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PERSPECTIVES ON MEDICAID FROM SELECT GOVERNORS

HEARING

BEFORE THE

COMMITTEE ON FINANCE UNITED STATES SENATE

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PERSPECTIVES ON MEDICAID FROM SELECT GOVERNORS

THURSDAY, JULY 14, 2011

U.S. SENATE,
COMMITTEE ON FINANCE,
Salt Lake City, UT.

The hearing was convened, pursuant to notice, at 2 p.m., 210 Senate Building, Utah State Capitol Complex, Salt Lake City, UT, Hon. Orrin G. Hatch (ranking member of the committee) presiding.

OPENING STATEMENT OF HON. ORRIN G. HATCH, A U.S. SENATOR FROM UTAH

Senator HATCH. The hearing will come to order. I want to begin today by thanking the chairman of this committee, my friend and colleague, Max Baucus, for scheduling this hearing today.

Though Republicans and Democrats do not necessarily agree on the details, I think there is some agreement that the Nation's Medicaid program as currently constituted is unsustainable.

The opportunity to hear from the Nation's Governors, the individuals on the ground who are responsible for administering this program, while also balancing their own State budgets, is an important one.

Medicaid was originally created as a safety net program for the Nation's poor. Fewer than 5 million individuals used Medicaid services in the program's first year. Today, however, nearly one in four Americans is on Medicaid, and half of those newly covered by PPACA, or what some call affectionately Obamacare, will be on Medicaid.

The liberal Center for American Progress tellingly wrote the other day that the House Budget Committee chairman, Paul Ryan's, Medicaid proposal would be bad for the middle class. Get that. It would be bad for the middle class. Now, that says it all.

The program, initially created to support the Nation's destitute, has been transformed into a spending program for the middle class. From what I can see, this is not only disastrous to Federal and State taxpayers, but it fails the beneficiaries themselves who are in a failing program.

There are four core features of Medicaid that show the need for significant reform. First, the impact of this program on Federal spending has become a genuine problem. Over just the next 10 years, the Federal Government will spend $4.6 trillion on the Medicaid program.

Secondly, Medicaid is now crowding out other critical needs in State budgets such as education and law enforcement. Medicaid

now represents 22 percent of State budgets, and the expansions of Medicaid in the health care law amount to an additional $118 billion burden on the States.

Third, it is not clear that all of this spending gets us the right results. Study after study shows incredibly poor outcomes for Medicaid beneficiaries, especially when compared to privately covered patients.

And finally, Medicaid is rife with fraud. Earlier this week, the Government Accountability Office, GAO, issued a report that we are not even able to accurately gauge the amount of fraud in Medicaid because we do not have the technological tools to track it.

Now, there just has to be a better way. And, as the ranking member on the Senate Finance Committee, I am working every day to personally ensure that we get this program under control.

As it currently exists, Medicaid threatens the fiscal integrity of the Nation and the States, and it fails to provide an adequate quality of care to those who depend on it.

I believe that we already have an existing model for successful reform. In 1996, a Republican Congress and a Democratic President succeeded in one of the greatest reforms of a major entitlement program in our Nation's history when we took up welfare reform.

Medicaid is failing patients and is a target for waste, fraud, and abuse, not because the States are doing a bad job, but because Washington's bureaucracy has tied States' hands, preventing them from making meaningful changes and reforms that make sense at a local level.

Solutions for sustainable Medicaid reform will come from the States, not just Washington. My goal is to empower the States to design and implement innovative Medicaid solutions that work for the States.

In May, along with the House Energy and Commerce Committee chairman, Fred Upton, I wrote the Nation's Governors asking for their ideas on Medicaid. The majority of the Nation's Governors responded with a request for flexibility and transparent accountable budgeting.

Today, we have two of these great Governors here today. I cannot be more pleased that both of you are here to give us your perspective.

Our State's Governor, Gary Herbert, has shown again that the Utah way can be a model for other States. The success of the primary care reforms in Utah shows that States can create innovative and efficient solutions if they are given some relief from Washington mandates.

Hardly anybody in the State understands State and local governments as well as our Governor. And I have seen him in action for all these years, and I have to tell you, I have great affection and respect for him.

And Governor Haley Barbour, as the Republican Governors Association Policy Chair, has been leading the effort to put energy behind Medicaid reform. Haley has led our party; he was the head of the Republican Governor's Association just a year or so ago. He is one of the truly great people in this country. And we are just very grateful to have you here, Haley.

Governor BARBOUR. Thank you, senator.

Senator HATCH. This hearing is part of a collaborative process with the Nation's Governors to reform the Medicaid program. Now, in my role as the Republican leader on the Senate Finance Committee, with responsibility for entitlement programs, I am determined that this process will end in a comprehensive Medicaid reform law.

Now, I want to be clear, though. For those on the ground in the States, this is not a Republican or a Democratic issue. Former Tennessee Governor Phil Bredesen has called Medicaid, "An obsolete and broken system." He has been highly critical of the status quo.

I wish that I could say that I disagree; but the more that one looks at this program, the more clear it is that this program cries out for fundamental reform. Only then can we restore fiscal integrity to the Federal and State governments, and only then can we deliver a higher level of care to those who depend on this system.

