Outline

- Theory – Federalism and the Constitution
- State & Federal Roles
- ACA
- Federal Funding of States
- Why Federal Involvement in Health Policy
- Why State Involvement in Health Policy
- Summary of Responsibilities
Attendance Question

- Who is this?

A. Adam Smith
B. George Washington
C. John Adams
D. John Quincy Adams
E. Isaac Newton

Source: abc15.com
Federalism

**National**
- Declare war
- Maintain armed forces
- Regulate interstate and foreign trade
- Admit new states
- Establish post offices
- Set standard weights and measures
- Coin money
- Establish foreign policy
- Make all laws necessary and proper for carrying out delegated powers

**Shared**
- Maintain law and order
- Levy taxes
- Borrow money
- Charter banks
- Establish courts
- Provide for public welfare

**State**
- Establish and maintain schools
- Establish local governments
- Regulate business within the state
- Make marriage laws
- Provide for public safety
- Assume other powers not delegated to the national government or prohibited to the states

Source: sentryjournal.com
What is Federalism

- A system of government with both a central authority and autonomous constituent jurisdictions.
  - Allocation of power & responsibilities between states & national government

- Constitutional Federalism is an American innovation…

- Arose from the desire to reconcile two powerful opposing forces:
  - The need for more national authority and mistrust of a single sovereign.

Source: Bovbjerg, Wiener, & Houseman, 2003
The Constitution

- According to the Articles of Confederation (1777), states printed money, & oversaw public safety, health, welfare, & morals – thus a weak national government

- Therefore, a stronger central government was deemed to be essential “to promote the general welfare” (U.S. Constitution, Preamble).

- However, fears of an overly strong central government lead to continued state authority as a counterweight to enhanced national authority

- Ambiguity in allocation of powers was built in to achieve compromise from time to time

Source: Bovbjerg, Wiener, & Houseman, 2003
State Government’s Role

- Started with the epidemics of the late 18th and early 19th century – instituting quarantine measures & improving community sanitation
  - Bubonic Plague in Boston in 1721
  - Diphtheria in MA and NH in 1730s
  - Yellow Fever in New York, Philadelphia & Baltimore in 1820s and Mississippi Valley in 1879
  - Cholera in New York and Cincinnati in 1832
  - Plague in San Francisco & Honolulu at the turn of 19th century
  - Polio in New York in 1916

- Led to creation of state health departments and appointment of health inspectors
  - ASTHO – Association of State & Territorial Health Officials
    - Track, evaluate and advise members on public and private health policy

- Licensing and accreditation of physicians and hospitals
  - Certificates of Need

Source: (Rosenberg, 2008) and (ASTHO, 2013)
Federal Government’s Role

- Creation of FDA in 1906
  - Enumerated Powers Clause in the Constitution gives Federal Government right over interstate commerce
  - Food and medications are transported across state lines
- Hill-Burton Act (1946) – Federal initiative to build healthcare facilities
  - Facilities must comply with community service obligation
- April 11, 1953 – Department of Health, Education and Welfare came into existence
  - May 1980 – Department of Health and Human Services established
McCarran-Ferguson Act (1945)

- Permitted states to regulate and tax foreign insurance companies doing business within their borders
  - Exempts states from federal antitrust laws if the state regulated the industry

- United States vs. Southern Eastern Underwriters Association (322 U.S. 533)
  - Before the Supreme Court questioning whether or not insurance was a form of Interstate commerce
    - If so the federal government would regulate
    - General opinion before this case was that insurance was not commerce
  - Decision: “Acts of Congress” that do not expressly purport to regulate the “business of insurance” will not preempt state laws or regulations that regulate the “business of insurance”

Source: Anderson, 1983
State Regulation of Health Insurance

- Rigor with which states oversee insurance varies by states

- States can regulate such things as:
  - Premium rates
  - Policy language
  - Unfair claims practices
  - Financial reserves
  - Accounting practices
  - Minimum coverage requirements
The Federal Employees Health Benefits (FEHB) Program

