MEMORANDUM

To: Carol Rasco

From: Chris Jennings

Date: January 27, 1995

re: Latest Version of Medicaid Background Memo

cc: Jennifer Klein
Jeremy Ben-Ami
Dianna F.

Attached is an updated version of the draft 7-page Medicaid background memo on implications of capping the program. I know you probably will not need it for the NGA meeting and that you have too much paper already. **However, in case it comes up and you wanted to get a sense of what the Department and OMB is now willing to consider in the face of the Medicaid cap, I thought you would like to in particular have page 7 available to you.** Preceeding the memo is the one pager on the advantages and disadvantages of the cap.

We have made a number of clarifying edits to the background memo, so I would suggest that you discard yesterday's version. If you have any questions, please do not hesitate to call me. (703) 527-6494 or 456-5560 or through signal. Good luck this weekend!
Thanks.

ADVANTAGES AND DISADVANTAGES OF MEDICAID CAP

Advantages

- Allows Federal Government to achieve savings by lowering or capping growth rate.
- Increases flexibility for States to design and administer Medicaid programs to reflect their priorities.
- Avoids requiring Congress or the Administration to specify cuts.
- Provides greater predictability in future Federal Medicaid funding.

Disadvantages

- Impact on States
    - Leaves States at risk during recessions.
    - Places States at risk for cost of aging population.
    - Makes States less able to expand coverage.
    - Forces Governors -- not the Congress -- to specify cuts.
- Impact on health reform
    - Increases number of uninsured.
    - Exacerbates cost shifting.

MEDICAID CAP/BLOCK GRANT BACKROUND INFORMATION

PURPOSE:

To review the implications for states and for coverage under the Medicaid program of NGA and likely Republican proposals to cap Medicaid spending.

BACKGROUND:

Although not on the formal agenda, it is possible that the topic of capping the Medicaid program may be raised at the upcoming meeting with the Governors. (In all likelihood, if it is raised, it would come up in the context of the balanced budget amendment discussion.)

NGA's proposed policy would give states the choice between continuing Medicaid as an individual entitlement or accepting a capped federal payment. The NGA staff recognize this "choice" is a political and not a practical policy response to a desire by many Republican Governors to assure that a Medicaid cap/block grant proposal is on the table for consideration. Democratic Governors, like Governor Chiles, have made the point that such a choice would not work in the Congress or in the budget world since states could choose what is best for them financially; as a result, the primary incentive for enacting a cap -- saving Federal dollars -- would likely not be achieved in any significant way.

A number of Governors have been discussing a Medicaid block grant with the Republicans in Congress. Both Governor Dean and Governor Thompson have indicated that they might be able to "live with" a Medicaid block grant that caps the growth in federal contribution at a 5% growth rate (the projected baseline growth rate is 9.3%). Under a 5% growth rate scenario, the reduction in federal spending would be very large -- about $375 billion over ten years (over $500 billion under the CBO baseline). In recent days, however, Governor Dean and his office have made clear he has made no deal and does have concerns.

It is worth pointing out that a 5% cap means that the states (in aggregate) must reduce total program costs by the $375 billion before they can begin reducing their own spending levels. While there are some low growth with fairly large base levels who could save money in the short-term, it is unlikely they could do so over the long term without cut-backs in services or programs.

Obviously, the Governors are interested in block grants because they free states from federal requirements and oversight. Many Governors appear to be willing to consider reductions in federal payments in exchange for greater flexibility that results from eliminating the individual entitlement. However, if the Administration can come up with proposals that are responsive to the flexibility requests of the States that do not include Federal caps, such an approach could well be more attractive. (Such approaches are discussed at end of the memo).

Proposals to convert Medicaid to a block grant raise a number of serious concerns. Some relate to converting Medicaid from an individual entitlement to a block grant. Others relate to the effect that significant reductions in federal payments would have on coverage. The following outlines these concerns.

Converting from Individual Entitlement to a Block Grant Raises State Concerns:

- **States At Risk from Inflation and Recession.** As an individual entitlement program, Medicaid automatically adjusts federal payments to meet changes in medical costs or the level of need. For example, when a recession occurs, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. Under an individual entitlement, the federal government shares the additional costs. Under a block grant, states must address the increased need on their own, either by increasing state spending or reducing services and coverage.

- **Block Grants Do Not Recognize Differences Among State Programs.** A block grant that fixes the growth in federal payments at a set percentage would benefit some states and penalize others. State growth rates can vary for many reasons, including changes in population, regional medical costs, enrollment patterns or service mix. States also have very different opportunities to achieve savings through managed care (e.g., some states already have achieved savings; rural states have less capacity to implement capitated payment arrangements). An individual entitlement adjusts federal payments to these changing circumstances; a block grant does not. The variation in state growth rates for the 1990 to 1993 period is shown in Attachment 1.

- **States At Risk for Cost of Aging Population.** As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. Under a block grant approach with a fixed federal payment, states would bear the burden for providing these services as the population ages.

- **Tough Choices Are Devolved To States.** Under a block grant approach, the federal government can achieve substantial federal budget savings without taking responsibility for identifying specific cuts in payments, services or eligibility. The tough choices about where to cut are left to the states. This problem is likely to get worse over time, since reducing the rate of growth of a block grant payment is much easier than making specific program cuts.

Effects of Capping Federal Payments

Given the magnitude of cuts necessary to fulfill Republican promises, a block grant would inevitably result in a significant reduction in federal Medicaid payments to states. For example, the 5% growth proposal that Speaker Gingrich has discussed with the Governors would reduce federal payments to states by $130 billion between 1996 and 2002, and by about $375 billion between 1996 and 2006. (Under the slightly higher CBO baseline, the reduction is over $500 billion over the ten-year period). In 1997, projected federal payments would be reduced by about 7% to 10%; in 2006, the reduction rises to 35% (40% under CBO baseline). This is due to the cumulative effect of annual reductions in federal payments. This is shown graphically in Attachment 2.

You may hear from some Republican Governors (and particularly Republicans from the Hill) that large reductions in the growth of federal payments are acceptable because managed care can produce enormous savings. Although managed care can improve efficiency and thereby produce meaningful savings , the savings are not nearly enough to compensate for the very large reductions being discussed with the block grant proposals.

Given the rapid expansion of managed care that already is occurring in states, a significant portion of the potential savings are already being realized. Also, managed care is applied almost exclusively to the nonelderly, nondisabled population, who account for only about one third of Medicaid expenditures. Preliminary OMB estimates show that if all nondisabled, nonelderly recipients were enrolled in managed care by the year 1999, any additional savings through 2005 would be less than $5 billion. However, some states may use managed care as a mechanism simply to make large cuts in provider payments. In reality, this is a cost shifting strategy rather than cost containment.

Under the current baseline, Medicaid enrollment is projected to grow at about 4% annually. Medicaid per capita spending actually is projected to grow at approximately the same rate as per capita private health spending. Therefore, capping federal Medicaid payments substantially below baseline would appear to assume either that states can contain costs much better than the private sector or that substantial reductions in the scope of the program (including cuts in eligibility) are acceptable. While some states may be able to adapt to such a large reduction in federal support for a few years, most probably cannot. Over a longer period, few states could respond to this level of reduction without significant program cuts.

Illustration of State Responses to Capping Federal Payments

The following discussion illustrates the impact on states of a block grant that caps the federal payments at a 5% rate of growth. For ease of presentation, the information is presented under the assumption that states would respond to reduced federal payments entirely through one of the following: (1) higher state spending, (2) lower provider payments, (3) benefit cut backs, or (4) eligibility cutbacks. Although a few states might increase spending in response to federal payment reductions, most would likely reduce eligibility, benefits or payment levels.

The following scenarios assume that states maintain (or in the first case, increase) the level of spending projected in the baseline. The state responses shown below merely offset the reductions in federal spending -- they do not produce any savings to states. If states were to reduce their spending below the projected levels in order to achieve savings in their own budgets, additional reductions would be needed.

- **Increase State Medicaid Spending**
  If states chose to increase their own spending in response to the reduction in federal payments, between 1996 and 2002, state spending would need to increase by over 20% over baseline projections. However, because the size of the federal payment reduction would grow each year, the percentage increase in state spending would also need to grow:

  - In 2002, the increase in state spending would be 32% over baseline projections;
  - In 2005, the increase in state spending would be 43% over baseline projections.

- **Reduction in Provider Payments**

  If states chose to reduce provider payments in response to the reduction in federal payments, between 1996 and 2002, payments to hospitals, physicians and nursing homes would be reduced on average by 13.7%. And because the size of the federal payment reduction would grow each year, the percentage reduction in provider payments (relative to baseline projections) would also need to grow. For example:

  - In 1997, a 6% reduction in hospital payments would be needed;
  - In 2002, a 22.9% reduction in hospital payments would be needed;;
  - In 2005, a 32.8% reduction in hospital payments would be needed.

  These reductions are on top of Medicaid's already low payment rates. This level of provider cuts will disproportionately harm public hospitals and clinics, for whom Medicaid is a significant payment source.

- **Reductions in Benefits**

  States also could choose to reduce benefit levels in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular categories of benefits is shown in Attachment 3. For example, eliminating all dental benefits could achieve about 28% of the necessary savings from baseline in 1997. Eliminating personal care services would achieve about 55% of the necessary savings.

These reductions, however, would not be sufficient over time, because the size of the federal reduction would increase each year. For example, in 2002, eliminating dental benefits would produce only 8% of the necessary savings, and in 2005, only 6%. In 2005, eliminating all benefits for dental, prescription drugs, EPSDT, home health care, hospice, personal care services and payments for Medicare premiums and cost-sharing still would not be sufficient to compensate for the lost federal funding.

- **Reductions in Program Eligibility**

  States also could choose to reduce coverage eligibility in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular eligibility categories is shown in Attachment 3. For example, eliminating eligibility for non-cash children (the OBRA expansions) would achieve about 62% of the necessary savings in 1997, but only about 14% in 2005. Again, because of size of the federal reduction would grow each year, the reductions in eligibility also need to grow.

In reality, states would respond through a combination of these approaches. However, given the magnitude of the reduction in federal payments, even when states spread the cuts over several of these categories, the reductions in each category would still be quite large. For example, a 5% cap would reduce federal payments to states in 2005 by about $66.3 billion below baseline projections. If a state chose not to increase spending and were to allocate their portion of this reduction roughly equally to reductions in provider payments, benefits and eligibility, it could achieve approximately the necessary savings through:

- Reducing provider payments by 12 to 13%.
- Eliminating coverage for prescription drugs and EPSDT, and
- Eliminating coverage for noncash children and qualified and special Medicare beneficiaries (QMBs).

And, because federal payments would continue to decline, further reductions would be needed in each future year. Other options are, of course, possible. Chart 3 gives you a partial menu of how much the elimination of particular populations and services (on a nantional level) would save. Some would argue that states would be more likely to choose eliminate AFDC adults rather than noncash kids and QMBs.

Even under less extreme proposals, federal payment reductions can be significant over time. For example, a 2 percentage point reduction in baseline rate of growth would result in a large reduction in federal payments -- $ 66 billion-- between 1996 and 2002. In 2006, projected federal payments to states would be reduced by nearly 20%.

CONCLUSION

Medicaid block grant proposals under discussion would dramatically reduce federal Medicaid payments to states over time. Increased use of managed care cannot generate the savings necessary to make up for these reductions and there is little room in state budgets to increase state Medicaid spending to compensate for the reduced federal commitment.

Unless states choose to offset federal reductions with increases in state spending, they would be forced to respond by reducing provider payments, services, and/or coverage. Given the inflexibility of a block grant to respond to the needs of individual states and differences in state political environments, the level and nature of the reductions in the scope of the program would vary significantly from state to state.

Reducing the scope of the Medicaid program to such a large extent would not only put those served by Medicaid at some risk, but also set back movement towards more comprehensive health reform in a number of ways, including:

- **Increasing the number of uninsured.** Recipient growth currently accounts for two-fifths of overall Medicaid program growth. In fact, spending per person under Medicaid is increasing at about the same rate as in the private sector.

  During the early 1990s, Medicaid increased coverage as employers decreased coverage. This trend would be reversed under a block grant, increasing the number of people who are uninsured. The changes in employer-based coverage and Medicaid are shown in Attachment 4.

- **Exacerbating cost shifting**. One of the central problems in our health system is the shifting of uncompensated care costs and Medicaid underpayments to business and families who purchase insurance. Reductions in Medicaid provider payments or increases in the number of people uninsured would exacerbate this problem.

Alternative To Capping Federal Payments that States May Find Attractive.

The obvious question is how to be responsive to States' legitimate need and desire for more flexibility without imposing significant reductions in Federal support. We have reviewed the NGA's health policy position paper's recommendations and have conducted our own internal analyis, which included discussions with OMB and HHS, and have come up with some interesting possibilities -- there may be even more -- that Iwe believe would be welcomed by the Governors. (Since Medicaid is not scheduled to come up before the NGA meetings, we probably should discuss when would be the most strategic and opportune time to begin discussions with the Governors on this issue.)

Specific and preliminary options to Medicaid cap now include:

- **Agree to NGA's request to eliminate the 1915(b) waiver approval process for states implementing managed care programs.** Instead, the states would simply file a standard state plan amendment and would be approved as long as basic accountability measures, such as budget neutrality, are achieved.

- **Consistent with NGA request, agree to eliminate the waiver approval process for states implementing home and community-based care programs.** Instead, the states would simply file a standard state plan amendment and would be approved as long as basic accountability measures, such as budget neutrality, are achieved.

- **Enable states to target programs and services to specific populations and communities.** Requirements that programs and services be uniform statewide would be removed for Medicaid managed care, home and community based programs, and optional services.

- **Agree to NGA's request to establish safe harbors under the Boren amendment for state hospital payments.**

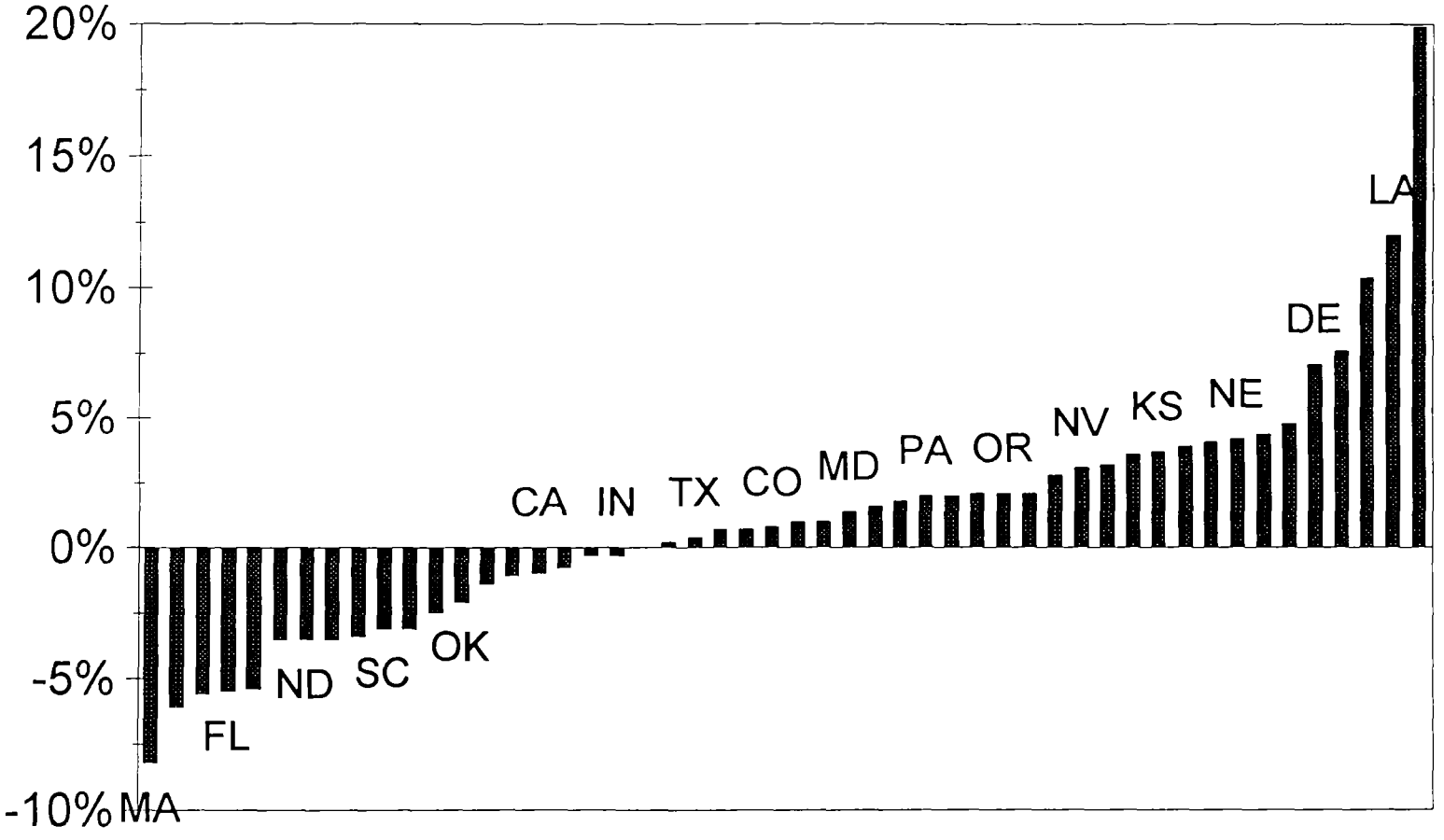
- **Agree with NGA that Boren amendment requirements do not apply to managed care arrangements.**

- **Agree to NGA's request for substantial modifications to the PASARR provisions under nursing home reform.** For example, agree that the annual resident review should be repealed.

