



Research Insights

■ Reimagining Federal and State Roles for Health Reform Under the Patient Protection and Affordable Care Act

Summary

The recently passed federal health reform legislation, the Patient Protection and Affordable Care Act (PPACA), mandates significant activities on the state and federal levels aimed at increasing access to health insurance coverage for low income individuals and for Americans previously shut out of the health insurance market. PPACA includes significant changes to Medicaid—the largest source of federal dollars provided to the states—expanding eligibility and benefit requirements nationwide and radically increasing federal funding provided to states. Changes are scheduled to take effect on a staggered schedule, and the federal government has implemented interim measures to bridge the gap between the current financial difficulties at the state level and dates in 2013 and 2014 when new funding provisions come into effect. In addition to the coming changes to Medicaid, PPACA creates new state and federal partnerships in the creation of high-risk insurance pools and the implementation of new protections for consumers with private health insurance. These efforts will eventually segue into the creation of health insurance exchanges, a national mandate to purchase health insurance, and a host of new consumer protections banning abusive practices such as rescission and denial of coverage for pre-existing conditions. Success will require new levels of coordination and support between state agencies and their federal counterparts—and new opportunities at every level of

government to ensure access to affordable and appropriate health care for all Americans.

Introduction

The unique relationship between the federal government and the states presents challenges and opportunities in the context of health care reform. The Patient Protection and Affordable Care Act (PPACA), the comprehensive health reform package signed into law March 23, 2010, contains a variety of provisions that impose requirements on states to implement reform, but attempts to preserve state-control over the details of design and implementation. Justice Brandeis famously observed “it is one of the happy incidents of the federal system that a single courageous state may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.”¹ State governments hold fast to their status as independent sovereigns with special knowledge concerning local needs and localized attitudes concerning the role of federal, state and local government in creating policy. On the state level, the disparity in health coverage and infrastructure is vast, so despite federal legislation imposing a measure of uniformity on how health reform efforts will proceed, individual states will retain substantial policy control and continue to face difficult financial burdens.

Genesis of this Brief

This brief is based, in part, on a panel discussion on “Reimagining Federal and State Roles in Health Care Reform” held at the National Health Policy Conference in Washington, D.C. on February 3, 2010. Ideas drawn directly from comments made at the conference are so referenced in the text.

In the context of the new health care reform legislation—and all of the policy elements included under that heading—states are required to take a range of specific actions based on a basic framework provided and paid for by the federal government, yet retain control over many details as long as they actively participate in implementation efforts. Some examples include:

- Changes to reimbursement structures and incentives under Medicaid;
- Design of localized insurance exchanges for the individual and small group health insurance markets; and,
- Creation or expansion of temporary high-risk insurance pools for uninsured people with pre-existing conditions.

Under PPACA and other federal initiatives, the states will receive a massive influx of funds to aid in the expansion of insurance coverage and engage in other reform efforts. Regardless of how much control states are able to retain over specific policy provisions in the health reform legislation, this influx of federal dollars will provide cash-poor states the opportunity to stabilize and the freedom to redirect state funds to local priorities.

Medicaid

Although PPACA greatly expands the relationship between the federal government and the states through new incentives and mandated programs, Medicaid remains the primary link between the states and the federal government in the area of health care and policy. Medicaid is a partnership between the federal government and the states that provides health coverage to certain low-income populations. The federal government imposes broad guidelines concerning what populations are eligible for Medicaid and what services will be covered, leaving states with significant discretion to determine their own eligibility requirements and to what extent services will be made available.² For example, once states decide to participate in the program, certain segments of the low-income population—such as pregnant women, people who are blind, and disabled persons—must have access to some rudimentary medical services. The federal government provides matching funds for every dollar spent under Medicaid, and states and localities cover the balance. The federal government regularly uses this reimbursement model to create financial incentives for states to provide additional services by making matching funds available for a wide range of services and a broader population than provided for by the baseline requirements.³

Although states are not required to participate, all 50 states and DC do—but at radically different levels. This model has resulted in dramatic discrepancies in services available to low-income populations

across the states.⁴ The percentage of state budgets allocated to Medicaid costs, already on a precipitous rise prior to the economic downturn, has grown even faster in the last two years,⁵ and states that have provided better care for more people under their Medicaid programs are now experiencing more severe budget shortfalls as a result.

