

**The Commonwealth  
Health Care Reform  
Implementation  
Advisory Committee**

**Final Report**

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## Overview

### **Building a Pennsylvania Plan for Implementing Health Care Reform**

January 2011

Facing skyrocketing costs and the erosion of health care access for small businesses and workers across the nation, in March 2010 Congress enacted the most sweeping transformation of the health care system since Medicare and Medicaid were established 45 years ago.

The goal of the Patient Protection and Affordable Care Act (ACA) is to ensure access to affordable quality health care for families and businesses who currently have health insurance and for those who do not. To achieve this goal, the law includes:

- Providing states with immediate resources to support high risk pools to cover individuals who can't get insurance in the private market due to a pre-existing condition, until the 2014 coverage expansions are in effect.
- Providing tax credits for businesses and non-profits with 25 or fewer employees that offer insurance, and penalties for employers with more than 50 employees that do not.
- Providing premium subsidies to moderate and low-income individuals with incomes above the Medicaid level to help them purchase health insurance.
- Imposing new regulations on health plans in the private market to offer coverage to individuals regardless of health status, to spend most of a product's premium dollars on health care, and to end other policies that limit coverage.
- Creating new state-based health insurance exchanges to facilitate the purchase of insurance and improve competition between health plans.
- Requiring individuals to maintain health insurance, enforced by a federal tax penalty.
- Expanding Medicaid to more low-income individuals.

The law also contains measures to reduce health care spending while improving quality of care, such as expanding access to preventive services, stopping payment for health care acquired infections, reducing fraud, accelerating development of home and community-based services for individuals needing long-term care, reducing unnecessary rehospitalizations and promoting development of alternative payment strategies to reward quality and outcomes for patients instead of the number of procedures and visits.

The ACA is structured as a joint federal-state initiative. It includes substantial federal funding and requirements, but vital components — particularly those that most directly affect the expansion of coverage to the uninsured — will require state legislation and will be administered primarily by the states. The major state responsibilities include setting up insurance exchanges for small businesses and individuals; determining the subsidy eligibility for millions of people to buy coverage in the exchanges; enforcing the new insurance reforms; and overseeing the new Medicaid expansion. States will also have to meet new administrative challenges such as reaching out to enroll new populations; integrating Medicaid and CHIP with the new exchanges; and applying new Medicaid and CHIP income eligibility standards established under the law.

In short, while the ACA creates the framework for these reforms, much of the implementation is left up to the states – which have the flexibility to make key decisions and the responsibility for much of the law’s administration. The law is complex and will be implemented over several years with all the major provisions taking effect by January 2014.

### **The Pennsylvania Context**

While Pennsylvania has made progress in increasing insurance coverage for children in recent years, more than 8% of the population -1 million Pennsylvanians - were uninsured in 2008. More than one out of four people (27.3 percent) under the age of 65 went without health insurance for all or part of 2007-2008. Those numbers have grown as a result of the economic downturn and the ever-increasing cost of health care. Indeed, health insurance premiums increased by more than 95% percent between 2000 and 2009, 5.4 times the rate of growth in wages during that period. By comparison, during the same timeframe, inflation grew 24.5 %.

When fully implemented in 2014, the ACA will greatly expand access to affordable health care for Pennsylvania families and individuals, with fewer than 4% of Pennsylvanians remaining uninsured when the law is fully implemented. But in order to reach the families and businesses that the law is intended to reach, Pennsylvania has many decisions to make and much work to do. It has the opportunity and the challenge to create a state-of-the-art web portal that provides consumers with information and tools needed to compare options for health coverage and to learn about and obtain a determination of eligibility for tax credits and reduced cost sharing.

As Pennsylvania achieves near-universal health care coverage, it will be imperative that it do so in a high-quality, affordable and sustainable way for our families, businesses and state government.

Health care is a major component of the state budget – costing an estimated \$7.3 billion this fiscal year to provide health care to 1.35 million low-income families and children, the elderly, and adults with mental and physical disabilities, 81,000 state employees, and more than 50,000 inmates in our correctional institutions – nearly one fourth of the state’s General Fund budget. Taking advantage of opportunities presented by the ACA to hold down costs will be key.

Indeed, the state must identify interventions and expand promising new models of care to address inefficiencies that lead to higher costs and poor quality care, such as reducing health-care acquired infections and unnecessary readmissions to hospitals due to lack of coordinated care.<sup>1</sup> It will also need to work to ensure that shortages of primary care providers and key specialty areas are addressed.

Implementation of the ACA provides an historic opportunity to not only provide affordable health care coverage to almost one million uninsured Pennsylvanians, but also to transform how health care is paid for and delivered in the Commonwealth.

While Pennsylvania faces a serious budget deficit, billions of federal funds are expected to be available to help finance the efforts Pennsylvania must undertake to implement the ACA. Many requirements are fully funded with federal funds, while others require only a small state match. The ACA also provides opportunities for Pennsylvania to expand implementation of the primary care medical home and pilot promising new ways to organize care to hold down costs and enhance quality.

Current estimates are that health care reform will generate between \$283 million and \$651 million in net savings to Pennsylvania over the next eight years. (See Appendix A for an estimate of costs and savings to the state). Some initiatives will increase the state’s costs, while other components, like greater federal funding for CHIP, will result in substantial savings and new revenues.

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<sup>1</sup> A recent Pennsylvania Health Care Cost Containment Council report found that there were 27,949 avoidable hospital-acquired infections in 2009, which were related to 3,416 annual deaths in Pennsylvania for which hospitals charged approximately \$4.4 billion for additional care due to the infections. PHC4 also reported that hospitals charged \$4 billion in 2009 for hospitalizations for Pennsylvanians with chronic conditions that could have been avoided if the patients had received evidence-based primary care.

## Provisions Already In Effect

Some of the law's reforms are already helping Pennsylvanians. For example, Pennsylvania has received a grant to create a high risk pool for those who have been uninsured for six months and who have a listed pre-existing condition. PA Fair Care has 2,046 enrollees as of December 1, 2010 receiving affordable care for their chronic conditions – the most of any state in the nation. The Pennsylvania Insurance Department has also applied for and been awarded \$1 million each for planning for the insurance exchange, improving rate review, and providing consumer assistance with health insurance issues.

Since September 2010, the health insurance plans of Pennsylvanians who become sick or injured cannot have lifetime limits, annual caps or arbitrary cancellations. Also, children cannot be denied coverage because of a pre-existing condition. Parents with employer-based coverage may add their uninsured adult children up to age 26 as dependents on their coverage. Many small businesses with lower wage employees are eligible for tax credits for the 2010 tax year for providing health care coverage to their employees. And, new plans must cover preventive health services without charge to the consumer.

## Timeline for Additional Changes

Many additional provisions of the ACA will require decisions at the state level and significant planning for implementation. The major provisions are described year-by-year below:

### 2010

- PA Fair Care offers health insurance to people with pre-existing medical conditions who have been denied coverage. This temporary program will be funded through January 1, 2014, when state-based health insurance exchanges will be available.
- Children may not be denied coverage due to pre-existing conditions
- New insurance plans must include free coverage of preventive care.
- Young adults up to age 26 can be added to their parents' insurance plans.
- Pennsylvania received a \$1 million Health Insurance Exchange planning grant, a \$1 million grant to improve rate reviews and a \$1 million consumer assistance grant.

### 2011

- Insurance companies are required to spend 80 to 85% of consumers' premiums on medical care and efforts to improve quality, rather than profits, marketing and administration. Companies that do not comply will have to give rebates to their customers.

- Small business tax credit begins. Qualified small businesses will receive a credit of up to 35% of their health care premiums paid when filing their 2010 taxes.
- Several programs to encourage home- and community-based care are scheduled to begin, including the voluntary CLASS long-term care insurance program. Participating employers will automatically enroll employees and employees will be able to opt-out of the program.
- Community Care Transitions Program will offer grants aimed at high-risk Medicare beneficiaries who are hospitalized to avoid unnecessary readmissions by coordinating care and connecting patients to services in their communities.

## **2012**

- Before January 1, 2013, the Secretary of Health and Human Services will make a determination of Pennsylvania's readiness to implement a state Health Insurance Exchange.

## **2013**

- The Health Insurance Exchange must be operational by July and be prepared for an open enrollment in the fall, including the qualification of health plans.

## **2014**

- Annual limits on health insurance claims are eliminated.
- Health insurance plans may no longer deny coverage due to pre-existing conditions.
- Health plans may no longer charge higher rates based on gender or health status.
- Individual mandate to have health insurance coverage takes effect.
- Individuals not offered coverage by their employer may compare and purchase qualified health plans through the exchange and apply for premium assistance.
- Medicaid expansion covering individuals with income up to 133% of the FPL begins, with 100% of the additional costs for expansion group paid for by the federal government for the first three years.
- Low and middle income families will receive tax credits that can help purchase health insurance through the exchange.
- Small business tax credit is expanded.

## **2015**

- The state exchange must demonstrate financial self-sufficiency.

## 2016

- Exchanges must cover employers with up to 100 employees if they have not opted to do so already.

## 2017

- Exchanges may expand to the large group market.

### **Commonwealth Health Care Reform Implementation Advisory Committee**

The implementation schedule set forth in the ACA is extremely ambitious. To design policies and program changes that meet Pennsylvania's unique needs and that adhere to the law's timelines, planning and work needed to start quickly. On June 20, 2010, Governor Edward G. Rendell signed an Executive Order creating the Commonwealth Health Care Reform Implementation Advisory Committee as a non-partisan, broadly representative working group to make recommendations on how to implement the health care reform law to best serve Pennsylvania's taxpayers, small businesses and working families.

The Advisory Committee is comprised of 47 members including consumers, small businesses, advocacy organizations, health care providers, health plans, hospitals, members of the Legislature and the Executive Branch. (See Appendix B for a list of members.) This group was charged with providing advice on:

1. Design of the optimal programmatic model for the Commonwealth's High Risk Pool.
2. Design of the optimal organizational model to support a customer friendly and efficient health benefit exchange.
3. Identification of technology, organization and process improvements necessary to support the implementation of all state obligations under the Act.
4. The strategic plan for the implementation of the Act.
5. Legislative action necessary to enable full implementation of the Act and draft legislation for discussion with appropriate members of the Legislature.

Meeting eight times over nearly six months, committee members explored the major issues the state will need to address as it implements the federal law hearing from national experts and learning from each other. The group worked together to develop broad strategic goals for implementation of health care reform in Pennsylvania.

The Advisory Committee unanimously adopted the following goals for Pennsylvania's implementation of the federal health care reform law:



1. To facilitate and encourage the purchase and provision of affordable health care coverage.
2. To improve the health care coverage marketplace by structuring the exchange to promote competition on the basis of value and to avoid adverse risk selection.
3. To provide a one-stop, easy to use, accessible portal for consumers and businesses to learn about and compare options for coverage.
4. To provide a unified and integrated approach for consumer application and enrollment in all other health and human services for which people may be eligible.
5. To assure administrative efficiency and to maximize the leveraging of all administrative funding.
6. To ensure increased access to quality health care through a diverse, robust network of health care providers, including safety net health care providers.
7. To support the goals of health care reform, transformation of the health care system to support improved quality of health care and reduced cost of care.

The Advisory Committee organized itself into three subcommittees to develop goals and recommendations for approaching creation of a health insurance exchange (Exchange Subcommittee), increasing access and enrollment (Access and Enrollment Subcommittee), and implementing other health care reforms (Other Critical Reforms Subcommittee) to enhance quality and contain costs. Each subcommittee reviewed its charge and the relevant strategic goals adopted by the Health Care Reform Advisory Committee, received background information geared to inform members about the current status of state policy and infrastructure and to examine potential options. Feedback was solicited throughout the process from all members of the larger Advisory Committee, and drafts were posted on the website to solicit public input.

These diverse constituencies found extensive common ground on a range of difficult issues that will need to be addressed to implement the reforms in the ACA. The consensus positions are summarized below and appear in greater detail in the three subcommittee reports attached to this document. In the areas where they did not find consensus, the subcommittee reports detail the conflicting opinions between the majority and minority.

## **Overview of Findings and Recommendations**

The findings and recommendations that follow are intended to serve as a blueprint for Pennsylvania's implementation of the ACA and a road map for achieving the strategic goals for Pennsylvania's exchange.

## **Health Insurance Exchange**

**Challenge:** *The Commonwealth must establish a state-based Health Insurance Exchange by mid-2013 or the federal government will implement this component of ACA in Pennsylvania. If Pennsylvania elects to establish an exchange, there are a multitude of policy, information technology, enrollment, and synchronization issues that will need addressed. The Exchange Subcommittee focused on broad policy issues associated with whether and how the state should operate a health insurance exchange.*

### **Recommendations**

Consensus was reached on many aspects of the exchange. The Advisory Committee recommends that the state create an exchange and that it have a consumer-oriented mission. While no consensus was reached, the majority felt that this exchange should be an independent public agency or authority that is governed by a diverse board with clear prohibitions on conflicts of interest and a strong management team. Additionally, it was agreed that qualified individuals should be able to access insurance inside and outside the exchange and that plans that are offered in both would have the same premiums and be subject to consistent Insurance Department rate review. Lastly, while consensus was not reached, the majority supports an exchange that has authority to negotiate as an active purchaser to drive the best value for employers and individuals.

### **Access and Enrollment**

**Challenge:** *State-operated exchanges must meet the needs of a wide variety of customers, from individuals who qualify for premium subsidies, to small businesses seeking to purchase insurance for their employees and applying for tax credits. States will be expected to streamline and simplify enrollment processes, maintain state-of-the-art web portals, and provide additional assistance to those in need. The Access and Enrollment Subcommittee focused its work on formulating a vision for how the exchange should support consumers – both individuals and businesses.*

### **Recommendations**

The Advisory Committee reached complete consensus on the subcommittee's findings and recommendations. Major recommendations include creation of a robust, state-of-the-art web portal for individuals and businesses to provide clear and understandable information about coverage available through the exchange and a full-service customer service call center to assist consumers. Also, the Advisory Committee recommends the exchange have a single

application for all insurance programs with integrated eligibility processes. Continuity of care was of particular concern for low-income individuals who may be transitioning in and out of Medicaid into subsidized coverage. For example, it was recommended that Medicaid and non-Medicaid plans create partnerships to assure access to the same providers. In this context, the state should carefully examine the Basic Health Plan option which may save the state money while better coordinating benefits for this gap population. Lastly, the Advisory Committee recommends the Commonwealth take full advantage of opportunities to support long-term care reform.

