REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

Health Care Compact

TO THE GOVERNOR AND
THE GENERAL ASSEMBLY OF VIRGINIA

REPORT DOCUMENT NO. 103

COMMONWEALTH OF VIRGINIA
RICHMOND
2013

Code of Virginia § 30-168.

The Joint Commission on Health Care (the Commission) is established in the legislative branch of state government. The purpose of the Commission is to study, report and make recommendations on all areas of health care provision, regulation, insurance, liability, licensing, and delivery of services. In so doing, the Commission shall endeavor to ensure that the Commonwealth as provider, financier, and regulator adopts the most cost-effective and efficacious means of delivery of health care services so that the greatest number of Virginians receive quality health care. Further, the Commission shall encourage the development of uniform policies and services to ensure the availability of quality, affordable and accessible health services and provide a forum for continuing the review and study of programs and services.

The Commission may make recommendations and coordinate the proposals and recommendations of all commissions and agencies as to legislation affecting the provision and delivery of health care.

For the purposes of this chapter, "health care" shall include behavioral health care.

Joint Commission on Health Care Membership

Chairman
The Honorable Linda T. Puller

Vice-Chairman
The Honorable John M. O'Bannon, III

Senate of Virginia

The Honorable George L. Barker
The Honorable Harry B. Blevins
The Honorable Charles W. Carrico, Sr.
The Honorable L. Louise Lucas
The Honorable Stephen H. Martin
The Honorable Jeffrey L. McWaters
The Honorable Ralph S. Northam

Virginia House of Delegates

The Honorable Robert H. Brink
The Honorable David L. Bulova
The Honorable Benjamin L. Cline
The Honorable Rosalyn R. Dance
The Honorable T. Scott Garrett
The Honorable Algie T. Howell, Jr.
The Honorable Riley E. Ingram
The Honorable Christopher K. Peace
The Honorable Christopher P. Stolle

The Honorable William A. Hazel, Jr.
Secretary of Health and Human Resources

Commission Staff

Kim Snead
Executive Director

Stephen W. Bowman
Senior Staff Attorney/Methodologist

Michele L. Chesser, PhD
Senior Health Policy Analyst

Jaime H. Hoyle
Senior Staff Attorney/Health Policy Analyst

Sylvia A. Reid
Publication/Operations Manager

Preface

House Bill 264, introduced by Delegate Christopher K. Peace during the 2012 General Assembly Session, sought to amend Title 32.1, Chapter 17 of the *Code of Virginia* to establish the Interstate Health Care Compact (HCC). Enacting HB 264 would allow Virginia to join other member states in requesting Congressional consent to regulate health care within state borders; suspend "the operation of any conflicting federal laws, rules, regulations, and orders within their states"; and secure federal funding. HB 264 was continued in the House Committee on Rules until 2013 and Delegate Peace requested that the Joint Commission on Health Care conduct an informational study regarding the HCC.

Interstate compacts are statutory and contractual agreements between member states; agreements that increase state political powers, like the HCC, require Congressional approval. The HCC seeks to transfer primary responsibility for health care policy and funding to state governments. Under the HCC, except for federal military-related care, states would have the ability to override any federal law, regulation, or funding decision; and in turn, those states would accept responsibility for funding state and federal health care obligations and receive an annually adjusted federal appropriation.

The idea for the health care compact came out of work by the Center for Tenth Amendment Studies. To date, 25 states that have considered HCC legislation and seven states have enacted the compact. It is expected that a request for Congressional consideration will only be made if a significantly larger number of states approve the compact.

The scope of the proposed HCC, in assuming responsibility for essentially all health care matters within each member state, produces much uncertainty. Consequently, many important questions will not be answered unless and until Congress approves the Compact and takes other related federal actions.

Joint Commission members and staff would like to thank the individuals who assisted in this study, including representatives from: Congressional Research Service, Health Care Compact Alliance, National Center for Interstate Compacts, National Conference of State Legislatures, and Virginia Department of Planning and Budget.

Table of Contents

BACKGROUND...1

FINDINGS 2

ATTACHMENTS:

SEPTEMBER 18, 2012 PRESENTATION

HOUSE BILL 264 (2012)

THE HEALTH CARE COMPACT
FINAL VERSION – 23 FEBRUARY 2011

Health Care Compact

House Bill 264, introduced by Delegate Christopher K. Peace during the 2012 General Assembly Session, sought to amend Title 32.1, Chapter 17 of the *Code of Virginia* to establish the Interstate Health Care Compact. Enacting HB 264 would allow Virginia to join other member states in requesting Congressional consent to regulate health care within state borders; suspend "the operation of any conflicting federal laws, rules, regulations, and orders within their states"; and secure federal funding. HB 264 was continued in the House Committee on Rules until 2013 and Delegate Peace requested that the Joint Commission on Health Care conduct an informational study regarding the Interstate Health Care Compact. (HB 264 was ultimately left in in the House Committee on Rules.)

Background

The U.S. Constitution (Article 1, Section 10) grants states the right to enter into agreements with other states for their common benefit. These agreements are known as interstate compacts and Virginia had entered into more than 215 compacts as of 2012.[1] Interstate compacts are statutory and contractual agreements between member states and in some instances require Congressional approval. For compacts requiring such approval, Congress has the power to modify the terms of the agreements.

The Interstate Health Care Compact (HCC), which allows for expansive authority and responsibility for health care regulation by member states, would increase state political power and therefore requires Congressional approval. The HCC seeks to transfer primary responsibility for health care policy and funding to state governments. Under the HCC, except for federal military-related care, states would have the ability to override any federal law, regulation, or funding decision; and in turn, those states would accept responsibility for funding state and federal health care obligations and receive an annually adjusted federal appropriation. (Again, the HCC would not grant states power to affect "care, services, or plans provided by the U.S. Department of Defense and the U.S. Department of Veterans Affairs.") In consideration for accepting the funding responsibilities, the federal government would provide an annual appropriation to each HCC-member state. The amount of the block grant would include a population- and inflation-adjusted funding level based on 2010 total federal health care spending in each state.

