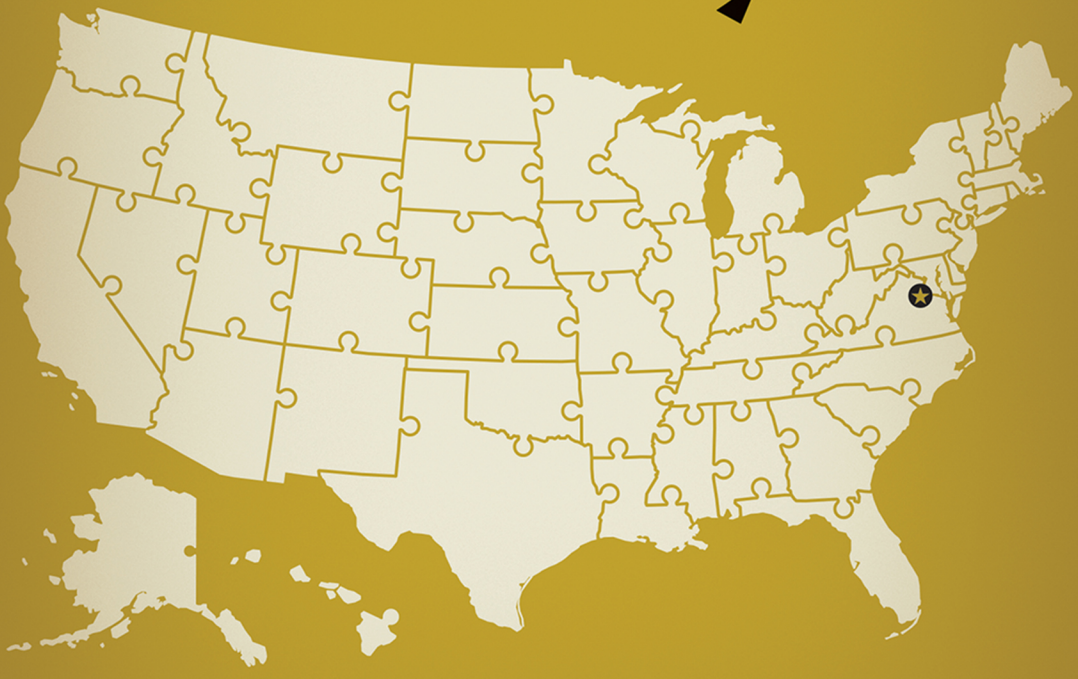
Perspectives on Political and Economic Governance

# American Federalism Today



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# 9

# Federalist System of Healthcare Financing in America

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## *Introduction*

The healthcare sector comprises a prominent segment of the American economy, touching all people's lives and supporting their health and well-being. This sector currently consumes nearly one-fifth of the US GDP, with its share continually rising. In 2019, the healthcare sector employed 11 percent of American workers, and healthcare spending accounted for 8.1 percent of consumer expenditures, one of the largest categories. Healthcare expenditures absorbed over 20 percent of total government spending and over 25 percent of federal government spending; in addition, health insurance constituted 26 percent of nonwage compensation, the largest component (BLS 1980–2019a, 1980–2019b, 2019a, 2019b, 2010–2023; BEA 1987–2019a; CMS 1960–2022; and authors' calculations).

The United States faces serious challenges in maintaining the ever-increasing burden of financing healthcare, which will relentlessly worsen in the upcoming decades. Private funding still makes up the largest financing source of healthcare spending, but this share has been falling steadily and will dip below the 50 percent mark in the next few years. Public funding will soon become the largest financing source, coming from a combination of federal and state coffers. Many commentators have fervently warned about the fiscal unsustainability of current public policies in maintaining the healthcare sector in its existing form with its projected trends.

In seeking policy reforms, all parties balance options in a spectrum demarcated by America's federalist system that allows for varying divisions of responsibilities and authorities between the federal and state governments in operating public programs. Both levels of government play prominent roles in managing and funding healthcare policies, and all policy solutions aimed

at circumventing the looming fiscal crisis in healthcare financing involve a rebalancing of the roles.

At one end of the federalism spectrum, advocates call for a more significant federal role in managing and funding healthcare, such as Medicare for All. These advocates point to the success of other countries in operating such health systems, such jurisdictions having central governments without powerful local governments.

At the other end of the spectrum, advocates promote giving states considerable discretion in offering health programs and more responsibility for funding costly special features. These advocates point to the success of welfare reform adopted in the mid-1990s when the federal government turned authority for designing and operating cash support antipoverty programs to the states and provided block funding grants with few qualifying criteria.

This paper presents an overview of America's health sector, focusing on its financing perspective, and explores the need and options for significant policy reforms to prevent a public fiscal crisis that goes well beyond healthcare alone. More specifically, the following discussion addresses five questions:

- What comprises the financing of healthcare spending in the United States, and where do the different types of health insurance fit into the picture?
- How is the landscape of healthcare financing changing over time?
- What roles do federal and state governments play in the design of healthcare programs and the evolution of their financing?
- What is the nature of the perceived fiscal crisis in healthcare funding?
- What prospects exist for restructuring America's federalist health policy system to create sustainable funding in the upcoming decades?

The discussion below consists of four sections. The first describes the sources of funding for healthcare and the relevance of these sources in financing the care of different segments of the US population. The second section outlines the roles public funding plays in healthcare financing, highlighting the federal government's circumstances. Next, there is a summary of the activities of states in healthcare policies, focused on identifying differences in design and operational features, potentially offering insights into cost-saving approaches. The final section assesses the features and prospects of several reforms of health policies advocated to enhance aspects of competition, reduce public spending, and stem the looming fiscal crisis of health financing.

## *Overview of Healthcare Funding and Insurance*

National health accounts (NHAs) provide the framework for measuring the levels and composition of economic activities and spending in the healthcare sector, with these accounts compatible with national income and product accounts. NHA statistics "identify all goods and services that can be characterized as relating to healthcare in the nation, and determine the amount of money used for the purchase of these goods and services" (Rice, Cooper, and Gibson 1982). NHA data provides essential information for understanding the structure of healthcare funding and delivery in the United States and critical factors underpinning international comparisons and formulation of public health policy.

### Sources of Healthcare Spending and Consumption

Two perspectives exist for measuring NHA activities and spending: where dollars come from (funding sources) and where dollars go (expenditures on goods and services). Figure 9.1 shows the levels and composition of spending from the funding perspective in 2021. For context, figure 9.2 below presents the second measurement perspective, showing the services and products purchased with this spending. The first of these perspectives provides a vital understanding of federalism's role in healthcare financing.

In figure 9.1, private funds sponsor a large portion of direct payments for healthcare, with 20 percent coming from private insurance and 10 percent from out-of-pocket (OOP) payments. Private insurance in NHA includes premiums paid to traditional managed care, self-insured health plans and indemnity plans, and the net cost of private health insurance (the difference between health premiums earned and benefits incurred). Figure 9.1 categorizes spending by sponsor type, aimed at estimating the individual, business, or tax source ultimately responsible for financing healthcare bills. Thus, while NHA data considers private health insurance as a private source of funding, the sponsor classifications in NHA divide this measure into business, household, and government sponsor categories based on who bears the underlying financial responsibility for the health insurance premiums.

Employer-sponsored insurance (ESI) comprises the largest source of health coverage in the United States and the primary source of private health insurance. ESI covers the majority of the nonelderly population, including over 160 million Americans representing over 60 percent of the nonelderly population. Employers offer ESI to their employees and dependents as a benefit of employment, with the bulk of funding coming from premiums paid for by employers and the remainder paid by employees through premium contributions.

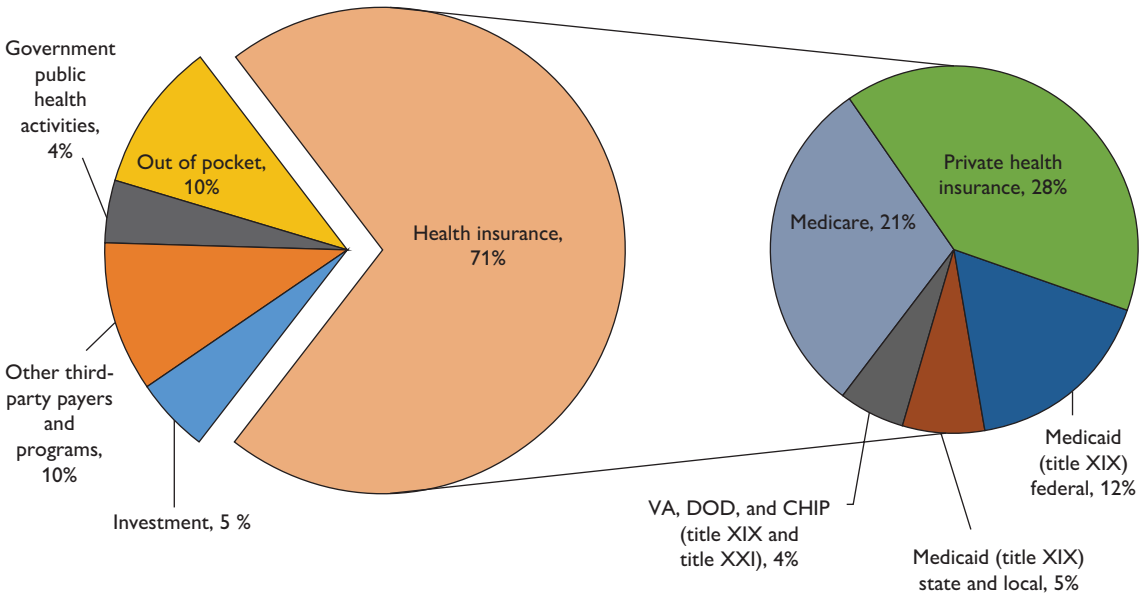


**Figure 9.1** Composition of healthcare funding sources

*Note:* Figures have been rounded, and added sums may not match.

*Source:* CMS 2023b.

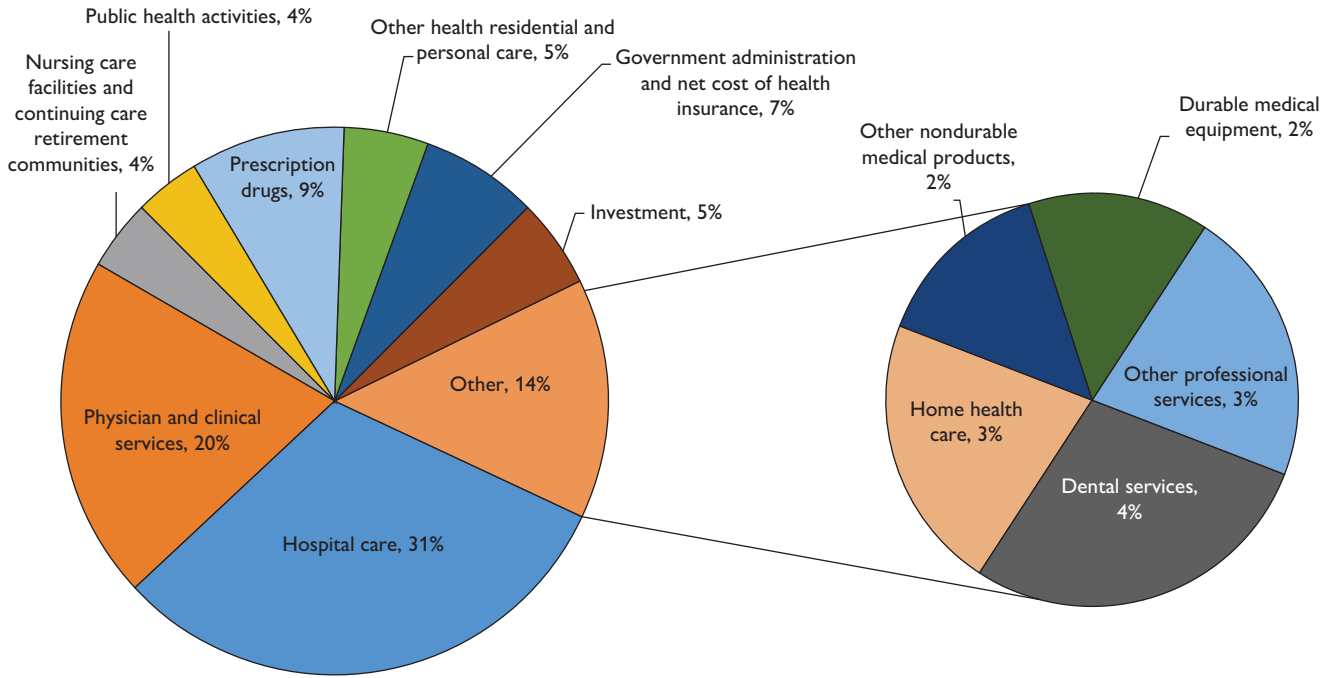


**Figure 9.2** Composition of healthcare expenditures on services and products

*Note:* Figures have been rounded, and added sums may not match.

*Source:* CMS 2023b.

Out-of-pocket funding sources include direct consumer spending for all healthcare goods and services, including coinsurance, deductibles, and any amounts not covered by insurance.

Enacted in 1965, Medicare pays the largest share of public funding for healthcare, contributing 15 percent to overall spending. Medicare provides nearly universal insurance coverage for the elderly (age sixty-five and over) and disabled nonelderly. The structure of Medicare consists of four programs: Part A pays for enrollees' hospital care; Part B pays for outpatient care and physician services; Part C, modernized in 2003, provides an option for Medicare enrollees to receive their health insurance from a private plan (typically a plan with managed care features) rather than through the government; and Part D, enacted in 2006, pays for prescription drugs for enrollees. Medicare subsidizes premiums for all these programs, with Medicare financing leading to the premiums paid by Medicare enrollees falling below actuarially fair values (the values needed to pay for the healthcare costs incurred by Medicare). Most enrollees pay no premiums for Medicare Part A at all. The shortfall in covering Medicare costs comes from payroll and income taxes paid principally by people still in the workforce.

