STATE AND NATIONAL HEALTH CARE REFORM:
A Case for Federalism

Because the new U.S. President, Barack Obama, campaigned on a platform that prominently featured health reform, and is welcomed to Washington by a Congress that has put health care near the top of its agenda, interest in and energy around broad federal health reform is gaining momentum. A sense of optimism by reform advocates has remained, even in the face of the nation's dismal economic situation. If health reform does move forward, policymakers will need to find a balance between the role of states, who have traditionally led the movement to reduce costs, expand access and improve quality, and the federal government, which has provided the policy setting and financial foundation for such reforms.

Within our structure of federalism and given the complexity of the health care system, it is imperative to build upon the respective strengths of both state and federal governance to fashion health reform solutions with the greatest potential for success.[1] This section looks at the strengths of states and the federal government, and outlines a potential framework for merging the two, informed by a growing body of research based on state reform efforts.

IMPLEMENTATION, SYSTEM REDESIGN, AND OTHER STATE STRENGTHS

In recent years, a lack of national consensus about how to address the growing number of uninsured people has prompted work at the state level to enact incremental, substantial, and comprehensive coverage reforms as well as other initiatives that address cost and quality. These states could not wait; due to the immediacy of constituent concerns—of individuals, employers, and other stakeholders in the health care system—state governors and legislatures felt compelled to act. Results were mixed. States have experienced both important successes and enlightening failures that can help inform a national plan and help frame the best structure for any new federal-state partnership.

States play a critical role in advancing coverage expansions and other health reforms by testing new ideas, both politically and practically. Because health care delivery is largely local, states are closer to the action when it comes to implementing some of the delivery and payment system changes that are needed to truly transform the health care system. This proximity and flexibility in system redesign is a key strength for states. In addition, states have first-hand knowledge of their local landscapes and relationships with the stakeholders that will be necessary to change the system. Much of the work related to implementing insurance reforms, delivery system redesign, and public health strategies traditionally have been led by states.

On the other hand, there are numerous limitations for states in these areas as well, including some structural and financial constraints that keep certain potential levers out of their reach. In these areas, the federal government offers key advantages.

FINANCING, CONTINUITY, AND OTHER FEDERAL STRENGTHS

While many states are attempting to move ahead with reform, they are not all equal in their capacity to address these large and complex problems. Significant variation exists across states in terms of resources, capacity, demographics, number of uninsured, insurance market structures, public programs, state funds available to invest in reform, employment base, political priorities, and a host of other relevant factors that must be considered if health reform is to succeed. For example, state uninsured rates vary from just under 8 percent to almost 25 percent and, generally, where those rates are the highest, the states have the fewest resources in terms of a tax base or population income levels to support funding for needed coverage expansions. So while some states have moved forward and will continue to try to expand or maintain coverage rates, there are a large number of states that need significant federal support.

It is extremely difficult, if not impossible, to construct an effective and efficient national health system one state at a time.[2] Importantly, as currently evidenced by the varying levels of public program eligibility, investments in public health, and quality

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measures, a state-by-state approach without sufficient national standards and support leads to inequity in the overall system.[3] Many states will not achieve universal coverage without a national framework and federal funding. This is a key argument for some federal reforms.

Differences in the way that state and federal governments are able to address budgetary issues also suggest advantages to federal leadership on reform:

- **Counter-cyclical Budgeting:** The federal government is able to maintain spending levels during times of recession because it is not constitutionally mandated to balance its budget every year. Almost all states have annual or biennial budgets that must balance, which makes coverage expansions more challenging for states as they may not be able to afford to maintain benefit and eligibility levels during economic downturns.

- **Multi-year Budgets:** Because the federal government does multi-year budgets, it has the capacity to score savings in the Medicare and Medicaid program that will be realized in future years. This makes it easier for federal policymakers to find resources for program expansions from cost-saving approaches because the savings from these programs are often realized several years in the future.

- **Revenue Raising Capacity:** In addition, the federal government has the capacity to raise revenues in a broader fashion. In a hypothetical example, if $100 billion was needed to cover all of the uninsured nationally, each state would have to increase their taxes by more than 13 percent. The federal government, on its tax base, would only need to increase taxes by about 4 percent to raise the same funds.[4] This example demonstrates the important difference in the scope of revenue-raising capacity at the two levels of government.

