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The ideas and opinions presented in this paper are the author's alone. Comments on the paper may be sent to the author at richardnathan55@gmail.com.

Ideas for Reconciling Two Cultures for Health Reform

Richard P. Nathan

When I began writing this paper on next steps for health reform, I led off with a discussion of the high cost of American health care, facts about people not covered, and expert opinion about the seemingly insurmountable costs to the country if we don't make changes. One expert, Eugene Steuerle of the Urban Institute, who is qualified to speak on all three subjects, commented on the draft: "Dick, No need to state that we are underestimating future growth in health care costs. Not necessary to your theme."¹ He is right.

My theme is that taking the next steps to reform health care is *a public management challenge of the highest order*. I view the subject institutionally. What kinds of structures and mechanisms would be needed? And once we decide this, what kinds of political strategies could be used to get them adopted?

The paper has three parts. The first looks at two dominant paradigms (I call them cultures) for reforming the government's role in health care and reining in health care costs. I argue that we should embrace both of them. The second part of the paper, which is the longest part, focuses on exchanges as structures for managing the provision of health insurance coverage and network care. The third part deals with political processes that might be adopted to legislate and then implement changes in the structures, mechanisms, and delivery systems for providing health care services

I. Two Cultures

There are distinctive intellectual and ideological paradigms for health reform. Two stand out that represent significantly different economic and political cultures. One, the generally more liberal position, has confidence in the efficacy of the 2010 Affordable Care reform law to enhance "*provider value*" by making administrative changes to coordinate (or "bundle") services particularly for the sickest patients while at the same time constraining costs and extending care. This approach emphasizes reforms that concentrate on the productivity and quality of service provision through such measures as giving physicians more and better information, using evidence-based guidelines, and reducing unnecessary procedures. Former insider, Congressional Budget Office and Office of Management and Budget Director Peter Orszag, who along with many health experts is concerned about rising health care costs, emphasizes this provider-value

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approach.² Quoting Orszag on the need to restrain health care costs, “It is no exaggeration to say that the United States’ standing in the world depends on its success in constraining this health-care cost explosion; unless it does the country will eventually face a severe fiscal crisis or a crippling inability to invest in other areas.”³

In a similar way, U.S. Representative Paul Ryan, chair of the House Budget Committee, on the conservative side has emerged as an equally well-informed advocate and intellectual leader of a phalanx of proposals advanced over the years favoring the “*consumer-directed*” alternative for reforming health care and reining in health care costs.⁴ Like Orszag, Ryan describes the basis for the health care reform challenge “as one of inflation, driven by the overutilization of services, dramatic underpayments, and massive inefficiency.”⁵ A book by George P. Shultz, the first director of the Office of Management and Budget (for whom I worked as a staff member), and Stanford Economist John B. Shoven published in 2008 effectively presents the consumer-directed position. In the authors’ words, their approach seeks to make “the consumer an empowered financial player.” They summarize a range of consumer-directed approaches beginning with Milton Friedman’s recommendations in 2001 and including successor proposals.⁶

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One purpose in writing this paper is to urge that on both substantive and political grounds, the wisest course of action going forward is to accept and reconcile the two paradigms. In substantive terms, I believe the two cultures can fit together and can work well together. Even more importantly, in political terms I believe that unless advocates of the two cultures come to terms, there is little prospect for the kinds of actions that must be taken to achieve either of their objectives, reforming provider-service systems and introducing “managed competition,” which is another and popular way of describing the consumer-directed alternative.

The role of government in health reform going forward should not be an either/or proposition. The two approaches standing alone cannot bend the cost curve sufficiently for the population as a whole. They have different strengths applying to different conditions, situations, and times of life. On the one hand, the consumer-directed approach as a general rule applies best for healthier and younger workers and families and for activities focused on maintaining health. In contrast, the provider-value paradigm is most important (in fact critically important) for dealing with serious illnesses where coordinated provider care and bundled service systems are essential.⁷

Taking into account these kinds of varied life and life-cycle situations, along with the political exigency of needing to have people with different views come together and work together, this

paper uses examples of current policies and proposals to develop the case for doing this. It emphasizes *implementation*. It focuses on the types of administrative mechanisms and organizational changes that in some form (though not necessarily as recommended here) would have to be put in place for such a two-culture reconciliation to occur. I begin with Paul Ryan's proposal to convert Medicare from guaranteed-benefits to premium-supports.