Medicaid, created alongside Medicare in 1965, pays the second largest share of public funding for healthcare, contributing 12 percent to overall spending. Medicaid provides highly subsidized insurance coverage to low-income families, with enrollees essentially making no payments in either premiums or cost sharing. Unlike Medicare, which is run by the federal government and administered uniformly across the United States, Medicaid is jointly run by the federal and state governments. Both levels of government contribute to its public funding, with the federal government matching state funding and solely covering some program services. State governments have wide latitude to set budgets, determine eligibility rules, and decide the relative generosity of their local Medicaid programs.

The Children's Health Insurance Program (CHIP), enacted in 1997, provides medical coverage for youths age eighteen and under whose parents earn too much to qualify for Medicaid but not enough to gain health insurance coverage for their children through private insurance or ESI. CHIP represents a US federal healthcare program administered and named differently by each state, with responsibility for managing CHIP programs falling to the state's Medicaid administration. CHIP provides many free medical services to its enrollees, but some require a copayment. Some states also require a monthly premium that cannot exceed 5 percent of the annual household income. The

bulk of CHIP spending comes from public funding paid by both the federal and state governments. As with Medicaid, the federal government provides matching funds to each state.

The Department of Defense (e.g., TRICARE) and Veterans Affairs (VA) funding sources in figure 9.1 pay for the healthcare services of military personnel and qualified veterans. The federal government solely covers the public funding of this spending.

Not explicitly identified in figure 9.1, the Affordable Care Act (ACA), enacted in 2010, includes premium tax credits and cost-sharing reductions to lower healthcare expenses for lower-income individuals and families and allows states to extend Medicaid coverage to all non-Medicare eligible individuals under age sixty-five (children, pregnant women, parents, and adults without dependent children) with incomes up to 133 percent of the federal poverty level (FPL). The ACA created state-based health benefit exchanges (marketplaces) through which individuals can purchase coverage, with premium and cost-sharing credits available to individuals and families with income between 133 and 400 percent of FPL. It also created separate SHOP (Small Business Health Options Program) exchanges through which small businesses can purchase coverage.

ACA mandated that ACA-compliant health insurance plans cannot deny coverage to anyone, including those with preexisting conditions, and further required employers to pay penalties for employees who received tax credits for health insurance through an exchange, with exceptions for small employers. All ACA-compliant health insurance plans must cover specific "essential health benefits," such as emergency services, family planning, maternity care, hospitalization, prescription medications, mental health services, and pediatric care, and provide preventive services (e.g., checkups, patient counseling, immunizations, and numerous health screenings) to policyholders at no cost.

The federal government covers practically all the spending on ACA, with the cost of marketplace and SHOP subsidies alone reaching about a quarter of the federal spending on Medicaid (CBO 2022, 2023b; and authors' calculations). In figure 9.1, this source of funding principally shows up in the "Other third-party payers and programs" category, with this category accounting for 10 percent of overall healthcare spending in total.

Figure 9.2 shows the allocation of health spending on goods and services. More than half of expenditures go to hospitals and physicians, with hospitals receiving almost a third of all expenditures and physicians earning a fifth. Two

expenditure items fall outside conventional notions of healthcare: administrative costs associated with managing payment systems (government and private insurance) and investment costs related to noncommercial research and structures/equipment. In total, these indirect health expenditures account for 12 percent of spending.

## Growth in Health Spending

Figure 9.3 shows the growth in health spending as a share of the economy since the turn of the century, with the share steadily increasing from 13.3 percent of GDP in 2000 to 18.3 percent in 2021. Sixty years ago, health accounted for 5 percent of the US economy, growing to 12.1 percent in 1990 and 18.3 percent in 2021 (CMS 1960–2022, National Health Expenditure Accounts, and associated downloadable data tables; and authors' calculations). After relatively slow growth throughout the 1990s, the health spending share of the economy increased by 4 percentage points in the first decade of this century and about 1 percentage point in the second decade.

The increase in healthcare funding over the past two decades comes from public funding, with the share paid by private funds essentially remaining constant. Private funds still comprise the largest funding source of healthcare payments, but just barely in 2021 at 51 percent. In 2000, private funding accounted for over 60 percent (CMS 1960–2022, National Health Expenditure Accounts, and associated downloadable data tables;

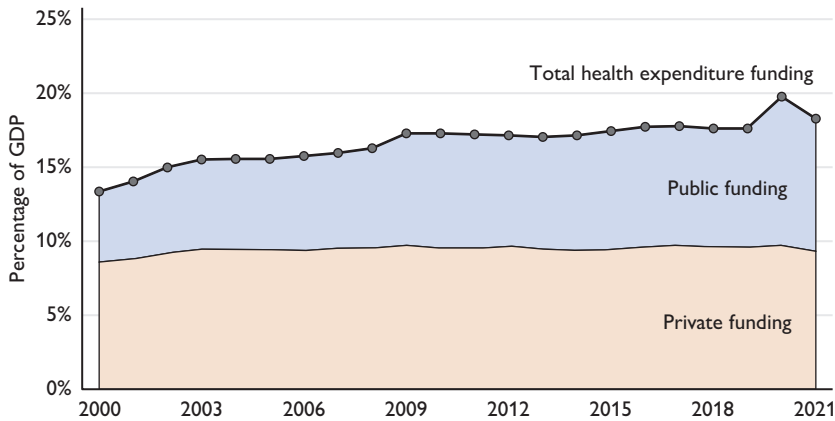


**Figure 9.3** Growth in healthcare spending by source of funds

*Source:* Chantrill 2023, national spending analysis; authors' calculations.

and authors' calculations). The higher share paid by public funding arises from increasing shares of the population enrolled in Medicare, Medicaid, State Children's Health Insurance Programs, and veterans' health benefits. Also, policy changes like the introduction of the Medicare prescription drug benefit (Part D) in 2006 and a significant expansion of Medicaid eligibility in 2014 played important roles.

### Composition of Health Financing and Insurance

Figure 9.4 shows the health insurance and sources of funding coverage of the nonelderly (under age sixty-five) in America in 2021. The figure distinguishes coverage according to three family income levels: below 150 percent of FPL, between 150 and 400 percent, and above 400 percent. Not surprisingly, the types of coverage that people enroll in vary substantially depending on their income.

For the lowest-income families, Medicaid and CHIP fund 57 percent of their health insurance coverage, followed by ESI at 15 percent as the second largest funder. Medicare supplies almost 5 percent of insurance (through its disability eligibility) for this population, with ACA (nongroup coverage and basic health program) covering 4 percent. Around 9 percent of low-income families have no insurance, with the bulk of their healthcare spending ultimately covered by supplementary Medicaid and other government programs, discussed further below.

For middle- and high-income families, ESI delivers most health insurance coverage, covering 52 percent of middle-income individuals and a dominating 88 percent of the highest income. Medicaid, CHIP, and ACA insure about 30 percent of the middle-income group and less than 8 percent of the highest-income population. Nearly 10 percent of middle-income families have no insurance, with less than 8 percent without insurance for the high-income group.

Viewed from a funding source perspective, figure 9.4 suggests that public funding conservatively finances two-thirds of health insurance for low-income nonelderly Americans, about one-third for those with middle incomes, and not more than 9 percent for high-income individuals.

## *Challenges in Public Funding of Healthcare*

As documented above, the principal source funding the increasing healthcare burden in the United States comes from the public side of finance, which the following discussion explores in more detail.

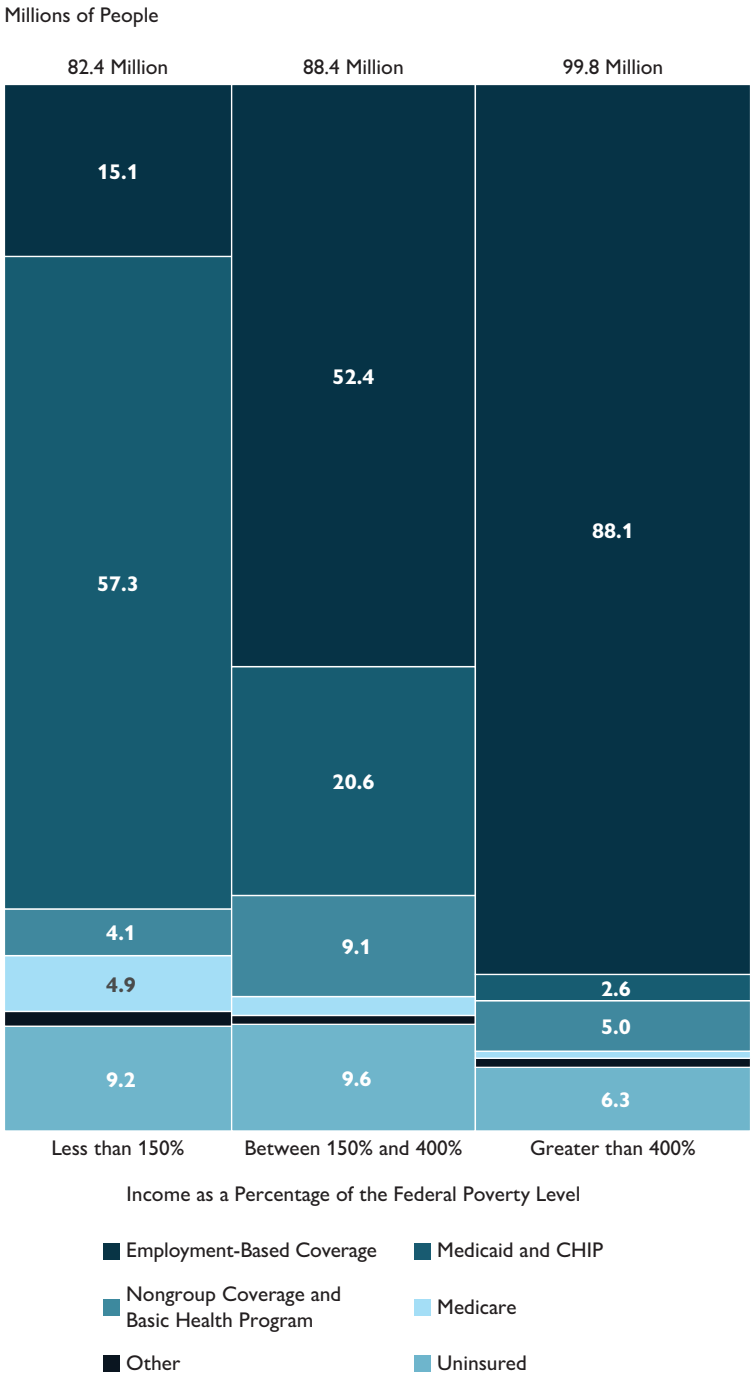


**Figure 9.4** Health insurance coverage for nonelderly

*Source:* CBO 2022.

## Composition and Growth of Government Healthcare Financing

Figure 9.5 decomposes the share of GDP spent on healthcare funded by public financing shown in figure 9.3 into its federal, state, and local government components. The curves track the share of GDP allocated by governments to health spending since 2010 and forecasted through 2028. Combined, federal, state, and local governments expended more than 8 percent of GDP on health in 2023, up from 7.5 percent in 2010, and an amount projected to reach 10 percent by 2028. Local government spending remained slightly below 1 percent of GDP from 2010 to 2023; total state funding increased from 3 to 3.5 percent over this period; and federal government direct spending increased from about 3.5 percent to over 4 percent since 2010, with projections taking it to over 5 percent by 2028.

A substantial part of state and local government spending on healthcare represents pass-through transfers paid for by the federal government. Figures 9.6 and 9.7 document the size and growth of these transfers. Figure 9.6 shows the levels and growth of the share of GDP allocated by the federal government to health, with federal total funding in this figure divided into a direct funding component captured by figure 9.5 and the transfer component supporting state and local total funding shares shown in figures 9.6 and 9.7. Figure 9.7 divides state and local total spending into their direct funding paid for by their treasuries and the federal transfer component provided to support state and local total spending.

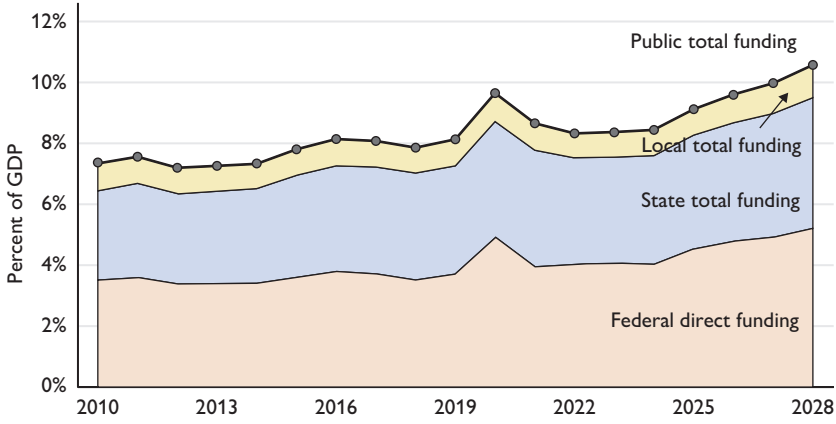


**Figure 9.5** Public spending on healthcare by government sources

*Source:* Chantrill 2023, national spending analysis; authors' calculations.

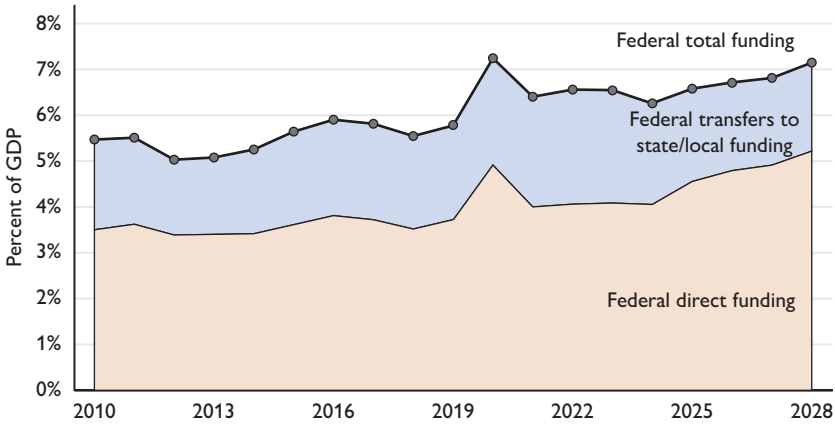


**Figure 9.6** Share of federal health spending transferred to state and local governments

*Sources:* Chantill 2023, national spending analysis; authors' calculations.