A FEDERAL-STATE PARTNERSHIP

Given the respective strengths and challenges of either an all-state or all-federal approach to health reform, a strong federal-state partnership that builds upon the best of both could be a useful approach. In this scenario, the federal government would use its leverage as the largest purchaser in the country to set minimum standards and guidelines upon which states can build; it would also provide the necessary resources to the states to facilitate reform. States would then be responsible for implementing the programmatic aspects of health reform within an overall framework established at the national level. Key features of this approach are outlined below.

Regulating Insurance Markets. States have significant and lengthy experience with insurance market oversight and consumer protection.[5] However, while they have the advantage of being more directly accountable to consumers and providers, their purview over some employers is limited by federal law (e.g., Employment Retirement Income Security Act of 1974 [ERISA]). In addition, many of their residents are covered by federal insurance programs such as Medicare, the Veterans Health Administration, the Indian Health Services, and the Federal Employee Health Benefit Plan (FEHBP), and are therefore also beyond the reach of state regulation.

States are limited in their ability to engage with employers regarding the provision of health insurance. States can regulate insurers and the business of insurance but ERISA is often an issue when state law appears to affect whether and how employers offer worker health coverage. The federal law preempts state laws that "relate to" private sector employer-sponsored benefit plans. In effect, health benefits offered by self-funded employers have been exempted from any state regulatory oversight. This exemption limits the scope of cost-containment, quality improvement, and coverage expansion efforts of states.

States recognize the need for large multi-state employers to have national standards within which they can operate more efficiently. However, states who seek to innovate, especially through the use of public-private partnerships, are hampered by their lack of oversight and ability to engage. Tension between these two legitimate concerns is inevitable.

Federal policy steps could be taken to address employer concerns while still allowing for state innovation. For example, two states have recently imposed assessments on employers to help fund health care access initiatives but, because the question about whether they are subject to federal ERISA preemption has only been tested through the judicial system, other states have been reluctant to even consider such a financing mechanism.[6] While Massachusetts managed to enact a very limited employer mandate that requires certain employers to offer coverage to employees or pay into a state fund to support public health programs, states have mostly felt the need to steer clear of requirements on employers to contribute to the financing of coverage expansions. The federal government could provide clarity on permissible state actions and/or allow safe harbors.

Several clear federal changes would allow states to require ERISA-protected health care purchasers to participate in payment reform collaboratives, quality improvement efforts, Medicaid premium assistance programs, and all-payer databases. States could be allowed to collect enrollment and benefit information from ERISA plans. An explicit allowance could permit states to apply premium taxes to employer plans. Due to federal preemption, states are not able to define the scope of benefits provided by ERISA plans; the federal government therefore could also set a national floor on benefits. Finally, while consumer protections for those covered by

ERISA plans are currently provided at the federal level, states have more infrastructure and experience in these areas. Oversight responsibility, using federal standards, could be shifted to the state level.

Public Programs—Medicaid and the State Children's Health Insurance Program (SCHIP): Medicaid and SCHIP are currently based on a federal-state partnership. Overall, the Medicaid program provides more than 59 million Americans with health coverage and long-term care services.[7] The federal government provides broad guidelines within which each state must operate and the states are responsible for implementing the programs on the ground. These programs allow, to a certain extent, variation in eligibility levels, benefit structures, payment parameters, and breadth of optional populations covered.

In recent years, this partnership has been strained. The allowance for flexibility through the waiver process has been granted by Congress in several laws governing these programs. However, many states believe that federal regulatory oversight has become too inflexible and administratively cumbersome, and that proposed federal changes to the program have been taken unilaterally with little or no consultation with states nor with any regard to the impacts those changes will have to the program on the ground.[8] National reform should address these tensions, particularly with regard to waivers, dual eligibles, citizenship requirements and other Medicaid policy changes, and SCHIP limitations.

While there are currently processes for approving State Plan Amendments and also for granting waivers that, ostensibly, allow for state flexibility, those processes are now viewed as being too time-consuming (often years), adversarial, and capricious. Waiver parameters that had been granted to some states are denied to others, leaving states with no guidance as to what may be acceptable. The waiver process needs to be more timely and collaborative. States are currently at the forefront of experimenting with payment reforms to contain costs and improve the delivery system; they need a better framework and an expedited approval process for payment reform demonstrations that allow them to experiment and move from a fee-for-service system that incents quantity and disregards quality to one that pays for value by rewarding quality improvement.

