Klein

MEMO TO DPC STAFF
FROM: JEREMY BEN-AMI
SUBJECT: RESOLUTIONS FOR CONFERENCE OF MAYORS
DATE: JUNE 12, 1995

As mentioned at the DPC morning meeting, everyone should review the attached documents and E-mail your comments to Anna Winderbaum by COB Tues., June 13. Please CC: Jeremy.

Your comments should explain what you see as problematic to the Administration. Attached also is Marcia Hale's memo, which explains the purpose of us reviewing the resolutions. Thanks.

JUN 7 1995

THE WHITE HOUSE

WASHINGTON

June 7, 1995

MEMORANDUM TO CAROL RASCO

FROM: MARCIA HALE

SUBJECT: RESOLUTIONS FOR THE 63rd ANNUAL CONFERENCE OF MAYORS

Attached are the proposed resolutions for the 63rd Annual Conference of Mayors. These resolutions will be reviewed by the mayors on Saturday, June 17 and will be voted on by the Standing Committees on Monday, June 19.

It is my understanding that some of these resolutions may be controversial. I would appreciate you and your staff taking a look at the resolutions so we can work together on determining the ones which may be problematic for the Administration.

Thanks for your help. I look forward to speaking to you about this.

JENNINGS
KLEIN

Resolution No. 31

Submitted by:

The Honorable Kay Granger
Mayor of Fort Worth

MEDICARE AND MEDICAID

1) **WHEREAS,** Medicare and Medicaid provide critical health care services to the elderly and to low income people in our nation; and

2) **WHEREAS,** significant cuts in both programs are under consideration in Congress and likely to occur; and

3) **WHEREAS,** repeal of the entitlement status of Medicaid and conversion of the program to a state block grant could well occur; and

4) **WHEREAS,** the significant growth in both Medicare and Medicaid in recent years has been due to spiralling health care costs, an increase in beneficiaries and, in the case of Medicaid, expansion of mandatory services; and

5) **WHEREAS,** the Medicare program has been financed since its inception by the Medicare Trust Fund, but trust fund revenues are not expected to be able to meet program costs beginning early in the next century,

6) **NOW, THEREFORE, BE IT RESOLVED,** that The United States Conference of Mayors opposes any cuts in Medicaid or Medicare which jeopardize the health status of those who receive assistance through these programs; and

7) **BE IT FURTHER RESOLVED** that The United States Conference of Mayors urges the federal government to take actions which would bring spiralling health care costs under control; and

8) **BE IT FURTHER RESOLVED,** that The United States Conference of Mayors believes that any revenues derived from cuts in the Medicare program be used to assure the future financial stability of the system and/or be kept within the context of the health care system; and

9) **BE IT FURTHER RESOLVED,** that The United States Conference of Mayors opposes repealing the entitlement status of the Medicaid program because it would likely increase significantly the number of low income people in the country who have no access to health care and shift costs for providing services to local governments; and

10) **BE IT FURTHER RESOLVED** that The United States Conference of Mayors urges that as it makes changes in Medicaid, the federal government specify standards for a benefit package which includes disease prevention, health promotion and enabling services, and assure access to primary and preventive, emergency, necessary specialty, and chronic care and reproductive health services for all Medicaid eligible populations.

Projected Cost: Unknown

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

12-Dec-1994 12:49pm

TO: Christine M. Heenan

FROM: Carol H. Rasco
Economic and Domestic Policy

CC: Jeremy D. Benami
CC: Jennifer L. Klein

SUBJECT: RE: medicaid directors meetings

Timeline is fine. You should make SURE these folks know that I will be approaching this meeting as regards Health Care Reform as we are approaching all the small groups meetings we are having with outside groups...I'll give a brief intro as to where we are in the process but it will be listening...there are NO decisions to share with them yet. You should give them the same questions we've been giving the groups Public Liaison sets us up with and those questions are:

1. If incremental reform is the way we go, what are the pieces and priority order they favor?

2. Any input they have gleaned on the political landscape.

3. What their groups are planning/willing to do in the next session?

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

12-Dec-1994 12:25pm

TO: Carol H. Rasco
TO: Jeremy D. Benami
TO: Jennifer L. Klein

FROM: Christine M. Heenan
Domestic Policy Council

SUBJECT: medicaid directors meetings

In response to a request from Jeremy, Jennifer asked me to work with her to prepare briefing materials for Carol's Friday meetings with ASTHO and the Medicaid directors (the Camden Yards group).

I have spoken to Ray Hanley, chair of the Camden yards group, and Richard Chambers, the Intergovernmental Affairs person at HCFA who is working to set up the meeting. In a nutshell, their issues are what you would expect: what are the Adminstration's plans for health reform? Where do we stand on balanced budget, Medicaid cap, and the Kassebaum Medicaid swap proposal? They will likely also ask about the VFC program, and whether there are any planned changes to that program for the coming year.