Medicaid Changes under Health Reform

The health reform legislation shifts the Medicaid power sharing significantly in favor of the federal government, and includes targeted provisions staggered to come into effect over four years. These include near-term increases to reimbursement rates for prescription drugs, pilot programs for creating “health homes” for Medicaid recipients with multiple health conditions, increased payments rates for long term care innovation, and limited-scope demonstration projects for bundling payments as a way to create incentives for delivering care efficiently.⁶ Most significantly, PPACA includes a sweeping federal expansion of Medicaid eligibility effective January 1, 2014, permitting all individuals under age 65 with incomes up to 133 percent of the federal poverty level to enroll.⁷ Under this expansion, the federal government will pay 100 percent of the anticipated cost through 2016, with funding gradually declining to 90 percent by 2020 and beyond. In every state, this expansion represents a radical increase in reimbursement levels and also a massive increase in the number of people who will be “newly eligible” for Medicaid.⁸ The increase in federal dollars is accompanied by a uniform set of eligibility requirements and benefits that will replace a highly variable set of provisions crafted by individual state governments.⁹

Unfortunately, the uniform expansion is complicated by a provision that limits the more generous reimbursement rates to “newly eligible” Medicaid beneficiaries. In other words, the higher reimbursement rates will only apply to individuals with income levels that fall between Medicaid eligibility levels in place as of March 23, 2010 (the date the new legislation took effect) and 133 percent of the federal poverty level (the new eligibility cut-off set by the health reform legislation).¹⁰ States will require systems to track the individuals eligible for the higher reimbursements, and states with stricter Medicaid eligibility requirements in place prior to passage of the new law—and, as a direct result, with a larger population of uninsured—stand to receive significantly greater financial assistance than states providing more comprehensive Medicaid coverage at the time the legislation was passed. In addition, it remains to be seen whether more generous benefits mandated under the Medicaid expansion will apply to all Medicaid beneficiaries or just the newly eligible population.

Critics contend the new law fails to address the existing state budget crises, caused in part by rising Medicaid costs, and does not address how states are meant to manage costs for both existing Medicaid

recipients and for the growing number that will become eligible for Medicaid under existing state guidelines. Across the states, the average allocation to Medicaid is 20 percent of the entire budget, with some states dipping as low as 13 percent and other states cresting as high as 30 percent of expenditures allocated to Medicaid.¹¹ As people have lost their jobs and homes, state tax revenues have decreased, creating state budget shortfalls and increasing the number of people turning to Medicaid for health coverage. These budget gaps, widespread and severe, led to many states cutting Medicaid spending by tightening eligibility requirements, decreasing provider reimbursement rates, and reducing services.¹²

Federal Efforts to Stabilize Medicaid

The federal government, in an attempt to financially stabilize state budgets and prevent further cuts to Medicaid services, allocated close to 90 billion dollars in Medicaid reimbursement subsidies as part of the American Recovery and Reinvestment Act (ARRA) passed in February of 2009.¹³ The legislative intent of the ARRA subsidy was to “protect and maintain State Medicaid programs during a period of economic downturn,” and create a disincentive for states to cut reimbursement rates to providers and tighten eligibility requirements for beneficiaries.¹⁴ The ARRA provisions included a “maintenance of effort” or “MOE” provision, that tied the short-term Medicaid reimbursement increases to a requirement that states freeze Medicaid eligibility requirements in effect as of July 2008, and also placed restrictions on any further reductions states could make to Medicaid services while receiving the additional federal funds.¹⁵ The consequence for states disregarding the freeze on Medicaid cuts is the loss of the ARRA subsidy, and thus far every state has honored the restriction and received enhanced funds for both the 2009 and 2010 fiscal years.¹⁶ ARRA subsidies are currently scheduled to end December 2010, and state officials have warned of dire consequences to Medicaid services if the ARRA funding subsidies are not extended, although congressional attempts to do so have failed thus far.¹⁷

Further complicating matters, the new health law contains a similar “maintenance of effort” provision. States are required to maintain current Medicaid eligibility levels, services and programs, as well as current enrollment procedures, until specific provisions of the new health law come into effect.¹⁸ The consequence for states disregarding this requirement is the complete loss of federal Medicaid funds—a far more draconian measure than the requirements imposed on states under ARRA. It is generally understood that this “maintenance of effort” provision includes a prohibition not only on eliminating eligibility categories or imposing stricter income eligibility requirements, but also prohibits states from reducing or eliminating CHIP benefits, and forbids states from imposing new barriers to enrollment, such as increasing required paperwork or requiring more frequent program renewals.¹⁹