The HCC, which came out of work by the Center for Tenth Amendment Studies, is the first interstate compact to attempt "to shield states from a whole area of federal law."[2] Specifically, the HCC model language contains seven elements that define the responsibilities and powers within the compact (*summarized below – see Attachments for full text of HCC*):

[1] The Evolution of Interstate Compacts, *The Council on State Governments*, accessed February 2013 at http://knowledgecenter.csg.org/drupal/content/evolution-interstate-compacts-0.

[2] Some States Seeking Health Care Compact, by Guy Gugliotta, *Kaiser Health News*, September 18, 2011 at http://www.kaiserhealthnews.org/Stories/2011/September/18/health-care-compact.aspx?p=1

1. ***Pledge**:* Member states agree to work together to pass this Compact, and to improve the health care in their respective states.
2. ***Legislative Power***: Member states have primary responsibility for regulation of all non-military health care goods and services in their state.
3. ***State Control**:* In member states, states can suspend federal health care regulations. Federal and state health care laws remain in force in a state until states enact superseding regulations.
4. ***Funding**:* Member states get an amount of money from the federal government each year to pay for health care. The funding is mandatory spending, and not subject to annual appropriations. This funding level will be adjusted annually for changes in population and inflation.
5. ***Commission**:* An advisory commission is created to gather and publish health care cost data, study various health care issues, and make non-binding recommendations to member states.
6. ***Amendments**:* Member states can amend this Compact with approval of the members, and no further Congressional consent is needed.
7. ***Withdrawal**:* Any member state can withdraw from this Compact at any time.

Findings

In 2010, advocates of the compact formed the Health Care Compact Alliance. The Alliance supports efforts to pass HCC-legislation in states.[3] As of December 2012, 25 states had considered joining the HCC with seven states enacting legislation.[4] The specific legislative actions taken to date include:

- 7 states enacted the HCC legislation
  - Georgia, Missouri, Oklahoma, Texas (2011)
  - Indiana, South Carolina, Utah (2012)
- 2 Governors vetoed HCC legislation
  - Governor Brewer in Arizona (2011)
  - Governor Schweitzer in Montana (2011)
- 16 states considered but did not enact HCC legislation (2011 and 2012)
  - Alabama, Colorado, Florida, Kansas, Louisiana, Michigan, Minnesota, New Hampshire, New Mexico, North Dakota, Ohio, South Dakota, Tennessee, Virginia, Washington, and West Virginia.

The HCC envisions significant expansion of state power to regulate health care within that member state's borders. Examples of existing laws and regulations that a member state could choose to repeal or change include:

- ***Pharmaceuticals and Medical Devices***
  - Regulation of market access to drugs and medical devices
  - Advertising and labeling of prescription and non-prescription drugs

- ***Hospitals, Facilities and Medical Staff***

[3] *See* Health Care Compact Alliance website at http://healthcarecompact.org.
[4] Some States Pursue Health Care Compacts, *National Conference of State Legislatures* at http://www.ncsl.org.

  - The Emergency Medical Treatment and Active Labor Act (EMTALA)
  - Hospitals' conditions of participation to receive Medicare and Medicaid funding

- ***Health Information Security and Privacy***
  - The Health Insurance Portability and Accountability Act (HIPAA) and allowable uses for health information
  - Requirements regarding personal health information breaches
- ***Private Health Insurance***
  - The Patient Protection and Affordable Care Act (PPACA)
  - Individual and group policies
  - Health Maintenance Organizations (HMOs)
  - Consolidated Omnibus Budget Reconciliation Act (COBRA) benefits
  - The Mental Health Parity Act
  - HIPAA limits on use of pre-existing exclusion periods

As noted previously, the HCC provides states with primary responsibility and obligation for funding health care services. Unless superseded by state law, the obligation extends to all non-military, federal programs including Medicare, Medicaid, and the State Children's Health Insurance Program. The HCC stipulates that the federal government will provide funding to each state based on its total federal health care spending during federal fiscal year 2010 with annual adjustments for inflation and population. (The HCC Alliance estimated that federal health care spending in Virginia was $15.3 billion in 2010.) The specific funding formula is shown in Exhibit 1.

Exhibit 1: HCC State Funding Formula

Base funding x Inflation adjustment x Population adjustment

- Base funding level:
  Total federal health care spending in member state during 2010 federal fiscal year

- Inflation adjustment:
  Current year gross domestic product (GDP) deflator ÷ 2010 GDP deflator
  (GDP will be determined by the U.S. Bureau of Economic Analysis)

- Population adjustment:
  (Current population – 2010 population) ÷ 2010 population
  (Population will be determined by the U.S. Census Bureau)

There are concerns regarding the funding formula and whether its adjustment factors for inflation and population will allow states to fund their health care needs in the coming years.

- The funding formula's inflation factor is based on a general inflation index rather than a health-care inflation index. Between 2000 and 2010, health-care inflation averaged 6.2 percent per year while general inflation averaged 2.2 percent per year. If health care inflation continues to outpace general inflation, federal funding will not meet the states' needs. Compact proponents however, believe that indexing to general inflation will encourage states to spend more efficiently and thus promote declining rates of health-care inflation.[5]

- The funding formula's population adjustment does not account for the effect of the aging population in the U.S.; in that, the elderly suffer from more costly chronic diseases and have accounted for a disproportionate share of medical expenditures. (In 2002, elderly individuals accounted for 13 percent of the population but 36 percent of the personal health care expenditures in the U.S.) While 1 million Virginians were over 65 years of age in 2010, that number is expected to rise to 1.8 million by 2030. This demographic shift is expected to result in higher health care costs leading to the need either for additional state funding to supplement federal funding or for significant policy changes to reduce expenditures.

Although the HCC includes specific, operational provisions, there is significant uncertainty regarding actual implementation. Congress does not have to approve the compact as written and could require extensive changes during the Congressional consent process. Moreover, if the compact were to receive Congressional approval, there are still many unanswered questions including those detailed in Exhibit 2. It is expected that a request for Congressional consideration of the HCC will only be made, if a relatively large number of states approve the compact.