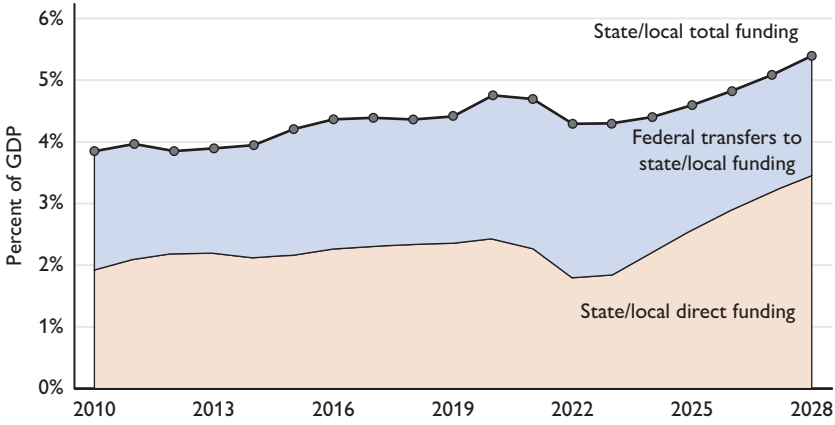


**Figure 9.7** Share of state and local health spending paid by the federal government

*Source:* Chantrill 2023, national spending analysis; authors' calculations.

These figures reveal that federal funding constitutes the primary source of growth in healthcare spending. Federal direct funding has increased by about 0.5 percentage points since 2010, with a projected increase of over 1 percentage point in the next five years. Federal transfers also increased by about 0.5 percentage points since 2010, but current law dictates no growth through 2028. Direct funding by state and local government has fluctuated over the past decade but changed little overall. Federal budget agencies'

five-year forecasts of this direct spending expect this share to rise by 1.5 percentage points to compensate for assumed zero growth in federal transfers. Extrapolating from experience about such budget assumptions strongly suggests that federal transfers will grow in the future as in the past to support most of the growth in total state and local funding needed to fund the anticipated overall increase in healthcare spending.

## Role of Healthcare Financing in Federal Budgets

With the primary growth in healthcare funding coming from the federal government, understanding the role of healthcare spending in the context of the overall federal budget becomes central to reforming policies in America's federalist system of funding healthcare.

The federal government and many state and local governments face a challenging fiscal outlook in maintaining current policies and trends in public spending, given existing profiles for public revenues. Figures 9.8 and 9.9 illustrate the budget outlook for the federal government through the next decade based on the Congressional Budget Office's analyses.

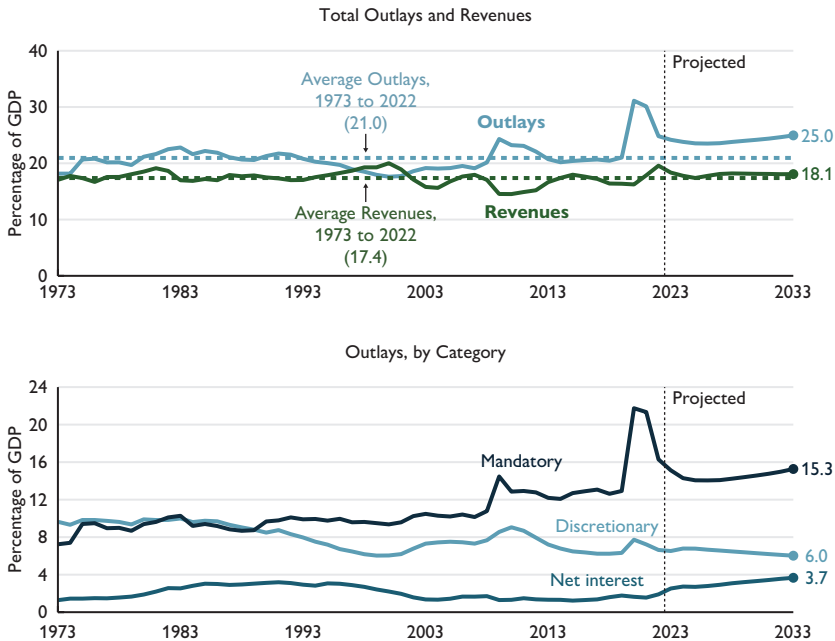


**Figure 9.8** Federal outlays growing faster than revenues

*Source:* CBO 2023a.

Figure 9.8 forecasts federal spending growing from 24 percent of GDP in 2023 to 25 percent in 2033. This trend continues for the following two decades, reaching 29 percent of GDP by 2053. Federal revenues effectively do not increase as a percentage of GDP.

Total spending comprises mandatory and discretionary spending and net outlays for interest. Mandatory spending encompasses outlays governed by statutory criteria and not usually constrained by the annual appropriation process (including most federal benefit programs). Discretionary spending comprises federal activities funded through or controlled by the congressional appropriations process (including most defense spending, infrastructure, education, international affairs, and justice). In the federal budget, net outlays for interest consist of the government's interest payments on federal debt, offset by interest income that the government receives.

Figure 9.8 shows that mandatory spending and interest payments on the debt constitute the primary sources of growth in federal government outlays. After a short recovery from pandemic-related outlays, mandatory spending is projected to grow relentlessly after 2026 from 14 to 15 percent of GDP by 2033 and continuing to 17 percent by 2053. Net outlays for interest will increase significantly during that period—from 2.5 percent of GDP in 2023 to 6.7 percent in 2053.

The projected budget deficits imply that federal debt will reach 120 percent of GDP in the next decade. Forecasts for 2053 indicate a debt of over 180 percent of GDP by 2053 (CBO 2023a, 2023b and associated downloadable data tables; and authors' calculations). The interest payment required to fund this debt would exceed all mandatory spending other than for the major healthcare programs and Social Security by 2027, all discretionary outlays by 2047, and all spending on Social Security by 2051.

Figure 9.9 shows that spending on the major healthcare programs and interest account for the overall growth in federal outlays in the next three decades. Under current policies, budget forecasts estimate that the share of federal outlays allocated to major health programs will grow by 11 percentage points over the next three decades. Estimates place the share of outlays devoted to interest to increase by 13 percentage points.

Medicare spending growth accounts for more than four-fifths of the forecasted increase in spending on the major healthcare programs over the next thirty years, with Medicare spending equaling 3.1 percent of GDP in 2023 and projected to reach 5.5 percent in 2053 (CBO 2023c, figs. 2–4). Spending on Medicaid and CHIP and the spending related to ACA (e.g., subsidies for

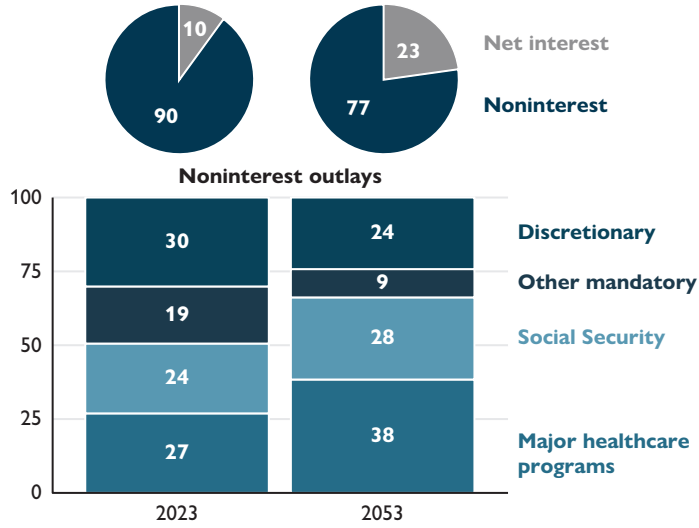


**Figure 9.9** Sources of growth in federal outlays

*Note:* Figures have been rounded, and added sums may not match.

*Source:* CBO 2023c.

health insurance purchased through the marketplaces) is projected to grow by 0.4 percentage points over the next three decades, starting at 2.7 percent of GDP in 2023 and reaching 3.1 percent in 2053.

Over the past five decades, spending on major healthcare programs has grown faster than the economy, with this trend projected to persist in the foreseeable future. Net federal spending on those programs amounts to 5.8 percent of GDP in 2023 and increases to 8.6 percent in 2053.

## Fiscal Need for Major Reforms of Health Policies

Stemming the unsustainable growth in the federal debt and the resulting devouring of federal spending by interest payments requires substantial reforms in federal healthcare funding. While states' total spending on healthcare programs rose over the past decades as a share of GDP, this increase came principally from federal transfers and not from state and local governments' own revenues. Experience suggests that there will be little change in this trend in the upcoming decades. Future increases in states' direct funding might arise in response to federal mandates requiring payments by states for eligibility and services not principally paid for by federal funds—e.g., the federal government could remove its commitment to fully fund the expansion

of Medicaid eligibility provided by ACA—but states' balanced budget constraints would effectively prevent such expansions.

The next section summarizes the differences in the health insurance programs and regulations currently in effect in states to provide perspective on the range of options states currently have to innovate and design their own approaches to healthcare funding. This perspective offers a framework for assessing the wisdom of expanding states' role in healthcare financing and regulation in an era when the federal government does not have the fiscal capacity to maintain current policy and is unlikely to have the political capabilities to enact substantial reforms.

## *Variation across States in Healthcare Funding*

While the federal government plays a dominant role in financing and regulating healthcare in the United States, state governments are also important, as seen in previous sections. In principle, states have considerable leeway on healthcare markets, including significant issues such as what services insurance policies are required to cover, who is eligible for public insurance, and other vital topics. However, federal law considerably constrains state power and thus often limits or preempts the range of state authority in these areas.

This section surveys three significant areas of state decision making on healthcare: (1) the administration of the Medicaid and CHIP programs; (2) the administration of the ACA; and (3) the regulation of private insurance and healthcare service organizations. Despite the potentially expansive scope of state activities, the state's role in healthcare—at least regarding healthcare financing—is surprisingly limited relative to the role played by the federal government and the private sector.

### Overview of State Differences in Medicaid and CHIP

States have considerable freedom of action in the administration of the Medicaid program in some aspects, less so in others. Medicaid covers a range of healthcare services, such as primary and preventive care, hospital care, prescription drugs, long-term care, and dental and vision care for children. The benefits and costs of Medicaid vary by state and eligibility group, but they must meet certain federal standards of adequacy and affordability. The 2010 expansion of Medicaid under the ACA allowed states to cover adults with incomes up to 138 percent of the federal poverty level (FPL), or about $17,000 for an individual in 2021. However, not every state has opted to expand Medicaid coverage under ACA's provisions.

CHIP is a critical element of the healthcare safety net in the United States. Like Medicaid, CHIP is a federal-state partnership. It provides health insurance coverage to low-income children who are not eligible for Medicaid but whose families cannot afford private insurance. Also, like Medicaid, the CHIP program covers a comprehensive set of services, such as preventive care, immunizations, hospital care, dental care, vision care, and mental health services. While CHIP eligibility, benefits, and costs vary by state, the federal government limits state variation by requiring that each state's CHIP program meets specific federal standards.

The remainder of this section discusses some critical moving parts of the Medicaid and CHIP programs, emphasizing the aspects that vary the most across states. These indicate the range and directions of experimentation with these programs that the federal government permits states to conduct under current law. First is a discussion of different types of healthcare organizations authorized by Medicaid programs—independent physician groups and hospitals paid via a traditional fee-for-service system, managed care organizations paid via a capitation arrangement, and a variation on managed care organizations called primary-care case management. The following section discusses variations in state administration of Medicaid nursing home services for the elderly. The last section discusses state variation in CHIP eligibility.

### *States' Use of Medicaid Managed Care*

Medicaid managed care delivery is a model of providing healthcare services to Medicaid beneficiaries through contracts with private managed care organizations (MCOs) that assume the risk and responsibility of coordinating and paying for the care of their enrollees. Medicaid managed care delivery has grown significantly in the past decades as states have sought to improve access, quality, and efficiency of care for their Medicaid populations while containing costs. The number of states that use Medicaid managed care delivery has increased from twenty-seven in 1999 to forty in 2019. The types of managed care arrangements that states use vary, but the most common are comprehensive risk-based MCOs, which cover a broad range of physical and behavioral health services for a fixed monthly payment per enrollee.

The proportion of Medicaid beneficiaries enrolled in Medicaid managed care delivery increased from 57 percent in 2008 to 69 percent in 2018. The enrollment varies by state, eligibility group, and service type, but most children, adults, and pregnant women are enrolled in comprehensive risk-based

MCOs. At the same time, the elderly and disabled are more likely to be enrolled in fee-for-service (FFS) or other arrangements. The spending on Medicaid managed care delivery has increased from $92 billion in 2008 to $308 billion in 2018. The spending accounts for about half of the total Medicaid spending and varies by state, eligibility group, and service type. The spending growth reflects the expansion of enrollment, benefits, and payment rates for Medicaid managed care delivery.

