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Implementing Health Reform

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New policies create new politics.
E. E. Schattschneider (1935)

Policy determines politics.
Theodore J. Lowi (1972)

Implementation is the short suit of American government. So much energy and political clash and clang go into making policy that high-level officials are exhausted and relieved when the game is over. Then, it's on to the next hot issue. In the case of the 2010 Patient Protection and Affordable Care Act (here abbreviated as ACA), this is a serious problem. The law is intricate and complex. It involves multiple federal agencies and offices, plus all of the nation's state governments. It intimately touches the lives of millions of people and affects tens of thousands of for-profit and nonprofit organizations. It will take at least four years to put it in place. To help deal with this massive governance challenge, this paper presents a theory of implementation for the new law and suggests strategies for improving the chances for successfully putting it into effect.

Richard P. Nathan is a former director of the Nelson A. Rockefeller Institute of Government. Thanks are owed to many people who contributed to his thinking and work on this discussion paper, including Henry Aaron, Thomas Gais, Timothy Jost, Robert Reischauer, Paul Starr, Robert Ward, and Micah Weinberg, along with field research associates in eleven states participating in a study coordinated by Nathan and Lawrence Brown. The bottom line, however — the ideas presented and reflected in this discussion paper are the sole responsibility of the author.

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I. Can we Implement?

I see several ways to answer the question, "Can we implement?"

1. *No — We can't.* The ACA's piecemeal, compromised, mix-and-match structure promises more than it can deliver. It will be too expensive. It will fall of its own weight. So, go back to the drawing boards.
2. *Yes — But we need new institutional machinery to make it work.* There are proposals for a Federal Reserve Board for Health or something analogous as a way to insulate health policy and management decisions from hot and heavy politics; if only we put somebody (a czar) or an independent, strong group (a Health Fed) in charge, then we can do it.

I reject these two ways to view the implementation challenge. It is too early to throw in the towel. Moreover, I don't see political support for a czar or a Health Fed to take corrective policy and administrative action along the way.

There is another possible answer.

3. **Yes, we can if we do it "the American way."**

It won't be easy and will require strong action, but there is a way of viewing and doing the job that can improve the chances for successful implementation. Here's how: Be flexible. Keep an open mind. Implementation is a discovery process. Work hard to discover institutional inventions that — as has been true throughout American history — have enabled the country to succeed in hard times. View implementation as an evolutionary process — one of trial and error. Don't view every decision that has to be made as top down, governmental, and Washington centered. Make every effort to take advantage of private market structures that could provide opportunities for enhancing efficiency and tightening systems. Work with — not against — the states. Consider implementation as a continuous process of learning and adaptation. Keep constantly in mind that there will be surprises along the way. Accept this from the start and be alert for opportunities that could not have been known in advance. Let everyone know that things that don't work will be changed.

There is a good base in social science theory for this approach. Aaron Wildavsky's writing on policy implementation stands out in the political science literature. In books with colleagues, he probed case material to construct a theory of implementation in line with the approach in this paper. Policy implementation, said Wildavsky (writing with Angela Browne in 1984) "is hypothesis testing; it is *exploration*." [Emphasis added] And continuing, Wildavsky and Browne buttressed their argument by saying, "Any political body that argues otherwise mistakenly regards itself as omniscient and omnipotent."[1] Despite a tendency sometimes to rationalize retroactively about their behavior, Wildavsky and Browne maintained that when implementers do their best

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work in the American setting their learning is evolutionary and their activities are exploratory.

This paper is written to provide an institutional/implementation perspective for the health policy and public administration fields. My view is somewhat upbeat. There are already indications that the flexible, adaptive, design-it-while-you-build-it approach to ACA implementation is underway. The form that the new law will take cannot be forecast except to say that when the job is largely completed (as far off as a decade down the road) the landscape for providing health care in America is bound to reflect the culture, history, and political setting in which the law is being implemented.

The whole federal system will be engaged. The size and complexity, for example, of the job of setting up health insurance exchanges by all state governments, which are slated to begin operations January 1, 2014, will require every bit of this time to work through intricate implementation issues set forth in the law, deal with forthcoming federal regulations, and set up and staff new state agencies.[2] In similar terms, complex technical issues (many of them with huge political and fiscal implications) remain to be dealt with in federal regulations — to mention just a few these issues: the definition of a qualified health plan, the payment of subsidies, and the determination of eligibility for subsidization.

