# Executive Summary

The *2011 State of the States: Laying the Foundation for Health Reform* outlines the myriad health-related activities of states in 2010, which were primarily driven by the ongoing effects of the downturn in the American economy and the passage of the Patient Protection and Affordable Care Act (ACA).

## BACKGROUND: FALLING REVENUES AND RISING NEEDS

The two major environmental trends that affected states were falling revenue and the rising need for state-based health coverage. New census numbers released in 2010 showed both a rise in the uninsurance rate to 16.7 percent from the previous 15.4 percent and an increase in the number of people covered by government-financed health insurance from 29.0 percent in 2008 to 30.6 percent in 2009.

As a result of these two trends, states had to close budget shortfalls in state fiscal year (SFY) 2011 that equaled $122.6 billion or 18.9 percent of state budgets on average. This was down from a 29 percent budget shortfall in SFY 2010. Making matters worse, budget stabilization, or rainy day, funds have been depleted across most states. In addition, a national workforce survey reported that 90 percent of respondents said their state government had implemented hiring freezes, with 65 percent instituting pay freezes, and about 46 percent furloughing employees.

Finally, the 2010 elections caused uncertainty and leadership change in many states. New governors were elected in 26 states; 17 of these governorships saw a change of party in control.

## REFORM COMMITTEES AND TASK FORCES

The impact of the ACA cuts across many states agencies, requiring even greater coordination among state-level departments, including those responsible for Medicaid, public health, insurance regulation, and state employee and retiree health coverage. As a result, many governors established multi-agency task forces to coordinate their state's health reform efforts. They also considered ways to engage and include stakeholders through task forces or public committee processes. The *2011 State of the States* includes a chart of the various ways states organized their response to the ACA.

## PRE-EXISTING CONDITION INSURANCE PLANS

One of the first major decisions facing states was whether or not to develop a state-run Pre-Existing Condition Insurance Plan (PCIP, also known as a high risk pool). The ACA's goal for these pools was to offer immediate access to coverage for those with health conditions that had previously prevented them from being able to access insurance. Ultimately, 27 states elected to run their own PCIP, while the remaining 23 states and the District of Columbia have federally-operated PCIPs.

By working with the federal government, states were able to help shape the coverage options available to their populations. This was especially important for states (mostly in New England) that already had insurance market rules that prevented plans from denying coverage based on health conditions. Those states were able to use federal funds to help make coverage more affordable for certain residents.

## INCREASING CAPACITY FOR INSURANCE REGULATION

The ACA included $250 million over five years to increase the capacity of states to review the premium rates of health plans. The first round of grants has been distributed and states are using them to:

- Pursue additional legislative authority for rate review;
- Improve and expand the scope of existing health insurance premium review;
- Make information more transparent and accessible to the public; and
- Develop and upgrade technology.

In addition, the ACA includes a requirement that insurance companies spend at least 80 (in the individual market) to 85 percent (in the small group market) of premiums paid on medical costs. The Secretary of Health and Human Services (HHS) has the ability to allow some exceptions in the individual market if the application of the 80 percent medical loss ratio would destabilize that market in the state.

State insurance departments have been working with health plans and HHS to assess the current market and determine where this exception might be needed.

## LAYING THE FOUNDATION FOR STATE-BASED EXCHANGES

Health benefit exchanges, which were established by the ACA and are required to be operational by January 1, 2014, will be the public face for health reform. Exchanges will be the place where consumers find out whether they are eligible for assistance in paying for insurance, and where they choose a health plan.

States are considering whether or not they will operate an exchange. In 2010, states applied for and received exchange planning grants, in part to help them make this important decision. In addition, states are using those resources to hire initial staff, host planning and stakeholder input meetings, assess current information technology infrastructure, and collect data on demographics and the insurance market that will inform future decisions.

In September, California became the first state to pass legislation to establish an exchange post-ACA. Other states are considering whether they will follow suit in their 2011 legislative session. States planning to seek legislation will need to make the key decision of how the exchange should be governed: through a state agency; an independent agency with a governing board; a non-profit; or a blended variation of those options. Many will follow California's lead of setting up a quasi-independent governing board with broad latitude to shape the policy decisions of the exchange.

## MEDICAID AND THE CHILDREN'S HEALTH INSURANCE PROGRAM PRESENT OPPORTUNITIES AND CHALLENGES

State Medicaid Directors felt the pressure of the ongoing economic crisis from all sides. A rising number of people were eligible for Medicaid and CHIP, resulting in national enrollment growth of 8.5 percent in SFY 2010. There were also imperatives to cut spending in order to meet state budget targets even though the federal government prevented states from reducing eligibility levels. On the other hand, states continued to benefit from an increased Federal Medical Assistance Percentage (FMAP) throughout 2010.

Several trends were evident in the Medicaid program. Provider rate reductions or freezes were common. There has been growth in the utilization of managed care, even for groups that have been traditionally excluded, including those with disabilities and those eligible for long-term care. States have also utilized chronic disease management programs to improve care and restrain spending.

A few states took advantage of the new authority to cover childless adults in the Medicaid program under the ACA, by moving individuals in state-funded programs into the federally-matched Medicaid program. States also continued to take advantage of the performance bonuses in CHIP for states that simplified their eligibility and enrollment processes and increased the number of children both eligible and enrolled.

## REFORMS IMPROVE QUALITY AND CONTAIN COSTS

Even as states work with the federal government to expand access to health care, the problem of growing costs and uneven quality remain. States have become active—both in their governing role and in their role as purchasers—in trying to work with consumers, payers, providers, businesses, and others to improve the health care system and, ultimately, to improve the health of the population. The strategies being employed are: medical homes and other investments in primary care, programs to improve transitions of care between hospitals and community-based settings, payment reform, health information exchanges and other investments in health information technology, development of all-payer claims databases and other key data infrastructure, and a renewed focus on population health. The *2011 State of the States* outlines numerous state activities in each of these areas.

## CONCLUSION

Despite a challenging fiscal environment, states made considerable strides in 2010. In many cases, they used federal resources to accomplish tasks laid out in the ACA. In response to federal health reform, the majority of states are considering the big questions related to their goals for the health system. These conversations have already begun to yield innovative and interesting results with much more to come over the next several years.