By COB Wednesday at the latest, I will get over to Carol:

1) briefing on meeting, participants, and discussion topics from Richard Chambers

2) background memo from Margaret Pugh and John Monahan on issues they've been working on with Medicaid directors and the concerns regarding health reform

3) points of note from my conversations with Ray Hanley and Valerie Morelli from ASTHO.

If you need more or need things sooner, please let me know.

THE WHITE HOUSE
OFFICE OF DOMESTIC POLICY

CAROL H. RASCO
Assistant to the President for Domestic Policy

To: KLEIN

Draft response for POTUS
and forward to CHR by: _____

Draft response for CHR by: _____

Please reply directly to the writer
(copy to CHR) by: _____

Please advise by: _____

Let's discuss: _____

For your information: _____

Reply using form code: _____

File: _____

Send copy to (original to CHR): _____

Schedule ? : ☐ Accept ☐ Pending ☐ Regret

Designee to attend: _____

Remarks:

They got the message and called today to set !!

DEC - 8 1994

THE WHITE HOUSE

WASHINGTON

December 7, 1994

MEMORANDUM TO CAROL RASCO ✓
MARCIA HALE

FROM: Jennifer Klein J.K.

RE: Intergovernmental Process for Health Care

In addition to the NGA Executive Committee meeting and Carol's meetings with Medicaid directors and NASTHO next week, I think it might be wise to begin setting up additional meetings with state and local groups -- as we have been doing with the Office of Public Liaison.

Please let me know if you agree and who I should be working with at Intergovernmental Affairs.

THE WHITE HOUSE

WASHINGTON

December 7, 1994

MEMORANDUM TO BOB RUBIN ✓
CAROL RASCO

FROM: Jennifer Klein J.K.

RE: NGA Meeting

Here are talking points for the health care portion of your meeting with the NGA Executive Committee.

- Provide an overview of the health care process, i.e., new NEC/DPC structure, meeting with groups, etc.

  NOTE: They may ask who will take over now that Bob Rubin will be Secretary of the Treasury. I assume that both of you know better than I do what will happen and when we can talk about it publicly.

- Invite them to share their views. Remind them that this is a listening session for us. We need their assessments of the political environment (in the states as well as in Congress) and of health care policy options.

  NOTE: As you know, the NGA has issued no new health care policy guidelines. According to John Hart, because there are so many new governors, there is great debate about whether to issue new guidelines at all and, if so, about what they should say.

  The current NGA guidelines support comprehensive health reform at the federal level with significant state flexibility. As you can guess, with so many more Republican governors, any new guidelines will likely recommend a less comprehensive approach with a continued strong emphasis on flexibility (although perhaps with less reliance on ERISA changes).

  The governors are likely to ask about our position on Medicaid waivers. The President has suggested that Medicaid waivers provide an opportunity for states to be innovative in the absence of national reform. However, Republican members are ready to argue that the Medicaid waiver program is only a demonstration project -- and that we can not

implement national health reform through the back door. Obviously, you should avoid casting the waiver program as a path to national reform through action at the state level. Instead, emphasize that waivers are evaluated on a case-by-case basis and permit states to develop innovative and cost effective ways to run their Medicaid programs.

- Suggest that this should be the beginning of ongoing consultation. Note that Chris will speak with Carl Volpe (they have actually already begun exchanging phone calls) to begin staff discussions.

cc: Chris Jennings
Sylvia Mathews
Jeremy Ben-Ami

THURSDAY, DECEMBER 8

7:30 - 8:30 Breakfast with VP and Small Business Roundtable in VP's office, contact: Matt Riordan x66540.

NOTE: Jeremy will cover senior staff meeting.

NOTE: There is a BUDGET MEETING with the POTUS (8:15 - 10:15, Cabinet Room), which Bill will attend for you.

8:55 - 9:05 Car to the Marriott at Metro Center

9:15 - 9:30 Meeting with member of the NGA hearing panel, re: agenda for WH meeting at 3:00, New York room.

9:30 - 11:45 NGA program @ Marriott, Ballroom, until break for governor's only lunch.

NOTE: GOVERNORS ONLY LUNCH from 11:45 - 12:45.

NOTE: Health Care Meeting with the First Lady, (Map Room), Bill and Chris will cover.

12:45 - 3:00 Afternoon session on NGA conference commences, Marriott Hotel, Ballroom.

3:00 - 3:10 Car back to White House.

3:30 - 5:00 NGA Lead Governors Meeting (Roosevelt Room) contact: Lawton x62896.

