The Impact of Health Care Reform on State Operations

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Executive Summary

Driven by steadily increasing numbers of uninsured and the continuing escalation of health care costs, health care reform remains at the forefront of state and national legislative agendas. At the time of publication, the prospects for federal health reform remain unclear, leaving states to consider and plan for two different scenarios. If comprehensive or incremental federal reform is enacted, states will likely play a key role in implementing those reforms. If not, states will likely continue to work independently to address the challenges of rising rates of uninsured and increasing health care costs. While a wealth of articles and analyses about how to design effective health care reform initiatives is available, relatively little has been published about the operational aspects of health care reform. This issue brief draws on the experiences of states who have implemented major reforms to provide insights into the operational aspects of reform and share key lessons for state policymakers.

The "nuts and bolts" of policy reform are critical. Effective implementation of policy reform can mean the difference between success and failure. This issue brief looks at what must happen operationally in a state once policymakers resolve various issues. It identifies key questions that policymakers should ask when considering health care reform. Drawing on the experiences of five states that have implemented major health care reform, it identifies not only the key questions that policymakers should ask when considering health care reform but also a set of related takeaways. The questions and takeaways are relevant to both state and national reform initiatives, in part because state governments are typically charged with implementing reforms and state experience offers insight into the overall design of reforms. Understanding these issues is particularly critical now as the potential enactment of federal reform will have enormous implementation implications especially for states.

The wide variation among state health care systems means that the approaches taken by states to implement health care reforms—and to respond to the associated operational challenges—differ from state to state. Nonetheless, some of the takeaways are particularly salient and should be carefully considered by state and national policymakers when developing health care reform:

- Allow sufficient time—7 to 8 months at a minimum, although 12 to 18 months is ideal—to implement information systems changes. Most systems' challenges seem to relate to timely and accurate data collection and sharing as well as to premium collection. Health reform is a moving target that requires flexible information systems as states contend with the implementation of health information technology initiatives.
- Consider contracting with health insurers whose infrastructure can accommodate the changes associated with premium collection, eligibility tracking, claims processing and payment, and with maintaining extensive provider networks. Reliance on insurers can reduce state administrative burdens and the need to create and staff new functions and, in turn, can help expedite program implementation. Contracting with insurers experienced in state government contracting can further expedite implementation.
- Coordinate the work of the numerous state agencies involved in the health care reform initiative. The lead state agency must be vested with the authority to coordinate efforts and share data. The agency should recruit state staff versed in commercial market issues, such as from the Department of Insurance, to help expedite dealings with commercial insurers. In addition, if hiring additional state staff is a challenge, the lead agency should refocus state contractors' responsibilities and reallocate staff among and within agencies to make the most productive use of available resources.
- Simplify eligibility determination and enrollment to encourage participation. Online enrollment has shown promise in maximizing consumer participation.
- Reach out creatively to potential consumers. With the funding of long-term marketing campaigns unlikely, involve local community organizations and the business community, developing the flexibility needed to adapt outreach strategies as health care expansions change and information about the target population's response becomes available.
- Involve state departments of labor and revenue, if applicable, in promoting employer assessment and Section 125 strategies. Materials for employers and consumers should be as straightforward and streamlined as possible. Section 125 requirements are particularly complex and thus pose a communication challenge.
- Develop program evaluation and reporting plans before implementation. State agencies should collect data from employers, insurers, or others during ongoing program operations to allow for any mid-course corrections.

Our findings are extensive, and the strategies successfully used by states may seem obvious to readers. But this inventory of state approaches (detailed in the body of this issue brief and in the appendices) and questions and takeaways can provide policymakers and state staff with a useful resource for navigating the complexities of designing and implementing a health reform program, especially given tight deadlines and limited resources.

Introduction

Health care researchers, policymakers, and the mainstream media have published a wealth of articles and analyses about how to design effective health care reform initiatives. At the same time, relatively little has been published about the nuts and bolts of how to implement and operate such initiatives. Thus, this issue brief focuses on many of the operational issues that state governments must address when implementing health care reforms.

The framework and insights presented in this brief apply to state and national health care reform. States are often the "test pilots" for innovative reform strategies that eventually work their way to the national level, as illustrated by federal policymakers' ongoing scrutiny of health care reform in Massachusetts. In addition, the federal-state intergovernmental partnership—a key component of the U.S. health care system—means that any national reform will likely involve the participation of state governments.[1] While the federal government provides the regulatory structure and considerable funding for health care services for low-income populations, state governments also fund these services and are largely responsible for the delivery of care.

Throughout this issue brief, we highlight some of the key questions and takeaways that health care policymakers should address (see Appendix A). Our findings are extensive, and many of the strategies successfully used by states may seem obvious, but they can nonetheless provide policymakers and state staff with a useful resource as they navigate the complexities of designing and implementing a health reform program, especially in the context of tight deadlines and limited resources.

Takeaways Applicable to All States

- Allow sufficient time—several months at a minimum—to implement information systems changes
- Consider contracting with health insurers
- Establish a strong coordination process among state agencies and provide the lead agency with sufficient authority to coordinate efforts and share data
- Involve state staff knowledgeable of commercial market issues
- Simplify eligibility determination and enrollment processes, with a special focus on online enrollment
- Find creative ways to reach potential consumers by involving local community organizations and the business community
- Involve state departments of labor and revenue in developing employer assessment and Section 125 plan policies
- Develop program evaluation and reporting plans before implementing reforms

The five states that are the subject of this issue brief—Massachusetts, New Mexico, Tennessee, Vermont, and Wisconsin—represent a wide range of health care reform initiatives implemented over the past few years. The initiatives include expansions of existing public programs, implementation of new health insurance plans, employer assessments, and—in the case of Massachusetts—a requirement that all residents obtain health insurance (individual mandate). Table A summarizes the key components of the state reform initiatives.

State health care systems vary widely; therefore, not surprisingly, their operational challenges likewise demonstrate broad variation. While some major takeaways are applicable to all states, others relate to state-specific characteristics. Differences in demographics, provider and insurer markets, and commonly held political views, among other factors, mean that there is no "one size fits all" solution to state operational challenges. For example, unlike states that have historically coordinated efforts with insurers, a state that has not used health insurers to support its CHIP and Medicaid programs may encounter contractual and information systems challenges when contracting with insurers to implement new health insurance options.

The key takeaways and questions presented in this issue brief are organized by major operational component:

- Section 2: Eligibility and Enrollment
- Section 3: Use of Health Insurers
- Section 4: Marketing and Outreach
- Section 5: Staffing and Coordination of Reforms
- Section 6: Employer Assessment and Section 125 Policy Considerations
- Section 7: Reporting and Evaluation

Table A: Overview of Reform Initiatives in Featured States

	Tennessee's CoverTN	New Mexico's State Coverage Insurance	Wisconsin's BadgerCare Plus	Vermont (comprehen-sive)	Massachusetts (comprehensive)
Children's Health Insurance Program (CHIP)/ Medicaid expansion		X	X	X	X
New state-sponsored health insurance product(s)	X	X	X	X	X
Premium subsidies for new product	X	X	X	X	X
Employer assessment				X	X
Individual mandate					X

Overview of Featured States

Wisconsin used its Medicaid and Children's Health Insurance Program (CHIP) BadgerCare program as a foundation to expand coverage options to all children, parents up to 200 percent of the federal poverty level (FPL), pregnant women up to 300 percent FPL, and childless adults up to 200 percent FPL. Premiums vary by income and population group. Consumers at the higher-income end of the expansion receive a "benchmark plan" with benefits consistent with those of the largest commercial plan offered in the state. The new consolidated program–BadgerCare Plus– uses the managed care delivery system developed for BadgerCare and other family Medicaid programs, streamlines eligibility and enrollment functions, combines a wide variety of federal and state funding streams, and markets existing and new public program options under the single BadgerCare Plus "brand."

New Mexico implemented a comprehensive benefit health insurance plan—State Coverage Insurance—available to small employers with 50 or fewer employees and individuals below 200 percent FPL without employer coverage. Premiums vary with the individual's income level and are paid by participating employers, individuals, and state and federal CHIP funds.

Tennessee implemented a limited-benefit health insurance plan—CoverTN—that is open to small employers with 50 and fewer employees, the self-employed, and individuals working for companies that do not offer employer-sponsored insurance. The state uses a fully-insured product with a commercial network, and program costs are funded entirely by individuals, participating employers, and state funds. Unlike New Mexico's State Coverage Insurance program, CoverTN does not involve CHIP or Medicaid funds.

Vermont and Massachusetts implemented far-reaching "packages" of health care reforms, including an assessment on employers not offering coverage and state-sponsored health insurance plans that are subsidized up to 300 percent FPL. Vermont's health reform strategy also involves a statewide multipayer initiative that provides preventive care and improves care for individuals with chronic conditions—the Blueprint for Health. The Massachusetts reform strategy mandates that all residents obtain health insurance (individual mandate) and requires the merger of the state's individual and small group insurance markets.

