HR-15. CHILDREN'S HEALTH

15.1 Preamble

The Governors share the commitment of Congress and the Administration to making health insurance available to children in need. States have long been leaders in expanding health care access for children.

States have been increasing eligibility levels for pregnant women and children for many years through Medicaid expansions and other state-designed programs. However, the Balanced Budget Act of 1997 authorized unprecedented increases in health care coverage for uninsured children not eligible for Medicaid. Under the State Children's Health Insurance Program (S-CHIP), states are using state-designed programs, Medicaid expansions, or a combination of both approaches to make more children eligible for health care coverage. Of the fifty-two states and territories that have approved S-CHIP plans, twenty-five states are expanding Medicaid, twelve states are using a separate state insurance program, and fifteen states are using a combined approach.

Today, almost 20 million children receive health care services through Medicaid and S-CHIP. Through these two programs, fifty-four states and territories have expanded coverage well beyond federally mandated levels.

Given their commitment to children's health and extensive experience in operating programs that provide health care to tens of millions of children, the Governors stand ready to work with Congress and the Administration to continue improving opportunities for states to expand health care access for uninsured children.

Strategies to extend coverage to currently uninsured children classify this population into two subsets: children who lack any connection to the insurance marketplace and children who are eligible for Medicaid or S-CHIP but are not enrolled in these programs. Consequently, the Governors' policy recommendations focus first on areas for improvement in S-CHIP and then on outreach.

15.2 Medicaid and S-CHIP Eligibility

Despite initial guidance to states that a majority of uninsured children would be eligible for S-CHIP, some states are discovering that a substantial number of uninsured children are not those in the S-CHIP income eligibility range. Instead, these children are eligible for, but not enrolled in, Medicaid. In fact, in some states, S-CHIP outreach has brought in nine Medicaid-eligible children for every S-CHIP-eligible child. This phenomenon is largely attributable to families that do not want to be enrolled in the welfare-associated Medicaid program. Many families have asked to participate in the state-designed programs, even volunteering to pay premiums and copayments. However, federal law prohibits states from enrolling Medicaid-eligible children in S-CHIP. States should not have to force beneficiaries into Medicaid when it is clear they want to be enrolled in a separate program. Such a policy may lead families not to enroll in any program, leaving children uninsured. The Governors call on Congress to make technical changes to the program to give states the option of allowing beneficiaries to voluntarily turn down Medicaid in favor of a separate S-CHIP program.

15.3 State Flexibility

For states to fully implement this program and cover the maximum number of children possible, they must be provided additional flexibility to expand access to employer-based insurance and family coverage, limit "crowd-out," and design innovative programs with regard to cost-sharing and other issues.

States have embraced many different approaches to expanding health insurance coverage for children through S-CHIP. As envisioned by the authors of the program, this flexibility has expanded coverage and fostered innovations in program design and development. State policymakers are dedicated to designing the most effective programs possible to meet the needs of citizens in their states. The Governors call on Congress and the Administration to work with states to ensure greater flexibility in reaching the common goal of expanding meaningful health insurance to children.

15.4 Guaranteed Funding

The design, development, and implementation of a health insurance program such as S-CHIP takes time. For states to enroll children, educate families about the benefits of a managed care delivery system, ensure that necessary services are received, and ensure that claims are submitted and subsequently paid, Governors must be confident that a stable funding stream will be available to provide health care services to beneficiaries. Any attempt to decrease funding will jeopardize states' ability to serve current populations, much less increase the number of children covered.

The authors of the S-CHIP legislation allocated $24 billion to this program over five years and a total of $48 billion over ten years. As states and territories develop their long-term goals for coverage and state spending, it is vital that Congress maintains its commitment to fully fund the federal share of S-CHIP. By law, this program is an entitlement to states and territories, which have up to three years to spend their annual allotments. If those funds are not spent in that period, they revert to a general pool that becomes available to other states that have expended their entire allotments. The territories should be allowed to share in this general pool. Current law provides one-fourth of 1 percent of the entire S-CHIP allotment for all of the territories.

In addition, states that have already significantly expanded coverage to the majority of their uninsured children should be permitted to use new program funds to offset existing state expenditures for expanded children's health insurance coverage.

15.5 Administrative Expenses

The effort required to start up any program is substantial. Initial capitalization and one-time funding is extremely limited when tied to a percentage of medical premiums. Under S-CHIP, states can only spend up to 10 percent of the cost of medical coverage for all administration and outreach. Consideration should be given to allow a larger percentage of funds to support administrative burdens for the first two or three years, or until a program reaches maturity. After maturity, administration could be reduced.

At a minimum, outreach should be removed from the 10-percent cap and addressed separately. Outreach is vitally important to all stakeholders, but the Health Care Financing Administration (HCFA) has based the 10-percent cap on expenditures, which are based on enrollment. Enrollment ultimately depends on effective outreach. The current system fails to recognize the importance of building outreach into the front end of S-CHIP.

15.6 Benefits

If a state chooses to develop a separate S-CHIP program, that program must have a benefits package that is actuarially equivalent to a benchmark package. If, however, states want to pursue the option of subsidizing employer coverage, it is prohibitive to monitor all potential employer benefits to determine whether such coverage is actuarially equivalent. The Governors call on Congress and the Administration to develop an alternative that is more efficient and effective, such as waiving the actuarial equivalence test for employer buy-in coverage.

15.7 Outreach

The Governors believe that children entitled to Medicaid or S-CHIP benefits should receive those benefits. Accordingly, states have implemented strategies designed to increase participation in these programs. Efforts include dropping the assets test, adopting presumptive eligibility, shortening application forms, expediting eligibility determinations, allowing application by mail, guaranteeing twelve months of coverage per eligibility period, and providing continuous eligibility for newborns. In addition, since the early 1990s, states have developed outreach campaigns designed to promote enrollment while educating the public about the importance of prenatal and primary health care services. These outreach activities include community enrollment centers and "one-stop shops." Additional outreach strategies are described in State Children's Health Insurance Program: 1998 Annual Report, the 1999 report of the National Governors' Association and National Conference of State Legislatures.

Despite efforts to increase participation, some eligible children still have not been enrolled. The Governors note that these children would be instantly enrolled should a need prompt them to seek health care services. Lack of enrollment could inappropriately discourage families from seeking preventive health care services for their children.

Exact estimates of the number of children who are eligible but not enrolled are difficult to develop. The Governors call on the U.S. General Accounting Office and the U.S. Department of Health and Human Services (HHS) to provide states with a more detailed and accurate explanation of the group of children who they believe are eligible but not currently enrolled. This explanation should include the number and characteristics of uninsured children, and it may require a national survey that is state-specific.

Uncoordinated federal outreach efforts would be administratively cumbersome and would fail to achieve the desired results. For example, although the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) serves a large number of children who are in need of health care coverage, the U.S. Department of Agriculture has determined that WIC administrative funds can be used only to provide information about S-CHIP and enroll children under very limited circumstances. Changing this policy and encouraging cooperation between the states and HHS will help states maximize their outreach and enrollment efforts.