Now, I look forward to the testimony of our esteemed witnesses here today, and I want to thank them for taking the time to share their experiences with us today.

We all know our Governor, Gary Herbert, and we are going to turn to him at this point.

[The prepared statement of Senator Hatch appears in the appendix.]

STATEMENT OF HON. GARY HERBERT,
GOVERNOR, STATE OF UTAH, SALT LAKE CITY, UT

Governor HERBERT. Well, thank you, Senator Hatch, and welcome back to your home State. We are honored to have you here and thank you for holding this hearing.

And certainly a good Utah welcome to Haley Barbour, the great Governor from Mississippi. We are just happy to have you here with us today. And, Haley, it is just an honor to be with you again and testifying before a congressional hearing.

Let me just begin by making a note that Governor Barbour and I are here as part of, not only this testimony given at this Senate Finance Committee today, but we are joined by many other Governors, about 35 other Governors from around the country, for the summer meetings of the National Governors Association.

We are colleagues. We are Governors who represent diverse States and diverse populations, all of which have their own unique challenges. What we share, however, is the rightful authority to advance unique solutions to our unique challenges.

I am a firm believer in the principles of federalism, those principles embodied in the Tenth Amendment. States are not powerless agents of Federal authority. A balance of powers between the States and the Federal Government is not only right and proper, but essential if we are ever to find solutions to the complex problems that we face as Americans.

To solve these problems, it is critical for the Federal Government to provide States with the flexibility to find better ways to conduct our business.

Simply put, the citizens of this great State and others deserve and expect that the Utah challenges that we have here and the challenges that other States face will be met by, in fact, here in

Utah, a Utah solution that addresses our unique demographics and our unique dynamics. We would want that privilege for all the States.

One of our most significant challenges, and a challenge I know we share with other States that are represented by their Governors here today, is the untenable growth of our Medicaid programs. Medicaid is poised to wreak havoc on the State's budget for years to come, threatening our ability to fund other critical services such as education and transportation.

In trying economic times such as those we have experienced over the past several years, families increasingly rely on programs like Medicaid to get them through the rough patches. In May of 2007, enrollment stood at 161,368 individuals in Utah. By last month, June of 2011, enrollment had ballooned to 244,470, an increase of 51 percent in just 4 years.

As you might imagine, this growth has created a tremendous strain on Utah's budget. Medicaid growth rates have exceeded the State's annual revenue growth rates the past 2 decades.

Last year, the program's share of our overall general fund was 18 percent, which was more than double its share from the 1990s. And by 2020, it is estimated to exceed 30 percent of our general fund budget, and that is without the federally mandated expansion of the program.

It is not just increased enrollment that is driving up cost; the cost of delivering medical care is also to blame, partly due to health care inflation that is rapidly outpacing overall inflation, and partly due to a reimbursement structure that provides financial rewards for overusing medical care.

We have a plan that addresses our unique challenges and will fundamentally change the way Medicaid services are delivered to Utah citizens. Our plan is patient-focused and provides for healthier people. It promotes individual responsibility and consumer choice, and it saves money by providing financial incentives to keep people healthy, not just to perform more tests and procedures on them.

It balances the policy demands of a growing program with looking out for those who desperately need its services. The plan is truly homegrown. It was crafted over the past several months by my administration and the legislature, along with input from Utah citizens, health care providers, and advocacy groups.

In order to make this work, the Federal Government needs to provide Utah with the flexibility to institute the plan. Our solution has a number of distinct advantages over the current Medicaid service delivery model.

Perhaps most importantly is that it realigns financial incentives for providers to deliver care in a manner that moves away from billable events or services and towards a focus on patient outcomes. In other words, when it comes to delivery of health care for Medicaid clients, we are going to stop paying for quantity and start paying for quality. Our proposal replaces the current Medicaid managed care and fee-for-service models with a Medicaid Accountable Care Organization or, as we call it, an ACO model.

The model works by paying doctors and hospitals a lump sum to manage the care of a patient. This offers the provider an incentive

to work towards the best possible health outcome for each individual patient and to move away from performing and, in turn, billing for services that may be medically unnecessary.

A centerpiece of this reform effort is the "medical home" concept. Each Medicaid client will have access to a primary care provider or a group of primary care providers who will not only deliver care but will also coordinate their patient's care throughout the entire network of providers.

This new model will incorporate something that has been missing from Medicaid for quite some time: consumer choice and individual responsibility. Not only will Medicaid clients have a choice to select from at least two Accountable Care Organizations, they will have the choice to opt out of the program altogether and, instead, receive a subsidy to purchase private insurance.

Currently, individuals who are eligible for Medicaid do not have a choice to participate in the State's premium subsidy program. Our proposal allows an individual who is eligible for Medicaid to make their own choice: enroll in the program or opt to receive a premium subsidy and purchase their own insurance through the Utah Health Insurance Exchange or through their employer.

I am a firm believer that Medicaid recipients need to take more responsibility for the delivery of their health care, both in terms of outcomes and payments. We know that better health outcomes lead to reduced health care costs, and we know that better health outcomes are often achieved by patient's cooperating and complying with the recommended course of treatment.