For more details on these states' initiatives, see their respective Web sites and the State Coverage Initiatives Web site (www.statecoverage.org).

Section 2: Eligibility and Enrollment

Key Questions

1. What will be the primary pathways for eligibility determination and enrollment, and what information systems will be required?
2. Will the state consolidate all public coverage options under one umbrella program?
3. Will employers enroll in the new health insurance offering? If so, how will the state handle eligibility and enrollment?
4. Are current state information systems equipped to perform the necessary eligibility and enrollment functions for the health insurance expansion initiative? If modifications are required, how extensive are they?

States face a critical decision in selecting a workable approach to determining eligibility and enrolling participants in health insurance expansions. Typically, states either perform both the eligibility and enrollment functions (the traditional Medicaid model) or make eligibility determinations themselves and contract with a health insurer(s) to enroll participants. If states use CHIP or Medicaid funds in their expansion, they must comply with federal eligibility and enrollment standards, which often translate into an additional layer of complexity and related systems changes.

Budget constraints often limit states' ability to make major changes to their eligibility determination and enrollment systems. While systems might support the requirements of existing programs, they might lack the flexibility needed for implementing new programs, especially those involving employer enrollment and premium payments. Even new systems may require changes if the health care expansion closely resembles a commercial market product.

States should allow 7 to 8 months at a minimum to implement needed systems changes. While 12 to 18 months is an ideal period, legislative timelines are often more restrictive. Examples of systems changes include:

- Establishing data-sharing processes for the state's eligibility systems and health insurers, including processes that synchronize data files.
- Creating new eligibility categories in the state's eligibility and claims processing systems.
- Developing the capacity to use employer databases from other state agencies to verify employer eligibility for specific programs or compliance with employer-related requirements.

Appendix B provides examples of information systems changes from the five states of interest.

Key Takeaway: Assess the ability of existing information systems to meet new reforms' eligibility and enrollment requirements; allow several months at a minimum to assess and implement needed systems changes.

Information System Issues

A state's information systems are critical to successful health care reform. They support almost every operational function needed for implementation, including eligibility determination, enrollment, premium payments, and determinations of compliance with individual and employer mandates. While information systems issues are beyond the scope of this issue brief, we highlight some information system considerations.

Flexible and nimble information systems allow states to respond efficiently and effectively to ever-changing health care reform policies and the implementation of health information technology initiatives. In some cases, however, budget or time constraints force states to rely on system workarounds to implement new programs. In the long run, workarounds usually prove problematic.

New Mexico used its existing eligibility systems and Medicaid information system to implement its State Coverage Insurance program. Certain features of the new program—particularly individual and employer premium payments and employer enrollment of individuals—stretched the systems' capabilities. In response, state staff developed a series of workarounds as budgetary pressures did not allow more significant information systems changes. The workarounds tracked individuals as part of employer groups, whereas the state's existing systems tracked enrollees as individuals. As the State Coverage Insurance program's enrollment grew, the workarounds became more cumbersome and time-consuming to administer. While budgetary pressures sometimes make using workarounds unavoidable, it is preferable to avoid this approach given its long-term limitations.

Key Takeaway: Support information systems flexibility and avoid system workarounds in favor of more flexible systems changes as budgets allow.

To avoid unnecessary systems changes, states have modified the traditional exchange of data between employers and health insurers. For example, New Mexico employs a "reverse roster" system to avoid significant changes to the state's eligibility system. Typically, the state sends its contracted managed care organizations (MCO) a capitation rate and a roster of eligible individuals. Under the reverse roster system, the MCO provides New Mexico with a file—based on a preliminary eligibility file from the state—of all individuals who have enrolled and paid their premiums. After verifying the individuals on the roster, the state sends capitation payments to the MCO.

Key Takeaway: Think "outside the box" to modify traditional health insurer information processes in order to avoid unnecessary state systems changes.

Simplifying Enrollment and Eligibility Processes

For both individuals and employers, the success of a health insurance expansion is highly dependent on the ease of determining eligibility and the ease of enrollment. Therefore, streamlining these processes is critical to health care reform, particularly among small employers. Small businesses typically do not operate human resource departments and are easily deterred by the administrative burden associated with new coverage options.

Some approaches used by states include the following:

- *Individualized enrollment assistance for employers.* New Mexico established an employer call center for its State Coverage Insurance program. Enrollment counselors at the call center are available to work one-on-one with employers, providing "one-stop shopping" for employer eligibility determination and enrollment or referrals to insurance brokers and insurance programs outside the state agency (e.g., a high-risk pool). The SCI's Web site posts extensive information for employers and insurance brokers, including enrollment forms for download and a video about the State Coverage Insurance program.
- *Maximizing the use of data submitted by employers.* Massachusetts recently passed legislation that allows the Massachusetts Health Insurance Connector Authority to use employer data submitted to the state to help determine Commonwealth Care (i.e., the subsidized program) eligibility, thereby minimizing employer burden.
- *Online eligibility and enrollment processes.* Web-based pathways are gaining popularity. The five states featured in this issue brief have reported success with their Web-based eligibility determination and enrollment tools. For example:
  - Massachusetts dedicated significant resources to establishing a comprehensive Connector Web site that provides information to individuals and families, employers, employees, and insurance brokers on the Commonwealth Care and Commonwealth Choice plans. Massachusetts currently receives 85 percent of its Commonwealth Choice enrollment applications through its Web site.
  - Tennessee reported that it greatly reduced the barrier to CoverTN enrollment by allowing individuals and employers to submit all information online. Initially, Tennessee required individuals and employers to print an eligibility form from the Internet, sign it, and send it in for attestation. The state's reporting system found, however, that the number of people enrolling in CoverTN was far below the number of people viewing the form online. After Tennessee allowed the form to be submitted electronically, CoverTN enrollment increased.
- *Centralizing eligibility and enrollment processing.* Some states delegate eligibility determination and enrollment responsibility to local offices with jurisdiction over a particular area of the state. In Wisconsin, county offices handle eligibility and enrollment for expanded coverage for pregnant women, parents, and children. With a significant increase in enrollment volume, however, Wisconsin found that local offices were operating at capacity. Consequently, when the state implemented its childless adult expansion, it designated a central office for processing the related applications and found that a centralized approach reduced costs and ensured the timely processing of applications.
- *Streamlining communications around premium payments.* Successful enrollment in health insurance expansions typically depends on whether individuals perceive premium contributions as affordable, and perceptions depend on sound communication. Massachusetts uses its Connector Web site to convey information on Commonwealth Care and Commonwealth Choice benefits and premium contributions, comparing elements such as provider networks and premiums.[2] Under Wisconsin's BadgerCare Plus, the eligibility system provides an initial estimate of individual premium contributions based on self-declared income. This process, however, creates confusion for consumers and county offices because the estimate often undergoes revision upon completion of the verification of family income. In response, shortly, Wisconsin will not charge a premium for the first month of services and will not rely on county offices (via the eligibility system) to provide an initial premium estimate; instead, it will allow sufficient time for completion of the income verification process.
- *Assessing contractor information systems capacity, particularly regarding premium payments.* Given time constraints, states might use existing contractors to enroll consumers and process premium payments. Contractors' experience with collecting premium payments and their systems capacity varies widely, however, such that a state may wish to switch to a more experienced contractor upon re-procurement after meeting immediate implementation deadlines.

Key Takeaways:

- Consider using Web-based eligibility and enrollment processes, establishing a "one-stop shopping" contact for employers, maximizing data submitted by employers, and using a centralized processing center.
- Streamline the process for determining and communicating consumer premium payment responsibilities.
- Assess contractor information systems capacity, particularly regarding premium payments.

Implications of Consolidating Public Programs While Expanding Coverage

In some cases—such as Wisconsin's BadgerCare Plus and Vermont's Green Mountain Care—states use the introduction of expanded health insurance options as an opportunity to consolidate and re-brand their public programs. Such consolidated programs are usually typified by variations in premiums, co-payments, and benefits depending on family income. This approach is thought to increase the administrative and operational efficiencies of a state's public insurance agency and reduce any perceived stigma of participation in a public program. Consolidation typically involves collapsing several public programs under one name, standardizing enrollment and eligibility functions, and marketing the "umbrella" program as a single entity.

Consolidating public programs as part of an expansion requires significant attention to the standardization and modification of eligibility and enrollment processes. When consolidating several programs under BadgerCare Plus, Wisconsin discovered that each program operated with slightly different guidelines and regulations that had to be reconciled. For example, income determination varied across programs and required standardization. In addition, the systems changes related to the standardization had to be completed in a mere four months due to legislative constraints. While the standardization process was challenging, Wisconsin found that it ultimately made enrollment and eligibility easier for consumers and state staff. Similarly, to ensure a seamless transition across programs as individual's eligibility status changed, Vermont had to align all of its eligibility statutes and information systems under its existing Medicaid expansion programs with the new state-sponsored premium assistance programs.