If the federal government is unable to extend the ARRA increases into the 2011 fiscal year, states will experience a sudden reduction in dollars available for Medicaid. In lieu of risking the loss of federal Medicaid funds entirely, states will likely make the strategic decision to close any gaps by making additional cuts to areas considered outside the scope of “maintenance of effort” requirements, including reductions in provider reimbursement rates under Medicaid.²⁰

For example, Maryland, the wealthiest state in the country, cut their state budget by 10 percent this year due to recession-based shortfalls. Maryland allocates 25 percent of the state budget to health care expenditures and was forced to close facilities, furlough state workers, cut provider rates and implement other reductions in services in order to balance the budget. Maryland previously expanded Medicaid eligibility to certain populations up to 116 percent of the federal poverty level, but for the last year has relied on the increased federal funds provided through ARRA. The state budget for 2011 has assumed continued ARRA funding that has not yet been legislated.²¹ Although it is unlikely Maryland will make cuts to Medicaid that could jeopardize access to federal funding, state officials will have to find other ways to address the shortfall should the ARRA reauthorization not come to fruition.

In the wake of the economic downturn, before maintenance of effort requirements were imposed on the states, budget shortfalls forced cuts to Medicaid across the country, including a reduction in the administrative infrastructure required to enroll and manage benefits for existing and newly eligible individuals. Rebuilding administrative capacity on the state level will be necessary to effectively implement health reform, and states will also need to address basic governance issues concerning which state agencies and officials will be responsible for reform implementation, and how these activities will be coordinated, monitored, and funded.²² Historically, the federal government has provided 50 percent of Medicaid administrative matching funds, but administrative burdens on states will increase as enrollment grows, and although there will likely be federal financial and technical assistance made available to the states for some of these costs, covering costs for ancillary capacity building efforts, such as expanding availability of primary care services and increasing Medicaid provider reimbursements, remain a serious concern and will fall to the states.²³

Despite short term budget concerns, experts on a panel discussion on “Reimagining Federal and State Roles in Health Care Reform” held at the National Health Policy Conference in Washington, D.C. on February 3, 2010 generally believed that “increases in state spending” under PPACA Medicaid expansion will be “small compared to increases in coverage and federal revenues and relative to what states would have spent if reform had not been enacted” and will have a long term positive effect on the health of

state economies.²⁴ Under PPACA, Medicaid will be transformed into a program that serves as a “national floor” for low-income adults and children to access health coverage, and for the first time allows Medicaid to serve as a major vehicle for providing health coverage for populations historically excluded from coverage, most significantly low-income childless adults under the age of 65.²⁵

When the new Medicaid expansion takes full effect in January 2014, the result will be the near elimination of “the troubling amount of variation” between the states in their levels of generosity for Medicaid.²⁶ Historically, states have had control over eligibility and reimbursements, and the federal government has used financial incentives to “help cajole state generosity.” Under health reform, states have far less control of Medicaid—and far less of a financial burden to cover associated costs. Critics contend this federal consolidation reduces the opportunity for states to act as Justice Brandeis’ famous “laboratories” and also reduces the role of political will—as expressed through state-level elections and governance—in determining the amount of tax dollars that should be spent on health care access for the poor.²⁷ Despite these concerns, eliminating the variation in eligibility and benefits in Medicaid programs has the potential to remedy “an uneven and unstable foundation” that could impede the success of national reform.²⁸

Health Insurance Exchanges

Under PPACA individual states are required to create health insurance exchanges by 2014. Exchanges are regulated marketplaces where individuals and businesses can purchase insurance. Insurance plans must provide a minimum set of benefits and meet other basic solvency requirements in order to gain access to an exchange. The legislation requires two forms of exchanges—one for individuals (referred to as American Health Benefit Exchanges) and one for small businesses (called Small Business Health Options Program Exchanges or “SHOP” Exchanges.) Similar to many of the reform provisions included in PPACA, states are mandated to implement exchanges or their functional equivalents, but have latitude as to their structure. States may establish exchanges directly or contract with a non-profit organization to create them, and also may choose to partner with other states to create regional exchanges. In addition, states are allowed to apply for a waiver to take allocated funds for creating exchanges and design an alternative solution that would provide the same access to comprehensive benefits and cost sharing parameters otherwise provided for in an exchange. Finally, a state may choose to forego responsibility for establishing and managing exchanges, and the federal government will run the exchange instead.²⁹