Our plan allows Accountable Care Organizations to offer incentives to patients with chronic diseases who follow their recommended treatments. Such incentives could come in the form of limiting or waiving co-payments or granting limited cash rewards or gift cards.

The State has nearly 20 percent of its budget, almost $1.8 billion, invested in this program. It is time to move away from the entitlement mentality that has gotten us into this situation by requiring recipients to shoulder a little more of the financial load.

Federal Medicaid copayment limits were established at $3 back in the early 1980s during an initial wave of Medicaid reform. Since that time, copayment limits have increased by only 60 cents. You would be hard-pressed to find a family in our State whose private insurance copayments have not increased by 60 cents in the past year, let alone the last 30 years.

Had the copayment adjustment been made to adjust for inflation throughout the years, it would be the equivalent of $11 today. These onerous and archaic restrictions established by the Federal Government have put States on a path of financial ruin. We are ready to change paths.

We are suggesting a modest increase from $3 to $5 for primary care co-payments. And to help ensure that patients seek care in the appropriate settings, clients visiting an emergency room for non-emergency care will be responsible for a $25 copayment rather than the current $6 amount.

We believe this will help reduce much of the unnecessary spending created by patients seeking primary care in the costly emergency room setting.

I have heard the criticisms that we are placing an undue burden on a population that can little afford to shoulder it, and I am not unsympathetic to the plight of those who truly would be unable to bear such a burden. Those with no income would still be exempt from the cost-sharing.

Additionally, our proposal grants the Affordable Care Organizations the flexibility to waive co-payments if they find it to be in the best interest of their patient's health outcomes.

Our intent is to implement these reforms in the State's four most populated counties on July 1st of 2012. This should give the Centers for Medicare and Medicaid Services (CMS) ample time to review our waiver and work through any concerns.

The highest levels of leadership at CMS have been receptive and supportive of our efforts thus far. I would encourage those leaders to provide their staff with the flexibility they will need to make sure that we are successful.

The ramifications of this reform effort extend well beyond the borders of our State. Not only could this model be the tipping point for Utah's public insurance program, but I believe private insurance companies will soon follow suit, at least in Utah, and then I think across the Nation.

This is where true health reform will rise from, from the laboratories of democracy that we call the States. In Utah, we know we are on the right track. Our health system reform efforts began 5 years ago, and the lessons we have learned are already serving as a guide to other States as they begin their own reform efforts.

Utah is unique in that a majority of our uninsured population is employed. Most work for small businesses which do not offer health insurance benefits. In order to reduce our uninsured population, we need to make insurance coverage accessible to our State's small employers.

Utah also has the youngest population in the country. Many of our uninsured are the so-called "young immortals," persons between the ages of 18 and 34 who are generally healthy and employed, but who have deemed traditional health insurance coverage to be either unnecessary or too expensive.

In Utah, we have chosen a path of business and consumer-oriented health system reform that responds to Utah's needs. One of the tools we are using to help reduce our uninsured population is the Utah Health Insurance Exchange, one of just two exchanges operating in the Nation.

The exchange gives Utah small business employers more than 100 plan choices, all of which retain the pretax and guaranteed issue advantages of traditional small group insurance. The Utah Health Insurance Exchange is now fully operational. In its first month alone, the Exchange helped more than 1,000 employees get health insurance that they have chosen.

Each month, enrollment continues to climb. Our figures show that 20 percent of businesses participating in our Defined Contribution Market through the Utah Health Exchange are offering health benefits for the very first time. This is another example where we have used market principles to create a Utah solution for Utah challenges.

These are the types of innovations Washington should be celebrating, not stifling. If there is one thing this committee can take away from my testimony here today and from the testimony you will hear from Governor Barbour and from other Governors that you will hear over time, it is that the States are poised to act.

We are ready to lead out, but we need the flexibility that only Washington can give to us in order for us to do so, and to find the solutions to the unique challenges and problems we face as States.

I thank you for the opportunity to come and speak here, Senator Hatch, and we wish you the best of luck in tackling this very difficult issue.

Senator HATCH. Thank you so much, Governor Herbert.

[The prepared statement of Governor Herbert appears in the appendix.]

Senator HATCH. We are very pleased to have one of the great leaders of all Governors in this country, Haley Barbour. And we will turn to you.

STATEMENT OF HON. HALEY BARBOUR,
GOVERNOR, STATE OF MISSISSIPPI, JACKSON, MS

Governor BARBOUR. Senator Hatch, thank you very much for having me.

Governor Herbert, I just say "amen" to your testimony. You will find so much of what I was going to say is already in your testimony. I may skip some of it, which I know the audience would appreciate.

Let me just say it is a propitious time for us to be here. Thank you, Gary, for hosting the Governors. But it also is a time when the debt reduction/debt ceiling talks are going on.

There is talk of a proposal by the Obama administration to reduce the amount of Federal matching funds that goes to States for the Federal share, to do this through what is called a blended rate. But it would have the effect that the Federal Government would pay a smaller percentage of Medicaid spending.

At a time when the administration, through Obamacare, is going to add tens of billions of dollars to States' Medicaid costs, you would think that Governors would all oppose any reduction in what the Federal Government pays of Medicaid costs today as part of deficit reduction.