Table 9.1 displays the proportion of Medicaid enrollees in each state in 2021 who receive care through a comprehensive managed care plan or through a primary-care case management organization (PCCM); the remainder enroll through a more traditional FFS arrangement and may also have coverage through limited benefit plans that cover, for instance, dental care and other ancillary healthcare expenses. A PCCM is a type of managed care

**Table 9.1** State variation in Medicaid managed care

| State | % in comprehensive MCO | % in PCCM |
|---|---|---|
| Alabama | 0.0 | 79.3 |
| Alaska | — | — |
| Arizona | 80.0 | — |
| Arkansas | 4.7 | 42.4 |
| California | 82.4 | — |
| Colorado | 10.6 | 84.3 |
| Connecticut | — | — |
| DC | 81.1 | — |
| Delaware | 87.1 | — |
| Florida | 78.3 | — |
| Georgia | 72.1 | — |
| Hawaii | 100.0 | — |
| Idaho | 5.6 | 80.8 |
| Illinois | 75.4 | — |
| Indiana | 78.8 | — |
| Iowa | 93.9 | — |
| Kansas | 88.1 | — |
| Kentucky | 89.4 | — |
| Louisiana | 85.3 | — |

**Table 9.1** (*continued*)

| State | % in comprehensive MCO | % in PCCM |
|---|---|---|
| Maine | — | 68.9 |
| Maryland | 85.4 | — |
| Massachusetts | 40.5 | 26.9 |
| Michigan | 100.0 | — |
| Minnesota | 86.7 | — |
| Mississippi | 61.2 | — |
| Missouri | 74.2 | — |
| Montana | — | 79.2 |
| Nebraska | 99.6 | — |
| Nevada | 75.6 | — |
| New Hampshire | 91.3 | — |
| New Jersey | 96.2 | — |
| New Mexico | 83.0 | — |
| New York | 75.2 | — |
| North Carolina | 60.6 | 20.3 |
| North Dakota | 27.0 | 41.8 |
| Ohio | 85.9 | — |
| Oklahoma | 0.1 | 58.4 |
| Oregon | 85.8 | — |
| Pennsylvania | 93.9 | — |
| Rhode Island | 84.6 | — |
| South Carolina | 66.6 | 0.1 |
| South Dakota | — | 61.1 |
| Tennessee | 92.9 | — |
| Texas | 81.7 | — |
| Utah | 82.9 | — |
| Vermont | 68.5 | — |
| Virginia | 91.3 | — |
| Washington | 88.3 | 0.2 |
| West Virginia | 81.0 | — |
| Wisconsin | 69.1 | — |
| Wyoming | — | — |

*Source:* MACPAC 2023, Exhibit 29, "Percentage of Medicaid Enrollees in Managed Care by State."

arrangement in the Medicaid program that provides coordinated and comprehensive care to Medicaid beneficiaries through a primary-care provider (PCP). A PCP is a physician, nurse practitioner, or other healthcare professional who serves as the main point of contact for the beneficiary's healthcare needs. The PCP is responsible for providing preventive and primary-care services, making referrals to specialists and other providers, and overseeing the quality and utilization of care. The PCP receives a monthly fee from the state for each beneficiary enrolled in their practice, in addition to the fee-for-service payments for the services they provide.

A PCCM differs from a managed care organization, which is a private entity that contracts with the state to provide a full range of healthcare services to Medicaid beneficiaries for a fixed monthly payment per enrollee. A PCCM is usually less restrictive and costly than an MCO but may offer fewer benefits and less care coordination. The availability and features of PCCMs vary by state, depending on their policy goals and operational capacities.

### *Differences in Medicaid Nursing Home Benefits for the Elderly*

While Medicare provides comprehensive financing of healthcare services for the elderly, including doctors, hospitals, and prescription drugs, it does not provide payments for long-term nursing home care. Instead, nursing home benefits are one of the long-term care services that Medicaid covers for elderly people who qualify for the program. States vary in how they provide nursing home benefits, including eligibility criteria, availability of nursing home beds, reimbursement rates, and support for managed care as a vehicle to pay for nursing home benefits.

*The eligibility criteria for nursing home benefits* States have different income and asset limits, functional and medical needs assessments, and spousal impoverishment protections for determining who qualifies for nursing home benefits under Medicaid. For example, some states use the federal minimum income limit ($2,382 per month for an individual in 2021), while others use higher or lower limits. Some states also have more or less stringent criteria for assessing the level of care needed for nursing home admission.

*The availability and quality of nursing home beds* States have different supply and demand factors that affect the availability and quality of nursing home beds for Medicaid beneficiaries. For example, states vary in the number

of nursing home beds per elderly resident and the quality ratings of nursing homes. Some states also have moratoriums or certificate-of-need laws that restrict the expansion or entry of new nursing homes.

*The reimbursement rates and policies for nursing homes* States have different methods and levels of reimbursing nursing homes for providing care to Medicaid beneficiaries. For example, some states use case-mix systems that adjust payments based on the complexity of residents, while others use flat rates or other systems. States vary in Medicaid daily payments to nursing homes, incentive payments, quality adjustments, and supplemental payments.

*The use of managed care or waiver programs for nursing home benefits* States have different approaches to delivering and financing nursing home benefits through managed care or waiver programs that aim to improve care coordination, quality, and efficiency. For example, some states contract with managed care organizations that assume the risk and responsibility of providing nursing home benefits to Medicaid beneficiaries, while others use fee-for-service or other arrangements. Some states also apply for waivers from the federal government that allow them to provide home and community-based services as an alternative to nursing home care for eligible beneficiaries.

### *Differences in CHIP Eligibility*

Rules for children to be eligible for the CHIP program vary across states, depending on their income thresholds, enrollment caps, waiting periods, and other criteria. Generally, states can cover children up to age nineteen with family incomes up to 200 percent of the federal poverty level, or about $53,000 for a family of four in 2021. However, some states have higher or lower income limits, ranging from 133 percent to 400 percent of the FPL. Some states also have CHIP programs covering pregnant women, parents, and adults.

The benefits and costs of CHIP also vary across states, but they must meet certain federal standards. CHIP benefits must include a comprehensive set of services, such as preventive care, immunizations, hospital care, dental care, vision care, and mental health services. CHIP costs must be affordable and cannot exceed 5 percent of the family's income. States can charge premiums, copayments, or deductibles for CHIP enrollees, depending on their income and the type of services they use.

Table 9.2 displays the income eligibility levels for families to qualify for the CHIP program in 2021 in each state. These ranges are shown as a proportion of the federal poverty level. For instance, "100–125 percent" means that a family would qualify for CHIP if its income was between 100 percent and 125 percent of the federal poverty level. Under CHIP, states can implement Medicaid expansion, separate CHIP, or a combination program. Ten states (Alaska, Hawaii, Maryland, New Hampshire, New Mexico, North Dakota, Ohio, South Carolina, Vermont, and Wyoming) and the District of Columbia use Medicaid expansion, and two states (Connecticut and Washington) use separate CHIP. Thirty-eight states use combination programs, although some of these are combination programs solely due to the transition of children in families with income less than or equal to 133 percent FPL from separate CHIP to Medicaid. In five states with combination programs (Michigan, Minnesota, Nebraska, Oklahoma, and Rhode Island), separate CHIP coverage is only through the unborn child option. This option makes children eligible for CHIP even while in their mother's womb, and it is especially important for children born to undocumented immigrant mothers who may themselves not qualify for Medicaid.

Under Medicaid-funded coverage, there is no lower threshold for income eligibility. The eligibility levels listed in table 9.2 are the highest income levels under which each age group of children is covered under the Medicaid state plan. The eligibility levels listed under CHIP-funded Medicaid coverage are the income levels to which Medicaid has expanded using CHIP funds, which became available when Congress authorized CHIP in 1997. For states that set different CHIP-funded eligibility levels for children ages six to thirteen and fourteen to eighteen, this table shows only the levels for children ages six to thirteen. In addition, Section 2105(g) of the act permits eleven qualifying states to use CHIP funds to pay the difference between the regular Medicaid matching rate and the enhanced CHIP matching rate for Medicaid-enrolled, Medicaid-financed uninsured children whose family income exceeds 133 percent FPL (not separately noted on this table).

## Differences in Affordable Care Act

While the ACA is a federal law, it relies heavily on decisions by states to implement it. As with Medicaid and CHIP, though, the range of options the federal government permits states to make is limited. A significant exception to this statement is that—due to a decision by the US Supreme Court—states have the option not to implement ACA's expansion of Medicaid eligibility for

**Table 9.2** CHIP eligibility thresholds as a percentage of the federal poverty level

| | | M-CHIP (Medicaid expansion CHIP) | | | Separate CHIP for uninsured children age 0–18 | |
|---|---|---|---|---|---|---|
| **State** | **CHIP program type** | **Infants under age 1** | **Age 1–5** | **Age 6–18** | **Birth through age 18** | **Unborn children** |
| Alabama | Combination | — | — | 107–141 | 312 | — |
| Alaska | Medicaid expansion | 159–203 | 159–203 | 124–203 | — | — |
| Arizona | Combination | — | — | 104–133 | 200 | — |
| Arkansas | Combination | — | — | 107–142 | 211 | 209 |
| California | Combination | 208–261 | 142–261 | 108–261 | — | 317 |
| Colorado | Combination | — | — | 108–142 | 260 | — |
| Connecticut | Separate | — | — | — | 318 | — |
| DC | Combination | 194–212 | — | 110–133 | 212 | — |
| Delaware | Medicaid expansion | 206–319 | 146–319 | 112–319 | — | — |
| Florida | Combination | 192–206 | — | 112–133 | — | — |
| Georgia | Combination | — | — | 113–133 | 247 | — |
| Hawaii | Medicaid expansion | 191–308 | 139–308 | 105–308 | — | — |
| Idaho | Combination | — | — | 107–133 | 185 | — |
| Illinois | Combination | — | — | 108–142 | 313 | 208 |
| Indiana | Combination | 157–208 | 141–158 | 106–158 | 250 | — |
| Iowa | Combination | 240–375 | — | 122–167 | 302 | — |
| Kansas | Combination | — | — | 113–133 | 225 | — |

(*continued*)

**Table 9.2** (*continued*)

| State | CHIP program type | M-CHIP (Medicaid expansion CHIP) | | | Separate CHIP for uninsured children age 0–18 | |
|---|---|---|---|---|---|---|
| | | Infants under age 1 | Age 1–5 | Age 6–18 | Birth through age 18 | Unborn children |
| Kentucky | Combination | — | 142–159 | 109–159 | 213 | — |
| Louisiana | Combination | 142–212 | 142–212 | 108–212 | 250 | 209 |
| Maine | Combination | — | 140–157 | 132–157 | 208 | — |
| Maryland | Medicaid expansion | 194–317 | 138–317 | 109–317 | — | — |
| Massachusetts | Combination | 185–200 | 133–150 | 114–150 | 300 | 200 |
| Michigan | Combination | 195–212 | 143–212 | 109–212 | — | 195 |
| Minnesota | Combination | 275–283 | — | — | — | 278 |
| Mississippi | Combination | — | — | 107–133 | 209 | — |
| Missouri | Combination | — | 148–150 | 110–150 | 300 | 300 |
| Montana | Combination | — | — | 109–143 | 261 | — |
| Nebraska | Combination | 162–213 | 145–213 | 109–213 | — | 197 |
| Nevada | Combination | — | — | 122–133 | 200 | — |
| New Hampshire | Medicaid expansion | 196–318 | 196–318 | 196–318 | — | — |
| New Jersey | Combination | — | — | 107–142 | 350 | — |
| New Mexico | Medicaid expansion | 200–300 | 200–300 | 138–240 | — | — |
| New York | Combination | — | — | 110–149 | 400 | — |

**Table 9.2** (*continued*)

| State | CHIP program type | M-CHIP (Medicaid expansion CHIP) | | | Separate CHIP for uninsured children age 0–18 | |
|---|---|---|---|---|---|---|
| | | Infants under age 1 | Age 1–5 | Age 6–18 | Birth through age 18 | Unborn children |
| North Carolina | Combination | 194–210 | 141–210 | 107–133 | 211 | — |
| North Dakota | Medicaid expansion | 147–170 | 147–170 | 111–170 | — | — |
| Ohio | Medicaid expansion | 141–206 | 141–206 | 107–206 | — | — |
| Oklahoma | Combination | 169–205 | 151–205 | 115–205 | — | 205 |
| Oregon | Combination | 133–185 | — | 100–133 | 300 | 185 |
| Pennsylvania | Combination | — | — | 119–133 | 314 | — |
| Rhode Island | Combination | 190–261 | 142–261 | 109–261 | — | 253 |
| South Carolina | Medicaid expansion | 194–208 | 143–208 | 107–208 | — | — |
| South Dakota | Combination | 147–182 | 147–182 | 111–182 | 204 | 133 |
| Tennessee | Combination | — | — | 109–133 | 250 | 250 |
| Texas | Combination | — | — | 109–133 | 201 | 202 |
| Utah | Combination | — | — | 105–133 | 200 | — |
| Vermont | Medicaid expansion | 237–312 | 237–312 | 237–312 | — | — |
| Virginia | Combination | — | — | 109–143 | 200 | — |
| Washington | Separate | — | — | — | 312 | 193 |
| West Virginia | Combination | — | — | 108–133 | 300 | — |
| Wisconsin | Combination | — | — | 101–151 | 301 | 301 |
| Wyoming | Medicaid expansion | 154–200 | 154–200 | 119–200 | — | — |

*Source:* MACPAC 2023, Exhibit 35, "Medicaid and CHIP Income Eligibility Levels as a Percentage of the FPL for Children and Pregnant Women by State."

certain low-income individuals. This section discusses four additional aspects with important state inputs: Section 1332 waivers under ACA, which gives states some options for the administration of ACA; the state operation of ACA insurance exchange markets; state-sponsored "public option" insurance plans offered on these markets; and state actions to increase the availability of ACA health insurance plans for rural residents.

### *States' Use of Section 1332 Waivers under ACA*

A Section 1332 waiver is a provision of ACA that allows states to apply for a waiver of certain requirements of the law and implement alternative strategies for providing health insurance coverage to their residents. These waivers aim to enable states to pursue innovative and flexible approaches that are at least as comprehensive, affordable, and accessible as ACA and do not increase the federal deficit. Some examples of policies that states have implemented or proposed under Section 1332 waivers are reinsurance programs, state-based subsidies, basic health programs, and waivers of the small business health options program.

