Balanced Federalism And Health System Reform

Leaders from more than forty states have produced a set of principles to guide states and the federal government in their health care reform efforts.

by the Reforming States Group

EDITOR’S NOTE: The Reforming States Group (RSG), organized in 1992, is a voluntary association of leaders in health policy in the legislative and executive branches of government, currently from more than forty states. This position paper was the basis for testimony given by Kansas State Senator Sandy Praeger, chair of the RSG Steering Committee, at a hearing on the oversight of the Health Insurance Portability and Accountability Act before the U.S. Senate Labor and Human Resources Committee, 19 March 1998. More than 100 state officials reviewed drafts of the paper at meetings convened by the RSG around the country. Staff members of congressional committees and officials of the federal Departments of Health and Human Services and Labor also contributed to the paper. The principal author of the numerous drafts was John Colmers, vice-chair of the RSG Steering Committee and executive director of the Maryland Health Care Access and Cost Commission. The members of the RSG Steering Committee are identified at the end of this paper.

The pace and magnitude of change are testing those in the federal and state governments who oversee the health care system. The difficulties of oversight include confusing and often blurred lines of authority that mark our federal system of government. Different levels of government have roles and responsibilities more often as a result of historical precedent than of sound policy analysis. As a result, the preferred locus of control is in a constant ebb and flow.

In this position paper the Reforming States Group (RSG) offers its colleagues in government and in the private sector both principles and practical examples of their implications to help guide future deliberations on reforming the health care system and holding it more accountable. Formed in 1992 by a bipartisan group of leaders from both the legislative and executive branches in the handful of states that began the task of making health care more affordable and accessible, the nonpartisan RSG is now composed of leaders from
more than forty states. This Commentary offers the experience of persons at the ground level of the vigorous health policy debate in each of those states.

The purpose of this paper is to encourage a pragmatic dialogue among all of the participants in the debate. Following this introduction, a background section interprets events in health policy from 1994 to the 1997 balanced budget agreement as a call for a new commitment to a balanced federalism. The next section proposes principles to guide this new view of federalism. The RSG then identifies overlapping interests among the various levels of government and between government and the private sector. The paper concludes with recommendations for testing this approach.

The Need For Balanced Federalism

Much has transpired since the failure of national health system reform legislation. In 1993 and 1994 many people hoped that for the first time in decades national legislation would expand access to health care services for the growing numbers of uninsured persons while simultaneously reining in endlessly spiraling costs. Although comprehensive reform legislation did not pass, the health care system—spurred in part by the potential of government action—has undergone tectonic change. The rapid emergence of managed care in its various forms has dramatically altered generation-old incentives and expectations. The lines separating provider, payer, and purchaser have become blurred, and massive consolidations have raised new questions of market dominance and new challenges for those who oversee the system. Some changes have been for the good; others have had unintended consequences. These changes also have been unevenly distributed among the states, with some areas experiencing managed care for the first time and other, more mature markets undergoing more systemic changes.

The exceeding complexity of the health care system in the United States is evident to every decisionmaker in the public and private sectors. The financing system alone contains thousands of different payers or plans, each with its own incentives, operating in an extremely competitive environment and facing increasingly sophisticated and demanding purchasers. In response to the payment incentives of capitation imposed by payers, providers are adopting some of the characteristics of those payers. Some large groups of providers, for example, are now eager to contract directly with business and government. At the same time, purchasers are imposing new standards of performance on their health plans, and in recent years they have simultaneously been successful in holding premium in-
creases to a minimum, in part through the shift to managed care. Depending on the maturity of the managed care market, there is evidence that such savings may be a one-time phenomenon and that a return to significant price increases could be imminent. Nevertheless, the structural changes that have occurred in certain markets may temper that increase.