Exhibit 2: Remaining Health Care Compact Questions

Legal Questions

1. Will Congress approve the HCC?
2. What specific provisions and language would be included in a Congressionally-passed compact?
   a. Would state powers or responsibilities change from existing HCC language?
   b. What state funding amounts would be authorized?
3. What state actions would be required to accept a compact as passed by Congress?
4. How quickly would conflicts of HCC interpretation be resolved administratively and in federal courts?

[5] JCHC email correspondence with Eric O'Keefe, Chairman of the HCC Alliance, on July 31, 2012.

5. If the HCC is enacted, what federal laws, regulations, or programs would be changed to improve the administration of health care in Virginia? How would any changes be implemented?

Funding Questions

6. Would Virginia manage health care benefits for Medicare beneficiaries in a more efficient and effective manner than the federally-run Medicare program?
7. Does Virginia have the infrastructure necessary to administer a State-based Medicare program?
8. What would be Virginia's base funding level?
9. How would general inflation compare to health care inflation over time?
10. What would be the financial impact on Virginia's budget for assuming responsibility for funding health-related services in the Commonwealth?
    a. Possible examples include health care for Virginians who have low-income or are aged, blind, disabled, or in need of in-home or nursing facility care.
11. Would the federal government continue funding some health-related programs or would that be included in the HCC funding allotment?
    a. Examples include public health activities, communicable disease surveillance and epidemiology, AIDS Drug Assistance Program, and health-related grants to states.

No policy options were developed by staff; Delegate Peace requested that the study be completed on an information-only basis.

JCHC Staff for this Report
Stephen W. Bowman
Senior Staff Attorney/Methodologist

Attachments

Health Care Compact

HB 264 – Delegate Christopher K. Peace

Presented to the:

Joint Commission on Health Care

September 18, 2012

Stephen W. Bowman
Senior Staff Attorney/Methodologist

Informational Study

Agenda

- Background
- Compacts Defined
- HCC Adoption in other States
- Health Care Compact (HCC)
- Remaining Questions

2

Background:
House Bill 264 (Delegate Peace)

- HB 264 would establish the Interstate Health Care Compact (as *Code of Virginia,* Title 32.1, Chapter 17) to allow Virginia to join other member states in:
  - Regulating health care within state borders,
  - Suspending "the operation of any conflicting federal laws, rules, regulations, and orders within their states," and
  - Securing federal funding.
- HB 264 was continued in the House Rules Committee until 2013
- Delegate Peace requested that JCHC study the issue of joining the Interstate Health Care Compact

3

What is a Compact?*

- "The U.S. Constitution (Article 1, Section 10) grants states the right to enter into agreements with other states for their common benefit."
- Compacts can "address common problems among states, such as border disputes, creating governmental commissions and establishing common guidelines for agencies in the member states."
- "Any compact that increases the political power of the member states must be approved by Congress."

Approximately 215 compacts are currently in force (2011)

Sources: National Conference of State Legislatures (NCSL) website, *Some States Pursue Health Care Compacts* at http://www.ncsl.org/issues-research/health/affordable-care-act-state-action-newsletter-11.aspx#Some
(* Compact explanation is verbatim from NCSL website) and Council of State Governments, *The Evolution of Interstate Compacts* at http://knowledgecenter.csg.org/drupal/content/evolution-interstate-compacts.

4

Virginia Has Entered Into Over 50 Compacts

Examples of Compacts which Virginia Has Entered

Transportation

- Metropolitan Washington Airports Authority
- Woodrow Wilson Bridge and Tunnel Compact

Corrections and Crime

- Agreement on Detainers
- Interstate Compact for Juveniles
- Interstate Corrections Compact
- National Guard Mutual Assistance Counter-Drug Activities Compact

Boundaries

- Maryland and Virginia Boundary Agreement of 1785
- Virginia and West Virginia Boundary Agreement of 1863
- Virginia-Kentucky Boundary Compact
- Virginia-Maryland Boundary Agreement of 1878
- Virginia-North Carolina Boundary Agreement of 1791
- Virginia-Tennessee Boundary Agreement

Gaming

- Licensure of Participants in Horse Racing with Pari-Mutual Wagering

Sources: National Center for Interstate Compacts *at* http://apps.csg.org/ncic/ and *Code of Virginia* § 59.1-394.1. Live Horseracing Compact.

5

Compacts Are Contracts, But More

- Compacts are "binding legal documents between member states that set forth certain terms and conditions, which must be construed and applied in accordance with the intent of the agreements…."
  - Intertwine considerations of contract law and statutory interpretation
  - "Contract principles generally inform and control the interpretation and remedies available in event of breach…."
- For compacts needing Congressional consent, Congress may modify the terms of the compact
  - U.S. Supreme Court: "The states who are parties to the compact by accepting it and acting under it assume the conditions that Congress under the Constitution attached." Petty v. Tennessee–Missouri Bridge Commission, 359 U.S. 275 (1959)

Source: Caroline Broun, et al., The Evolving Use and the Changing Role of Interstate Compacts: A Practitioner's Guide, American Bar Association, 2006.

6

Overview: The Health Care Compact

- There is one "Health Care Compact" (HCC) to which states may join
  - A state is required to accept all obligations and responsibilities within the HCC
  - States may join over time
- HCC has not been introduced in Congress
  - Congressional consent is needed for the HCC to become operational

Note: The HCC has "no legal relation to compacts that are authorized by the Affordable Care Act, which include 'regional health compacts' (Sec. 1331) or 'health care choice compacts' for 2 or more states to offer insurance policies (Sec. 1333)."

Sources: Health Care Compact website at http://healthcarecompact.org/compact and "Note" is verbatim from NCSL website at http://www.ncsl.org/issues-research/health/affordable-care-act-state-action-newsletter-11.aspx#Some.

7

Overview: The Health Care Compact (continued)

- HCC seeks to transfer primary responsibility to state governments for two health care areas:
  1. Policy
  2. Funding
- Each state would have primary responsibility for all health care regulation, administration, and government funding decisions

Sources: Health Care Compact website at http://healthcarecompact.org/compact.