Key Takeaway: Standardizing eligibility and enrollment processes across several programs generally requires extensive planning, changes to information systems, and the dedication of staff resources—all of which pays off over time in improved efficiency and effectiveness.

Considerations Related to Federal Requirements

States should be aware that, if they rely on CHIP and Medicaid funds for employer-based health insurance initiatives, some federal requirements might represent an administrative burden on employers. New Mexico observed that it was difficult for employers to determine household income as required by the federal government because individuals were reluctant to disclose such information to employers. In response, the state developed processes so that employers could collect household income information in a way that kept the information confidential. Over time, concerns around this issue subsided.

Recognizing that federal requirements often change, states must maintain a flexible posture. For example, the federal government's requirements for proof of citizenship for receipt of CHIP and Medicaid benefits required a significant adjustment to New Mexico's State Coverage Insurance program. The requirements took effect after program implementation and were more onerous than the employer requirements for verification for employment purposes. In response, the state created an "agent of the state" designation and certified approximately 300 people—including insurance brokers, MCOs, and primary care health clinic staff—to verify citizenship status. The state developed a database of agents of the state for employer and individual referrals, along with materials describing the types of documents to be presented for verification. Insurance brokers and MCOs, as agents of the state, visit employer groups as part of their standard customer service. In many cases, the agents of the state rely on the New Mexico Department of Health's Web portal that provides online access to birth certificates.

Key Takeaways:

- Identify federal requirements that may cause an additional administrative burden for the state and employers and implement processes to alleviate that burden.
- Maintain flexibility to respond to changes in federal requirements.

Section 3: Use of Health Insurers

Key Questions

1 Does the new health insurance expansion require the state to assume new responsibilities (e.g., premium collection) that have not been part of other public health insurance programs?

2 What contractual relationships has the state had with health insurers? How might those contracts be similar to or different from those required for the health insurance coverage expansion?

3 What is the capacity of the existing health insurance market? Are areas of the state underserved?

4 How can the state create a contractual relationship with health insurers to provide the state with maximum flexibility while maintaining appropriate oversight?

Not surprisingly, health care reform initiatives often involve employers and increasingly involve health insurers. States may choose to rely on health insurers that specialize in public programs (e.g., Medicaid MCOs) or commercial insurers that may or may not be experienced with public program products.

Over time, many state public health insurance programs—particularly those funded by CHIP—have grown to resemble commercial health insurance. Increased federal flexibility has allowed states to use a variety of benefit packages, managed care delivery systems, and—for individuals in higher-income brackets—individual cost-sharing (i.e., co-payments and premiums). Through federal Health Insurance Flexibility and Accountability waivers, states have also been encouraged to implement health insurance expansions that involve employers.

Health Insurer Responsibilities

States may choose to involve health insurers in a wide variety of functions, including provision of a managed care delivery system, claims payment, enrollment of consumers, and premium collection. For example:

- Wisconsin uses Medicaid MCOs to deliver services under BadgerCare Plus. The state retains the eligibility determination, enrollment, and premium subsidy collection functions.
- New Mexico uses MCOs to deliver services, pay claims, collect premiums, and enroll consumers. The state retains the eligibility determination function, and the MCOs and the state both perform marketing functions.
- Vermont provides new private insurance market-based plans that are coordinated with state premium subsidies. Two of the state's three largest insurers offer the state's new Catamount Plans in the individual market, but the state determines eligibility and manages the premium assistance program.

To ensure the cost-effective implementation of insurance expansion programs, states often turn to insurers, as these organizations typically have the experience and information systems essential for rapid start-up of expansion initiatives. New Mexico decided to use health insurers to collect premiums for its State Coverage Insurance program because the state, unlike the insurers, was inexperienced in premium collection. In particular, the health insurers had processes in place to collect premiums in the state's rural areas.

Policymakers must be careful, however, to assess their respective state's current health insurance market to ensure that the available health insurers can support the planned health insurance expansion. Specifically, states should consider the extent to which the health insurance market includes plans specializing in public programs (i.e., Medicaid MCOs) versus commercial insurers that may or may not have public program experience. Insurers specializing in public programs may offer the state experience with the targeted populations and related federal and state requirements. Commercial insurers, on

Sample Questions States Should Ask When Evaluating the Health Insurer Market

1. Do currently licensed health insurers have the:
   - Capacity, in terms of total volume and ability to serve a new patient mix, to deliver customer and provider services?
   - Ability to comply with new regulations, particularly if the expansion is through Medicaid or other government programs?
   - Ability to support a new product line?
2. What is the best geographic option for implementing the program (e.g., by state, region, or county) to ensure sufficient coverage and the interest of health insurers?
3. To encourage interest, how might the program be aligned with other state programs in which health insurers participate (e.g., developing similar geographic regions as other programs may help ensure sufficient provider networks)?
4. What incentives must be in place to encourage health plans to enter the market? What membership volume will be needed for a plan to enter the market?
5. Are there any current licensing requirements that may limit health plans' interest or ability to participate in the market?
6. How much time is needed to ensure that current health insurers would be prepared to enter the market and implement the new product appropriately?

the other hand, might offer experience with commercial product features such as premium collection and a variety of cost-sharing policies.

In determining the role of health insurers, states must identify which functions they want to retain in-house (typically, eligibility determination) and which functions they want to contract out. Appendix C summarizes how the five states featured in this issue brief use health insurers to implement their health care reform initiatives.

Key Takeaway: After careful assessment of the state's health insurer market, consider using health insurers' expertise and delivery systems to reduce the state's administrative burden.

States must verify that contracted health insurers have the capacity and systems to implement state expansions, especially if the health insurer has no experience with state contracts. While state health insurance expansions may closely resemble commercial products, they typically require data-sharing and reporting processes that differ somewhat from the processes used for commercial products, especially if CHIP and Medicaid funds are involved. For example, when a state retains eligibility determination and enrollment functions, it must put in place a system whereby it informs the health insurer(s) on an ongoing basis which individuals are eligible and enrolled in the health insurance expansion product. In turn, the health insurer(s) must be able to use the eligibility data in day-to-day operations.

When Vermont implemented its Catamount Health Plan, it made certain assumptions regarding the systems that health insurers would have in place to ensure the disenrollment of consumers when the state did not make premium payments on their behalf. The systems were not as well developed as the state had expected; as a result, Catamount required the insurers to perform additional work after initial plan implementation to make sure the disenrollment process was operating as intended. Vermont also faced a challenge in developing an information technology strategy that allowed the state's eligibility system (Medicaid Management Information System) and two health insurers to exchange data easily and synchronize their respective databases. The state's system is now the system of record for enrollment and disenrollment dates. Accordingly, the state transmits data electronically to the carriers; there is no application directly from an applicant to the carrier. In addition, the state produces weekly reconciliation files for the carriers to resolve any discrepancies between the state and carrier databases.

Key Takeaway: Especially when the health insurer has no experience with state contracts, do not make assumptions regarding health insurers' systems and processes, particularly as state health insurance expansions may require functions that differ from those associated with commercial products.

States that have existing relationships with health insurers (in particular, Medicaid MCOs) may find it easier to expand the health insurers' role to encompass a new health insurance plan. Wisconsin—which enrolls the majority of its CHIP and Medicaid consumers in managed care—uses the same Medicaid MCOs for BadgerCare Plus as it did for BadgerCare and other family Medicaid programs. The MCOs agreed to take on additional populations (e.g., childless adults) while maintaining the same standards in regard to delivery system capacity. The system capacity of existing MCOs is not a given, however, and a state should carefully assess its current health insurance market before making a decision about health insurers.

New Mexico found that reliance on the same MCOs for the State Coverage Insurance program as for its CHIP and Medicaid programs proved extremely helpful. The MCOs were familiar with most of the state's administrative and operational infrastructure issues.

In Tennessee, on the other hand, reliance on one of the same insurers to administer both CoverTN and TennCare (Medicaid) did not provide added benefits because of the two programs' dramatic differences.

Key Takeaway: States that currently involve MCOs in their CHIP and Medicaid programs may find it easy to expand health insurance coverage with the same group of MCOs (assuming similar roles for the MCOs). However, an in-depth analysis of a state's health insurer market is critical before determining how best to proceed.

Establishing and Leveraging Contractual Relationships with Health Insurers

States structure their contractual relationships with health insurers in a variety of ways:

- Vermont uses "trading partner agreements" with two health insurers (Blue Cross Blue Shield of Vermont and MVP Health Care) for Catamount Health. A more formal contractual arrangement is not necessary as the state collects premiums from individuals eligible for premium subsidies and makes payments to health insurers on behalf of those individuals.
- Wisconsin expanded its contracts with Medicaid MCOs. While the state did not seek out additional MCOs to meet the increased number of enrollees, it provided incentive payments to the existing MCO contractors to expand into new geographic areas.
- Massachusetts used its Commonwealth Care procurement process with MCOs to drive down premium costs.[3] In the first procurement for Commonwealth Care, Massachusetts could contract only with Medicaid MCOs under contract with Mass Health (Medicaid).