Government’s role. Government as both purchaser and regulator is not insulated from these complexities. Historically, government-financed health programs acted as bill payers. More recently, the Medicare and Medicaid programs have followed the example of the private sector and have acted more as purchasers. This change confronts government, as it does private purchasers, with controversial choices—controversial because the limitations they impose, although not always the benefits they confer, become obvious to consumers. As purchasers, federal and state governments are increasingly relying on managed care and imposing new standards of reporting and accountability on health plans. The diversity of the patient populations enrolled in Medicare and Medicaid requires that payments to plans be adjusted for risk and that the treatment of these vulnerable populations be closely monitored.

Government also has had a traditional responsibility in overseeing the health care market. In this role as regulator, federal and state governments are facing contradictory trends: on the one hand, a popular trend against big government and in favor of private-sector competitive forces; and on the other hand, increasing complaints from providers and patients about perceived burdens imposed by some managed care plans. Finding a balance, for example, between the desire to leave clinical decision making in the hands of professionals and the equally strong desire to have minimum standards apply across all health plans is becoming increasingly difficult. Furthermore, state government oversight is hampered by the preemption of state law by the Employee Retirement Income Security Act (ERISA) of 1974. Indeed, the portion of the health care market not covered by ERISA, Medicare, or Medicaid, and thus subject to direct state regulation, continues to shrink in virtually every jurisdiction, creating further fractures.

The patient/consumer. In the midst of all of this turmoil, the patient/consumer must navigate this new world with expectations for service and outcomes gained from years of experience with unbridled fee-for-service medicine. Indeed, the notion of consumer protection is emerging in some areas as a frontline issue.

A vision of balanced federalism. The complexity and interrelationship of the elements in the U.S. health care system require a balanced federalism. Such federalism accords preeminence to nei-
“Working together, we can make the system more responsive to ensuring quality, access, and cost containment.”

The health care system is like a fabric woven from many different threads. One cannot work on the fabric one strand at a time; instead, one must work on the whole cloth. Examples of the interplay between warp and woof abound: Efforts by the federal government to expand coverage to children, if poorly implemented, could encourage a decrease in private coverage. Expansion of the ERISA umbrella to certain small businesses could seriously hamper the underwriting reforms already under way in the states and could lead to renewed risk segmentation. Changes that the federal government makes in almost any aspect of the Medicare program affect the states and the private sector. Every state’s market is characterized by the fractures created by Medicare, Medicaid, private insurance, and ERISA-exempt plans.

In this vision of balanced federalism, the federal government appropriately establishes broad national standards, after consultation with the states and the private sector. The states then implement these standards and, at their discretion, expand upon them. Central to this vision is the recognition that government and the private sector have interests that are legitimate and that frequently are concurrent. These interests should be more closely coordinated.

This approach avoids the extremes of the debates of 1994 and 1996. For example, it seeks neither to abolish the advantages that large employers derive from ERISA nor to eliminate diversity among the states. Such a cooperative view of federalism is equally important in the current debate about oversight of the rapidly changing health care industry. Working together, we can make the system more responsive to ensuring quality, access, and cost containment.

The members of the RSG recognize that the complexities of this system are such that no single approach will fit every conceivable problem. In some instances, state flexibility may not be appropriate. For example, national standards are essential for uniform electronic claims transmission, but input from the states and the private sector should be considered.

Many states preceded the federal government in enacting health reform legislation, but it has become increasingly clear that neither the government (at any level) nor the private sector, acting alone, can be expected to make significant progress in addressing the problems of quality, access, and cost. In the midst of the national debate in 1994, bipartisan leaders from a number of those states...
known as the RSG articulated a vision of federalism that called for a new partnership among the federal government, the states, and the private sector. The essential elements of that vision are the same as those incorporated in the Health Insurance Portability and Accountability Act (HIPAA) of 1996 (P.L. 104-191), commonly known by the names of its cosponsors, former Sen. Nancy L. Kassebaum (R-KS) and Sen. Edward M. Kennedy (D-MA).

