file: NGA Winter meeting CHR FG1

THE WHITE HOUSE

Office of the Press Secretary

For Immediate Release February 1, 1993

REMARKS BY THE PRESIDENT
DURING PHOTO OPPORTUNITY WITH GOVERNORS
AFTER HEALTH CARE POLICY MEETING

The East Room

11:23 A.M. EST

PRESIDENT CLINTON: Well, I want to say good morning to the members of the press who are here from Washington, and many of you from around the nation.

I'd like to read a statement and then call on the Governors Romer and Campbell to make a statement about the meeting we had here today and the actions which I will take today as a result of this meeting and the work that I have been doing over the last couple of months.

The day before my inauguration, on one of the last days people called me Governor, I had lunch with many of the governors here and many others with whom I have served over the past 14 years. I pledged to them a partnership between the country's governors and this administration, rooted in our common experience on the front lines of people's lives.

I've told my friends, my colleagues, that the one thing I hoped that I could actually demand from them was a commitment to keep me rooted in that common experience, and the real problems of real people. The White House, after all, only works when it is the people's house.

Today we have continued our partnership in earnest. We agreed to challenge together the one obstacle that could keep us from success in virtually every arena of national endeavor: the twin monsters of spiraling health care costs and the agony of having no access to health care, no health care coverage, or living in fear of losing it.

Left unaddressed, the health care crisis has had devastating impacts on families, businesses, the fiscal conditions of state and local government and the economic performance of the United States. For 12 years our national government has ignored the problem, partisan gridlock has prevented action and Americans are paying the price.

The amount we spend on health care has more than tripled. Now we spend far more than any other nation on Earth -- about 30 percent more of our income -- and we get less for it.

We send American companies out into the world with this 30 percent handicap simply because of high health care costs. The average American car alone includes over $1,000 in health care costs -- twice as much as its Japanese competitor. You know as well as I do that the real people of this country are paying the price -- working families who live in fear of losing their insurance; small businesses who have to choose between dropping coverage or going broke; state and local governments who have to balance their books

every year and are now choosing between cutting education, raising taxes or cutting other needed investments just to pay more for the same health care bills.

If every person striving to overcome this challenge will bring to that work the same depth of drive and determination that our nation's governors have brought to the White House today with their policy position, the American people will have the commitment it takes to solve this problem.

This meeting was a model of everything I want my relationship with our governors to be. It wasn't scripted or staged, it was simply an honest discussion where real work was done, real opinions were argued and a room filled with women and men who left their partisan banners outside the door. And in that spirit and what I hope is the first of a series of announcements we will make together, I want to announce that I am taking the following steps to help them meet the health care needs of their people in their states.

For years the nation's governors have been arguing that the process through which waivers from the Medicaid mandates impose on them by the federal government is Byzantine and counterproductive. They are right.

I have today directed the Department of Health and Human Services and its health care financing agency to take immediately a series of actions designed to streamline the Medicaid waiver process to enable the states of our country to serve more people at lower costs. These include a requirement that from now on the health care financing agency and its regional centers will have only one opportunity to ask for additional information and clarifications on states' waiver requests. I also want the health care financing agency to examine the development of a list of standard initiatives for automatic approval for state action.

In consultation with the National Governors Association, I want a rapid review of the entire waiver request process that produces a list of additional streamlining recommendations within 60 days. And I am directing the health care financing agency to reopen negotiations with the National Governors Association to issue new regulations to how they can use provider taxes and disproportionate share reimbursement to meet the needs of the people in their state.

Finally, I am directing the Department of Health and Human Services to conduct a similar review of the non-Medicaid waiver submissions not addressed in the matters I have just discussed.

I'm also happy to announce that Hillary and the leadership of the National Governors Association have agreed on a formal process for the governors to have input into the Health Care Task Force. Their input, their advise, their perspective is essential to our success. When all this is said and done, the health care problems of this country can only be met if we have a good partnership.

And for those of you in the press and the general public who may not understand all the language that I have used about Medicaid and waivers, if I could put it in simple terms, it amounts to this. The federal government requires the states to provide a certain number of health services in a certain way to people who are poor enough to qualify for Medicaid. The states very often believe that they can provide more services at lower cost if we don't impose our rules and regulations on them.

For years and years and years, governors have been screaming for relief from the cumbersome process by which the federal government has micromanaged the health care system affecting poor Americans. We are going to try to give them that relief so that for

lower costs we can do more good for more people. This will be one big step on a long road to giving this country the kind of health care system it needs. (Applause.)