Massachusetts encouraged lower premium bids by automatically assigning members to the lowest bidder and encouraging enrollees who had to pay premiums to select the lowest-cost plan. During the third procurement, the state lifted the MCO-only restriction and did not experience as much downward pressure on premiums as hoped. Overall, Massachusetts used a different approach for each procurement, tailoring its approach to the unique circumstances and needs at the time of the procurement.

The amount of state staff time and resources involved in the procurement and re-procurement of insurers varies widely with the designated role of the insurer. States may want to assume—at least during initial implementation and the first procurement—that a significant amount of time and resources will be dedicated to structuring a relationship that achieves the state's policy goals and responsibilities. On an ongoing basis, however, states need to maintain enough flexibility in the procurement process to tailor each procurement to market conditions (e.g., the recent recession) and the availability of additional historical claims data.

Given legislative deadlines and funding constraints, time is often a luxury that states lack. Vermont, for example, had only nine months to implement its Catamount Health Plan but learned from other states that a period of at least a year was needed for implementation. As a result, Vermont staff were simultaneously designing and implementing the expansion. In such cases—and even when sufficient time is available—a state may want to consider establishing a contractual or other formal relationship with health insurers that allows it to adjust health insurer responsibilities and activities should unexpected challenges arise during implementation.

Key Takeaway: Dedicate sufficient time and staff resources to developing a contractual relationship with health insurers that best meets the state's needs; consider what type of contractual flexibility the state may find useful during implementation.

Section 4: Marketing and Outreach

Key Questions

1. What new populations will the state enroll in its health insurance expansion (e.g., childless adults, employers)? What modifications to current outreach approaches are needed?

2. To what extent can the state's current CHIP and Medicaid outreach activities be modified to include outreach and marketing for the health insurance expansion?

3. Does the state's outreach and marketing approach extend to community organizations? If so, what type of relationship does the state already have with these organizations? How will the state need to strengthen or otherwise change these relationships?

4. Does the state's outreach and marketing approach include the business community (e.g., chambers of commerce, insurance brokers)? If so, are marketing materials appropriately oriented to the business community?

The success of any health insurance option depends on the ability of the offering organization—whether public or private—to persuade eligible individuals or employers that they will benefit from enrollment. States use a wide variety of outreach and marketing approaches, including major media campaigns and targeted media campaigns; reliance on state outreach workers, state agencies, and community-based organizations (e.g., social service agencies and faith-based organizations); and working through the business community.

How states choose to structure their outreach and marketing activities for health insurance expansions and other initiatives depends on the targeted population(s). The target population may be a population segment to which the state is already reaching out (e.g., pregnant women at 185 to 200 percent FPL) or a new population (e.g., childless adults and small employers). Other reform initiatives may involve a broader population. A state might need to conduct a broad public awareness campaign to inform businesses and state residents about statewide chronic care, employer assessment, or individual mandate policies.

States rarely have funding for long-term, broad-based public awareness campaigns and must develop low-cost, highly-focused marketing strategies that effectively reach target populations. Highly focused strategies vary with the nature of the reform. For example, reforms that include employers may require a marketing strategy that generates interest within the business community while reforms targeting lower-income consumers may require strengthened relationships with community organizations.

Key Takeaway: States should establish relationships with community business organizations when marketing health insurance reforms targeted to employers. State staff may need additional training to communicate effectively with employers.

Working with the Business Community

Many health insurance expansions involve the provision of various employer incentives to stimulate the offer of coverage either in general or of a particular product. As a result, states have developed new ways to reach out to the business community, such as by working closely with insurance brokers, chambers of commerce, and other business associations.

Tennessee, for example, works with the National Federation of Independent Businesses, Rotary Clubs, chambers of commerce, and churches to motivate small employers to offer CoverTN. The state recently started working with Blue Cross Blue Shield insurance brokers and has partnered with the state's Department of Labor and Workforce Development to promote CoverTN. New Mexico uses broker certification to encourage group enrollment in its State Coverage Insurance program. It trains brokers in how to promote public insurance programs; brokers in return receive continuing education credits from the state's Department of Insurance.

Effective communication with business organizations means that state staff must develop a thorough understanding of how employers make coverage decisions and deal with related administrative burdens. Such an understanding is critical for designing effective enrollment and eligibility processes for employers and developing marketing approaches that attract employers to new products. Depending on their background, state staff may require training or look to the expertise of state agencies that deal with employers on a regular basis.

Key Takeaway: Recognize that funding is rarely available for long-term, broad-based public awareness campaigns. It is critical to develop focused, low-cost outreach strategies aimed at the target population(s).

Working with Community-Based Organizations

Traditionally, states have relied on state or county social service offices to reach out to individual consumers. Over time, however, states have developed innovative ways to collaborate with nongovernmental social service agencies to conduct outreach and even submit eligibility applications. As part of a far-reaching public outreach campaign, Massachusetts funded 50 community organizations to work with the Connector and MassHealth (Medicaid) to coordinate outreach and enrollment events across the state. The state is also using web-based outreach, including social networking initiatives, to reach out to consumers. New Mexico works extensively with the state

primary care provider association to reach out to individual consumers.

Wisconsin made its relationships with community-based organizations a cornerstone of its outreach for BadgerCare Plus. It assigned one full-time staff member and two temporary part-time staff members to develop and maintain relationships with approximately 200 community-based organizations and conduct other outreach activities. Wisconsin's marketing approach provided one-time mini-grants to 31 organizations (up to $25,000 per organization) and paid a $50 finder's fee per approved BadgerCare Plus application. The relationships with community-based organizations proved extremely useful during the expansion of coverage to parents, children, and pregnant women. As a result, the state is relying on these organizations as it expands coverage to childless adults.

Significant staff time and resources are needed to develop relationships with community-based organizations, unless such relationships already exist. The allocation of funds to support the increased involvement of community organizations—linked to pre-determined standards of participation—will motivate their involvement.

Key Takeaway: States should dedicate staff time and resources to establishing (or expanding) state relationships with community-based organizations; the allocation of funds for these organizations may be an effective strategy for encouraging their participation.

As states move beyond initial program implementation, their marketing and outreach requirements will change. CoverTN's marketing strategy, for example, initially targeted small businesses. As the program moved beyond initial implementation, the state modified its approach to focus on individual consumers. Reliance on flexible and dynamic outreach and marketing strategies allows states to adjust to challenges that arise during the health care expansion and respond to consumer feedback regarding the expansion.

Key Takeaway: Marketing and outreach approaches should be sufficiently flexible to allow for change as health care expansions are modified or as information on the target population's response to the expansions becomes available.

Section 5: Staffing and Coordination of Reforms

Key Questions

1. Which state agencies have been involved in developing the health care reform initiative(s), and what have been their roles? Is one agency a natural fit to oversee the health care reform initiative(s)?
2. Does the agency designated to oversee or coordinate the health care reform initiative(s) have sufficient authority to coordinate interagency functions, particularly data sharing?
3. What staff background and experience are needed to implement the health care reform initiative(s)? To what extent does state staff possess this experience?
4. What contracts does the state currently have in place that could be modified to include work on the initiatives?
5. What components of the health care reform initiative(s) could the state contract out if staff resources or experiences are insufficient?

Limited state funding and the need to establish new relationships among a variety of agencies and state contractors often pose a challenge to state agency staff and their efforts to coordinate health care reforms.

Identifying the Lead Agency

State health care reform initiatives typically require several state agencies and contractors to work together in new ways. For example, Vermont created the Vermont Office for Health Care Reform Implementation in the Agency of Administration to oversee and coordinate all newly enacted reforms. Implementation of just one program—the state's chronic care initiative (Blueprint for Health)—has required intense collaboration among several divisions within the Vermont Department of Health; the Medicaid Agency; the Department of Banking, Insurance, Securities and Health Care Administration; the University of Vermont Childhood Health Improvement Program; and the Vermont Program for Quality Health Care (a private, non-profit corporation), among others.

Typically, states designate an existing agency—often the state's department of health and human services—as the lead coordinating agency charged with providing most of the support needed to implement health care reform initiatives. The designations recognize that state departments of health and human services are usually responsible for developing health care reform initiatives and are closely linked to the scope of reform initiatives.

When initiatives are several and far-reaching, states may take the extraordinary measure of establishing a new agency. Massachusetts established an independent, quasi-governmental agency called the Commonwealth Health Insurance Connector Authority (the Authority) that is staffed by 50 new employees. While the Authority is not responsible for all facets of the state's health care reform strategy, it manages two new health insurance options (Commonwealth Care and Commonwealth Choice) and is responsible for several policy, administrative, and outreach functions.[4] The Connector received an initial appropriation of $25 million to fund its start-up and operating expenses but now generates its own revenues by imposing an administrative fee on all health benefit plans in which it enrolls beneficiaries.

Tennessee relies on its Department of Benefits Administration, which oversees operation of state employee health plans, to administer four of its health care programs, including CoverTN. The arrangement builds on existing expertise within state government and thus required minimal staff additions, with only two employees dedicated solely to CoverTN. Tennessee's approach achieves efficiencies and reduces the tendency toward "siloing" public programs.

