~~CONFIDENTIAL~~

May 17, 1993

MEMORANDUM TO CAROL RASCO

FROM: Bruce Vladeck

SUBJECT: Negotiations with States on Health Care Reform

As we discussed, I thought it might be useful for me to attempt to organize my thoughts on federal-state relations under Health Care Reform as you move forward with the process of negotiations with the states. I do this from the perspective of someone who, as you know, has recently spent a great deal of time in negotiations with NGA and individual states, and in conversations with Medicaid Directors, and as a former state official myself. I also do so because I am concerned that the issues in federal-state relations under Health Care Reform are sufficiently numerous, complex, and interrelated that it might be useful just to list them all (or almost all) in one place.

In general, there are four sets of issues that need to be addressed more or less simultaneously. These might be described as: Federal Subsidies and Fiscal Relief for the States; State Responsibilities for Global Budgets; Division of Labor on Health Systems Management and Governance; and the Boundaries of State Flexibility. Let me discuss each in turn.

Federal Subsidies and Fiscal Relief for the States

As I understand the current thinking about the phasing-in of the states into Health Care Reform, there is no immediate fiscal relief for the states, except for some modest "incentives" for those that agree to early implementation. To be sure, we are able to promise the governors that, after full implementation, their

costs for that part of Medicaid that will be folded into the alliances can be expected to grow no more quickly, per capita, than anyone else's; given recent rates of increase in Medicaid spending, that could represent significant savings in the long term. But the states still appear to be almost entirely on the hook for expense growth for all "out of plan" expenditures for all Medicaid's chronic care populations, including the frail elderly, the non-elderly disabled, the developmentally disabled, and the HIV-infected. All of those populations, of course, are expected to grow in number in the foreseeable future. Medicaid directors are especially concerned that the health plans will seek to shift as many costs as possible for those "residual" populations to them (just as Medicare now does with the elderly long-term care population), and preventing that kind of cost-shifting will be extremely difficult to do.

I know that it has been suggested that the inflation of state Medicaid expenditures by provider tax and donation and intergovernmental transfer schemes will provide those states with an inflated base for purposes of calculating "maintenance of effort" levels, thus effectively hoisting the states on their own petards. But there is a serious problem here. As you know, the states turned to such arrangements because they could find no other ways to raise the money to meet their existing Medicaid obligations. Not only are we proposing to maintain those obligations, and increase them over time for "residual" populations, but we have also talked about constraining their ability to use provider tax or similar arrangements - in part because we want to reserve provider tax revenues for financing what would otherwise be the federal share of coverage expansion of the uninsured and underinsured.

In short, unless I'm unaware of something, I don't think we're in a position to put very much on the table financially for the states. Perhaps that is why some of the governors now seem to be eyeing the Medicare trust funds.

Global Budgets

As I understand the current thinking, states will be **entirely at risk** for any spending (other than Medicare) in excess of what appear likely to be reasonably stringent global budget caps, while they are able to "share" some proportion of the savings. Frankly, I don't know why any governor would want to take that deal. The

equation gets significantly worse if there is some effort to move, over time, to some equalization of per capita spending across states. Under those circumstance, half the states, by definition, would have to enforce budget caps involving growth rates below the national average.

As a practical matter, enforcement of the global budget caps on the states is likely to involve protracted back-and-forth between the federal government and the states, requiring some kind of administrative due process proceedings, undoubtedly followed by extensive negotiation, efforts to induce Congressional interventions, and litigation - none of which is likely to foster or contribute to a friendly and productive partnership.

Further, it seems likely to me that states that exceed budget caps, and don't escape federal enforcement of those caps, are likely to seek to pass the entire risk onto those payors who can't escape the shift; to wit, small and medium-sized employers, and all public employers. The political scenarios that might ensue are worrisome.

I might also point out that no state has ever done anything remotely like this before. Most of the economic modelling appears to assume that the states will be completely successful at implementation of the global budget their first year of full implementation. I think that might be a big leap.