- **Agree to NGA's request for the development of more demonstration programs that investigate the integration acute and long-term care services.**

Variation in State Medicaid Growth

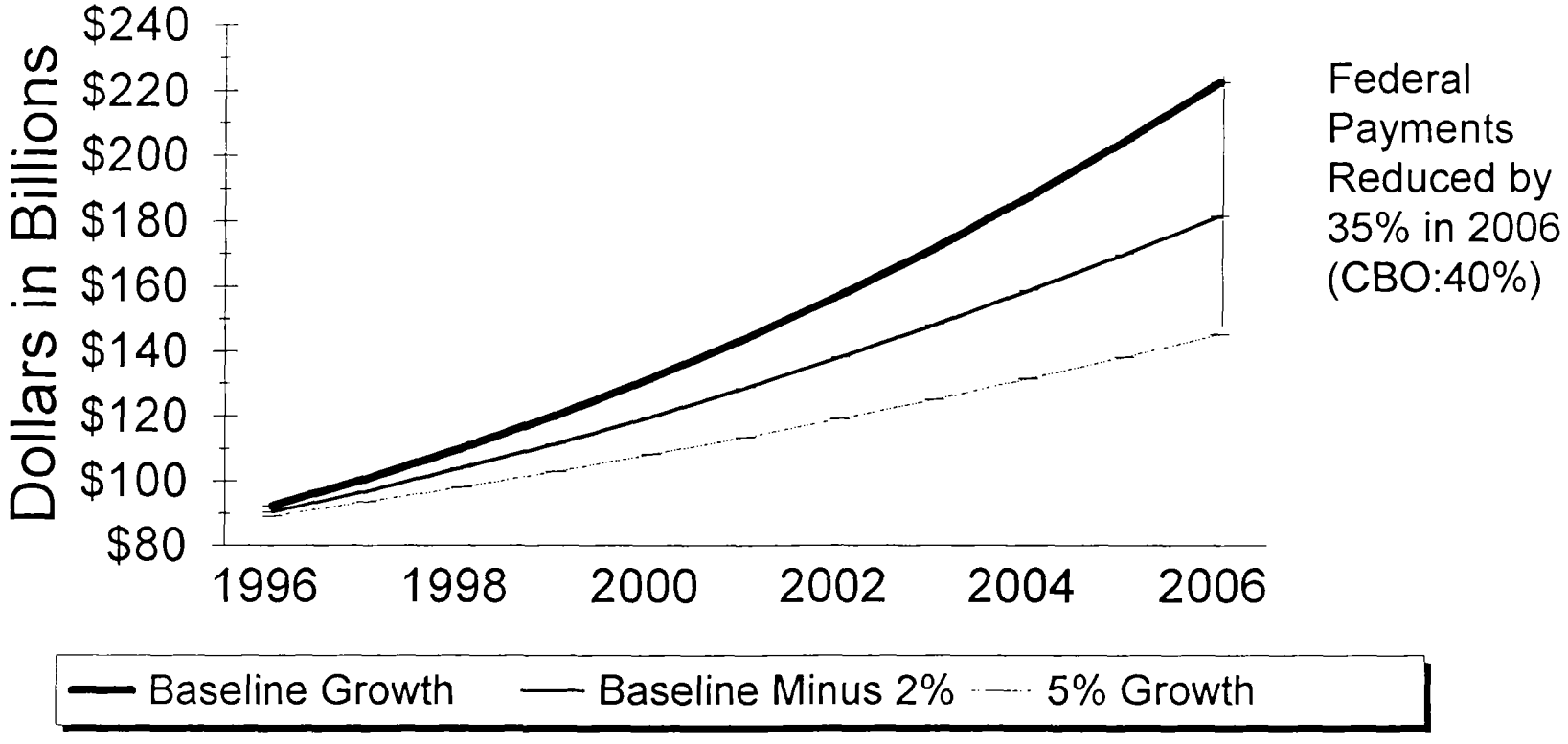
Difference from Average, 1990-1993



* Note: Average annual per capita growth rates, excluding Disproportionate Share Expenditures
Data from The Urban Institute and HCFA

Federal Medicaid Payments 1996-2006

Baseline & Capped Federal Payments



This wedge Illustrates the cumulative effect of capped expenditures. Over time, the size of the federal payment reduction grows.

Potential Savings From Eliminating Selected Services or Recipient Categories

	1997 $ in billions	2005 $ in billions
Reduction in Federal Payments with Growth at 5%	-7.0	-66.3
Cost of Services		
Dental	1.9	3.9
Drugs	9.3	17.6
EPSDT	1.1	4.0
Home Health & Hospice	2.5	5.8
Medicare Premiums & Cost Sharing	4.7	10.8
Personal Care Services	3.8	7.1
Cost of Services for Recipients		
AFDC Adults	12.0	24.4
NonCash Kids (OBRA Expansion)	4.3	9.5
QMBs/SLMBs (1)	4.7	10.8
Medically Needy	22.1	38.8

- The 1997 reductions will not be sufficient over time, because the size of the federal reduction would increase each year. For example, while eliminating dental benefits could achieve 28% of the required savings in 1997, in 2005 this service reduction would produce only 6% of the necessary savings.

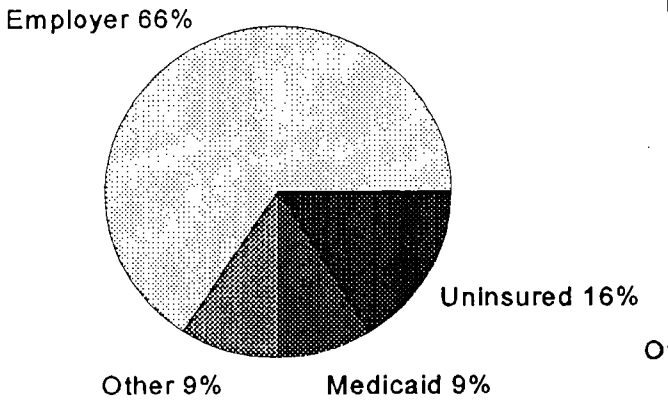
(1) Since there are no data that separately estimate costs associated with QMBs/SLMBs, this estimate is the full cost of Medicare premiums and cost sharing.

NOTE: All of these effects vary significantly across states, and overstate savings, because of interactions in the expenditure categories.

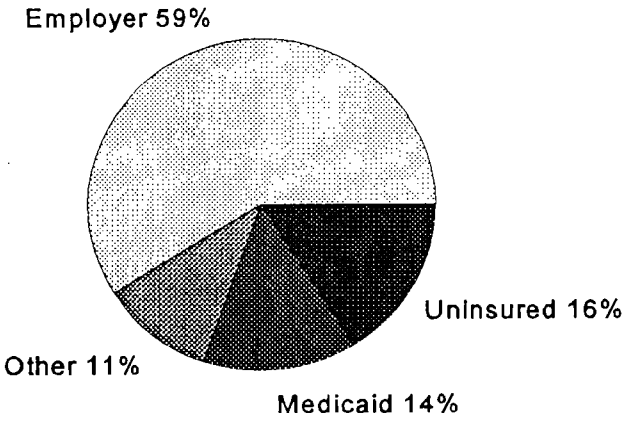
Changes in Insurance Coverage

1989 to 1994

1989



1994



SOURCE: The Urban Institute analysis of the TRIM2-edited March 1993 Current Population Survey.

The 1989 data represent an average of three years, 1988-1990, with 1989 data having a weight of .50 and 1988 and 1990 data having weights of .25. The 1994 estimates are based on 1993 CPS data on insurance coverage as adjusted by The Urban Institiute's TRIM2 microsimulation model and 1993 HCFA data on Medicaid enrollment. Estimates for 1994 were derived using CBO projections of changes in insurance coverage.

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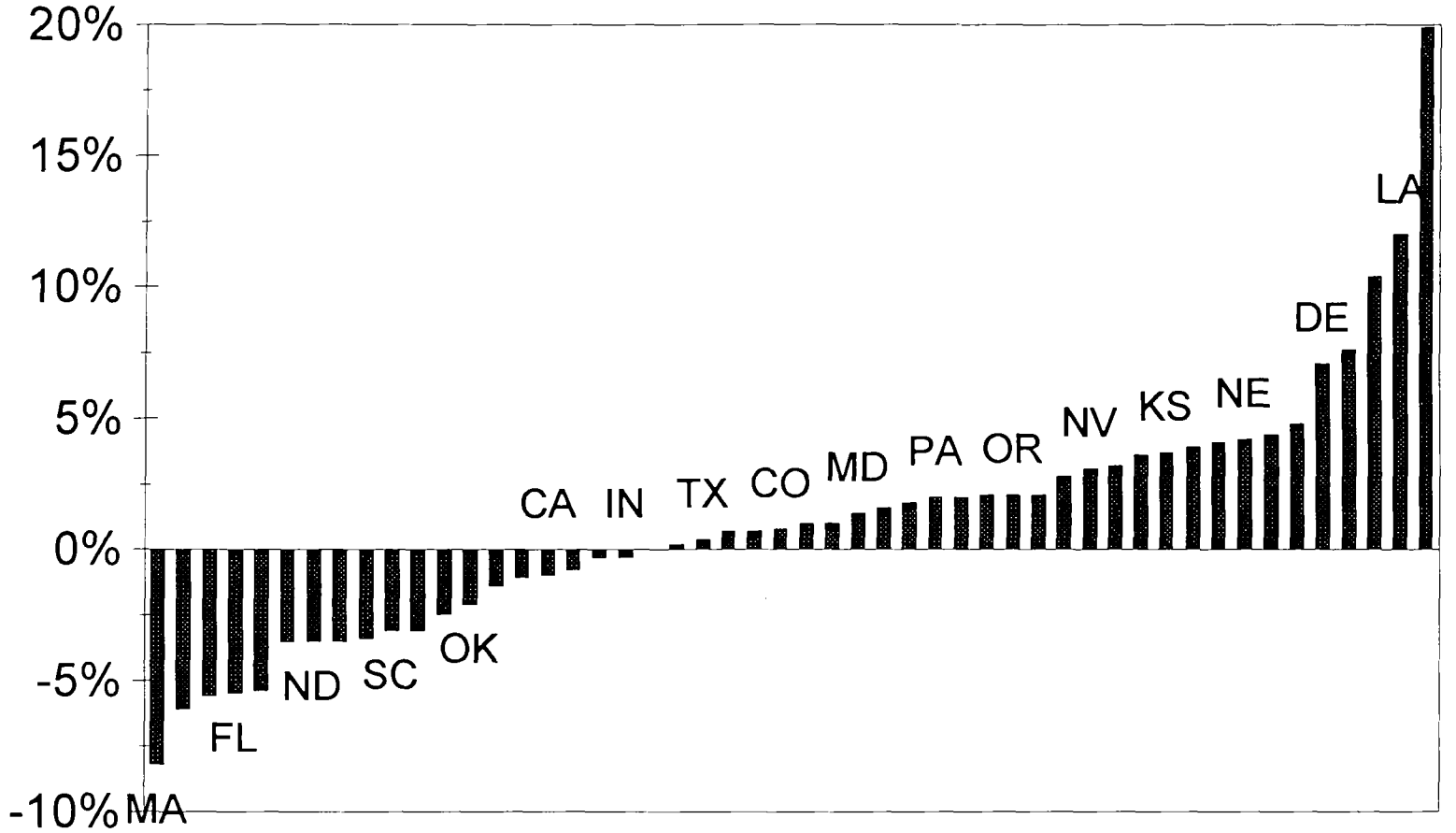

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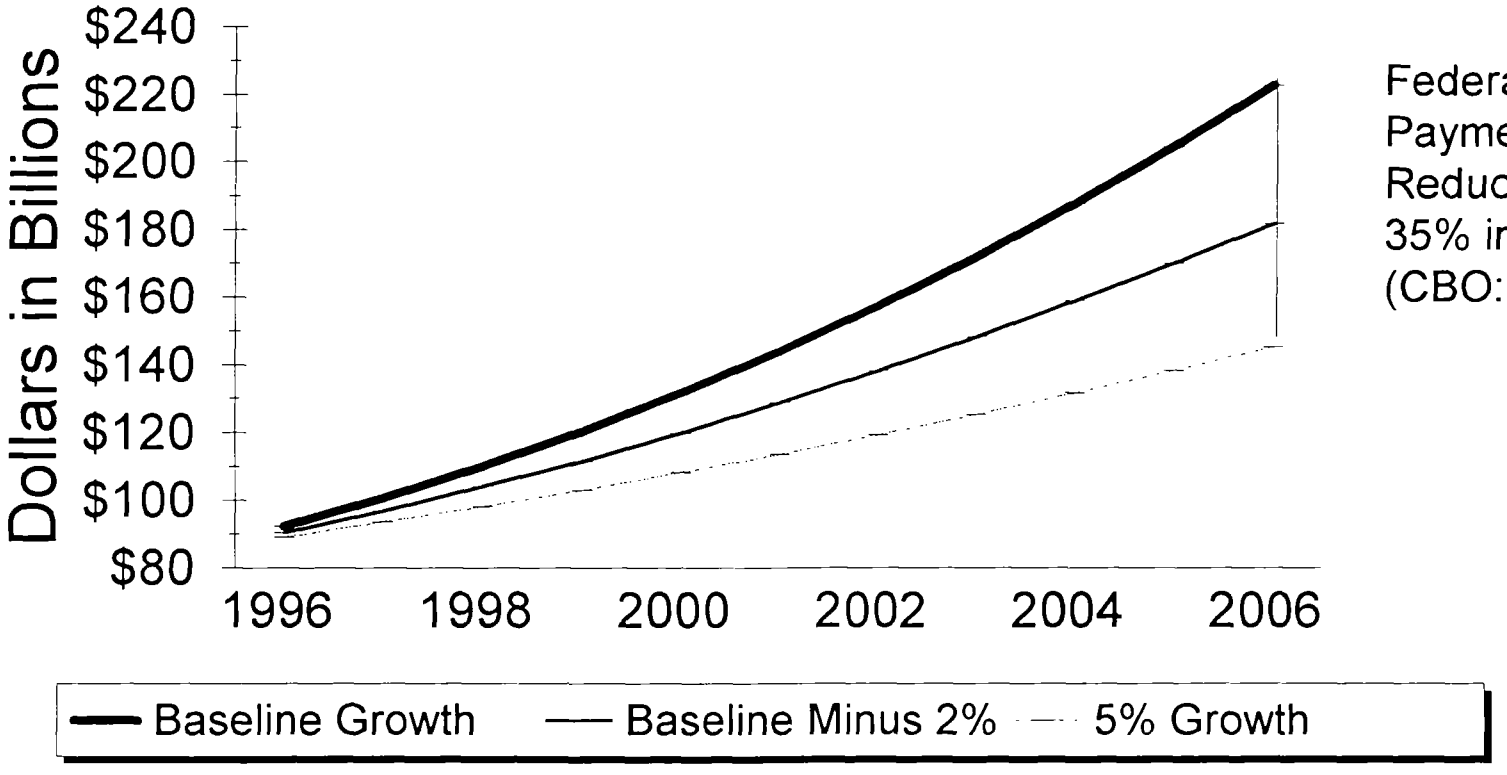

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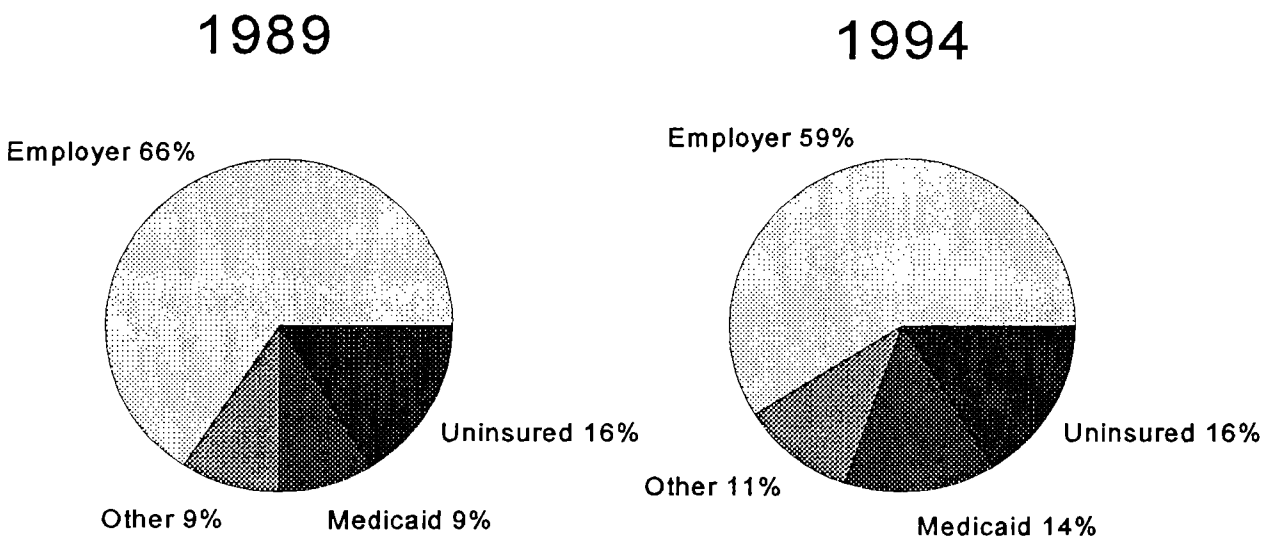

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MEDICAID: BUDGET AND POLITICAL ENVIRONMENT

- **Congressional Republicans need hundreds of billions of dollars** to finance tax cut and deficit reduction pledges.

- **Medicaid is seen as major cash cow** because it is vulnerable as it serves the poor and because many Governors may be willing to negotiate over a cap. (In addition, Republicans growing increasingly nervous about excessively large Medicare cuts.)

- **Speaker Gingrich discussing a 5% cap on Medicaid program growth,** which would yield $130 billion ($193 billion using CBO numbers) in Federal savings through 2002 and $375 billion ($500 billion using CBO) in Federal savings through 2005.

- **Republican Governors either supportive or staying quiet for now** because they philosophically support. Moderate Republicans from states with high growth rates are evaluating just how they could live with these reductions in Federal dollars.