Key Takeaway: Using existing state agencies to coordinate the reform effort is usually the most efficient and effective approach; however, a new state agency may be useful when implementing large-scale, far-reaching reforms.

Regardless of which agency(ies) takes the lead, successful implementation of health care reform initiatives requires the designated agency to have sufficient legislative authority to coordinate the efforts of the affected agencies and their related data-sharing activities. Legislative staff should work closely with the appropriate state agency staff when developing reform legislation to identify the type of authority needed by the participating state agencies.

For example, to administer its Section 125 plan requirement for employers, Massachusetts must share data among agencies. In some cases, the data-sharing requirements meant a return to the state legislature to obtain the needed authority. The time-consuming legislative process could have been averted if the state legislature had explicitly given the person(s) or agency(ies) leading the reform initiatives sufficient statutory authority. The Secretary of Health and Human Services has performed this role de facto for Massachusetts.

Key Takeaway: Work closely with legislative staff as reform legislation is drafted to ensure that the legislation designates a lead agency and provides it with the authority needed for coordination and data sharing among affected agencies.

Staffing of Reform Initiatives

Often state agencies are directed to implement health care reforms with existing resources or with limited funding for additional staff. In such cases, states have little choice but to reallocate existing staff, re-prioritize contractor responsibilities, and hire independent contractors on a time-limited basis.

The reallocation of existing staff—while sometimes resulting in organizational stress and short-term disruptions to workflow—can provide significant benefits by requiring states to draw on existing staff experience, develop needed staff expertise, and promote and gain staff buy-in and commitment to the reform effort.

Generally speaking, contractor roles with respect to reform initiatives fall into two categories—ongoing operations (e.g., call center and claims processing) and time-limited activities (e.g., development of a web site, initial advertising campaign). Often, states are already engaged in contracts for their CHIP and Medicaid programs for ongoing operational functions that are also needed for health care expansions (e.g., enrollment and claims processing). Therefore, states are advised to undertake a careful examination of contractor responsibilities to determine if current contracts may be re-directed and re-prioritized to support health care reform implementation. Wisconsin, for example, re-directed all its relevant contractors to BadgerCare Plus during the implementation period.

In some cases, reform initiatives involve a task(s) that requires a type or level of expertise beyond the capability of state staff or current contractors. In such cases, states may hire another contractor to complete the work within the given time frame. Whenever possible, however, states should transfer the contractor's responsibility to state staff as soon as possible in order to minimize the number of new contracts and the need for related funding. For example, a state may direct a contractor to develop a new Web site but then maintain the Web site in-house.

Key Takeaway: Maximize existing state and contractor staff resources by re-directing contractor responsibilities, reallocating state staff, and using new contractors on a time-limited, focused basis.

Building as much flexibility as possible into state contracts allows states to address implementation challenges quickly and effectively without the time-consuming process of re-negotiating or amending contracts. To respond to issues that arose during CoverTN's implementation, Tennessee had to modify several contracts numerous times. While the time-consuming modifications in part reflected state contracting requirements, CoverTN staff would have benefited from adjusting a contractor's scope of work rather than amending the contract. Sometimes states can modify a contractor's scope of work as long as both parties agree that the changes fall within overall contractor responsibilities and that sufficient funding is available.

Key Takeaway: Build as much flexibility as possible into contracts so that work can be re-directed to assist with implementation as needed.

If a state decides to create an independent agency to implement its reforms, the agency may have additional flexibility with respect to hiring new staff. In Massachusetts, creation of the Connector Authority allowed the state to hire staff experienced in both public policy and private commercial insurance. In addition, the Authority's independent status allowed for flexibility in regard to state employment and compensation rules, an important factor in attracting individuals with the appropriate mix of skills.

Key Takeaway: The use of an independent agency to implement reforms may allow for greater flexibility in hiring staff.

When several agencies are involved in implementing a reform initiative, it is critical to conduct regular meetings among senior agency staff with the expertise and authority to identify and rapidly resolve potential challenges. While the Vermont Department of Health is the lead agency for the state's Blueprint for Health, it conducts monthly executive committee meetings that bring together representatives from the affected state agencies, insurance carriers, and other relevant groups to discuss Blueprint implementation issues. The state has also convened a planning and evaluation committee made up of representatives from the same organizations and agencies.

Key Takeaway: Establish formal, ongoing communication among key senior agency staff with the expertise and authority to identify and rapidly resolve potential challenges.

Appendix D provides an overview of the contractors used for reform efforts by the five states featured in this brief while Appendix E provides an overview of each state's general staffing approach for reform.

Building Staff Knowledge

When health insurance expansions closely resemble commercial products, the staff involved in their implementation may require additional training if their experience is largely limited to the traditional public health insurance model. The marketing strategy for New Mexico's State Coverage Insurance program, for example, required an approach that differed from that for the state's existing public programs. Employers, one of the expansion's target populations, needed outreach materials that reflected their perspective rather than that of an individual consumer. In addition, staff underwent training to ensure accurate communication about employer issues, particularly in regard to enrollment.

Alternatively, a state may draw on the staff of agencies, such as a state department of insurance, already familiar with employer-related issues.

During the first 18 months of the State Coverage Insurance program, New Mexico conducted monthly work group meetings of MCO staff and state staff responsible for program development, eligibility determination, and income assessment. The meetings initially focused on orienting MCO and state staff to their respective roles and provided information on the differences between traditional Medicaid and the State Coverage Insurance program. The meetings continue but primarily include MCO staff and state program development staff.

Key Takeaway: Provide training and education to state staff to help them understand and effectively communicate aspects of new health insurance options that involve employers. Alternatively, involve individuals from other state agencies who are familiar with commercial market and employer issues.

State reform efforts typically occur over several years. Massachusetts and Vermont have phased in reform according to a pre-determined timetable. In addition, state legislatures may modify or add to reforms each year. Vermont, for example, has enacted significant health care reform legislation every legislative session since 2006, often requiring changes to state health care operations. State flexibility is essential in responding to unfolding reform initiatives.

Key Takeaway: Structure staffing approaches and coordination strategies around the assumption that health care reform will occur over several years and that operational changes will be somewhat unpredictable during that period.

Section 6: Employer Assessment and Section 125 Policy Considerations

Key Questions

1. What types of data are needed to implement the employer assessment and/or employers' use of Section 125 plans? What agencies currently collect such data? Are there data-sharing agreements between agencies?

2. What additional data are needed from employers, and what agency is best equipped to collect the data?

3. Based on current data collection efforts and staff experience, what agency is best suited to implementing and monitoring employer assessments and Section 125 plan requirements?

4. What new information systems or data-sharing capacities are needed to collect and use the required data sources?

State health care reform initiatives often involve employer assessments (for employers not offering coverage) and/or require employers to offer Section 125 plans (also known as cafeteria plans). Section 125 plans allow employees to use pre-tax funds to pay for health insurance coverage whether or not their employer contributes to the premium. The employer assessment and Section 125 plans differ markedly from the health insurance expansions discussed thus far.

Massachusetts and Vermont have imposed employer assessments for employers not meeting a minimum standard for providing coverage for their employees. Both states exempt very small employers and levy similar fees; $295 annually per full-time equivalent (FTE) employee in Massachusetts and $365 annually per FTE in Vermont, with an increase scheduled for January 2010 in Vermont.

More and more states require or encourage employers to implement Section 125 plans.[5] Massachusetts requires employers with 11 or more employees to maintain a Section 125 plan to enable employees to pay for their coverage on a pre-tax basis. Even though the state no longer requires employers to file a copy of the Section 125 plan document with the Connector Authority, employers must produce the plan at the Connector Authority's request and must file a Heath Insurance Responsibility Disclosure (HIRD) form, which reports whether or not they offer a qualified Section 125 Plan to their employees, with the Department of Insurance. Employers' non-benefit-eligible employees may participate in the Commonwealth Choice Voluntary Plan and choose from different benefit plan levels offered by a variety of insurers; employers pass along the employee's premium contribution to the Connector. In this way, employees may select from several insurers while the employer does not bear the administrative burden of working with a range of insurers.

The expertise and data needed to implement and oversee employer assessments and Section 125 plan requirements differ significantly from that needed for implementing and operating health insurance expansions. States must collect information on the type of insurance offered by each employer and the number of employees taking up that or other coverage (e.g., through a spouse). As a result, a state department with jurisdiction over employer issues (such as a department of revenue or department of labor)—rather than a state department of health and human services—often oversees the operation of employer assessments and Section 125 plans.

The Vermont Department of Labor is responsible for all facets of the employer assessment. It has developed the forms that employers must submit to the state to demonstrate compliance. It has conducted employer trainings and collects and monitors the assessment proceeds. It also reworked its information technology systems to accept the data entered on compliance forms and developed an accounting system that is separate from that for unemployment insurance.

