State legislative and regulatory barriers

Much of health care is financed and regulated at the state level. States have traditionally held responsibility for oversight of insurance. In 1945, Congress recognized state regulation of insurance with the McCarran-Ferguson Act, and has redefined and reaffirmed that principle since. Efforts to supplant state insurance regulation with federal oversight have been repeatedly rejected.[i] State laws vary concerning insurance risk and which products require regulation.[ii] Many quality-based purchasing arrangements could be considered insurance products for purposes of state insurance regulation. Arrangements that transfer risk, even partial risk, to providers such as bundled payments, global capitation and ACOs could be problematic. Proponents of these arrangements argue that insurers, self-insured employers and government payers should retain responsibility for "insurance risk" -- costs due to whether patients become ill -- and provider organizations such as ACOs should assume "performance risk" -- based on providing quality care that is cost-effective once a patient has a condition requiring care.[iii] Another open question is whether providers who accept risk, even performance risk, should be required to keep adequate capital reserves to cover that risk.

State and federal anti-trust legislation and regulation may create another barrier to quality-based purchasing. Multi-payer collaborations are critical to ensure that provider incentives are aligned and payers collaborate to reward quality and efficiency of care. However, competition in many states health insurance markets has eroded, leading to higher costs.[iv] Consolidation of providers into integrated care systems such as ACOs could create local monopolies, increasing the costs of care.[v] States can act as a neutral convener to avoid anti-trust violations and monitor market conditions to preserve competition.[vi]

Other concerns include ownership and guarding privacy and security of personal health information and data used to evaluate quality and define payments. Non-discrimination protections in state laws and constitutions could limit value-based insurance design, for example prohibiting the exemption of only some patients from cost sharing due to diagnosis or health history. Interactions between state and federal law, especially in the event that federal reform passes, create more uncertainty. Even if state law is silent on these issues, the ambiguity and resulting litigation could inhibit and delay participation in quality-based purchasing. States that wish to foster health reform would be advised to clarify state law.

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[i] Proposed Federal Insurance Regulation, National Association of Insurance Commissioners.
[ii] J. Kasprak, Provider-Sponsored Organizations, CT Office of Legislative Research, 1997.
[iii] H. Miller, How to Create Accountable Care Organizations, Center for Healthcare Quality & Payment Reform, September 2009, From Volume to Value, Network for Regional Healthcare Improvement, January 2009.
[iv] J. Robinson, Consolidation and the Transformation of Competition in Health Insurance, Health Affairs 23:11-24, November/December 2004.
[v] Key Issues in Analyzing Major Health Insurance Proposals, Congressional Budget Office, December 2008, C. Capps & D. Danove, Hospital Consolidation and Negotiated PPO Prices, Health Affairs 23:175-181, March/April 2004, A. E. Cuellar & P. Gertler, How the Expansion of Hospital Systems Has Affected Consumers, Health Affairs 24: 213-219, January/February 2005.

[vi] A. Torregrossa, op. cit., H. Miller op.cit.