Memo

To: *Interested Parties*
From: *Andrew Schwab, Senior Manager of Policy & Federal Affairs*
Re: *State Progress Informs DC Policy*

Key Highlights

- States are the laboratories of our democracy. Historically, states have implemented health care policies which have led to federal legislation.
- New policies are most politically durable when solutions have broad political support.
- Various state approaches give Congress a policy and political roadmap for solving important problems, like protecting consumers from surprise bills.

INTRODUCTION

As Congress returns from August recess poised to tackle legislation to protect patients from surprise out-of-network billing, it is clear this progress was made possible by the critical mass of states that have led on this issue. In fact, familiar and widely accepted federal solutions exist to many policy challenges because states and localities first charted a course for innovative ideas. In addition to surprise billing, the past several decades have shown states leading the way on important health policy solutions including value-based insurance design, home and community based care, and rural health. When states demonstrate an innovative solution effectively addresses a problem, it clears the way for Washington to follow. In 2019 alone, 14 states made meaningful progress on a wide range of health care issues.

SURPRISE BILLING

State Laws Show the Way, DC is Poised to Act

Congress comes back from August recess set to take action on an issue that has affected too many Americans, "surprise" medical bills. People use the term "surprise bill" to describe many different types of medical bills a patient did not expect to receive. However, it most commonly refers to unexpected "balance billing," when a provider sends a bill directly to the patient for the balance of the amount above and beyond what insurance covers and what was expected by the patient. This practice occurs when a patient is treated by a provider who is unknowingly out of their insurance network.

As press stories and egregious examples of out-of network bills continue to emerge, states from different regions of the country with divergent partisan compositions have taken action to protect people from surprise bills. 27 states have passed some form of surprise billing legislation, 13 of which are said to include "comprehensive" protections, such as emergency department and in-network hospital safeguards, with six more tightening their laws just this year. While states have taken the lead on this issue, a federal solution remains necessary to shield the 61 percent of all insured Americans covered by self-insured plans, which are subject to the Employee Retirement Income Security Act (ERISA), and are not protected by state law.

Federal policy makers can look to states for tested solutions as they debate approaches to broaden these protections. The questions federal lawmakers are now debating regarding surprise bills have already been addressed in varying ways in the states, yielding solutions which can serve as a roadmap for federal policy makers as the legislative process continues.

Across the spectrum of states with comprehensive protections, some key points of consensus have emerged. These state laws protect patients from surprise bills both in emergency departments and when receiving non-emergency care at an in-network facility, meaning that patients' out-of-network cost-sharing is no higher than if they had received in-network care. Some states also require facilities and providers to notify patients if a non-emergency service could result in an out-of-network bill.

States have taken different approaches to determine provider and facility payment for out-of-network services. For example, California and Connecticut established a set standard for how payment is determined. Other states, including Florida, New York, and New Jersey, established dispute resolution processes, such as arbitration.

In Congress, both the House Energy and Commerce and Senate Health Education Labor and Pensions Committees have passed bipartisan bills (H.R. 3630/S.1895) addressing surprise billing. These approaches reflect key areas of consensus and will be familiar to anyone who has studied state solutions for surprise billing. Like most of their state counterparts, both federal proposals hold consumers harmless by limiting patient cost-sharing to the in-network rate. The legislation also limits provider and facility payment to a set rate and imposes penalties if they balance bill. The measure passed by the House Energy and Committee also includes a compromise crafted by Reps. Raul Ruiz (D-CA) and Larry Bucshon (R-IN) which triggers arbitration after $1,250, a policy similar to the surprise billing law passed in New Jersey (with a $1,000 threshold).

Congress likely will continue to grapple with a major question which has split states: how to determine providers' and facilities' compensation when they can no longer balance bill. Thanks to state leadership, Congress has a menu of options - with data and evidence behind it - to inform their negotiations. For example, Congress can look to states such as New York, with four years of experience administering a "baseball-style" arbitration approach to understand potential outcomes. Researchers found that in New York, a patient protection law based on arbitration reduced the rate of out-of-network care by 6.8 percentage points off a baseline of 20 percent.

Despite the contentious debate which has ensued between providers and insurers, state leaders have been able to develop policies protecting consumers while fairly compensating providers for their years of training and the work they do treating patients. When critics suggest protecting consumers in this way could undermine the health care safety net, Congressional leaders are able to point to states' experiences as evidence that it is possible to shield consumers from the anxiety and fear of receiving an astronomical bill without undermining the health care system.

With federal lawmakers attempting to finalize surprise billing policy, they should look to the politics and policy of the many states that have acted - and the positive results after enactment - for ways to ensure this critical legislation passes Congress and is signed into law by the president.