- **Governor Dean sending signals he might be open to a cap, although most Democratic Governors appear to be extremely nervous about it.** Governor Chiles, for example, is very opposed to eliminating individual entitlement. Having said this, some low growth rate states think it might not be a bad deal for them and others are nervous about defending a program for the poor. The fear that unifies almost all of the Democrats, however, is the size of potential reductions in Federal support.

- **Not on NGA agenda for this weekend, although DGA meeting may discuss** to plan out a more unified Democratic Governors' strategy. Medicaid capping may also come up in context of balanced budget disucssions that may be raised at NGA meeting.

- **Any block grant deal on welfare reform will serve as precedence** and political cover for Republicans who need the Medicaid money.

- **Weak but vocal advocates are opposed and scared:** many of these are considered our traditional Democratic base.

PURPOSE:

To discuss the implications for states and for coverage under the Medicaid program of NGA and Republican proposals to cap Medicaid spending through a block grant.

DISCUSSION:

The topic of capping the Medicaid program is likely to be raised at the upcoming meeting with the Governors. NGA's proposed policy would give states the choice between continuing Medicaid as an individual entitlement or accepting a capped federal payment. In addition, the Governors have been discussing a Medicaid block grant with the Republicans in Congress, and both Governor Dean and Governor Thompson have indicated that they might be able to "live with" a Medicaid block grant that caps the growth in federal contribution at a 5% growth rate (the projected baseline growth rate is 9.3%). Under a 5% growth rate scenario, the reduction in federal spending would be very large -- about $375 billion over ten years (over $500 billion under the CBO baseline).

The Governors are interested in block grants because they free states from federal requirements and oversight. The Governors appear to be willing to consider very large reductions in federal payments in exchange for greater flexibility that results from eliminating the individual entitlement. However, their desire of states for additional flexibility can be accommodated without changing the entitlement nature of the program. For example, states could be permitted to implement managed care and home and community-based care programs without applying for a waiver. Boren amendment restrictions on hospital payments also could be eliminated. The key difference is that providing increased flexibility under the current structure, in contrast to a block grant, assures that coverage will not be reduced.

An interesting point is that under a block grant approach, states do not necessarily realize any savings in their own budget. In fact, if federal payments are capped at 5% growth, states must reduce total program costs by the $375 billion reduction in federal payments before they can begin reducing their own spending levels.

Proposals to convert Medicaid to a block grant raise a number of serious concerns. Some relate to converting Medicaid from an individual entitlement to a block grant. Others relate to the effect that significant reductions in federal payments would have on coverage. These concerns will be discussed below.

Converting Medicaid From an Individual Entitlement to a Block Grant

Although some Governors appear to favor block grants in order to get greater flexibility, converting Medicaid from an individual entitlement to a block grant would be a radical change to the structure of the program that would shift a substantial economic risk to the states.

- **States At Risk from Inflation and Recession.** As an individual entitlement program, Medicaid automatically adjusts federal payments to meet changes in medical costs or the level of need. For example, when a recession occurs, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. Under an individual entitlement, the federal government shares the additional costs. Under a block grant, states must address the increased need on their own, either by increasing state spending or reducing services and coverage.

- **Block Grants Do Not Recognize Differences Among State Programs.** A block grant that fixes the growth in federal payments at a set percentage would benefit some states and penalize others. State growth rates can vary for many reasons, including changes in population, regional medical costs, enrollment patterns or service mix. States also have very different opportunities to achieve savings through managed care (e.g., some states already have achieved savings; rural states have less capacity to implement capitated payment arrangements). An individual entitlement adjusts federal payments to these changing circumstances; a block grant does not. The variation in state growth rates for the 1990 to 1993 period is shown in Attachment 1.

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already being realized. Preliminary estimates show that if all nondisabled, nonelderaly recipients were enrolled in managed care by the year 1999, any additional savings through 2005 would be less than $5 billion. Some additional savings might be achieved in states that can use managed care as a vehicle to further reduce provider payment levels below costs (as opposed to achieving true program efficiencies).

Under the baseline, Medicaid per capita spending is growing at approximately the same rate as per capita private health spending. Therefore, capping federal Medicaid payments substantially below baseline assumes either that states can contain costs much better than the private sector or that substantial reductions in the scope of the program are acceptable.

Illustration of State Responses to Capping Federal Payments

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These reductions, however, would not be sufficient over time, because the size of the federal reduction would increase each year. For example, in 2002, eliminating dental benefits would produce only 8% of the necessary savings, and in 2005, only 6%. In 2005, eliminating all benefits for dental, prescription drugs, EPSDT, home health care, hospice, personal care services and payments for Medicare premiums and cost-sharing still would not be sufficient to compensate for the lost federal funding.

- **Reductions in Program Eligibility**

States also could choose to reduce coverage eligibility in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular eligibility categories is shown in Attachment 3. For example, eliminating eligibility for non-cash children (the OBRA expansions) would achieve about 62% of the necessary savings in 1997, but only about 14% in 2005. Again, because of size of the federal reduction would grow each year, the reductions in eligibility also need to grow.

In reality, states would respond through a combination of these approaches. For example, under the 5% growth proposal, federal payments to states in 2005 would be $66.3 billion below baseline projections. If a state were to allocate this reduction equally to reductions in provider payments, benefits and eligibility, it could achieve the necessary savings by (as compared to baseline projections):

- Reducing provider payments by about 11%.
- Eliminating coverage for prescription drugs and EPSDT, and
- Eliminating coverage for noncash children and qualified and special Medicare beneficiaries.

And, because federal payments would continue to decline, further reductions would be needed each future year.

Even under less extreme proposals, federal payment reductions can be significant over time. For

example, a 2 percentage point reduction in baseline rate of growth would result in a large reduction in federal payments -- $ 66 billion-- between 1996 and 2002. In 2006, projected federal payments to states would be reduced by nearly 20%.

CONCLUSIONS

Medicaid block grant proposals under discussion would dramatically reduce federal Medicaid payments to states over time. Increased use of managed care cannot generate the savings necessary to make up for these reductions and there is little room in state budgets to increase state Medicaid spending to compensate for the reduced federal commitment.

Unless states choose to offset federal reductions with increases in state spending, they would be forced to respond by reducing provider payments, services, and/or coverage. Given the inflexibility of a block grant to respond to the needs of individual states and differences in state political environments, the level and nature of the reductions in the scope of the program would vary significantly from state to state.

Reducing the scope of the Medicaid program to such a large extent would not only put families at risk, but also set back movement towards more comprehensive health reform in a number of ways, including:

- **Increasing the number of uninsured.** Recipient growth currently accounts for two-fifths of overall Medicaid program growth. In fact, spending per person under Medicaid is increasing at about the same rate as in the private sector.

  During the early 1990s, Medicaid increased coverage as employers decreased coverage. This trend would be reversed under a block grant, increasing the number of people who are uninsured. The changes in employer-based coverage and Medicaid are shown in Attachment 4.

- **Exacerbating cost shifting.** One of the central problems in our health system is the shifting of uncompensated care costs and Medicaid underpayments to business and families who purchase insurance. Reductions in Medicaid provider payments or increases in the number of people uninsured would exacerbate this problem.

The Administration can offer states flexibility without shifting costs to states or reducing coverage. For example, regulations could be relaxed so that states could use managed care to achieve savings without current restrictions. And, the 1115 waiver process could continue to be used to provide states with the flexibility to change categorical eligibility rules. While these changes would retain the individual entitlement under Medicaid, they would provide states with much of the flexibility they are seeking.

MEDICAID: BUDGET AND POLITICAL ENVIRONMENT

- **Republicans need hundreds of billions of dollars** to finance tax cut and deficit reduction pledges.

- **Medicaid is seen as major cash cow** because it is vulnerable as it serves the poor and because many Governors may be willing to negotiate over a cap. (In addition, Republicans growing increasingly nervous about excessively large Medicare cuts.)

- **Speaker Gingrich discussing a 5% cap on Medicaid program growth,** which would yield $130 billion ($193 billion using CBO numbers) in Federal savings through 2002 and $375 billion ($500 billion using CBO) in Federal savings through 2005.

- **Governor Dean sending signals he might be open to a cap,** although most Democratic Governors appear to be extremely nervous about it. Governor Chiles, for example, very opposed to eliminating individual entitlement. Having said this, some low growth rate states think it might not be a bad deal for them and others are nervous about defending a program for the poor. The fear that unifies almost all of them appears to be the size of potential reductions in Federal support.

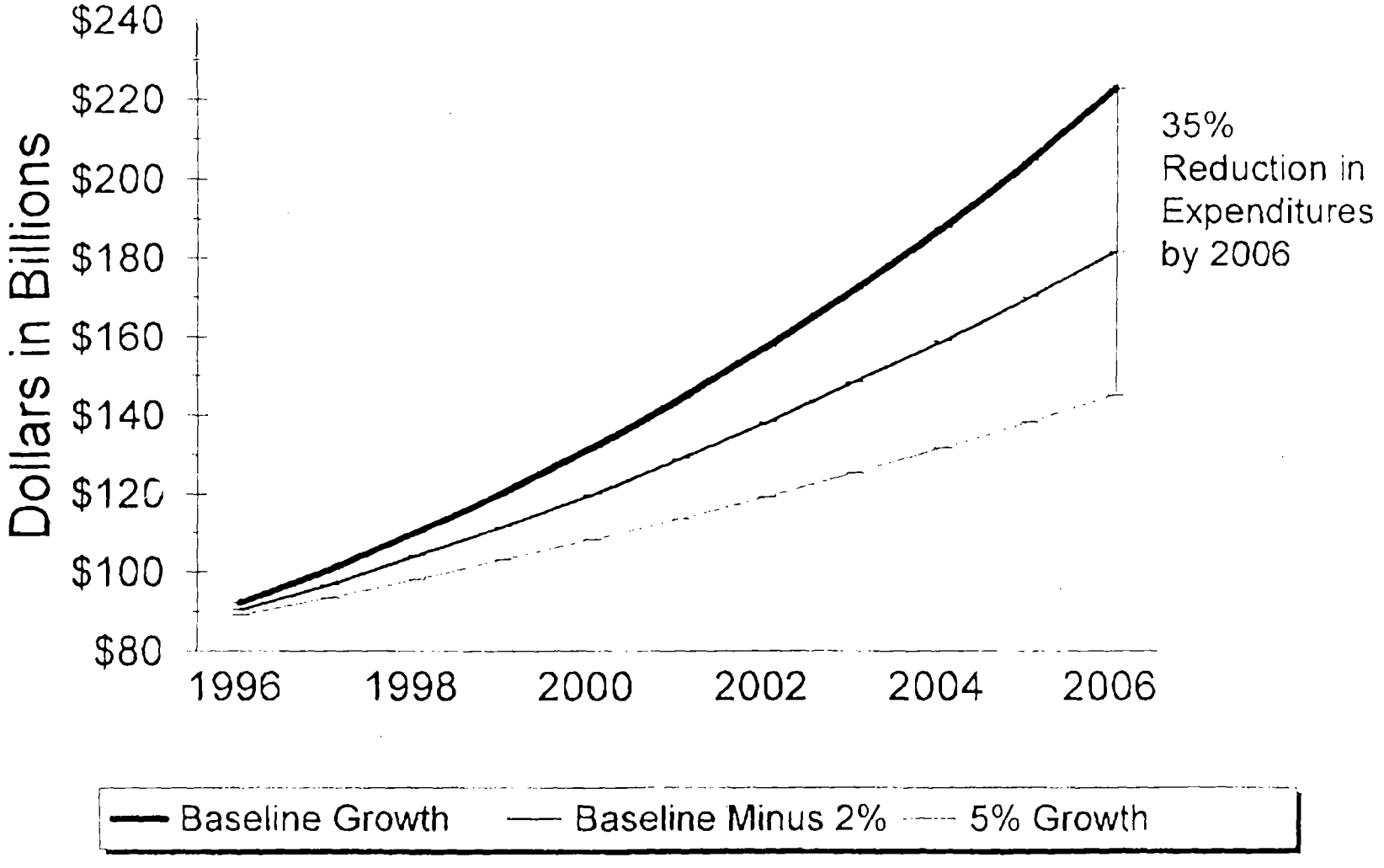
- **Not on NGA agenda for this weekend, although DGA meeting may discuss** to plan out a more unified Democratic Governors' strategy. Medicaid capping may also come up in context of balanced budget disucssions that may be raised at NGA meeting.

- **Any block grant deal on welfare reform will serve as precedence** and political cover for Republicans who need the Medicaid money.

- **Weak but loud advocates are very nervous:** many of these are considered our traditional Democratic base.

Medicaid Expenditure Growth 1996-2002

Capped Expenditures to States



HOW WOULD STATES RESPOND TO MEDICAID CAP?

(Recall states would need to realize savings to replace $130 billion Federal spending by 2002/$375 over 10 years -- using OMB numbers)

- **Increase State Medicaid Spending**

  -- A few states might, but seems much more unlikely in this environment.

- **Reduce Provider Payments**

  -- Medicaid baseline program growth is at 9 percent, but 4 percent of that number is population growth; the additional 5 percent is at or very near private sector growth rate.

  -- New baseline has assumed much of managed care/other delivery savings. There is some savings, OMB says at most 5 percent, but nowhere near what is necessary to cover the 35-40% reduction in Federal payments that would result from 5 percent cap.

  -- Rural states still having hard time getting new managed care delivery systems established.

- **Reduce Benefits**

- **Reduce Program Eligibility**

ROUGH EXAMPLE:

If a state were to reduce provider payments, benefits, and eligibility, it could achieve the necessary savings by (1) reducing provider payments by about 11 percent, (2) eliminating coverage for prescription drug and EPSDT, and (3) eliminating coverage for non-cash children and Medicare QMBs. And, because Federal payments would continue to decline, further reductions would be needed each future year. (No interactive effects assumed.)

Medicaid Services and Recipient Expenditures
(Dollars in billions)

	1997	2005
Reduction in Federal Payments with Growth at 5%	-7.0	-66.3
Cost of Services		
Dental	-1.9	-3.9
Drugs	-9.3	-17.6
EPSDT	-1.1	-4.0
Home Health & Hospice	-2.5	-5.8
Medicare Premiums & Cost Sharing	-4.7	-10.8
Personal Care Services	-3.8	-7.1
Cost of Services for Recipients		
AFDC Adults	-12.0	-24.4
NonCash Kids (OBRA Expansion)	-4.3	-9.5
QMBs/SLMBs (1)	-4.7	-10.8
Medically Needy	-22.1	-38.8

(1) Since there are no data that separately estimate costs associated with QMBs/SLMBs, this estimate is the full cost of Medicare premiums and cost sharing.

NOTE: All of these effects vary significantly across states

ADVANTAGES AND DISADVANTAGES OF MEDICAID CAP

Advantages

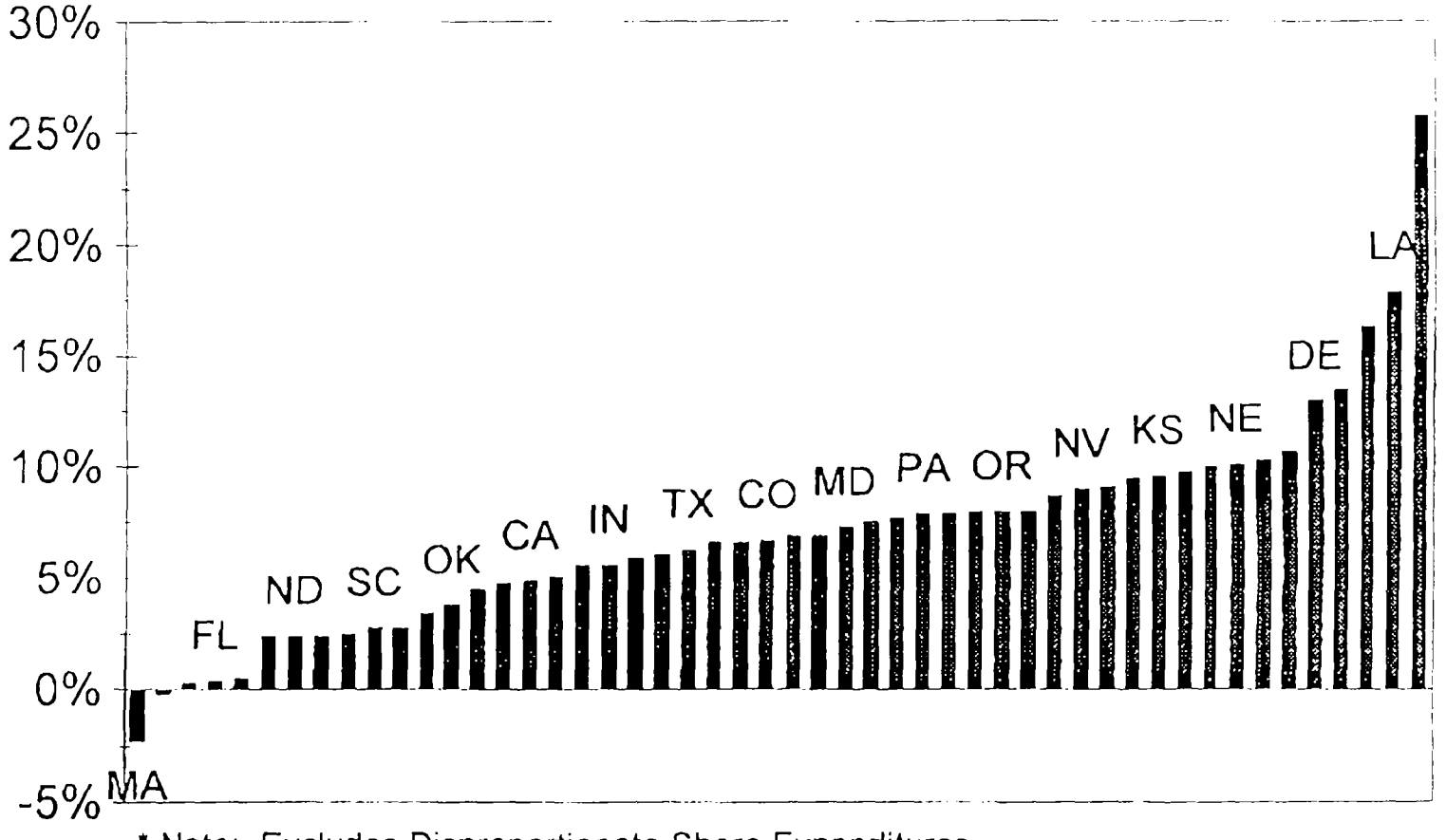
- Allows Federal Government to achieve savings by lowering or capping growth rate.
- Increases flexibility for States to design and administer Medicaid programs to reflect their priorities.
- Avoids requiring Congress or the Administration to specify cuts.
- Provides greater predictability in future Federal Medicaid funding.