Massachusetts employers file information annually online with the Division of Unemployment Assistance. The state uses the information to determine compliance with the employer assessment and Section 125 plan requirements. The Department of Revenue communicates with individual tax filers regarding their responsibilities under law, implements the schedule of tax penalties, and provides compliance data.

States should identify the agencies that collect data from employers, the types of data collected, and the extent to which the data are analyzed. Health reform initiatives should build on existing processes and the expertise of relevant agencies in order to avoid unnecessary complexity for the state, employers, and individual consumers. To the extent possible, states should consider online data submission that coincides with existing data submissions.

Key Takeaways:

- State departments other than the department of health and social services should plan for and participate in the implementation and operation of employer assessments and Section 125 plan requirements.

- It is important to determine if web-based data collection processes that coincide with other data collection efforts can help reduce the administrative burden on employers and state staff.

Section 125 plan requirements—while offering several benefits—tend to be particularly difficult to explain to employers and employees. It is important to develop clear marketing materials and enrollment processes. Despite implementation of the Commonwealth Choice Voluntary Plan and efforts to ease employers' administrative burden and encourage individual enrollment, Massachusetts found that a lower-than-expected number of individuals availed

themselves of Section 125 plans. After analyzing the results of an employer survey, the state simplified enrollment in the Commonwealth Choice Voluntary Plan and developed more user-friendly Section 125 plan materials for employers and employees. Since the introduction of the changes and the revised materials, the state has experienced a gradual increase in the number of employees enrolling in Section 125 plans. However, the state noted that its initial expectations regarding Section 125 plans were too high and that participation likely will never reach its original goal.

Key Takeaway: Carefully consider how Section 125 plans are communicated to stakeholders; the provisions are particularly difficult to understand.

Implementation of an employer assessment or a Section 125 plan requirement will most likely necessitate information systems changes. For example, Massachusetts made systems changes to implement the online filing process for employers under the employer assessment. The state's process for determining whether an employer has implemented a Section 125 plan and whether affected employees use the Health Safety Net requires the merger of data from several agencies and the development of customized programming for the related algorithm.[6]

Key Takeaway: Recognize that the implementation and operation of the employer assessment and Section 125 plan requirement typically require substantial information systems changes.

Individual Mandate Considerations

To date, only Massachusetts has mandated that all residents obtain health insurance. As such, it is difficult to draw conclusions regarding how this type of policy may affect other states' health care operations. Massachusetts residents who fail to purchase health insurance face a financial penalty of up to $912 (certain affordability standards and hardship exemptions apply). The Massachusetts Department of Revenue is responsible for communicating with tax filers, implementing the schedule of tax penalties, and providing compliance data. The department assesses the penalty when an individual files a tax return.

As evidenced by the fact that only one state has enacted an individual mandate, this is a difficult policy decision and one that may be made at the national level depending on the results of federal reform efforts. The primary challenge lies in the need for the simultaneous support of affordable coverage options, which generally involves a substantial subsidy for individuals without the resources to pay the full cost of an insurance policy. Regardless of whether the federal government or state governments enact an individual mandate, state government agencies will likely be charged with implementing and enforcing this requirement.

As states consider an individual mandate, they may need to ask the following questions related to state health care operations:

- What type of data does the state's department of revenue (or equivalent) currently collect that would assist the state in determining compliance with the individual mandate (e.g., changes in residents' reported income throughout the year)? What additional data must be collected (e.g., health insurance status)?
- Do other state agencies collect data that would assist the department of revenue (or equivalent) in determining compliance with the individual mandate (e.g., enrollment files for the state's public programs)? If so, what are the affected agencies' data-sharing capacities? Must those capacities be modified for effective data sharing?
- What processes will the state use to collect new data from individuals to assess compliance with the individual mandate and to determine exemptions and penalties (e.g., health insurance status throughout the year)?

Section 7: Reporting and Evaluation

Key Questions

1. Will the health care reform initiative(s) require a federal waiver approval? If so, will the state need to develop a new waiver, or can current CHIP and/or Medicaid federal waivers be modified?
2. Has the state legislature mandated specific reporting and evaluation activities?
3. Do health care reform initiatives include "hot button" issues that demand proactive evaluation and monitoring critical to maintaining stakeholder support?
4. How will various stakeholders assess whether programs achieve their goals?

State health care reform initiatives typically undergo intensive scrutiny as new approaches to delivering and financing health care services are tested. Establishing efficient and clear reporting and evaluation processes is critical both to maintaining stakeholder support over time and to meeting state legislative and federal requirements. Types of reporting and evaluation activities include:

- Ongoing federal reporting requirements related to CHIP and Medicaid funds, particularly as related to evaluations of CHIP and Medicaid waiver programs.
- Reporting and evaluation activities mandated by state legislatures.
- Reporting and evaluation activities that are not mandated but that are critical to determining if a particular policy is achieving its goals (e.g., population-based surveys regarding health insurance to gauge the success of an individual mandate and other policies).

States use a variety of approaches to evaluate health care reforms (see Appendix F). In some cases, the agency that implements reforms performs the evaluation, although such an arrangement may create concerns about an evaluation's objectivity. If a CHIP or Medicaid federal waiver is involved, the state is required to contract with an outside entity to perform the evaluation. States often engage a separate state agency or an independent contractor to perform evaluations. In Wisconsin, an office within the Department of Health Services is performing the federally-required evaluation of the childless adult waiver program (part of BadgerCare Plus); in addition, the state contracted with the University of Wisconsin's Population Health Institute for a more extensive evaluation of its expansions.

Key Takeaway: Consider contracting with a neutral third party to conduct evaluations of "hot button" issues; such an arrangement is required for federal waiver evaluations.

States should carefully consider the different reporting and evaluation requirements that they must satisfy. In some cases, requirements overlap, making it necessary to determine how to collect and analyze all specified data in a way that reduces the state's administrative burden. In other cases, the reporting and evaluation requirements require new data collection or systems changes.

Key Takeaway: Assess reporting and evaluation requirements before the implementation of reform initiatives in order to identify where additional data collection and systems changes are needed and where there is overlap between requirements.

Funding for evaluation and reporting purposes may be available from foundations or federal agencies, particularly in the case of untested reform strategies. For example, the University of Wisconsin's Population Health Institute received a grant from the Robert Wood Johnson Foundation (RWJF) to cover half the total cost of an evaluation. New Mexico is also using RWJF funds to evaluate employer participation in its State Coverage Insurance program. Vermont's reforms are the focus of two RWJF SHARE evaluation projects conducted by out-of-state research organizations.[7] When considering alternative sources of funding for evaluation purposes, states should confirm that the funding organization(s) is a neutral party that will not be perceived as influencing the results of the evaluation for its own purposes.

Key Takeaway: Explore alternative funding sources for evaluation and reporting.

States that use health insurers to administer their health insurance expansions generally receive numerous reports and data sets on a regular basis, enabling them to monitor progress in a variety of areas (e.g., enrollment and disenrollment statistics). Some reports may be standard commercial payer reports while others may be specific to a state's program. As states plan for reporting and evaluation processes, they should review the types of reports that health payers will generate and determine what additional reports they might need.

Key Takeaway: Identify the reports that will be needed from health insurers or other contractors and the reports that may vary from standard industry practice.

Section 8: Conclusion

The effective implementation of health care reforms—whether state or federal—depends largely on what happens at the operational level in each state. The wide variety of state health care systems means that each state's operational challenges will require state-specific solutions as opposed to a "one size fits all" approach.

When developing health reform policies, national and state policymakers should carefully consider operational issues related to eligibility determination and enrollment systems, employer involvement, staffing and coordination of reforms, and reliance on health insurers. Premium subsidy collection deserves special attention as it is often a relatively new feature for states and requires significant operational support.

Policymakers must carefully balance the need for rapid implementation of health care reform against the time required to develop the full range of operational supports. As part of achieving this balance, states must often decide what systems changes must be performed immediately versus those that may be phased-in over time.

Above all, it is important for states to maintain operational flexibility as they implement reforms. Health care reform will continue to be a moving target, and providers' and payers' constant implementation of new health information technology initiatives will only complicate matters. In finding that they need to merge systems across providers, state agencies, and health insurers, states often underestimate their related operational requirements.

Endnotes

1 The State Coverage Initiative's September 2009 issue brief, "Health Care Reform and American Federalism: The Next Inter-governmental Partnership," provides additional information on the partnership and its relationship to potential new federal rules. See www.statecoverage.org/node/2008.

2 Benefits design and cost sharing are the same across plans for the Commonwealth Care program but may vary for the Commonwealth Choice program.

3 Commonwealth Care is one of the new health insurance options offered in Massachusetts.

4 Functions include defining "Minimum Creditable Coverage" for the state's individual mandate, establishing an affordability schedule for the mandate, developing regulations to implement Section 125 plans for employers, conducting outreach and marketing around the state's health care reform efforts, and establishing and maintaining a consumer call center and Web site for individuals and employers to help them understand their health insurance options.

5 Information on other states' policies may be found on the State Coverage Initiatives Web site at www.statecoverage.org/node/1392.