4:30 - 4:40 POTUS BRIEFING ON NGA MEETING (with Marcia Hale), (Oval Office), contact: Marcia Hale, Carol Rasco

4:40 - 5:10 POTUS DROP-BY FOR MEETING, (Roosevelt Room), contact: Marcia Hale, Carol Rasco

6:30 - 6:40 Car to reception

6:00 - 7:30 Reception: Democratic Governors' Association, The Jefferson Hotel, 16th & M Streets, NW, contact: Caroline Cunningham (202) 479-5153.

7:15 - 7:25 Car back to White House.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

14-Nov-1994 08:04pm

TO: Christopher C. Jennings
TO: Jennifer L. Klein

FROM: Carol H. Rasco
Economic and Domestic Policy

CC: Jeremy D. Benami
CC: Rosalyn A. Miller

SUBJECT: Listening meetings

1. Marcia Hale is setting up for hopefully Bob and me to meet with a leadership group of bi-partisan governors on Dec. 8 when the leadership is to be in town for a children's event.

2. I have asked Marcia to think of other intergovernmental groups with whom we(I) need to meet: NCSL, NACO, Mayors, Black Elected officials, etc. and she will set those up in one group or a two groups.

3. I saw the director of the State Medicaid Directors' Assoc., Donna Checkett of Missouri, tonight and their exec. committee of ten directors will be in DC on Dec. 15, 16 for one of their regular meetings....we should meet with them at that time. I will ask Julie to call and get that one set up.

Can you all think of others with whom we should be meeting outside this list and the groups Public Liaison has contacted?

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

14-Nov-1994 08:12pm

TO: Rosalyn A. Miller

FROM: Carol H. Rasco
Economic and Domestic Policy

CC: Jennifer L. Klein

SUBJECT: previous email

Please print out my previous message to you on meetings and give to Julie asking her to expect calls from Marcia regarding numbers 1 and 2...we are to accommodate those as easily as possible.

Number 3: I need for Julie to call Richard Chambers at HCFA whom Checkett tells me can schedule the meeting with the Medicaid directors on Dec. 15 or 16 depending on my schedule and theirs. If he cannot be tracked, Julie, then go through Sid Johnson at APWA and explain to him what we need to do. This meeting like those we are currently doing with Public Liaison should be one hour, not in my office. When setting up the meeting it should be reiterated that these are listening meetings in that I listen, they share with me (1) their assessment of the new political environment and its effects for reform; (2) describe what, if any, incremental reform they would support and which incremental reforms they feel would be detrimental; (3) de-brief on what they have learned about the capabilities of their own menbership from the last two year, in addition to which reforms would find suport on the grassroots level and which would not.)

Roz: please also share the three points just above on the purposes of the meeting with Marcia Hale so that she can use that information as she calls the groups with whom she is setting me up.

Thanks.

E X E C U T I V E O F F I C E O F T H E P R E S I D E N T

16-Nov-1994 03:14pm

TO: Christopher C. Jennings

FROM: Carol H. Rasco
Economic and Domestic Policy

CC: Jennifer L. Klein
CC: Jeremy D. Benami
CC: Rosalyn A. Miller

SUBJECT: RE: Listening meetings

Yes, you should tell her we'll be calling her but don't assure her she will have a meeting alone with me. We may put together a group of several state organizations....we need to look at such a list next week. Please help me remember to add ASTHO to that group.

I believe Marcia will handle the elected official groups....we need to think of others like the one you mentioned, ASTHO, perhaps APWA, the Medicaid directors, etc.

Thanks.

NATIONAL GOVERNORS' ASSOCIATION

Hall of the States
444 North Capitol Street
Washington, D.C. 20001-1572
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Policy

EC-5. NATIONAL HEALTH REFORM AND COST CONTAINMENT

5.1 Preamble

The United States spends more on health care than any other industrialized nation even though fewer of our citizens have insured access to the health care system. Moreover, growth in the American health care industry has exceeded growth in the overall U.S. economy for almost every one of the last thirty years. As a result, health care expenditures represent an increasing share of the economy as measured by the gross domestic product (GDP). In 1980 health care was approximately 9.1 percent of GDP; in 1992 it represented 13.4 percent; and it is projected to represent about 17 percent of GDP by the turn of the century if current trends continue.

This phenomenal growth in costs has negatively affected government at every level and has seriously eroded the competitive edge of our businesses attempting to compete in a global marketplace.

Clearly the nation cannot sustain the current rate of growth in health care costs. If the system is expanded to include universal coverage without reform, the cost problems will be greatly exacerbated. While people may argue about the final target for an acceptable rate of growth in costs, the nation must develop a health care system that over the next several years will move growth in costs toward a long-term sustainable level.

The kinds of structural changes that must occur in the health care system to control costs cannot be effective unless and until every legal resident has health insurance. Universal access to health care is both a moral imperative and an invaluable cost containment tool.