Importance of Kassebaum-Kennedy legislation. The enactment of HIPAA was an important turning point in federal/state oversight of the health care system. After more than two decades of uneven and at times nonexistent lines of responsibility, the legislation addressed a series of insurance and health data issues with direct implications for federalism. For example, HIPAA established broad federal guidelines regarding underwriting practices in both the large- and small-group insurance markets. At the same time, the bill recognized the traditional role that states have played in regulating insurance and thus allowed states the ability to exceed the minimum standards if they so desire.

HIPAA also created new rules to protect certain persons, albeit modestly, who have lost their group coverage. Moreover, the states could establish their own provisions that meet federal standards, or the federal government would impose a “federal fallback.” In addition, the administrative simplification section of the bill mandated a process to create national electronic data reporting and confidentiality standards. Finally, and perhaps most significantly, the federal government created, for the first time, underwriting requirements for self-funded health benefit plans that enjoy protection from most state oversight because of ERISA. Although HIPAA has been faulted by some as promising far more than it delivers, it does change the roles of the federal/state partnership.

Next step. Further changes are in the offing that could be the next incremental step after HIPAA. Precipitous action on these changes must be avoided. Rather, the federal and state legislatures, the federal and state executives, and the many elements of the private sector must learn to work together to solve problems by respecting each other’s strengths and recognizing their own weaknesses.

The RSG proposes underlying principles to guide a new, balanced federalism and identifies areas of overlapping interest in which to implement these principles. Using this approach, we recommend an appropriate role for each participant in future discussions about health policy. Such a generalized approach is desirable because the health care debate of the 1990s has taught us that the problems and issues of today may not even be in the debate tomorrow.
Principles Of Balanced Federalism

Sound policy should embody a set of principles, each of which respects the requirements of fairness and the protection and enhancement of the public’s health. In applying these principles, there must be an objective evaluation of the trade-off that naturally occurs among cost, quality, and access. These principles also envision collaborative action where appropriate and feasible. Finally, consideration of these principles is guided by two overarching criteria: (1) the necessity for the clear delineation of responsibilities between the states and the federal government, and (2) a recognition of the capacity and expertise that exist at each level of government.

- **Market forces and oversight.** Regulation and competition will always be components of the health care system. A balance must be struck between reliance on market-based incentives to provide efficiency and the desire to ensure access and quality. The role of oversight is to ensure that market conduct and competition support and facilitate access, quality, and cost containment.

- **Accountability.** Health plans and providers should be held to standards of accountability established by both public and private purchasers on behalf of consumers. Such standards should be developed cooperatively with input from those subject to the standards and those receiving care.

- **ERISA.** If employer health benefit plans meet sufficient, clear, and enforced federal standards, states will not feel the need to subject these plans to further oversight. Such consumer protection standards include improved disclosure, financial testing, due process, and remedies. At the same time, however, any further expansion of ERISA preemption should be resisted. Removal of some small-group lives from the existing risk pool could resurrect many of the market segmentation problems solved by earlier state efforts to reform that market.

- **National standards.** In general, when the federal government sets broad national standards, as it did in a collaborative way with HIPAA and the State Children’s Health Insurance Program (CHIP) of 1997, the states should be responsible for implementation. At the same time, states should be permitted to exceed the required minimum standards in specified areas if they so desire, particularly if the states have preceded the federal government in acting. However, the legitimate interests of both the federal government and the states must be honored. This requires recognition of the degree to which federal standards may constrain the states and the effect that state flexibility may have on achieving federal policy objectives.

- **Two corollaries.** Two corollaries apply principles of balanced
federalism to relationships between government and business, acting as purchasers of care, and between government and the clinical community. The first corollary follows from the principle that there is a public interest both in the operation of market forces and in the oversight of professionals and organizations that deliver health services. Purchasers in the public and private sectors have a congruent interest in establishing standards of efficiency, quality, data, accountability, and confidentiality. Options for collaboration range from joint purchasing, through the development of common measures of performance, to the sharing of information.