6 The Health Safety Net is a program for Massachusetts residents who are not eligible for health insurance or cannot afford to buy it. The stated goal of the Safety Net is to make sure that all Massachusetts residents can get health care when they need it, regardless of income.

7 State Health Access Reform Evaluation (SHARE) is a national program of the Robert Wood Johnson Foundation created to support evaluations of health policy reform at the state level and to develop an evidence-based resource to inform future state health reform efforts.

Appendix A: Summary of Key Questions and Takeaways by Operational Area

Operational Area	Key Questions	Key Takeaways
Eligibility and Enrollment	• What will be the primary pathways for eligibility determination and enrollment, and what information systems will be required? • Will the state consolidate all public coverage options under one umbrella program? • Will employers enroll in the new health insurance offering? If so, how will the state handle eligibility and enrollment? • Are current state information systems equipped to perform the necessary eligibility and enrollment functions for the health insurance expansion initiative? If modifications are required, how extensive are they?	• Assess the ability of existing information systems to meet new reforms' eligibility and enrollment requirements; allow several months at a minimum to assess and implement needed systems changes. • Support information systems flexibility and avoid system workarounds in favor of more flexible systems changes as budgets allow. • Think "outside the box" to modify traditional health insurer information processes in order to avoid unnecessary state systems changes. • Consider using Web-based eligibility and enrollment processes, establishing a "one-stop shopping" contact for employers, maximizing data submitted by employers, and using a centralized processing center. • Streamline the process for determining and communicating consumer premium payment responsibilities. • Assess contractor information systems capacity, particularly regarding premium payments. • Standardizing eligibility and enrollment processes across several programs generally requires extensive planning, changes to information systems, and the dedication of staff resources—all of which pays off over time in improved efficiency and effectiveness. • Identify federal requirements that may cause an additional administrative burden for the state and employers and implement processes to alleviate that burden. • Maintain flexibility to respond to changes in federal requirements.
Use of Health Insurers	• Does the new health insurance expansion require the state to assume new responsibilities (e.g., premium collection) that have not been part of other public health insurance programs? • What contractual relationships has the state had with health insurers? How might those contracts be similar to or different from those required for the health insurance coverage expansion? • What is the capacity of the existing health insurance market? Are areas of the state underserved? • How can the state create a contractual relationship with health insurers to provide the state with maximum flexibility while maintaining appropriate oversight?	• After careful assessment of the state's health insurer market, consider using health insurers' expertise and delivery systems to reduce the state's administrative burden. • Especially when the health insurer has no experience with state contracts, do not make assumptions regarding health insurers' systems and processes, particularly as state health insurance expansions may require functions that differ from those associated with commercial products. • States that currently involve MCOs in their CHIP and Medicaid programs may find it easy to expand health insurance coverage with the same group of MCOs (assuming similar roles for the MCOs). However, an in-depth analysis of a state's health insurer market is critical before determining how best to proceed. • Dedicate sufficient time and staff resources to developing a contractual relationship with health insurers that best meets the state's needs; consider what type of contractual flexibility the state may find useful during implementation.

Appendix A: Summary of Key Questions and Takeaways by Operational Area

Operational Area	Key Questions	Key Takeaways
Marketing and Outreach	• What new populations will the state enroll in its health insurance expansion (e.g., childless adults, employers)? What modifications to current outreach approaches are needed? • To what extent can the state's current CHIP and Medicaid outreach activities be modified to include outreach and marketing for the health insurance expansion? • Does the state's outreach and marketing approach extend to community organizations? If so, what type of relationship does the state already have with these organizations? How will the state need to strengthen or otherwise change these relationships? • Does the state's outreach and marketing approach include the business community (e.g., chambers of commerce, insurance brokers)? If so, are marketing materials appropriately oriented to the business community?	• Recognize that funding is rarely available for long-term, broad-based public awareness campaigns. It is critical to develop focused, low-cost outreach strategies aimed at the target population(s). • States should establish relationships with community business organizations when marketing health insurance reforms targeted to employers. State staff may need additional training to communicate effectively with employers. • States should dedicate staff time and resources to establishing (or expandingntered onatein respondingequirements often chanbe,) state relationships with community-based organizations; the allocation of funds for these organizations may be an effective strategy for encouraging their participation. • Marketing and outreach approaches should be sufficiently flexible to allow for change as health care expansions are modified or as information on the target population's response to the expansions becomes available.

Appendix A: Summary of Key Questions and Takeaways by Operational Area

Operational Area	Key Questions	Key Takeaways
Staffing and Coordination of Reforms	• Which state agencies have been involved in developing the health care reform initiative(s), and what have been their roles? Is one agency a natural fit to oversee the health care reform initiative(s)? • Does the agency designated to oversee or coordinate the health care reform initiative(s) have sufficient authority to coordinate interagency functions, particularly data sharing? • What staff background and experience are needed to implement the health care reform initiative(s)? To what extent does state staff possess this experience? • What contracts does the state currently have in place that could be modified to include work on the initiatives? • What components of the health care reform initiative(s) could the state contract out if staff resources or experiences are insufficient	• Using existing state agencies to coordinate the reform effort is usually the most efficient and effective approach; however, a new state agency may be useful when implementing large-scale, far-reaching reforms. • Work closely with legislative staff as reform legislation is drafted to ensure that the legislation designates a lead agency and provides it with the authority needed for coordination and data sharing among affected agencies. • Maximize existing state and contractor staff resources by re-directing contractor responsibilities, reallocating state staff, and using new contractors on a time-limited, focused basis. • Build as much flexibility as possible into contracts so that work can be re-directed to assist with implementation as needed. • The use of an independent agency to implement reforms may allow for greater flexibility in hiring staff. • Establish formal, ongoing communication among key senior agency staff with the expertise and authority to identify and rapidly resolve potential challenges. • Provide training and education to state staff to help them understand and effectively communicate aspects of new health insurance options that involve employers. Alternatively, involve individuals from other state agencies who are familiar with commercial market and employer issues. • Structure staffing approaches and coordination strategies around the assumption that health care reform will occur over several years and that operational changes will be somewhat unpredictable during that period.

Appendix A: Summary of Key Questions and Takeaways by Operational Area

Operational Area	Key Questions	Key Takeaways
Employer Assessment and Section 125 Policy Considerations	• What types of data are needed to implement the employer assessment and/or employers' use of Section 125 plans? What agencies currently collect such data? Are there data-sharing agreements between agencies? • What additional data are needed from employers, and what agency is best equipped to collect the data? • Based on current data collection efforts and staff experience, what agency is best suited to implementing and monitoring employer assessments and Section 125 plan requirements? • What new information systems or data-sharing capacities are needed to collect and use the required data sources?	• State departments other than the department of health and social services should plan for and participate in the implementation and operation of employer assessments and Section 125 plan requirements. • It is important to determine if web-based data collection processes that coincide with other data collection efforts can help reduce the administrative burden on employers and state staff. • Carefully consider how Section 125 plans are communicated to stakeholders; the provisions are particularly difficult to understand. • Recognize that the implementation and operation of the employer assessment and Section 125 plan requirement typically require substantial information systems changes.
Reporting and Evaluation	• Will the health care reform initiative(s) require a federal waiver approval? If so, will the state need to develop a new waiver, or can current CHIP and/or Medicaid federal waivers be modified? • Has the state legislature mandated specific reporting and evaluation activities? • Do health care reform initiatives include "hot button" issues that demand proactive evaluation and monitoring critical to maintaining stakeholder support? • How will various stakeholders assess whether programs achieve their goals?	• Consider contracting with a neutral third party to conduct evaluations of "hot button" issues; such an arrangement is required for federal waiver evaluations. • Assess reporting and evaluation requirements before the implementation of reform initiatives in order to identify where additional data collection and systems changes are needed and where there is overlap between requirements. • Explore alternative funding sources for evaluation and reporting. • Identify the reports that will be needed from health insurers or other contractors and the reports that may vary from standard industry practice.