Another substantial change to the parameters of the federal-state program that should be considered is related to the "dual eligibles"—the almost 7.5 million individuals who receive both Medicare and Medicaid benefits. Currently, for dual eligibles, Medicaid pays Medicare premiums and cost sharing and clinical benefits such as long-term care that Medicare does not cover.[9] Dual eligibles represent more than 40 percent of all Medicaid spending and almost a quarter of Medicare spending.[10] Some states have argued that all health care for the duals should be the responsibility of the federal government. Because dual eligibles have substantial medical needs and cost more per capita than other Medicaid beneficiaries, both state and federal governments need to be concerned about the impact of these individuals on both public programs. The federal government could support efforts to integrate care to overcome administrative and operational hurdles and financial misalignments between the Medicare and Medicaid programs through a single delivery system.[11]

While both states and the federal government share the goal of maximizing pubic program enrollment and preventing ineligible individuals from taking advantage of benefits to which they are not entitled, the federal government added citizenship verification guidelines to the program that have proven to be severely burdensome to states. Many state officials report that the cost-saving benefit of trying to identify those individuals who are not eligible for programs is far outweighed by the administrative costs of implementing and maintaining such a verification effort.[12] In addition, many states have reported that the requirements have the unintended consequence of denying benefits to those who otherwise would be eligible but have no proof of citizenship. The federal government should consider allowing a waiver from the citizenship requirement if the state can demonstrate it has effective verification standards in place.[13]

Changes to federal Medicaid regulations designed to control the rate of growth in these programs have also caused concern for a number of states. States view these proposals as reversing long-standing Medicaid policy. The regulations, most of which are currently under a one-year moratorium, also severely limit state efforts to use their public programs as a building block for coverage expansions.[14] A state survey noted that "a vast majority of states indicated that the regulations would have a real and significant impact on states and beneficiaries."[15]

In addition, in a directive dated August 17, 2007, the Centers for Medicare & Medicaid Services (CMS) announced that states would be barred from extending SCHIP coverage to children in families with incomes above 250 percent of the Federal Poverty Level (FPL) unless the state can demonstrate that 95 percent of their residents who are eligible under 200 percent FPL are enrolled in the program.[16] That directive impacted 23 states—10 that had already increased eligibility beyond 250 percent FPL and 14 others had proposed doing so. (Washington State falls into both categories.)[17] This directive has not been modified nor rescinded.

Many Medicaid and SCHIP observers expressed frustration that the federal government had not sought state input or greater understanding of the potential impact of these policy changes, which severely reduce the flexibility that states have in their public programs and severely impact their budgets, before moving forward. CMS's statutory authority to even issue the August 17 directive has also been called into question.[18] If the federal government wants to continue to support innovation and coverage expansions by states, it will need to rescind the August 17 directive and pursue a more collaborative regulatory process.

System Redesign/Quality Improvement: States have increasingly recognized that coverage expansions must be accompanied by value-enhancing strategies that contain costs and improve quality. The implementation of delivery system redesign and payment reforms, as well as the integration of public health strategies into other health care reforms, happens primarily at the state and local level. States are able to convene stakeholders and help provide a framework for collaboration to move these efforts forward. State health care system redesign efforts can provide lessons about how to take on this work and how to overcome challenges. In addition, most of the necessary health information technology (HIT) infrastructure needed to support these redesign efforts must be built on the ground—states have been playing an extensive role in this area as well.

While states have been moving ahead on these issues, the federal government has a number of levers that allow it to have, in a certain way, substantially more impact on the health care system than any individual state. By leveraging and aligning the purchasing power of the federal programs of Medicare, Medicaid, the Veterans Health Administration, the Indian Health Services as well as the FEHBP, payment reforms to encourage better processes and improved outcomes could be accelerated.

Federal programs could provide the leadership to emphasize evidence-based care and to use their claims data to establish better baselines; set goals for improving population outcomes; improve risk-adjustment methodologies; and reward results.[19] The federal government could also promote the use of comparative effectiveness research in benefit design, value-based purchasing, and for determining best clinical practices. The federal government could consider including state programs (e.g., Medicaid, public employees) in any Medicare demonstration projects on payment reform and delivery system redesign. However, because states can move more quickly, the federal government could also assist states by developing a new process to allow Medicare to participate in state-based all-payer databases and other state pilots.

Federal leadership and support to encourage the rapid adoption of HIT and the use of requisite interoperability standards are critical. The health care sector is in dire need of uniform interoperability standards—that separate data from software applications—so that providers and health systems that purchase electronic medical record systems and other HIT can be assured that those systems will be able to exchange key medical information. While states are moving ahead in this area in a somewhat limited fashion, it is difficult for them to proceed, in part, because many health care systems, hospitals and employers cross state lines and they do not want to invest in information systems that will not operate across those borders and across systems. States recognize that it does not make sense for 50 states to set 50 different standards, so they are waiting for federal regulators to set the needed benchmarks so that investment in HIT can move forward.