### **Other Major Reforms**

***Challenge:** Expansion of health insurance coverage should be accompanied by measures to improve the ability of the health care system to provide quality care in the most effective and cost-efficient manner possible. In addition to making changes in Medicaid and Medicare that will improve quality and reduce costs, the ACA provides many tools that states can use to make progress on this overarching goal. The Other Major Reforms Subcommittee identified critical areas of focus for improving quality, reducing costs and assuring access to services for the newly insured.*

### **Recommendations**

The Advisory Committee also reached complete consensus on the subcommittee's report. Major recommendations for the incoming administration include reforming how the state pays for health care (e.g., PEBTF, Medicaid, CHIP, adultBasic, Corrections) so that providers are paid based on the efficient use of resources while providing high quality care – instead of simply for the number of procedures they perform or patients they see. In addition, the report recommends continuation of the Chronic Care Initiative, which is proven to save money and improve care and which currently includes 900 primary care practitioners which serve more than 1.4 million patients, so that it is the norm for practice in the Commonwealth. The report also recommends the state provide additional support for safety net providers and provide better supports for consumers to make informed decisions about options for treatment and take a more active role in their care. Finally, the report recommends measures for taking the state's efforts to reduce medical errors to the next level, to improve end-of-life care and to ensure the workforce can meet emerging health needs.

### **CONCLUSION AND NEXT STEPS**

Members of the Health Care Reform Implementation Advisory Committee spent significant time and resources to study the Affordable Care Act, analyze the implications of the complex law and understand the options and choices that

are presented to states. The discussions and debates that have taken place within the subcommittees and the larger group have deepened understanding and clarified the choices, and helped develop consensus around the best approach on many diverse issues that are presented by the new law. The Committee believes that it - or a similar advisory group appointed by the new administration - could play a vital role as a sounding board and source of counsel in implementing the federal law.

Finally, as detailed above, the ACA provides significant opportunity to improve access, quality and health status, reduce health disparities and contain health care costs, and it places new requirements on individuals and states to meet those goals. This report, and its appendices, provides Pennsylvania policymakers with a detailed understanding of the ACA, its implications for Pennsylvania and policy options to consider as the Commonwealth continues to work through implementation.

## Summary of Advisory Committee Recommendations

The enclosed report contains the following recommendations. All reflect the consensus of the Committee unless otherwise indicated.

### Pennsylvania Health Insurance Exchange

1. The exchange must have a strong consumer-oriented mission and goals.
2. The exchange should be guided by a governing board and a strong executive team. (Majority recommendation.)
3. The exchange should be established as an independent public agency (or public corporation) such as a board, commission or an authority, or as a regulated non-profit entity. (Majority recommendation.)
4. One exchange should service the entire state, but plans would compete on a regional basis.
5. Two decisions on the exchange's initial insurance pools – the size of the small groups in the small group pool and whether to merge the individual and small group pools - require additional data and analysis, and should be made based on providing the greatest benefit to consumers.
6. Individuals and small business consumers who are eligible to buy insurance through the exchange should also be allowed to buy insurance outside of the exchange (without a subsidy).
7. The exchange should set minimum standards for plans sold in the individual and small employer group markets. The minimum standards should include quality indicators.
8. Young adult/catastrophic plans should be available through the exchange.
9. The exchange should serve as a negotiator with insurance plans to promote low pricing and high quality for individuals and small employers. (Majority recommendation.)
10. The Insurance Department should have expanded rate review authority.
11. Agents and brokers should be neither required nor prohibited, and there should be total transparency as to their fees or commissions.
12. Pennsylvania should determine the role, oversight and compensation model for Navigators.
13. The General Assembly should retain authority to make changes to benefit requirements and mandates.
14. The exchange planning grant should be used to develop estimates of the cost of operating the exchange and options for funding, to provide the General Assembly with options to meet the federal requirement that the exchange must become financially self-sustaining by 2015.

## **Access and Enrollment**

1. Consumers must be able to obtain information and assistance to enroll in a health plan through a website and over the phone as well as through alternative means and sites. The system should facilitate enrollment and retention of all eligible applicants who provide the needed information.
2. Pennsylvania should have a single application for all insurance programs accessible through the exchange, including those which are subsidized and those which are not.
3. The eligibility process for all subsidized and unsubsidized insurance programs should be integrated.
4. Demonstrating eligibility for subsidized health care should be as easy as possible and application and verification processes should be simplified and automated.
5. Individuals that met the income guidelines established for Medicaid prior to ACA should have access to the essential benefits that will be covered for adults added to Medicaid under ACA.
6. Health plans that participate in the exchange should be expected to enable continuity of care for individuals and families with income below 400% of the federal poverty level.
7. The exchange should provide hands-on assistance in the community to inform employers and individuals about opportunities for health coverage and to help them to select a health plan.
8. Planning for the exchange should consider the needs of special populations.
9. A comprehensive communication plan is needed to prepare for implementation of the exchange.
10. Pennsylvania should carefully consider establishing a Basic Health Program for individuals with income up to 200% of the FPL, rather than offering coverage through the exchange.
11. Pennsylvania should take full advantage of the Long-Term Living provisions of the ACA.
12. Planning for implementation of federal health care reform should assure appropriate program integration to reflect coverage of most Pennsylvanians by health plans with essential benefits.

## **Other Critical Reforms**

1. Implement payment reform so that health care providers are reimbursed on the basis of increasing the quality and efficiency of the care they provide.
2. Continue to transform primary care and improve chronic care and transitions of care.
3. Support safety net providers, which will continue to play an important role in Pennsylvania's health care landscape after 2014.

4. Give consumers tools to make informed decisions.
5. Reduce medical errors and implement other means of improving health care.
6. Ensure the workforce can meet emerging health care needs.
7. Expeditiously implement a Pennsylvania Health Information Exchange and Electronic Health Records (EHRs).

## Pennsylvania Health Insurance Exchange

The Patient Protection and Affordable Care Act, known as the ACA or the national health care reform law, requires that individual consumers and small employers have the opportunity to purchase health insurance through a health insurance exchange starting in 2014. **A health insurance exchange is a central marketplace for health insurance that provides one-stop shopping for individuals and small businesses to compare rates, benefits and quality among plans.**

Analysts estimate that between 1.3 and 2.1 million Pennsylvanians will purchase health insurance through the state's exchange. By pooling people and reducing transaction costs, the exchange can create more efficient and competitive markets for small employers and individuals. The exchange will also serve as the marketplace for purchasing health insurance for individuals who qualify for assistance paying for health care through new federal health insurance premium tax credits.

Beginning in 2013, during the open enrollment period, an exchange will be available in each state (operated federally in states that choose not to operate an exchange) to help consumers make comparisons between plans that meet quality and affordability standards. Use of the exchange by the purchaser is voluntary, although premium tax credits will be available only for plans purchased through the exchange. Starting in 2014, small employer tax credits will be tied to purchasing group insurance through the exchange.

The federal law establishes parameters and identifies areas in which the federal Department of Health and Human Services (HHS) Secretary will provide guidance and regulations for states, if states choose to establish health insurance exchanges. An "Initial Guidance to State on Exchanges" has already been issued.

The federal law guides the state's development of an exchange in a number of areas:

- Basic exchange functions (e.g., plan certification, customer service, information provision, exemption administration);
- Open enrollment periods;
- Minimum benefits standards for exchange products (to be defined in regulation);
- Requirement that a state's exchange be financially self-sustaining by January 2015; and
- Requirement that the exchange consult with stakeholders.



Because HHS will issue a number of regulations that will impact the creation of state exchanges, recommendations in this document may change as a result of those federal regulations.

The federal government will approve state exchange plans before January, 1, 2013. This will allow states to implement their exchanges in time to conduct a public education campaign and an open enrollment period in the summer or fall of 2013. Coverage under plans sold through the exchange will begin January 1, 2014. If a state does not have an approved exchange plan in January 2013, the federal government will operate an exchange for the state.

## **Strategic Goals**

The Advisory Committee defines the strategic goals for Pennsylvania's exchange as follows:

1. To facilitate and encourage the purchase and provision of affordable health care coverage.
2. To improve the health care coverage marketplace by structuring the exchange to promote competition on the basis of value and to avoid adverse risk selection.
3. To provide a one-stop, easy to use, accessible portal for consumers and businesses to learn about and compare options for coverage.
4. To provide a unified and integrated approach for consumer application and enrollment in all health care coverage that is publicly-subsidized, with linkages to existing access points for other health and human services for which people may be eligible.
5. To assure administrative efficiency and to maximize the leveraging of all administrative funding.
6. To ensure increased access to quality health care through a diverse, robust network of health care providers including safety net health care providers.
7. To support the goals of health care reform: transformation of the health care system to support improved quality of health care and reduced cost of care.

## **Background: Functions Performed by Health Care Exchange**

The federal health care reform law specifies the basic functions a state-operated exchange must carry out. *States may choose to include additional functions.*

### Mandatory Functions

Under federal law, the exchange is required to perform the following functions:

- Certify health insurance plans for participation in the exchange, including implementing procedures for plan certification, recertification and de-certification based on federal guidelines.
- Grade health plans in accordance with criteria to be developed by the federal Department of Health and Human Services. This includes using a standardized format for presenting health benefit plan options in the exchange, including the use of the uniform outline of coverage, and maintaining a website through which enrollees and prospective enrollees of qualified health plans may get standardized comparative plan information.
- Make qualified health plans available to eligible individuals and employers.
  - Provide customer assistance via telephone and website. Have a toll-free telephone hotline to respond to requests for assistance and maintain a website through which enrollees and prospective enrollees may get standardized comparative plan information.
  - Allow customers to compare qualified health benefits plans offered by different insurance carriers.
  - Use a standardized format to present four coverage options (bronze, silver, gold, and platinum), plus the catastrophic plan design for young adults/exemptions.
- Provide the following to individuals and employers.
  - Information regarding eligibility requirements for Medicaid, CHIP and any applicable state/local public program.
  - An electronic calculator that allows users to determine the actual cost of coverage after accounting for any premium tax credit and cost sharing reduction.
  - Publication of the average costs of licensing, regulatory fees, other payments required by exchange; exchange administrative costs; waste, fraud, abuse.
  - For employers, the names of any of their employees who stop coverage under a qualified health plan during a plan year.
- Certify individuals who are exempt from the individual responsibility penalty (for not having health insurance) when:
  - No affordable qualified health plan is available through the exchange or employer;
  - Purchasing insurance is not possible on the basis of hardship or other criteria to be established by HHS.
- Provide information to the federal government regarding:
  - Pennsylvanians issued an exemption certificate;
  - Employees determined to be eligible for premium tax credits;
  - People who tell the exchange they changed employers and stopped coverage during a plan year; and
  - Individual mandate exemptions and subsidies awarded when a small employer does not provide sufficient affordable coverage.
- Have an annual open enrollment period and special enrollment periods.

- Establish a network of community-based “navigators” to raise awareness among customers of their coverage options and to facilitate people selecting and enrolling in health plans and accessing benefits.

### Optional Functions

At each state’s discretion, the exchange may perform additional responsibilities outside of those required by federal health care reform:

- Additional regulatory and market functions. These additional functions would be incorporated into the exchange’s role in an attempt to meet certain public policy objectives.
- Increase competition and quality and decrease cost by allowing only the highest quality plans to be available through the exchange after a competitive procurement.
- Negotiate with insurers over elements of coverage.
- Coordinate purchasing and procurement decisions with Medicaid and CHIP so that consumers have continuity with the same plan and provider network in transitions across exchange-based carriers and MA plans.
- Reward adoption of new tools (e.g., use of a medical home model – which is discussed in the “Other Critical Reforms” section of this report) in purchasing decisions.
- Require additional reporting from insurers aimed at providing consumers and the public with additional information.
- Actively elicit information from consumers covered through exchange products in order to remove barriers and modify future purchasing decisions based on consumer needs and consumer feedback.

The mandatory and optional functions of the exchange will require a sophisticated web portal and call center operation, as well as technology solutions to support other needed business functions. In November, Pennsylvania received a \$1 million exchange planning grant from HHS to assist in planning the exchange. A portion of this grant was designated for a high level assessment of existing Commonwealth information technology systems to determine the degree to which the existing systems’ infrastructure could support a health insurance exchange. Navigant Consulting was engaged by the Commonwealth to conduct this task, which has just been completed.

The assessment found that several Commonwealth applications could be leveraged to create the front door to the Pennsylvania exchange and to support individual eligibility determinations. On the other hand, the assessment found that existing technology does not support a number of required and optional exchange functions, particularly those needed to support small businesses. These would need to be developed – either by building upon the

existing infrastructure or by purchasing and adapting an off-the-shelf product already available in the market place. The IT assessment is included in Appendix C. (The section of the report on Access and Enrollment discusses desirable features of the web portal in detail.)

## MAJOR FINDINGS AND RECOMMENDATIONS

### Guiding Principles for Exchange

The Governor and the General Assembly must determine whether Pennsylvania will operate an exchange and, if so, the exchange's attributes.

**The Advisory Committee strongly recommends that Pennsylvania establish its own exchange** and it recommends the following guiding principles in adopting the necessary legislation for an exchange. (This is one of several law change identified by the Pennsylvania Insurance Department, or PID, needed to implement the ACA and contained in Appendix D)

Unless otherwise noted, each recommendation reflects a consensus of all of the committee's members:

1. The exchange must have a strong consumer-oriented mission and goals.
2. The exchange should be guided by a governing board and a strong executive team. (Majority recommendation.)
3. The exchange should be established as an independent public agency (or public corporation) such as a board, commission or an authority, or as a regulated non-profit entity. (Majority recommendation.)
4. One exchange should service the entire state, but plans would compete on a regional basis.
5. Two decisions on the exchange's initial insurance pools – the size of the small groups in the small group pool and whether to merge the individual and small group pools - require additional data and analysis, and should be made based on providing the greatest benefit to consumers.
6. Individuals and small business consumers who are eligible to buy insurance through the exchange should also be allowed to buy insurance outside of the exchange (without a subsidy).
7. The exchange should set minimum standards for plans sold in the individual and small employer group markets. The minimum standards should include quality indicators.
8. Young adult/catastrophic plans should be available through the exchange.
9. The exchange should serve as a negotiator with insurance plans to promote low pricing and high quality for individuals and small employers. (Majority recommendation.)
10. The Insurance Department should have expanded rate review authority.

11. Agents and brokers should be neither required nor prohibited, and there should be total transparency as to their fees or commissions.
12. Pennsylvania should determine the role, oversight and compensation model for Navigators.
13. The General Assembly should retain authority to make changes to benefit requirements and mandates.
14. The exchange planning grant should be used to develop estimates of the cost of operating the exchange and options for funding, to provide the General Assembly with options to meet the federal requirement that the exchange must become financially self-sustaining by 2015.