15.8 Waiver Authority

States must have the flexibility to design and implement programs that reduce the number of uninsured children in each state. To reach this goal, the S-CHIP statute provides a number of options for states, including the option to pursue research and demonstration projects through the Section 1115 waiver process. To maximize outreach and extend coverage to more children, states must be permitted to use this waiver authority without artificial restrictions.

15.9 Family Coverage

Many states would like to expand their S-CHIP programs to allow the parents of S-CHIP-eligible children to enroll in the state program. Even if a state is willing to expend its own funds to do this, it still has to pursue a federal waiver and demonstrate cost-neutrality, which is not feasible in most cases. S-CHIP is a promising vehicle to promote the goal shared by the Governors, Congress, and the Administration—decreasing the number of Americans without health insurance. The Governors encourage Congress and the Administration to provide opportunities outside the waiver process to enable states to enroll entire families in S-CHIP. IF CONGRESS DECIDES TO EXPAND S-CHIP COVERAGE TO FAMILIES, STATES THAT HAVE ALREADY DONE SO MUST NOT BE PENALIZED FOR HAVING MOVED FORWARD.

15.10 NATIVE AMERICAN COST SHARING

THE GOVERNORS RECOGNIZE THAT THE FEDERAL GOVERNMENT'S TRUST RESPONSIBILITY TOWARD AMERICAN INDIANS AND ALASKAN NATIVES PROHIBITS THESE INDIVIDUALS FROM CONTRIBUTING TO COST SHARING IN FEDERAL HEALTH PROGRAMS. THE GOVERNORS ASSERT THAT THIS IS A FEDERAL RESPONSIBILITY THAT MUST NOT BE MANDATED ON ALL STATES. THE GOVERNORS WOULD SUPPORT A STATE OPTION THAT WOULD PERMIT STATES TO ELIMINATE COST SHARING FOR THIS

POPULATION. S-CHIP AGENCIES THAT CHOOSE THIS OPTION SHOULD ALSO HAVE THE OPPORTUNITY TO BE REIMBURSED FOR COSTS THAT WOULD HAVE BEEN COVERED BY ENROLLEE COST SHARING. IN TERMS OF ADMINISTRATION OF THIS NEW REQUIREMENT, STATES WISH TO PRESERVE THE OPTION TO ACCEPT SELF-CERTIFICATION OF ETHNIC STATUS DURING THE INITIAL APPLICATION, AS ADDITIONAL REQUIREMENTS MAY BE A BARRIER TO ENROLLMENT.

Time limited (effective Annual Meeting 1999–Annual Meeting 2001).
Adopted Annual Meeting 1997; revised Annual Meeting 1999.

HR-16. MEDICAID

16.1 Preamble

The Medicaid program is a state/federal program that serves as the primary source of acute health care coverage and long-term care for the poor. Because it is a national program providing access to health care for more than 40 million beneficiaries, the Governors believe that quality services must be provided as efficiently and effectively as possible.

In 1998 approximately $184 billion was spent in the Medicaid program. Of that amount, about $80 billion was state funds. Medicaid is now one of the largest components of state budgets, comprising 20 percent of state spending. Medicaid spending has grown in both absolute and relative terms, and as a result of this growth, Medicaid is now the second-largest expenditure in state budgets. As a result, states are experiencing great difficulty in finding the money to fund Medicaid. Even more important, perhaps, is that increased Medicaid spending makes it difficult, if not impossible, to increase funding for other priorities. Finding ways to control Medicaid spending is a major priority for the Governors.

Medicaid financing and administration are shared jointly by the federal government and the states. This federal-state partnership of financial responsibility must be maintained without further cost shifts from the federal government to the states and without expansions of federal programmatic mandates that increase state costs or limit state flexibility. In recent years, federal policymakers have narrowed the administrative flexibility of states and made legislative and regulatory changes that mandate greatly increased state expenditures. As a result, states increasingly view their relationship with the federal government not as a partnership, but as a relationship in which states have been forced to accept federal mandates that have great impact on state budgets and health policy initiatives.

Congress helped to alleviate some of this pressure with its passage of the Balanced Budget Act of 1997 (BBA). The repeal of the Boren Amendment, the phase-out of the requirement for cost-based reimbursement for federally qualified health centers and rural health clinics, and the ability for states to operate mandatory managed care programs without a waiver were all much-appreciated programmatic improvements. Clearly, congressional intent was to provide states with more flexibility to develop and operate Medicaid managed care programs, and specifically to give states the ability to do so through the state plan amendment option without requiring a waiver. The Health Care Financing Administration (HCFA) has significantly restricted state flexibility to develop and administer Medicaid managed care initiatives by increasing its federal oversight role in promulgating regulations that go far beyond congressional intent.

There are enough real and pressing problems presented by the Medicaid program without creating new regulatory burdens. The Governors continue to believe that urgent changes are needed to promote effectiveness and efficiency. Therefore, the Governors call on Congress and the administration to work to immediately address the problems with this program. Included among those solutions must be an overall reduction in the federal statutory and regulatory micro-management that has typified the program in the last decade.

16.2 Federal Financing

16.2.1 The Federal Commitment to the Medicaid Program. The Governors are extremely concerned about various recent proposals that would actually reduce the federal commitment to the Medicaid program. Proposals to reduce the federal matching percentage for administrative costs of the program, or to, in any way, weaken the foundation of the federal-state partnership that guides the operation of the Medicaid program, are unacceptable. Medicaid has contributed significant savings to the historic balanced budget agreement, and there is simply no way for additional funds to be cut without seriously jeopardizing patient protections and such important functions as "Year 2000" (Y2K) contingency planning, Medicaid fraud control units, and third-party liability recoveries. The Governors are committed to conducting outreach to potentially eligible children and the elderly; cuts in needed administrative funding would interfere with their ability to do so.

Further, the Governors firmly hold that Medicaid should not be included in efforts to balance the budget, nor be used as a funding source for other purposes. Governors already have contributed to significant budgetary savings by controlling Medicaid growth rates. In the late 1980s and early 1990s, Medicaid spending grew at an annual average of more than 20 percent. From 1995 to 1997, Medicaid growth has been held to an average of less than 4 percent. The Congressional Budget Office recently

revised its Medicaid spending projections to reflect an average annual growth rate between now and 2008 of 7.4 percent.

These reductions in growth rates were made possible by taking advantage of the limited flexibility currently afforded by the Medicaid program to contain costs. However, economic pressures and other factors beyond state control will continue to be driving forces propelling Medicaid spending growth. States have maximized the efficiencies possible in their current managed care programs and will not be able to absorb any Medicaid cuts within existing program parameters. Additional flexibility will be needed to move beyond the results already achieved.

Any unilateral federal cap on the Medicaid program will shift costs to state and local governments that they simply cannot afford. The Governors adamantly oppose a cap on federal Medicaid spending in any form. If Congress and the administration are serious about reducing the costs of the program, they must reexamine the authorizing legislation that has brought the program to the condition it is in today and restructure the program to make it consistent with congressional spending strategies.