VALUE-BASED INSURANCE DESIGN

States Use Their Public Employee Health Plans to Innovate, DC Follows

Value-Based Insurance Design (VBID) promotes high-value health care by using financial incentives to encourage cost efficient services and consumer choices. In the mid 2000's, several states and local governments began experimenting with their public employee health benefit designs to incentivize high-value utilization and increase provider quality metrics. These benefit designs usually include reduced cost-sharing and refunds for patients when they choose prefered, high-quality providers or attend educational care management classes. Designs typically focus on a core set of chronic conditions, such as diabetes, congestive heart failure or stroke. Some VBID programs increase cost-sharing for procedures and drugs which have shown low value, or when consumers choose to see providers with poor quality measurements. 13 states are utilizing VBID for their public employee health benefit plans. Maine has one of the most advanced implementations where participants in the diabetes VBID program experienced an average adjusted cost reduction of $1,300. In addition, the number of patients who received their medication at least 80 percent of the time increased from 61 percent to 79 percent, a nearly 30 percent improvement.

State innovation with VBID led the way for federal action. In 2015, bipartisan legislation was introduced and passed by the U.S. House of Representatives requiring a three-year demonstration program in Medicare Advantage to test VBID. Subsequently, in 2017, the Center for Medicare and Medicaid Innovation on their own began a VBID model in seven states. The program was expanded to an additional three states in 2018 and 15 more in 2019. In 2018, Congress authorized expansion of VBID in Medicare Advantage to all 50 states by 2020. Preliminary federal data for the first year of the demonstration program (2017) is available but not yet robust due to the annual bid cycle in Medicare Advantage. However, additional evaluation on cost savings is expected by mid-2020.

PROGRAM FOR ALL INCLUSIVE CARE FOR THE ELDERLY (PACE)

40 Years of State Influence on Senior Care

The PACE program in Medicare and, in some states, Medicaid, developed in a quintessentially American way - from the local needs of residents when providers saw a demand for a different type of care for seniors. Today, the program "helps people meet their health care needs in the community instead of going to a nursing home or other care facility." PACE allows certain frail elderly people to receive comprehensive medical and social services in their own community. When enrolled in the PACE program, patients are cared for by an interdisciplinary team of health providers, which helps them stay out of a nursing home.

First started in 1971 in San Francisco, what is today the PACE Program was developed by a public health dentist and community social worker. After local success, their work was noticed by the federal government in 1979 and awarded a four-year grant to incubate a model of care for Americans with long-term care needs. After continued success, Congress in 1986 provided funding to ten additional organizations to replicate this model on a national basis. By 1994, there were 11 PACE programs nationally. In 1997, Congress passed the Balanced

Budget Act, which included provisions to make the program permanent and expand it to ensure there were 14 non-profit organizations running the program in rural areas. Today there are 122 PACE programs in 31 states.

Ahead of their time, PACE's original local leaders recognized it is better for seniors to stay in their home and community than in a facility. Today, PACE organizations, in partnership with Medicare and Medicaid, provide care to seniors with chronic needs in their home, in the community and at PACE centers around the nation.

PROJECT ECHO (EXTENSION FOR COMMUNITY HEALTHCARE OUTCOMES)

Local Providers Take Matters Into Their Own Hands, States and DC Take Notice

Dr. Sanjeev Arora, a liver disease specialist at the University of New Mexico, saw a problem in his community and wondered what he could do about it. Dr. Arora watched as thousands of rural New Mexicans suffering from Hepatitis C lacked access to specialists who could treat it. As in many regions of the United States, specialists are concentrated in population centers placing an unfair burden on rural residents in need of more specialized care. In 2003, Dr. Arora founded Project ECHO to bring the knowledge of specialists and the structure of team based care to primary care clinicians in rural areas with the goal of assisting the local care providers in managing and treating certain chronic conditions. The specialists remain in contact with the local care providers by utilizing telehealth and database care management tools to recommend changes in treatment and guide on-the-ground teams towards evidence-based protocols. Today, 175 ECHO hubs treat people in 46 states.

As of 2019, eight foundations and nine federal agencies provide operational grants to fund the ECHO program. The common sense approach Dr. Arora developed, and its support by federal agencies, attracted the attention of Congress, which enacted the ECHO Act in December 2016 with overwhelming bipartisan support. A subsequent report to Congress, issued in February 2019, found that while "existing empirical evidence for their impact on patient and provider outcomes remains modest... the evidence consistently shows positive effects in the areas that have been measured." Congress is now considering the bipartisan ECHO 2019 Act which, "builds on the findings of this report by providing grants and technical assistance to develop and evaluate technology-enabled collaborative learning and capacity building models." As more evidence demonstrates the ECHO program works, it is another reminder of how states are leading the way for federal policy makers.

THE BIG IDEA

States have always been the laboratories of our democracy. The above examples provide insight into both contemporary and historical instances where this paradigm has been true, and it is often easy to forget how popular and ingrained elements of our federal system began with creative state leadership.

Paying attention to what states are doing now can be the best preview of what the federal government will be talking about in the future. States usually respond more quickly to public attention and pressure and are often able to develop innovative solutions that are free of the partisan discord so often found in Congress. The non-ideological solutions that states develop to address real health care challenges can often pass with broad political support, and offer a roadmap to federal leaders in the future.