8

25 States Have Considered Joining the Health Care Compact

- 7 states enacted the HCC legislation
  - Georgia, Missouri, Oklahoma, Texas (2011)
  - Indiana, South Carolina, Utah (2012)

- 2 Governors vetoed HCC legislation
  - Governor Brewer in Arizona (2011)
  - Governor Schweitzer in Montana (2011)

- 16 states considered HCC legislation that was not enrolled (2011 & 2012)
  - Alabama, Colorado, Florida, Kansas, Louisiana, Michigan, Minnesota, New Hampshire, New Mexico, North Dakota, Ohio, South Dakota, Tennessee, Virginia, Washington, and West Virginia.

Source: National Conference of State Legislatures (NCSL) website, *Some States Pursue Health Care Compacts* at http://www.ncsl.org/issues-research/health/affordable-care-act-state-action-newsletter-11.aspx#Some

9

Health Care Compact Requirements

Pledge: Member states agree to work together to pass this Compact, and to improve the health care in their respective states.

State Control: In member states, states can suspend federal health care regulations. Federal and state health care laws, rules, regulations, and orders remain in force until the state enacts superseding laws or regulations.

Legislative Power: "Member states have primary responsibility to regulate health care in their respective states."
- Excludes "care, services, supplies, or plans provided by the U.S. Department of Defense and U.S. Department of Veterans Affairs, or provided to Native Americans"

Commission: An advisory commission is created to gather and publish health care cost data, study various health care issues, and make non-binding recommendations to member states. "The Commission may not take any action within a member state that contravenes any State law of the Member State."

Source: Health Care Compact website at http://healthcarecompact.org/compact and February 23, 2011 version of The Health Care Compact Sec. 6. (f).

10

Health Care Compact Requirements

Funding: Member states get an amount of money from the federal government each year to pay for health care. The funding is mandatory spending, and not subject to annual appropriations. Each state's funding is based on the federal funds spent in their state on health care in 2010. This funding level will be adjusted annually for changes in population and inflation.

Congressional Consent: Compact becomes effective upon adoption by two or more member states and approval by the U.S. Congress.

Amendments: Member states can amend this Compact with approval of the members, and no further Congressional consent is needed.

Withdrawal: Any member state can withdraw from this Compact at any time by adopting a law to that effect.

- Member state must provide 6-month notice before withdrawal can become effective.

Source: Health Care Compact website at http://healthcarecompact.org/compact.

11

HCC Would Provide Member States Primary Responsibility for Health Care

Member states would have primary responsibility for **all health care** regulation, administration, and government funding decisions

- Except for health care administered by "the U.S. Department of Defense and the U.S. Department of Veterans Affairs, or provided to Native Americans."

HB 264 defines "health care" as "care, services, supplies, and plans related to the health of the individual and includes but is not limited to:

i. the preventative, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care and counseling, assessment, services, or procedures with respect to the physical or mental condition or functional status of an individual or that affects the structure or function of the body;

ii. the sale or dispensing of a drug, device, equipment, or other item in accordance with a prescription; and

iii. the provision of or payment of the costs of care, services, or supplies related to the health of an individual pursuant to an individual or group plan."

Member states may choose to leave current federal health care laws in force.

12

Examples: Health Care Areas and Laws that States Potentially Could Regulate Under the HCC

Pharmaceuticals and Medical Devices

Regulation of market access to drugs and medical devices

Advertising and labeling of prescription and non-prescription drugs

Hospitals, Facilities and Medical Staff

Emergency Medical Treatment and Active Labor Act (EMTALA)

Hospitals' conditions of participation to receive Medicare and Medicaid monies

Health Information Security and Privacy

HIPAA: Allowable uses for health information

Requirements regarding personal health information breaches

Source: JCHC analysis using Mercatus Policy Series, Federal Health Care Regulation at http://mercatus.org/publication/federal-health-care-regulation(2006).

13

Examples: Health Care Areas and Laws that States Potentially Could Regulate Under the HCC (Cont'd)

Government Health Care Financing

Medicare: 1.2 million Virginians (2011)

- Part A – In-patient hospital care
- Part B – Physician and outpatient care
- Part C – Private health plans for Part A and B services
- Part D – Prescription drug benefit

Medicaid: 945,000 Virginians (2009)

- Medical care
- Long-term care

State Children's Health Insurance Program

- Family Access to Medical Insurance Security (FAMIS)

Sources: Kaiser Family Foundation's State Health Facts at http://www.statehealthfacts.org/profileind.jsp?cat=6&sub=74&rgn=48 & http://www.statehealthfacts.org/profileind.jsp?ind=198&cat=4&rgn=48

14

Examples: Health Care Areas and Laws that States Potentially Could Regulate Under the HCC (Cont'd)

Private Health Insurance

Patient Protection and Affordable Care Act (PPACA)
Individual and group policies
Health Maintenance Organizations (HMOs)
COBRA benefits (Consolidated Omnibus Budget Reconciliation Act)
Mental Health Parity Act
HIPAA limits on use of pre-existing exclusion period
Employee Benefit Plans that are insurance (ERISA)

- might exclude self-funded plans

Note: HCC does not enumerate any authority regarding federal taxation policy, including pre-tax treatment of health related care.

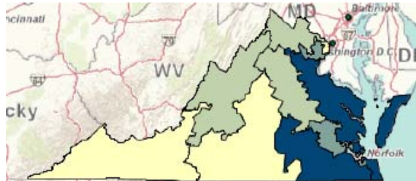
Source: JCHC analysis using Mercatus Policy Series, Federal Health Care Regulation at http://mercatus.org/publication/federal-health-care-regulation (2006)

15

HCC Excludes Military Health Care Services

- HCC ***does not*** apply to health care, services, supplies, or plans provided by U.S. Departments of Defense or Veterans Affairs

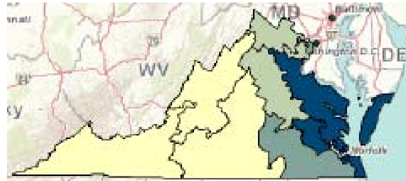
Civilian Veterans in Virginia
(737,000 in 2010)



Civilian Veterans by Congressional District

51,000 – 58,000
58,001 – 65,000
65,001 – 75,000
75,001 – 94.000

Active Duty Military in Virginia
(131,000 in 2010)



Active Duty Military by Congressional District

350 – 900
901 – 11,000
11,001 – 20,000
20,001 – 43,000

Sources: U.S. Census, Selected Social and Economic Characteristics in the United States 2008-2010 American Community Survey 3-Year Estimates and . Maps created by U.S. Census Factfinder using 2011 Congressional districts in quartiles.