II. The Role of Health Insurance Exchanges

Under the Ryan plan, a newly created Medicare Health Insurance Exchange would manage an arrangement whereby eventually eligible seniors would receive a lump-sum amount of subsidy often referred to as a voucher or, as many now prefer, "premium support."⁸ Other political leaders and experts have come on board to advance this approach since Ryan announced his position. There are many variations and there is much to be spelled out and probed to fill in the policy space. As an illustration, the way this approach is treated by George Shultz and John Shoven involves a complex system of risk- and income-adjusted subsidies requiring delicate and detailed follow-up decisions that reflect efficiency and equity values they favor.

The Affordable Care Act (ACA) relies on a similar role for health insurance exchanges to that under the Ryan proposal for Medicare. However, in the case of the low- and middle-income people added to coverage under the new law, there is an important difference in the organizational positioning of exchanges. Under the ACA law, exchanges are to be individually administered by *state* governments, while the Ryan Medicare-conversion proposal calls for a new national Medicare Health Insurance Exchange. This paper presents an approach for next-step health reforms relying on multiple *national* – not state – health insurance exchanges to administer premium-supports for health insurance for both groups (seniors and the newly covered) as components of a four-part "Health Choices System" consisting of:

- *A Medicare Exchange that would manage a system of choices of health insurance policies or care networks for seniors under which they would receive premium-support payments.*
- *A National Exchange (as opposed to individual state exchanges) that would provide similar premium supports for the low- and moderate-income population covered under the 2010 Affordable Care Act.*
- *A small business exchange also authorized under the ACA law, but again I think this should be administered at the national (not the state) level.*
- *And, finally, the existing exchange system that administers health insurance for federal government employees.*

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The first two of these covered groups, the Medicare group and the population added to coverage under the ACA law, involve the biggest changes and the hottest debates. Moreover, the politics involved are different. As noted, advocates of the Medicare conversion to premium supports tend to be conservatives. For the ACA newly covered group (low- and middle-income people to be added to coverage under the 2010 law) the push to do this mostly comes from liberals whose aim is to expand coverage. I treat each of the four types of exchanges separately in what follows, emphasizing the first two.

A Medicare Exchange. As a former OMB official, what appeals to me about the Ryan premium-support approach to Medicare reform is that it is a way “to close the end” on spending for health care for seniors. Currently (and I am one of the beneficiaries of this arrangement), the federal government is obligated to pay on an “open-ended” budget basis for whatever is billed for a wide range of services. The problem is that as the senior population increases, as people live longer, and as medical science advances, the projected costs of doing this grow at a much faster rate (double, even triple) than for the U.S. economy as a whole. According to former U.S. Senator Pete Domenici (Rep. Colorado) and Alice Rivlin (senior fellow at the Brookings Institution), “The principal driver of future federal deficits is the rapidly mounting cost of Medicare.”⁹

Meanwhile, efforts to deal with this challenge have fallen short. Requirements enacted into law in 1997 to hold down Medicare spending under the so-called SGR or “Sustainable Growth Rate” formula consistently have been delayed when they would have triggered cuts in physician payments. The most recent package of budget cuts for Medicare and other health programs proposed by the Obama administration (September 20, 2011) illustrate the dilemma involved. The administration’s proposals included ten-year savings of \$248 billion for Medicare (representing by far the dominant share of the proposed health-care savings). However, a substantial share of these funds is slated to erase already-enacted SGR cuts in physician reimbursements. The long-term challenge remains — the inexorable rise in Medicare costs.