And let me just say to you, most Governors agree with me. We will take a reduction in what the Federal Government pays for Medicaid if, in return, we get flexibility to run the program so we can achieve the savings that are required to meet what the Federal Government is asking for.

Unfortunately, this administration has gone in exactly the opposite direction of less flexibility. Governor Herbert has talked about some of the things that they are doing now. As we are strangled in State budgets often because of Medicaid—Senator Hatch talked about how 22 percent of the average State budget is Medicaid.

For many States, it is the biggest item in the budget. In my State, for decade after decade, education was far and away the biggest item in the budget. And for us, it still is, but only because we are working hard to constrain costs.

But it is more the administration's health care policy. Obamacare and Medicaid are doing more than strangling State government budgets. They are making it harder to have job creation and economic growth in the United States.

How does a business make a decision to hire more people if that business has no idea what its costs or obligations are going to be for health care under the Obamacare model? It should not be surprising that only 18,000 jobs were created last month and only 25,000 jobs were created the month before.

We are not going to see labor market recovery or job creation as long as businesses are facing uncertainties like Obamacare, and budget talks where one side says they want as much as $2 trillion of new tax increases that will fall almost entirely on employers.

Your colleague from North Dakota this week has said that President Obama's call for a trillion dollars of tax increases is not enough, that they need to have $2 trillion of tax increases. Well, how can businesses hire more people in the face of that?

But, as we focus more specifically on Medicaid, let me make some points that are bipartisan. The Governors, in a bipartisan way, have asked the administration and the Congress to get rid of the maintenance of effort requirements that came up in Obamacare that disallow States from taking anybody off the rolls.

My State never did this, so this is not a big problem for us. But for many States with Republican and Democratic Governors, when times were very flush during the Bush administration and the economy was booming and unemployment was 6 percent and 5 percent and lower than that in some States, they said, "Well, we are going to go from 135 percent of Federal poverty level income to 200 percent because we have so much extra money."

Well, now that we are at, you know, 9.2-percent unemployment, a lot of those States cannot afford to do that anymore. But the Federal Government is saying, "You cannot change." So I ask you for that particularly.

This problem is exacerbated by the fact that we do not get very good direction or guidance from CMS, from the Federal Government that runs Medicaid, about what Obamacare is going to require. Just this week, the Department of Health and Human Services put out guidance about exchanges.

We think Utah has the model exchange. It is market-driven; it is voluntary. Yet the 340 pages of guidance that HHS has given the States never says whether it can be voluntary, never says whether it can be not subsidized, and it never tells us what benefits are going to be mandated, what we are going to have to require to be sold on our exchanges.

And frankly, we need better information than that, particularly—and this does not apply to Mississippi, but it does to a number of other States—what will the Federal exchange look like? We have no information on that. And there are some States that are waiting to see if they think their State would be better by just letting the Federal Government run the exchange.

Well, all of these hundreds of pages of guidance gave you no idea, if you were one of those States, what you can expect. We need better information, and we need to understand what the Federal Government's own requirements are going to be as we deal with this.

Senator, let me tell you, you mentioned that you and Chairman Upton wrote us, all the Governors, asking for information. In a minute, I am going to spend my time talking about the principles that we advised you that we think should be the principles for Medicaid reform.

But before I do, I want to say "thank you" for asking us. You know, this is a supposedly Federal-State program. Senator Hatch and I can both remember vividly during the Clinton administration when the national health reform was proposed and driven primarily by Mrs. Clinton.

If somebody had said 18 years ago when that was going on that the way we were going to have health care for everybody in the country is we are going to expand Medicaid, most people would have laughed at the idea. It would have gotten even fewer votes in Congress than it got, because Medicaid, as you mentioned, Phil Bredesen, the then-Democratic Governor of Tennessee, said it is a broken, obsolete system.

For us, we were stunned—and I think both Republicans and Democrats—that, when the White House had a Summit in February of 2010 at Blair House on health care reform, talking about making Medicaid the principal vehicle for expanding health care coverage, not one Governor was invited; not a Democratic Governor, not a Republican Governor, not one Governor invited.

So we start off by saying "thank you" for realizing that you are—the Federal Government is—a partner in this with the States, and the States need to be at the table, and I do want to thank you personally for that.

Twenty-nine Governors wrote to you and Chairman Upton and set out seven principles that we think should be followed. First and foremost—and these are going to sound mighty consistent with everything that Governor Herbert said—first and foremost, we believe the States and territories are best able to make the decisions about the design of their health care systems based on those States' respective needs, cultures, and values. Let the States design what the program ought to be.

And I give you an example: Arizona. Their Medicaid program for many years has been almost entirely managed care, and that seems to work for them, and we are glad of it.

In Mississippi, we have virtually no managed care. This is not a model that makes any sense in Mississippi, which is not saying there is anything wrong with Arizona. It is a good model for them. But what works in Arizona might not work in Mississippi; what works in Vermont may not work in Utah.

And for the Federal Government to start off with the idea that they are going to decide what every State is going to do and that, if you want to deviate at all from what the Federal Government says, you have to go hat in hand and tug your forelock and kowtow to HHS to get to change, it is bad policy.