- A private insurance program for federal employees including the president and members of congress
  - Began in the 1960s
- It’s a system of over 100 competing private health plans offered by private insurance companies of employee associations
- Contracts with plans that offer a complete line of medical services but benefits vary from plan to plan
- Government pays either 72% of the average plan premium weighted by enrollment or 75% of premium for plan chosen – whichever is less
- Overseen by the Office of Personnel Management (OPM)

Source: PNHP; Physicians for A National Health Program
The Employee Retirement Income Security Act (ERISA) 1974

- A comprehensive federal scheme for the regulation of employee pension and welfare benefit plans offered by private sector employees
- Intends to protect the rights of plan participants & beneficiaries in benefit plans
- Include requirements relating to
  - Reporting and disclosure
  - Participation
  - Vesting and benefit accrual
  - Plan Funding
- ERISA contains various standards that a plan must meet in order to receive favorable tax treatment
- ERISA preempted state regulation however now missing national oversight

Source: Purcell & Staman, 2009
ERISA & Employer-Funded Coverage

- Department of Labor (DOL) created set reporting requirements
  - However regulation of rates, policy language like the states had was not a provision under the bill
- Self-insured companies were therefore able to ignore state mandates on services, restrict coverage, and rates
  - Did not have to disclose benefits, procedures of the plan, data on outcomes
  - No “medical loss ratio” – no minimal level set for expenditures as a proportion of health plan revenues
- In 1974, there were only a few self-insured companies
ERISA & Employer Coverage

- Today the number of self-insured companies has increased
  - ERISA applies to more plans
- Has created a dual system where some plans are subject to state regulation while other are not
  - Confusing landscape between state and federal regulation
- Conflict between state and federal authorities has increased
  - Example: State level tort law for coverage denial
  - Limits patient’s ability to sue administrators of employer sponsored insurance plans
Health Insurance Portability & Accountability Act (HIPPA) 1996

- An amendment to the Internal Revenue Code of 1986
  - To improve portability & continuity of health insurance coverage in the group & individual markets,
  - To combat waste, fraud, and abuse in health insurance and healthcare delivery, promote use of medical savings accounts, improve access to long-term care, simplify health insurance administration…

- Enacted after the failure of health care reform under President Bill Clinton & overseen by the Department of Labor (DOL)

- Restricted insurance use of pre-existing conditions to make coverage decisions & set standards for medical records privacy

Source: Congress, 1996
HIPPA cont...

- Could not deny coverage if a worker had a sufficient number of prior years of coverage
- Could not deny coverage to a group due to pre-existing condition to one member
  - Could set high premiums
- Provided for the provision of certificates of Creditable Coverage
  - Automatically & free of charge by plan or insurer when an individual loses coverage
- Special Enrollment rights
  - For individual who lose coverage in certain situations including separation, divorce, death, termination of employment & reduction in hours

Source: U.S. Department of Labor, 2004
Additional Federal Roles

- DOL charged with overseeing health insurance policies
  new minimum standards of covering specific services

  - Mental Health Parity Act (1996)
    - Lifetime and annual limits on mental health coverage
  - Newborns’ and Mothers’ Health Protection Act (1996)
    - Hospital stay after childbirth
  - Women’s Health and Cancer Rights Act (1998)
    - Reconstructive surgery after mastectomies
State vs. Federal Regulation: Legal Challenges to the ACA

- On March 23, 2010, a total of 28 parties filed joint or individual lawsuits against the ACA:
  - 26 states in a join action; the National Federation of Independent Businesses (NFIB); & Individual plaintiffs
- Challenged the constitutionality of 2 major provisions of the ACA:
  - The individual mandate – maintain min level of health coverage
  - Medicaid expansion – expand eligibility for Medicaid benefits
- 13 states filed *amicus* (“friend of the court”) briefs in the supreme court
- Legislators in 29 states have introduced measures to amend their constitutions to nullify portions of the health care reform law