Health Systems Management and Governance

Obviously, there is much to be said for implementing health care reform largely through the states, but I'm not sure our expectations of either the willingness or capacity of most states to perform all the tasks they will be assigned is entirely realistic. We have already concluded, within HHS, that much of the data collection, editing, compilation, and analysis that will be necessary for this extremely data-intensive system will need to be carried out at the federal level, if past experience with MMIS or the Cooperative Health Data Systems program is any guide. Similarly, the experience in state implementation of federally-defined regulatory programs when they are not accompanied by significant additional federal resources is decidedly mixed. Assuring adequate implementation in all states of such programs may be especially problematic when there is a particular federal interest in assuring access to services for low-income people and

minorities. Again, the experience with Medicaid is a relevant, if not entirely parallel, analogy.

Within HHS, as you might imagine, we are particularly concerned with the issue of determining income eligibility for subsidies of one sort or another. This is certainly not a role the states are seeking, and it would pose considerable problems for them; at the same time, however, it would not appear to make a lot of sense to set up an entirely separate new eligibility-determination process for low-income people.

As far as I know, we have not really dealt with the issue of what to do in those states that can't perform their assigned roles, or simply refuse to do so. We have talked about various financial sanctions, followed in the extreme case by federal "trusteeship" or "receivership," but it seems to me that, rather than creating a real division of labor between state and federal governments, we are giving the states most of the hard work, and planning to punish them if they don't do it well.

State Flexibility

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In addition, I'm sure that the Congress will require (if we don't anyway) that every citizen be offered the option of at least one fee-for-service health plan.

A skeptical governor might ask, "What's left to be flexible about?" To again make a rough analogy, that's substantially less flexibility than states now have in administering the Medicaid program, and I know how they feel about that.

Unless our promises of state flexibility are to be merely a concession to single-payor advocates, I think we need to do some very hard (and quick) thinking about just what it is we are prepared to be flexible about, and what we can't be, and I think we need to communicate that to the governors at the earliest possible point in negotiations.

More generally, I would urge that we establish a process to think a little more strategically about how we envision state-federal relations, in general, operating under health care reform. While we may find plausible resolutions for each of the specific issues I (or anyone else) might raise, these issues do interact with one another, and I would personally argue for a more comprehensive strategy.

In summary, if it's true that health care reform is going to be the largest domestic policy initiative in American history, it's certainly also true that it will be the largest experiment in federal-state relations we've ever tried. Obviously, the senior officials in this Administration are extremely experienced in the whole range of issues involving federal-state relations, but I'm not sure they have yet directly joined the whole range of issues with a really representative group of governors. We need to do that as soon as possible.

I hope this has been helpful to your thinking. Please let me know what other assistance we can provide.

cc.: Secretary Shalala
Kevin Thurm
Ira Magaziner
Judy Feder
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CONCERNS OVER A WAGE BASED PREMIUM

1) Although the mandate would be implemented at the federal level, the actual level of the rate could be set by the alliance or the state. Most Governors would be concerned over different rates for different alliances and, thus, would likely set one rate for the entire state. Given this, they could be viewed politically as the individual who is setting the rate. The politics of this from a state perspective are not good.

2) A wage based premium would force everyone into the alliance and therefore can be viewed as a single payer system in the disguise of managed competition. Also, because the rate would be set for the entire state, it is likely that states would move toward one large alliance for the entire state. This may be difficult to implement effectively in a short period of time.

3) Given that the actual premium rates would differ substantially by state, i.e., from eight to sixteen percent, states will begin to compete for industry based on low health care costs. Part of this difference may be due to different levels of uninsured in a state, e.g., the South has very high rates of uninsured that would be paid for by employers and employees in the state. To help equalize this problem it may be necessary to have some funds to help pay for states with higher than average rates of uninsured. However, to ask other states to pay for this redistribution (even through alcohol or cigarette taxes) would be very contentious. Overall, this approach highlights the state-by-state difference with considerable political baggage.