There is a dearth of federal standards and guidelines in the area of quality metrics. To reduce duplication of effort and capitalize on efforts underway, most states are using quality measures that have been approved by the National Quality Forum or national accreditation organizations such as the National Committee on Quality Assurance and the Joint Commission. However, variation in quality and efficiency across the country remains[20] and a national strategy and national benchmarks coupled with the necessary resources are needed to reduce this variation and the unacceptable amount of poor quality.

STATE VARIATION IN THE CONTEXT OF FEDERAL REFORM

While there may be broad agreement among the many stakeholders in the health care system and across political parties about the overall objectives for health care reform—expand access, improve quality, and contain costs, there is substantial disagreement about how to achieve these goals.

If it can be assumed that national reform will occur in the near future and it will have a federal-state partnership as its foundation, it will be critical to recognize that a national strategy will not lead to uniformity overnight. While working toward equity and less unwarranted variation in the cost and quality of care across states is critical, equity should not necessarily be equated with uniformity in the way that programs are implemented across all states. Understanding the diversity across the country means that any uniform national strategies, especially those targeting the uninsured, will have varying impacts and do not guarantee uniform national outcomes.[21]

One major area where extreme variation exists is in insurance market rating requirements; in essence, there are 50 different health insurance markets, so it will be important to understand how a national plan will affect each of those markets. As another example, focusing on the variation in public program eligibility levels, the effects of a federal policy to allow all adults up to 133 percent FPL into the Medicaid program will vary across states depending on previous efforts to expand coverage to adults. In addition, many of the states that have not enacted prior expansions may not have the financial resources to provide the required state match under such a requirement.

Three major possible solutions could address this variation in impacts across states; the federal government could: 1) make no attempt to address the variation in impact and let each state fend for itself; 2) provide variable assistance, both financial and technical, to the states based on each state's need; or 3) recognize that it may need to allow states to comply with the federal guidelines in a sequenced way over time.[22] A combination of variable assistance and sequencing could be the best method to help states comply over time. Any federal financial assistance should also aim to not penalize those states that have been able to expand coverage recently. While "maintenance of effort" is almost always encouraged when new programs are enacted, those states at the forefront should benefit in some way from any new federal funding that may accompany requirements to increase eligibility.

Arguably, states will always want more funding from the federal government and also maximum flexibility; a huge open question is what are the minimum requirements that should be expected from the states in exchange for this funding and flexibility? The variability between states also impacts this tension between the need for both leadership and flexibility from the federal government.

CONCLUSION: BUILDING A STRONG STATE-FEDERAL PARTNERSHIP

Many of the ideas related to essential elements of a federal-state partnership are not new—during the national reform discussions in the early 1990s, the Reforming States Group provided recommendations that still hold true today, including the establishment by the federal government of "a timetable for action, standard core benefits, and standards for access to and quality of care, cost containment, administrative efficiency, and portability of coverage between states, …[and that] the federal government should grant the states flexibility to implement reforms that meet federal requirements and that equitably and efficiently address access, coverage, and cost containment..."[23]

Despite the need for collaboration between federal and state governments, many state officials fear that some federal reforms could have a negative impact on states. This is based on the experience of the CMS August 17 directive, the citizenship requirements under DRA, the "clawback" provisions under the Medicare Part D legislation[24] and inflexible, burdensome Medicaid regulations. The federal government has often made changes to federal-state programs without appropriate consultation and communication with affected states. As a result, states have been forced to shoulder additional financial burden in the context of ambiguous or conflicting directives from the federal government.

While states may be skeptical about the possibility of national reform and anxious about the parameters of such reform, inaction is not an option. A collaborative federal-state partnership that builds on the respective strengths of each offers real potential and should be considered.

ENDNOTES

1 State Coverage Initiatives would like to acknowledge the extensive contributions, through testimony, presentations, and journal articles, of Alan Weil, executive director of the National Academy for State Health Policy, regarding these issues.

2 "Expanding Health Care Access," statement of Jeanne M. Lambrew, University of Texas at Austin and the Center for American Progress before the Appropriations Committee, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, U.S. House of Representatives, March 5, 2008.

3 Cantor, J.C. et al. "Aiming Higher: Results from a State Scorecard on Health System Performance," The Commonwealth Fund Commission on a High Performance Health System, June 2007.