Some limitations exist on what policies states can implement under Section 1332 waivers. According to ACA, states can only request waivers of certain provisions of the law, such as the individual and employer mandates, the essential health benefits, the premium tax credits and cost-sharing reductions, the marketplaces, and the metal tiers of coverage (bronze, silver, gold, and platinum). States cannot waive other consumer protections, such as the guarantee issue, rating rules, and the prohibition on preexisting condition exclusions. States must also enact a law authorizing actions under the waiver before applying for federal approval. Additionally, states must demonstrate that their waiver proposals meet the following four criteria, known as the guardrails:

- *Coverage must be comprehensive.* States must provide coverage at least as comprehensive as the essential health benefits required under ACA.
- *Coverage must be affordable.* States must provide coverage that is at least as affordable as what would be provided under ACA, considering premiums, deductibles, copayments, and other out-of-pocket costs.
- *A comparable number of people must have coverage.* States must ensure that at least an equivalent number of residents have health insurance coverage under the waiver as would have coverage without it.

- *The waiver must not increase the federal deficit.* States must show that their waiver will not increase the federal deficit over the waiver period (which can be up to five years) or over the ten-year budget plan submitted by the state.

Examples of policies that states have implemented under Section 1332 waivers include the following programs.

*Reinsurance programs* Several states have established reinsurance programs to help lower premiums and stabilize the individual health insurance market. Table 9.3 provides a list of states with such programs. Reinsurance programs provide payments to insurers for high-cost enrollees, reducing the risk and uncertainty that insurers face. These states have received federal approval to use a portion of the savings from lower marketplace subsidies (due to lower premiums) to help fund their reinsurance programs, a system known as pass-through funding.

**Table 9.3** State reinsurance programs, as of July 2022

| State | Effective years | Notes |
|---|---|---|
| Alaska | 2018–22 | On March 17, 2022, Alaska submitted a Section 1332 waiver extension application to extend its currently approved waiver. The Departments are reviewing the extension application and the public comment period ended on May 18, 2022. |
| Colorado | 2023–27 | On June 23, 2022, CMS approved Colorado's request to amend its State Innovation Waiver under Section 1332 of ACA. This approval is effective from January 1, 2023, through December 31, 2027. |
| Delaware | 2020–24 | |
| Georgia | 2022–26 | On April 29, 2022, the Departments sent a letter to Georgia informing the State that the departments were suspending Part II of Georgia's Section 1332 waiver, the Georgia Access Model, until certain requirements are met. |

(*continued*)

**Table 9.3** (*continued*)

| State | Effective years | Notes |
|---|---|---|
| Idaho | | On May 5, 2022, Idaho submitted a Section 1332 waiver application. The Departments are reviewing the waiver application, and the public comment period ended on July 3, 2022. |
| Maine | 2019–23 | On February 10, 2022, Maine submitted a Section 1332 waiver amendment application to amend its currently approved waiver. The amendment would extend its current reinsurance program to a pooled individual and small group market and transition to a retrospective claims cost-based reinsurance program. The Departments are reviewing the waiver. The public comment period ended on April 26, 2022. |
| Maryland | 2019–23 | |
| Minnesota | 2018–22 | On May 12, 2022, Minnesota submitted a Section 1332 waiver extension application to extend its currently approved waiver. CMS is reviewing the extension application, and the public comment period ended on July 3, 2022. |
| Montana | 2020–24 | |
| New Hampshire | 2021–25 | |
| New Jersey | 2019–23 | |
| North Dakota | 2020–24 | |
| Oregon | 2018–22 | On March 31, 2022, Oregon submitted a Section 1332 waiver extension application to its currently approved waiver. The Departments are reviewing the extension application and the public comment period ended on June 4, 2022. |
| Pennsylvania | 2021–25 | |
| Rhode Island | 2020–24 | |
| Virginia | 2023–27 | The Departments approved Virginia's waiver application on May 18, 2022. |
| Wisconsin | 2019–23 | |

*Note:* The "Departments" are the US Department of Health and Human Services and the Department of the Treasury.

*Source:* CMS 2022.

*State-based subsidies* A few states, such as California and Vermont, have created state-based subsidies to supplement the federal marketplace subsidies and make coverage more affordable for low- and moderate-income consumers. These states have also received pass-through funding to offset some of the costs of their state-based subsidies.

*Basic Health Program (BHP)* Minnesota and New York have established BHPs to provide coverage to low-income residents who are not eligible for Medicaid but would otherwise qualify for marketplace subsidies. BHPs offer standardized plans with lower premiums and cost sharing than marketplace plans. These states have also received pass-through funding equal to 95 percent of the federal marketplace subsidies that BHP enrollees would have received if they had enrolled in marketplace plans.

*Waiver of Small Business Health Options Program (SHOP)* Hawaii has waived the requirement to establish a SHOP, the marketplace for small businesses, because it has a long-standing state law requiring employers to offer their employees health insurance. Hawaii has also received pass-through funding equal to the amount of small business tax credits that would have been available under ACA.

### *State-Run ACA Insurance Exchange Marketplaces*

A federally facilitated marketplace (FFM) is a health insurance marketplace operated by the federal government through the website HealthCare.gov. A state-based marketplace (SBM) is a health insurance marketplace operated by a state through its own website. Both types of marketplaces are created under ACA to provide consumers with access to affordable and comprehensive health insurance plans. Table 9.4 provides a list of which states have federally run exchanges and which states have state-run exchanges. The table also lists the average number of insurance providers in rural areas in 2020; many states have only a single plan available. For every plan sold in the ACA health insurance exchanges, the ACA requires that the medical loss ratio of plans be at least 80 percent. This means that, at most, 20 percent of health plan premiums are permitted to be spent on nonmedical reimbursement items such as administrative costs, profits, etc.

The main difference between an FFM and an SBM is each state's level of control and flexibility over its marketplace. States that choose to operate their own SBMs can tailor their marketplaces to meet their specific needs and

**Table 9.4** Exchange features by state

| State | Exchange type | Average number of issuers in rural areas, PY2020 |
|---|---|---|
| Alabama | Federally facilitated marketplace | 1 |
| Alaska | Federally facilitated marketplace | 1 |
| Arizona | Federally facilitated marketplace | 2 |
| Arkansas | State-based marketplace, federal platform | 4 |
| California | State-based marketplace | 2 |
| Colorado | State-based marketplace | 4 |
| Connecticut | State-based marketplace | 4 |
| DC | State-based marketplace | N/A |
| Delaware | Federally facilitated marketplace | N/A |
| Florida | Federally facilitated marketplace | 3 |
| Georgia | Federally facilitated marketplace | 2 |
| Hawaii | Federally facilitated marketplace | 2 |
| Idaho | State-based marketplace | 5 |
| Illinois | Federally facilitated marketplace | 2 |
| Indiana | Federally facilitated marketplace | 2 |
| Iowa | Federally facilitated marketplace | 2 |
| Kansas | Federally facilitated marketplace | 3 |
| Kentucky | State-based marketplace | 2 |
| Louisiana | Federally facilitated marketplace | 3 |
| Maine | State-based marketplace | 3 |
| Maryland | State-based marketplace | 2 |
| Massachusetts | State-based marketplace | 8 |
| Michigan | Federally facilitated marketplace | 4 |
| Minnesota | State-based marketplace | 4 |
| Mississippi | Federally facilitated marketplace | 3 |
| Missouri | Federally facilitated marketplace | 3 |
| Montana | Federally facilitated marketplace | 3 |
| Nebraska | Federally facilitated marketplace | 2 |
| Nevada | State-based marketplace | 3 |
| New Hampshire | Federally facilitated marketplace | 3 |
| New Jersey | State-based marketplace | N/A |

**Table 9.4** (*continued*)

| State | Exchange type | Average number of issuers in rural areas, PY2020 |
|---|---|---|
| New Mexico | State-based marketplace | 5 |
| New York | State-based marketplace | 7 |
| North Carolina | Federally facilitated marketplace | 2 |
| North Dakota | Federally facilitated marketplace | 3 |
| Ohio | Federally facilitated marketplace | 5 |
| Oklahoma | Federally facilitated marketplace | 2 |
| Oregon | State-based marketplace, federal platform | 6 |
| Pennsylvania | State-based marketplace | 6 |
| Rhode Island | State-based marketplace | N/A |
| South Carolina | Federally facilitated marketplace | 4 |
| South Dakota | Federally facilitated marketplace | 2 |
| Tennessee | Federally facilitated marketplace | 3 |
| Texas | Federally facilitated marketplace | 2 |
| Utah | Federally facilitated marketplace | 3 |
| Vermont | State-based marketplace | 2 |
| Virginia | State-based marketplace, federal platform | 2 |
| Washington | State-based marketplace | 3 |
| West Virginia | Federally facilitated marketplace | 3 |
| Wisconsin | Federally facilitated marketplace | 4 |
| Wyoming | Federally facilitated marketplace | 1 |

*Sources:* (Column 2) KFF 2024; (column 3) CMS 2023a.

preferences, such as setting their own open enrollment periods, establishing their own eligibility and enrollment systems, certifying their own qualified health plans, conducting their own consumer outreach and assistance, and implementing their own policies and innovations to improve access and affordability. States that use the FFM rely on the federal government to perform most of these functions, although they can still regulate their insurance markets and assist consumers with enrollment.

One example of an option that the federal government has left open to states that operate their own ACA marketplace is that they are permitted

flexibility over open enrollment periods. These are the time frames when individuals can enroll in or change their health insurance plans through the marketplaces created by ACA. The federal open enrollment period for 2022 coverage ran from November 1, 2021, to January 15, 2022. However, states that operate their own marketplaces have the flexibility to extend their open enrollment periods beyond the federal deadline. States differ in how long and when they extend their open enrollment periods, depending on their policy goals and operational capacities.

### *State-Run "Public Option" Insurance Plan Offered on ACA Exchange*

A public option is a health insurance plan offered by the government, alongside private plans, on the health insurance marketplaces created by ACA. The public option aims to give consumers more choice, competition, and affordability in the health insurance market. ACA legislation itself does not provide financing or authorization for a federal public option, but several states have passed legislation to offer one. As of 2022, three states provide a public option on their ACA health insurance markets:

- *Colorado*: The state's public option, known as the Colorado Option, is a standardized plan offered by private insurers but regulated by the state. The plan has lower premiums and cost sharing than other plans on the marketplace and covers essential health benefits, preventive services, and primary care. The state also sets reimbursement rates for providers and hospitals participating in the plan.
- *Nevada*: The state's public option, known as the Nevada Public Option, is a plan offered by private insurers that contract with the state's Medicaid managed care organizations. The plan has lower premiums and cost sharing than other plans on the marketplace and covers essential health benefits, preventive services, and behavioral health. The state also sets reimbursement rates for providers and hospitals participating in the plan.
- *Washington*: The state's public option, known as Cascade Care, is a set of standardized plans offered by private insurers but administered by the state. The plans have lower premiums and cost sharing than other plans on the marketplace and cover essential health benefits, preventive services, and dental and vision care for children. The state also sets reimbursement rates for providers and hospitals participating in the plans.

### *Challenges with Rural Provider Networks*

A major structural problem for the states in implementing ACA is the thinness of rural markets for health insurance. It is often difficult for states to guarantee that at least one insurer offers a plan on ACA exchanges for rural areas. One of the main challenges for insurers to compete in rural areas is the lack of provider networks, which are essential for negotiating lower prices and ensuring access to care. Rural areas often have fewer providers, higher costs, and lower quality care than urban areas, making it hard for insurers to attract and retain customers. Additionally, rural areas have lower population density and higher rates of poverty, chronic conditions, and uninsurance, increasing insurers' risk and uncertainty.

As a result, some rural areas have experienced insurer exits or limited choices on ACA exchanges, especially in states that have not expanded Medicaid. To address this challenge, some states have encouraged insurer participation and competition in rural areas through measures such as providing reinsurance programs, expanding Medicaid, creating regional or statewide rating areas, and facilitating provider collaboration. Table 9.4 lists the average number of insurers in rural areas by state as of 2020.

## State Insurance Adequacy Regulation

Beyond Medicaid and ACA, states nominally have regulatory authority over healthcare provision. For instance, states are responsible for oversight over the licensing of physicians, the malpractice system, hospital quality, and a vast array of other topics. Most of these options, though, have only a marginal or indirect effect on macro trends in healthcare financing. While regulation of private insurance market products, in principle, could provide an avenue for states to have an appreciable impact on state-level macro health spending, in fact, a federal law—the Employee Retirement Income Security Act (ERISA) of 1974—preempts the ability of states to pass laws or regulations that impact employer-provided health insurance. This section describes some states' experiments with mandating health insurance coverage and how ERISA constrains state actions in insurance markets.

### *States' Mandated Insurance Coverage*

Five states (California, Massachusetts, New Jersey, Rhode Island, and Vermont) and Washington, DC, mandate insurance coverage for individuals and families. Except for Vermont, all of them financially penalize residents who do not have coverage for at least part of the year. The amount

of the penalty in the states depends on a family's size and income, and it is typically capped at the price of bronze plans available for purchase in the ACA exchanges in the state. The idea is that the penalty will push families to buy insurance, rather than pay the equivalent amount in penalties. Table 9.5 lists the states that mandate that individuals be covered by health insurance.