16.2.2 **Medicaid Mandates.** The Unfunded Mandates Reform Act of 1995 is designed to protect states from the cost shifts that occur when the federal government requires states to enact expensive new policies but fails to provide the funding necessary for implementation. The Governors unequivocally oppose unfunded federal mandates and call on Congress to clarify the original intent of the act with regard to Medicaid mandates. State Medicaid programs have historically been vulnerable to unfunded mandates and should particularly benefit from mandate relief. Governors call on Congress to enact statutory language to clarify that a cut or cap on the Medicaid program, without giving states new or expanded flexibility, is an unfunded mandate.

16.2.3 **Medicaid and Medicare.** As Congress and the administration debate possible Medicare reforms, the impact of those changes on Medicaid programs must be carefully considered. The Governors cannot support Medicare reform strategies, such as increased cost-sharing obligations for the dually eligible, that result in cost shifts to the states. The long-term financial needs of Medicaid and Medicare must be considered jointly to successfully prepare each program for the increased demands that will accompany the aging of the baby boomer generation. Although the aged, blind, and disabled represent roughly a quarter of the Medicaid caseload, they currently consume roughly three quarters of program spending. The Governors strongly support allowing demonstrations for the integration of acute and long-term care services for the elderly, as discussed in NGA's Long-Term Care Policy, HR-17. States should be allowed to build on the innovations they have developed in home- and community-based care programs. These programs have been proven to provide cost-effective services that are preferable for both beneficiaries and their families. With some ability to integrate Medicaid and Medicare funding streams, benefit packages, and delivery systems, states could vastly improve on the current fragmented systems of care.

16.2.4 **Disproportionate Share Hospital (DSH) Program.** Medicaid's DSH funds are an important part of statewide systems of health care access for the uninsured. The Governors strongly believe that DSH funds must continue to be distributed through states, and without further cuts, to ensure that the program effectively complements other federal and state sources of health care funding.

16.2.5 **Budget Neutrality.** For some individuals, government assistance comes in many forms: Medicaid, Medicare, Supplemental Security Income, and food stamps, as well as benefits from the Ryan White Care Act, the Maternal and Child Health Block Grant, and the Social Services Block Grant, to name a few. Just as it can be overwhelming for individuals to manage all the benefits for which they are eligible, it can also be very difficult for states to coordinate multiple benefits. The Governors call on Congress and the administration to recognize that expenditures in one program often realize savings in others. The Medicaid prescription drug benefit is responsible for preventing hospitalizations for the elderly, thereby saving the Medicare program from additional costs. State-funded respite care can prevent nursing home placements, thereby saving money for the Medicaid program. Funding for protease inhibitors for people who are HIV positive will prevent the onset of AIDS and provide savings to a number of other health and social welfare programs. Currently, states are unable to factor in such cost savings when applying for Medicaid waivers. The flexibility to consider budget neutrality across federal programs would enable the Medicaid program to help people with disabilities return to the workforce, integrate and coordinate care for seniors, and prevent the onset of AIDS in people infected with HIV.

16.3 Programmatic Recommendations

16.3.1 Allow States Greater Flexibility to Establish Managed Care Networks. There is a national trend in health care service delivery toward organized systems of care. These systems or networks have been shown to provide cost-efficient, quality care while ensuring that the patient has a reliable source from which to seek primary care and to which specialty care can be directed. Systems of coordinated care have particular benefits for Medicaid beneficiaries. These systems ensure a medical home for beneficiaries, encourage primary and preventive care, and discourage the use of emergency rooms and specialists for routine medical care.

Although the BBA contained many measures designed to give states more flexibility, the subsequent proposed regulations, if enacted, would not only fail to provide that flexibility, but would in fact place a greater regulatory burden on state Medicaid programs. The proposed rules would create so many barriers for states to implement mandatory managed care through the state plan amendment option that it would not become a valid option at all. Further, the decision to apply an entirely new set of prescriptive regulations to currently existing 1915(b) and 1115 waivers could very well result in the end of Medicaid managed care. The extension of this regulatory burden to even the relatively simple "gatekeeper" premise of primary care case management programs may prevent physicians and group practices from becoming Medicaid providers and thereby jeopardize continuity of and access to care for many families.

If the nation is serious about controlling health care costs, it is essential to give states the opportunity to establish networks in Medicaid (including fully and partially capitated systems) through the regular plan amendment process. The Governors recognize the special significance of consumer protections and assurance of solvency in establishing these systems of care.

Congress should clarify that under federal law, the states' obligation to provide services is satisfied if the state enters into a contract with a provider or HMO that covers the necessary benefits. Beyond that, any dispute by a client regarding covered services should be resolved as a contractual matter between the client and the provider or HMO under state law. Many states have alternative dispute resolution processes that should be exhausted before recourse to the state court system. There should be no private right of action for providers or health plans regarding payment rates.

16.3.2 Managed Care and Quality Standards. Governors are committed to ensuring that every Medicaid recipient receives high-quality health care. Managed care has been an effective strategy for meeting that goal by providing high-quality, cost-effective health care services to millions of recipients.

Given the expertise states have developed with Medicaid managed care, the Governors had hoped to work closely with the administration as quality issues were debated. Unfortunately, HCFA developed proposed rules on Medicaid managed care without any meaningful state input. The prescriptive approach will create systemic difficulties in implementing any form of managed care, particularly in the area of quality standards. A single reference in the BBA about grievance standards became many pages of prescriptive regulations and mandates for the states. The Governors recommend that states be allowed to establish meaningful goals and be given the tools to hold plans accountable for meeting those goals, rather than constraining all parties by prescribing in minute detail the step-by-step approach that must be followed. Many states have specific grievance and appeal procedures spelled out in their plan contracts, and/or have state laws in this area. None of them would conform in all respects to these proposed regulations.

Any time Congress mandates coverage of a particular benefit or sets requirements around the terms of that benefit, careful consideration must first be given to the fiscal impact of the change on Medicaid. Even requirements limited to the private sector can have a strong Medicaid impact through contractual relationships with HMOs. Governors oppose any changes in the health care market that will result in unfunded mandates to the states.

16.3.3 Waivers. Currently, each state must produce and defend waiver requests even if other states have already received approval to implement similar waivers. Obtaining redundant federal approval is an inefficient use of resources at both the state and federal level. States should be allowed to import any waiver in place in another state without securing additional federal approval.

16.3.4 Boren-Like Provisions. The repeal of the Boren Amendment in the BBA was one of the most important programmatic improvements to the Medicaid program in many years. States are now able to negotiate reimbursement rates for nursing homes and other facilities that more accurately reflect market pressures.