5.2 Basic Federal Framework

The Governors support a managed competitive approach to health care reform that is organized by the federal government. However, attention must be paid to ensuring that the approach will work in both rural and inner-city areas. Toward that end, the federal government should establish a national health care board that includes state and local representation. Much of the framework for implementing managed competition could be accomplished by the national board.

The basic and fundamental federal framework for a restructured health care system that both controls costs and provides access and coverage must, at a minimum, include the following.

5.2.1 **Universal Access.** Universal access to health care coverage should be guaranteed to every American. States should have the option of providing access to health care either through public or private programs or through an employer-mandated system similar to those pursued in Hawaii, Kentucky, and Oregon.

5.2.2 **A Standardized and Federally Organized Information Base for Consumers.** The database must include price and quality information for all providers of health care services in a given geographic area.

5.2.3 **Federally Organized National Outcomes Research.** One component of such research should focus on primary and preventive care. Among other uses, this research could be used as a basis for clinical practice models.

5.2.4 **Federal Minimum Standards for the Regulation of Health Insurance.** These minimum standards must be developed in consultation with states and include limitations on the variation in rates that different individuals and groups are charged; limitations on medical underwriting; and guaranteed renewability, portability, and availability of insurance products. States can exceed these minimum standards. These standards should apply to nontraditional insurance mechanisms, such as multiple employee welfare arrangements (MEWAs) and other Employee Retirement Income Security Act (ERISA) plans, and to newly formed health insurance purchasing cooperatives. Once reforms are implemented, individuals bear a personal responsibility to obtain coverage either through public or private programs. The cost of coverage would be supplemented for low-income individuals.

5.2.5 **State-Organized Purchasing Cooperatives.** Through purchasing cooperatives, affordable insurance products will be made available. States and the federal government must work together to ensure that states have flexibility in establishing and operating purchasing cooperatives within a national framework. Purchasing cooperatives should allow for public or private operation under state regulation.

5.2.6 **Tort and Liability Reform Standards.** Tort and liability standards for health care should be developed by the federal government. However, states must have the flexibility to design and regulate their own programs that meet the federal standards or further limit liability.

5.2.7 **A Single National Claims Form.** The federal government, in consultation with states, must develop a single claims form and support the development of electronic billing as a means to reduce administrative costs. A single electronic claims form system will simplify the administrative procedures for all health care participants, including hospitals, physicians, insurers, employers, government, and consumers.

5.2.8 **Core Benefits Package.** The federal government, in consultation with states, localities, businesses, and labor organizations, must develop a core benefits package comparable to those now provided by the most efficient and cost-effective health maintenance organizations. There may be some state or regional variations in the basic benefit package, but such variations must be certified by a national health care board. Individuals would be free to purchase additional insurance with after-tax dollars. This package could be adjusted as additional information from outcomes research becomes available.

5.2.9 **Limitations on Tax Deductibility of Health Insurance.** The federal tax code must be amended to limit the tax deduction/exemption of health insurance for both employers and employees. Employer-paid insurance above the limit would be taxable to either the employer or employee. The self-employed would be eligible to purchase fully deductible health insurance -- exempt from taxation as personal income -- within the federal limit and/or tied to a percentage of an income level. This limit may be tied to the local cost of a basic benefit package and set at a specific dollar amount. Additional coverage or care can be purchased with after-tax dollars.

5.2.10 **Primary and Preventive Care.** The federal government must greatly expand its support for primary and preventive care including, but not limited to, periodic health screenings, prenatal care, well-baby care, and childhood immunizations.

5.3 Specific Cost Containment Strategies

Even if a federal framework is established that adheres to the principles just described, a real possibility exists that the federal government will attempt cost control by capping the federal medical entitlement programs. A cap only on federal health care entitlement programs will most certainly continue to shift costs to the private sector and local governments and reduce real benefits. A more effective strategy is to control costs throughout the health care system by developing health care expenditure targets.

It is unrealistic to immediately enforce strict budget limits on health care spending since available data are not sufficient to set accurate spending ceilings. However, the national framework, developed in consultation with the states, should include cost control mechanisms that should be implemented by the states as quickly as possible. Cost containment strategies must consider all the major cost-drivers in the health care and health insurance systems. Incentives such as expedited waivers and Medicaid demonstrations also must be available to contain costs.

Goals for the growth of national health care expenditures should be established for expenditures that are publicly supported either directly or through the tax code. Health care expenditures made by individuals with after-tax dollars would not be included in the targets. The national goals should be used to estimate expenditure targets for each state.

Data systems necessary to objectively measure national and state health care expenditures must be established.

As data become available, there should be a review of the progress the federal and state governments have made toward achieving the national expenditure goals.

The federal government should issue an annual report to the states that addresses the following.