II. The American Setting

In other industrial democracies, the establishment of new health reform regimes occurred in different ways and took a decidedly different approach from that in the United States for two main reasons. One reason is that health reform in other national settings was adopted a long time ago as a whole new universal system where nothing, or very little, existed beforehand and when health care was less important as an employer, an economic sector, and a contributor to the national economy. A second reason for the American setting being different is attributable to the pluralist, federalist American political form.

Because the United States spent such a long time arduously and contentiously debating universal health reforms and in the meantime improvising to meet specific needs, the twenty-first century setting in the United States did not present a clean slate like that for Otto Bismarck more than a century ago in Germany and half a century ago for William Beveridge in Great Britain.

Conceptually, the path taken in the United States in 2010 is both revolutionary and incremental. It is revolutionary at its core in assigning to the federal government the responsibility for ensuring that everyone has affordable coverage. At the same time, it is incremental in its instrumentation: Namely, by endeavoring to fill in the blank spaces and rearrange and connect the existing parts — large and small — into a coherent and coordinated new form. Speaking of the new law in these terms, staff of *The*

Washington Post in a handbook on what the law means describes it as a "relatively moderate and incremental document."[3]

Several existing large health care coverage systems are to be overhauled and pulled together under the ACA to provide a minimum level of care (as yet to be defined in regulations for "essential services" and "qualified health plans") for all citizens. The major existing systems are both private and public in character — private coverage mostly tied to employment and in the public sector, Medicare and Medicaid. There are other existing public programs that are smaller that will continue in effect such as the federal-state Child Health Insurance Program (CHIP) and Veterans' Administration and Indian Health Service health care.

The theme of this paper is that this incremental landscape presents an opportunity. The existence of multiple private and public channels for reform makes it easier to adapt and invent new institutional forms and mechanisms that fit the reality of how U.S. medical care currently operates. But, make no mistake about it; reform is not going to succeed unless the reality on the ground of how the multifaceted U.S. medical care complex currently operates is changed. The essential job of implementation is to push for and achieve change, but not to the extent and in a way where opposition to change stymies progress.

Turning to the political landscape for implementation, major players are already in place. In the private sector this includes health insurance companies, the purchasers of health insurance (both corporate and individual), physicians (primary and specialist), other health service providers and personnel, pharmaceutical companies and pharmacies, medical-supplier industries, for-profit general hospitals, specialty hospitals, and clinics and other service agencies of many varieties. Their interests differ as do the incentives they face. This is an important point: What is needed is to build coalitions for innovation on a basis that takes these and other diverse interests and purposes into account. Actually, this process is not new. It goes on all the time, but will be accelerated and expanded in scale under the new law.

Health insurers want to make certain that a substantial amount of the new coverage will be *their* coverage. Purchasers of coverage (employers, employees, and other private payers) want *affordable, quality care efficiently delivered*. Providers want *freedom to select and administer needed services and treatments*. And still another important group, health reformers, wants to overhaul delivery systems to *integrate* services to provide them on a user-friendly, interconnected, and accessible basis.

All of these interests (others too) operate in a political environment in which a big elephant is roaming around — *cost issues*. The cost elephant tramples on everything. Many of the framers of the ACA wanted to put chains on the beast, and they did provide some restraining ropes and strings, but the political will to restrain costs dissipated as time went by.

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If ACA implementers are to succeed, they do not have the luxury of letting this beast roam. Herbert Stein said, "If something is unsustainable, it won't be sustained."[4] Insurers know that if prices keep going up, they will have trouble selling their products. Employers face a similar cost-squeeze. Health care reformers face the same fiscal exigencies. Many of them have been working for years to make the provision of health care more efficient.

Economists should find this territory familiar. Joseph Schumpeter stressed that the U.S. economic system is always changing to destroy the old and invent new products and techniques.[5]

For ACA implementers, the idea that they should seek and facilitate systemic innovations in the provision of health care services presents a special bureaucratic challenge: How can they focus and coordinate their efforts to do this? By my count, there are already six (probably more) high-level White House and agency presidential appointees newly charged with major responsibilities for ACA implementation. What they do; how they set priorities;, what priorities they set; and, importantly, how and how well they work together will be crucial over the road to full health care reform implementation.

III. A Detour into Welfare Medicine

As debates about health reform played out in the past, many participants came to the conclusion, not without justification, that medicine for the poor is poor medicine. In particular, efforts to rein in Medicaid costs by instituting managed care systems were seen as backfiring. The dream, particularly of liberal leaders of reform, increasingly coalesced around the ideal that everyone should be treated the same — that there should not be product differentiation in the health care market place.

