

Written Testimony for the Senate HELP Committee

**Presented by the National Governors Association
Executive Director Raymond C. Scheppach, Ph.D.**

June 11, 2009

Mr. Chairman and members of the committee, my name is Ray Scheppach, and I am the Executive Director of the National Governors Association. I appreciate the opportunity to be a part of this panel on behalf of the nation's Governors to discuss health reform and specifically the important issues involving health care coverage. We are prepared to work with federal policymakers to ensure that reforms are workable, cost-efficient, and sustainable over the long-term.

Need for Comprehensive Reform

Governors understand the vital role that health plays in productivity, competitiveness and quality of life and have made providing cost effective health care to their citizens a top priority. Given its unsustainable course, significant reforms of the health care system are necessary.

More than 45 million Americans are currently uninsured, and millions more are underinsured. Achieving greater access to affordable, quality health care is a critically important goal. However, health reform proposals must recognize that changing any one component will have direct and indirect impacts on other aspects of the health care system, and therefore, reform must move on parallel tracks to expand coverage, improve quality, and contain costs.

Governors' Views on Health Care Reform

Within the discussion on health care coverage, we wish to share the views of governors in five basic areas:

1. Insurance Regulation
2. Medicaid
3. Exchange Mechanisms
4. Long Term care and the Dual Eligibles
5. Transition Timelines

1. Insurance Regulation

While states are supportive of having the federal government establish certain insurance market reforms on such issues as guaranteed issue, health care reform should not diminish or impede the long standing establishment of state regulation of health insurance.

States strongly encourage federal policymakers to avoid measures that would preempt stronger state laws and regulations, and urge that any federal standards operate as floors rather than ceilings. Among the many regulatory authorities that should remain under state determination are to ensure the solvency of health insurance plans, and the enforcement of marketing requirements on those plans; the proper licensure of providers; and the protection of consumer rights and benefits.

2. Medicaid

Governors recognize Medicaid's important role in meeting the needs of our most vulnerable populations and they are committed to modernizing the program so that it better responds to their needs. There are several aspects of this transformation that I wish to highlight.

Governors understand that proposals under consideration would eliminate the categorical nature of the Medicaid program for individuals under a certain income threshold. While there is a reasonable case for streamlining eligibility policies, proposals to mandate a significant expansion of the Medicaid program raise important questions and some concerns.

Medicaid (Costs) — First of all is the cost. Governors oppose changes to the Medicaid program that will result in an unfunded mandate imposed on the states. Any increase in the mandatory minimum eligibility threshold will cost states tens of billions of dollars per year. States must take into consideration not only the actual cost of including additional individuals on the rolls, but also the complex interaction of reimbursement rates and access.

With any coverage expansion, states must consider the direct and indirect impact on provider reimbursement rates as well as health care workforce capacity, particularly primary care providers. There simply are not enough providers willing to treat additional Medicaid enrollees with complex conditions and situations at current reimbursement rates. Currently, Medicaid reimbursement rates average 72 percent of Medicare rates nationwide, and Medicare rates are often significantly lower than rates paid by private insurance. Those states that have already experimented with expanding Medicaid coverage broadly have demonstrated that Medicaid reimbursement rates must be increased to approximately Medicare rates to ensure access.

Combining the existing program expenditures with those required to meet new requirements and needs, without other changes to the program or adequate federal funding, could overwhelm states' budgets. Our initial estimate of the state impact of the Medicaid expansion as described in the Senate Finance Committee's proposal, including the reimbursement rates increases that would be necessary to ensure access would cost tens of billions of dollars per year in state funds alone. This would represent a significant percentage of total state general revenues.

Finally, Medicaid has become the nation's de facto source of long-term care coverage as well as a critical source of coverage for individuals eligible for both the Medicare and Medicaid program

– known as the dual eligibles. I will discuss those two issues later, but it is critical to remember that Medicaid’s continued coverage of these responsibilities may be fiscally incompatible with an increased role in coverage of all low-income Americans.

States are in dire financial straits now and any additional costs in the short run must be 100 percent federally financed. Furthermore, future projections of state fiscal capacity show a slow recovery and weak growth in the long run. This will necessitate permanently increasing the federal share of the program to account for not only the increased eligibility and reimbursement rates, but also the demographic trends for long term care, which alone could bankrupt the states.

Medicaid (reforms) — States would also like to work with federal policymakers to do more to streamline the Medicaid program and eliminate cumbersome requirements which make the program difficult to administer and sometimes work against the interests of both beneficiaries and taxpayers. For example, the committee’s proposals seek to limit the use of categorical eligibility determinations, but still leave in place a patchwork system for determining eligibility for the program and for specific services.

Should federal policymakers approve mandatory income eligibility changes, these must be balanced by the pressing need to modernize the Medicaid program as well as establish a path to incorporate state innovations as permanent parts of the state Medicaid plan. States require new flexibilities to administer a more efficient Medicaid program that better meets today’s needs of low-income and vulnerable populations and reduces costs for both states and the federal government.

Specifically, states support providing new flexibility to develop evidence-based benefit packages. This could minimize complexity in determining which services are medically necessary. States need flexibility to determine which services are purchased and how they are delivered. This would help ensure that expansion populations have access to the Medicaid services they need while providing states flexibility to improve the value of services offered to beneficiaries and manage costs. In addition, if the exchange is used to connect any low-income population to Medicaid coverage, new state flexibility will be needed to break down barriers to building systems of care and supporting care coordination.