The premium-support idea is basically simple. Originated by economists, notably Alain Enthoven of Stanford University, the aim is to manage competition in order to control costs.¹⁰ Ideally, supporters of this approach would like to apply it to more than just seniors (i.e., the Medicare population that includes disabled recipients). In fact, average health-care costs and cost increases tend to be higher for other populations. Eligible people would receive a fixed subsidy to help them pay for care. The idea of managed competition is that consumers of services as a result would be motivated to be wise shoppers, to make sure a particular service or treatment is needed. Providers of care (physicians, hospitals, and others) would have an incentive to help their patients

select the most efficient service and treatment packages or approach. This is the theory anyway. It is a marketplace theory (call it a capitalism theory). On the other side, a more liberal view emphasizes the idea that people should get what they need. There shouldn't be restraints on health care services. Health care should be a right, not a commodity.

The Role of Health Savings Accounts. Experts who favor greater reliance on consumer choice have proposed connecting premium-support payments with what already exists in law — Health Savings Accounts whereby consumers decide how to spend before-tax money in these accounts.¹¹ If they don't spend the full amount for health care in any given year, these funds carry over into the future and even can be bequeathed to their heirs. This is depicted, and I agree with this view, as a better vehicle than many current “Medigap” supplementary health insurance policies under which seniors are exposed to minimal health-care costs because these policies cover so many of the deductibles, co-pays, premiums, and other charges not covered by Medicare.

Health Savings Accounts could be (and, in my view, desirably should be) used for all four of the exchange populations discussed in this paper (seniors under Medicare, the newly covered ACA low- and middle-income population, small business, and government employees). Using this technique, some (not all) of the packages certified for support under health insurance exchanges could include an up-front proscribed form of a Health Savings Account that would give consumers a way to make their own choices that fit their particular situation and needs, and be able to do so on an efficient risk-adjusted basis, which also affords them an opportunity (typically in special election time periods) to change their coverage plan when conditions warrant.¹²

Under a Medicare health insurance exchange system, new entrants who already have a Health Savings Account could choose to keep their account, carrying it over into the new Medicare exchange, and adding to it over time in order to maintain a predetermined minimum balance in future years. Since this would lower the subsidy cost to the government of their coverage, an opportunity thereby would be created for these consumers to supplement their Medicare coverage package, for example, by adding long-term residential and home-care benefits. In particular, being able to do this would have the advantage of compensating for the decision made in 2011 not to fund the program authorized in the 2010 Affordable Care Act to assist in the financing of long-term nursing home and home care.¹³

A writer should not go further into this subject without noting the hard politics and hard choices that would be involved in going down the consumer-directed health reform road for Medicare and also for other populations. The industry is vast and ubiquitous — hospitals, physicians, pharmaceutical companies, and myriad other health care institutions and provider groups. The

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politics of major reform such as this are confounding. Each reader should judge whether we are close to — or at — a serious enough economic crisis point where this political barrier must be overcome. My view is, yes, we are at (or anyway very close to) the point where exploding health-care costs represent one of the most important ways to reform and deleverage American public finances.

An ACA low- and moderate-income exchange. When Senator Ted Kennedy died in 2010, the big political surprise was the victory of Republican Scott Brown to succeed him. Brown opposed the national health reform bill that at the time had passed the House of Representatives and was pending in the Senate. When sworn in, Brown would have provided the forty-first vote needed for a filibuster in the Senate that could have killed health reform. As a result, the tactical decision was made by supporters of reform that, in order to act on this legislation, it was necessary before Scott Brown was sworn in to adopt the Senate version of reform as the base for action.

In one particular and crucial way the Senate bill differed from the House version. The Senate bill, as noted earlier, assigned the responsibility for establishing health insurance exchanges to state governments (ironically modeled on the precedent of the Massachusetts “Connector” health insurance exchange) rather than assigning this responsibility to the national government as under the House bill.

I have studied what has been happening as a result of this decision and have come to the conclusion that this was a serious mistake and that if the ACA health reform law survives (i.e., in the courts, the elections, and the Congress) this decision should be reversed. Studies that have been done and reports issued about what state governments are doing to fulfill their required administrative role to establish health insurance exchanges under the ACA law show wide diversity. In administrative terms, the work goes slowly and is made difficult by the (fair to say) unprecedented fiscal pressure and problems state governments face. Even in liberal states where there is support for the ACA law, the process is rocky and slow going.

