universal coverage. The states will continue to administer Medicaid and the Children's Health Insurance Program, and the

expansion of those programs is expected to account for about half of the increased coverage beginning in 2014. Coordination between these older programs and the new exchanges is vitally important. The Affordable Care Act offers the states strong incentives to cooperate: For newly eligible Medicaid and CHIP beneficiaries, the federal government will bear 100 percent of the cost in 2014, dropping to 90 percent in 2020.

Still, the states will have to bear a larger share of the cost for previously eligible people who finally sign up for Medicaid or CHIP in 2014, when the individual mandate goes into effect. Despite new federal requirements for streamlined enrollment, a state could try to keep down its own expenditures by limiting outreach and raising barriers to enrollment in Medicaid and CHIP, leaving many people below or near the poverty line without insurance or steering some of them into the exchanges, where the subsidies are entirely federal.

In a perverse twist, because the federal government will cover all the cost of expanded eligibility for Medicaid and CHIP, the states that have had the most limited eligibility in the past—typically the red states—stand to receive more federal money under the Affordable Care Act than do the historically generous blue states. And because of that prospective flow of federal dollars, the anti-reform states may come under conflicting ideological and interest-group pressures. While conservatives call for resistance, the hospitals, doctors, insurers, and other business interests are likely to favor at least minimal



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compliance with the federal law to maximize both the stream of revenue and the influence they can exert over it. Advocates of universal health care in the red states may consequently find themselves at least temporarily allied with local health-care interests to defeat the Tea Party dead-enders.

THE PROGRESSIVE RESPONSE

For progressively minded states, the Affordable Care Act is a political windfall. It provides the financial support for universal coverage and the legal authority for restructuring the health-insurance market that progressive state leaders have been trying to establish for years. The law also appropriates funds for such complementary initiatives as the development of community health centers, insurance co-ops, accountable-care organizations, and public-health programs as well as the new insurance exchanges. To prepare for change and take full advantage of these opportunities, many states have created legislative committees and planning groups—a process that should ideally be broadly representative and collaborative without being captured by the insurance or health-care industries.

The federal government has already begun giving grants to the states to strengthen resources for insurance regulation and asked their governors whether they have sufficient authority to review insurance rates. “If legally they don’t have the power now,” Secretary Sebelius said in a recent online discussion, “we need them to seek that power [from their state legislatures].” Federal grants are also available to the states to build up consumer-assistance programs, to help people in appealing denials of claims, for example.

Besides strengthening insurance regulation, states should also be modernizing and streamlining their health programs. The Affordable Care Act calls for a single enrollment process for Medicaid, CHIP, and the exchanges to be accessible not only in government offices but also online and by phone. One reason for the successful start-up of the Massachusetts insurance exchange in 2006, according to Kingsdale, was that the state’s Virtual Gateway for state programs made it easy to set up online enrollment for the exchange. Angoff’s federal office has created a Web portal for health-insurance options, healthcare.gov, that can be turned over to the states.

Looking ahead to 2014, states need to decide how to structure the market for health insurance. The broader the population an exchange serves, the better it will be able to spread risks and the more likely insurers will compete on price to gain enrollment. Those considerations ought to push most states toward creating a single exchange rather than separate ones for the individual and small-group markets, or separate exchanges for different regions of the state.

The Affordable Care Act requires states to apply insurance reforms outside as well as within the exchanges. The danger here is that where state regulation is lax, insurers may be able

to cherry-pick healthy and affluent consumers through policies sold directly to them, leaving a sicker population to the exchanges. People using the exchange would then pay higher premiums, and the federal government would be saddled with higher subsidy costs. According to Angoff, federal officials will work with state regulators to minimize this problem, known as adverse selection.

Another challenge in implementation is to make sure there are enough health-care providers in the geographic areas and medical fields where they will be required. Expanded insurance coverage will likely increase the demand for primary-care services, particularly in low-income communities. The new federal funds available for community health centers—\$12.5 billion over 5 years, counting the expansion of the National Health Service Corps, which helps provide doctors to underserved areas—could potentially double the approximately 20 million people the centers currently serve. Other measures under the law aim to increase the number of physicians going into primary care, but because of the enormous financial incentives favoring specialization, it’s unlikely these steps will be enough to remedy the undersupply of generalists.

The Affordable Care Act also appropriates \$6 billion for nonprofit health-insurance cooperatives—an idea that emerged in the Senate Finance Committee as an alternative to a federal insurance plan (the “public option”). Though disparaged at the time, the co-ops would build on a tradition going back to the 1930s that created such organizations as the Group Health Cooperative of Puget Sound, which now has 580,000 enrollees. Prepaid health plans were mostly nonprofit before the 1970s, when federal as well as state legislation helped usher in a shift toward for-profits; the Affordable Care Act is the first federal legislation to offer targeted support for consumer-controlled health insurance.