A second corollary extends the principle of balanced federal and state roles in setting standards to the relationship between the obligation of government to protect the public health and the professional duty of clinicians. Clinical decisions should be made by the clinical community, based on the best available scientific evidence, take into account reasonable financial constraints established by payers and purchasers, and be consistent with reasonable expectations of consumers.

**Areas Of Overlapping Interest: Applying The Principles Of Balanced Federalism**

The following examples of overlapping interests offer opportunities to apply these principles. These issues are identified because we believe that they require joint effort. They also are identified to initiate a dialogue among the public and private organizations that are responsible for overseeing this complex health care system. The RSG does not propose detailed solutions to the problems raised by these issues. We believe, however, that various parties’ simple recognition that such areas of overlapping interest exist will increase the likelihood of finding creative, mutually beneficial solutions. Furthermore, these issues are not listed in priority order, in recognition of the fact that the priorities will change based on local circumstances and the nature of the policy debate.

- **Standards for the oversight of multistate plans and providers.** Through mergers and consolidations and the emergence of several national managed care plans and providers, states increasingly encounter limits in their ability to oversee activities in their own jurisdictions. At the same time, these large organizations may face multiple and at times contradictory regulations.

- **Oversight of new forms of risk-bearing entities.** As provider-based and other nontraditional groups assume additional risk through direct contracting with purchasers, public and private decisionmakers have reason for increasing concern about the solvency of
these entities, similar to the concerns that first led state governments to impose solvency standards on insurance companies and health maintenance organizations (HMOs). Current examples include provider-sponsored organizations (PSOs) and downstream risk, although new models are likely to emerge.

**Impact of PSOs on government payers.** Acting as both provider and payer for Medicare and Medicaid beneficiaries, these entities, known alternatively in different jurisdictions as PSOs, integrated service networks (ISNs), or managed care organizations (MCOs), are sole contractors to government purchasers on a prepaid basis. Given the size and importance of these organizations, however, they necessarily affect others in the market. The financial failure of such organizations could have serious ramifications for nongovernment patients and purchasers who rely on the providers that make up the organization.

**Downstream risk.** This is similar to the previous issue, but at a different point in time. Traditional insurance risk may not have been transferred to a provider group, but through capitation and other forms of reimbursement, business risk and potentially conflicting incentives have been created.

- **Telemedicine.** The emergence of new diagnostic and therapeutic techniques, when combined with advances in telecommunication, permit the patient and the practitioner to be separated by state, if not international, borders. This presents new challenges. Overlapping interests include, among many others, the Federal Communications Commission (FCC), state licensure laws, and the effect on graduate medical education.

- **Graduate medical education.** Market forces have posed new challenges to the traditional methods of financing graduate medical education. Approaches to removing these costs from the traditional payment stream are being developed at the federal and state levels. Concurrently, the debate on the number and distribution of the future supply of health care providers has been reengaged by changes in utilization and delivery systems. Opportunities exist for collaborative action with the private sector in addressing these issues.

- **Fraud and abuse.** There is mounting evidence that changes in payment arrangements require different and more sophisticated methods to detect and prevent abuse in the system. With increasing complexity and increasing amounts of money changing hands, the opportunity for fraud and abuse rises exponentially. The blurring of lines between providers and payers through the rise of integrated delivery systems will necessitate new forms of monitoring. Constantly changing rules and incentives require those colleagues in both the public and private sectors who monitor the integrity of the system to better coordinate oversight activities with each other.
Quality improvement and performance measurement. One of the most significant changes in the health care system is the greater emphasis on accountability. This is seen in both ongoing efforts to improve the quality of the care being rendered as well as formal procedures to measure and compare the performance of plans and providers. Many of these efforts to improve quality and measure performance began in private-sector collaborations, but government purchasers are collaborating increasingly with colleagues in business and labor to improve accountability.

Efforts to expand insurance coverage. Recent evidence suggests that the number of uninsured persons continues to grow. Despite this, incremental reforms likely will be the approach taken for the foreseeable future. States are looking to expand coverage through underwriting reforms and subsidies. The federal government has recently taken steps to expand coverage for uninsured children and pregnant women. These steps should be taken in ways that create incentives to increase overall coverage.