4) Perhaps the greatest problem is one of enforceable budgets. Given that the employer community needs a guarantee that the rate will not increase this puts the state budget at a significant risk. If the states are held accountable for any overage over the target, i.e., they cannot raise the rate on the wage base, this means the state would have to raise other taxes. The wage base is likely to be between $400 and $500 billion, which means that a one percent overage is between $4 and $5 billion. However, states general fund revenues are only $300 billion and are only growing about three percent, or $9 billion, per year. This means that one percent overage in the budget is equal to one-half of the revenue growth expected for all states. This is a huge risk to say the least.

This all adds up to significant political problems for Governors. An employer mandate is much cleaner from a state perspective--perhaps a federal perspective--politically.

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DRAFT - FOR COMMENT ONLY

ENFORCEABLE BUDGETS:
With an Employer Mandate

1) The legislation will state that the national program target would be to reduce the annual (average) national rate of growth in health care spending over the next five years to the average annual rate of growth in nominal Gross Domestic Product (GNP) over the last ten years. For each year after the first five, new estimates would be provided based on a rolling ten year average of the most recent rates of nominal GDP growth.

2) That rate can be adjusted up or down by a maximum of 2 percent through a negotiation between the following:

   - The chairman and ranking minority member of both the House and Senate Budget Committees
   - Four Governor's, two Democrats and two Republicans appointed by the National Governors' Association
   - The Secretary of HHS and the Director of OMB

   Once there is an agreement on the rate it would implemented by the administration. While Congress could charge the target, it would be the intent to keep it as an administrative estimate. There would be criteria in the legislative that could be used to guide the negotiation. For example, if inflation exploded or there was a major recession for a number of years it would be important to modify the rate set by the formula.

3) The group of congressional members, Governors, and administration representatives would make a recommendation regarding the criteria to be used for the state-by-state distribution. The national targets would then be allocated on a state-by-state basis by an independent commission based on the criteria. For planning purposes it would be important to have these estimates for three future years The Congress would have to vote the recommendation up or down, but would not be able to modify the distribution. The state-by-state distributions would have to reflect demographic and population changes as well as cost and medical practice differences.

4) If total state spending exceeds state premium targets by more than 2 percent, the state would have to provide a state plan on how it would meet the target the next year. The state could request that federal rate regulation or premium taxes be imposed at that time.

5) The state share of the program costs would increase if state spending for the public program went above the target. The share would adjust for each .25 percent above the target. It would start with the implicit federal-state share of the base program and adjust up to a 100 percent state share if it would go above the 2 percent add on. For example, in state X the state maintenance of effort would be equal to 20 percent of the public program. This means that the state share would increase by 10 percent for each .25 percent that spending would be over the budget. For example, if the state exceeded its target by .67 percent, the state share for the first .25 percent overage would be 30 percent, the next .25 percent overage would be 40 percent, while the last increment of .17 percent would be 50 percent. Similarly, if the state comes under the target the state share would increase for each of the eight increments below the target. The percentage change, however, would be much smaller as the federal share would be larger.

6) States would not be required to pay an increased share of costs above the target during the first two years, i.e., the base year when a state chooses to have all individuals in the system as well as the next year. The increasing state share of costs over the budget would become effective only in the third year after all residents are in the program.

7) There would be no rebasing of the estimates until the third year after the state system is fully functional. Given that the data will be extremely poor the first two years it would be important not to rebase the estimates at that time. If a state is above the target for the third year, however, the target for the forth year would represent an average of both the estimate of the third year completed in year two as well as the actual.

8) At the end of the sixth year, i.e., six years after all residents are in the system, the enforceable budget would sunset. However, during the fifth and sixth years a commission would study the experience of states and make recommendations regarding how the process should be modified.