My second reason for suggesting that before the ACA law goes into effect it should be amended to assign the exchange-making responsibility to the national government pertains to cost containment. The way things are going now, most state health insurance exchanges would not fulfill the efficiency (cost constraining) goal for managing competition envisioned for the national Medicare exchange.

States can be divided pretty much according to the philosophy for their health insurance exchange. Some state governments, as in Massachusetts, California, Vermont, and Oregon, favor an activist market-making role for their exchange. Under this approach, the state government certifies eligible insurance companies and provider networks on the basis of whether they offer “good”

packages of benefits, i.e., packages that are cost-efficient for their citizens. Typically, these “activist” market-making states favor making a limited number of such options available to simplify choice making in the belief that consumers would have trouble picking among multiple options that differ in complicated and detailed ways.

Other less- or nonactivist state governments have a different philosophy, which many economists support, favoring an open-market approach. Let many flowers bloom; let all the insurance companies that come forward participate so that the market determines what the “best” offerings are. This is sometimes referred to as the “Yellow Pages” approach. States favoring this view tend to be conservative states and generally have been foot draggers when it comes to setting up and running an ACA exchange.

Reasons for recommending that the state-by-state approach under the ACA law be changed are twofold. On one hand, I see decided advantages in making available nationally portable (not state-restricted) health insurance policies. People frequently move across state lines. Having state-level exchanges is a problem for this purely physical reason. But there is another reason too. And in my mind it is a more important one.

The federal government should manage competition in both a national Medicare and low-income exchange to promote competition and efficiency by certifying health insurance policies and network-care choices that help consumers understand them and take account of the costs and prices of care. That is the basic reason Rep. Paul Ryan and others want to “close the end” (in budgetary terms) on Medicare. If the country is going to expand care to an estimated thirty-plus million low- and middle-income people as under the 2010 ACA health reform law, this efficiency purpose should be intrinsic to how the law is implemented.

A Digression on Medicaid. An assumption made in this paper is that what might be called “traditional Medicaid” for the lowest- income groups should be left pretty much as is. I refer to the grants-in-aid made by the federal government to the states for health care for people below 138 percent of the Federal Poverty Level¹⁴ and which also provides aid for the disabled and nursing home care. For the former group (mostly consisting of families), states place primary reliance on what are called “managed care systems” that bundle services (that is, put them together) in order to assist and treat the whole person and the whole family. There are good reasons why this is desirable, and while there is much more to be said on the subject, my inclination is to leave this as is in contrast to the many ways in which the delivery of health care would be changed by the market-building reforms envisioned in this paper for managing competition. Among many Republicans, the dominant conservative position on Medicaid is that Medicaid should be converted to a closed-ended block grant to the states. As a student of state-local finances for a long time, I feel

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compelled to add my two cents here. I favor the status quo for Medicaid (i.e., that it continue to be a shared federal-state fiscal responsibility on an open-ended basis) because there are so many unknowns and because the pressures at this time on state and local finances across the nation are epochal.

Small Business Exchange. For a long time the most nettlesome issue of health policy has been how to cover two groups, individuals (mainly people not in employer-supported groups) and small businesses. The ACA law ultimately seeks to achieve universal coverage; it contains provisions that cover both unconnected individuals and small businesses. Small businesses often have a hard time obtaining and supporting health insurance benefits for their workers, and not infrequently the benefits they provide are limited. The ACA law offers states the option of merging the low- and middle-income and small business exchanges in one exchange. It also provides income-tested subsidies for small businesses.

States are divided on whether these two risk pools (the ACA newly covered pool and small businesses) should be covered in a merged exchange or treated separately. Although I am not expert in the ins and outs of this decision, what I know suggests that it makes most sense (because of their different risk pools, profiles, and characteristics) to treat small businesses separately. Hence, the point of this section is that, as in the case of the newly covered ACA population, there should be coordinated (but separate) sets of rules and procedures for covering small businesses. But *not* at the state level. This too should be a national system

Public Employees. The final group in this health insurance exchange inventory is public employees. The national government and many states and large local governments administer programs whereby eligible participants select the coverage they want, and the administrative operations involved in providing it is handled by an exchange-like entity.¹⁵ The Federal Employees Health Program is a case in point. It has been around since 1960 and is administered by the Office of Personnel Management. For this group, it is best to leave the situation as it is.