Second is something you have already mentioned. States and territories should have the opportunity to innovate by using flexible, accountable financing mechanisms that are transparent and hold States accountable for efficiency and quality care. And these could include a block grant, a capped allotment outside of a waiver, or other accountable and transparent financing approaches.

Gary has already talked about Accountable Care Organizations. You have talked about block grants. Rhode Island, in 2009, started a historic program that the Bush administration had approved where they capped Medicaid spending for 5 years.

Rhode Island said, "We will take the same amount of money for 5 years if, in return, you will give us essentially total flexibility. Give us a block grant." They collapsed 11 waivers together, and they saved a hundred million dollars a year in this program in the first 2-year period.

Our point is, they should never have had to go to Washington to ask for that. They should have the authority to do that themselves. And it would save the Federal Government money.

In my State—I testified before the House Committee—we would like to have a block grant, and, in return, we will accept less money from the Federal Government than we would have received. Right now, Medicaid spending nationally goes up somewhere between 6 and a half and 8 percent a year.

I will suggest to you, that is going to increase, by the way. It is going to go up even faster. But let us say it does not. We in Mississippi would be willing to say to the Federal Government, "In return for a block grant with total flexibility, we will take half the increase. Instead of 6 and a half, we will take 3 and a quarter."

Just at that, it would be a hundred million dollars a year less for Mississippi in Federal money. But because we are 1 percent of the program, the Federal Government, if they said, "We will give you a block grant but you only get half the increase," it would save the Federal Government $10 billion a year. Ten billion dollars a year based on today's numbers.

The status quo has to change. We do not like the waiver system, because it is unpredictable and it is slow, and we think it often has bad outcomes. Let me remind you of one of the programs that Orrin Hatch was very involved in, if I remember right, which was the creation of the Children's Health Insurance Program.

In the Children's Health Insurance Program, the States get a block grant. And all the people who say, "Oh, we cannot trust the States to have a block grant and give them this flexibility," many of them are the very people who brag the most about how great SCHIP is, the State Children's Health Insurance Program.

States have shown there that we use the money responsibly and we get the most out of it. We do not have to wait on these waivers. We have in Mississippi a program called the Healthier Mississippi Demonstration Waiver. It was approved my first year as Governor. It is to allow the State to buy pharmaceuticals through the Medicaid program for people who are not eligible for Medicare but make too much money under our rules to get Medicaid.

This program was approved in 2004, but, because the waivers only last 5 years, we had to go back and ask for the waiver to be reinstated or re-upped. It took us 15 months. It took us 15 months to get a waiver renewed that was for a program where we were giving pharmaceutical benefits to people who would not be eligible without the waiver.

So I suggest to you the system is broken for dealing with waivers and with State implementation plans.

Now, it is not just Utah and Mississippi. Florida, North Carolina, and Pennsylvania have been hugely innovative in the SCHIP program. I mentioned Rhode Island. But Massachusetts—Massachusetts has a very innovative program. We do not want it. We do not think it is the right program for Mississippi, but we think they have every right to have it. And as long as they can do it within the financial bounds that the Federal Government was going to make available to them anyway, more power to them. But do not make us have Massachusetts's care in Mississippi under the name of Obamacare.

And I will tell you, Montana, Michigan, Minnesota, New Mexico—you can pick all sorts of States—Missouri, as well as Mississippi, we do not want to have forced on us what happens to have worked somewhere else.

Massachusetts, Rhode Island, Vermont, West Virginia, Florida, Kentucky, Tennessee, Indiana, Iowa, and Idaho have all had innovative programs, but they had to go to the Federal Government and beg for permission.

Ask Tom Vilsack, President Obama's Secretary of Agriculture and the former Governor of Iowa, about his ideas on basic health insurance coverage that they have instituted in Iowa. You mentioned Phil Bredesen. Phil Bredesen got important flexibility put in his program in Tennessee, which was going broke.

And I would suggest, if you have not, read his book, Phil Bredesen, former Democratic Governor of Tennessee. Read his book, "Fresh Medicine," and you will see a Democratic Governor's view of both Obamacare and Medicaid as it exists today. We have to get a way to move through these things and sometimes even to abide by the law.

You know, of course, that home- and community-based care have been mandated by the Federal courts, and there is a huge move in America for more home- and community-based care for long-term care in the United States. Yet for States, we have to go to the Federal Government and ask for permission by waiver to add one person to home- and community-based care—to our home- and community-based care waiver. It is an optional program under Medicaid.

So—and, of course, we do not ask for them one at a time. We ask for them a thousand at a time or 2,000 at the time. But we cannot go one beyond our waiver despite the fact that this is a mandated law.

Third, Medicaid should focus on quality, value-based, patient-centered programs that work in concert to improve the health of our citizens, and drive, as Governor Herbert said, value over volume, quality over quantity, and which, at the same time, will contain costs.

Let me say—and I do not think I mentioned this—under Obamacare, the number of people on Medicaid in my State will increase by two-thirds from just over 600,000 to more than 1 million in a State with a population of 3 million.

This is going to cost us $1.7 billion over the first 10 years above what we pay now. And, by year ten when everything is fully implemented, Mississippi's Medicaid costs under Obamacare will be $443 million a year higher. Consider that this year our whole cost was only $800 million. So it is a 50-percent increase for us.