## **TIMELINE FOR LEGISLATION**

Understanding the need for legislation to establish an exchange in Pennsylvania under the present federal law, the Legislature should consider necessary legislation during 2011.

**October 2010 – HHS awards planning grants to states for implementation planning for exchanges.**

**January 2013 – HHS will approve states that are able to implement exchanges by 1/1/2014.**

**July 2013 – Exchanges must begin accepting applications.**

**January 2014 – Exchange must be fully operational.**

## **Recommendations**

### **1. The exchange must have a strong consumer-oriented mission and goals.**

The exchange should focus on improving service and access for consumers and be for the benefit of all Pennsylvanians.

The exchange should facilitate access, simplify options, enrollment and regulation, and contain costs to improve the experience of getting and keeping insurance coverage.

To do this, the exchange must have a strong mission and goals that will guide the work of the exchange. These goals must be clearly articulated and signal to consumers and businesses that the exchange is working in their best interest and exists to improve access and service.

**2. The exchange should be guided by a governing board and a strong executive team. (Majority recommendation.)**

The governing board should:

- Be broadly representative and include members chosen for individual, professional and community leadership and experience;
- Be free of all conflicts of interest among its members, including financial and be subject to ethics laws;
- Include the secretaries of the Departments of Public Welfare and Health, and the Insurance Commissioner;
- Provide policy guidance to the exchange;
- Guide the design, implementation, and administration of the exchange;
- Develop a plan for integration and transition of existing public programs to ensure the seamless transition between Medicaid and other programs and the exchange;
- Be responsive to the needs of the public;
- Be flexible enough to change with shifting market and economic environment;
- Not be politicized;
- Be stable;
- Be Independent;
- Have professional management;
- Ensure that the exchange is not to be overly bureaucratic;
- Employ a strong executive team that has the expertise, authority, and sensitivity to work with:
  - Consumers
  - Small businesses
  - Insurers
  - Third-party administrators
  - Producers (agents and brokers)
  - Navigators
  - Other stakeholders
  - State Medicaid/CHIP offices
  - The Internal Revenue Service
  - Providers.

This recommendation reflects the Committee's majority. Dissenting members felt that recommendations regarding governance require additional information and should be made through the legislative process.

**3. The exchange should be established as an independent public agency (or public corporation) such as a board, commission or an authority, or as a regulated non-profit entity. (Majority recommendation.)**

Federal law gives states the ability to decide how the exchange is structured. It could be administered by a state agency (e.g., the way that parents apply for subsidized children's health insurance through the Insurance Department even though the coverage is provided by private insurance companies) or it could be administered by an independent commission (e.g., the Pennsylvania Health Care Cost Containment Council operates independently with appointees from the Governor and Legislature).

In considering this issue, the General Assembly should determine a structure to govern the exchange so that the exchange is accountable, flexible, free of conflicts of interest and transparent in its operation. In addition, the following issues should be weighed in determining the optimal structure:

- The exchange's ability to focus on consumers and to maintain good relations with insurance carriers and health care organizations who will serve the consumers;
- How state procurement, hiring, and human resource rules, and the flexibility and responsiveness of state agencies may affect exchange governance;
- If an exchange independent from state fiscal processes and insulated from political influence would best serve the needs of the Commonwealth;
- The federal requirements for a consumer oriented exchange and the ability for the exchange to conduct its federally mandated business in tight fiscal times;
- The necessity of user fees and other financial requirements, including potential for support through Medical Assistance, for the continued operation of the exchange; and
- The oversight that will be needed in the implementation and structure of an exchange and what type of exchange will ensure accountability to consumers.

Regardless of the exchange's structure, it is clear that legislation creating the exchange is needed, likely in 2011, to allow for all of the set-up and interoperability to permit HHS to determine, by 1/1/13, that Pennsylvania will have an operational exchange by 1/1/14.

The majority recommendation of the Committee is that the exchange should be established as an independent public agency (or public corporation) such as a board, commission or an authority, or as a regulated non-profit entity. The Committee identified advantages and disadvantages of the major options:

### **State agency**

#### Advantages

- The exchange would have a direct link to the state administration and a more direct ability to coordinate with other key state agencies, such as DPW and the Insurance Department.

#### Disadvantages

- The exchange would not be governed by an independent board as recommended above.
- The exchange's decision-making and operations may be politicized.
- It would be potentially difficult for the exchange to be nimble in hiring and contracting practices, unless exceptions are made to the state's personnel and procurement rules while ensuring accountability and transparency.

### **Independent public agency or public corporation such as a board or commission**

#### Advantages

- Enabling legislation could specify how board members would be appointed, the size of the board and the composition and terms of the members.
- The board may select the exchange's executive director.
- A public sector entity outside of the executive branch is more independent and is therefore insulated from the political process more so than an executive branch agency.
- An independent agency or public corporation is likely more nimble in hiring and contracting.

#### Disadvantages

- The exchange could have more difficulty coordinating strategies and initiatives with key state agencies, such as DPW and the Insurance



Department, because the exchange would not be located at a state agency.

- Potentially less access to the executive administration.

## **Non-profit Entity**

### Advantages

- Accountability to the government could be clearly defined by its establishment as a licensed entity subject to regulatory oversight.
- Would have flexibility in setting accountable and transparent hiring and procurement practices.
- The board of the non-profit entity would be more insulated from the political process than the other two options, which may maximize freedom and flexibility in decision making.
- Greater flexibility in governance, the ability to be more nimble in decision-making and less chance of being politicized.

### Disadvantages

- Would be more difficult being held publicly accountable.
- Unless specified in the enabling legislation, potential isolation from state policymakers and key state agency staff and more difficulty coordinating with other public sector health purchasers.

This recommendation reflects the Committee's majority. Dissenting members felt that recommendations regarding governance require additional information and should be made through the legislative process.

#### **4. One exchange should service the entire state, but plans would compete on a regional basis.**

Federal health care reform requires that all states establish an American Health Benefit Exchange for the individual market and a Small Business Health Options Program (referred to as a "SHOP" exchange) for the small group market. Federal law gives states the option of combining these two exchanges into a single exchange. The Pennsylvania exchange should operate as a single organization offering products and services to individuals and small employer group customers and utilizing a common entry point, access to correct information and assistance based on information provided about the consumers' needs and interests. Even if Pennsylvania elects to have separate exchanges for the individual small employers, they should appear to the user as a single seamless exchange serving the entire state. Once prospective purchasers have entered the portal, they would be

directed to the appropriate exchange and the appropriate regional insurance products.

**5. Two decisions on the exchange's initial insurance pools – the size of the small groups in the small group pool and whether to merge the individual and small group pools – require additional data and analysis, and should be made based on providing the greatest benefit to consumers.**

States have the opportunity to make two decisions about how they structure the insurance pools in the exchange's initial years:

1. Small businesses with 51-100 employees. Federal law defines "small employer" eligible to purchase insurance on the exchange as an employer with 2-100 employees. Until 2016, states may limit this federal definition to 2-50 employees. Pennsylvania presently defines small employers as employers with 2-50 employees. This issue requires additional analysis. The vast majority of Pennsylvania employers have less than 50 employees. There are approximately 259,000 employers with fewer than 50 employees, employing 1.46 million Pennsylvanians. If Pennsylvania were to allow firms with up to 100 employees to purchase health care coverage on the exchange, it would add the opportunity for approximately 6,300 businesses with over 430,000 additional employees to purchase on the exchange.
2. Merging the individual and small group insurance pools. The law allows states to either pool all of their individuals into one risk pool and all of their small employer group members into another risk pool or pool all covered persons into one pool. Maintaining separate risk pools for individuals and small employer group members would result in insurers rating premiums separately for each of the two groups; that is, the adjusted community rating rules in federal health care reform would still apply, but the two groups would be rated separately.

These issues will be a major focus of the planning grant, but without additional data and analysis the Advisory Committee could not make a recommendation about whether to combine the small group or individual exchanges or whether to initially limit participation on the exchange to small businesses with 50 or fewer employees.

In general, a strong and stable market relies on a large, variable risk pool to reduce destabilization by large claims or a small number of high users (people with very poor health status). Therefore, in order for the exchange to be successful with separate risk pools, each pool must be large enough to be stable.

In order to prevent the exchange from becoming a high-risk pool, it will be critical to consider rating, pools, and take-up rate if the individual and small group risk pools are separated. Pooling individuals and small employer group members into one pool will also present a need to promote take-up, but the pool would be larger. In this case, the profiles of individuals and small employer group members must be determined to ensure that the two groups are not so drastically different that they cause a single pool to be more unstable than two separate pools.

Another consideration for the exchange is the current individual health insurance market. Currently, the association and non-association plans in the individual market are underwritten. In addition, the Insurance Department's jurisdiction over association plans is limited. As a result, these markets offer relatively affordable premiums to the individuals who are offered coverage and who are healthy.

The Pennsylvania Insurance Department is in the process of defining and obtaining data from insurance companies in order to analyze the impact of these options. The study should be conducted as expeditiously as practicable and its results should be made publicly available so that decision-making is informed by a public process. The state should ultimately adopt the policies that provide the greatest benefit to individual and small business consumers. (See Appendix K of the merged market analysis design.)

**6. Individuals and small business consumers who are eligible to buy insurance through the exchange should also be allowed to buy insurance outside of the exchange (without a subsidy).**

Federal law requires the creation of health insurance exchange(s), but does not eliminate the insurance market outside the exchange. Eliminating sales outside the exchange could ensure a larger pool of enrollees inside the exchange, and eliminate risk selection between the exchange and the insurance market outside the exchange. However, eliminating sales outside the exchange would mean that individuals who choose not to use the exchange or who are not eligible to purchase health insurance in the exchange (such as non-citizens or undocumented immigrants) could not purchase health insurance. Likewise, if sales were not permitted outside the exchange, an individual eligible for Medicaid or CHIP would have no alternative for insurance coverage if the individual chose not to enroll in those programs.

Federal health care reform specifies the following rules to protect against adverse selection issues in a dual market.

- a. Plans sold inside and outside the exchange must be in the same risk pool.
- b. Plans sold inside and outside the exchange must have the same premium rate.
- c. Plans sold inside and outside the exchange must meet the same minimum benefits standards.
- d. Insurers inside and outside the exchange may not deny coverage on the basis of pre-existing conditions, medical status, or claims history.
- e. Premiums may vary based on age, geographic location, and smoking status but must apply to plans inside and outside the exchange.
- f. Insurers inside and outside the exchange must participate in reinsurance and risk adjustment to ensure that plans covering a sicker population are not penalized.

The best outcome would be for insurers to sell identical plans inside and outside the exchange because doing so puts all into one risk pool. There is a risk to the exchange if insurers inside the exchange sell slightly different products outside the exchange – especially if those products are priced less expensively because (1) they would not be in the risk pool and (2) they would attract consumers to purchase a product outside the exchange, meaning healthy people might buy a less expensive product (even with a lesser benefit), and that would cause the exchange to become the insurer of last resort, and could end up driving up rates inside the pool.

If insurers offer identical products inside and outside the exchange, they will benefit from the exchange providing some of the administrative tasks and thus save on administrative costs when they are in the exchange, and benefit from what will hopefully be a new market of insured individuals with subsidies to help purchase insurance. It would protect against adverse selection in the exchange if Pennsylvania mandated that insurers must have an identical product outside the exchange; otherwise they could not participate inside (and hopefully benefit from) the exchange. But forcing companies to only sell products in Pennsylvania if they are in the exchange could invite smaller insurers to leave Pennsylvania altogether.

**7. The exchange should require minimum standards for plans sold in the individual and small employer group markets. The minimum standards should include quality indicators.**

As required by the federal law:

- g. All health plans must meet federal essential benefits requirements;
- h. All companies selling insurance in Pennsylvania must offer at least one silver and one gold plan; and

- i. Some exemptions are made for “grandfathered plans” (those issued before March 23, 2010) and self-insured plans for larger groups under ERISA.

In implementing these requirements, the exchange should address the following related issues:

- j. The exchange should consider strategies to maximize the participation of private insurance plans offered through the exchange;
- k. Pennsylvania will need to ensure that its insurance laws and regulations are consistent with federal law;
- l. Pennsylvania should take steps to ensure that insurance carriers do not attempt to route low risk people outside the exchange by offering less comprehensive coverage (and less expensive) plans only outside the exchange; and
- m. The federal law requires that carriers participating in the exchange offer at least a silver and a gold level plan. While carriers not participating in the exchange may not want to offer all plan levels, the state may want to require carriers off the exchange to offer a variety of level plans to minimize adverse selection for plans on the exchange.
- n. The exchange should create metrics that consider customer satisfaction, quality within each plan’s provider network, and health outcomes.

**8. Young adult/catastrophic plans should be available through the exchange.**

The federal law allows for a catastrophic plan to be sold to individuals under age 30 and to people with hardship exemptions from the insurance mandate. The catastrophic plan will provide coverage of the essential health benefits, with deductibles based on those allowed for HSA-qualified high deductible health plans. Deductibles will not apply to at least three primary care visits.

As these plans are only open to specific categories of purchasers, it will be necessary to certify that the buyer is eligible to enroll in a catastrophic plan. This can most easily be done through the exchange.

This is particularly important for individuals deemed exempt from the insurance mandate, as the exchange is responsible for granting exemptions and informing the federal government about which Pennsylvanians are receiving exemptions. If the plans are sold in the outside market, additional coordination will be required to ensure the exchange receives the information it needs.

Young adults have a financial stake in the offering of a catastrophic option. Qualified consumers may opt out of comprehensive coverage and choose

to pay a penalty if this option is not available. By offering this option, qualified consumers would be more likely to purchase such a plan at a more reasonable cost.

Offering catastrophic coverage through the exchange provides an incentive to carriers to participate in the exchange. Young adults tend to be healthier than the average under-65 population, making this group a lucrative market. It is also a group that has historically had high uninsurance, thus many Pennsylvanians in this age group will be new entries into the health insurance market.

If catastrophic plans are exclusively offered through the exchange, this hard-to-reach group will already have a relationship with the exchange and insurers with qualified offerings when they are required to purchase more comprehensive coverage.

**9. The exchange should serve as a negotiator with insurance plans to promote low pricing and high quality for individuals and small employers purchasing through the exchange. (Majority recommendation.)**

The interim guidance issued by CMS states: “State have a range of options for how the Exchange operates from an ‘active purchaser’ model, in which the Exchange operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers, to an ‘open marketplace’ model, in which the Exchange operates as a clearinghouse that is open to all qualified insurers and relies on market forces to generate product offerings. In both cases, consumers will end up with options, and States should provide comparison shopping tools that promote choice based on their price and quality and enable consumers to narrow plan options based on their preferences.”