So, now I am finished with the inventory of types of a health insurance exchanges for a national “*Health Choices System*” and can turn to the challenge of implementing exchange-making, particularly for the first two populations discussed (the Medicare and low- and middle-income populations).

III. Phasing In and Administering New Health Insurance Exchanges

Debates about health care tend to focus on end points and not enough on a process. There needs to be recognition of the necessity to make changes in ways that provide for preparation to give substance to, and lay the groundwork for, how new institutions and programs will work. This requires recognition that after new programs are established there is a necessary period of institutionalization and adaptation.

Over time, a “*Health Choices System*” of exchanges that blends the two health reform cultures (provider-value and consumer-directed) could change the health-care marketplace in ways that would alter behavior across the board on the part of patients, their families, physicians, and other health-care service providers. This won’t happen smoothly, easily, or all at once. It will require a jolt to the system, launching a process of change.

Much would be gained by having a single organization charged with developing, phasing in, and starting new exchanges that encompass the aims of both the consumer-choice and provider-value reform cultures. Unless ways can be found to share common ground, it is hard to see how progress could be made on next steps for health-care reform without falling back into the conflict and controversy that has undercut the nation’s ability to come to grips with its health conundrum.

The lead agency should be nimble and compact, for example a three- or five-member commission appointed by the president and confirmed by the Senate with the stipulation that members do not have ties to a particular health-care interest or business. The role of the commission should be to prepare for and at the outset administer new federal laws that would have to be enacted to convert Medicare to a premium-support system and establish a national exchange (as opposed to having individual state exchanges) to expand ACA coverage.

Such an office or commission should be charged with presenting an implementation plan, say by the end of two years after legislation is adopted, to develop new policies for converting Medicare into a new premium-support form by some future date and revising the Affordable Care Act to have a single national exchange. Of necessity, these plans would go into depth and detail on varied coverage packages, how they would work, and how they could be tailored to the different needs and conditions of different groups of exchange participants. The plans could then be submitted to the president and the Congress under facilitative arrangements for their consideration. This could include an up-or-down vote in Congress and a similar take-it-or leave-it decision by the president, in which case one would expect that there would be prior review and bargaining before a legally specified trigger date for their adoption.

Although they will have different time frames for coming on line, the exchanges have to perform similar managerial tasks and will have many shared functions and overlapping information needs. For operations like data handling and tracking, they should use similar rules, definitions, procedures, and information systems. They will also need to deal with people who move in and out of the different exchange categories and families with members in more than one exchange.

The ultimate aim of a two-part or three-part process for next-step health reforms should be to have workable machinery to chart new policy directions legislatively while at the same time

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allowing the necessary time on a calibrated basis for implementation. Large administrative tasks like converting Medicare to a premium-support system and implementing the Affordable Care Act if it endures require vast subsystems of decision making. Complex and sensitive technical matters have to be dealt with. The political stakes would be high. Few functional areas of government are as personal, emotionally charged, and difficult as health care.

There is a general point involved here for public management. The suggested several-step policy and implementation process for health reform has two features. It envisions having both the time and an expert process for putting together, vetting, and negotiating the particulars of the new policies and institutional designs that are adopted in law to overhaul the government's role in providing health-care subsidies. At the same time, it assures that legitimate political processes (involving the president and the Congress) have the final say on the plans that are developed to carry out the new policies. Doing this is emblematic of a broader need in government to be inventive and innovative in the operation of the nation's policy and management systems. One can think of an approach like this as a way to temper American political pluralism on a basis that preserves the legitimate role of elected political leaders while at the same time introducing a method by which they can work together better when there is a window of opportunity for next-step health reforms.

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The Nelson A. Rockefeller Institute of Government, the public policy research arm of the University at Albany, State University of New York, was established in 1982 to bring the resources of the 64-campus SUNY system to bear on public policy issues. The Institute is active nationally in research and special projects on the role of state governments in American federalism and the management and finances of both state and local governments in major areas of domestic public affairs.