I take this detour here to address the challenge — how to manage differentiated health care systems — that has beguiled government agencies and leaders for half a century. My reason for doing this is to suggest that we should not reject out of hand the experience of systems to aid needy citizens in the effort now underway to aid *all* citizens. In an ironic and yet important way, Medicaid managed care resonates with the generalized aims of reformers working on methods to connect, bundle, and integrate services in the health care market place. Both seek to provide care for the whole person and eliminate at least some of the frustrations of the multipart U.S. health care marketplace.

Going back to the late 1990s, state government activities to create Medicaid managed care systems — both the experience and the politics of doing this — led to disappointments, complaints, and confusion, which in turn led commercial insurers to retreat from this market.[6] But that didn't end Medicaid managed care. Increasingly, it was turned over to noncommercial providers, notably not-for-profit community hospitals and clinics, mostly located in or near low-income areas and neighborhoods.

Although there is a common view in writing about health policy that managed care has failed and is declining, the fact of the matter is that it still exists and widely for low-income nonelderly and disabled populations. Much can be learned from the comparative study of Medicaid managed care systems in the states.[7]

Meanwhile, the health care reformers, as noted, are building new generalized ways to more efficiently manage health care services. Two popular reforms to achieve service integration illustrate the point — health care homes and accountable care organizations. Both are praised where they exist. State governments are experimenting with health care homes under Medicaid; similar efforts to integrate services are advanced for Medicare, as for example those advocated by MedPAC (the Medicare Payment Advisory Commission).[8]

IV. Incremental Implementation Strategies and Tactics

Returning to the theme about flexibility and adaptation to take advantage of opportunities that come to the fore as the ACA is put into effect, a recent article in *The New York Times* described an opportunity that demonstrates the theme. The article reported that efforts are underway whereby major health insurance companies are "promoting plans with reduced premiums that require participants to use a narrower selection of doctors and hospitals." Large employers were said to be showing increasing interest in such new products that could reduce premiums by as much as 15 percent. The article quotes a company spokesperson saying "affordability is the most pressing agenda item" and noted that average family premiums are fast rising and currently around $13,000 a year.[9]

How should we view developments like this? If employers want to offer and buy health insurance policies for and with their employees that pay for services from networks of local providers, there is an opportunity here: Such new products could be linked to bundling arrangements similar to those of health care homes and accountable care organizations. The policy outcome in this instance could be decisions by ACA implementers (at both the federal and state levels) to support and assist the development of linked innovations and to help to make sure they are consonant with the new law.

Politically, it is useful to think in summary terms of three main groups of players: (1) *Purchasers* of service (employers, governments, individuals) concerned about the costs they face; and (2) *Insurers* who, in order to sell health insurance policies, need to be able to offer affordable packages. For both of these groups, there is an essential connection to the third main player — (3) *Providers*. Hopefully, the providers of health care services can be brought along on systemic innovation. Increased demand for their services under ACA makes this a — if not *the* — critical implementation challenge. The exigency, to repeat, is the elephant — relentless cost pressures.[10]

At first glance, the outcome suggested above (new types of insurance products) may appear to apply primarily to the private sector. In the public sector as well, however, both for governments and for people who are or in the future will be covered by commercial health insurance through state health exchanges, ACA implementers face similar challenges for market-making and management reform. This particularly applies to state exchanges (to be established and operating in all states in 2014) for small businesses and low-income people.

The political interests involved here are those of state governments and, most important, those of low-income participants in state health insurance exchanges. In the latter case (for exchanges), this is true both if participants are partially subsidized and even if they are not subsidized. Subsidized participants in the exchanges will still face some premium costs and copay, and over time they may move in and out of eligibility for subsidization. (Under the ACA, employers are required to cover at least 60 percent of premium costs, which means their employees can be subject to 40 percent premium-cost requirements.)

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My reading of the law is that what is suggested above in the way of new forms of health insurance is in line with the spirit and letter of the law and probably wouldn't require legislative changes. But this may not be so; I can envision circumstances under which legislative changes could facilitate administrative and organizational arrangements, enabling the federal government to work cooperatively on new products and management techniques with state governments and state government organizations such as the National Governors Association, the National Conference of State Legislatures, the National Association of Insurance Commissioners, and the National Association for State Health Policy.

"Affordability" is the catchword now; it is emblazoned in the title of the law. Both regulations promulgated under the law and their interpretation need to be flexible if affordability is to be achieved — and sustained. As noted, it is possible that changes in the law — hard as this would be to accomplish — may need to be countenanced. Hopefully, the ACA cost estimates are on track. However, there is every reason to be vigilant in the complex, contentious political setting for implementing ACA as to whether the design and mechanisms of the new law can operate as intended.[11]

Other Possible Incremental Implementation Opportunities

The country is huge and complex. Any subject you dig into is bigger than a blog blurt. We tend to talk about health care reform in such grand terms that we miss opportunities for important operational changes inside hospitals, clinics, doctors' offices, pharmacies, billing offices, data systems, etc.