Governor Romer.

GOVERNOR ROMER: We have had a very fruitful, over two hours of discussion. And I speak for both Republican and Democratic governors and the two independents when I say that this issue of flexibility on the waiver process has been critical to us, and the prompt response of this administration to give us more flexibility, give us more certainty, give us quicker deadlines will simply help us to do our job better.

Now, in addition to the short-term measures, we've had some extensive discussion about what kind of long-term health care reform we need to do together. There is an acknowledgement it has to be a partnership between the federal and the state government. There's an acknowledgement there that we have made a good start -- the Governors Association will have on its agenda in the next few hours some measures relating to cooperation with this administration on managed care. And if you have further questions about that, we'll be available out on the lawn very shortly.

And I want to say in closing that we've had a very strong bipartisan approach in the Governors Association. And I want to compliment Governor Campbell and his colleagues for working with the Democrats in the Governors Association and this administration. We know that we need to solve this problem on a bipartisan basis, and I think we made a very good start here this morning. Thank you.

GOVERNOR CAMPBELL: Mr. President, we appreciate the opportunity to work with you in a bipartisan sense to find an answer to some of the problems that are really driving the states' costs to the point that we cannot fund the programs that we need to fund. The cost shifting away from such important items as education to fund rising medical costs are, of course, driving all of our states.

We all realize that it is a difficult program and, quite frankly, that it probably cannot be solved in short order. But we're willing to roll up our sleeves and go to work with you and try to find those answers. We recognize the need to get the small employers into a position that they have access to groups and lower cost insurance for their employees. We recognize the need to go into preventive care. We know that there is a problem with the preventive care aspect in that the liability costs and the cost of doing this in the private sector are, in fact, prohibitive.

I would think that after our discussion the opportunity may exist for us to look at the immunization side of preventive care from a joint national framework in order to meet some of these needs, much as we would do if we did a crash program for any country that was in need that we were aiding, doing it for ourselves.

I believe that, working together, we can, in fact, find some answers. We know that there has to be competition. We believe in managed competition. We also believe that there has to be a structure that lets people have access to primary care physicians instead of just the emergency rooms for their care because of the cost factor, as well as the fact that it's not a preventive type of program.

So we, as members of the National Governors Association look forward to continuing this work with you and continuing to work with Hillary and her task force, because we think that, working together that we will find answers.

And in closing, let me just add my thanks to your willingness to expedite the waiver process and to deal with some of

the problems that have been so vexing for us as governors as we've tried to deal with this overall problem. We appreciate it.

PRESIDENT CLINTON: That's our statement. I know a lot of you here want to take pictures of your governors, so have at it.

Governor King, of all of the people of America, they know you from behind as well as from the front. But turn around -- I think you ought to turn around. How about giving them a profile, at least -- that sort of tough Western profile? (Laughter.)

Thank you all very much.

END 11:34 A.M. EST

NATIONAL GOVERNORS' ASSOCIATION

Roy Romer
Governor of Colorado
Chairman

Carroll A. Campbell Jr.
Governor of South Carolina
Vice Chairman

Raymond C. Scheppach
Executive Director

Hall of the States
444 North Capitol Street
Washington, D.C. 20001-1572
Telephone (202) 624-5300

IMMEDIATE ASSISTANCE TO THE MEDICAID PROGRAM

Rapidly rising Medicaid costs are breaking states' budgets. Without changes in federal law and regulation to allow cost containment in some Medicaid programs, increased flexibility in financing and implementing programs, and financial assistance from the federal government, many states cannot afford to stay in compliance with federal laws and millions of people stand to lose important services.

Governors know that, once adopted and implemented, national health reform may change or replace the current Medicaid program. However, until health reforms are in place, states must have cooperation and assistance from the federal government.

Through the National Governors' Association, Governors sent President Clinton a list of recommendations for changes in federal laws and policies to improve access and contain costs in the Medicaid program. From that rather lengthy list, the Governors recommend several priorities for immediate action by the President, the Congress, and the U.S. Department of Health and Human Services (HHS). Action on the following priorities can have a positive impact on state Medicaid budgets and accomplish overall cost containment without limiting access or reducing quality of services:

1. **No caps for federal spending on Medicaid entitlements until another health financing system is in place.**

   Federal caps on medical entitlements will not cut health care costs or reduce people's need for health services. Such caps will shift costs to state and local governments that they simply cannot afford. Capping federal Medicaid entitlements will result in a loss of services for millions of people and will shift additional costs to people with private insurance.

