SB208: HEALTH CARE COMPACT IS A POOR CHOICE FOR UTAH
Are these the states Utah wants to hang with?

A Utah Health Policy Project Position Paper — February 9, 2012

SUMMARY

SB208 (Sen. S. Adams) proposes Utah join the *Health Care Compact.* By joining the *Compact* Utah would commit to asking Congress for an exemption from all federal health reform laws (ACA) and regulations and for a block grant of all federal health care funds (except veterans' health care and Indian Health Services). To date 4 states have enacted similar legislation, 2 governors have vetoed the idea (including Arizona Governor Jan Brewer), and another 10 have considered but not passed legislation.[i] Utah leaders should think twice before joining the *Health Care Compact* and here's why…

TOP 8 REASONS FOR UTAH TO STAY OUT OF THE HEALTH CARE COMPACT

1. **Utah has already committed to Medicaid transformation. It's called accountable care.** SB180 (2011, Sen. Dan Liljenquist) created a Utah game-plan for reducing Medicaid cost growth while improving health outcomes. For the first time, Medicaid will begin paying providers for making and keeping people well and will be held accountable for meeting those goals. By comparison, Compact supporters don't have answers to basic, practical questions, but still want Utah to partner with states that are far behind the curve in state health care and Medicaid reform.

2. **A Medicaid block grant would undermine accountable care.** Utah is asking providers of all types to commit to provide better, more coordinated care to patients, but under a block grant, low-spending states like Utah would likely scale back provider rates. For accountable care to work, we need new providers to step forward and work together in a team. Let's give this process a chance to work.

3. **The compacted states are way behind Utah** in terms of health outcomes, health care spending, and efforts to modernize payment and delivery systems. For example…

MEASURE	UT	TX	OK	MO	GA
Teen births/1000 (*low # is good*)	30.7	60.7	60.1	41.6	47.7
Infant mortality/1000 live births	4.9	6.3	8.1	7.5	8.1
Overweight/obese children	23.1	32.2	29.5	31	37.3
Overweight/obese adults	57.7	66.5	67.3	65.8	65.7
Cancer incidence/100,000	388.7	444.2	502	468.3	464.8
Adults visiting a dental clinic (high # is good)	74.3	61.7	57.2	64.3	70.2
Pre-term births as a % of births	11.3	13.1	13.8	12.2	13.8
% of adults age 50+ receiving colonoscopy	69.9	61.6	58	65.2	67.7
Breast cancer death rate/100,000	19.8	21.8	23	24.8	21.8
Private Sector Premiums (Individuals, 2010)	$4,501	$4,951	$4,658	$4,694	$4,758

Sources: AHRQ: http://statesnapshots.ahrq.gov/snaps10/ and Commonwealth Fund: http://www.commonwealthfund.org/Publications/Issue-Briefs/2011/Nov/State-Trends-in-Premiums.aspx.

The question is: what would Utah learn from collaborating with these states? Would we just be helping them improve their performance?

4. **Utah has already sent a strong message to Washington about federal reform as part of a multistate lawsuit to invalidate the Accountable Care Act. Joining a compact does not strengthen that message.** This was the basis for Governor Jan Brewer's recent veto of Health Care

Compact legislation in Arizona: "I continue to believe the multistate lawsuit is the best and most appropriate route to invalidate the requirements of federal health care reform legislation."[ii]

5. **The block grant is a bad financial deal for Utah.** Right now, federal Medicaid funding increases in hard economic times to help people when they lose their jobs or their health coverage. That's why we call it a safety net. Under a block grant, the federal government provides the state with a set dollar amount. In an economic downturn, the state would have to fund the increased demand for services on its own.

6. **Other block grants of federal funds have proven to be a one-sided win for the federal government.** The history of the federal block grants shows what would happen to federal Medicaid funding over time; federal funding for 11 block grants fell an average of 11% over time.[iii] State flexibility–the selling point for the original block grants–disappeared as federal requirements gradually were reattached to the funds.[iv] Utah's Medicaid is already lean and has inadequate provider rates. A block grant would lock us in to current spending levels—having truly tragic consequences, such as dropping seniors from Medicare, closing nursing homes, and invalidating laws that protect privacy.

7. **The compact is likely to grow government.** States have formed collaborations around many other issues. They may start as loose confederations, but often end up with their own bureaucracies and regulations. Case in point: Interstate Compact for Adult Offender Supervision. Two years after its establishment in 2000, the compact inaugurated a commission to oversee day-to-day operation of the compact and to create rules and regulations. *Does Utah really want to throw in with TX, OK, GA, and MO and operate its Medicaid program under rules those states would support?*

8. **The compact idea has not been fully thought through.** When asked whether a block grant would give Utah sufficient funds to *administer* the Medicare program, local proponents of the compact answered that they hadn't factored that in. What other implications of the compact have not been thought through? While they think over this and other issues, we should be coming together behind the state's existing commitment to accountable care in Medicaid.

INSTEAD…MAXIMIZE UTAH'S EXISTING MEDICAID REFORM GAME-PLAN, OTHER FLEXIBILITY

The truth is, states already have meaningful options for flexibility in how they operate their Medicaid programs and implement insurance market reforms. Secretary Sebelius has outlined these options and summarized the many tools states can use to rein in Medicaid spending over time.[v] Utah has yet to maximize this flexibility, though our commitment to accountable care is moving in the right direction. Utah also has flexibility, within certain limits, to determine the Essential Health Benefit standards for our exchange marketplace. Utah is on the path to meaningful health system reform. ***We don't need to take a detour to join with the poor performing states like Texas, Oklahoma, Georgia, and Missouri in a compact that promises few benefits while endangering the long-term financial health of our health care system.***

---

[i] National Conference of State Legislatures State Legislation and Actions Challenging Certain Health Reforms, 2011-2012. http://www.ncsl.org/issues-research/health/state-laws-and-actions-challenging-aca.aspx

[ii] Arizona Capitol Times. Brewer vetoes interstate compact bill on health, measure allowing purchase of out-of-state insurance," April 28, 2011. http://azcapitoltimes.com/news/2011/04/28/brewer-vetoes-health-insurance-proposal/.

[iii] Sard, Barbara, and Will Fischer. 2003. *Housing Voucher Block Grant Bills Would Jeopardize an Effective Program and Likely Lead to Cuts in Assistance for Low-Income Families*. Washington, DC: Center on Budget and Policy Priorities; Conlan, Timothy J. 1998. From *New Federalism to Devolution: Twenty-Five Years of Intergovernmental Reform*. Washington, DC: Brookings Institution Press.

[iv] Ibid.

[v] Kathleen Sebelius, "Sebelius Outlines State Flexibility and Federal Support Available for Medicaid," http://www.hhs.gov/news/press/2011pres/01/20110203c.html.

For more information, please contact Judi Hilman, Executive Director or Jason Cooke, Medicaid Policy Director
judi@healthpolicyproject.org jason@healthpolicproject.org (801) 870-3887