Disadvantages

- Impact on States
    - Leaves States at risk during recessions.
    - Places States at risk for cost of aging population.
    - Makes States less able to expand coverage.
    - Forces Governors -- not the Congress -- to specify cuts.
- Impact on health reform
    - Increases number of uninsured.
    - Exacerbates cost shifting.

Medicaid Per Capita Expenditure Growth

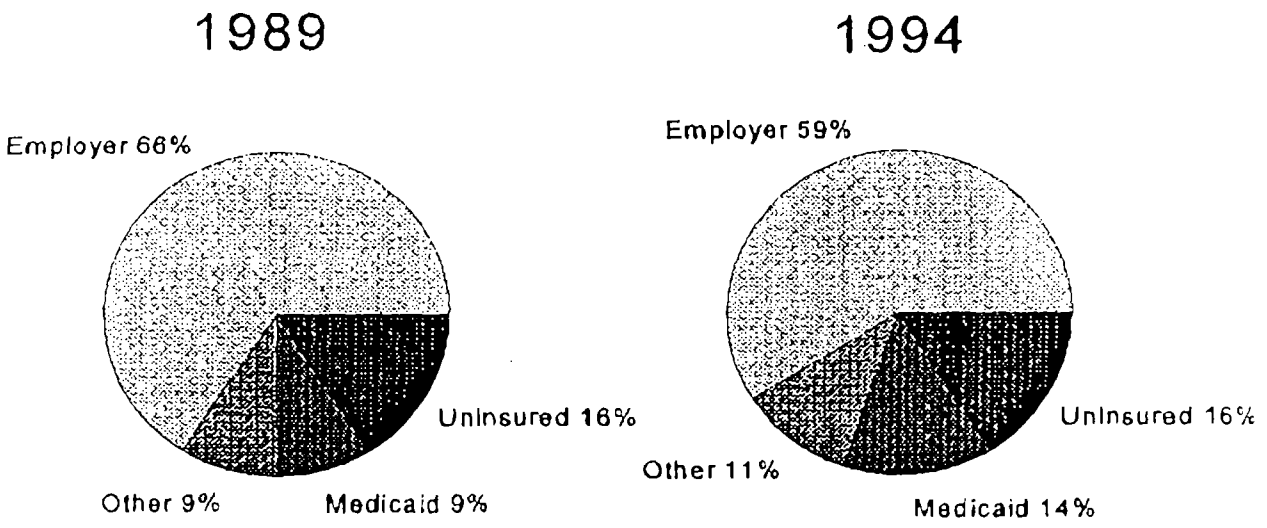
Average Annual Growth Rates, 1990-1993



* Note: Excludes Disproportionate Share Expenditures
Data from The Urban Institute and HCFA

Changes in Insurance Coverage

1989 to 1994



SOURCE: The Urban Institute analysis of the TRIM2-edited March 1993 Current Population Survey.

The 1989 data represent an average of three years, 1988-1990, with 1989 data having a weight of .50 and 1988 and 1990 data having weights of .25. The 1994 estimates are based on 1993 CPS data on insurance coverage as adjusted by The Urban Institute's TRIM2 microsimulation model and 1993 HCFA data on Medicaid enrollment. Estimates for 1994 were derived using CBO projections of changes in insurance coverage

POSSIBLE ALTERNATIVE TO MEDICAID CAP

- **Agree to NGA request to eliminate waiver approval process for states implementing managed care programs.**

- **Enable states to target programs and services to specific populations and communities.** Requirements that programs and services be uniform statewide would be removed for Medicaid managed care, home and community based programs, and optional services.

- **Agree to NGA proposal to establish safe harbors under the Boren amendment for state hospital payments.**

- **Agree with NGA that Boren amendment requirements do not apply to managed care arrangements.**

- **Agree to NGA proposal for substantial modifications to the PASARR provisions under nursing home reform.** For example, we agree that the annual resident review should be repealed.

Advantages

- **Federal Government could achieve savings by lowering or capping growth rate.**
- **States given more flexibility to design and administer Medicaid programs to reflect their priorities.**
- **Avoids having Congress or the Administration being required to specify cuts.**
- **Greater predictability in future Federal Medicaid funding.**

Disadvantages

- **States at risk during recessions.** As an individual entitlement program, Medicaid automatically adjusts federal payments to meet the current level of need. During recessions or natural disasters, the number of families without work and without insurance can increase dramatically. Because of the entitlement nature of Medicaid, the amount of federal support will automatically adjust to help states cope with the increased need for services. A capped entitlement to states would not respond to changes in economic conditions, leaving states to address the increased need on their own. Although states in theory could cut off participation or benefits if funds were not available, as a practical matter states would be unable to make significant reductions at times of recession.

- **States at risk for cost of aging population.** The demographic changes that are occurring in the Medicaid population increase the risk that a capped entitlement to states will result in states getting fewer federal resources over time. As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. If federal payments to states are fixed based on current enrollment and growth, the states will would bear the burden for providing these services as the population ages.

- **States less able to expand coverage.** States that wish to expand coverage are better able to do so under Medicaid an individual entitlement than under a capped entitlement to states. The current system is a partnership, in which the federal government has agreed to match state spending. For example, virtually every state has elected to expand coverage to one or more of the optional coverage categories under Medicaid, in part because the federal government is paying between 50 and 78% of the cost of each new enrollee. Under a capped entitlement to states, expanding coverage would require states to pick up 100% of the costs of the new enrollees, making it far less likely that states would expand enrollment.

- **Governors -- not the Congress -- have to specify cuts.** The Congress can talk about "reducing the rate of growth" to a seemingly generous 5% (or so) amount. The Governors will be the ones who have to deal with the reality that they, on average, are now facing an almost 10% growth rate in their programs and cutting the rate down to 5% translates into an almost $100 billion dollar reduction in Federal Medicaid support. It will be the Governors who have to come up with the politically painful spending cuts.

PURPOSE:

To discuss the implications for states and for coverage under the Medicaid program of NGA and Republican proposals to cap Medicaid spending through a block grant.

DISCUSSION:

The topic of capping the Medicaid program is likely to be raised at the upcoming meeting with the Governors. NGA's proposed policy would give states the choice between continuing Medicaid as an individual entitlement or accepting a capped federal payment. In addition, the Governors have been discussing a Medicaid block grant with the Republicans in Congress, and both Governor Dean and Governor Thompson have indicated that they might be able to "live with" a Medicaid block grant that caps the growth in federal contribution at a 5% growth rate (the projected baseline growth rate is 9.3%). Under a 5% growth rate scenario, the reduction in federal spending would be very large -- about $375 billion over ten years (over $500 billion under the CBO baseline).

The Governors are interested in block grants because they free states from federal requirements and oversight. The Governors appear to be willing to consider very large reductions in federal payments in exchange for greater flexibility that results from eliminating the individual entitlement. However, their desire of states for additional flexibility can be accommodated without changing the entitlement nature of the program. For example, states could be permitted to implement managed care and home and community-based care programs without applying for a waiver. Boren amendment restrictions on hospital payments also could be eliminated. The key difference is that providing increased flexibility under the current structure, in contrast to a block grant, assures that coverage will not be reduced.

An interesting point is that under a block grant approach, states do not necessarily realize any savings in their own budget. In fact, if federal payments are capped at 5% growth, states must reduce total program costs by the $375 billion reduction in federal payments before they can begin reducing their own spending levels.

Proposals to convert Medicaid to a block grant raise a number of serious concerns. Some relate to converting Medicaid from an individual entitlement to a block grant. Others relate to the effect that significant reductions in federal payments would have on coverage. These concerns will be discussed below.

Converting Medicaid From an Individual Entitlement to a Block Grant

Although some Governors appear to favor block grants in order to get greater flexibility, converting Medicaid from an individual entitlement to a block grant would be a radical change to the structure of the program that would shift a substantial economic risk to the states.

- **States At Risk from Inflation and Recession.** As an individual entitlement program, Medicaid automatically adjusts federal payments to meet changes in medical costs or the level of need. For example, when a recession occurs, the number of people without work that qualify for Medicaid can rise dramatically, increasing program costs. Under an individual entitlement, the federal government shares the additional costs. Under a block grant, states must address the increased need on their own, either by increasing state spending or reducing services and coverage.

- **Block Grants Do Not Recognize Differences Among State Programs.** A block grant that fixes the growth in federal payments at a set percentage would benefit some states and penalize others. State growth rates can vary for many reasons, including changes in population, regional medical costs, enrollment patterns or service mix. States also have very different opportunities to achieve savings through managed care (e.g., some states already have achieved savings; rural states have less capacity to implement capitated payment arrangements). An individual entitlement adjusts federal payments to these changing circumstances; a block grant does not. The variation in state growth rates for the 1990 to 1993 period is shown in Attachment 1.

- **States At Risk for Cost of Aging Population.** As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. Under a block grant approach with a fixed federal payment, states would bear the burden for providing these services as the population ages.

- **Tough Choices Are Devolved To States.** Under a block grant approach, the federal government can achieve substantial federal budget savings without taking responsibility for identifying specific cuts in payments, services or eligibility. The tough choices about where to cut are left to the states. This problem is likely to get worse over time, since reducing the rate of growth of a block grant payment is much easier than making specific program cuts.

Effects of Capping Federal Payments

Given the magnitude of cuts necessary to fulfill Republican promises, a block grant would inevitably result in a significant reduction in federal Medicaid payments to states. For example, the 5% growth proposal that Speaker Gingrich has discussed with the Governors would reduce federal payments to states by $130 billion between 1996 and 2002, and by about $375 billion between 1996 and 2006. (Under the slightly higher CBO baseline, the reduction is over $500 billion over the ten-year period). In 1997, projected federal payments would be reduced by about 7% to 10%; in 2006, the reduction rise to 35% to 40%. This is due to the cumulative effect of annual reductions in federal payments. This is shown graphically in Attachment 2.

You may hear from the Governors that managed care can produce enormous savings. Although managed care can improve efficiency and thereby produce meaningful savings , the savings are not nearly enough to compensate for the levels of reductions being discussed with the block grant proposals. Given the rapid expansion that already is occurring in states, significant savings are

already being realized. Preliminary estimates show that if all nondisabled, nonelderaly recipients were enrolled in managed care by the year 1999, any additional savings through 2005 would be less than $5 billion. Some additional savings might be achieved in states that can use managed care as a vehicle to further reduce provider payment levels below costs (as opposed to achieving true program efficiencies).

Under the baseline, Medicaid per capita spending is growing at approximately the same rate as per capita private health spending. Therefore, capping federal Medicaid payments substantially below baseline assumes either that states can contain costs much better than the private sector or that substantial reductions in the scope of the program are acceptable.

Illustration of State Responses to Capping Federal Payments

The following discussion illustrates the impact on states of a block grant that caps the federal payments at a 5% rate of growth. For ease of presentation, the information is presented under the assumption that states would respond to reduced federal payments entirely through one of the following: (1) higher state spending, (2) lower provider payments, (3) benefit cut backs, or (4) eligibility cutbacks.

The following scenarios assume that states maintain (or in the first case, increase) the level of spending projected in the baseline. The state responses shown below merely offset the reductions in federal spending -- they do not produce any savings to states. If states were to reduce their spending below the projected levels in order to achieve savings in their own budgets, additional reductions would be needed.

- **Increase State Medicaid Spending**

  If states chose to increase their own spending in response to the reduction in federal payments, between 1996 and 2002, state spending would need to increase by over 20% over baseline projections. However, because the size of the federal payment reduction would grow each year, the percentage increase in state spending would also need to grow:

  - In 2002, the increase in state spending would be 32% over baseline projections;
  - In 2005, the increase in state spending would be 43% over baseline projections.

- **Reduction in Provider Payments**

  If states chose to reduce provider payments in response to the reduction in federal payments, between 1996 and 2002, payments to hospitals, physicians and nursing homes would be reduced on **average by 13.7%**. And because the size of the federal payment reduction would grow each year, the percentage reduction in provider payments (relative to baseline projections) would also need to grow. For example:

  - In 1997, a 6% reduction in hospital payments would be needed;
  - In 2002, a 22.9% reduction in hospital payments would be needed;;

- In 2005, a 32.8% reduction in hospital payments would be needed.

These reductions are on top of Medicaid's already low payment rates. This level of provider cuts will disproportionately harm public hospitals and clinics, for whom Medicaid is a significant payment source.

- **Reductions in Benefits**

States also could choose to reduce benefit levels in response to the reduction in federal payments. The amount of savings that could be achieved through eliminating particular categories of benefits is shown in Attachment 3. For example, eliminating all dental benefits could achieve about 28% of the necessary savings from baseline in 1997. Eliminating personal care services would achieve about 55% of the necessary savings.

These reductions, however, would not be sufficient over time, because the size of the federal reduction would increase each year. For example, in 2002, eliminating dental benefits would produce only 8% of the necessary savings, and in 2005, only 6%. In 2005, eliminating all benefits for dental, prescription drugs, EPSDT, home health care, hospice, personal care services and payments for Medicare premiums and cost-sharing still would not be sufficient to compensate for the lost federal funding.

- **Reductions in Program Eligibility**

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In reality, states would respond through a combination of these approaches. For example, under the 5% growth proposal, federal payments to states in 2005 would be $66.3 billion below baseline projections. If a state were to allocate this reduction equally to reductions in provider payments, benefits and eligibility, it could achieve the necessary savings by (as compared to baseline projections):

- Reducing provider payments by about 11%.
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- Eliminating coverage for noncash children and qualified and special Medicare beneficiaries.

And, because federal payments would continue to decline, further reductions would be needed each future year.

Even under less extreme proposals, federal payment reductions can be significant over time. For

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CONCLUSIONS

Medicaid block grant proposals under discussion would dramatically reduce federal Medicaid payments to states over time. Increased use of managed care cannot generate the savings necessary to make up for these reductions and there is little room in state budgets to increase state Medicaid spending to compensate for the reduced federal commitment.

Unless states choose to offset federal reductions with increases in state spending, they would be forced to respond by reducing provider payments, services, and/or coverage. Given the inflexibility of a block grant to respond to the needs of individual states and differences in state political environments, the level and nature of the reductions in the scope of the program would vary significantly from state to state.

Reducing the scope of the Medicaid program to such a large extent would not only put families at risk, but also set back movement towards more comprehensive health reform in a number of ways, including:

- **Increasing the number of uninsured.** Recipient growth currently accounts for two-fifths of overall Medicaid program growth. In fact, spending per person under Medicaid is increasing at about the same rate as in the private sector.

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The Administration can offer states flexibility without shifting costs to states or reducing coverage. For example, regulations could be relaxed so that states could use managed care to achieve savings without current restrictions. And, the 1115 waiver process could continue to be used to provide states with the flexibility to change categorical eligibility rules. While these changes would retain the individual entitlement under Medicaid, they would provide states with much of the flexibility they are seeking.

Possible Sources and Uses of Funds

Fiscal Years. Billions of Dollars

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-year Total 1996-2000	10-year Total 1996-2005
Sources of Funds														
Tobacco Tax (phased-in)	1/	0.0	0.0	4.3	6.0	6.0	5.9	5.9	8.3	9.1	9.0	8.9	22.2	63.4
Medicare Savings	2/	0.0	0.5	3.4	4.9	6.6	9.1	11.8	14.1	16.6	19.6	22.6	24.5	109.2
Medicare Receipt Proposals	3/	0.0	1.4	2.9	2.6	2.8	3.0	3.3	3.6	4.0	4.3	4.8	12.7	32.7
Medicaid DSH Freeze	4/	0.0	0.6	1.1	1.7	2.4	3.1	3.8	4.6	5.4	6.2	7.0	8.9	35.9
Indirect Effects on Receipts	5/	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.8	2.0
Medicaid Offset	6/	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.5
Total Sources of Funds:		0.0	2.5	12.1	15.7	18.3	21.7	25.5	31.2	35.8	39.8	44.1	70.3	246.7
Uses of Funds														
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	7,8,9/	0.0	0.0	6.9	9.6	10.1	10.8	11.4	12.2	13.0	13.8	14.7	37.3	102.4
Subsidies for Kids		0.0	0.0	4.2	5.7	5.9	6.1	6.3	6.6	6.9	7.3	7.7	21.9	56.7
Subsidies for Temporarily Unemployed Adults		0.0	0.0	2.7	3.9	4.2	4.6	5.1	5.6	6.1	6.5	7.1	15.4	45.7
Net Effect on Unemployment Insurance Program	10/	0.0	0.0	0.6	0.7	0.5	0.4	0.2	0.2	0.2	0.2	0.2	2.1	3.2
Self-employed Tax Deduction Phased to 100%	11/	0.5	0.5	0.9	1.4	2.0	2.2	2.4	2.7	3.0	3.2	3.5	7.5	22.3
Long-term Care Program	12/	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
Long-term Care Tax Changes	13/	0.0	0.2	0.5	0.6	0.8	0.9	1.0	1.1	1.2	1.4	1.5	3.0	9.2
Public Health Service/FQHC Expansion	14/	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.0
Total Uses of Funds:	15/	0.5	0.9	10.5	14.0	15.2	16.0	16.9	18.2	19.4	20.7	22.2	57.1	154.5
Impact on Deficit:	15/	0.5	-1.6	-1.6	-1.7	-3.1	-5.7	-8.5	-13.1	-16.4	-19.2	-21.9	-13.2	-92.3

NOTES:

All estimates are preliminary. Totals may not add due to rounding.