There was consensus that initially the exchange should permit all qualified plans to sell via the exchange to ensure adequate plan participation.

The majority recommends that the exchange should be able to gradually cull poor performers based on cost and quality, and should use market leverage to obtain optimum price for individual and small business purchasers.

Minority representatives from the insurance industry pointed out that their rates had to be approved by the Insurance Department and they are opposed to a second set of rate negotiations. Representatives of hospitals are also concerned about the impact this leveraging might have on the adequacy of health care provider reimbursement. Of all the issues discussed

by the Advisory Committee, this issue was most strongly felt by members on both sides.

The exchange has an opportunity to create greater levels of competition by assuring consistency across plans to maximize comparability.

**10. The Insurance Department should have expanded rate review authority.**

The federal law requires that premiums rates be the same for a given health plan offered both inside and outside of the exchange. Federal law also implemented medical loss ratio (MLR) requirements and a prohibition of “unreasonable” rate increases.

State law must follow the federal requirement; rates for plans offered both inside and outside the exchange will be subject to regulation by the Insurance Department, with pricing consistent inside and out. However, current Pennsylvania law does not require most for-profit insurers to file rates for small group plans with the Insurance Department for review. The department’s rate review authority should be strengthened to ensure compliance with federal law, implementation of the MLR requirements and unreasonable rate increase prohibition, and to ensure that insurers are pricing plans appropriately.

**11. Agents and brokers should be neither required nor prohibited, and there should be total transparency as to their fees or commissions.**

The federal law allows states to decide whether to use agents in the exchange, directing states that do utilize them to follow certain rules. Agents can be knowledgeable about a range of insurance products and helpful to individuals and employers seeking to buy insurance through the exchange, and provide information about how to access premium tax credits and how to offer a range of coverage choices to their employees. If the exchange is sufficiently user-friendly, providing easily understood comparative information on cost and quality, the added expense of brokers and agents may not be necessary. However, the new medical loss requirements may limit the ability of plans to provide some services now provided by brokers. Therefore, the Committee recommends that agents and brokers should be neither required nor prohibited, but there should be total transparency as to their fees or commissions so consumers can make an informed choice as to their use.

The exchange should acknowledge the Insurance Department’s licensure and regulation of agents, which may include a certification process with educational standards developed by the Department with input from the exchange for agents selling exchange products.

## **12. Pennsylvania should determine the role, oversight and compensation model for Navigators.**

The ACA requires that exchanges award grants to eligible entities that meet standards established by HHS to carry out exchange education and enrollment, since the health insurance market will have more lower-income, ethnic and racial minorities and special needs populations than is the case today. The law says that Navigators are to be available to provide personal assistance to those who need it to be able to purchase health insurance and qualify for subsidies. The ACA sets forth the duties of Navigators to:

- Conduct public education activities to raise awareness of the availability of qualified health plans;
- Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under and cost-sharing reductions
- Facilitate enrollment in qualified health plans;
- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under the law, or any other appropriate state agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange or exchanges.

The Advisory Committee recommends implementation of the following National Association of Insurance Commissioners (NAIC) recommendations regarding Navigators:

- Navigators should be credentialed and reviewed for performance, but not licensed;
- They should be compensated based on the quality of the information provided and not the volume so as not to create incentives to encourage or discourage certain consumer behavior or preferences;
- Navigators must have the consumer as their client; and
- They must provide understandable consumer information in a culturally sensitive manner for those with low-proficiency English and people with special needs.



**13. The General Assembly should retain authority to make changes to benefit requirements and mandates.**

Once the federal government establishes requirements for essential health benefits, the General Assembly may want to consider additional requirements. Pennsylvania should retain its authority to make changes to benefit requirements once more information is known on the federal requirements.

To ensure that the exchange is responsive to needs identified over time, the exchange board should be given statutory authority to establish contract standards with an emphasis on quality, access and evidence-based care. Additionally, the exchange should require standardization for as many processes as possible to reduce administrative costs for providers and consumers. For benefits requirements that would affect all plans offered both inside and outside the exchange, the General Assembly should retain the authority to change the rules as needed. This is not an exchange role as it would affect all plans whether they were offered inside the exchange or not.

**14. The exchange planning grant should be used to develop estimates of the cost of operating the exchange and options for funding to provide the General Assembly with ways to meet the federal requirement that the exchange must become financially self-sustaining by 2015.**

Federal law allows states to apply for federal grants to assist with costs associated with establishing an exchange. In addition, federal funds will be available to support the costs of operating the exchange during 2014. Beginning January 1, 2015, federal law requires that state exchanges must be financially self-sustaining and the exchanges may not rely on federal funds for support. In order to accomplish this, Pennsylvania needs to determine the method by which the exchange's operations will be financed. This will depend on the function of the exchange and the cost of operation.

The federal law explicitly presents one financing option: the exchange is allowed to charge assessments or user fees to participating health insurance providers. However, the federal health care reform law neither suggests nor limits options to achieve financial sustainability. Regulations to be issued by HHS may address this point.

Other funding options include:

- State funds;

- Assessing health plans, employers, and/or individuals;
- Assessing health care providers; and
- Surcharging insurance premiums.

If the exchange is used to enroll Medicaid beneficiaries in plans, 90% of that cost will be paid through federal funding.

In developing the state's strategy for financing, it is important to consider how any funding option:

- Encourages or discourages participation in the exchange by individuals, small businesses, and insurers;
- Affects the reputation of the exchange;
- Affects accountability, transparency, and cost-effectiveness; and
- Is sustainable over time.

Possible effects include the following:

- Charging user fees to insurers may discourage participation in the exchange by insurers;
- Attaching administrative fees to health care providers may discourage providers from serving members insured through the exchange
- Attaching administrative fees to health plans may discourage individuals and small businesses from participating in the exchange;
- Assessments on premiums may discourage participation in the exchange by insurers who are required to charge the same premiums inside and outside the exchange and, thus, may retain less of the cost inside the exchange;
- Using state-appropriated funds may cause some to view the exchange as a public program instead of a marketplace; and
- Using state-appropriated funds may make the exchange vulnerable to the under-funding of essential functions during periods of state fiscal distress.

Establishing a reliable, sustainable way to finance the exchange is vital to its ability to reach its goals. Throughout the process, it is important to keep in mind the potential effects on enrollment as well as the economic, social, and political implications of each financing option. The exchange planning grant should be used to determine costs of operation and the positive and negative effects various funding methods would have.

## Access and Enrollment

The Patient Protection and Affordable Care Act (ACA) will greatly expand access to affordable health insurance when it is fully implemented in 2014 through:

**Expanding Medicaid eligibility.** Currently Pennsylvania adults with significant and long-lasting disabilities or illnesses qualify for Medicaid if they have income below 77% of the Federal Poverty Level (FPL). Parents raising a minor child qualify with income at 47% of the FPL. Healthy adults without children do not qualify even if they have no income. The ACA will extend Medicaid coverage to all Pennsylvanians with income below 133% of the FPL<sup>2</sup> – covering an estimated 483,000 additional individuals, including<sup>3</sup>:

- 97,000 individuals currently eligible for existing health insurance programs but not enrolled;
- 245,375 individuals on the adultBasic waiting list<sup>4</sup>;
- 8,817 young adults who have aged out of foster care; and
- 135,917 other adults currently uninsured.<sup>5</sup>

**Helping to pay for health insurance premiums.** In addition to expanding Medicaid eligibility, an estimated 723,000 Pennsylvanians<sup>6</sup> with income between 133% and 400%<sup>7</sup> of the FPL will qualify for premium assistance to help them purchase insurance through the exchange.<sup>8</sup> About 200,000 of this subsidy-eligible group are currently uninsured, 317,000 are insured through their employer and 206,000 have non-group coverage. (Appendix E shows current and future income eligibility limits for Medicaid and health insurance subsidies).

**Making it easier to purchase insurance.** Individuals who don't qualify for subsidy can take advantage of the marketplace established by the state health insurance exchange to compare and purchase "qualified" insurance plans that meet federal and state standards. An estimated 219,000 individuals in the

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<sup>2</sup> In 2010, 133% of the federal poverty level equated to \$14,404 in annual income for a single individual and \$24,842 for a family of three.

<sup>3</sup> The new law will also make 55,860 children now covered by the Children's Health Insurance Program (CHIP) eligible for Medicaid.

<sup>4</sup> The 42,000 individuals now covered by adultBasic would also be eligible for Medicaid under the expansion.

<sup>5</sup> Potential new Medical Assistance eligibles estimated by the Department of Public Welfare (DPW) Budget Office.

<sup>6</sup> Based on national estimates from the Lewin Group's Health Benefits Simulation Model.

<sup>7</sup> In 2010 figures, this would mean individuals would qualify for a tax credit with annual income between \$14,404 and \$43,320. A family of 3 would qualify with annual income between \$24,842 and \$73,240.

<sup>8</sup> About 200,000 of this subsidy-eligible group are currently uninsured; 317,000 are insured through their employer; and, 206,000 have non-group coverage. (These numbers are extrapolated from the Lewin Group's Health Benefits Simulation Model.

individual market who would previously have had to purchase insurance on their own will be able to do comparative shopping and take advantage of lower prices possible due to new rating rules that will put individuals in a single pool (or potentially merge the individual and small group markets). The law will make it easier for the 232,000 employers with fewer than 100 employees in the Commonwealth to access coverage at a lower cost and take advantage of tax credits through the exchange<sup>9</sup>.

In all, it is expected that between 1.3 and 2.1 million Pennsylvanians will potentially use the exchange to obtain health insurance. But achieving these goals depends largely on the Commonwealth's ability to enroll people in the new and existing coverage options. Many implementation decisions are left to states. Some of these decisions will create the foundation for how Pennsylvania connects people to coverage and the extent to which the ACA's goals of expanding insurance coverage and reducing the number of uninsured are met. The Access and Enrollment Subcommittee of the Commonwealth's Health Care Reform Advisory Committee identified eligibility and enrollment options for Pennsylvania to consider in its approach of entry into coverage.

### **Much Federal Guidance Still to Come, but the Development of Eligibility and Enrollment Systems Will Take Significant Time**

This report notes the relevant statutory requirements of the ACA; however, federal regulatory guidance is pending on several issues important to Pennsylvania's implementation efforts. For example, federal regulations on eligibility issues were expected by the fall of 2010, but have not been released to date. Until regulations are released, states do not know the essential requirements of the new systems. Federal policy makers are also considering the possibility of providing either standards for eligibility system development or possibly components of an eligibility system to states through the use of open source software or common systems. The data exchange standards and details of how verifications will be streamlined through connections to the IRS and other federal databases have also yet to be determined. A simplified common application form across health programs that states can use is yet to be developed by the federal government. Although there are a number of uncertainties about implementation, the development of eligibility and enrollment systems will take significant lead time and state implementation efforts must begin immediately.

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<sup>9</sup> Approximately 139,000 employers with fewer than 50 employees have between 1 and 4 employees – an unknown portion of which are single proprietorships or self-employed individuals. While self-employed individuals without other employees are not eligible for the small business tax credits, they would be eligible to purchase individual insurance through the exchange and if income is below 400% of the FPL, qualify for premium subsidy and reduced cost-sharing.

## MAJOR FINDINGS AND RECOMMENDATIONS

1. Consumers must be able to obtain information and assistance to enroll in a health plan through a website and over the phone as well as through alternative means and sites. The system should facilitate enrollment and retention of all eligible applicants who provide the needed information.

### **ACA Provisions**

*The exchange must maintain an Internet website that:*

- *Allows individuals and employers to determine whether they are eligible to participate in the exchange;*
- *Directs qualified individuals and qualified employers to qualified health plans;*
- *Assists individuals and employers in determining whether they are eligible for a premium tax credit or cost sharing reduction;*
- *Presents standardized information (including quality ratings) regarding qualified plans, to assist consumers in making a choice;*
- *Provides an automatic calculator that allows users to determine the actual cost of coverage after accounting for any premium tax credit and cost sharing reduction; and*
- *Allows individuals and small businesses to purchase qualified health plans. (HHS will develop a web portal template that states may use.)*

*The exchange must also provide for operation of a toll-free telephone hotline to respond to requests for information and to assist with the application process. The state is obligated to demonstrate an implementation plan for establishing an exchange by January 1, 2013. The exchange must begin to accept applications in July 2013. (If the state chooses not to establish an exchange or fails to establish an exchange by January 1, 2014, the federal government will set up and run a state exchange, either directly or through an agreement with a non-profit entity.)*

### **As It Is Today: Federal Website Launched**

HHS is required to create and operate an Internet portal to help consumers identify and compare affordable coverage options, including Medicaid and CHIP. This website, found at [www.healthcare.gov](http://www.healthcare.gov), is a “forerunner” of the kind of portal that exchanges are expected to operate. State websites must be operational by January 2014 – but states must begin accepting applications in July 2013 so, in effect, the deadline is six months earlier.<sup>10</sup> Pennsylvania has

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<sup>10</sup> By January 1, 2013, HHS must determine whether a state will have an operational exchange ready by January 1, 2014. If not, HHS will establish and operate an exchange for the state either directly or through contract with a non-profit entity.

an Internet portal for application for Medicaid, CHIP and other social services programs, but the requirements for many of the other functions of the portal required by the ACA have not yet been established. The Commonwealth's COMPASS application does have a screening function that helps consumers determine eligibility for Medicaid, CHIP or other income based services.

### **Recommendations**

- The exchange must support the needs of individuals who are required to obtain insurance, including those eligible for subsidies.
- The exchange must also meet the needs of small businesses to choose qualified health plans for their employees.
- The exchange should operate a robust, state-of-the art web portal for individuals and businesses to provide clear and understandable information about coverage available through the exchange, to enable individuals and employees to enroll in qualified health care insurance plans and to apply for subsidy (individuals) or tax credits (businesses).
  - The web portal should maximize technology, utilize smart prompts, and retain information once an application has been started. Assistance should be immediately available over the telephone and through a robust "help" function for individuals and small businesses that have difficulty completing the electronic application process to ensure that applicants can find out their options for coverage (whether unsubsidized or subsidized) and complete the process of obtaining insurance.
  - The portal should utilize a standardized format to help consumers and small businesses select a plan including, but not limited to, the provider network, quality ratings, cost-sharing obligations, and any additional benefits included in plans offered on the exchange. This would include supporting the plan selection and enrollment process for individuals eligible for Medicaid.
  - Work should begin now to plan the web portal to assure it is operational by July 2013.
- The exchange should operate a full-service toll-free customer service hotline to answer questions, assist in the enrollment process, and help individuals to apply for subsidies and reduce cost sharing.
  - Work should begin now to identify the requirements, procurement strategy, staffing plan and opportunities for leveraging existing customer service assistance resources for the exchange's customer service call center.
  - The staffing plan must accommodate the need to respond to an initial large volume of inquiries and applications for assistance from small businesses and the uninsured.