- The effectiveness of our health care expenditures toward producing and maintaining health for all of our citizens. The data should be presented in at least the following categories: populations, state-by-state, urban and rural, fee-for-service, various types of managed care, and comparative therapies.
- The status of data system improvements, including the development of data categories, sample sizes, and timeliness.
- The progress or failure of each state toward any state or per capita expenditure goals.

5.4 State and Local Management

Within the context of a managed competitive approach to health care reform that ensures universal access and controls costs, the Governors support the principle of state and local management. State and local governments will need a set of tools to manage a cost-effective health care system.

States wishing to undertake reforms that complement the federal framework described above and that are aimed at significantly expanding access to health care and controlling health care costs should be encouraged to move ahead in advance of full implementation of national reforms and should be given the tools necessary to be successful. For example, Governors encourage prompt approval of the Oregon waiver request.

Assuming that there still is a public program, even if that public program is modeled after Medicaid, state and local governments will need stable financing and a uniform definition of eligibility. Beyond that, however, state and local governments must be given the flexibility and authority to fully integrate the public program into a service delivery system that reflects the national movement toward managed care. The federal government must not impose mandates beyond the core benefits or

service delivery restrictions on the public program. A streamlined and efficient public program will obviate the need for the complex and costly waiver process.

If Medicare continues to exist as a separate program, state and local governments will need the flexibility to fully integrate Medicare into their health care systems.

States must have the ability to include the current self-insured market (ERISA plans) in their state design.

States must have additional authority now precluded by federal antitrust statutes.

5.5 Additional Federal/State Issues

The federal government must participate in a discussion about how to deal with the access issues of rural areas, inner cities, and populations currently financed by federal programs, including Native Americans, veterans, and dependents of military personnel. The federal government also must participate in discussions about the provision of care to undocumented aliens.

The federal government must reaffirm the traditional role of public health programs, including epidemiology, environmental health, and disease prevention, while integrating primary and preventive care services into the core benefits package to the extent possible. Adequate federal resources and technical assistance must be provided to ensure that the public health needs of states and communities can be met.

Federal, state, and local governments must work toward agreement on a long-term care program that recognizes the need for different levels of care and support either within or outside a health care institution.

The Governors are prepared to work with other interested organizations and with the President and Congress to flesh out the details of specific proposals and then to secure formal support and enactment.

Time limited (effective February 1993-February 1995).
Adopted February 1993.

NATIONAL GOVERNORS' ASSOCIATION

Hall of the States
444 North Capitol Street
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HR-12. PUBLIC HEALTH SERVICES

12.1 Preamble

Effective community-based public health services improve the health of our citizens and prevent illness that results in the use of expensive medical services. The National Governors' Association is concerned that the current cost and institutional bias of the major publicly financed medical care programs has diminished our capacity to provide community-based public health services. Public health services are particularly critical for low-income individuals and families who are not eligible for Medicaid or other health care financing coverage. The Governors therefore believe that renewed emphasis on the provision of community-based public health services should be an integral element of cooperative federal/state initiatives to improve the health of our nation's citizens and the efficiency of our delivery systems.

12.2 Federal, State, and Local Responsibilities

Since the enactment of the first quarantine law, the delivery of public health services has been a responsibility of state and local governments. States continue to be in a better position to allocate resources and develop policies that respond to differing local needs and health care characteristics. The Governors, however, believe that the federal government has a responsibility to provide financial assistance to state and, in turn, local governments for the delivery of public health services. They also call on the federal government, in cooperation with state and local governments, to assume more responsibility for certain public health functions that are primarily national in nature. Federal assistance to state and local governments should be based on the following principles.

- The responsibility for the delivery of public health services must remain with state and local governments.
- Federal financial assistance must be flexible enough, preferably in the form of broad-based grants, to permit states to target available resources on the highest priority health problems affecting the citizens of each state.
- State government, through a state health plan, should be responsible for the design of public health programs that reflect national priorities, while focusing on local needs.
- All public health activities financially assisted by the federal government within a state should be under the sponsorship of agencies specified by the state.
- The federal government should establish policies for the surveillance of environmental threats to the public health and the establishment of health registries to monitor health trends and identify the long-term chronic health effects of exposure to toxic substances and other environmental contaminants.

- The federal government, in concert with state and local governments, should provide the leadership necessary to establish nationwide health promotion efforts such as those focused on childhood immunization and the hazards of smoking.

12.3 **Coordination of Services**

The Governors believe that cooperative federal, state, and local initiatives based on these principles will assist the development of a coordinated intergovernmental delivery system for public health services. The development of a coordinated system of public health services can help to ensure that our citizens have the optimal opportunity to lead healthy lives in an environment that minimizes exposure to hazardous practices, environments, and products. Toward this end, the Governors call on the President and Congress to review and expand on the following elements of federal public health services assistance.