While both Sources and Uses of Funds appear in this table as positive numbers, in the budget, Medicare and Medicaid savings would be indicated in negative numbers as reductions in outlays. Similarly, the cost of the self-employed tax deduction would be indicated in negative numbers as a revenue loss. Increased receipts would be shown in positive numbers.

1/ Increases from $0.24 to $0.64 1/1/97 and to $0.90 1/1/2002. Estimate from Treasury. ESTIMATE SHOWN MUST BE REESTIMATED (to reflect change in kids' subsidy cost).

2/ Estimates from HCFA/OACT.

3/ Includes income-related Part B premium and extension of HI tax to all state and local employees. Estimates from HCFA/OACT and Treasury.

4/ Includes 25% behavioral offset. Estimate from HCFA/OACT.

5/ Indirect effects on receipts of the kids subsidy. Subsidies for unemployed cause a negligible effect on receipts under standard assumptions. Includes on-budget effects only. Estimates from Treasury. ESTIMATE SHOWN MUST BE REESTIMATED (to reflect change in kids' subsidy costs.)

6/ Medicaid offset reflects savings to Medicaid as a result of Part B savings. Estimates from HCFA/OACT.

7/ These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.

8/ Assumes that unemployed compensation is included in income determinations. Also assumes that kids and families with access to employer contriubtions of 50% or more are ineligible for subsidies. Assumes 100% ESI takeup for unemployed program. Assumes durational effects on health insurance subsidies.

9/ Eligibility for subsidies based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.

10/ Reflects increase in duration and incidence in Unemployment Insurance program as a result of health insurance subsidies. Net of offsetting UI reciepts.

11/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995. Assumes that self-employed must provide health coverage to their employees in order to claim a deduction in excess of 25%.

12/ Grant program to states to expand home & community-based services for disabled individuals. Estimate from HHS/ASPE.

13/ Includes long-term care insurance tax incentives, personal assistance services tax credits, and accelerated death benefit changes. Estimates from Treasury.

14/ Estimate from HHS/PHS.

15/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995.

Possible Sources and Uses of Funds

Fiscal Years. Billions of Dollars

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Medicare Receipt Proposals	2/	0.0	1.4	2.9	2.6	2 8	3 0	3.3	3.6	4.0	4.3	4 8	12.7	32.7
Medicaid DSH Freeze	3/	0.0	0.6	1.1	1.7	2.4	3.1	3.8	4.6	5.4	6.2	7.0	8.9	35.9
Indirect Effects on Receipts	4/	0.0	0 0	0.2	0.2	0.2	0 2	0 2	0.2	0.2	0.2	0.3	0.8	2.0
Medicaid Offset	5/	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.5
Total Sources of Funds:		0.0	2.5	7.8	9.7	12.3	15.7	19.6	23.0	26.7	30.8	35.1	48.1	183.3
Uses of Funds														
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	6,7,8./	0 0	0 0	6 9	9.6	10.1	10.8	11.4	12.2	13.0	13.8	14.7	37.3	102.4
Subsidies for Kids		0.0	0.0	4.2	5.7	5.9	6.1	6 3	6.6	6.9	7.3	7 7	21.9	56.7
Subsidies for Temporarily Unemployed Adults		0.0	0.0	2 7	3 9	4.2	4 6	5 1	5.6	6.1	6.5	7 1	15.4	45.7
Net Effect on Unemployment Insurance Program	9/	0.0	0.0	0.6	0 7	0 5	0.4	0.2	0.2	0.2	0.2	0.2	2.1	3.2
Self-employed Tax Deduction Phased to 100%	10/	0 5	0 5	0.9	1.4	2.0	2.2	2.4	2.7	3.0	3 2	3.5	7.5	22.3
Long-term Care Program	11/	0.0	0 0	1 5	1.5	1.6	1.6	1.7	1.8	1 8	1.9	2.0	6.2	15 4
Long-term Care Tax Changes	12/	0 0	0.2	0 5	0.6	0.8	0.9	1 0	1 1	1 2	1 4	1.5	3.0	9.2
Public Health Service/FQHC Expansion	13/	0.0	0.2	0 2	0.2	0.2	0.2	0.2	0.2	0.2	0 2	0.2	1.0	2.0
Total Uses of Funds:	14/	0.5	0.9	10.5	14.0	15.2	16.0	16.9	18.2	19.4	20.7	22.2	57.1	154.5
Impact on Deficit:	14/	0.5	-1.6	-2.7	-4.3	-2.9	-0.2	-2.6	-4.8	-7.3	-10.1	-13.0	-9.0	-28.8

NOTES:

All estimates are preliminary. Totals may not add due to rounding.

While both Sources and Uses of Funds appear in this table as positive numbers, in the budget, Medicare and Medicaid savings would be indicated in negative numbers as reductions in outlays. Similarly, the cost of the self-employed tax deduction would be indicated in negative numbers as a revenue loss. Increased receipts would be shown in positive numbers.

1/ Estimates from HCFA/OACT.

2/ Includes income-related Part B premium and extension of HI tax to all state and local employees. Estimates from HCFA/OACT and Treasury.

3/ Includes 25% behavioral offset. Estimate from HCFA/OACT.

4/ Indirect effects on receipts of the kids subsidy Subsidies for unemployed cause a negligible effect on receipts under standard assumptions. Includes on-budget effects only. Estimates from Treasury. ESTIMATE SHOWN MUST BE REESTIMATED (to reflect change in kids' subsidy costs.)

5/ Medicaid offset reflects savings to Medicaid as a result of Part B savings. Estimates from HCFA/OACT.

6/ These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.

7/ Assumes that unemployed compensation is included in income determinations. Also assumes that kids and families with access to employer contriubtions of 50% or more are ineligible for subsidies. Assumes 100% ESI takeup for unemployed program. Assumes durational effects on health insurance subsidies.

8/ Eligibility for subsidies based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.

9/ Reflects increase in duration and incidence in Unemployment Insurance program as a result of health insurance subsidies. Net of offsetting UI reciepts.

10/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995. Assumes that self-employed must provide health coverage to their employees in order to claim a deduction in excess of 25%.

11/ Grant program to states to expand home & community-based services for disabled individuals. Estimate from HHS/ASPE.

12/ Includes long-term care insurance tax incentives, personal assistance services tax credits, and accelerated death benefit changes. Estimates from Treasury.

13/ Estimate from HHS/PHS.

14/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995.

Possible Sources and Uses of Funds

Fiscal Years, Billions of Dollars

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-year Total 1996-2000	10-year Total 1996-2005
Sources of Funds														
Tobacco Tax	1/	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
Medicare Savings	2/	0.0	0.5	3.4	4.9	6.6	9.1	11.8	14.1	16.6	19.6	22.6	24.5	109.2
Medicare Receipt Proposals	3/	0.0	1.4	2.9	2.6	2.8	3.0	3.3	3.6	4.0	4.3	4.8	12.7	32.7
Medicaid DSH Freeze	4/	0.0	0.6	1.1	1.7	2.4	3.1	3.8	4.6	5.4	6.2	7.0	8.9	35.9
Indirect Effects on Receipts	5/	0.0	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.8	2.0
Medicaid Offset	6/	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.0	0.5
Total Sources of Funds:		0.0	2.5	7.8	9.7	12.3	15.7	19.6	23.0	26.7	30.8	35.1	48.1	183.3
Uses of Funds														
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	7,8,9/	0.0	0.0	6.9	9.6	10.1	10.8	11.4	12.2	13.0	13.8	14.7	37.3	102.4
Subsidies for Kids		0.0	0.0	4.2	5.7	5.9	6.1	6.3	6.6	6.9	7.3	7.7	21.9	56.7
Subsidies for Temporarily Unemployed Adults		0.0	0.0	2.7	3.9	4.2	4.6	5.1	5.6	6.1	6.5	7.1	15.4	45.7
Net Effect on Unemployment Insurance Program	10/	0.0	0.0	0.6	0.7	0.5	0.4	0.2	0.2	0.2	0.2	0.2	2.1	3.2
Self-employed Tax Deduction Phased to 100%	11/	0.5	0.5	0.9	1.4	2.0	2.2	2.4	2.7	3.0	3.2	3.5	7.5	22.3
Long-term Care Program	12/	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
Long-term Care Tax Changes	13/	0.0	0.2	0.5	0.6	0.8	0.9	1.0	1.1	1.2	1.4	1.5	3.0	9.2
Public Health Service/FQHC Expansion	14/	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.0
Total Uses of Funds:	15/	0.5	0.9	10.5	14.0	15.2	16.0	16.9	18.2	19.4	20.7	22.2	57.1	154.5
Impact on Deficit:	15/	0.5	-1.6	-2.7	-4.3	-2.9	-0.2	-2.6	-4.8	-7.3	-10.1	-13.0	9.0	-28.8

NOTES:

All estimates are preliminary. Totals may not add due to rounding.

While both Sources and Uses of Funds appear in this table as positive numbers, in the budget, Medicare and Medicaid savings would be indicated in negative numbers as reductions in outlays. Similarly, the cost of the self-employed tax deduction would be indicated in negative numbers as a revenue loss. Increased receipts would be shown in positive numbers.

1/ Increases from $0.XX to $0.64 in 1/1/9X. Estimate from Treasury. ESTIMATE SHOWN MUST BE REESTIMATED (to reflect change in kids' subsidy cost).

2/ Estimates from HCFA/OACT.

3/ Includes income-related Part B premium and extension of HI tax to all state and local employees. Estimates from HCFA/OACT and Treasury.

4/ Includes 25% behavioral offset Estimate from HCFA/OACT.

5/ Indirect effects on receipts of the kids subsidy. Subsidies for unemployed cause a negligible effect on receipts under standard assumptions. Includes on-budget effects only. Estimates from Treasury. ESTIMATE SHOWN MUST BE REESTIMATED (to reflect change in kids' subsidy costs.)

6/ Medicaid offset reflects savings to Medicaid as a result of Part B savings. Estimates from HCFA/OACT.

7/ These estimates assume some employer or employee dropping of insurance, which would result in small, increased tax revenues.

8/ Assumes that unemployed compensation is included in income determinations. Also assumes that kids and families with access to employer contriubtions of 50% or more are ineligible for subsidies. Assumes 100% ESI takeup for unemployed program. Assumes durational effects on health insurance subsidies.

9/ Eligibility for subsidies based on monthly cash income. Basing eligibility on annual cash income would reduce costs and coverage.

10/ Reflects increase in duration and incidence in Unemployment Insurance program as a result of health insurance subsidies. Net of offsetting UI reciepts.

11/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995 Assumes that self-employed must provide health coverage to their employees in order to claim a deduction in excess of 25%.

12/ Grant program to states to expand home & community-based services for disabled individuals. Estimate from HHS/ASPE.

13/ Includes long-term care insurance tax incentives, personal assistance services tax credits, and accelerated death benefit changes. Estimates from Treasury.

14/ Estimate from HHS/PHS.

15/ Five and ten year totals include $0.5 billion cost for self-employed tax deduction in FY 1995.

Possible Uses of Funds

Fiscal Years, Billions of Dollars

		1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	5-year Total 1996-2000	10-year Total 1996-2005
Kids Program (133% - 240%)	1,2,3/	0.0	0.0	4.2	5.7	5.9	6.1	6.3	6.6	6.9	7.3	7.7	21.9	56.7
Temporarily Unemployed (100% - 240%) Only	3,4,5/	0.0	0.0	3.8	5.4	5.7	6.0	6.4	7.0	7.6	8.2	8.9	21.0	59.2
Subsidy Cost		0.0	0.0	3.3	4.7	5.2	5.7	6.2	6.8	7.4	8.0	8.7	18.9	56.0
Net Effect on Unemployment Insurance		0.0	0.0	0.6	0.7	0.5	0.4	0.2	0.2	0.2	0.2	0.2	2.1	3.2
Kids Program (133% - 240%) + Temporarily Unemployed (100% - 240%)	1 - 5/	0.0	0.0	7.4	10.2	10.7	11.1	11.7	12.4	13.2	14.0	15.0	39.4	105.6
Subsidy Cost		0.0	0.0	6.9	9.6	10.1	10.8	11.4	12.2	13.0	13.8	14.7	37.3	102.4
Net Effect on Unemployment Insurance		0.0	0.0	0.6	0.7	0.5	0.4	0.2	0.2	0.2	0.2	0.2	2.1	3.2
Self-employed Tax Deduction Phased to 100%	6/	0.5	0.8	0.9	1.4	2.0	2.2	2.4	2.7	3.0	3.2	3.5	7.5	22.3
Long-term Care Program	7/	0.0	0.0	1.5	1.5	1.6	1.6	1.7	1.8	1.8	1.9	2.0	6.2	15.4
Long-term Care Tax Changes	8/	0.0	0.2	0.5	0.6	0.8	0.9	1.0	1.1	1.2	1.4	1.5	3.0	9.2
Public Health Service/FQHC Expansion	9/	0.0	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.2	1.0	2.0

DRAFT

STIMATED IMPACTS OF MEDICARE AND MEDICAID PROPOSALS

'iscal years, $ in billions, FY 1996 President's Budget baseline)

		1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	1996-2000	1996-2005
1EDICARE													
Hospital Proposals													
Moratorium on Long-Term Care Hospitals		-0.0	-0.0	-0.1	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.4	-0.4	-1.8
Expand Centers of Excellence		0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.5
Reduce PPS-Exempt Capital Payments		-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.4	-1.0	-2.6
Lower Indirect Medical Education		0.0	0.0	0.0	-0.5	-1.5	-2.4	-2.7	-3.0	-3.3	-3.6	-2.0	-17.0
GME Reform	1/	-0.2	-0.4	-0.6	-0.8	-1.1	-1.3	-1.6	-1.9	-2.2	-2.5	-3.1	-12.6
Reduce Medicare DSH Payments by 25%		0.0	-1.1	-1.3	-1.4	-1.5	-1.6	-1.7	-1.8	-1.9	-2.1	-5.2	-14.2
Reduce Hospital PPS Update		0.0	-0.3	-0.7	-1.2	-1.7	-2.3	-3.0	-3.7	-4.5	-5.4	-4.0	-22.8
Physician Proposals													
Eliminate MVPS Upward Bias		0.0	0.0	0.0	-0.1	-0.4	-0.9	-1.6	-2.5	-3.5	-4.5	-0.4	-13.5
Other Provider Proposals													
Competitive Bidding for Labs		0.0	-0.1	-0.3	-0.3	-0.3	-0.4	-0.4	-0.5	-0.5	-0.6	-1.0	-3.3
Competitive Bidding for Part B Services		0.0	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.6	-1.8
HMO Payment: Part B Floor/Ceiling		-0.0	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.5	-1.8
Home Health Prospective Payment		0.0	0.0	0.0	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.4	-1.7
Home Health Coinsurance (10%; exempt 30-day post-discharge)	2/	0.0	-1.2	-1.5	-1.6	-1.7	-1.8	-1.9	-2.0	-2.1	-2.2	-5.9	-15.8
Receipt Proposals													
Income-Related Part B Premium		-0.3	-1.3	-1.1	-1.3	-1.6	-1.9	-2.3	-2.7	-3.1	-3.7	-5.5	-19.2
Extend HI Tax to All State & Local Employees	3/	-1.1	-1.6	-1.5	-1.5	-1.4	-1.4	-1.3	-1.3	-1.2	-1.1	-7.1	-13.5
TOTAL, Medicare		-1.9	-6.3	-7.5	-9.4	-12.1	-15.1	-17.7	-20.6	-23.9	-27.4	-37.3	-142.0
MEDICAID													
Freeze DSH at 1995 Level	4/	-0.6	-1.1	-1.7	-2.4	-3.1	-3.8	-4.6	-5.4	-6.2	-7.0	-8.9	-35.9
TOTAL, Medicare + Medicaid		-2.5	-7.4	-9.2	-11.8	-15.2	-18.9	-22.3	-26.0	-30.1	-34.4	-46.2	-177.9
Memo: Medicaid Offset		0.0	-0.0	-0.0	-0.0	-0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.5

NOTES:

All savings estimates are net of beneficiary premium offsets.

Current estimates assume that the 25% Part B premium is extended beyond 1998.

Numbers may not add due to rounding.

1/ Pricing assumes 7/1/95 implementation date for most GME proposals. Pricing does not include proposal to remove GME and IME from the AAPCC formula.

2/ An alternative proposal with no 30-day post-discharge exemption would have savings of $8.8 billion over FY 1996-2000 and $23.5 billion over FY 1996-2005.

3/ Treasury estimate (1/12/95).

4/ Estimate assumes 25% behavioral offset.

Sources: HCFA/OACT, Treasury, and OMB/HFB.

MEDICAID

Medicaid block grant that caps the growth in federal contribution at a 5% growth rate. The projected baseline rate of growth is about 9.3% (per capita spending growing at approximately same rate as per capita private spending).

Federal savings

Federal reduction = $375 billion over 10 years. Projected federal payments would be reduced by 7 to 10% in 1996 and 35 to 40% in 2006 (due to cumulative effect of annual reductions).

Govs say that managed care can produce enormous savings. Not nearly enough to compensate for levels of reductions of block proposals. ($5 billion over 10 years if all nonelderly, nondisabled recipients enrolled in MC.)

Possible state responses

- Higher state spending (Between 1996 and 2002, state spending would need to increase by 20%. In 2005, increase would be 43% over baseline projections.)

- Reduction in provider payments (Between 1996 and 2002, payments to hospitals, physicians and nursing homes would be reduced on average by 13.7%)

- Reductions in benefit levels (But, in 2005, eliminating all benefits for dental, prescription drugs, EPSDT, home health care, hospice, personal care services and payments for Medicare premiums and cost sharing still would not be enough.)