- The exchange should also provide up-to-date information regarding options for assistance to find coverage for individuals and businesses not eligible to purchase insurance through the exchange. This should include information about federally qualified health centers, nurse-managed clinics and free clinics, free and reduced cost dental clinics, and county-based state health centers. The exchange should also provide information about free or discounted care offered as a community benefit by non-profit hospitals to individuals in need in return for local state and federal tax exemptions.
  - Both the website and the call center must meet the needs of individuals with limited English language proficiency. The exchange should also assure access for individuals with sensory, motor, intellectual or other impairments that might restrict their ability to use the phone or the portal.
  - Pennsylvania's web portal environment should present CHIP, Medicaid and other subsidized health benefits as a subset of the many products available for health insurance coverage for qualified applicants.
  - The exchange should provide avenues for feedback from consumers on the quality of customer service experienced from the exchange, as well as on the quality of the plans offered.
  - The exchange should publicly report wait times for service through the call center, length of time for application processing and other indicators of quality customer service.
  - The portal should allow for access by a COMPASS partner or other advocate on behalf of a consumer when that is the consumer's preference.
  - The portal should provide information about advocacy resources for individuals, including, but not limited to, the Pennsylvania Health Law Project, local legal services programs, and the Insurance Department's Bureau of Consumer Services.
- 2. Pennsylvania should have a single application for all insurance programs accessible through the exchange, including those which are subsidized and those which are not.**

### **ACA Provisions**

*The law requires that a single, streamlined, user-friendly form for use for all applying for all forms of subsidized coverage. (HHS will develop a template, or states can develop their own, but it must meet federal standards). Application can be filed online, in person, by mail or by telephone.*

### **As It Is Today: COMPASS Web Portal**

Pennsylvania has developed COMPASS, which is a web portal through which consumers can apply for Medicaid, CHIP, adultBasic, and the new PA Fair Care Program over the Internet. COMPASS can also be used to apply for a

wide menu of health and social services programs, including Supplemental Nutrition Assistance Program, Temporary Assistance to Needy Families, Child Care, Low Income Heating Assistance Program and waiver programs for individuals with intellectual disabilities. It has been adopted by a number of other states, and has been nationally recognized. The website can be found at: <https://www.humanservices.state.pa.us/compass.web/CMHOM.aspx>

Currently, about 18% of Medicaid applications (18,000 a month) and 9% of renewals (4,500 a month) are completed through COMPASS.

### **Recommendations**

- Pennsylvania should have a single, streamlined, consumer-friendly application that is used for all forms of state and federal subsidy for health care. Renewal of eligibility should be accomplished through a single form as well.
- Electronic applications and renewals should be promoted as the “preferred” means of application, though paper forms must also be accepted.
- The Commonwealth should complete the assessment of COMPASS as the vehicle for a single application for all health care programs offered through the exchange with special focus on errors or limitations already identified by COMPASS users.
- Following the assessment of technology options for the portal, planning and development should commence expeditiously in order to achieve HHS certification in January 2013 that the state will have a fully functioning portal ready by January 2014.<sup>11</sup>

### **3. The eligibility process for all subsidized and unsubsidized insurance programs should be integrated.**

#### **ACA Provisions**

*The law requires that states establish streamlined and integrated application and renewal procedures so that there is no wrong door into coverage. States must enable individuals to apply for, be enrolled in or renew Medicaid coverage through an Internet website that is linked to the exchange website. The eligibility process must enable individuals identified by the exchange to be eligible for CHIP or Medicaid to be enrolled without any further need for information. In addition, states must ensure that individuals found ineligible for CHIP or Medicaid are screened for the exchange and any applicable premium assistance and enrolled without an additional or separate application.*

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<sup>11</sup> Since the exchange is expected to begin to accept applications for insurance subsidy in July 2013, the portal should be operating by that time to allow sufficient lead time to have applications processed by January 2014.



### **As It Is Today: Eligibility Process Integration**

CHIP and Medicaid eligibility processes are already nearly completely integrated. Applications for Medicaid that appear to meet income requirements for CHIP or adultBasic are transmitted electronically to the Insurance Department for action through COMPASS. Applications for CHIP that appear to meet income guidelines for Medicaid are transmitted electronically to DPW for action. However, this process still has some imperfections that can cause delays in authorization of insurance.

The eligibility process for coverage through the high risk pool recently created by the Commonwealth (PA Fair Care) has been added to COMPASS.

Medical Assistance Eligibility Determination Automation (MEDA), built in to the DPW Client Information System, applies a complex set of rules to determine which eligibility criteria for the many different types of state health care coverage are met by the applicant. MEDA may provide a backbone for achieving eligibility integration. The Department of Public Welfare is in the middle of a multi-year project to modernize the eligibility technology supporting this important function. While the foundation for program integration is established, significant work is likely needed to upgrade the system and build in the new rules for Medicaid eligibility enacted in the ACA.

### **Recommendations**

- First and foremost, the portal should enable applicants to complete a streamlined application for health care insurance, including any available subsidies. The portal should also make it possible for applicants to choose to be screened and apply for other assistance programs, without the need to supply the same information twice, as is now possible through COMPASS.
- The Commonwealth should determine whether it is feasible and cost effective to build on its present technology in determining whether individuals are eligible for a premium tax credit or cost sharing reduction or another option in the exchange, or whether it should procure and implement a new technology platform.
- The Commonwealth should identify the system enhancements that would be needed to provide the seamless integration of eligibility processes required by the act.
- The Commonwealth should identify policy and practice obstacles to program integration and develop a plan for making changes needed, including recommendations for changes to the Public Welfare Code.
- Personal health information utilized to determine eligibility for subsidy must be protected.

- The eligibility system must provide a clear explanation for denials and provide a means for quick response to questions about and appeals of eligibility determinations.
  - The exchange should be an entry point for other special health programs operated by the Commonwealth.
- 4. Demonstrating eligibility for subsidized health care should be as easy as possible and application and verification processes should be simplified and automated.**

### **ACA Provisions**

*The law increases uniformity in income rules for all health subsidy programs, by using the modified adjusted gross income for Medicaid, with a few exceptions.<sup>12</sup> The law standardizes the information that individual applicants must provide and requires that verifications and determinations of eligibility for participation in the exchange, premium tax credits, cost-sharing reductions, Medicaid and CHIP, as well as exemptions from the individual mandate be done electronically by checking information submitted against federal records. There are no resource limits for eligibility for premium assistance and cost-sharing reductions. Resource limits are eliminated for Medicaid except for individuals eligible due to eligibility for another assistance program, elderly individuals, medically needy individuals, and individuals eligible for Medicare cost-sharing. The new law uses the modified adjusted gross income from the federal income tax form as the basis for eligibility for both expanded Medicaid and for premium assistance.*

### **As It Is Now: Electronic Data Exchanges**

DPW has used electronic record exchanges to identify discrepancies in eligibility information for Medicaid and other programs for many years, matching applicant information with databases operated by the Social Security Administration, U.S. Department of Labor, Citizen and Immigration Services (formerly Immigration and Naturalization Services), PA Department of Labor and Industry, PA Department of Transportation, and PA Department of Health. Information from these databases is used to verify identity and citizenship but, so far, has not been used as the primary source for verifying income. The PA Insurance Department has recently made system changes needed to be able to take advantage of these exchanges for verifying citizenship for CHIP applicants. Work is underway to make exchange information more accessible and “consumable”.

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<sup>12</sup> Exceptions include individuals eligible because of their eligibility for other aid or assistance elderly individuals, medically needy individuals, and individuals eligible for Medicare cost-sharing.

## **Complex Eligibility Requirements for Medicaid**

The Medicaid application in use today is lengthy because there are 130 different categories of assistance, each with different eligibility criteria. The application must collect information to discern which, if any, type of assistance the applicant qualifies for.

### **Recommendations:**

- Electronic verification processes should replace paper documentation for all public benefit programs and health insurance subsidies, and such databases used as the primary source of information, to the extent that accurate information needed to document eligibility is available. Electronic verification should be done on a real-time basis to the maximum extent possible. However, the verification process should also be able to accommodate individuals and families who have experienced a reduction of income that is not reflected in their prior year's income tax return.
- By broadening the population eligible for Medicaid, the ACA provides an opportunity to greatly simplify the eligibility requirements for Medical Assistance. The Commonwealth should identify and recommend changes in existing policies and rules for CHIP or Medicaid that add unnecessary complexity and are inconsistent with the call for a simplified eligibility process.
- The General Assembly should review current statutory requirements for Medicaid eligibility to assess their compatibility with federal ACA requirements and make necessary changes. An initial assessment of needed changes to the Public Welfare Code is found in Appendix F, and includes creating an eligibility group based on income below 133% of the federal poverty level and modifying provisions that govern treatment of resources and income.
- The General Assembly should consider modifying the state requirement for eligibility redetermination every six months for some categories of Medicaid recipients in order to align Medicaid with the annual eligibility determination process established in the ACA for health insurance subsidies.
- Presumptive eligibility for health insurance should be afforded to individuals with disabilities, pregnant women and children as permitted by current law. Uninsured individuals who are hospitalized should be able to apply for subsidized insurance at the hospital. The state should take the option provided in the ACA to qualify hospitals to make presumptive eligibility determinations for eligible individuals to the maximum extent permitted by federal law.

5. **Individuals that met the income guidelines established for Medicaid prior to ACA should have access to the essential benefits that will be covered for adults added to Medicaid under ACA.** *(See Appendix G for a comparison of essential benefits under ACA with benefits covered in various state programs currently.)*

### **ACA Provisions**

*The new law requires that individuals covered by the Medicaid expansion have access to at least those services covered under a “benchmark” or “benchmark-equivalent” plan as defined in Section 1937(b) of the Social Security Act. Plans used to establish the benchmark in Pennsylvania all offer some coverage of prescription drugs. In order to qualify to be offered on the exchange for purchase, private plans will be required to cover essential health services, to be further defined by the Secretary of Health and Human Services, but will definitely include prescription drugs.*

### **As It Is Now: Lack of Uniform Benefits**

Currently, there are 14 different benefit packages in the Medicaid program. Childless adults now eligible for Medicaid are generally not eligible for prescription drugs, medical devices and vision and dental services, unless they meet the disability standard for Supplemental Security Income benefits. This lack of uniformity of covered benefits creates issues of equity.

### **Recommendation:**

- The state should explore the feasibility of adding prescription drugs and other coverage included in the essential benefits package for the small group of Medicaid recipients now eligible for limited benefits to ensure equitable benefits by 2014. The enhanced federal reimbursement for the Medicaid expansion group (100% in 2014 through 2016, with gradual shift of 10% of the responsibility to the state by 2020) should make this financially feasible.
- The exchange should provide information and assistance to connect with publicly available prescription drug coverage through low or no-cost prescription programs offered by FQHCs, community health centers, nurse-managed clinics, pharmacies, retailers and drug companies,

6. Health plans that participate in the exchange should be expected to enable continuity of care for individuals and families with income below 400% of the federal poverty level.

### **ACA Provisions**

*Exchanges are responsible for implementing procedures for certifying health plans as qualified health plans that are consistent with federal guidelines. One of the criteria is that the plans ensure a sufficient choice of providers.*

### **As It Is Now: Lack of Continuity of Care**

Currently, families with children receiving health care coverage through CHIP and/or Medicaid have difficulty maintaining continuity of care when income changes or when the child has a birthday and coverage switches from Medicaid to CHIP or vice versa. This is because, in some instances, CHIP and Medicaid do not have the same provider networks. This makes it difficult for families and does not support optimal care, when primary care providers or specialists that were providing care previously are suddenly not accessible due to the switch in coverage.

### **Recommendations:**

- When eligibility for subsidized benefits changes in any direction, families and individuals should not have to change providers during a course of treatment and especially for those with incomes below 200% of the federal poverty level. Medicaid plans should have non-Medicaid plan partnerships that offer access to the same provider network.
- The exchange should consider how continuity of coverage can be encouraged through the process of qualifying plans for participation in the exchange.
- The Commonwealth should explore a new approach to coverage changes that allows for continued relationships with care providers through eligibility changes by making behind-the-scene adjustments to charge the correct plan for the cost of premiums.
- The state should re-assess the current requirements for Transition of Care coverage in the Medicaid Program and other health insurance programs to assure maximal continuity.
- The Commonwealth should explore how to require or strongly encourage the use of a uniform credentialing standard and clearinghouse for credentialing packets for all plans to facilitate continuity of care relationships, while reducing cost to payers and health care providers and maintaining quality.

7. The exchange should provide hands-on assistance in the community to inform employers and individuals about opportunities for health coverage and to help them to select a health plan.

### **ACA Provisions**

*Exchanges are required to set up a Navigator grant program to provide fair and impartial, culturally and linguistically appropriate information concerning enrollment in qualified health plans and available subsidies through the exchange, facilitate enrollment and provide referrals for complaints. To be eligible for a grant, an entity must demonstrate to the exchange that it has existing relationships or could readily establish relationships, with employers and employees, physicians, consumers (both uninsured and underinsured), or self-employed individuals likely to be eligible to enroll in a qualified plan. Grantees may include trade, industry and professional associations, farming organizations, community and consumer-focused non-profit groups, chambers of commerce, unions, small business development centers, and other licensed insurance agents and brokers (but may not be a health insurance issuer or receive any consideration from any health insurance issuer connected to the enrollment of individuals or employers in a qualified health plan).*

### **As It Is Now: Assistance for Consumers and Businesses**

Two hundred thirty-five (235) community-based organizations and health care providers currently act as partners and provide outreach and application assistance for Medicaid, CHIP and the Supplemental Nutrition Assistance Program in the communities they serve. In August, for example, they assisted 4,500 families or individuals to make application for benefits through COMPASS.

### **Recommendations:**

- The exchange should establish its Navigator program in a manner that provides fair, impartial, culturally and linguistically appropriate information concerning enrollment in qualified health plans and available subsidies through the exchange, facilitates enrollment in qualified health plans, and provides referrals for complaints.
- Special outreach efforts and enrollment efforts should be designed for small businesses.
- Community organizations that now serve as COMPASS partners should continue to be able to assist individuals to apply for subsidized insurance through the web portal.
- Safety net providers, such as FQHCs, community health centers and nurse-managed clinics should be encouraged to become sites that can assist consumers to enroll.

- The exchange should consider providing resources where needed to community agencies to help defray the cost of assisting consumers to enroll and select a plan.