Source: The Kaiser Family Foundation, 2012
Constitutional Arguments on the ACA

- Most time was spent debating the constitutionality of the individual mandate

- An array of constitutional arguments:
  - Whether the individual mandate is a permissible exercise of Congress’s powers under the Commerce Clause in Article I of the Constitution
  - Whether the individual mandate is permissible under Congress’s power to tax for the general welfare in Article I of the constitution
  - Whether the individual mandate is permissible under the Necessary and Proper Clause in Article I of the Constitution
## Supreme Court Ruling on ACA

### Vote Breakdown of the Court’s Decision

<table>
<thead>
<tr>
<th>Outcome</th>
<th>For</th>
<th>Against</th>
</tr>
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<tbody>
<tr>
<td>Court has jurisdiction to decide case now</td>
<td>9</td>
<td>0</td>
</tr>
<tr>
<td>Mandate is a constitutional exercise of Congress’ power to tax</td>
<td>5</td>
<td>4</td>
</tr>
<tr>
<td>Medicaid expansion violates Congress’ spending clause power as unconstitutionally coercive of states because all existing Medicaid funds at risk and states not given adequate notice to voluntarily consent</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Remedy is to limit HHS Secretary’s power to withhold existing federal Medicaid funds for state non-compliance with Medicaid expansion</td>
<td>5</td>
<td>4</td>
</tr>
</tbody>
</table>


Source: The Kaiser Family Foundation, 2012
Take Home Message: Insurance

- Understand how insurance is regulated
  - While regulation is primarily state controlled, the Federal Government has taken the role of governing how insurance is provided
  - This incremental manner of adjusting power has created a complex web of uncoordinated rules and potential legal challenges
- Understand how federalism allows for shifts in power, which can cause problems of ambiguity
- Understand how the individual mandate of the ACA will impact states
Funding: How States Receive Federal $s

- A component of Federalism
  - Intergovernmental grants
    - Mix of incentives and regulation

- Entices states to fix health care problems by providing federal dollars

- In exchange federal government gets to impose rules
  - Federal highway dollars if state has 21+ age drinking limit

- Most states find this type of money hard to “leave on the table”
Outlays for Federal Grants to State and Local Governments, by Budget Function and Type of Spending, 2011

(Billions of dollars)

- **Health**: Large bar
- **Income Security**: Smaller bar
- **Education**: Even smaller bar
- **Transportation**: Small bar
- **Other**: Smallest bar

Source: Congressional Budget Office based on *Budget of the United States Government, Fiscal Year 2013: Analytical Perspectives*, Table 18.1.
Categorical Grants

- Grants issued by the US Congress and can only be spent for narrowly-defined purposes
  - Well-defined rules and requirements
  - Have program standards in addition to budgetary controls
  - Limit scope & function, but when combined with mandates & entitlements create continued financial growth to meet demand

- The main source of federal aid to state & local governments

- Recipients are often required to match a portion of federal funds

- Medicaid is currently a categorical grant
Block Grants

- One large sum
  - Tends to focus on short-term solutions rather than long term effects
- General provisions as to how to be spent
- Little to no rules or requirements

Criticism of Block Grants

- The award process can be manipulated so that grants can be distributed to reward the federal administration's own party
- At the local level, partisan favoritism may occur when the state distributes the funds to local government units
- Disbursing the funds through state or local governments makes federal oversight of their proper use very difficult
Medicaid: The Shared Expense

- Each state administers own program: fee-for-service/managed care, varies by state
- Center for Medicare and Medicaid Services monitors all state programs
- Federal government provides matching funds to each state
- PPACA expanded eligibility for Medicaid, starting in 2014
- Republican Budget “Path to Prosperity” would change how states are paid
- Presidents Obama’s budget plan would change how much states receive
GOP “Path to Prosperity” Plan

- Turn Medicaid into a block grant program
  - Gives states more control over what Medicaid money is used for
  - Total dollar amount of the block grants would increase annually with population growth and with growth in the consumer price index (average inflation)