The same ambiguity that has caused problems for states in the Boren Amendment exists in other parts of the Medicaid statute as well. For example, Section 1902(A)(30) allows states to set reimbursement rates to safeguard against unnecessary utilization of care and to ensure that payments are "consistent with efficiency, economy, and quality of care." To clarify this undefined terminology, courts have begun to establish parameters for reimbursement rates. Given the past problem of court interpretations of "Boren-like" provisions in statute, Section 1903 (M)(2)(A)(III) also appears vulnerable to litigation. This section ambiguously requires state contracts with HMOs to be made on an "actuarially sound basis." The Governors recommend that all such reimbursement provisions be repealed in order to preclude any litigation over provider or health plan payment rates. In all instances, provisions should include the opportunity to allow the market to establish rates, as through the competitive bidding process or direct negotiation.

16.3.5 **Allow States to Manage Costs in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) Program By 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. The U.S. Department of Health and Human Services should work with the states to develop and finalize rules that allow states to efficiently manage case costs and utilize the least expensive alternatives for providing services without reducing the quality of care.

16.3.6 **Ensure that States Will Not Be Expected to Implement Any Medicaid Program Changes Until the Health Care Financing Administration Has Published Final Regulations to Guide Program Administration.** In too many cases, HCFA has failed to publish regulations associated with statutory changes in the Medicaid program or has done so after many years of delay. Too often, states have had to implement statutory changes and in some cases, have been held financially accountable for unclear laws, even though HCFA failed to provide clarification through implementing regulations. Lack of timely action by HCFA in issuing regulations has resulted in particular difficulties in the area of spousal impoverishment protection. States should not be held liable for operating under state law or state interpretation of federal statutes until the federal regulations are adopted. This policy would replace arbitrary HCFA interpretations that have no basis in law. Nor should states be bound by informal policy directives that are issued in violation of the formal rulemaking process.

16.3.7 **Promote Cost Control and Efficiency.** States should be encouraged to continue innovations in provider payment methods. Though Medicare and most private payers have moved away from cost-based reimbursement, federal legislation has mandated that certain Medicaid providers be paid on the basis of costs. Mandatory "reasonable cost" reimbursement strategies should be repealed.

16.3.8 **Assume Full Financial Responsibility for All Low-Income Medicare Beneficiaries Who Are Not Otherwise Medicaid-Eligible.** Since 1988, the federal government has increasingly passed on to the states the responsibility to protect low-income Medicare beneficiaries (e.g., the Qualified Medicare Beneficiary Program, the Specified Low-Income Medicare Beneficiary Program, and the new groups of beneficiaries created by the BBA, the Qualifying Individuals). Currently, Medicaid is responsible for meeting the Medicare cost-sharing obligations of many low-income beneficiaries and for providing a full range of benefits to others. The Governors want to ensure that elderly beneficiaries receive the best possible care, but the Medicare program is a federal program and the federal government should bear all of its costs. Should Medicare not assume full financial responsibility, Congress should consider the implications of this cost shift when it makes changes to the eligibility provisions of the Medicare program.

16.3.9 **Make Audit and Disallowance Policies More Equitable.** Under current law, federal audit and disallowance requirements do not discriminate between violations of "obscure policies" and those that have direct harm to beneficiaries. The statute should be revised to prohibit federal practices that impose heavy penalties when the violation constitutes no beneficiary harm. States should be held harmless against possible penalties or disallowances for reasonable interpretations of law based on departmental guidance prior to the issuance of regulations.

16.3.10 **Allow Greater Flexibility in Medicaid Home- and Community-Based Care (HCBC) Programs.** Home- and community-based care is an important alternative to institutional care for the elderly and people with chronic and disabling conditions. Currently, every state in the country has at least one

HCBC program providing a broad range of medical and social services to beneficiaries. Existing Medicaid statute requires states to establish and administer these programs through waivers. The statutes must be revised to give states the authority to administer HCBC programs through a plan amendment process. However, states must be able to retain the authority to control the number of beneficiaries receiving Medicaid home- and community-based care. Finally, Congress and the states must work together to restructure the Medicaid program to eliminate the incentive to place beneficiaries in institutional care when community care would be more appropriate and cost-effective.

16.3.11 **Children Eligible for Medicaid.** Recently there has been a great deal of attention focused on the population of children eligible for Medicaid but not currently enrolled in the program. Governors agree that health care is essential to the well-being of children. Accordingly, children entitled to Medicaid benefits should receive those benefits.

Exact estimates of the number of children who are Medicaid-eligible but not enrolled are difficult to develop. Eligible children may not be enrolled in Medicaid for a number of reasons. For example, a child may have health insurance coverage through a noncustodial parent. Many states already have implemented a range of innovative outreach strategies targeted to those who need benefits but may not be aware of their Medicaid eligibility. These strategies include enrollment centers located out in communities, "one-stop shops," and simplified presumptive eligibility processes.

Should the federal government consider additional strategies to reach out to families of children eligible for Medicaid but not receiving benefits, those strategies must be developed in conjunction with the states. Uncoordinated outreach efforts would be administratively cumbersome and would fail to achieve the desired results. For example, while the Special Supplemental Nutritional Program for Women, Infants, and Children (WIC) serves a large number of children who are in need of health care coverage, the U.S. Department of Agriculture has determined that WIC administrative funds can only be used to provide information about the State Children's Health Insurance Program (SCHIP) and enroll children under very limited circumstances. Changing this policy would help states maximize their outreach and enrollment efforts.

Outreach efforts also must be designed in a way that discourages employers from discontinuing private sector insurance coverage for children. The Governors believe strongly that no Medicaid outreach strategy should create an opportunity for shifting private sector insurance costs to the public sector.

Because the group of children currently eligible for Medicaid but not enrolled has proved difficult to accurately quantify and has been resistant to previous outreach efforts, the Governors would oppose tying receipt of Medicaid funds to achieving increased enrollment targets. The full results of these outreach efforts may take some time to develop, as states experiment with methods that will be most effective for reaching the families in those states.

16.3.12 **Flexibility for Optional Eligibility Groups.** States interested in expanding or restructuring Medicaid eligibility for optional beneficiary categories should have the flexibility to customize a package of optional benefits to meet the particular needs of the optional group. This flexibility would require the waiver of benefit comparability and statewideness standards related to the amount, duration, and scope of benefits. States have shown that the provision of a few well-placed services, such as respite care, minor home modifications, or limited amounts of personal care can significantly delay the onset of debilitating conditions and keep beneficiaries in their homes for longer periods of time. Not only is this sound public policy, but the potential savings for the individual, the family, and the state and federal governments is significant.

16.3.13 **The Americans with Disabilities Act.** The Americans with Disabilities Act of 1990 (ada) is a civil rights law prohibiting discrimination against the disabled. Recent court decisions have interpreted ada in a way that means that states must provide community placements for virtually all of the mentally and physically disabled persons eligible to receive state services. Governors believe these decisions have extended ada's reach beyond anything Congress intended. Without reconsideration of this caselaw and constructive clarification of the reasonable and permissible limits on states' ADA obligations, the proliferation of costly litigation against states will continue and the integrity of the state Medicaid programs will be jeopardized.