## 8. Planning for the exchange should consider the needs of special populations.

### **ACA Provisions**

*States are required to conduct outreach to vulnerable and underserved populations including: children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.*

### **As It Is Today: Outreach to Special Populations**

COMPASS community partners conduct outreach to many hard-to-serve populations. Currently, some Medicaid MCOs make special efforts to reach out to vulnerable group members to assist them to complete renewal processes to maintain their health benefits.

The Department of Health (DoH) operates many programs to address the specific needs of individuals with specific diseases or special health care needs. (See Appendix H for a catalogue of programs for special health needs.) The Health and Human Services Helpline supported by DoH, PID, PDA, OLTL and DPW and the DPW's Office of Income Maintenance's Helpline currently provide consumers with help to connect to these specialty programs.

FQHCs provide access to comprehensive services, frequently including mental health and dental services.

### **Recommendations:**

- The navigator program should be used to do outreach to children, unaccompanied homeless youth, children and youth with special health care needs, pregnant women, racial and ethnic minorities, rural populations, victims of abuse or trauma, individuals with mental health or substance-related disorders, and individuals with HIV/AIDS.
- The hotline and website should accommodate the needs of individuals with disabilities and those with limited English proficiency. The exchange should also assure access for individuals with sensory, motor or other impairments that might restrict their ability to use the phone or the portal.
- The exchange should maximize the ability of technology to guide individuals with special health care needs and concerns to appropriate services. To the extent possible, application processes for special services

should be integrated with or linked to the application process for health insurance – with information from the health insurance application populating the application for other health services.

- Information about specialized health programs offered by the Department of Health should be accessible through the website, and the customer service helpline should be able to provide applicants with additional help to connect to these programs.
- Although the exchange is focused on providing access to insurance for adults under 65 and children, it should be able to connect senior citizens to other health care resources that are available through the Department of Aging and the Office of Long-Term Living, and CMS including, but not limited to:
  - APPRISE, which provides health insurance counseling to individuals over age 60 and answers questions about Medicare, Medicare Supplemental Insurance, Medicaid, and Long-Term Care Insurance;
  - PACE and PACENet, which provide prescription coverage to Pennsylvania seniors;
  - Home and community-based programs that enable seniors to obtain the services they need to remain in their own homes or in a community setting.
  - Long-Term Care facilities; and
  - Medicare.gov.
- The exchange should be able to route individuals with disabilities and their families to the full range of health care and other services available in Pennsylvania including, but not limited to, those provided through:
  - Consolidated Waiver for Individuals with Mental Retardation;
  - OBRA Waiver;
  - Person/Family-Directed Support Waiver for Individuals with Mental Retardation;
  - Attendant Care Waiver;
  - Mental Retardation Services (non-Medical Assistance);
  - Act 150 Program;
  - Infants, Toddlers and Families Waiver;
  - Independence Waiver;
  - Community Care Waiver (COMMCARE); and
  - Head Injury Program.
- The exchange should be able to direct individuals and family members to services available to address behavioral health issues through the county-based services systems and FQHCs, community health centers and nurse-managed clinics.
  - Substance Abuse Services
  - Mental Health Services



**9. A comprehensive communication plan is needed to prepare for implementation of the exchange.**

- The Commonwealth should conduct outreach and marketing to explain the importance of preventive care, how the purchase of health insurance permits and encourages access to health care, and the potential outcomes of receiving regular checkups, immunizations, etc.
- The Commonwealth should develop an outreach plan and implement a marketing campaign to reach small businesses and uninsured individuals well before the exchange is operational. This campaign should include town halls, regional and local forums to explain how the exchange will work and what assistance will be available.
- Outreach materials in multiple formats, including posters, pamphlets, and webinars, must be available for small businesses and individuals.
- Products available to consumers at reduced cost (Medicaid, CHIP and premium assistance) should be presented as health insurance products, not as “welfare programs.”

**10. Pennsylvania should carefully consider establishing a Basic Health Program for individuals with income up to 200% of the federal poverty level, rather than offering coverage through the exchange.**

**ACA Provisions**

*Section 1331 requires the federal HHS to establish a basic health program (BHP) under which a state may choose to offer, via contracts with insurers, health care coverage to individuals who:*

- *Are not eligible for Medicaid;*
- *Lack affordable comprehensive employer-based coverage (as defined by the ACA); and*
- *Have income at or below 200% of the FPL.*

*The plan(s) must cover at least the essential health benefits required for a qualified plan and would be selected through a competitive process. The state would have to ensure that the monthly premiums charged and cost sharing required did not exceed limits established in the law.<sup>13</sup> If the state opts to offer a basic health plan, eligible Individuals would be offered only the plan (or plans) that the state had selected to provide coverage for this*

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<sup>13</sup> The ACA sets the limit on Basic Health Plan premiums at the amount of the monthly premium the individual would have been required to pay if enrolled in the second lowest cost silver plan. Cost sharing cannot exceed that required under a platinum plan for those with income below 150% of the FPL and cannot exceed the cost sharing required under a gold plan for anyone else.

*group, instead of being eligible for a federal subsidy that they would use to purchase health insurance through the exchange.*

*The state is expected to coordinate its administration of the basic health plan with Medicaid, CHIP, and other state-run health care programs, to maximize efficiency and continuity of care. In return for administering the basic health plan, states will receive federal payments consisting of 95% of the premium tax credits, and the amount of any reductions in enrollee cost-sharing based on the formula in Section 1402, that enrollees would have received to enroll in exchange health plans. The state must place these payments in a trust fund, and use the funds only to cover premiums and cost sharing, or to provide additional benefits, for basic health plan enrollees.*

**As It Is Today:**

Pennsylvania achieves significant cost savings and attention to quality through the DPW contracting process used to select managed care organizations (MCOs) to deliver both physical health and behavioral health services for the Medicaid Health Choices program. PID selects commercial health plans to provide the specified health benefit package for CHIP and adultBasic enrollees through a competitive bid process. The reimbursement rates for providers are somewhat higher under this approach.

HealthChoices Medicaid managed care plans, CHIP insurers, and current adultBasic insurers might be interested in contracting for the new population using the same provider networks and similar contract terms. If a managed care approach is desired, Pennsylvania would need to expand managed care to all regions of the state. This would enhance continuity of care for a group of beneficiaries who experience frequent income fluctuations.

The Urban Institute estimates that for most states, the economies of purchasing coverage for this large new group with the basic health plan approach could have important benefits to consumers. First, this approach could achieve lower out-of-pocket costs for consumers – economies of scale achieved could make it possible to offer the essential benefits package with lower premiums and cost-sharing to participants. In addition, states may be able to negotiate extra services to improve health care quality outcomes, such as care coordination and care management for enrollees with chronic conditions and incentives for use of preventive services. Furthermore, this approach could enhance the continuity of care for a group of consumers that is prone to frequent income fluctuations. Other states that have purchased services for Medicaid expansion groups have achieved lower costs and enhanced quality through this approach

On the other hand, the basic health plan approach limits consumer choice and potentially removes an incentive for insurance companies to offer plans on the exchange. Adding this large new group of purchasers to the private market would make participating on the exchange more enticing for insurers. Including this large group in the new consumer pool for insurers via the exchange may also help to hold down premium costs.

**Recommendation:**

- DPW and PID should do an in-depth analysis of the potential benefits of providing a basic health plan and the potential impact on insurers' willingness to participate in the exchange, once the essential benefit package has been defined and the guidelines for basic health plans are issued by HHS, and this analysis should be made available to the public and the Legislature for consideration. Present information indicates that the state would receive 95% of the premium tax credit and reduction in cost sharing that the enrollee would have received through the exchange which is estimated to be \$4,940. The average, non-elderly, non-disabled adult cost for those receiving care under Medicaid for most states will be less than that. Thus, it may make sense to establish a Basic Health Care Program for those with incomes up to 200% FPL, if the state can leverage its buying power to purchase services at or below the amount the enrollee would have received for a premium tax credit and reduced cost sharing reduction, reduce the out-of pocket costs for consumers, improve benefits and increase coordination of plans and providers for consumers.

**11. Pennsylvania should take full advantage of the Long-Term Living provisions of the ACA.**

**ACA Provisions**

*Three major long term living programs and funding streams were established by the act that will help to support community living assistance.*

**a) Community Living Assistance Services and Supports (CLASS) Program**

*This voluntary insurance program will provide a cash benefit for eligible enrollees, which can be used to purchase community living assistance services and supports. Beginning in January 2011, individuals 18 and older who are actively employed will be auto enrolled. Employers as well as individuals may opt-out. Enrollee premiums will be paid through a payroll deduction. While HHS has not yet established premiums, low-income workers and employed full-time students may enroll at the minimum of \$5/month. There is a five year vesting period and individuals must have a certified functional limitation in their activities of daily living for benefits to commence. Benefits will be placed in an individualized Life*

Independence Account and beneficiaries will receive a debit card to access funds. The minimum daily benefit will be \$50/day and is expected to average \$75/day with no lifetime limit, indexed to inflation. Medicaid will be coordinated with CLASS and beneficiaries will receive half of the benefit simultaneous with Medicaid home and community-based services and 5% while in an institution.

**b) State Balancing Incentive Payment Program**

This is a first ever financial incentive for states to accelerate efforts to support home and community-based services (HCBS) and reduce institutionalization in the Medicaid program. The program has a fixed term: October 1, 2011 – September 30, 2015. States spending less than 25% of long-term-care expenditures on HCBS may apply for incentive payments of 5% additional federal match through the program's term if they agree to exceed 25% spending by the program's end date. Similarly, states between 25 and 50% spending for HCBS would qualify for a 2% incentive for meeting or exceeding the 50% threshold.

States must make the following structural changes within six months of application:

- "Single entry point" for information, referrals and applications for all long-term care services and supports statewide;
- "Conflict-free case management" across all affected HCBS programs that would likely separate service provision from service coordination; and
- "Standardized assessment" statewide and across programs for determining needs and developing service plans.

**c) Community First Choice Option**

Beginning October 1, 2011<sup>14</sup>, the Community First Choice Option will offer a 6% enhancement to a state's federal match for personal care and related services for states that:

- Offer personal care to eligible individuals over age 21 with up to 300% of the Federal Poverty Level in Pennsylvania (the same income level as the state's home and community-based waiver programs);
- Establish an Implementation Council with a majority consumer membership; and
- Monitor quality through health outcomes and incorporate consumer feedback.

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<sup>14</sup> It is likely that the date for starting this program will be delayed.

**As It Is Today:**

Pennsylvania ranks third in the nation for share of the population age 65 and older. Pennsylvanians do not tend to differ significantly from the national average for this age group on characteristics such as marital status, poverty status, and prevalence of disability and certain chronic health conditions. This means that a similar proportion of Pennsylvania's elderly population requires long-term-care services.

The ability of states to offer a wide range of to those needing long-term-care has a profound impact on the choices individuals are able to make and the costs incurred by the individual, their families and state and federal government. Staying at home or in the community generally costs far less than seeking services in a long-term-care facility, and is the preferred option for many consumers. As the baby boom generation reaches old age, the need for long-term-care services will grow significantly, as will the costs to the Medicaid program. With spending for long-term care in the Medicaid budget expected to exceed \$3 billion in 2010-11, developing alternatives to nursing homes will be critical, not only to provide consumers with real choices, but also to reduce the rate of growth of government spending on long-term care.

Few Pennsylvanians have individual long-term care insurance or a savings program that could be relied upon to help with the cost of care in the community should they be unable to care for themselves. With only limited funding available through the Medicare program, a majority of those who need long-term care find themselves quickly spending their resources, and eventually turning to Medicaid.

Since FY 02-03, when only 21% of Medicaid recipients of long-term living services received their care in home and community-based settings, Pennsylvania has focused intently on increasing families' options as to where and how they receive services. That percentage has steadily risen over these last eight years and now approximately 35,000 people, or 40% of Pennsylvanians receiving Medicaid long-term living services, will receive those services in their homes and communities.

This change in investment can also be seen in spending. In FY 02-03, Pennsylvania devoted only 8% of all Medical Assistance long-term living expenditures on home and community-based services – ranking us next-to-last in the nation. By way of contrast in the current fiscal year, Pennsylvania will likely increase that figure to nearly 24%. This dramatic shift is a result of our increased investment for home and community-based waivers by over \$600 million during that time. Despite a surge in the number of older adults in the Commonwealth, that investment has played a major role in reducing Medicaid-paid days in nursing facilities by two million over a decade.

*Nationally, states spend an average of 40% of their Medicaid long-term care budgets on home and community-based alternatives. That number is growing every year. Pennsylvania needs to continue to invest in home and community-based services in order to keep pace with the rest of the nation. When the state achieves the same level of balance as the average US state, Pennsylvania will save \$520 million annually.*

*As explained above, the ACA provides enhanced match to states that have not yet achieved a 25% benchmark in their spending dedicated to home and community-based services. Because Pennsylvania would likely meet the criteria, the Commonwealth could benefit from the higher matching rates for states to move to the 50% target in the State Balancing Incentive Program. The Office of Long-Term Living estimates a best case scenario of four year savings of over \$200 million from the additional federal match. However, if CMS includes services for individuals with intellectual disabilities, Pennsylvania would qualify for a smaller 2% incentive, and need a much greater investment to reach the 50% threshold.*

*Pennsylvania does not offer this personal care assistance as a state plan service under Medicaid. However, qualified individuals may receive personal care through home and community-based waiver programs that serve as alternatives to nursing facilities and intermediate care facilities for persons with intellectual disabilities. The waivers operated by the Office of Long-Term Living will spend nearly \$800 million in total funds this fiscal year. Personal care and related services account for over 80% of waiver costs in each program and is often much higher. It is estimated that the additional 6% FMAP through Community First could save over \$200 million in five years. However, the Commonwealth must balance creating a state plan entitlement with maximizing the additional match on existing expenditures.*

**Recommendations:**

- CLASS should be promoted by the Commonwealth as an opportunity for working adults to save for their future needs and assure control over their long-term services and supports in the setting they choose. Today, 68% of nursing home residents are on Medicaid. CLASS offers a real alternative for Pennsylvanians to take control of their future, direct their own care, and reduce Medicaid expenditures.
- Pennsylvania should continue its rebalancing initiative and should maximize federal funds available to do so. Because states have developed higher proportion of home and community based services for some populations than for others, but still have significant unmet needs, Pennsylvania should work to persuade HHS to take a flexible approach to implementation of the State Balancing Incentive Payment Program,

providing incentives for states to develop additional resources for populations that have fewer options.