16

State Funding Obligations and Formula

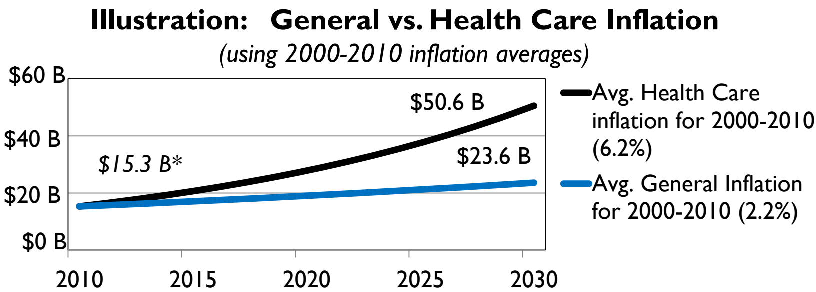
- Obligation: State accepts all responsibility for funding obligations for any federal or state laws that remain in effect after passage of HCC by Congress
  - Would include Medicare & Medicaid programs and any other federal health care funding obligations if such programs were not superseded by state law
  - *HB 264: Art III(C) "A member state shall be responsible for the associated funding obligation in that state for any federal law, rule, regulation, or order that remains in effect in that member state after the effective date of this compact."*
- Initial base funding level is binding on member state

Funding Formula: Base funding x Inflation adjustment x Population adjustment

- *Base funding level: Total federal health care spending in Virginia during 2010 federal fiscal year*
  - *HCC Alliance Virginia estimate = $15.3 billion*
- *Factor 1 - Inflation adjustment: Current year gross domestic product (GDP) deflator ÷ 2010 GDP deflator* (GDP will be determined by the U.S. Bureau of Economic Analysis)
- *Factor 2 - Population adjustment: (Current population – 2010 population) ÷ 2010 population* (Population will be determined by the U.S. Census Bureau)

17

Factor 1: HCC Funding Formula Uses General Inflation



*Note: HCC Alliance estimates Virginia's 2010 base funding level =$15.3 billion

By indexing to general inflation, the states have a strong incentive to spend efficiently, and stretch their health care dollars; and when they find lower cost ways to deliver services, they can cause declining health care inflation.
- Eric O'Keefe, Chairman of HCC Alliance

Source: EconStats, World Economic Outlook data, IMPForum, http://www.econstats.com/weo/CUSA.htm , CMS Office of the Actuary, National Health Expenditures https://and JCHC staff email correspondence with Eric O'Keefe July 31, 2012..

18

Factor 2: HCC Funding Formula Does Not Incorporate an Adjustment for an Aging Population

- Virginians over 65 years of age
  - 2010 – 1 million
  - 2030 – 1.8 million

- Elderly accounted for 13% of the population but consumed 36% of total U.S. personal health care expenses (2002).

Source: (Inflation computations completed by JCHC staff), U.S Census Bureau http://www.census.gov/population/www/projections/projectionsagesex.html, Agency for Health Care Research and Quality, The High Concentration of U.S. Health Care Expenditures, , http://www.ahrq.gov/research/ria19/expendria.htm.

19

Examples: Federal Health Care Funding to Virginia

Virginia Agency	FY 2013 est.
Dept. for the Aging (health related)	$ 8,327,562
DBHDS (Dept. of Behavioral Health and Developmental Services)	$ 8,851,748
VDH	$ 98,225,503
DMAS	$ 3,891,053,592
Medical Assistance Program	*$ 3,704,387,049*
Money Follows The Person Demonstration	*$ 8,500,000*
State Children's Insurance Program (SCHIP)	*$ 177,066,543*
Other programs	*$ 1,100,000*
Other Agencies	$ 12,067,813
Federal Health Care Funding to Virginia*	**$ 4.2 billion**

Medicare Expenditures in Virginia (2009)	**$ 9.7 billion**

*Note: JCHC staff analyzed non-general revenue projections for health related programs provided by agencies to the Department of Planning and Budget within the Health and Human Resources area. JCHC analysis of health related programs may or may not match any federal determination of whether program funding would be eliminated if Virginia received funding through the HCC.
Source: Centers for Medicare and Medicaid Services, National Health Expenditure Report, Health expenditures by state of residence: Summary Tables, 1991-2009 at http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/res-tables.pdf.

20

21

1. Will Congress pass the HCC?
2. What specific provisions and language would be included in a Congressionally passed compact?
   - Would state powers or responsibilities change from existing HCC language?
   - What state funding amounts would be included?
3. What state actions would be required to accept a compact as passed by Congress?
4. How quickly conflicts of HCC interpretation would be resolved administratively and in federal courts?

22

HCC Policy Questions

5. If the HCC is enacted, what federal laws, regulations, or programs would be changed to improve the administration of health care in Virginia? How would any changes be implemented?

6. Would Virginia manage health care benefits for Medicare beneficiaries in a more efficient and effective manner than the federally-run Medicare program?

7. Does Virginia have the infrastructure necessary to administer a State-based Medicare program?

HCC Funding Questions

8. What would be Virginia's base funding level?
9. How would general inflation compare to health care inflation over time?
10. What would be the financial impact on Virginia's budget for assuming responsibility for funding health-related services in the Commonwealth?
    - Possible examples include health care for Virginians that may be low-income, aged, blind, disabled, or in need of in-home care or nursing facility care.
11. Would the federal government continue funding some health-related programs or would that be included in the HCC funding allotment?
    - Examples include: public health activities, communicable disease surveillance and epidemiology, AIDS Drug Assistance Program, and health-related grants to states.