16.3.14 **DRUG REBATE PROGRAM.** UNDER CURRENT MEDICAID LAW, COVERAGE OF PRESCRIPTION DRUGS IS AN OPTIONAL SERVICE. ALL STATES HAVE ELECTED TO COVER PRESCRIPTION DRUGS, BUT IN ORDER TO DO SO, THEY MUST ABIDE BY THE RULES OF THE DRUG REBATE PROGRAM (DRP). ESTABLISHED IN THE OMNIBUS BUDGET RECONCILIATION ACT OF 1990, THE DRP PROVIDES AN INCENTIVE FOR STATES BY REQUIRING THE DRUG COMPANIES TO OFFER DISCOUNTS ON PRESCRIPTION DRUGS. IN RETURN, STATES ARE ESSENTIALLY OBLIGATED TO COVER ALL U.S. FOOD AND DRUG ADMINISTRATION-APPROVED PRESCRIPTION DRUGS DEVELOPED BY THE PARTICIPATING DRUG COMPANIES. ALTHOUGH THE STATUTE SETS OUT A LIST OF DRUGS THAT MAY, AT STATE OPTION, BE EXCLUDED FROM COVERAGE, THE LIST IS OUTDATED AND NO MECHANISM EXISTS TO UPDATE THE LIST.

THERE ARE INCREASING CONCERNS FROM STATES THAT THE DRP NO LONGER ADEQUATELY MEETS THE NEEDS OF STATE MEDICAID PROGRAMS. CURRENTLY, EVEN ENTITIES SUCH AS CHAIN DRUG STORES CAN RECEIVE DISCOUNTS FROM THE MANUFACTURERS, WITHOUT THE PRESCRIPTIVE COVERAGE GUIDELINES CONTAINED IN THE DRP. STATES ARE CLEARLY NOT ABLE TO EFFECTIVELY UTILIZE THEIR PURCHASING POWER TO LEVERAGE THE LOWEST POSSIBLE PRICES FOR PHARMACEUTICALS.

16.3.14.1 **RECOMMENDATIONS**

- REWRITE THE DRUG REBATE STATUTE TO PROVIDE STATES WITH MORE FLEXIBILITY IN DETERMINING WHICH TYPES OF DRUGS THEY COULD COVER.
- INCREASE THE RETURN THAT STATES RECEIVE ON THEIR INVESTMENT IN PHARMACEUTICAL COVERAGE. SUCH A RETURN COULD TAKE THE FORM OF INCREASED REBATES FROM GENERIC DRUGS, INCREASED REBATES FOR CERTAIN VERY EXPENSIVE DRUGS, OR A LARGER ACROSS-THE-BOARD REBATE. THIS COULD ALSO TAKE THE FORM OF ENHANCED FEDERAL FINANCIAL

PARTICIPATION OR INCREASED MANUFACTURERS' INCENTIVES FOR REDUCING COSTS ON CERTAIN TYPES OF VERY EXPENSIVE DRUGS.

- ENCOURAGE MULTI-STATE, PUBLIC/PRIVATE OR INTERNATIONAL PURCHASING ALLIANCES, OR OTHER INNOVATIVE WAYS TO BETTER LEVERAGE STATE BUYING POWER.
- ENSURE THAT MEDICAID MANAGED CARE DOES NOT IMPOSE ARTIFICIAL RESTRICTIONS THAT PROHIBIT STATES FROM REALIZING THE MAXIMUM POTENTIAL BENEFIT OF THE DRUG REBATE.

Time limited (effective Winter Meeting 1999–Winter Meeting 2001).
Adopted Winter Meeting 1995; revised Winter Meeting 1997 and Winter Meeting 1999.

HR-20. CONSTITUTIONAL AND CIVIL RIGHTS IN MANAGING INSTITUTIONALIZED POPULATIONS

20.1 PREAMBLE

THE GOVERNORS STRONGLY SUPPORT THE RELIGIOUS RIGHTS AND THE CIVIL RIGHTS OF INDIVIDUALS. THESE INCLUDE THE FIRST AMENDMENT RIGHTS THAT PROTECT AN INDIVIDUAL'S FREEDOM TO WORSHIP, AND THE CIVIL RIGHTS OF INDIVIDUALS WHO ARE INSTITUTIONALIZED UNDER SPECIAL CIRCUMSTANCES. HOWEVER, GOVERNORS BELIEVE THAT THERE SOMETIMES MUST BE A BALANCE BETWEEN THESE FREEDOMS AND RIGHTS, AND THE INTEREST OF THE STATES IN MANAGING INSTITUTIONALIZED POPULATIONS.

20.2 RELIGIOUS FREEDOM

ANY FUTURE LEGISLATION REGARDING RELIGIOUS FREEDOM SHOULD SPECIFICALLY EXCLUDE PRISON AND JAIL INMATES OR ANY PERSON HELD OR INCARCERATED AS A PRETRIAL DETAINEE. LIKEWISE, SINCE THE RELIGIOUS FREEDOM RESTORATION ACT (RFRA) WAS INVALIDATED BY THE SUPREME COURT, ANY LIABILITY THAT MAY HAVE ACCRUED TO STATE AND LOCAL GOVERNMENTS AS A RESULT OF THE MISAPPLICATION OF RFRA TO INDIVIDUALS WHO ARE INCARCERATED IN A STATE OR LOCAL CORRECTIONAL, DETENTION, OR PENAL FACILITY SHOULD BE ELIMINATED.

20.3 CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS

WITH REGARD TO THE CIVIL RIGHTS OF INDIVIDUALS, CONGRESS ADOPTED THE CIVIL RIGHTS OF INSTITUTIONALIZED PERSONS ACT (CRIPA) TO SECURE THE RIGHTS OF INDIVIDUALS WHO ARE INSTITUTIONALIZED IN GOVERNMENT INSTITUTIONS. UNDER CRIPA, THE U.S. DEPARTMENT OF JUSTICE (DOJ) HAS THE AUTHORITY TO LITIGATE ALLEGED CIVIL RIGHTS VIOLATIONS AND TO ENTER INTO CONSENT DECREES OR SETTLEMENT AGREEMENTS WITH STATE GOVERNMENTS AS AN ENFORCEMENT MECHANISM OF THE ACT. THEREFORE, TO ENSURE RESPECT FOR A STATE'S STRONG

INTEREST IN INDEPENDENTLY OPERATING ITS INSTITUTIONS, THE GOVERNORS URGE CONGRESS TO ENACT INTO LAW THE FOLLOWING PRINCIPLES TO GUIDE DOJ IN ITS CRIPA INVESTIGATIONS OR ACTIONS.