Conversions and mergers of nonprofit plans and providers. Through acquisition or internal decision making, many nonprofit plans and providers are changing their tax status to for-profit or are merging. Although there are many legitimate reasons for such changes, they present the communities served by the plans and providers with many difficult issues. Such issues include asset valuation, asset ownership, distribution of assets, level of access to services, and the degree of oversight of both the transaction and any newly created foundation. Such activities should be coordinated and focused on the community.

Antitrust. The new health care marketplace is spawning new organizational arrangements and structures among provider and payer groups. A reevaluation of existing antitrust laws and regulations should determine whether an appropriate balance has been struck between the need to protect consumers from anticompetitive behavior and the desire to allow for increased efficiency, enhanced quality, the availability of certain services, innovation, or, for some institutions, survival.

Grievance procedures and consumer protection. Methods of reporting and resolving consumer grievances with providers, managed care plans, and insurance carriers are, in many cases, poorly documented and inconsistently applied. Changes to the delivery system have changed, in the view of some, the locus of responsibility. Previously, if patients were dissatisfied with the services they were receiving from a particular provider, they simply found a new provider; or, if the problems were serious enough, they relied on the legal system. The trend toward reduced choices in employer-
sponsored coverage has exacerbated this problem. Grievances with payers or plans generally have been limited to interpretation of the benefit plan. Increasingly, consumers are joining providers in attempts to redress coverage and access issues with the health plans. Rules of procedure for both internal plan review and external appeal vary enormously. Oftentimes, consumers may be unaware of their rights and obligations under a plan. Similarly, there may be multiple points of entry to official appeal or complaint mechanisms. Finally, there are no enforcement mechanisms in this area for ERISA plans.

- **Health data collection and confidentiality.** Increasing demands for more information place additional burdens on those who are collecting, interpreting, and disseminating such data. Privacy and confidentiality, consistency of reporting formats and definitions, and the legitimate demands for weighing the costs of such additional data against the benefits of collecting them are a few of the areas of common interest.

**Concluding Comments**

Topics in the national health care reform debate are ever changing. For this reason, this position paper has proposed a generalized approach to examining issues of federalism through the use of principles and the identification of areas of overlapping interest. The debate resulting in the Balanced Budget Act (BBA) of 1997 revealed two new issues that may prove to be opportunities to test this proposed approach.

The children’s health program (CHIP) that emerged from the conference committee is a compromise. Some argued for greater flexibility in the design of the benefits, and others preferred more uniform standards. As best can be determined, the use of actuarially equivalent standards allows for experimentation to meet the needs of different jurisdictions while at the same time affording a basic level of coverage. Similarly, some argued for a distribution formula that recognized the earlier efforts of some of the states, while others suggested a different standard. Despite the apparent resolution of these issues in the BBA, new and unforeseen challenges will become evident with the legislation’s implementation through federal rule-making and state proposals. Just as in the implementation of HIPAA, there will be ample opportunity for federal, state, and private-sector interaction over the details of implementing CHIP. As questions arise, the RSG suggests that the principles described above be used.
to assist in assessing and resolving issues.

The budget reconciliation debate also produced some new areas of overlapping interest that did not survive in the final bill. In particular, the proposal to increase the Medicare eligibility age raised a variety of issues, not the least of which is the availability and affordability of private insurance coverage for those who otherwise would have been eligible for Medicare coverage at age sixty-five, especially persons who leave the workforce, willingly or not, before age sixty-five. The RSG believes that any future consideration of this change in Medicare policy should be accompanied by a broader review of health coverage for persons over age fifty-five. This topic involves areas of overlapping concern for the states, the federal government, and the private sector.

The RSG invites responses to this paper from colleagues in the federal government, the states, and the private sector. A balanced federalism, in our view, can result from debate among colleagues and the negotiation of competing perceptions and interests.

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