4 State tax revenue estimated at $750 billion. *State Government Tax Collections: 2007,* U.S. Census Bureau. www.census.gov/govs/statetax/0700usstax.html; Federal tax revenue estimated at $2,568 billion. *The Budget and Economic Outlook: Fiscal Years 2009 to 2018,* Congressional Budget Office, January 2008, Table F-3 for 1968-2007, www.cbo.gov/ftpdocs/89xx/doc8917/01-23-2008_BudgetOutlook.pdf.

5 "State Comprehensive Access Initiatives," Statement of Deborah Chollet, Mathematica Policy Research, Inc., before the Appropriations Committee, Subcommittee on Labor, Health and Human Services, Education and Related Agencies, U.S. House of Representatives, March 5, 2008.

6 Butler, P. "Including Employer Financing in State Health Reform Initiatives: Implications of Recent Court Decisions," State Coverage Initiatives and the National Academy for State Health Policy, January 2009.

7 Smith, V. et al. "Headed for a Crunch: An Update on Medicaid Spending, Coverage and Policy Heading into an Economic Downturn, Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2008 and 2009," Kaiser Commission on Medicaid and the Uninsured, September 2008.

8 Ibid, pp. 58-59.

9 "Dual Eligibles: Medicaid's Role for Low-Income Medicare Beneficiaries," Kaiser Commission on Medicaid and the Uninsured, February 2006. www.kff.org/medicaid/upload/Dual-Eligibles-Medicaid-s-Role-for-Low-Income-Medicare-Beneficiaries-Feb-2006.pdf.

10 "Medicaid Best Buys - Integrating Care for Dual Eligibles: Opportunities for States," Center for Health Care Strategies. www.chcs.org/publications3960/publications_show.htm?doc_id=747565.

11 Center for Health Care Strategies, Presentation by Melanie Bella. www.chcs.org/usr_doc/Bella,_CHCS.pdf.

12 Smith, V. op. cit., p. 36.

13 "Report to Oregon's Congressional Delegation," Oregon Health Fund Board, Federal Laws Committee, November 25, 2008. www.oregon.gov/OHPPR/HFB/Federal_Laws/Federal_Laws_Report_Final_to_print.pdf.

14 "Federal-State Policy Tensions," presentation by Dave Lucas, Office of Governor Arnold Schwarzenegger, AcademyHealth National Health Policy Conference, February 2008. www.academyhealth.org/nhpc/2008/Lucas.ppt#405,11,Federal - State Policy Tensions.

15 Smith, V. op. cit., p.60.

16 Centers for Medicare & Medicaid Services, Letter to State Officials, August 17, 2007. www.cms.hhs.gov/smdl/downloads/SHO081707.pdf. For more information about the impact of this directive on states, see "The CMS August 2007 Directive: Implementation Issues and Implications for State SCHIP Programs," State Health Policy Briefing, Vol. 2, No. 5, Portland, ME: National Academy for State Health Policy, April 2008.

17 Smith, V. op. cit., p. 62.
18 "Applicability of the Congressional Review Act to Letter on State Children's Health Insurance Program," Government Accountability Office, B-316048, April 17, 2008 and Memorandum from the Congressional Research Service, January 10, 2008. http://rockefeller.senate.gov/press/CRSMemo01102008.pdf.
19 "State Health Reform Series: Strengthening State/National Partnerships to Support Delivery System Reform," Engelberg Center for Health Care Reform, Brookings Institution, October 2008.
20 Cantor, J.C. et al. op. cit.
21 Glied, S. and D. Gould. "Variations In The Impact Of Health Coverage Expansion Proposals Across States," *Health Affairs* Web Exclusive, June 7, 2005.
22 State Coverage Initiatives would like to acknowledge Sherry Glied for her thoughts about this issue.
23 Rydell, C. "An Agenda for Federalism from State Leaders," *Health Affairs*, Vol.13, No. 5, Winter 1994, pp. 252-55.
24 On January 1, 2006, prescription drug coverage for the duals was transitioned from Medicaid to the Medicare Part D program but states remain required to finance a portion of this coverage through a payment to the federal government, often referred to as the "Clawback" (Smith, V. p. 13).

About State Coverage Initiatives

The State Coverage Initiatives (SCI) program provides timely, experience-based information and assistance to state leaders in order to help them move health care reform forward at the state level. SCI offers an integrated array of policy and technical assistance services and products to help state leaders with coverage expansion efforts as well as with broader health care reform. Our team of policy experts tailors its approach to meeting state decision makers' needs within the context of each state's unique fiscal and political environment. SCI is a national program of the Robert Wood Johnson Foundation administered by AcademyHealth.

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