As in the case of the example given above about new forms of health insurance, the fact of the matter is that reform is often going on at just the time politicians and pundits are calling for it.

Changes in health care delivery have been taking place for a long time. If you have a rash, you don't have to go to the hospital emergency room. You can go to a pharmacy in many places and a nurse practitioner will prescribe an ointment to relieve it. My Medicare pays for this; your coverage may too.

In much the same way, a next tier of care — emergency clinics — are springing up in shopping malls faster than new retailers of other products. Similarly, nurses, nurse practitioners, physician assistants, and pharmacists in many states are lobbying to be able to do more, for example, to administer and interpret tests and prescribe medications for what in their view can be considered routine and early-entry procedures. Likewise, the operations of new types of clinics that are springing up, especially in low-income areas (often operating under federally approved qualifications), should be closely assessed to consider new delivery systems and arrangements.

V. The Federalism Dimension

The example above of nurses, nurse practitioners, and physician assistants and pharmacists doing more provides a transition into the next subject, the federalism dimension of ACA implementation.

States differ significantly in their capacity, values, and purposes when it comes to health policy and the delivery and oversight of health care services. Some, as above, are actively expanding the role of support personnel and developing ways to reform health care delivery systems. They are encouraging and supporting techniques for step-wise access to care and related efficiency measures like using the Internet and group meetings with medical care personnel.

So, there are opportunities — opportunities to learn from state best practices. Under the new law, some states are already out front getting ready and developing management structures and strategies for the establishment of health insurance exchanges. In most cases these activities, both legislatively and via planning processes, are modeled on the Massachusetts' "Commonwealth Connector" system. The slogans one hears, and the thing to look for in implementation studies, is the extent to which, and in what ways, will states be "value purchasers" and "prudent purchasers" in approving health insurance policies for their exchange.

There will be challenges too — challenges, for example, for federal officials in getting states to carry out and oversee specific requirements of the new law, as well as more subtle challenges about the way states carry out their two biggest charged tasks to expand coverage — establishing exchanges and expanding Medicaid.

It was always a balancing act for access, quality, and cost containment, both by the feds (different agencies, interests, and actors therein) and by and within the states in the same way involving multiple actors and interests. States can be arrayed in many ways:

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in sympathy with the new law and in some cases ahead of it; willing and ready to go along; not happy with the new law and yet willing to go along; and not happy with the new law and dragging their feet. For the feds, what has often been a sticking point is the need to differentiate among the states — to adopt different strokes for different folks (state governments). Innovations in intergovernmental relations are as much a necessity here as innovations in program management and service delivery.

VI. The Politics of Implementation

As Mancur Olson emphasized in his insightful writings about the rise and decline of nations, entrenched interests in democracies grow in power and influence over time.[12] This is clear as a bell in the health field. Many strong interests have to be reckoned with as federal and state officials and agencies swing into action to implement the new law. The environment is vastly intricate and complex. Hopefully, there will be opportunities where shared interests among players can produce systemic changes, new products, and new administrative techniques and management systems. This will require steady vigilance to identify and understand situations in which coalitions can be built to take advantage of opportunities and surprises along the way, a willingness to change direction and adapt to changed conditions, and political adroitness. The last of these watchwords — political adroitness — is not to be sneezed at. Implementation is a hard job substantively and administratively. It is also a political game.

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Endnotes

1 Angela Browne and Aaron Wildavsky, "Implementation as Exploration" in *Implementation*, ed. Jeffrey L. Pressman and Aaron Wildavsky (Berkeley, CA: University of California Press, 1984), 254.

2 Some states already have exchange-like agencies (notably Massachusetts and Utah). Others are working on setting them up. The Secretary of the U.S. Department of Health and Human Services is authorized to provide funds to help them do this in the first year after ACA enactment. California recently enacted a law to establish a quasigovernmental structure for its exchange modeled on the Massachusetts system. A similar effort is underway in Wisconsin. For information on the California law, see the statement by Micah Weinberg, "In the States: The California Health Benefit Exchange," New American Foundation, Health Policy Program, August 20, 2010. On the subject of the role of the states in ACA implementation, I am working on a successor paper focusing on a representative group of states (including California) for a December conference at the Woodrow Wilson School, Princeton University.