Exchanges are intended to provide transparency and competition in the individual and small employer health insurance markets, although PPACA allows for larger employers to utilize exchanges beginning in 2017. Currently the majority of states have little or no competitive

health insurance market, and a small number of large insurance carriers generally dominate. The problem is more acute in rural states and in smaller states with low population density.³⁰ For individuals and businesses in states with minimal or no consumer choices, the new exchanges have the potential to cultivate increased coverage options at lower prices. Exchanges, or their structural equivalents, are also required to provide broader access and eligibility information for Medicaid and CHIP, as well as information via a web portal for comparing available plans and services. State exchanges are expected to act as both an incentive and an opportunity for streamlining outreach and administrative practices to maximize participation and generate additional cost savings for states.³¹ Subsidies will be available for lower-income individuals purchasing insurance through exchanges who do not qualify for Medicaid, and tax credits are available for small businesses that wish to provide health benefits for their employees but are currently unable to afford coverage.

Other Reform Provisions

In addition to sweeping changes to Medicaid, the federal government has taken the lead on a range of other reform initiatives, including the imposition of an individual mandate to purchase insurance, the expansion of high risk insurance pools, and the creation of market-based insurance exchanges. Although Massachusetts was able to impose an individual mandate at the state level with reasonable success, many state officials across the country who agreed that a mandate was necessary for effective reform felt it was too risky to implement state-based mandates in a patchwork fashion. In part, this stemmed from the fear that mandates would drive people and businesses into states without mandates, and the administrative burden of tracking coverage was perceived as daunting.

Health reform legislation also includes a wide range of provisions aimed at increasing efficiency and quality in the delivery of medical services, as well as new rules that attempt to mitigate the perverse financial incentives that cause over-treatment and medical waste. The new law also broadens access to preventive care services such as cancer screenings and employer-based wellness programs, begins to address structural problems under Medicare, and includes new protections for consumers purchasing insurance on the individual and small group market.

Conclusion

State officials generally agree, despite substantive policy differences, that to achieve comprehensive reform, leadership and financing could only be provided on an adequate scale by the federal government.³² The federal reform legislation extends beyond the implementation of significant Medicaid reforms and provides the opportunity for states to move forward with both nationally mandated and state specific reform initiatives. Over the long term, many of the state funds currently used to cover costs incurred by the uninsured and fund

programs such as high risk pools will be offset by the broad range of additional services and initiatives included in the federal legislation. The hope is that these funds can then be repurposed to address local priorities including workforce development, malpractice reform, and service delivery reforms.³³ The legislation also provides funds for localized pilot programs and demonstration projects that attempt to address other pressing concerns related to cost containment, improving and maintaining quality and efficiency of care, and addressing scope of practice and health worker shortage issues.³⁴

Health reform legislation provides significant federal funding to the states, without which any hope of achieving universal coverage would be unrealistic. The federal government has a proven track record of effectively creating financial and other incentives for states to implement localized models of national policy initiatives. The hope is that under PPACA the federal government can encourage states to address health reform as a top priority through increased funding. In response, policymakers expect that states will be able to achieve close to 95 percent insurance coverage, expand primary care services by expanding scope of practice and licensing provisions, and develop models for controlling costs through local demonstration projects and similar initiatives.³⁵

Taken together, the changes to health insurance coverage and delivery of care that go into effect between now and 2014 will require major efforts at every level of government, and will necessarily enlist state agencies, officials and legislatures in regular dialogue and partnerships with their federal counterparts in order to effectively implement and enforce reform.