- REQUIRE DOJ TO DEVELOP STANDARDS AND PROMULGATE RULES IMPLEMENTING CRIPA UNDER THE FEDERAL ADMINISTRATIVE PROCEDURES ACT.
- REQUIRE THAT ANY DOJ PRELITIGATION INVESTIGATION INTO A STATE INSTITUTION BE PRECEDED BY COMPLAINTS THAT PROVIDE A FACTUAL BASIS TO ESTABLISH A THRESHOLD FOR CRIPA INVESTIGATION WITH RESPECT TO THE FACILITY. IN ADDITION, THE IDENTITY OF THE COMPLAINANTS SHOULD BE PROVIDED TO THE STATE'S LEGAL AUTHORITIES. THESE VERIFIED FACTS, ALONG WITH THE IDENTITY OF THE COMPLAINANTS, SHOULD BE PROVIDED TO THE STATE PRIOR TO LITIGATION SO THAT THE ACCURACY OF THE ALLEGATIONS CAN BE INVESTIGATED AND ANY APPROPRIATE REMEDIAL ACTION CAN BE TAKEN WITHOUT THE NEED FOR LITIGATION.
- CLARIFY THAT THE ONLY RELIEF THAT DOJ MAY SEEK UNDER CRIPA IS THAT WHICH IS NARROWLY DRAWN, EXTENDS NO FURTHER THAN IS NECESSARY TO CORRECT THE VIOLATION OF THE FEDERAL CIVIL RIGHT, AND IS THE LEAST INTRUSIVE MEANS NECESSARY TO CORRECT THE PROVEN VIOLATION OF A FEDERAL RIGHT. THESE STANDARDS SHOULD APPLY ACROSS THE BOARD TO ALL CRIPA INVESTIGATIONS AND ACTIONS.
- CLARIFY THAT BEFORE DOJ FILES SUIT IN A CRIPA ACTION, STATES MUST BE PROVIDED AN OPPORTUNITY TO SUBMIT A REMEDIAL PLAN FOR CORRECTING ALLEGED CONSTITUTIONAL VIOLATIONS. DOJ SHOULD PROCEED IN FILING SUIT ONLY IF THE STATE'S PLAN FAILS TO REMEDY THE FLAGRANT CONSTITUTIONAL VIOLATION THAT IS ALLEGED.

- CLARIFY THAT DOJ, IN ORDER TO MAINTAIN AND SUBSEQUENTLY PREVAIL IN A CRIPA ACTION IN FEDERAL COURT, MUST FIRST ALLEGE AND THEN PROVE ACTUAL HARM TO INSTITUTIONALIZED PERSONS AS A RESULT OF THE ALLEGED UNCONSTITUTIONAL CONDITIONS WITHIN AN INSTITUTION.
- PROVIDE THAT IN ALL CRIPA ACTIONS, DOJ AND THE COURTS MUST GIVE SUBSTANTIAL WEIGHT TO ANY ADVERSE IMPACT ANY RELIEF MIGHT CAUSE ON THE PUBLIC SAFETY AND THE OPERATION OF THE INSTITUTION AT ISSUE.
- REQUIRE THAT ANY SETTLEMENT AGREEMENT ENTERED UNDER THE AUTHORITY OF CRIPA THAT IMPOSES AN OBLIGATION ON A STATE OR LOCAL FACILITY LAST NO LONGER THAN TWO YEARS AFTER THE DATE OF THE ORIGINAL AGREEMENT.

Time limited (effective Winter Meeting 2000–Winter Meeting 2002).

HR-37. PRIVATE SECTOR HEALTH CARE REFORM

37.1 Preamble

The health of our nation depends on the health of our people. The United States has the most sophisticated and technologically advanced health care system in the world. However, the technological excellence of our system has come with a price. For several decades, growth in the American health care industry exceeded growth in the overall economy. In the mid 1990s, there was a moderation in medical inflation thanks in large part to the cost controls and management efficiencies implemented in Medicaid and other state health programs by Governors.

However, recent indications are that health care premiums are beginning to rise in response to increases in underlying health care costs as well as market pressures. States must have the flexibility to work with the private sector health care delivery system to explore strategies to help control costs and ensure quality of care.

A growing number of Americans, including children and adolescents, are without private sector health coverage, with even basic care beyond the reach of many. With health care costs having exceeded general economic growth for decades, coverage has declined, and costs have shifted to a smaller percentage of Americans who can afford to pay. Affordable quality care is becoming more elusive. The challenge that we face is to extend access to affordable quality care to all Americans, including those in underserved and rural areas, while containing costs.

The last several years have seen intense federal efforts to develop a consensus on national health care reform. Although efforts to enact fundamental national reform have been unsuccessful thus far, important progress has been made with the passage of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). In addition, the reform efforts of Governors and state legislators have been much more successful than federal attempts at fundamental reform. The emphasis of Governors today is to develop state-based health care reform efforts.

In almost every state, strategies have been implemented to improve the quality and availability of health care. In most states, the reform efforts have been focused to address a specialized problem. States are testing strategies to restructure both the health care market and the public programs that support the most vulnerable citizens.

37.1.1 Private Market. Even before the enactment of HIPAA, states have acted to enhance access and improve equity for both employers and employees within the private insurance market. In some states, for example, limits have been placed on preexisting conditions exclusions for certain market segments. In both the individual and small group markets some states have implemented reforms setting forth guaranteed issue, which requires insurers in the small group market to accept every small employer who applies for coverage, and portability of coverage, through which individuals can be ensured access to coverage after changing jobs. And within the small group insurance market, a number of states are establishing modified community rating systems, while two states have moved to a pure community rating.

Many states are experimenting with tax incentives to increase coverage. Included among these strategies are transitional tax credits to small businesses and medical savings accounts. These state experiments are applicable only to state taxes and do not affect federal tax laws.

Some states are encouraging the establishment of purchasing alliances or group purchasing pools. By spreading risk and encouraging competition among health networks and insurers, alliances are able to offer affordable coverage to individuals, those who are self-employed, and people who work in small businesses—those who find it most difficult to purchase affordable coverage. Although these programs are still in their earliest stages, the results look promising. The Governors continue to be concerned about federal preemption of state law in the regulation of health care networks.

By experimenting with a number of innovations within the private insurance market, states have taken the lead in developing and implementing reforms designed to expand affordable access to insurance coverage while controlling costs. The experience gained through state reform efforts laid the groundwork for the passage of the federal Health Insurance Portability and Accountability Act of 1996.

37.2 Federal Support for State-Based Health Care Reform

States have made significant progress in reforming their health care systems; however, much more needs to be done. The nation's Governors call upon the President and Congress to work with states to facilitate and accelerate the development of state reform efforts.

37.2.1 **Employee Retirement Income Security Act.** Although the Governors are extremely sensitive to the concerns of large multistate employers, the fact remains that one of the greatest barriers to some state reform initiatives is the Employee Retirement Income Security Act (ERISA).

ERISA was enacted in 1974 and applies to employee benefits plans, including employee health plans. ERISA provides for a complete federal preemption of state laws that "relate to" employee health plans. Under the McCarran-Ferguson Act, states retain the ability to regulate insurance carriers, such as indemnity plans and health maintenance organizations. However, states are powerless to regulate or otherwise affect employee health plans that "self-insure" under ERISA rather than buy insurance.