- Opponents say that both of these measures will reduce the number of people and services the program can cover and place a greater burden on the states
  - Arizona recently dropped coverage of transplants
President Obama’s 2013 Budget Plan

- Replace complicated Federal matching formulas with a single rate for all states
  - There is a provision to allow for increasing the rate if a recession increases an enrollment or State costs rise
- National Governors Association (NGA) to create a Task Force to recommend ways to reform and strengthen Medicaid
- Some language about incentives to make more efficient, higher quality, reform of care for the high-cost beneficiaries (dual eligible)
- Improving patient safety: Partnership for Patients
  - Addressing issues such as wrong sided surgery, hospital acquired infections
  - Projected to reduce billions of dollars in Medicaid over the next 10 years
- Reducing abuse and increasing accountability in Medicaid
  - Reduce States’ use of provider taxes to lower their own spending while not providing additional health services
  - Establish upper limits on Medicaid payments for durable medical equipment
  - Take other actions to improve program integrity

Adopted from S. Prakash 2012
Rhode Island’s Plan

- 3 main areas to dealing with increasing costs and reduction in federal money
  - Reorganizing and coordinating care to move people toward less-intensive settings as soon as they’re ready
  - Reducing payments to nursing homes, hospitals and ambulance companies
  - Winning federal approval for changes in programs that, if successful, would bring in more than $14 million in new federal money

- A key proposal in the budget: the U.S. Centers for Medicare and Medicaid Services will reimburse 90 percent of the costs of behavioral health programs called Health Homes
  - Provide coordinated care of both the mental and physical needs of mentally ill people

- Increasing the federal reimbursement from 52 percent to 90 percent is worth nearly $13 million to Rhode Island’s Medicaid program in the 2012 budget – for 2 years only

Adopted from S. Prakash 2012
Arguments for Federal Government Involvement in Health Policy/Regulation

- Intervention when markets fail or do not function efficiently
- Regulation of interstate commerce
  - National insurance companies
- Uniformity across states
  - Uniform policies and mandates
- Protection of share social values

Adopted from S. Prakash 2012
Arguments Against Federal Government Involvement in Health Policy/Regulation

- Bureaucratic inflexibility, excessive regulation
- Inconsistent enforcement of rules and regulations
- Fraud, abuse, lobbying?
- Insensitivity to local needs
- Accusations government programs promote welfare dependence

Adopted from S. Prakash 2012
Arguments For State Government Involvement in Health Policy/Regulation

- Closer to the people and more familiar with needs
- More accessible and accountable
- More responsive
- More willing to take risks
- Serve as important laboratories for testing health policies
  - Oregon Experiment
  - Mass. Health Care Reform

Adopted from S. Prakash 2012
Arguments Against State Government Involvement in Health Policy/Regulation

- Harder to develop and coordinate national strategy
- Disparities among states
  - Access and resources; values
- Complicates employer-based health insurance for national companies
- Political considerations get mixed up with allocation policy decisions at the state and local level
  - Could argue happens at every level

Adopted from S. Prakash 2012
Funding: Take Home Message

- Understand how funding and regulation at state and federal levels often creates overlap
  - Sometimes, jurisdiction is not clear

- Understand how federalism will play a role in what changes are made

- Understand the pros and cons to increasing governmental control over health expenditures
  - It is situation-dependent
Summary

- Medicare
- Medicaid*
- Department of Health and Human Services
  - FDA
  - CDC
  - NIH
- Department of Labor
  - ERISA
  - COBRA
  - HIPPA
Summary of State Responsibilities

- Licensing
  - Hospitals
    - Certificates of Need
  - Physicians

- Public Health Departments
  - Health Monitoring
  - Sanitation
  - Disease control

- Medicaid*
  - Environmental protection
  - Regulation of health care costs and insurers

Adopted from S. Prakash 2012
Health and the Economy

Source: sciencedirect.com
Sources

“You’ve got a rare condition called ‘good health’. Frankly, we’re not sure how to treat it.”