Appendix B: Examples of Information Systems Changes from Five States' Health Reform Initiatives

State	Examples of Information Technology Changes
Massachusetts	• Developed and implemented the online equivalent of a tax form to implement the employer assessment and the Section 125 plan requirement – developed by an outside contractor and maintained by Massachusetts • Developed a data matching process that determines if employees and/or their dependents are using the Health Safety Net, with which employers those individuals are associated, and what will be the employer penalty • Developed an integrated eligibility system for MassHealth (Medicaid) and Commonwealth Care
New Mexico SCI	• Established workarounds for the state's existing enrollment and eligibility systems • Developed a Web site to facilitate enrollment and insurance broker certification
CoverTN	• Developed a fully automated application and enrollment website for CoverTN
Vermont	Catamount Health • Modified old mainframe used for eligibility (originally from 1980s) to accommodate new eligibility categories • Modified MMIS system (administered by EDS) to provide payment to the health plans Employer Assessment • Changed the Department of Labor's information technology system to accept new data • Developed an accounting system separate from that being used by the Department of Labor for unemployment insurance Blueprint for Health • Developed DocSite, a Web-based clinical tracking system • Expedited the development of the statewide health information exchange
Wisconsin BadgerCare Plus	• Modified online applications tool (ACCESS Tool) • Developed capacity to process Core Plan applications through a separate centralized location • Modified eligibility system to standardize eligible processes across Wisconsin's public health care programs • Developed a new Employer Verification of Health Insurance Database for the state to determine if a potential BadgerCare Plus enrollee has an employer offer of coverage

Appendix C: Use of Health Insurers in Five States' Health Reform Initiatives

	Use of Health Plans	Eligibility Determination	Enrollment	Premium Subsidy Collection	Outreach/ Marketing
Massachusetts Commonwealth Care	Managed Care Organizations (MCOs) provide services	State	State (via Perot Systems)	State (via Perot Systems)	State and MCOs
Massachusetts Commonwealth Choice	Health Maintenance Organizations (HMOs) provide services	State (via contractor Small Business Service Bureau)	State (via contractor Small Business Service Bureau)	Not applicable – there are no premium subsidies for Commonwealth Choice	State and HMOs
New Mexico SCI	MCOs provide services	State	MCO	MCO	State/MCOs
CoverTN	Blue Cross Blue Shield of Tennessee (BCBS of TN) provides services	State	BCBS of TN	BCBS of TN collects premiums from employers, individuals and the state	State and BCBS of TN
Vermont's Catamount Health Plan	Blue Cross Blue Shield of Vermont (BCBS of VT) and MVP Health Care have "trading partner agreements" with the state to provide services	State – for individuals eligible for premium assistance Health plans – for individuals not eligible for premium assistance	State – for individuals eligible for premium assistance Health plans – for individuals not eligible for premium assistance	State	State, with collaboration from health plans for rebranding state's public programs as "Green Mountain Care." State had a contract with marketing agency for original program rollout.
Wisconsin BadgerCare Plus	14 HMOs provide services	State via county offices	State via CARES eligibility system; community health centers and community-based organizations provide assistance with applications	State	State

Appendix D: Use of Outside Contractors in Five States' Health Reform Initiatives

	Massachusetts (various[1])	New Mexico's SCI	CoverTN	Vermont (various[2])	Wisconsin's BadgerCare Plus
Program Development	None	✓ Development of new HIFA waiver to respond to recent changes in federal regulations	None	✓ Development of take-up rates for the Catamount Health Plan	None
Eligibility Determination	✓ (Commonwealth Choice)	None – State did use contractor to reprogram state eligibility system to include the State Coverage Insurance program	None	None	✓
Enrollment	✓ (Commonwealth Choice, Commonwealth Care)	None	✓	None	✓
Premium subsidy collection	None	None	✓	State had an existing contract with a bank lockbox for premium payments and added premium payments for the new program into that contract	None
Marketing and outreach	✓	✓ Advertising firm, and a videographer for training video for broker certification	✓ Initially used an advertising agency; currently use a contractor to outreach to community organizations	✓ Coordination of the rebranding of public programs to "Green Mountain Care," including collaboration from contracted commercial insurers State had a contract with marketing agency for original program rollout	✓ Mini-grants to community agencies

Appendix D: Use of Outside Contractors in Five States' Health Reform Initiatives

	Massachusetts (various[1])	New Mexico's SCI	CoverTN	Vermont (various[2])	Wisconsin's BadgerCare Plus
Evaluation and Reporting	None A number of outside entities already performing independent evaluations	None	None	✓ Evaluation of the Blueprint for Health and two evaluations of coverage reforms through Robert Wood Johnson Foundation grants	✓ Evaluation of BadgerCare Plus funded by a Robert Wood Johnson Foundation grant
Website development	✓ Development and administration of the Connector's Web site	✓	None	✓ GMMB designed the Web site, which is now maintained by the state staff	✓
Other information systems support	✓ Call centers, eligibility and enrollment determinations	✓ State uses a contractor for its MMIS	None	✓ Blueprint for Health: Expedited implementation of the State's Health Information exchange network and expansion of clinical tracking system for providers (DocSite) Catamount Health: Eligibility system changes	None
Analytic and Actuarial Support	✓	✓ Actuarial firm sets premiums (also used for Medicaid program)	✓ Analysis of cost and utilization data	✓ Development of a Return on Investment Model for the Blueprint for Health and actuarial analysis for new Catamount Health Plans	✓ Actuarial firm certifies HMO rates
Program Integrity	✓	✓	None	None	None
Other	✓ Analysis of best practices and the development of online equivalent of a tax form to implement the employer assessment	None	✓ Health plan procurement	✓ Blueprint for Health: Provider workflow technical assistance and provider training and annual maintenance for DocSite	✓ Vendor staff help with HMO selection and Core plan applications

Footnotes

1 Health reform initiatives include Commonwealth Care, Commonwealth Choice, individual mandate, employer assessment and the creation of the Connector Authority.
2 Health reform initiatives include Catamount Health, Blueprint for Health and employer assessment.

Appendix E: Staffing Approaches for Five States' Health Reform Initiatives

		Staffing Approach for Expansion	New State Staffing Upon Implementation
Massachusetts	Employer Assessment and Section 125 Plans	Responsibilities are split between the Division of Health Care Finance and Policy and the Division of Unemployment Assistance. • Division of Health Care Finance and Policy develops employer assessment (fair share) policies (i.e., filing requirements and compliance rules) and implements Section 125 plan requirements. • Division of Unemployment Assistance applies employer assessment policies, which required implementing a compliance structure including auditors, management and other staff.	• Six to ten new full-time employees (FTEs) for the Division of Unemployment Assistance • One FTE for the Division of Health Care Finance and Policy
	Connector Authority	The Commonwealth established an independent, self-sustaining state authority that manages Commonwealth Care and Commonwealth Choice, develops policy and regulatory components of the reform, and informs public and other interested/affected parties on the new insurance options and requirements associated with health care reform.	• 50 FTEs
New Mexico's SCI		The state created the InsureNM Bureau within the Department of Human Services, along with special State Coverage Insurance units within the Income Support Division of the department.	• 35 FTEs for eligibility determination • 10 FTEs for program management
CoverTN		• Department of Benefits Administration developed, implemented and monitors four major public programs, including CoverTN. • State emphasizes cross-staffing across programs, which has reduced overhead costs, bridged the siloing of public programs and improved staff ability to understand relationships between the various programs and make appropriate referrals for individual consumers.	• Approximately 25 FTEs for all four new health care reform programs. Five of these positions have marketing responsibilities and the remaining 20 have operational, administrative and contracting responsibilities
Vermont .	Catamount Health Plan	State uses existing staff from the Agency of Human Services to determine eligibility for premium assistance.	• 20 FTEs, including six FTE eligibility specialists, six coordination of benefits FTEs and three to four FTEs with business office and quality assurance responsibilities
	Blueprint for Health	State uses 11 FTEs to support the Blueprint; four of these FTEs are dedicated to the Blueprint while others are Department of Health staff who also have non-Blueprint responsibilities.	• Five FTEs
	Employer Assessment	State used pre-existing staff.	• None
Wisconsin's BadgerCare Plus		State primarily used existing staff structure as follows: • Reallocated current staff; • Reprioritized contractor responsibilities; and • Increased contractor budgets if requested work exceeded current contract amounts.	• One FTE to manage outreach to community-based organizations • Two temporary part-time employees to assist in community outreach

Appendix F: Examples of Program Evaluation or Report Requirements in Five States' Health Reform Initiatives

State	Reporting or Evaluation Requirements
Massachusetts	• MassHealth is responsible for the majority of evaluation and reporting functions, including legislative reports and federal waiver reporting and evaluations. • Annual Connector Authority reports.
New Mexico SCI	• Federal waiver reporting requirements include quarterly progress and enrollment reports, monitoring calls with the Centers for Medicare and Medicaid Services, annual reports and final report. • State has a grant with the Robert Wood Johnson Foundation to study employer participation in the State Coverage Insurance program. • State reports on quarterly and annual departmental performance measures.
CoverTN	• Sunset provision in legislation requires a legislative committee to review the program in Fiscal Year 2010. • State produces a standard annual performance report and reviews commercial payer reports on an on-going basis.
Vermont	• The Health Care Reform Commission will review the Catamount Health insurance plans and the Catamount Health Assistance Programs by the end of 2009 to determine the cost-effectiveness of the program. • State legislature requires monthly reports on the Global Commitment waiver, which includes enrollment by category, a financial report and demographic data. This is a new report and has involved a fairly manual and labor intensive process to collect data from multiple sources. State is proposing to move from a monthly to a quarterly reporting process.
Wisconsin BadgerCare Plus	• University of Wisconsin is performing an extensive evaluation of BadgerCare Plus, part of which receives Robert Wood Johnson Foundation funding. • A separate office within the Department of Health Services will perform the federally-required evaluation for Wisconsin's childless adult waiver.