For self-motivated, high-energy Internet surfers, try this to dig into the terrain for yourself: Google the name of any state and the words "health insurance exchange." This will tell you a lot about how big and complex the subject matter is, how much already is (or was) going on, and what kinds of innovations and inventions are being worked on and advocated currently both nationally and in individual states.

3 Staff of *The Washington Post*, *Landmark: The Inside Story of America's New Health-Care Law and What It Means for Us All* (Washington, DC: Public Affairs Reports, 2010), 68.

4 On the Internet, Stein is widely cited for this remark. Hard as I looked, however, I could not find the original source — a paper, an article, etc. So, it is in the ether of cyberspace. It is so characteristic of Stein that it must be what he said.

5 Thomas McCraw, *Prophet of Innovation: Joseph Schumpeter and Creative Destruction* (Cambridge, MA: Harvard University Press, 2007).

6 For an excellent sumary source, see The Henry J. Kaiser Family Foundation, "Medicaid and Managed Care: Key Data, Trends, Issues," February 2010, available at www.kff.org/medicaid/upload/8046.pdf and John Holahan, Suresh Rangarajan, and Matthew Schirmer, "Medicaid Managed Care Payment Methods and Capitation Rates: Results of a National Survey," Occasional Paper Number 26, May 1999, available at www.urban.org/UploadedPDF/occa26.pdf. The Rockefeller Institute conducted studies in five states on the role of Medicaid managed care systems as prudent purchasers, with decidedly mixed results. See James W. Fossett, Malcolm Goggin, John S. Hall, L. Christopher Plein, Richard Roper, and Carol Weissert, "Managing Medicaid Managed Care: Are States Becoming Prudent Purchasers?," *Health Affairs* 19, 4 (July/August 2000): 36-49.

7 Some states, notably California, have launched notable initiatives for Medicaid managed care and health homes for single persons and the disabled, the so-called SPD population. See The Henry J. Kaiser Family Foundation, "Expanding Medicaid to Low-Income Childless Adults under Health Reform, Key Lessons from State Experience," June 2010, available at www.kff.org/medicaid/upload/8087.pdf. See also John J. DiIulio and Richard P. Nathan, eds., *Making Health Reform Work* (Washington, DC: Brookings Institution Press, 1994); Frank J. Thompson and John J. DiIulio, eds., *Medicaid and Devolution* (Washington, DC: Brookings Institution Press, 1998); The National Commission on the State and Local Service, *Frustrated Federalism: Rx for State and Local Health Care Reform* (Albany, NY: The Rockefeller Institute of Government, 1993).

8 Lawrence Brown and Richard P. Nathan, "Chickens, Eggs, and Institutions" (Albany, NY: The Rockefeller Institute of Government, August 2009), available at www.rockinst.org. Also see various MedPAC reports, including "Report to the Congress: Aligning Incentives in Medicare" (June 2010) available at www.medpac.gov/documents/Jun10_EntireReport.pdf.

9 Reed Abelson, "Insurers Push Plans Limiting Patient Choice of Doctors," *The New York Times*, July 17, 2010.

10 There is already evidence that the demand for health services may be abating in the recession, and that enrollment in high-deductable plans is rising. This could change, however, with a stronger economy and the expansion of coverage as the ACA law is implemented. See Avery Johnon, Jonathan D. Rockoff, and Anne Wilde Matthews, "Americans Cut back on Visits to Doctors," *The Wall Street Journal*, July 29, 2010.

11 Legislative cost estimates are notoriously inexact. Douglas Elmendorf, director of the Congressional Budget Office in his blog, October 7, 2009, is candid in his discussion of the CBO cost estimates for the ACA health reform law. Specifically citing past legislative changes in the payment rates for providers of Medicare services: "The long-term budgetary impact could be quite different" if these provisions are "ultimately changed or not fully implemented." The same point applies to Medicaid costs dependent on yet-to-be issued regulations defining "essential services," both for existing and newly expanded Medicaid coverage. In addition to these two federal programs, ACA cost estimates by the Congressional Budget Office are suitably cautious in their discussion of the effects of provisions of the law intended to restrain what in recent experience have been the inexorable pressures of health care cost escalation. With 30-plus millon people ultimately slated to be newly covered, providers will be in the catbird seat. Implementers are sure to be sorely tested. Pressure is already mounting. See Robert Pear, "Short of Repeal, G.O.P. Will Chip at Health Law," *The New York Times*, September 21, 2010.

12 Mancur Olson, *The Rise and Decline of Nations: Economic Growth, Stagflation, and Social Rigidities* (New Haven, CT: Yale University Press, 1982).