12.3.1 **Health Services Block Grants.** Although the Governors continue to strongly support the block grant concept, states have been forced to adjust to severe reductions at the time of initial program consolidation. The Governors oppose additional federal fund reductions, even if associated with further consolidation of federal public health programs. The establishment of the three health services block grants in the Omnibus Reconciliation Act of 1981 has enhanced the states' ability to target limited federal resources. However, NGA believes that the effectiveness of the block grants could be greatly improved by:

- removing the remaining categorical elements, such as the complex allocation and set-aside requirements in the alcohol, drug abuse, and mental health services block grant;
- establishing uniform reporting requirements; and
- establishing uniform provisions for transferring funds between block grants.

The association also believes that any increased state responsibility for federal programs should be accompanied by adequate federal financial assistance.

12.3.2 **Maternal and Child Health Services.** The health status of American children has improved dramatically over the last two decades. Federal programs such as Medicaid, Aid to Families with Dependent Children (AFDC), and food stamps have contributed significantly to this improvement, and the Governors recognize the important link between health care and income security. As a result, the Governors are concerned that millions of children living below the federal poverty level are not covered by Medicaid or lack access to a regular source of health care or adequate income assistance.

The Governors believe that meeting the health care needs of underserved or unserved children should be a priority as well as a responsibility of all levels of government. Federal support for maternal and child health services and nutrition programs such as the Supplemental Food Program for Women, Infants, and Children (WIC), should be increased. A Harvard University study concluded that every dollar spent in WIC services resulted in three dollars of Medicaid savings. Despite these savings, the current level of federal support will enable far less than half of the potentially eligible women and infants to participate in the WIC program.

12.3.3 **Health Promotion and Prevention.** The Governors call on the federal government to expand its health promotion activities and encourage critical state preventive health initiatives and programs. Most health care professionals believe that personal behavior and habits such as smoking, exercise, diet, and alcohol and drug abuse are major determinants of morbidity and mortality. In many instances, health education and promotion programs can play an important role in modifying unhealthful practices. Federal financial assistance should be made available to states on a flexible basis for public health services that can be demonstrated to reduce net federal expenditures by preventing illness and expensive hospitalization and are demonstrated to be of special need in the affected state.

In addition, the federal government should enhance the capacity of federal agencies, such as the Centers for Disease Control, that work in concert with state public health officials to maintain high levels of childhood immunization, reduce chronic diseases, and respond to public health emergencies.

Time limited (effective February 1994-February 1996).
Adopted August 1980; revised August 1981, February 1982, July 1984, February 1986, August 1986, February 1988, February 1989, August 1989, February 1990, and February 1994 (formerly Policy C-5).

NATIONAL GOVERNORS' ASSOCIATION

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EC-7. HEALTH CARE REFORM: A CALL TO ACTION

7.1 Preamble

The nation's Governors are committed to comprehensive health reform that calls for a federal framework with significant state flexibility, and they will work with Congress and the administration to develop such a system. At the same time, however, the growing demand for affordable quality health care, coupled with the immediate budgetary pressures caused by the Medicaid program, requires immediate action. Virtually every Governor has some health reform initiative in progress. These include comprehensive state-based reform initiatives, programs that assist small businesses in securing affordable health insurance, programs that expand health care coverage to a greater number of uninsured poor, and programs that implement managed care networks for Medicaid beneficiaries. None of these state initiatives are incompatible with national reform; instead, they continue to build a strong policy foundation for reform at the federal level.

7.2 Federal Barriers to State Health Care Reform

As states have moved ahead, their success has been limited by barriers resulting from current federal statutes. The nation's Governors call upon the administration and Congress to immediately remove those federal barriers.

7.2.1 Medicaid. By far, Medicaid represents the largest health care expenditure for states. On average, only spending for elementary and secondary education constitutes a larger portion of state budgets. Governors believe that irrespective of any national health reform strategy, Medicaid costs must be brought under control. Should Congress move to limit or cap the federal contribution to Medicaid, a move the Governors adamantly oppose, the Governors believe these changes and other relief will become even more urgent. The Governors recommend the following changes that will contribute to controlling those costs.

7.2.1.1 Managed Care Waivers. There is a national trend in health care service delivery toward systems of care. These systems or networks have been shown to provide cost-efficient care while ensuring that the patient has a reliable place from which to seek primary care and to which specialty care can be directed. Although the private sector is moving aggressively toward these networks, the Medicaid program continues to require states, in virtually all cases, to apply for a waiver from fee-for-service care in order to enroll Medicaid beneficiaries in such networks. And while the Bush and Clinton administrations have taken significant steps toward simplifying the application and renewal process, states still must apply for renewals every two years. Moreover, states have been unable to sustain networks where there is a predominance of Medicaid beneficiaries because, under current law, states are permitted only one nonrenewable three-year waiver to have beneficiaries served in a health maintenance organization (HMO) where more than 75 percent of the enrollees in the HMO are Medicaid beneficiaries. This requirement should be repealed.