About the Author

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Endnotes

- 1 From Justice Brandeis' dissent in *New State Ice Co. v. Liebmann* 285 U.S. 262 (1932)
- 2 Center on Budget and Policy Priorities. "Policy Basics: Introduction to Medicaid," Last Updated December 17, 2008. Also see <http://www.cbpp.org/cms/index.cfm?fa=view&id=2223>.
- 3 Center for Medicare & Medicaid Services. "Medicaid Program – General Information". Last updated March 29, 2010. Also see <http://www.cms.gov/MedicaidGenInfo/>.
- 4 Mathematica Policy Research Inc., *Defining and Measuring State Medicaid Spending Efficiency: A Literature Review*, Report to U.S. Department of Health and Human Services, March 2009. Also see <http://aspe.hhs.gov/health/reports/09/medeff/report.shtml>.
- 5 Rowland, D. "Health Care and Medicaid - Weathering the Recession." *New England Journal of Medicine*, Vol. 360, March 26, 2009, pp. 1273-1276.
- 6 American Hospital Association. *Summary of 2010 Health Care Reform Legislation*, Legislative Advisory, April 2010.
- 7 Henry J. Kaiser Family Foundation, "Health Reform Implementation Timeline," Focus on Health Reform series, Last modified March 25, 2010a. Also see <http://www.kff.org/healthreform/8060.cfm>.
- 8 Bakhtiari, E. "States Will Pay Little for Reform's Medicaid Expansion," *HealthLeaders Media*, May 2010. Also see <http://www.healthleadersmedia.com/content/FIN-251636/States-Will-Pay-Little-for-Reforms-Medicaid-Expansion%23>.
- 9 Under the Medicaid expansion provisions of PPACA, States must provide a "benchmark" or "benchmark equivalent" package of benefits. For a detailed explanation of the Medicaid expansion see <http://www.healthreformwatch.com/2010/05/11/medicaid-programs-state-flexibility-for-medicaid-benefit-packages/>.
- 10 Families USA. "Early Medicaid Expansions Under Health Reform," Understanding the New Health Reform Law fact sheet series, May 2010. Also see <http://www.familiesusa.org/assets/pdfs/health-reform/early-medicaid-expansions.pdf>.
- 11 Wildasin, D.E. and J. Marton. "Medicaid Expenditures and State Budgets: Past, Present, and Future." *National Tax Journal*, Vol. 60, June 2007, pp. 279-304.
- 12 Angeles, J. and J. Solomon. "Recession Threatens State Health Care Programs: Extension of Recovery Relief Needed to Avert More Drastic Cuts that Would Swell the Ranks of the Uninsured and Weaken the Economy," *Economic Recovery Watch series*, Center on Budget and Policy Priorities, March 2010. Also see <http://www.cbpp.org/cms/index.cfm?fa=view&id=3105>.
- 13 Turner, A. "Impact of ARRA on State Medicaid Programs; Downturn Opportunities for Providers?" *Health Law Vantage Point*, Spring 2009. Also see http://www.gklaw.com/news.cfm?action=pub_detail&publication_id=830#ARRA
- 14 The stated purpose of Title V (State Fiscal Relief) of the American Recovery and Reinvestment Act (ARRA) of 2009. Bell, G. et al. *The American Recovery and Reinvestment Act of 2009: A Guide for State and Local Governments*. Report to the Council for State Governments, February 2009. Also see <http://www.staterecovery.org/Websites/staterecovery/Images/Appendix.pdf>
- 15 Boyle, R. and J. Perkins. *State Maintenance of Effort Requirements for Enhanced FMAP*. National Health Law Program Information Sheet, March 2009. Also see <http://www.tilrc.org/assets/news/0309news/0309comm10.html>
- 16 See <http://www.hhs.gov/recovery/statefundsmap.html> for state-by-state reporting of funds received under the ARRA Medicaid subsidy program.
- 17 Henry J. Kaiser Family Foundation. "Medicaid's Continuing Crunch In a Recession: A Mid-Year Update for State FY 2010 and Preview for FY 2011" Accessed at <http://www.kff.org/medicaid/upload/8049.pdf>; Murray, S. and L. Montgomery. "Senate approves emergency war funding; larger aid bill stalls in House," *Washington Post*, May 28, 2010.
- 18 The "maintenance of effort" provisions under PPACA applies to children through October 1, 2019 and applies to adults until the state health insurance exchanges are in place in 2014.
- 19 Center on Budget and Policy Priorities, "Holding the Line on Medicaid and CHIP: Key Questions and Answers About Health Care Reform's Maintenance-Of-Effort Requirements," March 2010. Also see <http://www.cbpp.org/cms/?fa=view&id=3146>; See also Section 2001(a)(2)(A) of PPACA (PL 111-148 and PL 111-152), which amends Section 1902 of the Medicaid statute.
- 20 Arizona and California are two states already facing these challenges. Arizona was forced to repeal cuts to state Medicaid passed just before PPACA was enacted. In early May the state reversed the benefit reductions in order to protect their federal Medicaid funding, and now must seek other alternatives. Trapp, D. "CHIP, Medicaid cuts in Arizona on hold for now," *American Medical News*, May 18, 2010. Also see <http://www.ama-assn.org/amednews/2010/05/17/gvsd0518.htm>.
- 21 Impact of health reform and stimulus dollars on Maryland were discussed at a presentation by John Colmers, Maryland Secretary of Health and Mental Hygiene, during the panel "Reimagining Federal and State Roles in Health Care Reform." National Health Policy Conference, Washington, DC, February 9, 2010.
- 22 Weil, A. et al. Supporting State Policymakers' Implementation of Federal Health Reform. State Health Policy Briefing, National Academy for State Health Policy, November 2009.
- 23 Henry J. Kaiser Family Foundation. "Health Reform Issues: Key Issues About State Financing and Medicaid," Focus on Health Reform, May 2010b. Also see <http://www.kff.org/healthreform/upload/8005-02.pdf>.
- 24 Holahan, J. and L. Headen. "Medicaid Coverage and Spending in Health Reform: National and State by State Results for Adults at or Below 133% FPL," Kaiser Commission on Medicaid the Uninsured, Henry J. Kaiser Family Foundation, May 2010.
- 25 Remarks concerning potential changes to Medicaid under proposed health reform provisions made by Diane Rowland, Kaiser Family Foundation, during the panel "Reimagining Federal and State Roles in Health Care Reform." National Health Policy Conference, Washington, DC, February 9, 2010. (Provisions subsequently signed into law March 23, 2010.)
- 26 Observations concerning state disparities in Medicaid coverage discussed by Mark Pauly, University of Pennsylvania, during the panel "Reimagining Federal and State Roles in Health Care Reform." National Health Policy Conference, Washington, DC, February 9, 2010.
- 27 *Ibid*.