**Table 9.5** States mandating health insurance coverage

| State | Effective date | Penalty structure |
|---|---|---|
| California | January 1, 2020 | CA residents without coverage or an exemption will pay a penalty when filing state tax returns.<br>The penalty will be the higher of either:<br>• A flat amount based on the number of people in the tax household ($900 per adult and $450 per dependent child under 18), or<br>• 2.5% of the amount of gross income that exceeds the filing threshold requirements based on the tax filing status and number of dependents. |
| DC | January 1, 2019 | Citizens and legal residents are required to have health insurance, with exceptions for individuals experiencing financial hardship.<br>The penalty will be the higher of either:<br>• A flat dollar amount ($745 per person and $375.50 per child under the age of 18), or<br>• 2.5% of household income that is over the federal tax filing threshold.<br>*There is a maximum tax penalty for not having coverage in DC: in 2024, this amount is $2,235/year per person; for households with more than one person without coverage, it is multiplied by the number of people in the household without coverage up to a maximum of 5. |
| Massachusetts | January 1, 2019 | Residents must have minimum creditable coverage or pay the penalty, with exceptions for individuals experiencing hardship. |

**Table 9.5** (*continued*)

| State | Effective date | Penalty structure |
|---|---|---|
| Massachusetts (*continued*) | | The penalty will be:<br>• 150% to 300% FPL: half of the lowest-priced enrollee premium that could be charged to an individual at the corresponding income level for the tax year.<br>• Above 300% FPL: half of the lowest-priced individual bronze premium.<br>• For married couples, the amount will equal the sum of individual penalties.<br>*Penalty applies only to adults. No penalty if income is at or below 150% FLP. |
| New Jersey | January 1, 2019 | Unless exempt, residents must have health insurance coverage throughout the year. Residents who do not have coverage must pay a penalty, which depends on the family size and income and is "capped at the statewide average annual premium for Bronze Health Plans in New Jersey."<br>In 2024, for an individual taxpayer, the minimum penalty was $695 and the maximum penalty $3,960. For a family with two adults and three dependents earning $200,000 per year or less, the minimum penalty was $2,351 and the maximum penalty $4,500.<br>*The penalty amount is capped at the cost of the statewide average annual premium for bronze plans per person. |
| Rhode Island | January 1, 2020 | All residents are required to have qualifying health coverage unless exempt.<br>The penalty will be the higher of either:<br>• A flat dollar amount ($695 per person and $347.50 per child under the age of 18), or<br>• 2.5% of modified adjusted gross income that is over the federal tax filing threshold<br>*The maximum penalty can be no more than the average bronze plan amount as determined by HealthSource RI. For those with partial-year coverage, the fee is one-twelfth of the annual amount for each month without coverage. There is no penalty for people who are uninsured for less than three consecutive months. |

(*continued*)

**Table 9.5** (*continued*)

| State | Effective date | Penalty structure |
|---|---|---|
| Vermont | January 1, 2020 | Residents must report if they had health insurance (including Medicaid and Medicare) for each month of the year when filing a state tax return.<br>*There is no cash penalty for not having health insurance. |

*Sources:* (California) Franchise Tax Board 2024; DC Health Link 2024; Commonwealth of Massachusetts 2024; State of New Jersey 2023; (Rhode Island) HealthSource RI 2024; Vermont Health Connect 2024.

### *ERISA and State Regulation of Private Health Insurance*

ERISA stands for the Employee Retirement Income Security Act of 1974, a federal law that regulates employee benefit plans, including health insurance plans, sponsored by private employers. ERISA preempts state laws relating to employee benefit plans, meaning states cannot impose additional or conflicting requirements on these plans.

One of the implications of ERISA preemption is that states cannot mandate healthcare benefits provided by employer-sponsored health insurance plans within the state. For example, suppose a state requires health insurance plans to cover a specific service, such as infertility treatment or mental health counseling. In that case, this requirement does not apply to employer-sponsored plans that ERISA governs. This preemption limits the ability of states to regulate the quality and scope of healthcare coverage for millions of workers and their dependents enrolled in these plans.

However, some exceptions and limitations exist in ERISA preemption. For instance, ERISA does not preempt state laws that regulate insurance companies, such as licensing, solvency, and consumer protection laws. Therefore, states can still impose benefit mandates on health insurance policies sold by insurers to employers or individuals, as long as these policies are not self-funded by the employers. Self-funded plans are those where the employer assumes the financial risk of paying for the healthcare claims of its employees rather than purchasing an insurance policy from an insurer. Self-funded plans are more common among large employers who can spread the risk among a large pool of employees.

Another exception to ERISA preemption is ACA's essential health benefits (EHB) requirement, which applies to all non-grandfathered health insurance plans in the individual and small group markets, regardless of whether they

are sold on or off the exchanges. The EHB requirement establishes a minimum set of ten categories of benefits that these plans must cover, such as ambulatory care, hospitalization, prescription drugs, maternity and newborn care, and preventive services. States can also choose to define their own EHB benchmarks within these categories as long as they are at least as comprehensive as the federal default benchmark. However, the EHB requirement does not apply to employer-sponsored plans in the large group market or self-funded plans in any market.

### Limited Innovation by States in the Design of Healthcare Policies

While the range of authority that states have over healthcare markets may seem expansive, in fact, from a fiscal perspective the federal government sharply limits the range of policy discretion granted to states. States have most power over the set of people to be covered by public insurance sources and over what sets of services are to be provided to people on public insurance. They have regulatory authority over some aspects of medical practice by physicians and hospitals. But federal law greatly restricts state governments' ability to control private and public healthcare expenditures within their states.

First, federal matching and waiver requirements for Medicaid and CHIP limit states' authority. Medicaid and CHIP are joint federal-state programs. The federal government matches a certain percentage of each state's spending on these programs, depending on the state's per capita income and the eligibility group. The federal government also grants waivers to states that allow them to implement alternative or innovative approaches to provide Medicaid and CHIP services. However, these matching and waiver requirements also constrain the ability of states to design and finance their own Medicaid and CHIP programs, as they have to comply with federal rules and standards.

Relevant to this point is the well-known "flypaper effect." The flypaper effect suggests that a government grant to a recipient state increases local public spending more than an increase in local income of an equivalent size. In other words, money sticks where it hits. For traditional Medicaid, the federal government matches a certain percentage of each state's Medicaid spending, depending on the state's per capita income. The matching rate ranges from 50 percent to 83 percent, averaging 61 percent in 2020. With such high matching rates, states pay a heavy cost for restricting Medicaid eligibility and will be loath to do so unless there is tremendous political pressure (such as faced by some Republican-led states regarding Obamacare's Medicaid expansion—more on that below). And, of course, it may not be wise policy

to restrict the set of poor, elderly, disabled, or children who are eligible for public health insurance in the first place.

Second, as discussed previously, federal law limits the ability of states to regulate most employer-provided health insurance plans. ERISA preempts state laws that impose additional or conflicting requirements on these plans, such as benefit mandates, premium taxes, or consumer protections. This limits the ability of states to regulate the quality and scope of healthcare coverage for millions of workers and their dependents enrolled in these plans. It prevents, for instance, states from passing regulations to evaluate the quality and efficiency of care provided in these plans in a bid to reduce expenditures on low-value healthcare.

Finally, while state and federal governments can regulate, fundamental market forces and competition in the healthcare sector play a primary role in healthcare spending outcomes. Healthcare is a market; therefore, the sector is influenced by various market forces and competition factors that affect the supply and demand of healthcare services and products, such as providers, insurers, consumers, employers, pharmaceuticals, medical devices, and technology. The demand for services is affected by demographic realities like the aging of the workforce, the growing number of elderly in the United States, and the high rates of chronic conditions like obesity, diabetes, and heart disease in the population. These factors can affect the prices, quality, utilization, and innovation of healthcare in different ways, depending on each actor's market structure and behavior. States have limited control over these market forces and competition factors, as they may face legal, political, or economic barriers to intervene or influence them.

## *Policy Options for Addressing the Fiscal Crisis in Public Financing of Healthcare*

With the current policies of the public financing of healthcare widely deemed fiscally unsustainable in the next decades, governments must undertake major reforms to resolve the imminent insolvency problems. Reform proposals generally fall into three basic categories: (1) for Medicare, modify payment approaches to stem its excessive growth in federal spending; (2) for health programs with shared federal and state funding, delegate more responsibilities and authorities to states; and (3) for private insurance, relax federal restrictions on health insurance allowing states greater freedom in enabling private insurance to substitute for public funding. The latter two categories involve restructuring the federalist system of health policy toward reducing

the federal role. The following discussion summarizes and evaluates features of these three categories of health reform policies.

## Policy Approaches for Enhancing Competitiveness in Medicare

As discussed above, the federal government must sharply mitigate the growth in Medicare spending to prevent interest payments on its debt from crowding out considerable shares of spending on all other programs and services. The *2022 Medicare Trustees Report* posits two principal factors explaining the excessive growth of Medicare healthcare costs in the upcoming decades: (1) increasing enrollment and (2) rising per capita costs. Increasing enrollment reflects an aging population, with no viable policy options available for limiting Medicare eligibility in the near future. Rising per capita costs consist of two components: volume/intensity (i.e., quantity) and price (i.e., per service). Projections attribute the higher per capita costs predominately to greater volume/intensity of services and not to price changes.

A principal motivation underlying proposed Medicare reforms by policymakers is to slow the growth of per capita costs by engaging competitive forces to reshape care delivery. Such policy approaches fall into three main categories: (1) consumer-directed healthcare, (2) competitive bidding of Medicare services, and (3) value-based purchasing (VBP) (i.e., pay for performance). Consumer-directed policies operate on the patient side of the equation, with beneficiaries induced to share in Medicare spending through their decisions to select lower-cost healthcare options. Competitive bidding and VBP policies operate on the provider side, both intended to reduce the per capita Medicare costs. Whereas competitive bidding focuses on introducing market-style competitive forces to lower the price component of per capita costs, VBP targets engaging these forces to lower the volume/intensity component. The following discussion briefly summarizes these three policy reform approaches and their prospects for achieving savings in Medicare spending.

### *Potential Roles of Consumer-Directed Healthcare*

The basic idea motivating greater integration of consumer-directed healthcare policies in Medicare revolves around the vision that patients, faced with exposure to the financial consequences of their decisions, would reduce Medicare spending through diminished use of low-value services and cost-ineffective innovations in healthcare delivery. When beneficiaries have substantial insurance coverage of deductibles and copayments, many experts

believe they seek excessive nonemergency and discretionary medical services, driving up Medicare spending.

Advocates of this approach for reducing Medicare spending point to the coverage provisions of Medigap insurance policies in traditional (i.e., FFS) Medicare as a primary culprit in shielding patients from the financial implications of their treatment decisions. The Medicare Payment Advisory Commission (MedPAC) recommended restricting Medigap coverage, citing MedPAC reports (Hogan 2009, 2014) that argued that eliminating first-dollar coverage in secondary insurance would yield savings in Medicare spending. Legislation implemented these recommendations in 2015, and starting in 2020, Medigap plans sold to new Medicare enrollees no longer covered the deductible in Medicare for physician and outpatient services.

Critics of the effectiveness of this approach point out that most Medicare spending occurs for beneficiaries with costs far beyond the maximum out-of-pocket (MOOP) thresholds currently mandated by the Centers for Medicare & Medicaid Services (CMS) for Medigap plans. The highest-cost users in Medicare FFS—constituting less than 10 percent of beneficiaries, with total annual per capita medical costs exceeding $37,400 in 2019—accounted for more than two-thirds of total Medicare costs and even a larger share of Medicare outlays covering the federally insured share of these costs. The lowest-cost two-thirds of beneficiaries—with total annual per capita medical costs below $3,500 in 2023—accounted for only 5 percent of total Medicare FFS medical costs and even a smaller share of Medicare outlays.

Medigap plans offer ten standard packages of benefits, with the highest MOOP falling below $7,000 in 2023. High-deductible Medigap plans, with monthly premiums of about $150, offer annual deductibles falling below $3,500. With these levels of MOOPs, the Medicare beneficiaries who account for nearly all Medicare spending face little cost exposure and incentives to save costs.

The same challenges exist in effectuating consumer-directed healthcare forces to save spending in those parts of Medicare associated with managed care. MOOP in Medicare Advantage (MA) could not exceed $8,300 for individuals in 2023. In practically all regions of the country, MA plans exist with MOOPs below $5,000, with no monthly premium beyond that paid to Medicare for discounted cost shares for physician and outpatient services.

Medicare beneficiaries also eligible for Medicaid face no cost sharing in any form. Medicaid pays both the premiums and any cost share not covered by Medicare.

An avenue available in Medigap and MA plans for exposing beneficiaries to the financial costs of their decisions involves offering lower premiums to those enrollees willing to forgo some high-cost delivery selections. However, current CMS regulations rule out such options. Medigap premiums can only depend on beneficiaries' age and not on their prospective health risk (preexisting conditions). While MA premiums can vary to incorporate services supplemental to those in traditional Medicare, MA plans must cover the same range of services available in traditional Medicare, including all varieties of high-cost services. MA premiums paid by individuals do not depend on their age or health circumstances.

Consequently, policy opportunities for adapting Medigap and MA plans to generate savings in Medicare spending through patient financial incentives would necessitate allowing for either (1) considerable increases in MOOPs; or (2) some dependence of premiums on the health risk (preexisting conditions) of insurance enrollees. Given the unlikely prospects of such changes, no effective opportunities exist for exposing high-cost insurance enrollees to the costs of their decision making. Moreover, Medigap plans in traditional Medicare cover less than a third of the Medicare beneficiary population, and much of the remainder faces even less exposure to costs (e.g., beneficiaries with supplementary coverage through Medicaid [duals], VA, or TRICARE).

### *Potential Roles of Competitive Bidding in Medicare*

Advocates for introducing competitive bidding features into Medicare aim to reduce the price-per-service component of per capita Medicare costs. Under current policy, price determination in Medicare's FFS payment systems essentially involves calculating the cost of production and setting prices to cover these imputed costs. Competitive bidding introduces market forces intended to lower prices below these administrative calculations. Establishing competitive bidding in a market requires two essential conditions: (1) products must be well-defined and understood by suppliers and consumers; and (2) the market must embody a competitive environment to achieve lower costs.

Individual Medicare "products" do exist that satisfy the first condition, which policymakers have or could consider for competitive bidding. Medicare already competitively bids such items as durable medical equipment and generic pharmaceuticals (in Part D), which readily satisfy the first criterion cited above. Policymakers might also entertain introducing competitive bidding for such products as lab tests and imaging.

Other potential categories of Medicare "products" include some forms of bundled services representing relatively distinguishable and complete care components. Medicare managed care represents a prominent example, with the bundling constituting the full range of services covered under traditional Medicare. MA plans competitively bid premiums and cost-sharing regimes subject to CMS regulations. Other potential service bundles in traditional Medicare include diagnosis-related groups used by Medicare to pay for the services of acute hospitals. A similar possibility exists in the case of reimbursements to skilled nursing homes, which receive payments depending on the delivery composition of six service bundles (e.g., physical therapy and nursing services).