Self-insurance was very rare when ERISA was enacted, but it now covers a majority of the employees in the United States who receive health benefits. This proliferation of self-insurance, coupled with the federal courts' broad interpretation of the reach of ERISA preemption, has made ERISA a formidable barrier to states wishing to implement certain health care reform.

ERISA preempts all self-insured health plans from state regulations and subjects those plans only to federal authority. As a result of judicial interpretations of ERISA, states are prohibited from:

- establishing minimum guaranteed benefits packages for all employers;
- requiring all health plans to provide states with information crucial to developing a comprehensive understanding of the status of the state's health care access and delivery systems;
- establishing a statewide employer mandate;
- imposing a level playing field through premium taxes on self-insured plans; and
- overseeing quality in self-funded health plans and establishing consumer protections.

The decision in New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Company affirmed states' ability to establish all-payer rate-setting systems. The same case indicated that provider taxes would be permissible, but concerns remain that these taxes could be preempted by ERISA through evolving judicial interpretation.

37.2.1.1 **Strategy for Reform.** A multidimensional approach to reform could be taken that includes flexibility for states directly in the ERISA statute, and through new waiver authority.

- **Statutory Flexibility.** Congress may act quickly to help states by including flexibility directly in statute. This may be accomplished through statutory directives to the federal executive branch regarding national uniformity. Specifically, a state would be permitted to impose requirements on self-funded plans if the state was willing either to adopt and build upon minimum national standards or work within some type of federal framework. The federal executive branch must be instructed to work with states to identify and define those standards.

  This approach has the potential for broad applicability but is most relevant to quality and utilization review procedures.

  To facilitate the process, the legislation should be structured to rely on existing national standards. Where none exist, the legislation could direct the executive branch to develop them. However, if the executive branch finds it necessary to develop a national standard, states should be given limited flexibility during the development period so that they can move ahead with their innovations.
- **Waiver Authority.** In addition to direct statutory flexibility, Congress should establish direct waiver authority in ERISA. Waiver authority would be most applicable for states that wish to develop alternative financing and cost-control strategies that are now precluded by the statute. Waiver authority could have the following parameters.
  - The secretary of the U.S. Department of Labor would have the authority to review and grant ERISA waivers.
  - There would be no prohibition against replicating other state ERISA waivers. However, each state would have to submit a waiver application.

- Waivers would be approved for an initial five-year period with five-year renewals thereafter.
- Waiver applications would be submitted by the Governor.
- ~~As a condition for waiver approval, the state would have to demonstrate that the strategy has the support of the state's legislature.~~
- For states making requests for exemptions in the areas of financing or cost control, the state's waiver application would have to include a plan for expanding coverage and maintaining quality, and a strategy for documenting the state's progress toward achieving these goals.

37.2.2 **The Health Insurance Market.** With the enactment of the McCarran-Ferguson Act in the 1940s, a state's prerogative to regulate health insurers has been recognized by federal law. However, since ERISA's enactment in 1974, that delineation of state and federal responsibilities has been blurred. ERISA provides that self-funded single employer or Taft-Hartley jointly administered plans are exempt from state regulation. States cannot establish minimum solvency and capital requirements for these self-funded plans. They cannot ensure that employees and dependents in self-funded plans receive the basic consumer protections that are offered to those in commercial state-regulated plans; nor can they ensure that those in self-funded plans have remedies available when problems arise over coverage decisions and other matters. As such plans proliferate, they represent a growing share of the total health care market and greatly erode the ability of states to regulate the private health care market. The federal government must act to rectify the situation.

The nation's Governors call on the federal government to correct these inequities by adopting one or more of the following options.

- Congress should work with the states to establish national health care standards for self-funded plans that are similar to those imposed by states on commercial plans. If Congress is unwilling to define legislative standards in ERISA, the U.S. Department of Labor, in consultation with the states, should be given the authority to develop regulations that, at the very least, establish essential consumer protections and remedies standards for self-funded plans.
- Anecdotal evidence suggests that consumer protections problems are more likely to arise in small self-funded plans. Congress could limit self-funding authority to businesses above a certain size. Businesses below that limit would be required to follow state laws. The U.S. Department of Labor would need to enforce standards for those plans that remain under its jurisdiction.

If Congress chooses to set minimum national standards, they should be developed with state officials in consultation with representatives of affected small businesses, insurers, and consumers.

37.2.2.1 **Special Group Arrangements and Markets**

Healthmart Arrangements. Although Governors support many of the goals of healthmarts and recognize that they would preserve some important state prerogatives, states do have some serious concerns about the proposal. First, healthmarts would preempt state benefit requirements, which already provide some of the strongest consumer protections. These benefit requirements include automatic coverage of newborns without any preexisting condition exclusions. A healthmart could design its own benefit package without any requirements or oversight.

Second, a healthmart is allowed to determine what geographic area it will serve. This would leave people who are poorer risks in a smaller pool, raising their rates, and increasing the likelihood that their employer will drop coverage.

Finally, healthmarts would undermine state health reforms by fragmenting the health insurance marketplace. They would also undermine efforts undertaken by states to ensure that their small business communities have access to affordable health insurance.

37.2.2.2 **Multiple Employer Welfare Arrangements.** The Governors support efforts designed to enable small employers to join together to participate more effectively in the health insurance market. In fact, states have taken the lead in facilitating the development of such partnerships and alliances. However, these partnerships must be carefully structured and regulated by state agencies. Many states have experienced extensive and well-documented problems with fraudulent Multiple Employer Welfare Arrangements (MEWAs) in recent years. In many cases, state legislation has been adopted to protect against further abuse.

The Governors strongly oppose congressional reforms that would extend ERISA status to MEWAs or otherwise limit state oversight. State insurance regulation is crucial to ensuring that small business alliances receive reliable and secure coverage. Before any change is made in federal statute with regard to MEWAs, the impact of the small market reform changes set forth by the Health Insurance Portability and Accountability Act of 1996 should be carefully analyzed.

37.2.3 **The Health Insurance Portability and Accountability Act of 1996.** With the passage of this important new law, the federal government has made progress toward extending basic market reforms to ERISA plans. Although Governors recognize the importance of national protections and applaud the extension of those protections to ERISA plans, it is important to remember that states have primary responsibility for insurance regulation. That role must be preserved.

The U.S. Department of Health and Human Services (HHS) plans to evaluate HIPAA during the year. The Governors look forward to working closely with the federal government in the evaluation process. In particular, Governors will be following very carefully the process for determining whether state alternatives for the regulation of the individual insurance market are deemed acceptable by HHS. The statute provides examples of what constitutes an acceptable alternative, and Governors do not want state flexibility to be diminished through the regulatory process.

The Governors also believe states should be consulted extensively as HHS develops standards for the administrative simplification provisions in the new law, especially regarding privacy. National standards will be adopted and enacted within twenty-four months of promulgation regarding transactions, data elements for such transactions, and standards for the electronic transmission of certain health information. State participation is needed to ensure that state data needs are addressed and that patient privacy is protected.