If the nation is serious about controlling health care costs, it is essential to give states the opportunity to establish networks in Medicaid (including fully and partially capitated systems) through the regular plan amendment process. Governors recognize the special significance of consumer protections and assurance of solvency in establishing these systems of care and support federal guidance through the regulatory process.

7.2.1.2 **Comprehensive Waivers.** States have begun to look seriously at comprehensive systems of health care where the artificial categorical barriers of Medicaid are removed and where they can establish statewide networks of care for Medicaid beneficiaries. Unfortunately, there are no provisions in the Social Security Act that can be used to establish such programs on an ongoing basis.

Currently, states have been developing these more comprehensive networks through the research and demonstration provisions of the Social Security Act (Section 1115a). Section 1115a, however, was designed for research purposes and has some important limitations. States must demonstrate, through the application process, that they are testing an innovation. The law requires an evaluation that, in some cases, requires control groups. Projects approved under the 1115a process are approved for a limited time period, usually three to five years at the discretion of the administration, and require special statutory changes to go beyond the demonstration period. Finally, these projects must be cost neutral over the life of the project.

Section 1115a is essential to ensure the testing of alternative health and social policies. However, the current statute falls short by requiring statutory changes if a state wants to continue its successful effort. In short, once a state has proven that its research project works, it cannot continue without congressional action. Governors support changes to the Social Security Act so that a state may apply through the executive branch of government for renewable waivers of their innovations. This waiver process should be consistent with the streamlined approaches used by the Clinton administration and states should have to reapply for these waivers no less than every five years.

7.2.1.3 **Boren Amendment.** The Boren Amendment to the Medicaid provisions of the Social Security Act was passed in the early 1980s to give states greater flexibility in establishing reimbursement rates for hospitals and nursing homes and to encourage health care cost containment. Instead, it has led to havoc in the administration of Medicaid programs. Court decisions have interpreted the Boren Amendment to embody a restrictive and unrealistic set of requirements in setting reimbursement rates, and have in effect given judges the power to establish reimbursement rates levels and criteria. Because of these decisions, states remain frustrated in their ability to bring some discipline to their budgets and have been thwarted in their attempts to achieve the original purpose of the amendment.

The nation's Governors believe that any coherent approach to national health reform must address the issue of the Boren Amendment. They believe that a statutory change to this amendment is an important tool necessary to bring Medicaid institutional costs under control. Therefore, the Governors urge the administration and Congress to adopt these or other changes to the Boren Amendment that will give states the relief they need.

Statutory and Regulatory Changes. The Governors agree that standards for establishing adequate reimbursement rates for hospitals, nursing facilities, and intermediate care facilities for persons with mental retardation (ICF/MRs) must be designed to promote access to care for Medicaid patients, quality of services, cost containment, and efficient service delivery. The Governors support a strategy that would replace the current cost-efficiency-based standard in the Boren Amendment with provisions that establish "safe harbor" standards where a state meeting any of these "safe harbor" provisions would satisfy the statute. Standards might include the following.

- The payment rate is equal to the Medicare-based upper payment limit.
- The payment rate is no less than the rate agreed to by the facility for comparable services paid for by another payer (e.g. payment rates for Medicaid patients would not have to be higher than rates paid by any large managed care plans or large business).
- Regarding nursing facilities, the aggregate number of participating licensed and certified nursing home beds in the state (plus resources devoted to home or community-based care for the elderly) is at least equal to a specified percentage of the population age 65 or over.

- The reimbursement rate is sufficient to cover at least 80 percent of the allowable costs of all facilities in the class in the state in the aggregate, or is sufficient to cover the allowable costs of 50 percent of all facilities in the class in the state.
- The reimbursement rate is equal to a benchmark rate plus inflation no less than the rate of inflation for the overall economy according to a general index (national or state), such as the consumer price index (CPI) or the gross domestic product (GDP-IPD). The benchmark rate would be the approved rate as of the date of enactment of the statute or the current rate approved by the Health Care Financing Administration (HCFA). This standard is satisfied by a rate methodology currently in effect and approved by HCFA that contains a provision for inflation adjustments.

The Governors also believe that the procedural requirements in the current Boren Amendment must be streamlined. Finally, the Governors support strategies that would reduce or eliminate the costs of prolonged and costly litigation.