- Pennsylvania should consider defining personal assistance as a state plan service available to all who qualify for it, and implementing the other changes required to qualify for enhanced match for these essential services under the ACA.

## **12. Planning for implementation of federal health care reform should assure appropriate program integration to reflect coverage of most Pennsylvanians by health plans with essential benefits.**

### **ACA Provisions**

*The ACA greatly expands the population in Pennsylvania covered by health insurance. In addition, the new law establishes an essential benefits package that must be provided by all qualified health plans. Essential benefits will be defined by HHS to include at least the following general categories and the items and services covered within these categories:*

- a) Ambulatory patient services;*
- b) Emergency services;*
- c) Hospitalization;*
- d) Maternity and newborn care;*
- e) Mental health and substance use disorder services, including behavioral health treatment;*
- f) Prescription drugs;*
- g) Rehabilitative and rehabilitative services and devices;*
- h) Laboratory services;*
- i) Preventive and wellness services and chronic disease management; and*
- j) Pediatric services, including oral health and vision care.*

### **As It Is Today**

Pennsylvania's Department of Health operates many small programs designed to take care of the needs of special populations with serious diseases. A chart in Appendix I provides details about these special health care programs. Some pay for care for individuals with particular serious conditions who are uninsured; some pay for discrete services which are in short supply or are very expensive; and still others help to pay for infrastructure needed to adequately treat a particular condition.

Some of these programs are funded entirely by federal dollars. Federal program guidance could change to make the programs line up with the new health care reform structure. There may be services that are now paid for within special health programs that may be considered essential benefits and paid for under all qualified health insurance plans.

**Recommendation:**

- The Commonwealth should conduct a systematic review of programs for special target populations operated by the Department of Health to assess the impact of federal health care reform and recommend appropriate changes in program design.



## Other Critical Reforms

As Pennsylvania takes the steps necessary to implement the federal health care reform law, it is important to simultaneously continue making progress on other strategies that will improve the quality of care and reduce health care costs. The reforms detailed below complement the Affordable Care Act and together will better serve consumers and taxpayers<sup>15</sup>.

### MAJOR FINDINGS AND RECOMMENDATIONS

#### 1. Implementing Payment Reform

Changing how Pennsylvania pays for health care is critical to improving the quality and value of care and to bending the cost curve. State government itself is one of the largest purchasers of health care in the state. By using an integrated set of payment reforms, the state is positioned to take a leadership role that will result in more collaboration among health care providers, improve primary and specialty care, reward high performing providers, more efficiently use taxpayer resources, and promote the restructuring of the health care system in Pennsylvania. Any payment reforms need to assure adequate health care provider networks and timely access to care.

Pennsylvania should reform how the state pays for health care (through Pennsylvania Employee Benefit Trust Fund [PEBTF], Medicaid, CHIP, adultBasic, Corrections, etc.) so that providers are reimbursed for increasing the quality and efficiency of care provided. This approach should include and be applied to both physical and behavioral health care. In order to maximize our health care dollars, efforts should be made to reduce the burden of preventable disease, make health care delivery more efficient, reduce nonclinical health system costs that do not contribute to patient care, and promote value-based decision making at all levels. In order to advance these objectives, the state should consider the following options:

- Paying for an entire episode of care. Right now, we often pay for individual services – like a doctor’s visit or a hospital stay. The federal health care reform law establishes a pilot program to start no later than January 1, 2013, to bundle payments for ten specific conditions so that a payment for each “episode of care” will cover acute hospital care, physicians’ services, outpatient hospital care, services such as home

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<sup>15</sup> There are many funding opportunities contained within the ACA for states and health care partners that can be used to support many of the goals outlined in this section. Appendix I contains a chart showing anticipated funding opportunities through ACA, which may help Pennsylvania to improve quality and bring down costs.

health, skilled nursing, inpatient rehabilitation, care coordination, medication reconciliation and discharge planning for three days before the hospital admission and 30 days following discharge. Pennsylvania should work even more quickly to pilot bundled payments for certain hospital stays, including a post-discharge period of time (e.g., 30 days), in order to encourage health care providers to collaborate, eliminate avoidable complications and provide better care. Hospitals and other health care providers would be encouraged to coordinate care to minimize readmissions by arranging for home health care or other step down care. The 2009 Pennsylvania Hospital Performance Report found 58,084 hospital readmissions in 2009 representing 343,000 hospital days for which hospitals charged \$2.6 billion. The readmission rate for 15 commonly reported conditions was 19.2%, with congestive heart failure the highest at 27%. By providing a bundled payment, Pennsylvania would be offering hospitals, physicians, home health agencies, etc., the opportunity to share the savings from reducing readmissions, including readmissions for complications from infections (21,688 in 2009 for Pennsylvania).

- Linking payment to performance, with performance evaluated by evidence-based process and outcome measures, patient satisfaction measures and an assessment of organizational structures known to improve quality. Continued development and implementation of health information technology will facilitate this initiative. To achieve more affordable, better quality health care, we must pay for the evidence-based care and outcomes we want. Paying fee-for-service payments encourages unnecessary volume of care, wastes resources, and results in unacceptably wide variations in safety and quality. Payment needs to encourage the kind of care that is proven to keep people healthy and reward high quality, efficient care and effectively controls cost. Pennsylvania should work with other payers and providers to agree on uniform performance measures, where appropriate and possible, to minimize distraction and administrative difficulty for health care providers. This should include consideration of federal performance measures as the basis for agreement.
- Encouraging and adopting non-monetary incentives for health care providers who provide quality care and efficiently and effectively use medical resources, such as elimination of prior authorization and prior certification requirements, e.g., gold card providers.
- Sharing cost savings achieved by improved health care quality and efficiency with the providers that made the savings possible. Pennsylvania should gradually increase the percentage of revenue potentially available to health care providers from shared savings programs in order to provide an incentive for improving the quality of care while reducing health care costs. It is important to require achievement of attainable benchmarks for health outcomes, utilization and process criteria to qualify

for shared savings in order to guard against adverse health outcomes that result from inappropriately limiting necessary access to care. Savings from avoidable hospitalizations, readmissions and emergency department visits should be an integral part of this effort and should optimally involve as many integrated and other providers as possible.

- Paying providers more for efficiently and effectively treating sicker patients. Any payment methodology needs to be risk adjusted to acknowledge the extra effort needed to effectively and efficiently treat sicker patients.
- Exploring incentives for primary care providers to provide behavioral health care for stable patients in the medical home setting. (This recommendation does not imply that it would replace the need for separate behavioral health providers caring for other behavioral health patients.) Patients needing behavioral health care may not accept referrals to behavioral health providers because of the stigma they may feel in seeking that care. Primary health care providers are ideally situated to identify behavioral health care needs with their patients and provide some of that care in the primary care setting, which may be more comfortable to the patient. For instance, depression can interfere with a patient's ability to self manage a chronic condition. By screening for and treating depression, the primary care provider can help the patient improve care for the chronic condition.
- Joining with other payers and providers in a common risk-adjusted payment methodology that could include the components listed above to help drive more efficient, quality care and encourage administrative efficiency. Providers can be faced with numerous pay-for-performance initiatives sponsored by the various payers, which focus on different conditions and use different performance measures. This is very distracting to providers and leads to providers focusing on some patients, but not on others. All payer initiatives have the advantage of aligning all payers and participating health care providers in a shared focus to improve health care quality and bend the cost curve. Multi-payer initiatives can be a much more powerful force to reorganize how health care is paid for and delivered. Wherever possible, use of national standards, such as National Quality Forum-endorsed standards, National Guideline Clearinghouse, and meaningful use standards, should be used.
- Exploring the development of a pilot using Department of Health and Pennsylvania Health Care Cost Containment Council data and **Population Based Payment**<sup>®</sup> (a payment methodology which compensates health care practitioners for providing an agreed-upon set of services for a specific population of covered beneficiaries for a specific period of time). Using a county or a specific set of zip codes, historical (3-5 years) claim cost experience is actuarially determined. Performance targets (clinical and financial) are established and a provider network is

engaged. Providers participating under this payment methodology are paid on a fee-for-service basis that is reconciled against established financial targets. If both clinical and financial targets are met, providers organized via clinically integrated panels share in the savings.

- Driving delivery system reform through innovation, collaboration, and process improvement on the front lines of care. Payment reform should drive delivery system reform by incentivizing innovations and best practices, promoting collaboration among front-line staff and managers, and reorganizing health care services in ways that result in process improvement and better outcomes for patients. Payment systems should take account of the well documented link between adequate nurse staffing and quality of care

The American health care system is inefficient and does not provide comparable health outcomes for its citizens. The largest limiting factor is not a lack of money, technology, information, or even people, but rather a lack of an organizing principle that can link money, people, technology and ideas into a system that delivers more cost-effective care (meaning value) than current arrangements.<sup>16</sup>

There are many ways to organize to provide better quality, less expensive care. See, for instance, the discussion of the Patient-Centered Medical Home/Chronic Care initiative below. Another method, piloted in the federal health care reform legislation, is Accountable Care Organizations (ACOs). An ACO is an organization of health care providers that agrees to be accountable for the quality, cost and overall care of its patients and to meet quality performance measures and is eligible to share realized savings. Normally, health care payers cannot get together to determine what they will pay health care providers because of antitrust laws. One way to address this is if the state convenes and supervises the discussions for the public good.

The next administration should play an important role in facilitating better organization and accountability for care by:

- Charging a high-ranking official in the Governor's Office with bringing payers and providers together with accountability to drive payment reform that reduces costs and improves quality. This should include convening interested multi-payers and providers to initiate an ACO or similar organizations to provide the antitrust protection necessary for those

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<sup>16</sup> S. M. Shortell and J. Schmittdiel, in: *Toward a 21st Century Health System: the Contributions and Promise of Prepaid Group Practice*, A. C. Enthoven and L. Tollen, eds. (San Francisco: John Wiley & Sons, 2004)

discussions and efforts and to look at eliminating unnecessary impediments to successful ACO formation and operation.

- Establishing a multi-payer claims database to provide a better understanding of health care cost drivers and to assist in identifying costs in the system that are not medically effective and permit population-based payments. A number of states have created multi-payer claims databases to support quality improvement efforts and to reduce costs. These databases use readily available claims data and provide important information on utilization and cost. Details on who could access the data and for what purposes would need to be carefully determined.
- Exploring how to create a scientifically valid value-based ranking of health care providers on quality and efficiency that can be offered to the public and to payers. Such a ranking could be a tool for payers that wish to offer reduced cost sharing for enrollees who seek care from the highest rated providers. Pennsylvania should study the experience and lessons learned from other states (especially Minnesota and the Rand critique) to determine if this would be feasible in our state.
- Creating a commission with representation from all appropriate stakeholders to recommend the best cost and quality measures to be provided by the exchange to assist consumers in selecting health care plans and health care providers. PHC4 provides charge information but not actual cost, and it provides very little information about the quality of outpatient providers. It is critical that Pennsylvania quickly determines how to produce quality and cost data needed to assist consumers using the exchange to make informed choices of health care plans and to use market forces to help reduce health care costs and drive quality improvement. It is also critical to minimize the data reporting burden for providers and to simplify the information for optimum consumer use.

## **2. Transforming Primary Care and Improving Chronic Care and Transitions of Care**

Everyone needs an accessible primary health care provider who knows the patient's medical history and who works with the patient to ensure that care is timely, coordinated, appropriate and centered on the patient's needs. This approach to primary care is called a "patient-centered medical home." The Pennsylvania Governor's Office of Health Care Reform has been working with 900 primary care practitioners and all major payers (except Medicare fee-for-service) to transform primary care in Pennsylvania in those practices to patient-centered medical homes for the 1.4 million patients they serve, and to change payments for primary care to encourage the use of interdisciplinary teams, patient registries, assistance with patient self-management and embedding care coordinators in the practice. The primary care practices are participating in nine learning collaboratives

across the state, attending regular training sessions, submitting monthly health process and outcome data, and participating in monthly conference calls with quality improvement experts who review their monthly data. This effort has resulted in a significant increase in delivery of evidence-based care to patients with chronic conditions keeping them healthier and out of the hospital, improving their blood pressure, blood sugar, cholesterol levels and engaging patients in doing what they can to improve their care. This initiative tests the ability of primary care practices to increase the quality of care while reducing costs by preventing chronic disease complications and resulting hospitalizations. To build on this effort, Pennsylvania should:

- Continue the Chronic Care/Patient-Centered Medical Home (PCMH) Initiative. This initiative has significantly improved process and health outcome measures and has provided invaluable insight into effective tools practices can use. The Commonwealth Fund is funding a study by Rand to also evaluate the impact of this initiative on bending the cost curve. If the longer term results are promising, this initiative should be spread and sustained across the state.
- If the results are promising, work with medical schools, residency programs and other health professional schools in the Commonwealth to include teaching and training in the PCMH/Chronic Care models in their curricula. In addition to retraining interdisciplinary primary care staff in the field, Pennsylvania should do what it can to assure that newly graduated primary care providers are trained in the PCMH/Chronic Care models.
- Encourage, as quality of care and cost reduction information indicates, all plans/insurers, public and private, under contract with the Commonwealth to fully participate in the PCMH/Chronic Care initiative. Although an excellent beginning has been made with the 900 primary care providers involved to date, Pennsylvania should encourage further involvement so that PCMH is the norm in Pennsylvania and not the exception.

Beyond the Chronic Care/Patient-Centered Medical Home Initiative, these are additional steps to consider in regard to improving both access and quality in health care:

- Provide enhanced reimbursement to primary care practices to embed care managers in their practices to support the highest risk patients and to improve care transitions at the community level. Eighty percent (80%) of all health care costs are for 20% of patients who have multiple chronic conditions. These patients often unsuccessfully try to navigate a very fragmented health system with only their family helping them coordinate care in a system they don't understand. One of the most cost-effective investments for primary care is to fund a care manager located in the

practice. Care managers work with patients at highest risk for hospitalization, readmission and care transitions to help them find quality, cost-effective solutions that are congruent with patient wishes.