2. **Give greater leeway in containing the cost of health services and long-term care through issuing rules for the Boren Amendment.**

   The Boren Amendment was intended originally to allow states to contain costs for hospital and nursing home services. Because no rules were issued to guide states in implementing the law, hospitals and nursing homes sued states, and courts have interpreted the law in a manner that drives up health care costs significantly. HHS needs to issue rules for the Boren Amendment as soon as possible. In addition, legislative revisions need to be reviewed and strongly considered.

3. **Allow states to manage costs in the EPSDT program through providing services within their state Medicaid plan and selecting less costly alternatives for diagnosis and treatment without risking quality.**

   Under current policy, states have no ability to limit the range or cost of services required in the EPSDT program. This open-ended requirement is driving up the cost of the Medicaid budget at uncontrollable rates. 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.

4. **Provide fairness and flexibility in the Disproportionate Share Hospital (DSH) Program through rules and laws that will:**

   a. Modify the interpretation of the statute to allow for growth in low-DSH states without penalizing high-DSH states.
   b. Ease restrictions on how states raise matching funds for the Disproportionate Share Hospital Program.
   c. Give states flexibility to use disproportionate share funds in whatever way best fits the needs in serving Medicaid-eligible and other medically indigent people in their state.

   When caps were set for spending on the Disproportionate Share Hospital Program, some states' share in the program was frozen at rates below the maximum spending level set for each state. Fairness requires that these low-DSH states be allowed to move up to the level of the cap for states without penalizing high-DSH states that are already at or near the cap.

   Different revenue-raising measures are chosen by different states, and the federal government should not dictate to state governments how they raise their matching funds for the Medicaid program.

   By allowing states to spend disproportionate share funds in whatever way will serve the most Medicaid-eligible and other medically indigent people in each state, the disproportionate share funds can be used to cover the unmet needs of the greatest number of people. The federal government can give states flexibility in using disproportionate share funds without increasing demands on the federal budget, and the flexibility will allow each state to make the best use of these dollars.

   The Governors recognize the Administration is already proceeding on these and other issues relating to provider taxes and disproportionate share. We applaud this work.

5. **Provide waivers to encourage or provide incentives to states to use in-home and community-based services for elderly and disabled people as a means of containing long-term care costs and providing the most appropriate services.**

   Medicaid laws and regulations favor institutional care by paying for services when a person is in a hospital or nursing home that would not be paid for if the person lived at home or in a community-based program. More people can be served for less money in non-institutional settings, and in-home and community-based services allow people to gain or maintain greater independence. HHS needs to expedite waivers that allow states to serve people outside of hospitals or nursing homes and to develop incentives for states to contain costs through increasing in-home and community services when this is in the best interest of the person served.

6. **Expedite the waiver process so states can implement managed care systems, comprehensive demonstration projects, and limited Medicaid services in school-linked clinics.**

   Delays in getting waivers from HCFA have curtailed states' efforts to implement managed care as a means of cost containment and improved access. Waivers also have been delayed or denied for large demonstration projects attempting to set up comprehensive, integrated health care systems in states. School-linked clinics can offer improved access to health services at relatively low costs, and these clinics need to be Medicaid approved even if they do not offer the full range of services available in Medicaid community primary care clinics. HHS needs to respond quickly to waiver requests and to favor requests that will improve access to health care and contain costs.

Adopted February 1, 1993.

NATIONAL GOVERNORS' ASSOCIATION

Roy Romer
Governor of Colorado
Chairman

Carroll A. Campbell Jr.
Governor of South Carolina
Vice Chairman

Raymond C. Scheppach
Executive Director

Hall of the States
444 North Capitol Street
Washington, D.C. 20001-1572
Telephone (202) 624-5300

NATIONAL HEALTH REFORM AND COST CONTAINMENT

1. Introduction

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

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

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

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

2. Basic Federal Framework

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

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

- **Universal access.** Universal access to health care coverage should be guaranteed to every American. States should have the option of providing access to health care either through public or private programs or through an employer mandated system similar to those pursued in Kentucky, Oregon, and Hawaii.
- **A standardized and federally organized information base for consumers.** The database must include price and quality information for all providers of health care services in a given geographic area.
- **Federally organized national outcomes research.** One component of such research should focus on primary and preventive care. Among other uses, this research could be used as a basis for clinical practice models.
- **Federal minimum standards for the regulation of health insurance.** These minimum standards must be developed in consultation with states and include limitations on the variation in rates that different individuals and groups charge; limitations on medical underwriting; and guaranteed renewability, portability, and availability of insurance products. States can exceed these minimum standards. These standards should apply to nontraditional insurance mechanisms, such as Multiple Employee Welfare Arrangements (MEWAs) and other ERISA plans,

and to newly formed Health Insurance Purchasing Cooperatives. Once reforms are implemented, individuals bear a personal responsibility to obtain coverage either through public or private programs. The cost of coverage would be supplemented for low-income individuals.