And my view is very simple. If the Federal Government wants to have a Federal health program, they ought to pay for it. They ought not to pay for it through the backdoor by sticking States for what CBO says will be $118 billion over the next 11 years—$118 billion.

Giving us the authority to run these programs and keeping them separate improves the quality of care. I will give you an example that you will, I think, find funny. We in Mississippi require every person on Medicaid to recertify their eligibility annually, as is the Federal law, but we make all those who are not homebound or in nursing homes, we make them do it in person.

While they are there, we quiz them over their health and talk to them. We offer them a free physical. We offer them a free annual physical. One percent a year take us up on it, but CMS will not let us require it. Even though we pay for it and it is free, we are not allowed to do it.

We believe in a year or two that that free physical would save everybody a lot of money, but it would greatly increase the health of our people. We are currently partnering with the Mississippi Health Care Alliance, a physician-led group that helps promote screenings and physical exams. We think that the Federal Government ought to let us pay for those through the Medicaid program, which right now we are not having to because we are doing it as a free partnership.

But we cannot provide incentives to the Medicaid participants to encourage healthier behaviors.

States and territories must be allowed to streamline and simplify the eligibility process to ensure coverage for those most in need, and States must be able to enforce reasonable cost-sharing.

We have already talked about maintenance of effort, about the State being able to control who is eligible. We have talked about face-to-face redetermination. But let me give you an example of what we run into with beneficiaries. We, at the in-person interview, offer to enroll beneficiaries in what we call Mississippi Cool Kids Program, what you know as an early periodic screening, diagnosis, and treatment program.

The State allows exceptions for this, but we think this is very worthwhile for what we are doing. We think it improves the quality of care, we think it gets more kids in better programs. At the same time, it has resulted in our eligibility error rate being reduced to .1 percent.

The national average is 6.47 percent. Now, if you reduce the eligibility error rate, that is, if every State only had one-tenth of 1 percent of the people on Medicaid not eligible, if everybody got down to where Mississippi is, that would be from 6.47 to .1. Well, let us say that is unrealistic. Say we only get it down to 1.47, 15 times higher than ours.

The savings from that would be $20 billion a year, just by getting your eligibility rate down to do that. Today, you have to get a waiver to do what we do. Thank goodness we did not have to do it when we started.

We also endorse what Governor Herbert said about co-payments, and we think not only should we be able to adjust them in the right direction, they should be enforceable. When somebody drives

up to the pharmacy's drive-in window to pick up their pharmaceuticals and their child is talking on the cell phone and they say they cannot pay the $1 copayment, by the Federal rules, we cannot challenge that. The pharmacist is supposed to give them the drugs anyway, but the pharmacist eats it.

Well, I can assure you, even though the State does not eat it, that cost finds its way back to us. I promise you that. Enforceable co-pays are very important, and running the program right is very important. In Mississippi, our pharmaceutical program has grown more than 20 percent a year in costs since when I became Governor.

We reduced our pharmaceutical program from $697 million a year to, 18 months later, $279 million a year, a 61-percent decrease. Seventy-eight percent of our pharmaceuticals now under Medicaid are generic. The savings, if you do that, for the Federal Government are gigantic. Gigantic.

States' and territories' Medicaid recipients ought to get a choice—Governor Herbert has talked about that—the choice to get into something more like a private health insurance market through subsidized premium support or whatever.

Let me remind you of that idea that, what the Federal Government does is the only way it works. You know, that is a Federal attitude: "If there is not a Federal mandate, then it is a no-good program."

I thought it was very clearly shown by the risk-pool program that is part of Obamacare. Thirty-five States already had risk pools to help people who were being denied coverage because of pre-existing illnesses. Thirty-five States. That was not good enough for this administration and Congress. They mandated a $5-billion Federal program for this.

Well, it turns out that, in a State like mine where 3,600 people are in our risk pool and the Federal Government program came on board for a lower premium, today there are seventy-five—7-5, fewer than 100—people in the Federal risk pool. They had predicted 200,000 people who were being denied health insurance because of pre-existing illnesses would be saved by this health care program.

In these risk pools, 21,000 people have signed up nationally. And I am sure most States are like mine. The vast majority of the people who are in risk pools to help them get across to when their pre-existing illnesses expire, so to speak, most of them are still in those 35 State pools.

We want to see—our sixth principle, frankly, is, we want to see the territories treated like States. They are citizens of the United States, too, and they ought to be treated that way.

Finally, our seventh principle, States need to have greater flexibility in eligibility, financing, and service delivery for long-term care. We have already talked about the fact that we have to get waivers to move people out of long-term care in a nursing home to long-term care in home- and community-based care. We can only do it if we get a waiver.

But it is even worse than that. I have to tell you a little story about Mississippi. There is a program called the Civil Money Penalty Fund where, when nursing homes have some violation, they

pay a fine into this pool of money, and we use it to improve the nursing homes in the State or to improve long-term care.

Our State wanted to use Civil Money Penalty Funds as startup money to develop a specialty skilled nursing facility for children. We have a number of children in our State who are in long-term care who are eligible for Medicaid. Generally, they will be on a ventilator or they will eat through a tracheal tube.