- Reductions in program eligibility (But, eliminating eligibility for non-cash children would achieve 62% of the savings in 1997, but only about 14% in 2005.)

Concerns

- Risk for states:

    - States would be at risk for inflation and recession. Block does not react to changing numbers of Medicaid eligibles as individual entitlement does.

    - Would benefit some states and penalize others. (State growth rates vary for numerous reasons, like changes in population, different medical costs in different regions -- this would fix the growth rate.)

    - Population is aging and long-term care needs, therefore, increasing. States would bear this burden.

- States must make the tough choices. Federal government gets savings without taking responsibility for specific cuts.

- Number of uninsured will increase. (See chart)

- Cost shifting will be exacerbated (because of reductions in Medicaid provider payments or the number of uninsured).

Alternatives:

Admin can offer additional state flexibility without shifting costs to states or reducing coverage:

- Permitting states to implement managed care and home and community-based care programs without applying for a waiver.

- Using 1115 waiver process to allow states to change categorical rules.

- Eliminating Boren amendment restrictions on hospital payments (i.e., they must be "reasonable").

ERISA

[Federal preemption of state laws that "related to" employee health plans. States can regulate indemnity plans and HMOs; can't regulate employee health plans that "self-insure" under ERISA rather than buy insurance.]

- NGA is proposing two ERISA preemption changes:

  (1) Create a set of national minimum standards, including minimum insurance reform and uniform data collection standards. States could regulate self-insured plans if states adopt these standards.

  (2) Dept of Labor can issue ERISA waivers, especially for states that want to develop alternative financing and cost control strategies. State's waiver would have to include plan for expanding coverage.

- Also proposing that federal health care standards be developed for self-funded plans (e.g., remedies, minimum solvency). NGA is also proposing that employers below a certain (unspecified) size threshhold be prohibited from forming self-funded plans.

Gov. Dean Nears Medicaid Deal

A week after publicly applauding a sweeping Medicaid reform proposal pending in the Senate, the head of the National Governors' Assn. (NGA) began privately crafting a Medicaid deal with the House Speaker. NGA Chair Howard Dean (D-VT) and Speaker Newt Gingrich (R-GA) last week discussed a pact under which the states would receive fewer federal Medicaid dollars than in years past, but have more say over how to use them. Under the most likely scenario, states would receive an annual Medicaid block grant equal to the amount received the year before plus 5 percent, Dean told *M&H* Jan. 19. That increase would be far below today's roughly 10 percent growth, but Dean said he would be willing to live with the smaller rise because the block-grant funding stream would free him from Medicaid "categorical hoops" such as requiring federal permission to move recipients into managed care. "There is a real possibility of a deal" on the block grant idea, he said. "A lot of governors would be interested." Dean will likely try to sell the idea to his fellow governors at the association's annual winter meeting beginning Jan. 28. Dean also lobbied Gingrich to support Senate Human Resources Chair Nancy Kassebaum's (R-KS) welfare bill, which would turn the Medicaid acute care program entirely over to the states (*M&H* 1/16/95), but got no commitment. Dean said the meeting took place largely because the Speaker was intrigued by statements on Medicaid by New York Gov. George Pataki (R-NY). He urged the House Ways & Means Committee Jan. 12 to provide states with incentives — such as increased federal matching funds — for using their Medicaid dollars more efficiently. Following his conversation with Dean, Gingrich brought the block grant proposal up with Gov. Tommy Thompson (R-WI), the Speaker reported at a Jan. 19 Capitol Hill news conference. Thompson, who will succeed Dean as NGA chair this summer, "said he could live with a 5 percent increase," Gingrich said, adding that he has tapped the Wisconsin governor to head a task force assigned to address Medicaid reform.

GOP Budget Plans Grow Less Ambitious

House Republican leaders, who pledged to crank out budget-cutting legislation early in the 104th Congress, are having trouble finding the revenue they need and have already missed their first self-imposed deadline. The GOP plan at the outset of the session was to raise $200 billion in five- [illegible] end of January *before* cuts promised in the "Contract with America." But Budget Committee Chair John Kasich (R-OH) said Jan. 18 that that schedule has changed. Now a spending reduction package will be released Feb. 9; a separate, more far-reaching budget reconciliation bill that will be the "down payment" for balancing the budget will be released later in the spring, budget aides said Jan. 20. The delay allows Republicans to see President Clinton's budget — to be unveiled Feb. 6 — before showing their own hand. Kasich's rationale is that lawmakers need extra time to examine budget options "more thoughtfully." The Ohio Republican backed away from another promise: to propose a seven-year budget with a surplus at the end. Instead, he said, GOPers will release program changes for fiscal years 1996-2000 as a "road map" for reaching the zero target by year seven. Meanwhile, a series of new reports show just how daunting that target is. A Price Waterhouse report released Jan. 17 estimates that if the Contract's tax cuts and the GOP's proposed defense spending increase of $80 billion are enacted, and Social Security is exempted, Medicare, Medicaid, and all discretionary programs would have to absorb cuts of 24.1 percent over seven years. Democratic leaders and the Center on Budget and Policy Priorities have arrived at similar estimates.

GOP Offers Long Term Care Plums

The budget hits that Medicare will likely take later this year could stir up the powerful seniors' lobby, but House Republicans are considering some early-session long term care tax proposals to sugar-coat the bitter medicine. The House Ways & Means Committee last week held separate hearings on three "Contract with America" provisions designed to benefit the elderly: repealing a 1993 tax increase on Social Security benefits (at a five-year cost of $15 billion); providing a $500 refundable tax credit for providing long term care at home ($8 billion); and providing tax incentives for the purchase of long term care insurance ($1.3 billion). During a Jan. 19 hearing on the tax repeal, American Assn. of Retired Persons spokesperson Bob Shreve argued that the 1993 law that made 85 percent of Social Security benefits taxable instead of 50 percent was unfair, since the program is in surplus. Ways & Means Committee Democrat Andrew Jacobs (IN) agreed taxes on the elderly should be more progressive, but said means testing of Medicare would be "better" than repealing the new tax. Several other Democrats are wary of the repeal, including Reps. Gerald Kleczka (WI) and Benjamin Cardin (MD), because the revenue goes

Policy Number: EC-7
Committee: Executive
Title: Health care Reform

RESPONSE TO: **7.2.1 Employer Retirement Income Security Act**

SUMMARY: NGA is proposing that ERISA preemption of state laws be modified in two respects. The first calls for a set of national minimum standards to be created by federal regulators. States would be able to impose requirements on self-funded ERISA plans, such as minimum insurance reform and uniform data collection standards. The second calls for empowering the Department of Labor to issue ERISA waivers to states that apply for them. There are no specific criteria for who get such a waiver except that states applying for waivers to impose financing or cost containment strategies on ERISA plans would be required to show a plan for expanding coverage.

CONCERNS: This proposal will be very controversial with large employers and many labor unions, particularly because there is such a lack of standards for which states could apply for an ERISA waiver. Advocates of big business have stated that maintaining ERISA preemption is their highest legislative priority.

RESPONSE TO: **7.2.2 The Health Insurance Market**

SUMMARY: NGA is proposing that federal health care standards be developed for self-funded ERISA plans. The standards would be similar to the standards states apply to commercial insurers. The NGA paper suggests that standards might be appropriate in the areas of portability requirements, minimum solvency standards, and remedies for people that have problems with their plans. NGA also is proposing that employers below a certain (unspecified) size threshold be prohibited from forming self-funded health plans.

CONCERNS: Although both of these proposals are consistent with the policy the Administration took in the Health Security Act, they are likely to be controversial with the business community, particularly the requirement to create a remedy standard under ERISA. The small business community will particularly oppose a prohibition on their forming self-funded health plans. (Note: Rep. Fawell, new chair of the Employer-Employee Relations Subcommittee in the House has indicated that he intends to sponsor legislation expanding ERISA to permit small business associations to form self-funded health plans outside of state jurisdiction).

RESPONSE TO: **7.2.3.2 Entitlement and Financing**

SUMMARY: NGA is proposing that each state be able to choose between continuing under an individual entitlement or switching to a capped entitlement to states.

CONCERNS:

This appears to be a no-lose proposition for states, they can keep what they have or make a change in program structure if it appears more advantageous. However, by making this proposal, NGA is signaling that a capped entitlement might be acceptable. This opens the door to deficit hawks in Congress who want to use a program cap to dramatically reduce federal Medicaid spending.

Advocating transforming Medicaid into a capped entitlement is a risky strategy for states. Given the current budget climate, capping the federal payments to states would inevitably result in a reduction in the federal government's financial commitment to the program. Reducing the "level" of a block grant payment is much easier than making specific program cuts, because the hard choices about how to make do with the reduced payments are devolved to the states. Even if initial payment reductions were a small (e.g., one percentage point below baseline), over a reasonably short period of time the reduction in federal resources provided to states would be tens of billions of dollars.

State and local governments ultimately will face the consequences of such a reduction, because the need for medical and long-term care by the poorest and most vulnerable populations will continue. States will be forced to respond either through increased state spending or reductions in coverage and benefits. Cuts in Medicaid coverage and services not only would result in severe hardships for needy populations, but would also result in more uncompensated care and greater costs shifts to other private and public payers.

1. **States At Risk During Recessions.** As an individual entitlement program, Medicaid automatically adjusts federal payments to meet the current level of need. During recessions or natural disasters, the number of families without work and without insurance can increase dramatically. Because of the entitlement nature of Medicaid, the amount of federal support will automatically adjust to help states cope with the increased need for services. A capped entitlement to states would not respond to changes in economic conditions, leaving states to address the increased need on their own. Although states in theory could cut off participation or benefits if funds were not available, as a practical matter states would be unable to make significant reductions at times of recession.

2. **States At Risk for Cost of Aging Population.** The demographic changes that are occurring in the Medicaid population increase the risk that a capped entitlement to states will result in states getting fewer federal resources over time. As the population continues to age, the growing need for long-term care services will put increased stress on the Medicaid program. If federal payments to states are fixed based on current enrollment and growth, the states would bear the burden for providing these services as the population ages.

3. **States Less Able to Expand Coverage.** States that wish to expand coverage are better able to do so under an individual entitlement than under a capped entitlement to states. The current system is a partnership, in which the federal government has agreed to match state

spending. For example, virtually every state has elected to expand coverage to one or more of the optional coverage categories under Medicaid, in part because the federal government is paying between 50 and 78% of the cost of each new enrollee. Under a capped entitlement to states, expanding coverage would require states to pick up 100% of the costs of the new enrollees, making it far less likely that states would expand enrollment.

Policy Number: EC-12
Committee: Executive
Title: Medicaid

RESPONSE TO: **12.2.3 Give States Greater Leeway in Containing the Cost of Hospital and Long-Term Care Through the Boren Amendment**

SUMMARY: NGA believes that any coherent approach to national health care reform must address the inflexible provider reimbursement standard of Boren. The governors support a strategy that would replace the current Boren Amendment with provisions that establish "safe harbor" standards, where a state meeting any of them would satisfy the statute. The NGA resolution describes five "safe harbors."

NGA also believes that Boren is not applicable when a hospital is part of a managed care network for Medicaid, and that procedural requirements in the current Boren process be streamlined.

CONCERNS: We support the "safe harbor" standards for hospital reimbursement. While the nursing home standards are less onerous than what has been previously proposed by states, we still are concerned that payments to facilities may be inadequate for efficiently run facilities. Reducing payments below current law Boren requirements may result in deteriorating quality of care.

We agree with NGA that the current Boren Amendment language does not apply in managed care settings, and this is reflected by our current operating policy. We also support NGA's recommendation that the current Boren procedural requirements be streamlined, and will gladly work with NGA on proposing changes to the process.

RESPONSE TO: **12.2.4 Allow States to Manage Costs in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program**

SUMMARY: According to NGA, States currently have no ability to limit the range or cost of services required in the EPSDT program. HHS needs to issue rules that allow States to efficiently manage case costs and utilize the least expensive alternatives for providing services without reducing the quality of care.

CONCERNS: This issue was part of the HHS/NGA negotiations in 1993. In response to States' concerns, HCFA issued an "All States" letter on May 24, 1993 emphasizing the flexibility States have in applying medical necessity criteria to determine the scope of services provided under the EPSDT program. We would be willing to continue discussions with NGA on ways that States can select less costly alternatives for diagnosis and treatment without risking quality.

Even with the 1993 policy clarification, States have continued to express a desire to seek legislative change to limit the scope of Medicaid services even

further, perhaps limiting EPSDT services to only those covered in their State plan. We believe that in matters concerning EPSDT, as well as other statutorily required services, the Federal government has a role in assuring that those required services are covered.

RESPONSE TO: **12.2.5 Ensure that States Will Not be Expected to Implement any Medicaid Program Changes Until HCFA Has Published Final Regulations to Guide Program Administration.**

SUMMARY: NGA claims that HCFA has too often failed completely to publish regulations associated with statutory changes in Medicaid, or, has do so after many years of delay. States have had to implement statutory changes and have been held financially accountable for unclear laws, even though HCFA failed to provide clarification through regs.

CONCERNS: We have been committed to making every effort to develop and publish regulations as rapidly as possible, resources permitting. HCFA has continued to disseminate timely information in other ways (Medicaid manual issuances, "All States" letters, etc.). In addition, HCFA works closely with States through Medicaid Technical Assistance Groups (TAGs) which provide States with an opportunity to assist HCFA in the development of new regulations.

RESPONSE TO: **12.2.8 Reconsider The Nursing Home Reform Mandates In The Omnibus Reconciliation Act of 1987.**

SUMMARY: The NGA proposes that the quality of care provisions included in the nursing home reform legislation in 1987 should be modified to increase State flexibility and reduce the Federal government "micro-management." In addition, the NGA recommends repeal of the preadmission screening and annual resident review (PASARR) provisions, since they are not cost-efficient and States have developed alternative methods to ensure appropriate placement.

CONCERNS: We do not support changes to the basic quality of care provisions for nursing homes. We believe that these provisions are necessary for the protection of this especially vulnerable population.

We agree in concept that the PASARR provisions are duplicative of other efforts, and believe that the annual resident review should be repealed.

At this time, we wish to retain the preadmission portion of the statute. We believe that more information is needed before we are convinced that this portion of the law could also be repealed.

RESPONSE TO: **12.2.9 Make Audit And Disallowance Policies More Equitable.**

SUMMARY: The NGA wants to revise the current program disallowance process to focus the Federal review process on those policies that might have direct harm to

beneficiaries. The NGA proposal would prohibit heavy sanctions for violations that have no harm to beneficiaries.

CONCERNS:

We would oppose this proposal. We share the States' concern that the size of a disallowance often seems out of proportion to the significance of the State violation. This occurs because HCFA is charged with ensuring State compliance, and has no choice but to disallow all Federal funding related to a violation. The Departmental Appeals Board (DAB) likewise must sustain or reverse the disallowance in its entirety, on appeal.

We do not agree that penalties should be limited only to violations that directly harm patients. The Federal government could not responsibly oversee the Medicaid program if it lacked the threat of disallowances for such violations as unauthorized or inappropriate payments.

Proposals for basing the magnitude of disallowances on the seriousness of the violation were considered by Congress in 1993. We support this concept and provided extensive technical assistance to Hill staff to develop acceptable language. This proposal was included in section 1668, introduced by Senator Moynihan on November 17, 1993.

U.S. Department of Health and Human Services

RESPONSE TO: **7.2.3.3 Statutory Changes to the Social Security Act**

SUMMARY: Change the statute to allow activities currently conducted under research and demonstration waivers to be enacted through state plan amendment.

If the statute is not changed as described above, remove the requirement that the waiver include a research and demonstration component, streamline administration and allow for five-year renewal.

CONCERNS: Disagree with changing statute: The reason why reform activities occur within the waiver context is that we do not know if they are effective at delivering high quality, efficient care. The research results are needed prior to consideration of letting these activities occur through plan amendments.

Disagree with removing research and demonstration requirement (see reasons above).

Currently, no statutory change is required to extend the demonstration beyond the demonstration (e.g., Arizona).

THE WHITE HOUSE

WASHINGTON

To Jen
2FL/WW
b. 2594

January 13, 1995

MEMORANDUM

TO: Chris Jennings
Jennifer Klein MH

FROM: Marcia Hale

SUBJECT: NGA Policy on Health Care Reform

As you know, the National Governors' Association will hold its Winter meeting on January 28-31 in Washington. Please review the proposed policy on Health Care Reform and let me know of any comments or suggestions you may have regarding this policy so that I may advise the Democratic Governors' representatives on the Executive Committee. Please return your written comments to my office on Tuesday, January 17.

During the last NGA meeting, your office was helpful in providing talking points on health care reform that were distributed among Democratic governors. I would appreciate it if you could again provide talking points on this subject. Please return them to Lawton Jordan in Room 106 by Friday, January 20.

Thank you for your help in reviewing the NGA policies and in providing these talking points. Please call me if you have any questions.

Attachment

NATIONAL GOVERNORS' ASSOCIATION

Howard Dean, M.D.
Governor of Vermont
Chair

Tommy G. Thompson
Governor of Wisconsin
Vice Chair

Raymond C. Scheppach
Executive Director

Hall of the States
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Washington, D.C. 20001-1512
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1995 Winter Meeting

EXECUTIVE COMMITTEE

Governor Howard Dean, M.D., Chair
Governor Tommy G. Thompson, Vice Chair

Raymond C. Scheppach, Executive Director

Proposed Changes in Policy

Reaffirm Existing Policy

New language is typed double-spaced and in ALL CAPS, with deleted material lined-throughout (—).

The Executive Committee recommends the consideration of three new policy positions, one of which is current interim policy, amendments in the form of substitutes to two existing policy positions, and the reaffirmation of seven existing policy positions (three with technical amendments). Pursuant to the recommendations of the Strategic Review Task Force, these proposals are time limited to two years. Background information and fiscal impact data follow.