Serious challenges, however, arise in satisfying the second condition required to establish competitive markets in Medicare. Effective bidding requires a sufficient number of firms (bidders) to avoid collusion and monopolies. Economics describes such a market as having a low concentration ratio of firms—meaning that no firm possesses a high concentration or share of the market.

This condition fails in many Medicare instances for two reasons. First, many of the most expensive medical products and services (e.g., new brand-name drugs) operate under patents, giving innovating firms monopoly rights. Second, in many medical care markets there are few providers offering services. Rural markets typically have one hospital available, and many others have just two or three covering a large service area. Plus, effective competitive bidding implies that one hospital wins and the others lose, which would mean the allocation of all Medicare services for the bid "product" to a single hospital. This winning hospital would need to expand capacities substantially, and losers would essentially no longer serve Medicare beneficiaries for that service and would likely go out of business.

Another factor limiting the promise of competitive bidding in reducing Medicare costs is the fact that Medicare administrative pricing already incorporates a form of competitive bidding in healthcare markets through the commercial insurance side of the market. Statutes and regulations keep Medicare prices for services and products below these unconstrained healthcare prices. Commercial in-network prices already reflect health-organization competition and physician-hospital integration. Studies show that these commercial prices vary considerably across regions, with typical prices far exceeding Medicare FFS prices for many distinct medical procedures. Consequently, such evidence does not support the view that competitive bidding in Medicare would yield lower prices for many medical services.

### *The Promise of Value-Based Purchasing Policies*

Much of the policy reforms in Medicare over the last decade focused on transforming reimbursement in FFS programs to reward healthcare providers for achieving outcomes rather than for the quantities of services (inputs). Broadly labeled value-based purchasing (VBP)—or pay for performance (P4P)—these new reimbursement frameworks aim to pay for "value," defined as the health outcomes and quality achieved relative to the costs of the care. Cost efficiency of care constitutes a significant component of value, with other measures included to track nonmonetary aspects of the quality of care (e.g., mortality, measures of activities of daily living). Currently, VBP payment systems cover all major provider types in Medicare (e.g., hospitals, physicians, nursing homes).

The new design of cost measures conforms to providers' self-view of what constitutes efficient practice, with clear benchmarks guiding clinicians on the steps needed to improve performance and raise their incomes. The cost constructions accumulate claims-based expenses of treatments delivered by providers who are assigned accountability for episodes of care and the costs of services delivered by other providers for care directly clinically related to the accountable providers' treatments. Cost includes treatments directly delivered by the evaluated provider and the cost of care downstream deemed preventable with high-quality original treatment (e.g., hospital readmissions). Providers receive performance scores benchmarked against peer groups performing the same type of care. Achieving high performance requires providers to balance the benefits of their delivered services against the systematic cost savings attained by mitigating costly poor health outcomes in the episode and by coordinating care with other involved providers to keep costs low.

With such cost measures sufficiently weighted in scoring performance, accountable providers can secure higher personal incomes through VBP rewards by generating cost savings across the entire episode of care. Cost savings come from the forgone revenues of other providers who no longer deliver unnecessary services or services arising from poor outcomes (e.g., hospitalizations). Such VBP designs emulate competitive markets for providers treating similar illnesses, with VBP rewards and penalties acting to incentivize the changes in healthcare delivery needed to optimize scores (i.e., achieve lower total costs).

Finally, whereas our exploration of policy opportunities suggests dim prospects for implementing reforms in the consumer-directed and competitive bidding areas to produce impactful savings in Medicare spending,

advances and expansions of VBP programs offer a rich set of prospects for supporting significant redesigns of care delivery, promising to save considerable costs. Medicare's VBP programs aim to lower the volume/intensity component of per capita Medicare costs. When tailored appropriately, VBP programs introduce market-style forces in healthcare delivery that penalize waste and encourage care coordination in Medicare, thus saving money. Whereas Medicare payment systems cover service costs, VBP programs value outcomes and can act as pricing systems. Operating like prices, rewards and penalties incentivize healthcare providers to make those changes in practice needed to optimize performance scores. With scoring metrics properly specified, VBP programs can emulate competitive market structures in the healthcare industry.

## Delegating More Authority to States for Shared Healthcare Financing

Drawing on the discussion in the previous section, the following subsections explore several reforms in health policies that states might pursue if given an expanded role in financing and regulating their healthcare programs. The existing federal regulatory and funding environment sharply constrains the opportunities for states to innovate and devise policies limiting spending on healthcare. However, commentary in the literature points to a range of reforms that some states would implement if given the opportunity.

The first section discusses options for states to reform their Medicaid offerings, given the constraints and opportunities provided by ACA. Next is a discussion of options states have to restructure and reform ACA health insurance exchange marketplaces, then a discussion of options for states to expand the provider networks available to Medicaid patients, which are quite limited at present in most states. The last section discusses options for states to regulate pharmaceutical offerings and pricing in state Medicaid programs.

### *Opportunities for States to Reform Medicaid under ACA*

One of the most controversial aspects of the ACA was its provision requiring states to expand Medicaid programs to cover low-income adults with incomes up to 138 percent of the federal poverty level, or about $17,000 for an individual in 2021. Unlike the traditional Medicaid program, where eligibility for coverage depends on income, assets, and other criteria, such as family structure, ACA's Medicaid expansion depends only on income relative to the federal poverty level. Under ACA, the federal government covers 90 percent of the cost of expansion, while states cover the remaining

10 percent. However, a 2012 Supreme Court decision made Medicaid expansion optional for states, and as of 2023, twelve states have not adopted it. States can adopt ACA's Medicaid expansion or not as they see fit, though the movement has been in the direction of adoption.

According to the flypaper-effect hypothesis (discussed above), state governments would increase their healthcare spending more when they receive more federal grants than when they have more state income. However, in the case of ACA's Medicaid expansion, some states are reluctant to embrace expansion nearly a full decade after the federal funds became available to do so. Why have some states decided against expanding Medicaid coverage under ACA? Some considerations include:

- *The fiscal impact of expansion*: Some states are concerned about the long-term cost and sustainability of expanding Medicaid, especially in times of economic downturn or uncertainty. Opponents of expansion have expressed worry that even a 10 percent share of expansion costs could strain their budgets and crowd out other spending priorities, such as education, transportation, or public safety. They also worry that the federal government could reduce or eliminate its funding for expansion in the future, leaving them with an unfunded mandate.
- *The political opposition to expansion*: Some states face strong resistance to expanding Medicaid from their governors, legislators, or voters, who are ideologically opposed to ACA or the role of the federal government in healthcare. They view expansion as an endorsement of ACA or a dependency on federal handouts and prefer to pursue their own solutions for healthcare reform. They also distrust the federal government's promises and regulations regarding expansion and fear losing their autonomy and flexibility in managing their Medicaid programs.
- *The alternative approaches to expansion*: Some states are exploring or pursuing other ways to provide healthcare coverage to their low-income populations without fully expanding Medicaid under ACA. For example, some states have applied for or received waivers from the federal government to implement modified versions of expansion, such as imposing premiums, copayments, or work requirements on Medicaid enrollees or using federal funds to purchase private insurance plans for them. Other states have proposed

or enacted state-funded programs offering limited benefits or subsidies toward the purchase of private insurance to certain low-income individuals.

### *Options for Reforming ACA Marketplace Exchanges*

Healthcare exchange marketplaces are online platforms where consumers can compare and purchase health insurance plans that meet the standards and requirements of the ACA. The ACA gives states the option to create and operate their own marketplaces. However, as seen in the third section of this paper, the range of choices available to states to customize marketplaces to local needs is limited under the ACA. Some of the aspects that states can customize include:

- *The design and features of the marketplace website*: States can decide how to present and display information about health plans, such as premiums, benefits, quality ratings, provider networks, and consumer reviews. States can also add tools and resources to help consumers compare and choose plans, such as calculators, decision support tools, chatbots, or videos. States can also integrate their marketplace websites with other state programs or services, such as Medicaid, CHIP, or social services.
- *The outreach and enrollment strategies*: States can decide how to market and promote their marketplace to consumers, such as through advertising, media campaigns, social media, or events. States can also choose how to provide consumer assistance and education, such as through navigators, brokers, agents, call centers, or community organizations. States can also tailor their outreach and enrollment efforts to specific populations or regions, such as rural areas, minority groups, or young adults.
- *The plan management and oversight policies*: States can decide how to certify and regulate health plans that participate in their marketplace, such as by setting standards for network adequacy, benefit design, quality improvement, or consumer protection. States can also decide how to monitor and evaluate health plan performance and compliance, such as by collecting data, conducting audits, imposing sanctions, or resolving disputes.
- *The innovation and experimentation opportunities*: States can apply for waivers from the federal government to implement alternative

or innovative approaches to provide health insurance coverage to their residents through their marketplace. For example, states can use waivers to modify the eligibility criteria, benefit requirements, subsidy structure, or marketplace enrollment periods. States can also use waivers to create public options, reinsurance programs, or other initiatives that aim to improve access, affordability, and quality of health insurance coverage, as discussed above.

While these options may have a considerable impact on the experience of people in accessing and signing up for a health insurance plan in a state's ACA health insurance exchange and may have some marginal impact on the types of plans available, none of these options are likely to make a significant dent on the macro-level fiscal challenges of financing health spending in the United States. None of the alternatives fundamentally change the underlying supply and demand forces determining American health spending.

### *Options to Expand Provider Networks for Medicaid Enrollees*

One of the challenges that Medicaid enrollees face is finding physicians willing to see them and provide them with adequate and timely care. This is partly due to the inadequate provider networks that often exist for Medicaid patients, which limit their access and choice of healthcare providers. Provider networks can vary in size, composition, quality, and geographic distribution, depending on the plan's policies and the market conditions, and many of these depend on state Medicaid policies. The fiscal consequences of inadequate networks are challenging to quantify because inadequate healthcare in the early stages of managing a health condition can sometimes lead to the need for much larger expenditures as the disease progresses.

The primary reason for inadequate provider networks for Medicaid patients is that providers receive lower reimbursement for equivalent services provided to Medicaid patients than they do for other patients with Medicare or private insurance, so physicians are reluctant to participate in Medicaid. Low rates can affect the profitability and sustainability of providers, especially those who serve a large share of Medicaid patients. They can also affect the quality and availability of care, as providers may reduce their services, staff, or equipment.

Another reason physicians are deterred from participating in Medicaid is the administrative burden associated with the program, such as complex billing procedures, extensive documentation requirements, frequent audits,

or delayed payments. Administrative burdens can increase the financial and time costs of providing care and reduce the satisfaction and morale of providers.

A third reason provider networks are inadequate for Medicaid patients is the limited supply and uneven distribution of providers across states and regions, especially in rural areas or underserved specialties. Provider shortages can affect the access and quality of care for Medicaid enrollees, as they may face longer wait times, longer travel distances, or referral delays. Provider shortages can also affect health plans' competition and negotiation power, as they may have fewer options or incentives to contract with providers.

States have the flexibility to design and administer their own Medicaid programs within federal guidelines, and they can also apply for waivers to implement innovative or alternative approaches to providing Medicaid services.

Some options that states have to expand the network of doctors and hospitals available to enrollees under the Medicaid program include the following:

*Increasing the reimbursement rates for providers who participate in Medicaid* One of the main barriers to provider participation in Medicaid is the low payment rates compared to Medicare or private insurance. States can use federal or state funds to raise the rates for certain services, specialties, or regions and incentivize more providers to join or stay in the Medicaid network. For example, some states have increased the rates for primary care, behavioral health, or rural health services.

*Implementing alternative payment models for providers who participate in Medicaid* Another way to improve provider participation and performance in Medicaid is to change how Medicaid reimburses providers from fee-for-service to value-based payment models. These models reward providers for delivering high-quality, cost-effective, and coordinated care rather than for the volume of services. Some examples of value-based payment models are capitation, shared savings, pay for performance, or bundled payments. These options are discussed in more detail above.

*Expanding the scope of practice and roles of nonphysician providers who participate in Medicaid* A third option to expand the network of providers in Medicaid is to allow nonphysician providers—such as nurse practitioners, physician assistants, pharmacists, or community health workers—to provide

more services and functions within their scope of practice and training. These providers can help increase access, quality, and efficiency of care for Medicaid enrollees, especially in underserved areas or populations. Some examples of expanding the scope of practice and roles of nonphysician providers are allowing them to prescribe medications, order tests, refer patients, or manage chronic conditions.

### *Altering Regulations of Pharmaceutical Benefits in Medicaid*

Medicaid patients sometimes have problems accessing prescription drug medications due to several factors. Perhaps the most important of these is Medicaid's reimbursement rates and policies for pharmacies and drug manufacturers. Payments may be lower than what they receive from other payers, such as Medicare or private insurance. This may affect the availability and affordability of drugs for Medicaid patients, even if their OOP payments for prescription drugs are low, as pharmacies and drug manufacturers may limit their participation.

State Medicaid programs sometimes impose specific rules or restrictions on the use of certain drugs, such as requiring clinical criteria, step therapy, quantity limits, or prior approval before dispensing or covering them. These requirements may delay or deny Medicaid patients' access to needed drugs or create administrative burdens and confusion for them and their providers. Finally, Medicaid patients may have difficulty finding or accessing pharmaceutical providers who will accept their coverage and dispense drugs to them, especially in rural areas or underserved specialties.

Some options where states can regulate Medicaid payments and coverage of prescription drugs include the following:

*Setting reimbursement rates for pharmacies that dispense drugs to Medicaid beneficiaries* States can use different methods and levels of payment, such as the actual acquisition cost, the national average drug acquisition cost, or the federal upper limit for generic drugs. States can also adjust the rates based on the type, quantity, or quality of drugs dispensed. All three methods are variations on a theme aimed at setting the prices that Medicaid pays pharmacies based on actual or average costs of drug acquisition by pharmacies themselves.

*Negotiating supplemental rebates with drug manufacturers* In addition to the mandatory rebates required by the federal government, states can leverage

their purchasing power and formulary management to obtain additional discounts or concessions from drug manufacturers, such as price freezes, volume discounts, or performance-based agreements.