The nursing homes that serve senior citizens do not want them, and you cannot blame them. Their nurses and their personnel, they do not know how to deal with these acutely ill, often little, children.

So we said, "Hey, we have 7 million bucks that we can use out of the Civil Money Penalty Funds, and we are going to build a small nursing home for children on the campus of the University of Mississippi Medical Center." They would not let us. They would not let us.

They said, "That is not an appropriate use of the money in the Civil Penalty Fund," that it has to be used for long-term care. Well, long-term care for children is long-term care; but the point is, until Obamacare, we did not have to ask for permission. So States need to have the authority to go forward this way.

I will remind you of one other thing that was talked about by Governor Herbert, that a lot of people want to have a more insurance-like health care coverage than to be in a Medicaid program. Nothing proves that more vividly than the fact that 25 percent of the people who have come on Medicare in the last 10 years chose Medicare Advantage.

They chose the Medicare program that is the most like private health insurance, and all voluntarily. In fact, you have to jump through a lot of hoops to choose Medicare Advantage. Well, there are a lot of people who would rather have something that is more like private health insurance than Medicaid.

So let me close. Those are our seven principles. So you can see, if the primary factors that drive Medicaid spending are eligibility, provider rates, and utilization services, then recent Federal actions, including the MOE restrictions that you cannot take people off, the proposed access rules that were handed down this week that say you cannot cut provider rates without doing a study that is approved by the Federal Government—and, frankly, that is where most of the States have had to make their savings—that is two out of three factors that you cannot change the cost of.

So you only can deal with utilization. But as a Governor, I can tell you, we do not want to sacrifice health for money by cutting the utilization of Medicaid. We want people who need to see the doctor, who need to be in the hospital, we want them to have that need met.

So we think that is the poorer way to try to drive down the cost. It is unrealistic and unfair to think that States can manage their Medicaid programs when the Federal Government permits the States no flexibility in designing, and no flexibility in administering, their programs, while continuing to push the ever-growing costs for the program down to the States.

Most Governors like me accept the fact that States will receive less money from the Federal Government for Medicaid; but, in re-

turn, we must have more flexibility in order to meet the savings the Federal Government requires.

Thank you.

[The prepared statement of Governor Barbour appears in the appendix.]

Senator HATCH. My gosh. I have to say, both of you Governors have done a tremendous job of outlining the problems and making honest suggestions as to how we can solve these problems and get our health care system working a lot better.

I have a few questions I would like to ask. Let me ask you this one, Governor Barbour. The new health care law puts many mandates, such as the requirement to create a Washington micromanaged set of exchanges, and expanding requirements, such as the burdens from the Medicaid expansions, on the States.

Now, I am concerned that these new dictates from Washington are simply unrealistic to force on the States. Now, did the Obama administration or the Democrats in Congress ask for your feedback on Obamacare as they wrote it, and do you agree that these new mandates from Washington are simply unrealistic?

Governor BARBOUR. They are unrealistic. And, as I said earlier, when they had the summit on health care, the obvious omission was that they had no Governors. It is not that they did not ask Haley Barbour; they did not ask any Governors.

They did not ask a Democratic Governor, Republican Governor, did not ask the chairman of the National Governors Association, yet it falls more heavily on State governments than any other institution.

Senator HATCH. Let me ask this for both of you, and we will start with you, Governor Herbert. Back in the 1980s, Congress reformed the welfare entitlement in a highly successful and bipartisan way. I had a lot to do with that. The key to success was to have Washington listening to solutions outside the Washington Beltway.

In fact, the primary reason we are here today is to begin getting ideas from outside Washington on how to fix Medicaid, and I would like to get each of your thoughts on how partnering with the States, just as we did with welfare reform, might possibly work as a model for Medicaid reform.

I will turn to you first, Governor Herbert, and then——

Governor HERBERT. Well, thank you, Senator. And let me say "amen" to Governor Barbour's testimony also. He has had great experience in this arena.

I am relatively new, but I do remember back when Governor Tommy Thompson took on the welfare state and said, you know, "We can do better as States if you will just give us flexibility." And gradually, Washington came around and embraced that, and the welfare system was improved in a significant way where we are giving better service for less money.

I think the point we are emphasizing probably, Senator, here today is that States do have experience. It was, in fact, very, I think, eye-opening to me as a new Governor coming in and finding out, when we had the watercooler topic of debate of the day, which was health care reform, the States and the Governors were not invited to the table to give an opinion.

What you do in Washington, as you know, has a dramatic impact on what the States do and how they can do it. And to not ask for our opinion and say, "Well, how will this impact you in your States?" I think, is just to not get all the information you need to have to make decisions.

There is no question, I think, that the States have opportunities. We have used the phrase that came from our founding fathers, "laboratories of democracy." For Heaven's sake, the political phrase that we all use, and we have heard it many times, is unintended consequence.

We do something that we think is right and proper and noble, we probably have good reason for doing it, but we end up having an unintended consequence. We think, "Oh, my gosh. We should have changed it, modified it, not maybe done it at all."