Endnotes

- 1 Email correspondence, July 30, 2011.
- 2 Peter R. Orszag, "How Health Care Can Save or Sink America: The Case for Reform and Fiscal Sustainability," *Foreign Affairs*, 90, 4 (July/August 2011). See also Peter R. Orszag and Ezekiel J. Emanuel, "Health Care Reform and Cost Control," *New England Journal of Medicine* 363, August 12, 2010): 601-3, <http://www.nejm.org/doi/pdf/10.1056/NEJMp1006571>.
- 3 Ibid, p. 601.
- 4 There has been support for the consumer-directed/Medicare reform position from the liberal side, notably by Alice Rivlin, Brookings senior fellow and former federal budget official, who in 2010 issued a statement with Rep. Ryan supporting the premium-support approach to Medicare reform. See Alice Rivlin and Paul Ryan, "A Long-Term Plan for Medicare and Medicaid," November 17, 2010, <http://budget.house.gov/News/DocumentSingle.aspx?DocumentID=225826>. Now, however, Rivlin's views are different from Ryan's for Medicare premium-support, which she prefers to call "defined support" to distinguish the approach she favors from Ryan's; see "Domenici-Rivlin Protect Medicare Act," Bipartisan Policy Center, November 1, 2011, <http://www.bipartisanpolicy.org/sites/default/files/Domenici-Rivlin%20Protect%20Medicare%20Act%20.pdf>.
- 5 See Paul Ryan, "The Optimist's Guide to Repeal and Replace Patient-Centered Health-Care Reform for the 21st-Century," Remarks prepared for delivery at the Hoover Institution, Stanford University, September 27, 2011, <http://paulryan.house.gov/News/DocumentSingle.aspx?DocumentID=261967>.
- 6 George P. Shultz and John B. Shoven, *Putting Our House in Order: A Guide to Social Security & Health Care Reform* (New York: W.W. Norton & Company, 2008).
- 7 The history of coordination systems (for "bundling" services) goes way back. It includes notable, often-cited successes and many alphabet-soup efforts to innovate and push providers in this direction. The Affordable Care Act highlights what are called "Accountable Care Organizations" (ACOs) to accomplish this purpose, although to date it has been slow going. The regulations issued for ACOs have engendered controversy. The beat goes on. Few management challenges in the health field are more difficult and more urgent than this one.
- 8 Henry Aaron and Robert Reischauer are credited with suggesting this term for the current debate.
- 9 Domenici-Rivlin, Op. Cit, p. 1.
- 10 Enthoven began writing about management competition in the mid-1970s. Among his recent writings, see "What Paul Ryan's Critics Don't Know About Health Economics," *The Wall Street Journal*, June 3, 2011, "Reforming Medicare by Reforming Incentives," *New England Journal of Medicine* 364, 44 (May 26, 2011), <http://www.nejm.org/doi/pdf/10.1056/NEJMp1104427>, and "The U.S. Experience with Managed Care and Managed Competition," a paper presented at the Federal Reserve Bank of Boston's 50th Economic Conference, June 15-17, 2005, <http://www.bos.frb.org/economic/conf/conf50/conf50d.pdf>.
- 11 Health Savings Accounts, which were authorized in law in 2003, have precursors going back a longer period of time in which this cost-sharing technique has been developed and refined.
- 12 That is, to switch to an alternative form of coverage that does not include an up-front Health Savings Account. See the discussion of HSAs and possible reforms of these accounts in Shultz and Shoven, Op. Cit., p. 165-8. Their proposals include extending HSAs to individual purchasers (as opposed to limiting them to employer purchasing), allowing risk adjustment, and making them portable. Additional discussion of different types of coverage packages including HSAs is included in Part III of this paper on "Phasing In and Administering New Health Insurance Exchanges," p. 8 and following.
- 13 The reference here is to the now-deferred CLASS Act provisions of the 2010 Affordable Care Act, which provide in the law for the creation of what is called the Community Living Service and Support program.
- 14 This is the level prescribed in the ACA law.
- 15 Indeed, some state and local government health insurance-benefit systems for employees and retirees, as is now well known, are in financial trouble, but that is a subject for another time.