Through these and other provisions, progressive state leaders could use the Affordable Care Act as a floor and build on it, strengthening the provision of care, developing alternative forms of coverage, and perhaps topping up the affordability subsidies. The individual mandate could create a backlash, especially among people who get no contribution from an employer and whose incomes put them near or just above the level where subsidies phase out. The states could address that problem both by raising subsidies to people in that income bracket and by using their regulatory authority to hold down medical costs and premiums.

BEFORE HEALTH-CARE REFORM goes fully into effect, we have to cross the shaky bridge to 2014. The Affordable Care Act will have only a marginal effect on health-care costs before then, but it is certain to be blamed for the health-care inflation that will occur and would have occurred anyway. Although the temporary high-risk-pool program was never intended to serve everyone

The legislation is a political windfall for progressive states, providing funds and authority they have wanted for years.

in need, it will be blamed for failing to meet that objective.

Since the president signed the Affordable Care Act on March 23, many of those who support it have said confidently that it would become just as well established as Social Security and Medicare. But neither of those initially called for changes as complex and far-ranging as this legislation, nor did they depend on hostile state governments. If Republicans win control of Congress in November, Obama will presumably veto any effort to repeal or defund health-care reform. But thanks to compromises in the Senate, the timeline for implementation stretches well past the 2012 election. If the House of Representatives had prevailed, the federal government would have run the exchanges, and implementation of the law would have been substantially complete even for an incoming Republican in January 2013.

Instead, the law's reliance on the states, delays in delivering benefits, and limited authority to control costs all create political vulnerabilities for reform. If reform is to become a reality, its supporters will have to overcome those vulnerabilities and prevail in the coming tests in the courts, the states, and the voting booth. **TAP**

Getting Insurers to Behave

Job No.1: Write new rules for health insurers and make sure they follow them.

BY JONATHAN COHN

Now that the Patient Protection and Affordable Care Act is law, the Obama administration has to translate the law's requirements into specific rules, particularly for the health-insurance industry. The act requires insurers to do a lot of things they haven't done before, like making sure all plans cover at least a basic array of services and limit out-of-pocket expenses. But under a so-called grandfather clause, plans already in existence are exempt from many of the new requirements. How the administration has interpreted "grandfathering"—one of its first rule-making decisions—may be an indication of things to come.

The exemption exists because of the president's promise that people who already have insurance can keep their current coverage if they like it. But from a policy perspective, the grandfather clause is dangerous. An employer eager to slash its benefit costs could try to exploit the exemption to whittle away coverage in a plan it currently offers.

The Affordable Care Act left it to the secretary of health and human services to determine the precise rules for when plans lose grandfather status. Under the interim rule that Secretary Kathleen Sebelius and her staff issued in June, employers can

make modest adjustments to their workers' plans and remain exempt from most of reform's requirements. But if an employer tries to reduce coverage significantly—say, by suddenly bumping up deductibles by more than \$1,000 per person—the plan becomes subject to the full protections of the Affordable Care Act. Insurers and employers didn't much like the decision, which discourages them from reducing benefits, but consumer advocates were delighted.

For the new law to fulfill its promise, it must change how insurers behave. But as with the grandfather clause, it's up to the administration to turn the law's general language into clear regulations. The challenges are political as well as technical: Plenty of conservatives see the regulatory process as a chance to re-litigate health reform and perhaps roll it back. If they succeed, they could undermine much of what reform is supposed to achieve.

FIRST, THE GOOD NEWS: The most important new restrictions on insurance-company behavior are also the most straightforward. These are the rules guaranteeing that people who represent high medical risks because of their personal characteristics or pre-existing conditions have access to policies at the same prices as healthy people do. For the most part, this is already true for people who get insurance through large companies—but not for people who buy on their own or through small businesses. As of 2014, under the law, insurers that sell to these markets will have to practice "community rating" (charging everybody the same rate for a given policy) and "guaranteed issue" (selling policies to anybody willing to pay the premiums).

The Affordable Care Act leaves relatively little to chance here. The law spells out the requirement unambiguously, allowing insurers to vary rates only by geographic area, tobacco use, and age (on a three to one ratio between old and young). In 2014, the prices for all policies will be publicly listed on the new insurance exchanges, where people can sign up for them. Enforcing the rule will be a simple matter of checking what insurers are charging for policies and investigating any reports of discriminatory pricing in policies sold outside the exchanges.

But community rating and guaranteed issue alone won't be sufficient to change the behavior of insurance companies. Even if insurers are required to take all comers at relatively nondiscriminatory prices—"relatively" since age can be a rough proxy for medical condition—they'll still have financial incentives to restrict care. This isn't entirely a bad thing: Given the evidence of rampant overtreatment in American medicine, insurers should exercise some check on the use of technology, drugs, and other resources, for the sake of the patients as well as the insurers' bottom line. But because insurers sometimes deny even necessary care, just to increase profit margins, the law seeks to limit the insurers' authority—most obviously, by opening up treatment denials to outside appeal.

The idea sounds simple enough: Allow patients convinced they've been wrongly denied care to make their case to independent experts with authority to overrule the insurer. But who are the experts? How quickly must they rule? And what's to stop insurers from ignoring the recommendations? The Obama