37.2.4 **Privacy.** HIPAA sets a deadline for congressional action on privacy standards for medical records of August 1999, and requires the secretary of HHS to promulgate regulations by February 2000, should Congress fail to enact legislation. THE DEADLINE FOR CONGRESSIONAL ACTION HAS PASSED WITHOUT A MEDICAL RECORDS PRIVACY BILL. AS A RESULT, HHS HAS RELEASED A PROPOSED REGULATION. HOWEVER, CONGRESS RETAINS THE POWER TO EXTEND OR ELIMINATE THE HIPAA DEADLINE AND TO PASS LEGISLATION THAT WOULD SUPERSEDE DEPARTMENTAL REGULATIONS.

In considering legislation and/or regulations, Governors urge the administration and Congress to take into consideration the fact that many states have privacy laws governing medical records. WHILE IT IS CERTAINLY PREFERABLE THAT STATE LAWS ON MEDICAL RECORDS PRIVACY NOT BE PREEMPTED BY FEDERAL ACTION, ANY FEDERAL STATUTE, REGULATIONS, OR GUIDELINES SHOULD REPRESENT A MINIMUM STANDARD, OR "FLOOR," THAT STATES SHOULD BE PERMITTED TO MOVE BEYOND IN ORDER TO CREATE MORE STRINGENT PRIVACY STANDARDS AND BEST MEET THE NEEDS OF THEIR CITIZENS. A MAXIMUM FEDERAL STANDARD FOR MEDICAL RECORDS WILL REVOKE PRIVACY RIGHTS PREVIOUSLY BESTOWED UPON STATES' CITIZENS AND WILL PREVENT STATES FROM

RESPONDING TO FUTURE MEDICAL RECORDS PRIVACY NEEDS THAT CANNOT BE FORESEEN AT THIS TIME. ADDITIONALLY, THE GOVERNORS EXPECT THAT FEDERAL LEGISLATION OR REGULATION WILL NOT INHIBIT THE NECESSARY ACTIVITIES OF STATE INSURANCE COMMISSIONERS, PARTICULARLY IN REGARD TO THE INVESTIGATION OF FRAUD AND ABUSE, THAT ALLOW STATES TO PRESERVE THE FINANCIAL INTEGRITY OF PUBLIC PROGRAMS AND PROTECT CONSUMERS. GOVERNORS ARE CONCERNED THAT THE REGULATIONS COULD IMPOSE SIGNIFICANT AND COSTLY ADMINISTRATIVE BURDENS FOR THE STATES, SUCH AS REWRITING AND DISTRIBUTING MEMBER HANDBOOKS, PROVIDING ADDITIONAL TRAINING FOR STATE AGENCY PERSONNEL, AND ESTABLISHING PRIVACY OFFICERS. ~~These state laws should not be preempted in any way by federal action regarding HIPAA.~~

37.2.5 **Medical Tort Reform.** Reform of the medical tort system should be undertaken with a view toward achieving high-quality and appropriate care. Ideally, medical tort reform will reduce the cost of defensive medicine and provide appropriate levels of compensation for patients injured by medical negligence. Toward that end, the federal government should establish national minimum tort and liability standards. States could establish more restrictive standards if they so choose. The federal government, working with states, also must consider alternative dispute resolution strategies that could be used to reduce the costs of litigation.

37.2.6 **Antitrust.** More and more Americans are receiving their care through health delivery networks. Establishing these networks requires new approaches to cooperation among providers and businesses that heretofore have been competitors. Congress and the administration must work with the states to accommodate this new health care environment while ensuring that competition remains in the marketplace.

37.2.7 **Outcome and Quality Standards.** If meaningful choices are ever to be made in health care, research must be supported to develop outcomes and quality standards for use by providers, purchasers, and consumers alike. Also, information systems must be developed that include price and quality information for all providers and consumers of health care services in a given geographic area. The federal government, the states, and the private sector (both purchasers and providers) must cooperate in the development and implementation of such standards. Data measures must provide information relevant to state programmatic decisions and consumer choice. The collaborative processes of standard development and measurement must be designed in such a way that they do not create unreasonable administrative burdens without yielding useful results.

37.2.8 **Administrative Simplifications.** The administrative complexity of the current system must be reduced. The Governors support the reforms set forth in the Health Insurance Portability and Accountability Act to move the nation toward uniform claims forms and uniform standards for electronic data interchange. However, states must be closely involved in the development of the national standards to ensure that state data needs are met and individual privacy rights are protected.

37.2.9 **Public Sector Health Care Delivery.** Although the Governors support the delivery of care through the private health care system, a public system of services, funded by the state and federal governments, has arisen to address needs unmet by the private sector. (See the Governors' Public Health Services policy, HR-7.)

37.2.10 **Enhance Opportunities for Primary Care Practice.** Despite the recent increase in the percentage of medical students choosing to pursue careers in general medicine, the medical education system still is not preparing the providers that are needed for a health care system with a focus on preventive and primary care. States are currently experimenting with a wide variety of initiatives that address the critical issues of increasing primary care practice and improving the distribution of primary care providers, especially in rural and urban medically underserved areas. These initiatives include data collection to better understand the distribution of, and need for, providers in specific locations; loan repayment programs to practitioners who practice in underserved areas; and technical assistance programs to enhance primary care delivery systems in underserved locations.

Therefore, the Governors recommend that the federal government recognize, review, and support programs currently underway in states that are successfully addressing the issue of increasing and preserving access to primary care physicians in medically underserved and rural areas. Moreover, the Governors recommend that the federal government provide incentives for students, physicians, and mid-level health professionals to serve in primary care professions, particularly in rural and underserved areas.

37.2.11 **Managed Care and Quality.** See the Governors' Medicaid policy, HR-16.

37.3 **Conclusion**

In many states, Governors have begun to meet the challenge of reforming their health care systems and are beginning to learn about the successes and failures. The federal government should support states as they demonstrate different approaches to achieve universal access to affordable health care and should evaluate creative comprehensive approaches to health care reform.

Time limited (effective Winter Meeting 1999–Winter Meeting 2001).
Adopted Winter Meeting 1994; revised Winter Meeting 1995, Winter Meeting 1997, and Winter Meeting 1999.

HR–39. SENIOR PRESCRIPTION DRUGS

IF CONGRESS DECIDES TO EXPAND PRESCRIPTION DRUG COVERAGE TO SENIORS, IT SHOULD NOT SHIFT THAT RESPONSIBILITY OR ITS COSTS TO THE STATES. FURTHERMORE, IN THE PROCESS OF DEVELOPING A SENIOR PRESCRIPTION DRUG POLICY, THE FEDERAL GOVERNMENT SHOULD ACKNOWLEDGE AND ACCOMMODATE STATE PROGRAMS AND AVOID DISINCENTIVES TO STATE INNOVATION, SUCH AS UNREASONABLE MAINTENANCE-OF-EFFORT REQUIREMENTS, REDUCED FEDERAL MATCHING FUNDS, OR OTHER PENALTIES.

Time limited (effective Winter Meeting 2000–Winter Meeting 2002).