*Implementing preferred drug lists or prior authorization policies for specific drugs or classes of drugs* States can use these tools to encourage the use of lower-cost or more effective drugs and to limit the usage of higher-cost or less effective drugs. States can also use these tools to manage the utilization and quality of medications, such as by requiring clinical criteria, step therapy, or quantity limits. Depending on implementation details, these changes may improve policy by focusing limited resources on high-value drugs or they may prevent patients from obtaining medically necessary drugs in a timely way. Sometimes both are true of such programs.

*Participating in multistate purchasing pools or arrangements for prescription drugs* States can join forces with other states or entities, such as Medicaid managed care organizations, to increase their bargaining power and achieve economies of scale in purchasing drugs. States can also share information and best practices with other states or entities to improve their drug management strategies.

## Allowing States Greater Flexibility in Regulating Private Health Insurance Options

The Employee Retirement Income Security Act (ERISA) is a federal law that sets minimum standards for most retirement and health plans in the private sector. It aims to protect the rights and benefits of employees and their beneficiaries participating in these plans. It also regulates the fiduciaries who manage and control the plan assets and requires them to act in the best interest of the plan participants. ERISA covers various types of plans, such as pensions, 401(k)s, health insurance, disability insurance, and life insurance. ERISA does not apply to plans sponsored by governmental entities, churches, or plans outside the United States. With regard to the topic of our paper, the critical thing to know about ERISA is that it limits the extent to which states can regulate employer-provided health insurance.

ERISA considerably constrains states in serving as laboratories of experimentation to address healthcare financing issues. However, if ERISA provisions governing employer-provided health insurance were relaxed, states could implement various reforms to health insurance markets that are

currently preempted or challenged by federal law. Some examples of such reforms that states would likely implement include the following:

*State-level employer mandates* States could require employers to offer health insurance coverage to their employees or pay a penalty or a fee to the state. This could increase the coverage and affordability of health insurance for workers and their dependents and reduce the uncompensated care costs for the state, though likely at the cost of higher state taxes. For example, despite the possibility that ERISA might preempt its ability to do so, Massachusetts enacted an employer mandate as part of its 2006 health reform. This reform served as a model for the national ACA, which is not subject to ERISA preemption.

*State-level public options* States could create public health insurance plans that compete with private plans offered by employers to employees. Several states offer a publicly administered health insurance product on the state-based ACA marketplaces, as described previously. For example, Washington, Colorado, and Nevada have enacted or proposed public option plans offered by private insurers but regulated by the state.

*State-level single-payer systems* States could create universal healthcare systems that provide comprehensive health insurance coverage to all residents through a single public payer that collects taxes and pays providers. For example, Vermont passed single-payer legislation in 2011 but later abandoned it due to fiscal and political challenges.

In addition to policies like these focused on expanded insurance coverage, a relaxation of ERISA would permit states to regulate the quality and pricing of privately provided healthcare services by promulgating standards for the measurement of quality of health services provided by physicians and hospitals, like the episode-based care cost and quality assessment described in the previous discussion.

## *Consequential Changes Required in the Direction of America's Health Policies*

The contemplated reforms in health policies discussed above will not solve the looming fiscal insolvency of public funding confronting America in the coming decades. The necessary reforms will involve substantial alterations in healthcare delivery and a decrease in the per capita consumption of

healthcare relative to the paths anticipated, assuming current policies continue to apply. Significant reductions must occur in the growth rate of public spending on healthcare.

A popular set of proposals for reforming health policy in the United States involves restructuring the federalist system to delegate more program design and funding responsibilities to state and local governments. These proposals embody combinations of two essential elements: (1) decoupling states from federal regulations that restrict reform options; and (2) providing federal funding that minimally distorts states' decisions relating to health program designs and operations.

Regarding the decoupling of federal regulations, the federal government invariably imposes restrictions on federal healthcare funding to states—restrictions that rigorously constrain states' range of actions in designing and managing their programs. Federal authorities mandate state aid programs to operate according to federal preferences and force states to increase spending on activities that federal policymakers deem important. Federal aid programs tend to be poorly managed by federal and state governments, with state policymakers unable to manage programs effectively in the complex federal regulatory environment. In many cases, these federal regulations result in spending that states would otherwise not pursue.

Relaxing the federal regulatory environment and giving states more flexibility in tailoring their healthcare programs would likely lead to reduced spending on healthcare programs while meeting population needs. Residents of each state have different preferences for health policies and different views on taxes and spending. In America's federal system, state and local governments can maximize value by designing policies to suit the preferences of their residents. At the same time, individuals can freely move to jurisdictions that suit them best.

Turning to the funding element of restructuring the federalist system, the use of "block grants" represents the centerpiece of most proposals to assist states in financing local health insurance programs. In its most basic form, the federal government pays annual lump sums (block grants) to states designated to support the provision of health insurance and care to their residents. Proposed calculations of block grant values depend on a variety of factors. Grant amounts can (1) depend on per capita amounts and states' population and composition; (2) impose per capita caps and vary according to enrollment; (3) redistribute resources across states and populations to finance

activities deemed high-value by the federal government; and (4) increase in times of economic downturns, natural disasters, or higher-than-expected costs (such as when a new drug or procedure increases healthcare costs). Block grants often come with maintenance of effort (MOE) rules, ensuring minimal state funding levels and health insurance coverage for particular populations. The critical feature of block grants is that states are made to pay for incremental provisions of healthcare beyond some basic care levels used in determining block grant values.

Block grants mitigate many of the public finance shortcomings of the existing federal funding mechanisms. Under current law, the federal government deems health insurance as an entitlement, with coverage ensured to everyone who qualifies, paid for by a combination of state and federal government funds. Such combined funding allows both federal and state policymakers to claim credit for the spending and be responsible for portions of the tax costs. Such circumstances raise the ratio of the political benefits of spending to the tax costs, thus inducing excess spending. Additionally, the ability of the federal government to finance spending through debt produces the impression of deep pockets. States respond by expanding those programs highly subsidized by federal sources and by taking advantage of federal funding matching provisions to increase spending on programs beyond levels of marginal benefits. Many federally funded programs include MOE rules that restrict states from reducing state funding of a program when they take federal aid. MOE rules can discourage states from finding program efficiencies and saving taxpayer money. Together, these features of the existing funding system encourage imprudent deficit financing.

Shifting federal funding to block grants forces state policymakers to balance the benefit of healthcare spending with the cost of raising taxes to pay for it. Moreover, whereas the federal government's debt finances much of its spending, state governments must generally balance their budgets and limit their debt issuance. The federal government could reduce its debt accumulation by controlling the size of its block grants.

America faces significant challenges in restructuring its federalist system of healthcare funding necessary to achieve sustainable financing profiles in the upcoming decades. The longer the current system remains in place, the more dramatic will be the reforms needed to avoid a fiscal crisis in the public financing of all programs supported by federal and state governments.

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## DISCUSSION

Thomas MaCurdy: Medicare is undergoing major reforms right now. The program is moving to a pay-for-performance sort of system, with fee for service vanishing. Irrespective, the reason why America's healthcare is so costly is we spend a lot of money on sick people. Other countries don't.

Joshua Rauh: Hasn't the profession for the last ten years been trying to run away from the results of the Oregon Health [Insurance] Experiment, where putting people on Medicaid in a quasi-exogenous way didn't improve health outcomes?

MaCurdy: Yes, but that was already known.

Jay Bhattacharya: It was the RAND Health Insurance Experiment that first failed to show a causal link between health insurance coverage and mortality. For most of the population, health insurance likely doesn't save lives.

MaCurdy: Yes, it doesn't do very much of that. Medicaid coverage sends beneficiaries to the emergency rooms, because they can't get care otherwise.

Bhattacharya: For most of the population, it doesn't matter that much. But for a small fraction on whom a lot of money is spent, it matters a ton.

MaCurdy: You can obtain drug plans in Medicare, at this point, where the program spends a hundred thousand dollars a year for a life expectancy extension of two months. Such cases are not uncommon.

Rauh: And that was added by Medicare Part D, right? The middle of the first decade of the 2000s, that was when they—

MaCurdy: Yes, Part D. The criteria for including high-cost drugs on Part D formulas relies primarily on whether the drug is effective. No cost-benefit analysis is performed.

Dennis Epple: So, Tom, is this $28 million because the cost to whoever is manufacturing this medication is really $28 million?

MaCurdy: These drugs can be expensive to produce. For drugs produced at low marginal costs, we do have the problem you just described related to encouraging drug innovation. This is also a challenging policy issue in the medical device area.

Bhattacharya: Other countries, for the same medication, it'll be half that cost.

MaCurdy: Yes. But the thing is, that's not really fair to the US.

Eric A. Hanushek: But they're using our technology.

MaCurdy: Exactly. They are. Germany, France will come along and say to pharmaceutical manufacturers, "If you don't give us a discount on this drug, we're going to take all your drugs off our formulary." The manufacturers cave in negotiations and give price discounts, recognizing that these markets are small relative to overall sales.

Bhattacharya: This is something that the Bush administration tried: to allow the reimportation of drugs from foreign countries. In the Bush administration, what happened was that there was a pushback saying, "Well look, we don't know that Canada is regulating drugs appropriately. We'll get bad, unsafe drugs from Canada." During the Trump administration, some folks said, "Okay, let's not actually get the drugs. We'll just import the lower drug prices from Canada." But given the political influence of pharmaceutical companies, it's very difficult politically to put any of that through into policy.

MaCurdy: If we were able to do that, it would put some elasticity in the demand, because that means when the drug companies came along and gave France a good deal, they realized, "Oh, the US is going to take advantage of this." We must move to something of that nature creating an open competitive market. Other countries take advantage of our research. We pay for it. They don't.

John B. Taylor: Do you guys have a reform?

Bhattacharya: We suggest a few things like block grants to states to encourage experimentation. Our paper proposes several of these kinds of ideas. But I don't think they meet the scope of the problem we're facing of excessively high health spending and inadequate medical coverage for millions. Dennis, you asked the right question. How do we reform the healthcare system so it spends money more wisely? There are some easier things like, for instance, there was this drug called Aduhelm [aducanumab], which was aimed at slowing the progress of Alzheimer's disease, and it was shown in clinical trials to be very effective at reducing lab values of proteins that correlate with the progress of Alzheimer's.

But unfortunately, the clinical trial showed no ability of the drug to prevent Alzheimer's disease. And it was a tremendously expensive drug. That's the first time I've seen Medicare actually say no to a drug, and I believe its expense was a major factor. At first Medicare approved the drug for use, but there was a lot of political pressure about its lack of clinical efficacy and high expenditures, and so Medicare ultimately said no. But the way that the FDA is now set up, you can basically, with a drug, show an effect on a biomarker that has no clinical benefit—just the biomarker—and the FDA basically will approve it.

MaCurdy: And then, once it's approved, it's difficult for Medicare not to allow it. Advocates argue that it's available and effective. The most recent law passed declaring that it lowered the price of drugs only lowered the cost covered by beneficiaries, not the total cost paid to drug plans. The government increased its share of costs.

Moreover, this legislation decreased the max out of pocket. Previous law imposed no max out of pocket for drugs when patients reached the catastrophic payment portion of Part D plans' schedules, with beneficiaries paying only 5 percent in this portion. But 5 percent of a hundred thousand is noticeable; 5 percent of a million's noticeable. The new legislation caps the annual maximum out of pocket at about $2,000.

Hanushek: So, the traditional argument with the FDA was that they were too slow. Now, you're saying they're too fast?

Bhattacharya: They're too fast. Yes.

Hanushek: Or is it they don't take into account anything about cost-benefit analysis?

Rauh: Well, there's in theory a difference between approving something for private use, like any private agent who has the money for it can pay for and use it, versus for government programs. The problem is, when the FDA approves it, it means that Medicare is going to pay for anybody who needs it. It seems like there's no way out of this without some kind of rationing of who's actually going to get access to the technology through the government program.

Bhattacharya: This is the reason we include suggestions for pay-for-performance reforms in our paper. The idea is that, say a doctor describes some drug to you or gives you surgery or a recommendation for some surgery, there's a law called MACRA [Medicare Access and CHIP Reauthorization Act], which requires every doctor in the country who accepts Medicare dollars to be evaluated. Basically, Medicare will provide a report card on nearly every doctor in the country. Actually, Tom and I worked helping CMS [Centers for Medicare and Medicaid Services] develop this system. Suppose there are two drugs—one's really expensive, one's cheap—and then you follow the patients along and there's no difference in the outcomes between patients who receive one drug versus the other. In the report card, the doctor who prescribed the high-cost drug will get dinged. Maybe they'll get a C on their report card instead of an A. And the grade matters, because it's closely tied to physician payments. It's tied to a lot of money, actually. There is an 18 percent swing in Part B payments for each doctor based on the grade they get on these evaluations for MACRA. So in principle you could move doctors to start prescribing the cheaper drugs as long as they have no big effect on outcomes. I mean, that is a tool you can use for reform. The big question is: Is it enough to solve the cost and access problems?

Hanushek: Do doctors know which are effective when they're prescribing?

MaCurdy: They do when they get dinged.

Bhattacharya: I'll tell you a story about this. So to create this system of grading, we held panels of experts to provide input. And one of the panels was about cataract surgery. In these surgeries, doctors have choices over what lens to use to replace the cloudy ones in cataract patients. During one of these panels, the question came up: "Well, a patient goes blind shortly after the surgery, should the surgeon be be held responsible in their report card for this bad outcome?" One of the physicians on this expert panel actually said out loud that if the patient goes blind after the cataract surgery, it's an act of God and thus the doctor should not be held responsible. The rest of the room of physician experts was very dismissive of this comment, and ultimately, physicians are dinged in their report card if their cataract surgery patient goes blind after the surgery.

Michael J. Boskin: I have to make just a couple of quick comments. One is, clearly, this will reverberate throughout the federal system, because if the federal government starts curtailing, there'll be pressures on state and local governments to spend. They'll start reducing payments to hospitals and so on. County hospitals will be bearing more of a burden. So all that's, I think, really important. In any event, fingers crossed that we'll implement many of the things you've recommended and that'll get us at least a leg up.