Written Testimony for the Senate Finance Committee

"Roundtable to Discuss Health Care Reform Coverage"

Presented by the National Governors Association
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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 proposals.

Need for 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. To continue their valuable work, the National Governors Association (NGA) formed a 12-member, bipartisan Health Care Reform Task Force to identify and define the gubernatorial priorities. We believe these steps can be used to inform and advise the important work of the Congress, including the Senate Finance Committee, as well as the Administration's efforts.

Health care is now a $2.4 trillion industry, making it a major driver of the nation's economic engine while also having a far reaching impact on the lives of all American families. Despite the vast amount of resources invested, an extensive body of research indicates the health care system is dramatically underperforming. As the number of uninsured Americans continues to rise, health care costs continue their upward spiral, the quality of health care services is increasingly called into question, and in turn, the economic competitiveness of America's businesses is threatened. These realities are heightening the need for health reform.

Given its unsustainable course, significant reforms of the health care system are necessary. Governors are prepared to work with you to build on these initiatives as you advance comprehensive health care reform proposals. Governors understand that in order to develop a uniquely American solution, health reforms must engage all stakeholders – individuals, the private sector, and government, both federal and state – who have a shared responsibility to address the existing limitations of the health care system.

Comprehensive Reform

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.

It is also critical for the health reform discussion to define which level of government will perform certain roles. Specifically, proposals must be thoughtfully crafted to determine who will finance, regulate, and purchase health coverage. While a number of states have enacted comprehensive reforms, nearly all states have enacted some reforms, including expanded coverage, insurance market reforms, small business reforms, quality improvements, and support for the adoption of electronic health records. Given both the momentum and the expertise that has developed in the states, national health reform should focus on enacting a broad federal framework with incentives for states to build upon their strengths and accomplishments. With that in place, states can build upon the existing policies and structures to expand coverage, protect consumers, evaluate quality, encourage price transparency, and meet the shared health reform goals of governors and federal policymakers.

In other words, health reform cannot focus solely on the federal role. We must strengthen aspects of the existing state/federal partnership and use the combination of their structures, expertise, and capacity to develop a more efficient, value-based health care system that facilitates broader coverage.

Existing Public Programs

A significant component of reform involves the broad range of public programs run by states, including Medicaid, the Children's Health Insurance Program (CHIP), and traditional public or population health programs which serve a vital safety-net function for low-income individuals and vulnerable populations. Health reform proposals must involve decisions about the financing, regulation, and administration of such programs.

Although Medicaid is the largest health care program in the nation, generalizations about the program are difficult to make, because it operates so differently in each of the states and territories. In addition, Medicaid is even more complicated than 56 different programs, because within each state, Medicaid plays a number of very distinct roles while serving a number of very distinct populations.

<u>Expanding Coverage</u>

In the absence of major federal progress, states have acted upon the immediacy of concern about the millions of uninsured individuals and families. In recent years, more than half of states have undertaken coverage increases, including significant initiatives intended to achieve broad-based coverage expansions. However, as this most recent economic recession demonstrates, states lack the financial capacity to pay for coverage over the long term. In addition, states do not have the necessary statutory authority to affect the type of broad-based market changes needed to achieve a rational system.

There is a reasonable federal role in paying for and shaping the type of coverage available and aligning the market incentives to drive quality care and appropriate outcomes. However a careful balance must be struck to preserve the state role of regulator and protector of consumer interests. States must have the flexibility to respond to justifiable variation in local conditions and costs as well as differences in approaches to health insurance coverage, delivery system models, and the types of services delivered.

The following key coverage-related principles could help create such an environment:

- The goal of coverage expansions should be improving options for individuals to access affordable coverage.
- Where possible, the existing system of employer sponsored coverage should be maintained.
- State administered programs can have a role, but careful consideration must be given to state's short and long term fiscal capacity.
- If the federal government establishes a national baseline benefit package model, it must contain a fair amount of flexibility within certain parameters.
- The federal government should establish guidelines for determining sliding scale subsidies for individuals who need assistance in affording insurance.

Medicaid Expansion

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.

There is widespread agreement that Medicaid's role is complicated because of the complex categorical nature of eligibility. Low-income pregnant women, children, seniors and people with disabilities are often eligible, but for the most part, other categories of Americans are not.

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.

First of all is the cost. An increase in the mandatory minimum eligibility threshold to 100% FPL could cost states at least $24 billion in fiscal 2009. This figure represents only the actual cost of additional individuals on the rolls, and does not take into consideration the complex interaction of reimbursement rates and access, which I will discuss later.

Medicaid is a system built upon a complex balance of federal mandates and state options. Just as no state is offering the maximum of all possible options; neither does any state cover only the bare minimum mandates. Every state makes political and fiscal calculations with regard to how expansive they can afford their Medicaid program to be. Therefore, imposing broad new unfunded mandates upon states could force them to reduce spending on optional categories. This

is not ideal policy solution, but unfunded mandates will likely force many states to consider it as an option.

Finally, coverage and delivery system reforms require thorough consideration of 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, will overwhelm states' budgets. One initial estimate of the state impact of an expansion of Medicaid to 100 percent of the federal poverty level (FPL), combined with reimbursement rates increases that would be necessary to ensure access are $75 billion per year in state funds alone.

There is support for moving away from quantity-based reimbursement towards quality and outcomes-driven approach. However, any cost efficiencies generated by this approach are unlikely to offset the additional expenditures required to expand coverage and increase provider reimbursements without additional reforms to the program or adequate federal financing.

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. Continued coverage of these responsibilities is fiscally incompatible with an increased role in coverage of all low-income Americans using the existing Medicaid framework.

Alternatively stated, the federal government should only consider mandating significant expansions in Medicaid if they are prepared to pay for not only the expansion populations but both the short-run additional costs for the existing population and the additional long-run costs of the demographic changes in long-term care. Changes to Medicaid eligibility policies also will require close collaboration between governors and Congress to determine a reasonable, workable implementation time period.

<u>Medicaid reforms</u>

The following programmatic reforms to the Medicaid program should be considered as a part of overall health reform, regardless of whether or not the program is expanded. If the program IS expanded, these changes MUST also occur.

- For low-income, but relatively healthy individuals who rely on Medicaid as a health insurance product, states should have more flexibility with respect to the benefits package.

- For individuals with disabilities who have no other recourse than to rely on Medicaid, reforms should encourage more consumer choice. Reforms also must allow Medicaid to be more flexible in targeting services to individuals that will improve the quality of their care and produce good outcomes.
- The Medicaid funding formula – the Federal Medical Assistance Percentage (FMAP) – should be adjusted so that it responds in a timely, predictable manner to changing state economic conditions. The existing FMAP formula is based on a three-year rolling average that reflects economic conditions from several years ago that may be vastly different than current conditions, and as a result, can exacerbate problems states have financing Medicaid during fiscal downturns.
- A new national dialogue is needed to confront the issues of an aging population and the potential sources of funding for end-of-life care.

Medicare and Medicaid

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 last month, 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.

States administer and help finance Medicaid, and they use the flexibility inherent in Medicaid and other public programs to design and pilot new models and approaches to health care. Many of these policies subsequently have been adopted by other insurers and provider systems, thereby earning states the reputation as "laboratories for reform." Health reform must have a long-term strategy for encouraging ongoing innovation. Policymakers can facilitate this by enhancing the flexibility states currently have to explore new approaches while minimizing any penalty for approaches that may later be found not to meet intended goals.

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.