12100091D

1 **HOUSE BILL NO. 264**
2 Offered January 11, 2012
3 Prefiled January 10, 2012
4 *A BILL to amend the Code of Virginia by adding in Title 32.1 a chapter numbered 17, consisting of a*
5 *section numbered 32.1-370, relating to the establishment of the Interstate Health Care Compact.*
6
Patrons—Peace, O'Bannon and Ransone; Senator: Vogel
7
8 Referred to Committee on Commerce and Labor
9
10 **Be it enacted by the General Assembly of Virginia:**
11 **1. That the Code of Virginia is amended by adding in Title 32.1 a chapter numbered 17,**
12 **consisting of a section numbered 32.1-370, as follows:**
13 *CHAPTER 17.*
14 *INTERSTATE HEALTH CARE COMPACT.*
15 *§ 32.1-370. Interstate Health Care Compact.*
16 *The Interstate Health Care Compact is hereby enacted into law and entered into with all*
17 *jurisdictions legally joining therein in the form substantially as follows:*
18 *Article I.*
19 *Purpose.*
20 *It is the purpose of this compact to (i) secure the right of the member states to regulate health care*
21 *in their respective states pursuant to this compact and to suspend the operation of any conflicting*
22 *federal laws, rules, regulations, and orders within their states and (ii) secure federal funding for*
23 *member states that choose to invoke their authority under this compact.*
24 *Article II.*
25 *Definitions.*
26 *As used in this compact, unless the context clearly requires a different meaning:*
27 *"Commission" means the Interstate Advisory Health Care Commission.*
28 *"Current year inflation adjustment factor" means the total gross domestic product deflator in the*
29 *current year divided by the total gross domestic product deflator in federal fiscal year 2010. Total gross*
30 *domestic product deflator shall be determined by the Bureau of Economic Analysis of the U.S.*
31 *Department of Commerce.*
32 *"Effective date" means the date upon which this compact shall become effective for purposes of the*
33 *operation of state and federal law in a member state, which shall be the later of (i) the date upon which*
34 *this compact shall be adopted under the laws of the member state or (ii) the date upon which this*
35 *compact receives the consent of Congress pursuant to Article I, Section 10 of the United States*
36 *Constitution, after at least two member states adopt this compact.*
37 *"Health care" means care, services, supplies, or plans related to the health of an individual and*
38 *includes but is not limited to (i) preventative, diagnostic, therapeutic, rehabilitative, maintenance, or*
39 *palliative care and counseling, assessment, services, or procedures with respect to the physical or*
40 *mental condition or functional status of an individual or that affects the structure or function of the*
41 *body; (ii) the sale or dispensing of a drug, device, equipment, or other item in accordance with a*
42 *prescription; and (iii) the provision of or payment of the costs of care, services, or supplies related to*
43 *the health of an individual pursuant to an individual or group plan. However, for the purposes of this*
44 *compact, "health care" shall not include care, services, supplies, or plans provided by the U.S.*
45 *Department of Defense and U.S. Department of Veterans Affairs, or provided to Native Americans.*
46 *"Member state" means a state that is signatory to this compact and has adopted it under the laws of*
47 *that state.*
48 *"Member state base funding level" means a number equal to the total federal spending on health*
49 *care in the member state during federal fiscal year 2010. On or before the effective date, each member*
50 *state shall determine the member state base funding level for its state, and that number shall be binding*
51 *upon that member state.*
52 *"Member state current year funding level" means the member state base funding level multiplied by*
53 *the member state current year population adjustment factor multiplied by the current year inflation*
54 *adjustment factor.*
55 *"Member state current year population adjustment factor" means the average population of the*
56 *member state in the current year less the average population of the member state in federal fiscal year*
57 *2010, divided by the average population of the member state in federal fiscal year 2010, plus one.*
58 *Average population in a member state shall be determined by the U.S. Census Bureau.*

11/21/12 11:33

Article III.
Pledge; legislative authority; state control; Congressional consent; amendments; withdrawal and dissolution.

A. The member states shall take joint and separate action to secure the consent of Congress to this compact in order to return the authority to regulate health care to the member states consistent with the goals and principles articulated in this compact. The member states shall improve health care policy within their respective jurisdictions and according to the judgment and discretion of each member state.

B. The legislatures of the member states shall have the primary responsibility to regulate health care in their respective states.

C. Each member state may, pursuant to this compact, suspend by legislation the operation within that state of all federal laws, rules, regulations, and orders regarding health care that are inconsistent with the laws and regulations adopted by the member state. Federal and state laws, rules, regulations, and orders regarding health care shall remain in effect unless and until such time as a member state expressly suspends such laws, rules, regulations, and orders pursuant to its authority under this compact. A member state shall be responsible for the associated funding obligation in that state for any federal law, rule, regulation, or order that remains in effect in that member state after the effective date of this compact.

D. This compact shall be effective on its adoption by at least two member states and consent of Congress. This compact shall be effective unless Congress, in consenting to this compact, alters the fundamental purposes of this compact, which are:

1. To secure the right of the member states to regulate health care in their respective states pursuant to this compact and to suspend the operation of any conflicting federal laws, rules, regulations, and orders within their states; and

2. To secure federal funding for member states that choose to invoke their authority under this compact.

E. The member states may, by unanimous agreement, amend this compact from time to time without the prior consent or approval of Congress and any amendment shall be effective unless, within one year, Congress disapproves that amendment. Any state may join this compact after the date on which Congress consents to the compact by adoption into law under its state constitution.

F. Any member state may withdraw from this compact by adopting a law to that effect, but no such withdrawal shall become effective until six months after the Governor of the withdrawing member state has given notice of the withdrawal to the other member states. A withdrawing state shall be liable for any obligations that it may have incurred prior to the date on which its withdrawal becomes effective. This compact shall be dissolved upon the withdrawal of all but one of the member states.

Article IV.
Funding.

A. Each federal fiscal year, each member state shall have the right to federal moneys up to an amount equal to its member state current year funding level for that federal fiscal year, funded by Congress as mandatory spending and not subject to annual appropriation, to support the exercise of member state authority under this compact. This funding shall not be conditional on any action of or regulation, policy, law, or rule being adopted by the member state.

B. No later than the first day of each federal fiscal year, Congress shall establish an initial member state current year funding level for each member state based upon reasonable estimates. The final member state current year funding level shall be calculated and funding shall be reconciled by Congress based upon information provided by each member state and audited by the U.S. Government Accountability Office.