- 28 Pauly, M. and T. Grannemann. "Reform Medicaid First: Laying the Foundation for National Health Care Reform," AEI Press, June 2009.
- 29 See comprehensive summaries of the health reform law published by Families USA, available at <http://www.familiesusa.org/assets/pdfs/health-reform/summary-of-the-health-reform-law.pdf>, the Commonwealth Fund, available at http://www.commonwealthfund.org/~media/Images/Publications/Other/2010/Fund_Reform_Timeline_web_1387x675.pdf, the American Hospital Association *op.cit.* and the Kaiser Family Foundation 2010a *op.cit.*
- 30 Health Care for America Now, Premiums Soaring in Consolidated Health Insurance Market: Lack of Competition Hurts Rural States, Small Businesses (May 2009)
- 31 Some states, such as Wisconsin, have already begun the process. See Moore, J. "Wisconsin seeks firm to build health insurance exchange," Government Health IT, May 21, 2010. Also see <http://govhealthit.com/newsitem.aspx?nid=73793>
- 32 See note 18.
- 33 Role of the federal government in driving state level health reform activities, as well opportunities for states to repurpose funds saved at the state level through the influx of federal dollars were presented for discussion at a presentation by John Colmers, Maryland Secretary of Health and Mental Hygiene, during the panel "Reimagining Federal and State Roles in Health Care Reform." National Health Policy Conference, Washington, DC, February 9, 2010.
- 34 Kaiser Family Foundation, 2010b, *op.cit.*

- 35 The role of federal legislation on state roles in health reform were discussed by Jon Kingsdale, Commonwealth of Massachusetts Health Insurance Connector Authority, during the panel "Reimagining Federal and State Roles in Health Care Reform." AcademyHealth National Health Policy Conference, Washington, DC, February 9, 2010.

Additional Reading:

Cutler, D. M. et al. *The Impact of Health Reform on Health System Spending*, Center for American Progress and The Commonwealth Fund, May 2010. (Explaining how under health reform legislation, the "reduction in Medicare and Medicaid spending is approximately on par with the increase in medical costs associated with covering the uninsured.")

Cutler, D. M. et al. *Why Health Reform Will Bend the Cost Curve*, Center for American Progress and The Commonwealth Fund, December 2009. (Explaining provisions under PPACA that provide "authority for states to review and reject premium increases.")

Office of the Actuary, Centers for Medicare and Medicaid Services, "Estimated Financial Effects of the 'Patient Protection and Affordable Care Act,' as Amended," April 22, 2010 (Washington, D.C: CMS, 2010).