- **State-organized purchasing cooperatives.** Through purchasing cooperatives, affordable insurance products will be made available. States and the federal government must work together to ensure that states have flexibility in establishing and operating purchasing cooperatives within a national framework. Purchasing cooperatives should allow for public or private operation under state regulation.
- **Tort and liability reform standards.** Tort and liability standards for health care should be developed by the federal government. However, states must have the flexibility to design and regulate their own programs that meet the federal standards or further limit liability.
- **A single national claims form.** The federal government, in consultation with states, must develop a single claims form and support the development of electronic billing as a means to reduce administrative costs. A single electronic claims form system will simplify the administrative procedures for all health care participants, including hospitals, physicians, insurers, employers, government, and consumers.
- **Core benefits package.** The federal government, in consultation with states, localities, businesses, and labor organizations, must develop a core benefits package comparable to those now provided by the most efficient and cost-effective health maintenance organizations. There may be some state or regional variations in the basic benefit package, but such variations must be certified by a national health care board. Individuals would be free to purchase additional insurance with after-tax dollars. This package could be adjusted as additional information from outcomes research becomes available.
- **Limitations on tax deductibility of health insurance.** The federal tax code must be amended to limit the tax deduction/exemption of health insurance for both employers and employees. Employer-paid insurance above the limit would be taxable to either the employer or employee. The self-employed would be eligible to purchase fully deductible health insurance -- exempt from taxation as personal income -- within the federal limit and/or tied to a percentage of an income level. This limit may be tied to the local cost of a basic benefit package and set at a specific dollar amount. Additional coverage or care can be purchased with after-tax dollars.
- **Primary and preventive care.** The federal government must greatly expand its support for primary and preventive care including, but not limited to, periodic health screenings, prenatal care, well-baby care, and childhood immunizations.

3. Specific Cost Containment Strategies

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

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

- Goals for the growth of national health care expenditures should be established for expenditures that are publicly supported either directly or through the tax code. Health care expenditures made by individuals with after-tax dollars would not be included in the targets. The national goals should be used to estimate expenditure targets for each state.
- Data systems necessary to objectively measure national and state health care expenditures must be established.
- As data become available, there should be a review of the progress the federal and state governments have made toward achieving the national expenditure goals.

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

4. State and Local Management

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

- States wishing to undertake reforms which complement the federal framework described above and which are aimed at significantly expanding access to health care and controlling health care costs should be encouraged to move ahead in advance of full implementation of national reforms and should be given the tools necessary to be successful. For example, Governors encourage prompt approval of the Oregon waiver request.
- Assuming that there still is a public program, even if that public program is modeled after Medicaid, state and local governments will need stable financing and a uniform definition of eligibility. Beyond that, however, state and local governments must be given the flexibility and authority to fully integrate the public program into a service delivery system that reflects the national movement toward managed care. The federal government must not impose mandates beyond the core benefits or service delivery restrictions on the public program. A streamlined and efficient public program will obviate the need for the complex and costly waiver process.
- If Medicare continues to exist as a separate program, state and local governments will need the flexibility to fully integrate Medicare into their health care systems.
- States must have the ability to include the current self-insured market (ERISA plans) in their state design.
- States must have additional authority now precluded by federal anti-trust statutes.

5. Additional Federal/State Issues

- The federal government must participate in a discussion about how to deal with the access issues of rural areas, inner cities, and populations currently financed by federal programs, including Native Americans, veterans, and dependents of military personnel. The federal government also must participate in discussions about the provision of care to undocumented aliens.
- The federal government must reaffirm the traditional role of public health programs including epidemiology, environmental health, and disease prevention while integrating primary and preventive care services into the core benefits package to the extent possible. Adequate federal resources and technical assistance must be provided to ensure that the public health needs of states and communities can be met.
- Federal, state, and local governments must work toward agreement on a long-term care program that recognizes the need for different levels of care and support either within or outside a health care institution.

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

Time limited (effective February 1993-February 1995).

Adopted February 1, 1993.