Article V.
Interstate Advisory Health Care Commission.

A. The Interstate Advisory Health Care Commission established pursuant to this compact shall consist of members appointed by each member state through a process to be determined by each member state. A member state may not appoint more than two members to the Commission and may withdraw membership from the Commission at any time. Each Commission member shall have one vote. The Commission shall not act unless a majority of the members are present, and no action shall be binding unless approved by a majority of the Commission's total majority.

B. The Commission may elect from among its membership a chairperson, and may adopt and publish bylaws and policies that are not inconsistent with this compact. The Commission shall meet at least one time each year, and may meet more frequently.

C. The Commission may study issues related to the regulation of health care that are of particular concern to the member states. The Commission may make nonbinding recommendations to the member states for consideration by the legislatures of the member states during determination of appropriate health care policies in those states.

D. The Commission shall collect information and data to assist the member states in their regulation

121 *of health care, including assessing the performance of various state health care programs and compiling*
122 *information on the price of health care. The Commission shall make this information and data available*
123 *to the legislatures of the member states. Notwithstanding any other provision of this compact, no*
124 *member state shall disclose to the Commission the health information of any individual, nor shall the*
125 *Commission disclose the health information of any individual.*
126 *E. The Commission shall be funded by the member states as agreed to by the member states. The*
127 *Commission shall have the responsibilities and duties as may be conferred upon it by subsequent action*
128 *of the legislatures of the member states in accordance with the terms of this compact.*
129 *F. The Commission shall not take any action within a member state that contravenes any state law*
130 *of the member state.*

The Health Care Compact

Whereas, the separation of powers, both between the branches of the Federal government and between Federal and State authority, is essential to the preservation of individual liberty;

Whereas, the Constitution creates a Federal government of limited and enumerated powers, and reserves to the States or to the people those powers not granted to the Federal government;

Whereas, the Federal government has enacted many laws that have preempted State laws with respect to Health Care, and placed increasing strain on State budgets, impairing other responsibilities such as education, infrastructure, and public safety;

Whereas, the Member States seek to protect individual liberty and personal control over Health Care decisions, and believe the best method to achieve these ends is by vesting regulatory authority over Health Care in the States;

Whereas, by acting in concert, the Member States may express and inspire confidence in the ability of each Member State to govern Health Care effectively; and

Whereas, the Member States recognize that consent of Congress may be more easily secured if the Member States collectively seek consent through an interstate compact;

NOW THEREFORE, the Member States hereto resolve, and by the adoption into law under their respective State Constitutions of this Health Care Compact, agree, as follows:

Sec. 1. **Definitions.** As used in this Compact, unless the context clearly indicates otherwise:

“Commission” means the Interstate Advisory Health Care Commission.

“Effective Date” means the date upon which this Compact shall become effective for purposes of the operation of State and Federal law in a Member State, which shall be the later of:

a) the date upon which this Compact shall be adopted under the laws of the Member State, and

b) the date upon which this Compact receives the consent of Congress pursuant to Article I, Section 10, of the United States Constitution, after at least two Member States adopt this Compact.

“Health Care” means care, services, supplies, or plans related to the health of an individual and includes but is not limited to:

(a) preventive, diagnostic, therapeutic, rehabilitative, maintenance, or palliative care and counseling, service, assessment, or procedure with respect to the physical or mental condition or functional status of an individual or that affects the structure or function of the body, and

1 (b) sale or dispensing of a drug, device, equipment, or other item in accordance with a
2 prescription, and

3 (c) an individual or group plan that provides, or pays the cost of, care, services, or supplies
4 related to the health of an individual,

5 except any care, services, supplies, or plans provided by the United States Department of
6 Defense and United States Department of Veteran Affairs, or provided to Native
7 Americans.

8 "Member State" means a State that is signatory to this Compact and has adopted it under
9 the laws of that State.

10 "Member State Base Funding Level" means a number equal to the total Federal spending
11 on Health Care in the Member State during Federal fiscal year 2010. On or before the
12 Effective Date, each Member State shall determine the Member State Base Funding Level
13 for its State, and that number shall be binding upon that Member State. The preliminary
14 estimate of Member State Base Funding Level for the State of [STATE NAME] is
15 [ESTIMATE FROM TABLE].

16 "Member State Current Year Funding Level" means the Member State Base Funding Level
17 multiplied by the Member State Current Year Population Adjustment Factor multiplied by
18 the Current Year Inflation Adjustment Factor.

19 "Member State Current Year Population Adjustment Factor" means the average population
20 of the Member State in the current year less the average population of the Member State
21 in Federal fiscal year 2010, divided by the average population of the Member State in
22 Federal fiscal year 2010, plus 1. Average population in a Member State shall be
23 determined by the United States Census Bureau.

24 "Current Year Inflation Adjustment Factor" means the Total Gross Domestic Product
25 Deflator in the current year divided by the Total Gross Domestic Product Deflator in
26 Federal fiscal year 2010. Total Gross Domestic Product Deflator shall be determined by
27 the Bureau of Economic Analysis of the United States Department of Commerce.

28 Sec. 2. **Pledge.** The Member States shall take joint and separate action to secure the
29 consent of the United States Congress to this Compact in order to return the authority to
30 regulate Health Care to the Member States consistent with the goals and principles
31 articulated in this Compact. The Member States shall improve Health Care policy within
32 their respective jurisdictions and according to the judgment and discretion of each Member
33 States.

34 Sec. 3. **Legislative Power.** The legislatures of the Member States have the primary
35 responsibility to regulate Health Care in their respective States.

1 Sec. 4. **State Control.** Each Member State, within its State, may suspend by legislation
2 the operation of all federal laws, rules, regulations, and orders regarding Health Care that
3 are inconsistent with the laws and regulations adopted by the Member State pursuant to
4 this Compact. Federal and State laws, rules, regulations, and orders regarding Health
5 Care will remain in effect unless a Member State expressly suspends them pursuant to its
6 authority under this Compact. For any federal law, rule, regulation, or order that remains in
7 effect in a Member State after the Effective Date, that Member State shall be responsible
8 for the associated funding obligations in its State.