7.2.2 **Employee Retirement Income Security Act.** Although the Governors are extremely sensitive to the concerns of large multistate employers, the fact remains that one of the greatest barriers to state reform initiatives is the Employee Retirement Income Security Act (ERISA). ERISA preempts all self-insured health plans from state regulations and subjects those plans only to federal authority. As a result of judicial interpretations of ERISA, states are prohibited from:

- establishing minimum guaranteed benefits packages for all employers;
- developing standard data collection systems applicable to all state health plans;
- developing uniform administrative processes, including standardized claim forms;
- establishing all payer rate-setting systems;
- establishing a statewide employer mandate;
- imposing premium taxes on self-insured plans; and
- imposing provider taxes where the tax is interpreted as a form of discrimination on self-insured plans.

7.2.2.1 **ERISA Flexibility.** Governors call on the administration and Congress to modify the ERISA statute to give states the flexibility they need to move ahead on health reform. This may be done either by establishing the flexibility directly in statute or through the establishment of waiver authority. The flexibility could include a requirement that the state demonstrate broad-based support for the change, such as by passage of state legislation. States must be assured, however, that the flexibility is stable and not time limited.

7.3 **A Call to Action**

The nation's Governors call upon President Clinton and Congress to pass health care legislation this year that includes, at a minimum, the following.

7.3.1 **Insurance Reform.** The Governors support minimum federal standards that result in portability of coverage; guaranteed renewability of policies; limitations on both medical underwriting and preexisting conditions exclusions; and modified community rating that limits the variation in rates that different individuals and groups are charged.

7.3.2 **State-Organized Purchasing Cooperatives.** Through purchasing cooperatives, affordable insurance products will be made available. States and the federal government must work together to ensure that states have flexibility in establishing and operating these cooperatives.

7.3.3 **Core Benefits and Access.** In order to ensure portability of coverage, Governors believe that there must be a core benefits package that is comparable to those that are now provided by the most efficient and cost-effective health maintenance organizations. The cornerstone of this package must be primary and preventive care. All employers must make the core benefits package available to those employees who wish to purchase it. Although Governors do not agree on whether employers should be required to pay for any portion of the premium, Governors agree that coverage should be available.

7.3.4 **Tax Deductibility of Health Care Premiums.** Health insurance premiums should be tax deductible to the value of the core benefits package regardless of who pays the premium. Governors do not support limiting health benefits; however, policies that afford benefits above the limit should be subject to taxation. The Governors do support tax changes that would correct the inequities now suffered by self-employed individuals. These individuals would be eligible to purchase fully deductible health insurance within the federal limit.

7.3.5 **Low-Income Subsidies.** Low-income families and individuals will require subsidies in order to afford health care. Governors support a streamlined eligibility process for these subsidies and believe that the subsidies must be sufficient to make this goal a reality. Governors also look forward to a system of subsidies that provides low-income families and individuals with a core benefits package that Governors believe will be a more effective method for providing care than the current Medicaid program. This program could be financed partially through revenues resulting from limits on tax deductibility.

7.3.6 **Changes to the Current Medicaid System.** Governors strongly believe that some critical changes to the Medicaid program must be made now to improve the cost efficiency of the program. Specifically:

- States should have the ability to move their Medicaid populations into managed care settings through a plan amendment rather than through a waiver.
- During the phase-in of the new low-income subsidy program, states must have the flexibility to establish new programs that expand eligibility to a larger indigent population. This flexibility would require additional waiver authority under Medicaid.
- In addition, states have been unable to control the costs of reimbursement rates to institutional health care providers as a result of judicial interpretation of the Boren Amendment. States must be given legislative and regulatory relief from these interpretations in order to get better control of these costs.

7.3.7 **Medical Malpractice and Liability Reform.** Another important step in developing a rational health care system is the modification of current medical malpractice and liability statutes. The Governors believe that minimum standards should be set by the federal government. Alternative dispute resolution is among the strategies that should be explored to reduce the amount of litigation in this area.

7.3.8 **Relief from Antitrust Statutes.** More and more Americans are receiving their care through health delivery networks. Establishing these networks requires new approaches to cooperation among providers and businesses that heretofore have been competitors. The current antitrust statutes must be revised to accommodate this new health care environment.

7.3.9 **Relief from the Employee Retirement Income Security Act.** ERISA must be modified to give states the flexibility they need to move ahead on state reform. At a minimum, Congress should enact ERISA waiver authority for states that meet certain criteria for health care reform.

7.3.10 **Federally Organized Outcome and Quality Standards.** If meaningful choices are ever to be made in health care, research must be supported to develop outcomes and quality standards for use by providers and consumers alike. Also, information systems must be developed that include price and quality information for all providers and consumers of health care services in a given geographic area.

7.3.11 **Administrative Simplifications.** The administrative complexity of the current system must be reduced. At a minimum, we must adopt a single national claims form and electronic billing.

7.3.12 **Conclusion.** We believe that these provisions should be included in any reform strategy. As Governors, we do not vary in our support of these changes, and we urge Congress and the President to act as quickly as possible.

Time limited (effective February 1994-February 1996).
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