1. Health Care Reform (Amendment in the form of a substitute to EC-7)

   While federal efforts to develop a consensus on national health care reform have to date been unsuccessful, reform efforts in the states continue to move ahead. However, more needs to be done. This proposed policy describes policy areas where additional federal support is needed to facilitate and accelerate the development of state-based efforts. Included among the areas are the Employee Retirement Income Security Act (ERISA), the health insurance market, acute care services for low-income individuals and families, medical tort reform, and administrative simplifications.

2. HIV/AIDS (EC-10, amendment in the form of a substitute to C-17)

   The human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) are critical public health problems. This proposed policy calls for strong action by all levels of government, including the reauthorization of the Ryan White Care Act, to address this disease. isn't this in the FY96 budget?

3. Long-Term Care (New Policy Position, EC-11)

   With an aging United States population, the demand for long-term care will continue to grow for the next half century. This proposed policy calls for a more integrated approach to long-term care that supports the availability of a continuum of services, including home- and community-based care, so that placement in nursing homes can be prevented or delayed for as long as possible. The proposed policy supports a comprehensive approach to long-term care and recognizes the importance of a viable market for long-term care insurance and managed care networks that address long-term care needs.

4. Medicaid (New Policy Position, EC-12)

   The Medicaid program, now more than 18 percent of total state spending, continues to be the fastest-growing state expenditure. Over the last decade, the partnership between the states and the federal government has eroded to the point that states now have relatively little flexibility in administering this program. This proposed policy calls on the federal government to reestablish that partnership through a series of programmatic recommendations that restore important flexibility to states. Included among the recommendations are allowing more flexibility in establishing managed care networks, establishing institutional reimbursement rates, and designing and implementing home- and community-based care programs as an alternative to institutional long-term care. The proposed policy also opposes a unilateral cap on federal Medicaid spending and calls for the repeal of certain unfunded mandates.

5. Conference of the States (EC-13, Current Interim Policy Position adopted by the Executive Committee on December 19, 1994)

On December 19, 1994, the Executive Committee unanimously adopted this proposal as "interim" policy. The rules require the association to approve all interim policy at its next meeting.

It is proposed that state legislatures pass a "Resolution of Participation" in a conference of the states that would develop a "States' Petition" as a new form of communication between the states and Congress. Once adopted by a majority of the states, the petition would be presented to Congress for action.

6. Reaffirmation of Existing Policy Positions

Indian Gaming (EC-4)
Under the sponsorship of the Senate Committee on Indian Affairs, the Governors, attorneys general, and Indian tribal government leaders participated in a negotiation process aimed at resolving the conflicts arising out of the implementation of the Indian Gaming Regulatory Act (IGRA) of 1988. After numerous meetings and hearings, as well as hours of staff-level negotiation, no compromise was reached.

No action has been taken on this issue since Senator Inouye and Senator McCain, then chair and vice chair respectively of the committee, presented a substantially revised version of S. 2230 to amend IGRA in August 1994. The revised bill discarded the scope of gaming and process framework that was developed through months of negotiations between state and tribal government representatives and replaced it with scope of gaming language similar to the original IGRA and a fast-track compacting process for tribes. NGA forwarded a letter to Senator Inouye and Senator McCain expressing disappointment with the revised bill and predicting the Governors' vehement opposition to such legislation.

Senator McCain, the current chair of the committee, intends to revise the bill's language further and to introduce a third version around March 1, 1995. He has requested gubernatorial input. NGA's current policy on amending IGRA will be held over to allow Governors to review and revise their policy position based on new information gained through the negotiation process and recent court decisions. The objective would be to have policy developed in time for the 1995 NGA Annual Meeting.

Political Self-Determination for Puerto Rico (EC-6, with a technical amendment)
The National Governors' Association has continuously supported Puerto Rico's request for a plebiscite regarding its status either as a state of the Union, a commonwealth, or independent status. The Executive Committee once again endorses the right of the people of Puerto Rico to political self-determination made freely by majority vote.

Commonwealth Status for Guam (EC-14)
The Executive Committee recommends reaffirmation of NGA's support of legislation designating Guam as a commonwealth.

Public Pay and Pension Plans (EC-15)
The Executive Committee recommends reaffirmation of this policy, which states that these issues are the primary responsibility of state and local governments. It also calls upon the federal government to revise the Fair Labor Standards Act with regard to state and local government concerns.

Out-of-State Sales Tax Collections (EC-16)
The Executive Committee recommends reaffirmation of this policy. The Supreme Court, in its 1992 decision North Dakota v. Quill Corporation, said that interstate sales tax collection was not a due process question but a Commerce Clause issue to determined by Congress. This policy calls upon Congress to exercise its powers to regulate interstate commerce and to grant states authority to collect the taxes owed on interstate mail transactions.

Ethics in Government (EC-17, with a technical amendment)
The Executive Committee recommends reaffirmation of this policy, which calls on every elected official to support actions to maintain citizen confidence in government.

Equal Rights (EC-18, with a technical amendment)
The Executive Committee recommends reaffirmation of the principles embodied in the Equal Rights Amendment.

EC-7. HEALTH CARE REFORM

7.1 **PREAMBLE**

THE HEALTH OF OUR NATION DEPENDS ON THE HEALTH OF OUR PEOPLE. AND TODAY, THE UNITED STATES HAS THE MOST SOPHISTICATED AND TECHNOLOGICALLY ADVANCED HEALTH CARE SYSTEM IN THE WORLD. HOWEVER, THE TECHNOLOGICAL EXCELLENCE OF OUR SYSTEM HAS COME WITH A PRICE. GROWTH IN THE AMERICAN HEALTH CARE INDUSTRY HAS EXCEEDED GROWTH IN THE OVERALL ECONOMY FOR ALMOST EVERY ONE OF THE LAST THIRTY YEARS. THE COST OF THIS EXTRAORDINARY GROWTH CONTINUES TO CONCERN GOVERNMENT, BUSINESSES, AND INDIVIDUALS. A GROWING NUMBER OF AMERICANS ARE WITHOUT HEALTH COVERAGE, WITH EVEN BASIC CARE BEYOND THE REACH OF MANY. WITH HEALTH CARE COSTS EXCEEDING GENERAL ECONOMIC GROWTH, COVERAGE DECLINING, AND COSTS SHIFTING TO A SMALLER PERCENTAGE OF AMERICANS WHO CAN AFFORD TO PAY, AFFORDABLE QUALITY CARE IS BECOMING MORE ELUSIVE. THE CHALLENGE THAT WE FACE IS TO EXTEND ACCESS TO AFFORDABLE QUALITY CARE TO ALL AMERICANS, INCLUDING THOSE IN UNDERSERVED AND RURAL AREAS, WHILE CONTAINING COSTS.

THE LAST SEVERAL YEARS HAVE SEEN INTENSE FEDERAL EFFORTS TO DEVELOP A CONSENSUS ON NATIONAL HEALTH CARE REFORM. THUS FAR, THOSE EFFORTS HAVE BEEN UNSUCCESSFUL. BY CONTRAST, THE REFORM EFFORTS OF GOVERNORS AND STATE LEGISLATORS HAVE BEEN MUCH MORE SUCCESSFUL. THE EMPHASIS OF GOVERNORS TODAY IS TO DEVELOP STATE-BASED HEALTH CARE REFORM EFFORTS.

IN ALMOST EVERY STATE, STRATEGIES HAVE BEEN IMPLEMENTED TO IMPROVE THE QUALITY AND AVAILABILITY OF HEALTH CARE. IN MOST STATES, THE REFORM EFFORTS HAVE BEEN FOCUSED TO ADDRESS A SPECIALIZED PROBLEM. IN SEVERAL NOTABLE CASES, THE STATE IS ENGAGED IN A COMPREHENSIVE EFFORT THAT IS LIKELY TO PROVIDE NEAR-UNIVERSAL COVERAGE FOR ITS CITIZENS. IN GENERAL, STATES ARE TESTING STRATEGIES TO RESTRUCTURE THE HEALTH CARE MARKET AND RESTRUCTURE THE PUBLIC PROGRAMS THAT SUPPORT THE MOST VULNERABLE CITIZENS.

7.1.1 **PRIVATE MARKET.** WITHIN THE PRIVATE INSURANCE MARKET, STATES HAVE ACTED TO ENHANCE ACCESS AND IMPROVE EQUITY FOR BOTH EMPLOYERS AND

EMPLOYEES. IN SOME STATES, FOR EXAMPLE, LIMITS HAVE BEEN PLACED ON PREEXISTING CONDITIONS EXCLUSIONS FOR CERTAIN MARKET SEGMENTS. SOME STATES ARE EXPERIMENTING WITH GUARANTEED ISSUE AND PORTABILITY OF COVERAGE WHERE INDIVIDUALS CAN BE ENSURED ACCESS TO COVERAGE AFTER CHANGING JOBS. AND WITHIN THE SMALL GROUP INSURANCE MARKET, A NUMBER OF STATES ARE ESTABLISHING MODIFIED COMMUNITY RATING SYSTEMS, WHILE TWO STATES HAVE MOVED TO A PURE COMMUNITY RATING.

MORE THAN SIXTEEN STATES ARE EXPERIMENTING WITH TAX INCENTIVES TO INCREASE COVERAGE. INCLUDED AMONG STRATEGIES ARE TRANSITIONAL TAX CREDITS TO SMALL BUSINESSES AND MEDICAL SAVINGS ACCOUNTS. THESE STRATEGIES ARE APPLICABLE ONLY TO STATE TAXES AND DO NOT AFFECT FEDERAL TAX LAWS.

FINALLY, SOME STATES ARE ENCOURAGING THE ESTABLISHMENT OF PURCHASING ALLIANCES OR GROUP PURCHASING POOLS. BY SPREADING RISK AND ENCOURAGING COMPETITION AMONG HEALTH NETWORKS AND INSURERS, ALLIANCES ARE ABLE TO OFFER AFFORDABLE COVERAGE TO INDIVIDUALS, THOSE WHO ARE SELF-EMPLOYED, AND PEOPLE WHO WORK IN SMALL BUSINESSES—THOSE WHO FIND IT MOST DIFFICULT TO PURCHASE AFFORDABLE COVERAGE. ALTHOUGH THESE PROGRAMS ARE STILL IN THEIR EARLIEST STAGES, THE RESULTS LOOK PROMISING.

7.1.2 **PUBLIC PROGRAMS.** THE MEDICAID PROGRAM REMAINS THE ONLY NATIONAL HEALTH CARE PROGRAM FOR THOSE WHO ARE POOR. ALTHOUGH THE PROGRAM SERVES MORE THAN 30 MILLION BENEFICIARIES ANNUALLY, MANY EXTREMELY POOR PEOPLE DO NOT QUALIFY FOR CARE.

SEVERAL STATES HAVE ACTED TO ELIMINATE THIS INEQUITY BY RESTRUCTURING THEIR MEDICAID PROGRAM. PROVISIONS OF THE SOCIAL SECURITY ACT, OF WHICH MEDICAID IS ONE PART, ALLOW STATES TO EXPERIMENT WITH THE PROGRAM SO THAT INDIVIDUALS NOT OTHERWISE ELIGIBLE FOR THE PROGRAM MAY BECOME SO. THESE PROVISIONS ALSO HAVE BEEN USED TO ENSURE THAT MEDICAID BENEFICIARIES RECEIVE CARE THROUGH SYSTEMS OF MANAGED CARE.

7.2 FEDERAL SUPPORT FOR STATE-BASED HEALTH CARE REFORM

STATES HAVE MADE SIGNIFICANT PROGRESS IN REFORMING THEIR HEALTH CARE SYSTEMS; HOWEVER, MUCH MORE NEEDS TO BE DONE. THE NATION'S

GOVERNORS CALL UPON THE PRESIDENT AND CONGRESS TO WORK WITH STATES TO FACILITATE AND ACCELERATE THE DEVELOPMENT OF STATE REFORM EFFORTS.

7.2.1 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 SOME STATE REFORM INITIATIVES IS THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA).

ERISA WAS ENACTED IN 1974 AND APPLIES TO EMPLOYEE BENEFITS PLANS, INCLUDING EMPLOYEE HEALTH PLANS. ERISA PROVIDES FOR A COMPLETE FEDERAL PREEMPTION OF STATE LAWS THAT "RELATE TO" EMPLOYEE HEALTH PLANS. UNDER THE MCCARRAN-FERGUSON ACT, STATES RETAIN THE ABILITY TO REGULATE INSURANCE CARRIERS, SUCH AS INDEMNITY PLANS AND HEALTH MAINTENANCE ORGANIZATIONS. HOWEVER, STATES ARE POWERLESS TO REGULATE OR OTHERWISE AFFECT EMPLOYEE HEALTH PLANS THAT "SELF-INSURE" UNDER ERISA RATHER THAN BUY INSURANCE.

SELF-INSURANCE WAS VERY RARE WHEN ERISA WAS ENACTED, BUT IT NOW COVERS ALMOST HALF OF THE EMPLOYEES IN THE UNITED STATES WHO RECEIVE HEALTH BENEFITS. THIS PROLIFERATION OF SELF-INSURANCE, COUPLED WITH THE FEDERAL COURTS' BROAD INTERPRETATION OF THE REACH OF ERISA PREEMPTION, HAS MADE ERISA A FORMIDABLE BARRIER TO STATES WISHING TO IMPLEMENT CERTAIN HEALTH CARE REFORM.

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 A LEVEL PLAYING FIELD THROUGH PREMIUM TAXES ON SELF-INSURED PLANS; AND
- IMPOSING A LEVEL PLAYING FIELD THROUGH PROVIDER TAXES WHERE THE TAX IS INTERPRETED AS HAVING AN IMPERMISSIBLE DIRECT OR INDIRECT IMPACT ON SELF-INSURED PLANS.

7.2.1.1 STRATEGY FOR REFORM. A MULTIDIMENSIONAL APPROACH TO REFORM COULD BE TAKEN THAT INCLUDES FLEXIBILITY FOR STATES DIRECTLY IN THE ERISA STATUTE, AND THROUGH NEW WAIVER AUTHORITY.

ERISA Reforms

- STATUTORY FLEXIBILITY. CONGRESS MAY ACT QUICKLY TO HELP STATES BY INCLUDING FLEXIBILITY DIRECTLY IN STATUTE. THIS MAY BE ACCOMPLISHED THROUGH STATUTORY DIRECTIVES TO THE FEDERAL EXECUTIVE BRANCH REGARDING NATIONAL UNIFORMITY. SPECIFICALLY, A STATE WOULD BE PERMITTED TO IMPOSE REQUIREMENTS ON SELF-FUNDED PLANS IF THE STATE WAS WILLING EITHER TO ADOPT AND BUILD UPON MINIMUM NATIONAL STANDARDS OR WORK WITHIN SOME TYPE OF FEDERAL FRAMEWORK. THE FEDERAL EXECUTIVE BRANCH WOULD BE INSTRUCTED TO WORK WITH STATES TO IDENTIFY AND DEFINE THOSE STANDARDS.

Minimum national standards
· administrative simplification
· ins. reform

THIS APPROACH HAS THE POTENTIAL FOR BROAD APPLICABILITY BUT IS MOST RELEVANT TO ADMINISTRATIVE SIMPLIFICATIONS AND INSURANCE REFORM. FOR EXAMPLE, STATES AND THE BUSINESS COMMUNITY GENERALLY AGREE ON THE NEED FOR UNIFORM CLAIMS AND DATA REPORTING PROCEDURES. IN ORDER TO ENCOURAGE UNIFORMITY IN HEALTH PLAN ADMINISTRATIVE REQUIREMENTS, THE U.S. SECRETARY OF LABOR, IN CONSULTATION WITH THE U.S. SECRETARY OF HEALTH AND HUMAN SERVICES AND THE STATES, COULD BE DIRECTED TO COMPILE, PUBLISH, AND PUBLICIZE EXISTING NATIONAL STANDARDS FOR CLAIMS PROCESSING FORMATS AND PROCEDURES FOR DATA REPORTING. IF A STATE SELECTED ONE OF THE EXISTING STANDARDS, IT WOULD BE PERMITTED TO IMPLEMENT THAT STANDARD AND INCLUDE SELF-FUNDED PLANS. THIS TYPE OF DIRECTIVE ALSO COULD BE EXTENDED TO QUALITY AND UTILIZATION REVIEW PROCEDURES.

TO FACILITATE THE PROCESS, THE LEGISLATION SHOULD BE STRUCTURED TO RELY ON EXISTING NATIONAL STANDARDS. WHERE NONE EXIST, THE LEGISLATION COULD DIRECT THE EXECUTIVE BRANCH TO DEVELOP THEM. HOWEVER, IF THE EXECUTIVE BRANCH FINDS IT NECESSARY TO DEVELOP A NATIONAL STANDARD, STATES SHOULD BE GIVEN LIMITED FLEXIBILITY DURING THE DEVELOPMENT PERIOD SO THAT THEY CAN MOVE AHEAD WITH THEIR INNOVATIONS.

waiver authority
· financing
· cost control

- **WAIVER AUTHORITY.** IN ADDITION TO DIRECT STATUTORY FLEXIBILITY, CONGRESS SHOULD ESTABLISH DIRECT WAIVER AUTHORITY IN ERISA. WAIVER AUTHORITY WOULD BE MOST APPLICABLE FOR STATES THAT WISH TO DEVELOP ALTERNATIVE FINANCING AND COST-CONTROL STRATEGIES THAT ARE NOW PRECLUDED BY THE STATUTE. WAIVER AUTHORITY COULD HAVE THE FOLLOWING PARAMETERS.