9 Sec. 5. **Funding.**

10 (a) Each Federal fiscal year, each Member State shall have the right to Federal monies up
11 to an amount equal to its Member State Current Year Funding Level for that Federal fiscal
12 year, funded by Congress as mandatory spending and not subject to annual appropriation,
13 to support the exercise of Member State authority under this Compact. This funding shall
14 not be conditional on any action of or regulation, policy, law, or rule being adopted by the
15 Member State.

16 (b) By the start of each Federal fiscal year, Congress shall establish an initial Member
17 State Current Year Funding Level for each Member State, based upon reasonable
18 estimates. The final Member State Current Year Funding Level shall be calculated, and
19 funding shall be reconciled by the United States Congress based upon information
20 provided by each Member State and audited by the United States Government
21 Accountability Office.

22 Sec. 6. **Interstate Advisory Health Care Commission.**

23 (a) The Interstate Advisory Health Care Commission is established. The Commission
24 consists of members appointed by each Member State through a process to be
25 determined by each Member State. A Member State may not appoint more than two
26 members to the Commission and may withdraw membership from the Commission at any
27 time. Each Commission member is entitled to one vote. The Commission shall not act
28 unless a majority of the members are present, and no action shall be binding unless
29 approved by a majority of the Commission's total membership.

30 (b) The Commission may elect from among its membership a Chairperson. The
31 Commission may adopt and publish bylaws and policies that are not inconsistent with this
32 Compact. The Commission shall meet at least once a year, and may meet more
33 frequently.

34 (c) The Commission may study issues of Health Care regulation that are of particular
35 concern to the Member States. The Commission may make non-binding recommendations
36 to the Member States. The legislatures of the Member States may consider these
37 recommendations in determining the appropriate Health Care policies in their respective
38 States.

1 (d) The Commission shall collect information and data to assist the Member States in their
2 regulation of Health Care, including assessing the performance of various State Health
3 Care programs and compiling information on the prices of Health Care. The Commission
4 shall make this information and data available to the legislatures of the Member States.
5 Notwithstanding any other provision in this Compact, no Member State shall disclose to
6 the Commission the health information of any individual, nor shall the Commission
7 disclose the health information of any individual.

8 (e) The Commission shall be funded by the Member States as agreed to by the Member
9 States. The Commission shall have the responsibilities and duties as may be conferred
10 upon it by subsequent action of the respective legislatures of the Member States in
11 accordance with the terms of this Compact.

12 (f) The Commission shall not take any action within a Member State that contravenes any
13 State law of that Member State.

14 Sec. 7. **Congressional Consent.** This Compact shall be effective on its adoption by at
15 least two Member States and consent of the United States Congress. This Compact shall
16 be effective unless the United States Congress, in consenting to this Compact, alters the
17 fundamental purposes of this Compact, which are:

18 (a) To secure the right of the Member States to regulate Health Care in their respective
19 States pursuant to this Compact and to suspend the operation of any conflicting federal
20 laws, rules, regulations, and orders within their States; and

21 (b) To secure Federal funding for Member States that choose to invoke their authority
22 under this Compact, as prescribed by Section 5 above.

23 Sec. 8. **Amendments.** The Member States, by unanimous agreement, may amend this
24 Compact from time to time without the prior consent or approval of Congress and any
25 amendment shall be effective unless, within one year, the Congress disapproves that
26 amendment. Any State may join this Compact after the date on which Congress consents
27 to the Compact by adoption into law under its State Constitution.

28 Sec. 9. **Withdrawal; Dissolution.** Any Member State may withdraw from this Compact by
29 adopting a law to that effect, but no such withdrawal shall take effect until six months after
30 the Governor of the withdrawing Member State has given notice of the withdrawal to the
31 other Member States. A withdrawing State shall be liable for any obligations that it may
32 have incurred prior to the date on which its withdrawal becomes effective. This Compact
33 shall be dissolved upon the withdrawal of all but one of the Member States.

1 The following table lists estimated Member State Base Funding Level for each State:

STATE	MEMBER STATE BASE FUNDING LEVEL	STATE	MEMBER STATE BASE FUNDING LEVEL
Alabama	$13,880,000,000	Montana	$2,330,000,000
Alaska	$1,438,000,000	Nebraska	$4,144,000,000
Arizona	$16,266,000,000	Nevada	$3,991,000,000
Arkansas	$8,727,000,000	New Hampshire	$2,920,000,000
California	$109,102,000,000	New Jersey	$25,579,000,000
Colorado	$8,907,000,000	New Mexico	$6,010,000,000
Connecticut	$12,174,000,000	New York	$78,319,000,000
Delaware	$2,336,000,000	North Carolina	$24,644,000,000
Florida	$58,876,000,000	North Dakota	$1,657,000,000
Georgia	$21,556,000,000	Ohio	$35,043,000,000
Hawaii	$3,081,000,000	Oklahoma	$10,344,000,000
Idaho	$2,988,000,000	Oregon	$9,149,000,000
Illinois	$40,048,000,000	Pennsylvania	$47,448,000,000
Indiana	$16,785,000,000	Rhode Island	$4,316,000,000
Iowa	$8,453,000,000	South Carolina	$11,144,000,000
Kansas	$6,985,000,000	South Dakota	$1,922,000,000
Kentucky	$13,836,000,000	Tennessee	$21,840,000,000
Louisiana	$15,957,000,000	Texas	$60,434,000,000
Maine	$3,540,000,000	Utah	$4,102,000,000
Maryland	$13,994,000,000	Vermont	$1,966,000,000
Massachusetts	$29,085,000,000	Virginia	$15,301,000,000
Michigan	$29,466,000,000	Washington	$15,497,000,000
Minnesota	$13,348,000,000	West Virginia	$6,372,000,000
Mississippi	$9,648,000,000	Wisconsin	$21,888,000,000
Missouri	$18,669,000,000	Wyoming	$1,104,000,000

2 This table is not intended to be included in the compact language itself, but rather as a
3 reference for each State to include in the definition of Member State Base Funding Level.

Joint Commission on Health Care
900 East Main Street, 1st Floor West
P. O. Box 1322
Richmond, VA 23218
804.786.5445
804.786.5538 (fax)

Website: http://jchc.virginia.gov