3. Health Insurance Exchanges

A properly designed health insurance exchange can help correct inefficiencies in the existing health insurance markets and should be considered in the context of other proposed reforms. If federal policymakers adopt the exchange concept, states support the following approaches for developing the exchange framework:

- Exchange mechanisms should be established, operated, and regulated at the state-level. States also should retain the right to establish and participate in no more than one multi-state based exchange. Enhancing the ability of states to establish such mechanisms could help realize efficiencies in the health insurance marketplace as well as coordination between Medicaid and other subsidized populations.

- The number of exchanges in a state should be limited to one and no other exchange should preempt, compete, or interfere with state and multi-state based exchanges. The presence of multiple exchanges in a state is likely to perpetuate competition based on risk minimization.
- State flexibility is needed to design the structure, specify the functions, and determine how insurance products operate within a marketplace that has an exchange. This state-based approach can minimize disruption in the marketplace, ease the transition of market reforms for all stakeholders, leverage existing state infrastructure and public-private partnerships, and avoid disruption of the reforms already underway in some states.
- Provide federal support for start-up costs for state and multi-state based exchanges.
- Preserve the right of states to collect health insurance premium taxes on insurance businesses offered through the exchange.

4. Long Term Care and the Dual Eligibles

It is clear that Medicaid can no longer be the financing mechanism for the nation's long-term care costs and other costs for individuals eligible for Medicare and Medicaid – known as the dual eligibles. The demographic changes and escalating costs make it critical for states to begin to transition to the federal government much of their current financial responsibility in Medicaid for financing of long-term care. As stated in my testimony to the Subcommittee on Health of the Finance Committee earlier this year, postponing the discussion on long-term care perpetuates the fragmented system of care that exists today. Efforts to improve the financing mechanisms, care coordination and quality of long-term care services can be complementary and very important in the efforts related to strengthening the rest of our health care system.

Additionally, more than seven million Americans are dually eligible for full Medicare and Medicaid benefits, and nearly two million others receive financial assistance to cover out-of-pocket costs, such as co-payments and deductibles. These individuals represent just 18 percent of Medicaid's caseload, and despite the fact that they are fully insured by Medicare, a disproportionate percent of all Medicaid expenditures is consumed by filling in the gaps in Medicare services. In fact, they are responsible for over 42 percent of all Medicaid expenditures and 24 percent of Medicare expenditures (\$250 billion in FY2008).

Health care reform must include a streamlining of the current dysfunctional silos that dual eligibles currently access. There are at least two options for approaching this challenge. Full federalization of financing the care for this population would serve many policy goals, including creating enormous efficiencies and savings for both states and the federal government and treating the most medically fragile citizens in a holistic manner that dramatically improves the quality of their health care.

Alternatively, if the federal government does not provide the financing to improve the care of these beneficiaries, provide states with the tools to do so. Despite recent state and federal efforts to address structural problems, the existing system for dual eligibles is predominantly a fragmented, uncoordinated, and inefficient system of care. Misaligned benefit structures, opportunities for cost-shifting, and unresolved tensions between the federal and state

governments as well as an uncoordinated system of care for beneficiaries remain. Specifically, states must be credited for generating savings to Medicare when making Medicaid investments for this population. States also should have a certain level of influence over the coverage and financial decisions being made for the duals. And certain administrative rules and policies between Medicare and Medicaid must be streamlined to improve care for the dual eligibles.

In addition to specific reforms to improve care for the dual eligibles, a stronger, more equitable partnership between Medicare and states is essential to the success of health reform efforts. Medicare has significant influence in shaping cost and coverage decisions in the public and private domain and thus has a tremendous impact on health care trends. Yet Medicare largely is not engaged in state specific health reform initiatives which involve both public and private stakeholders.

5. Transition Timetable

Federal policymakers should work with states and the territories to determine an appropriate transition and implementation timeline for all health care reform changes. This includes changes both to state administered programs such as Medicaid and the Children's Health Insurance Program (CHIP), as well as any national reforms to the health insurance marketplace. It also may be helpful to have early planning grants to states while the federal government promulgates rules. It also would involve general certifications by governors at given benchmarks.

Significant health care reforms will require a lengthy process of state, federal, and market changes. This includes sufficient transition time for any coverage expansions, the proposed removal of income disregards, changes to benefit package requirements and services, new requirements which may involve a health insurance exchange entity, and other changes being considered.

States also urge federal policymakers to consider the health care workforce capacity, particularly with regard to the implementation of any coverage expansions that may be approved. Proposed coverage and delivery system reforms must be coupled with federal support for developing and retaining health care workers who are prepared to deliver quality care across the health care spectrum.

Conclusion

Any reforms approved at the federal level must allow states flexibility to adapt to local conditions and retain the primary state roles of administration, regulation, and consumer protection. It is also important that this framework support the role that states play in innovations around delivery system reform and value-based purchasing.

If a federal framework is developed it should include sustainable, sufficient financing mechanisms (through a combination of public programs and private sector incentives) to ensure that coverage and delivery system reform goals can be met. On their own, states are not well-positioned to sustain increases in their health care budgets.

Governors look forward to working with our federal partners on a bipartisan basis to address these important issues.