  - THE SECRETARY OF THE U.S. DEPARTMENT OF LABOR WOULD HAVE THE AUTHORITY TO REVIEW AND GRANT ERISA WAIVERS.
  - THERE WOULD BE NO PROHIBITION AGAINST REPLICATING OTHER STATE ERISA WAIVERS. HOWEVER, EACH STATE WOULD HAVE TO SUBMIT A WAIVER APPLICATION.
  - WAIVERS WOULD BE APPROVED FOR AN INITIAL FIVE-YEAR PERIOD WITH FIVE-YEAR RENEWALS THEREAFTER.
  - WAIVER APPLICATIONS WOULD BE SUBMITTED BY THE GOVERNOR.
  - AS A CONDITION FOR WAIVER APPROVAL, THE STATE WOULD HAVE TO DEMONSTRATE THAT THE STRATEGY HAS THE SUPPORT OF THE STATE'S LEGISLATURE.
  - FOR STATES MAKING REQUESTS FOR EXEMPTIONS IN THE AREAS OF FINANCING OR COST CONTROL, THE STATE'S WAIVER APPLICATION WOULD HAVE TO INCLUDE A PLAN FOR EXPANDING COVERAGE AND A STRATEGY FOR DOCUMENTING THE STATE'S PROGRESS TOWARD ACHIEVING THAT GOAL.

· plan for expanding coverage

7.2.2 **THE HEALTH INSURANCE MARKET.** WITH THE ENACTMENT OF THE MCCARRAN-FERGUSON ACT IN THE 1930S, A STATE'S PREROGATIVE TO REGULATE HEALTH INSURERS HAS BEEN RECOGNIZED BY FEDERAL LAW.

HOWEVER, SINCE ERISA'S ENACTMENT IN 1974, THAT DELINEATION OF STATE AND FEDERAL RESPONSIBILITIES HAS BEEN BLURRED. ERISA PROVIDES THAT SELF-FUNDED SINGLE EMPLOYER OR TAFT-HARTLEY JOINTLY ADMINISTERED PLANS ARE EXEMPT FROM STATE REGULATION. STATES CANNOT ESTABLISH MINIMUM SOLVENCY AND CAPITAL REQUIREMENTS FOR THESE SELF-FUNDED PLANS. THEY CANNOT ENSURE THAT EMPLOYEES AND DEPENDENTS IN SELF-FUNDED PLANS RECEIVE THE BASIC CONSUMER PROTECTIONS THAT ARE OFFERED TO THOSE IN COMMERCIAL STATE-REGULATED PLANS; NOR CAN THEY ENSURE THAT THOSE IN SELF-FUNDED PLANS HAVE REMEDIES AVAILABLE WHEN PROBLEMS ARISE OVER COVERAGE DECISIONS AND OTHER MATTERS. STATES, ATTEMPTING TO MAKE THE PRIVATE INSURANCE MARKET MORE STABLE AND EQUITABLE, ARE PROHIBITED FROM IMPOSING GUARANTEED ISSUE OR LIMITATIONS ON PREEXISTING CONDITIONS EXCLUSIONS REQUIREMENTS ON SELF-FUNDED PLANS. AS SUCH PLANS PROLIFERATE, THEY REPRESENT A GROWING SHARE OF THE TOTAL HEALTH CARE MARKET AND GREATLY ERODE THE ABILITY OF STATES TO REGULATE THE PRIVATE HEALTH CARE MARKET. THE FEDERAL GOVERNMENT MUST ACT TO RECTIFY THE SITUATION.

THE NATION'S GOVERNORS CALL ON THE FEDERAL GOVERNMENT TO CORRECT THESE INEQUITIES BY ADOPTING ONE OR MORE OF THE FOLLOWING OPTIONS.

- CONGRESS SHOULD ESTABLISH NATIONAL HEALTH CARE STANDARDS FOR SELF-FUNDED PLANS THAT ARE SIMILAR TO THOSE IMPOSED BY STATES ON COMMERCIAL PLANS. IF CONGRESS IS UNWILLING TO DEFINE LEGISLATIVE STANDARDS IN ERISA, THE U.S. DEPARTMENT OF LABOR SHOULD BE GIVEN THE AUTHORITY TO DEVELOP REGULATIONS THAT, AT THE VERY LEAST, ESTABLISH ESSENTIAL CONSUMER PROTECTIONS AND REMEDIES STANDARDS FOR SELF-FUNDED PLANS.

nat'l standards for self-funded plans

- ANECDOTAL EVIDENCE SUGGESTS THAT CONSUMER PROTECTIONS PROBLEMS ARE MORE LIKELY TO ARISE IN SMALL SELF-FUNDED PLANS. CONGRESS COULD LIMIT SELF-FUNDING AUTHORITY TO BUSINESSES ABOVE A CERTAIN SIZE. BUSINESSES BELOW THAT LIMIT WOULD BE REQUIRED TO FOLLOW STATE LAWS. THE U.S. DEPARTMENT OF LABOR WOULD NEED TO ENFORCE STANDARDS FOR THOSE PLANS THAT REMAIN UNDER ITS JURISDICTION.

size limitations on self-funded plans

THE GOVERNORS ALSO SUPPORT STANDARDS THAT RESULT IN PORTABILITY OF COVERAGE, GUARANTEED RENEWABILITY OF POLICIES, LIMITATION ON BOTH MEDICAL UNDERWRITING AND PREEXISTING CONDITIONS EXCLUSIONS, AND OPPORTUNITIES FOR STATES TO ESTABLISH MEANINGFUL AND EQUITABLE RATING SYSTEMS.

IF CONGRESS CHOOSES TO SET MINIMUM NATIONAL STANDARDS, THEY SHOULD BE DEVELOPED WITH STATE OFFICIALS IN CONSULTATION WITH REPRESENTATIVES OF AFFECTED SMALL BUSINESSES, INSURERS, AND CONSUMERS.

7.2.3 **ACUTE CARE SERVICES FOR LOW-INCOME INDIVIDUALS AND FAMILIES.** IRRESPECTIVE OF THE HEALTH CARE REFORM STRATEGY, A PUBLIC SECTOR ROLE WILL REMAIN IN THE FINANCING AND DELIVERY OF SERVICES TO THE POOR, THE ELDERLY, AND PEOPLE WITH DISABILITIES. THE MEDICAID PROGRAM IS THE VEHICLE CURRENTLY USED TO FINANCE SUCH CARE. TODAY, MEDICAID STRUGGLES TO SERVE A WIDELY DIVERSE POPULATION WITH A BROAD ARRAY OF SERVICES. IT IS NOT ONLY DIFFICULT TO EFFECTIVELY ADMINISTER, BUT ALSO PROHIBITIVELY EXPENSIVE.

Medicaid

THE GOVERNORS BELIEVE THAT THE MEDICAID SYSTEM HAS BECOME A RIGID AND OVERLY COMPLEX PROGRAM. ITS BIAS TOWARD INSTITUTIONAL CARE PREVENTS STATES FROM PROVIDING PREVENTIVE AND PRIMARY CARE IN SETTINGS MOST APPROPRIATE FOR ITS BENEFICIARIES, AND ELIGIBILITY FOR THE PROGRAM IS DOMINATED BY ARCANE RULES THAT PENALIZE ALL WHO INTERACT WITH IT.

THEREFORE, THE GOVERNORS ENVISION A STRATEGY THAT WOULD ALLOW THE STATES TO MANAGE PUBLIC RESOURCES IN A MORE EFFICIENT AND EFFECTIVE MANNER THAN IS CURRENTLY POSSIBLE THROUGH MEDICAID.

7.2.3.1 **PROGRAM STRUCTURE.** MANY STATES BELIEVE THEY CAN MAKE BETTER USE OF THEIR MEDICAID DOLLARS BY RESTRUCTURING THEIR MEDICAID PROGRAMS. SPECIFICALLY, SOME STATES WOULD RATHER OFFER A CORE BENEFITS PACKAGE TO LOW-INCOME PEOPLE WITHOUT TYING THE PROGRAM TO ELIGIBILITY FOR CATEGORICAL PROGRAMS. THIS MAY BE A BETTER APPROACH THAN THE CURRENT MEDICAID STRUCTURE, WHICH PROVIDES A VERY COMPREHENSIVE PACKAGE TO THOSE WHO ARE CATEGORICALLY ELIGIBLE, BUT LEAVES MANY LOW-INCOME PEOPLE WITHOUT ANY INSURANCE AT ALL. IN

broader coverage w/ core package

ADDITION, SOME STATES WOULD LIKE TO OFFER SLIDING SCALE SUBSIDIES SO THAT LOW-INCOME PEOPLE CAN PURCHASE HEALTH INSURANCE ACCORDING TO THEIR ABILITY TO PAY. THE FEDERAL GOVERNMENT SHOULD ENCOURAGE THESE INNOVATIONS.

7.2.3.2 ENTITLEMENTS AND FINANCING. STATES AND THE FEDERAL GOVERNMENT SHOULD SHARE IN FINANCING THIS PROGRAM. STATES SHOULD BE GIVEN THE OPTION TO OPERATE THIS PROGRAM AS AN INDIVIDUAL ENTITLEMENT OR AS AN ENTITLEMENT TO STATES. AS AN INDIVIDUAL ENTITLEMENT, THE PROGRAM WOULD OPERATE IN A MANNER SIMILAR TO THE CURRENT MEDICAID PROGRAM AND ANYONE QUALIFYING FOR THE PROGRAM WOULD HAVE TO BE SERVED.

AS AN ENTITLEMENT TO STATES, THE FEDERAL GOVERNMENT'S FINANCIAL EXPOSURE WOULD BE ESTABLISHED BY AN UPPER LIMIT ON AVAILABLE FEDERAL DOLLARS. STATE CONTRIBUTIONS TO THIS PROGRAM ALSO WOULD BE LIMITED BY THE FEDERAL UPPER LIMIT. IN OPERATING IT AS AN ENTITLEMENT TO STATES, INDIVIDUALS COULD QUALIFY FOR THE PROGRAM; HOWEVER, PARTICIPATION WOULD BE LIMITED BY AVAILABLE STATE AND FEDERAL FUNDS.

STATES COULD NOT OPERATE THESE PROGRAMS WITH FUNDS THAT ARE SUBJECT TO ANNUAL FEDERAL APPROPRIATIONS. RATHER, THE FINANCING STRUCTURE SHOULD APPEAR IN STATUTE AND BE TREATED AS A PERMANENT APPROPRIATION.

7.2.3.3 STATUTORY CHANGES TO THE SOCIAL SECURITY ACT. 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 SECTION 1115(A) OF THE SOCIAL SECURITY ACT. SECTION 1115(A), 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 1115(A) 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 1115(A) IS ESSENTIAL TO ENSURE THE TESTING OF ALTERNATIVE HEALTH AND SOCIAL POLICIES.

HOWEVER, THE CURRENT STATUTE FALLS SHORT BY REQUIRING STATES WHO WANT TO CONTINUE A SUCCESSFUL EFFORT TO CONTINUALLY REAPPLY FOR AND RENEW THEIR WAIVERS. IN SHORT, ONCE A STATE HAS PROVEN THAT ITS RESEARCH PROJECT WORKS, IT CANNOT CONTINUE WITHOUT PURSUING DEMONSTRATION GOALS AND WAIVER RENEWALS FOR A PROGRAMMATIC EFFORT OR WITHOUT SPECIAL TREATMENT IN FEDERAL LAWS UNDERTAKEN BY CONGRESS. EXISTING SECTION 1115(A) WAIVERS SHOULD BE GRANDFATHERED INTO THIS NEW SYSTEM.

THE GOVERNORS SUPPORT CHANGES TO THE SOCIAL SECURITY ACT TO PERMIT THESE TYPES OF PROGRAMS TO BE APPROVED IN A MANNER SIMILAR TO THE "PLAN AMENDMENT PROCESS" UNDER MEDICAID, WHERE THE STATE DESCRIBES THE PLAN AND, ONCE APPROVED, IT BECOMES A PERMANENT PROGRAM SUBJECT TO ROUTINE FEDERAL OVERSIGHT. IF THIS STRATEGY IS NOT CHOSEN, THE WAIVER APPLICATION PROCESS MUST BE STREAMLINED, THERE MUST BE NO RESEARCH AND DEMONSTRATION REQUIREMENTS, AND THE WAIVERS MUST BE APPROVED FOR FIVE YEARS AND BE RENEWABLE NO LESS THAN EVERY FIVE YEARS. MOREOVER, THE EXECUTIVE BRANCH MUST BE INSTRUCTED TO STREAMLINE THE WAIVER OVERSIGHT PROCESS AND SHORTEN REVIEW AND APPROVAL PERIODS.

7.2.4 MEDICAL TORT REFORM. REFORM OF THE MEDICAL TORT SYSTEM SHOULD BE UNDERTAKEN WITH A VIEW TOWARD ACHIEVING HIGH-QUALITY AND APPROPRIATE CARE. IDEALLY, THE MEDICAL TORT REFORM WILL REDUCE THE COST OF DEFENSIVE MEDICINE AND PROVIDE APPROPRIATE LEVELS OF COMPENSATION FOR PATIENTS INJURED BY MEDICAL NEGLIGENCE. TOWARD THAT END, THE FEDERAL GOVERNMENT SHOULD ESTABLISH NATIONAL MINIMUM TORT AND LIABILITY STANDARDS. STATES COULD ESTABLISH MORE RESTRICTIVE STANDARDS IF THEY SO CHOOSE. THE FEDERAL GOVERNMENT, WORKING WITH STATES, ALSO MUST CONSIDER ALTERNATIVE DISPUTE

RESOLUTION STRATEGIES THAT COULD BE USED TO REDUCE THE COSTS OF LITIGATION.

7.2.5 **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. CONGRESS AND THE ADMINISTRATION MUST WORK WITH THE STATES TO ACCOMMODATE THIS NEW HEALTH CARE ENVIRONMENT WHILE ENSURING THAT COMPETITION REMAINS IN THE MARKETPLACE.

7.2.6 **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. THE FEDERAL GOVERNMENT AND THE STATES MUST COOPERATE IN THE DEVELOPMENT AND IMPLEMENTATION OF SUCH STANDARDS.

7.2.7 **ADMINISTRATIVE SIMPLIFICATIONS.** THE ADMINISTRATIVE COMPLEXITY OF THE CURRENT SYSTEM MUST BE REDUCED. THE NATION MUST MOVE TOWARD UNIFORM CLAIMS FORMS AND UNIFORM STANDARDS FOR ELECTRONIC DATA INTERCHANGE.

7.2.8 **PUBLIC SECTOR HEALTH CARE DELIVERY.** ALTHOUGH THE GOVERNORS SUPPORT THE DELIVERY OF CARE THROUGH THE PRIVATE HEALTH CARE SYSTEM, THERE ARE SOME AREAS IN THE COUNTRY THAT HAVE AN INADEQUATE NUMBER OF HEALTH CARE PROVIDERS OR SERVICES. IN OTHER AREAS, THE PRIVATE SYSTEM DOES NOT PROVIDE SERVICES TO LOW-INCOME INDIVIDUALS AND FAMILIES, AND THESE PEOPLE SEEK CARE THROUGH PUBLIC CLINICS. IN THESE CIRCUMSTANCES, FEDERAL AND STATE GOVERNMENTS HAVE PROVIDED FOR THE DELIVERY OF PERSONAL HEALTH CARE SERVICES. THE GOVERNORS BELIEVE THAT THIS PUBLIC HEALTH CARE SYSTEM SHOULD BE CONSIDERED IN ANY BUDGET STRATEGY AND COORDINATED WITH THE PRIVATE HEALTH CARE SECTOR, WHEREVER POSSIBLE.

7.2.9 **ENHANCE OPPORTUNITIES FOR PRIMARY CARE PRACTICE.** THE MEDICAL EDUCATION SYSTEM IS NOT PREPARING THE PROVIDERS THAT ARE NEEDED FOR

A HEALTH CARE SYSTEM WITH A FOCUS ON PREVENTIVE AND PRIMARY CARE. STATES ARE CURRENTLY EXPERIMENTING WITH A WIDE VARIETY OF INITIATIVES THAT ADDRESS THE CRITICAL ISSUE OF INCREASING PRIMARY CARE PRACTICE, ESPECIALLY IN RURAL AND URBAN MEDICALLY UNDERSERVED AREAS. THESE INITIATIVES INCLUDE DATA COLLECTION TO BETTER UNDERSTAND THE DISTRIBUTION OF, AND NEED FOR, PROVIDERS IN SPECIFIC LOCATIONS; LOAN REPAYMENT PROGRAMS TO PRACTITIONERS WHO PRACTICE IN UNDERSERVED AREAS; AND TECHNICAL ASSISTANCE PROGRAMS TO ENHANCE PRIMARY CARE DELIVERY SYSTEMS IN UNDERSERVED LOCATIONS.

THEREFORE, THE GOVERNORS RECOMMEND THAT THE FEDERAL GOVERNMENT RECOGNIZE, REVIEW, AND SUPPORT PROGRAMS CURRENTLY UNDERWAY IN STATES THAT ARE SUCCESSFULLY ADDRESSING THE ISSUE OF INCREASING AND PRESERVING ACCESS TO PRIMARY CARE PHYSICIANS IN MEDICALLY UNDERSERVED AND RURAL AREAS. MOREOVER, THE GOVERNORS RECOMMEND THAT THE FEDERAL GOVERNMENT PROVIDE INCENTIVES FOR STUDENTS, PHYSICIANS, AND MID-LEVEL HEALTH PROFESSIONALS TO SERVE IN PRIMARY CARE PROFESSIONS, PARTICULARLY IN RURAL AND UNDERSERVED AREAS.

7.3 CONCLUSION

IN MANY STATES, GOVERNORS HAVE BEGUN TO MEET THE CHALLENGE OF REFORMING THEIR HEALTH CARE SYSTEM AND ARE BEGINNING TO LEARN ABOUT THE SUCCESSES AND FAILURES. THE FEDERAL GOVERNMENT SHOULD SUPPORT STATES AS THEY DEMONSTRATE DIFFERENT APPROACHES TO ACHIEVE UNIVERSAL ACCESS TO AFFORDABLE HEALTH CARE AND SHOULD EVALUATE CREATIVE COMPREHENSIVE APPROACHES TO HEALTH CARE REFORM.

Time limited (effective Winter Meeting 1995-Winter Meeting 1997).

~~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.~~

~~*Adopted February 1994.*~~