- Explore the concept of using the community hospital as a Primary Care Support Center. Community hospitals stand to lose admissions as chronic disease management reduces hospitalizations and readmissions. However, in other countries, there are successful models of Primary Care Support Centers that offer services that small primary care practices (PCPs) cannot (e.g., clinical pharmacy, behavioral health screenings, team interventions, care management). Both community hospitals and federally qualified health centers (FQHCs) offer promising venues for providing easily accessible, quality support services to the small practices in which the majority of our PCPs practice. This would also be a means to maintain the community hospitals whose financial situation is often precarious and will continue to decline if admissions are significantly reduced.
- Facilitate ways for hospitals, psychiatric facilities, long-term care facilities, pharmacies, pharmacy benefit managers, etc., to electronically send or fax discharge summaries to the patient's primary care practitioner/behavioral health care provider at time of discharge to facilitate better transition in care. Significant and costly readmissions can be avoided if primary health care and behavioral health care providers are promptly notified of discharge details such as diagnosis, clinical course, and medications given so that these providers can contact the patient within 24-48 hours of discharge to do medication reconciliation and arrange for follow up care. Similarly, information from primary care physicians about a patient at time of an emergency department or other hospital admission will result in better care.
- Examine and eliminate barriers to appropriate integration of behavioral and physical health, consistent with patients' rights to confidentiality.
- Take advantage of the new Medicaid incentive for high-need patients to designate a medical home. The state plan option permits Medicaid enrollees with at least two chronic conditions, one condition and risk of developing a second, or at least one serious and persistent mental health condition, to designate a provider, including the behavioral health provider, as the patient's medical home. This initiative provides 90% federal matching money for several years and would be a way to stretch limited state funds while improving care for the most vulnerable Medicaid enrollees.
- Address the high readmissions rate of recurrent hospitalizations among HIV/AIDS patients by activating the state-funded community-based organizations (CBOs) with Ryan White funds to form a learning collaborative to address this issue.

## 5. Supporting Safety Net Providers

The Institute of Medicine defines safety net providers as:

*"Those providers that organize and deliver a significant level of health care and other health-related services to uninsured, Medicaid, and other vulnerable patients."*

In particular, they define a group of "core safety net providers":

*"These providers have two distinguishing characteristics: (1) by legal mandate or explicitly adopted mission they maintain an 'open door', offering access to services to patients regardless of their ability to pay; and (2) a substantial share of their patient mix is uninsured, Medicaid, and other vulnerable patients."*

Safety net providers can be the only point of access to primary care for the uninsured, underinsured, or those in medically underserved areas. The present economic situation and the increasing cost for employers to provide employer-based health care coverage has led to a sizable increase in the number of uninsured in Pennsylvania. With the extension of coverage in 2014, the number of uninsured will be significantly reduced, but not eliminated, and the many Pennsylvanians who are newly covered will continue to rely on safety net providers, especially FQHCs, nurse-managed centers and community health centers for access to primary care, and on behavioral health providers for mental health and substance abuse issues.

Pennsylvania should use the next three years to fortify its safety net providers, including maximizing resources for FQHCs in Pennsylvania, by:

- Providing planning grants and technical assistance to existing FQHCs that want to expand into other areas, and to communities in seriously underserved or under resourced areas that need and want to have an FQHC. There is \$9.5 billion in federal money available to double the number of FQHC's and planning support and technical assistance are needed to ensure that Pennsylvania can leverage as much of that funding as possible.
- Working with the Pennsylvania Association of Community Health Care Centers to identify access problems with dental, behavioral health, diagnostic testing, and hospital services that clinics are having for their patients and to remedy these problems. Several states have been successful in working with professional health care organizations (of both primary and specialty providers of care) to get their members to



- agree to take a “fair share” of appointments for the uninsured, underinsured or those on Medicaid fee-for-service. Scheduling software, used by Connecticut and Wisconsin, allows FQHCs to make limited appointments with participating specialists for the uninsured.
- Working collaboratively with existing state programs and partners to refer Pennsylvanians on waiting lists or who do not qualify for coverage to the FQHC’s toll-free number and to nurse-managed and other community health resources that provide sliding scale or free medical care. Increased collaboration can help ensure that no one in Pennsylvania has to go without primary care.
  - Staying competitive with other states by increasing the amount available and the number of slots for the health care professional loan repayment programs for all needed providers that work in medically underserved areas and by providing enhanced repayments for those graduates trained in Pennsylvania schools. Students graduating from health professional schools are doing so with increasingly large student loans. In many cases, the only way they can even consider working for a safety net provider or in a medically underserved area with lower earning potential is to receive help paying for their student loans. Every state around us has these programs and has increased both the amount of loan eligible for repayment and the number of slots, making it difficult for Pennsylvania to compete. It is important that Pennsylvania stay competitive with other states’ loan repayment programs and significantly increase the number of slots funded, so we can attract health care providers in anticipation of the large increase of people seeking health care in 2014.
  - Creating a technical assistance center for FQHCs and other safety net providers to offer assistance with business operations and financial management. Many safety net providers are in fragile financial shape, often lacking the financial and business skills to improve their position. As we move towards the influx of the newly insured in 2014, it is critical that assistance be given to financially fragile safety net providers to improve their ability to manage and maximize their resources.
  - Applying for a federal waiver, as Montana has done, that permits FQHCs to provide ancillary services to small primary care practices. FQHCs can provide services beyond the reach of small primary care practices because their staff includes social workers, care managers, dental hygienists, behavioral health providers, etc. Practices in Montana are able to refer their patients to the FQHC for these ancillary services without losing their patient for other primary care needs which the practice can meet.

## 6. Giving Consumers Tools to Make Informed Decisions

Informed and engaged consumers can play a vital role in improving the quality of health care in our Commonwealth and in improving their own health. To do so, consumers must make decisions about their choice of health plan, choice of health care provider, choice of treatment and choice of whether to actively participate in the management of their own health. The Chasm Report of the Institute of Medicine in the United States contains the following two passages:

*“Patients should be given the necessary information and the opportunity to exercise the degree of control they choose over the decisions that affect them. The health care system should be able to accommodate differences in patients’ preferences and encourage shared decision making.”*

*“The health care system should make information available to patients and their families that allow them to make informed decisions when selecting a health plan, hospital, or clinical practice or when choosing among alternative treatments. This should include information describing the system’s performance on safety, evidence-based practice, and patient satisfaction.”*

Pennsylvania should:

- Assist consumers to make an informed choice of plan through the exchange. The information provided must allow easy comparison of plans based on cost and quality, and services covered.
- Determine the best means of providing easy-to-use information to consumers, so they can pick their health care providers using timely cost and quality information. This information is currently unavailable.
- Develop pilots on shared decision making. The Dartmouth Atlas has documented unjustified variation in medical practice and use of medical resources in the United States (not clear what this sentence means). There is too little use of proven, effective care, overuse of supply-sensitive care (where there are more hospital beds, surgeons, specialists, etc., than may be needed) and misuse of preference-sensitive care (where there are significant tradeoffs among various options, that are not adequately explained to the patient). This problem leads to significant additional costs and outcomes that are unwanted by the patient. The use of impartial, medically accurate materials and counseling has been proven to reduce costs and to result in outcomes consistent with the patient’s values. Further research

- is needed to expand clinical knowledge and focus on best practices to decrease unnecessary variation.
- Continue to train primary care provider teams to help patients set and achieve goals (e.g., medication compliance, weight loss, exercise, nutrition) that will lead to improved health.

## 8. Reducing Medical Errors and Implementing Other Means of Improving Health Care

Other recommended initiatives that will reduce medical errors or are other means of improving health care include:

- Eliminate perverse payment incentives for National Quality Forum’s list of 28 “Never Events.” Pennsylvania should stop paying for any care related to health-acquired infections or other medical errors, consistent with national best practices. It is critical that Pennsylvania eliminate the perverse financial incentives of paying more money for care due to medical errors and fully implement Act 1 of 2009.
- Improve performance through data and evidence. Pennsylvania should foster and build data collection and reporting capabilities with analytics to be able to rapidly determine and share the impact of reforms on cost and quality, first by using existing data sources and improving and supplementing the data as it becomes available.
- Support quality improvement initiatives of providers. The state should support and make providers aware of initiatives such as value stream mapping, Six Sigma, tight targets for lean provision of care and other business initiatives to improve quality and efficiency.
- Revise and update the Department of Health’s Hospital Regulations. For the most part, Pennsylvania’s hospital regulations are over two decades old and do not reflect current hospital quality requirements. Pennsylvania should develop model regulations to improve the quality of care in hospitals, including consideration of requiring hospitals to institute checklists modeled on the aviation industry to improve quality and requirements to eliminate medication errors.
- Align Pennsylvania’s reforms with the Institute of Healthcare Improvement’s Triple Aim. The Institute for Healthcare Improvement (IHI) urges health care reform efforts to simultaneously accomplish three key objectives (thus the “Triple Aim”):
  - Improve the health of the population;
  - Enhance the patient experience of care (including quality, access, and reliability); and
  - Reduce, or at least control, the per capita cost of care.

IHI identified five components for a system that would meet the Triple Aim (See Appendix J for a more detailed description of these components):

1. focus on individuals and families,
2. redesign of primary care services and structures,
3. prevention and health promotion,
4. cost control platform and
5. system integration

Pennsylvania's health care reform efforts should be crafted to build these necessary components for achieving the Triple Aim into all segments of the health care delivery system.

- Encourage/require/reward frontline staff for taking a basic web-based course on safety science and quality improvement techniques. Existing courses are certified, interactive, and appropriate for frontline staff and will help reduce the high cost and human cost of preventable errors.
- Pennsylvania should create a more patient-focused environment for pain management for persons at the end of life by:
  - Creating pain-management standards for nursing facilities, quality indicators for end-of-life care and training for staff on palliative/hospice care. Too often nursing home residents at the end of life suffer in pain or are transferred to a hospital because the staff has not been adequately trained in palliative/hospice care.
  - Ensuring Medicaid and other state-funded health care payment for palliative/hospice care in a variety of settings. Pennsylvania should support payment to make consumers as comfortable as possible at the end of life in all appropriate settings.
  - Reviewing and revising laws and regulations which put undue restrictions on medical decision making regarding palliative/hospice care. Well-meaning laws to prevent prescription abuse can keep consumers at end of life from getting needed pain relief.
  - Making Education on Palliative/Hospice and End-of-Life Care (EPEC) Project training widely available and eligible for continuing medical education (CME) credits. EPEC training is online training for health care providers to increase competency in providing palliative care.
  - Exploring opportunities to educate consumers, families and providers on palliative/hospice care end of life care options, including the Physician Orders for Life-Sustaining Treatment Paradigm (POLST )and making this information widely available.

## 9. Ensuring the Workforce Can Meet Emerging Health Care Needs

Although the federal government is providing significant funding to address current and future health care workforce issues, much of the leadership, analysis and planning will need to be done by the state. Pennsylvania should:

- Quickly determine what additional health care providers by category and region will be needed to meet the increased demand due to an aging population, increased prevalence of chronic conditions, and extension of coverage to the uninsured starting in 2014, and develop a plan to meet those needs. Where appropriate, consider expanding the scope of practice of health care providers to meet these needs while ensuring quality of care, cost effectiveness, and patient safety. This should be done through the Center for Health Care Careers, which was created by law for this purpose and has board member representatives from all critical health care providers.
- Revise scope of practice laws and regulations to ensure that health care providers can practice to the extent of their education and training. Although Pennsylvania's scope-of-practice laws have recently been revised, more work is needed to maximize the skills and deployment of every member of the current health care workforce to the fullest extent of their training and individual capabilities, consistent with quality and safety of the patient.
- Support pilots to improve outpatient services by utilizing ancillary personnel (e.g., office staff, medical assistants, care coordinators, etc.) in collaboration with licensed professionals to decrease costs and increase quality of health care services.
- Support use of a consultative model for physical therapists, occupational therapists, speech therapists to instruct patients, parents, family, teachers, etc., in therapies for them to perform on a daily basis.
- Encourage the growth of family practice, internal medicine, pediatric, nursing, psychiatry, OBGYN, geriatric and adolescent medicine programs in Pennsylvania's medical schools and social work and counseling for behavioral health care. The state should specifically foster development of additional interdisciplinary primary care providers focused on disease prevention and care coordination for chronic illness with specialists.
- Promote health care as a future career in junior and high schools.
- Promote medical malpractice liability reform, such as an apology law.
- Provide medical malpractice liability relief for critical care providers in short supply, such as OBGYNs and neurosurgeons.
- Address pay and benefit issues for direct care workers and personal care assistants. To avoid expensive and unwanted nursing facility care,

- Pennsylvania must work with others to address pay and benefit issues that help in the retention and recruitment efforts for these critical health care providers.
- Support efforts to improve performance of skilled nursing facilities, including efficiency, safety and clinical care, and productivity. This involves using successful models for transforming care that include training and coaching, and which would yield better care at lower cost.
  - Leverage all opportunities for grants and federal assistance to recruit, retain and train health care workers. The state and individual health care professional schools should apply for available funding opportunities. Pennsylvania should work with Pennsylvania schools, labor-management training partnerships, health care provider associations, and other training organizations to maximize federal funding.
  - Promote and support labor-management partnerships to ensure that workers who directly serve patients have a voice in delivery innovations, worker training and quality improvement strategies. Such collaborations can lower cost and improve quality by driving process improvement, increasing patient satisfaction, promoting workforce stabilization, and reducing workplace injuries.
  - Support transition to electronic health records and prepare health care workers to make the best use of new technologies. As health care systems transition to electronic health records and the health information exchange, a growing workforce of information technology workers with working knowledge of the health industry will be needed. Frontline workers from doctors to home health attendants will need support and training to effectively use the new technologies.
  - Create strategies to address public and private health care worker shortages in rural and urban areas.
  - Increase training capacity for allied health occupations where shortages currently exist.
  - Assist employers in developing initiatives that create an environment of learning for organizational boards, administrators and clinical staff in regard to embracing principles that transform organizational cultures to incorporate employee retention principles.
  - Reinstitute grant programs for nurses seeking advanced degrees to become nurse practitioners, nurse faculty and nurse researchers to meet projected shortages by 2013. This is consistent with recent recommendations from the Institute of Medicine Report and supported by data from the PA Center for Health Careers.
  - Change training requirements so that home health aides/nurse aides working in acute care, home health care and long term care have the same curriculum for entry into the health care system. This will allow

- mobility within the system and address one of the primary retention issues related to direct care workers.
- Consider changing the requirement that requires a licensed nurse to care for persons receiving feeding by gastrostomy tubes or performing self catheterization to allow home health aides, educational assistants, as well as families to be trained to do so.

## **10. Health Information Exchange and Electronic Health Records (EHRs)**

Clinicians need up-to-date clinical information to treat their patients. Pennsylvania has been awarded \$17.1 million in federal funds for the creation of the Pennsylvania Health Exchange (PHIX) that will provide the electronic highway that will allow clinicians to share information to improve health care and lower costs. PHIX should be governed by a public-private board, including representative stakeholders who use PHIX.

- The General Assembly should quickly pass legislation creating an authority for the operation of the Pennsylvania Health Information Exchange to maximize federal incentive payments to health care providers with electronic health records to use the exchange. The authority should have the power to assess subscription fees as one possible method to pay for PHIX's operation.