That is the problem with a one-size-fits-all approach. What is going to be the unintended consequence of that? It may work for a few, but it may not work for many. But, if every State has an opportunity to address the issue, it may not work in every State, but we do not have the whole country in turmoil because of a bad policy. We can learn from the successes, and we can learn from the failures.

And gradually, we will evolve to a point where, with health care reform as the example, we will get it right. And, again, we will address the unique circumstances that we all have as States. I have a younger State; I have a different demographic than most other States. We need to address our health care issues probably from a different point of view.

Again, the goal and objective, I think for all of us, is to make sure that we have quality health care that is affordable and takes care of those who are, you know, impoverished among us, those who are most vulnerable among us. The government has a role in that kind of safety net approach that Ronald Reagan talked about.

So, by golly, if you take away anything, it is the fact that we ought to be partners with the Federal Government, not subservient, but coequal, and give us the flexibility, give us the charge, give us the opportunity, to find solutions to the problems out there.

And we will find them. We did it with welfare reform. We—again, that was under President Clinton. He finally signed the bill that was passed, and you were a part of that, Senator Hatch. Again, a great step forward for this country, but it came from the States.

So let us help you, and let us help you reform Medicaid, because we cannot continue in this way we are going in Washington. You know as well as anybody, Senator Hatch, this continued borrowing and spending is not sustainable. When you are spending 40 percent of your budget as borrowed money, that is not going to work.

Medicaid and health care are a part of that challenge, and we can help you balance your budget and be fiscally responsible in doing it.

Senator HATCH. Thanks, Governor. I surely agree with you.

Governor?

Governor BARBOUR. Gary touched on something very important. It was, welfare reform was bipartisan; you had a Republican Congress and Democratic president. And Obamacare, on the other

hand, was purely partisan. Absolutely nothing but one party—nothing but one party's votes, and then there was a lot of strong-arming to do that.

But something else about welfare reform that I think made it so successful: it had been tried out. You learn from your mistakes. And you talk about Tommy Thompson in Wisconsin and John Engler in Michigan. There were a number of States that had tried some of this, some of it not successfully, by the way, and so they took what worked but they also gave States flexibility.

It is a monument to the right way to do things, welfare reform.

Senator HATCH. Yes. They worked with us on it. And I have to say, one of the first things that the Obama administration did was just completely make that another form of welfare—another entitlement program.

Governor HERBERT. Senator, can I make another comment on that, again, as a new Governor, that I found interesting?

Again, I know the politics probably in Washington, DC, in the Beltway, is different than what we find in the States. You know, the emotion back there and the lack of bipartisan effort, I think, is disturbing to the public.

But the Patient Protection and Affordable Care Act was kind of run through in 2 or 3 days. Again, nobody had a chance to read it, nobody had a chance to even understand it. That is a bad principle in itself. We, as a State, had to respond. They asked us to give some response on a couple things, the high risk pool, for example, and some other things.

And as a State, I said, "Well, answer me these questions, and then I will respond." So we sent our request to the Secretary of Health and the Department of Health, thinking we will get a response to the questions. We had about 15 or 20 different questions.

You know, weeks go by. We do not get a response. Finally we say, "Hey, we cannot make a decision unless we can get some answers." The answer that came back was, "We do not know what the answer is because we have not had a chance to understand and study and read the bill yet."

Now, this is weeks after you guys had passed it, for Heaven's sake. And we are still—I mean, you know, the famous phrase from the Speaker was, "We have to pass it to find out what is in it." That is not a good way to run a railroad. We would not do that in the States.

Senator HATCH. Well, I knew what was in it, and I have to tell you, I was totally opposed to it.

Governor Herbert, let me ask you this question. I know you have worked hard to make Medicaid as efficient and responsive as possible here in Utah, but I know you have to get permission to do things from the bureaucrats from the Center for Medicare and Medicaid Services, CMS, and I bet that that often makes your job very difficult.

How would you characterize your working relationship with Washington on Medicaid?

Governor HERBERT. Well, it is getting better. I mean, that is the good news. It is getting better. And I think, again, we have been a State that has been at the forefront for health care reform. We started on this 5 years ago.

The Patient Protection and Affordable Care Act came into life after we were already down the road a bit. We are concerned that what you are going to do is, you are going to trump what we are already trying to do. That is that mandate aspect of it. It gives us some frustration at the State level.

So we are saying, "Hey, do not upset our apple cart, because we are doing things pretty well here in Utah." And I will give you an example. Governor Barbour talked about this before. We came up with the idea that, why don't we go paperless? You know, we are kind of a high-tech society anymore, and Utah has been very high-tech.

And so our folks here with our Medicaid reform said, "Let us just go paperless. We will save Utah about $6.3 million. It is a voluntary program. We will have better ability to deliver services, have better accountability for it, and save our State $6.3 million."

I know that is not much in Washington talk, that is just chump change; but for Utah, that is a significant amount of money.

Senator HATCH. Sure it is.

Governor HERBERT. And if every State, in fact, adopted it, it would be closer to a billion dollars, which still is not much—you guys round it up to a billion.

But, again, we were surprised at the resistance we found, because the regulations require paperless. We asked for a waiver, and guess what happened, Senator? We got a denial sent to us in Utah saying, "You cannot go paperless," and the denial was sent to us by e-mail. [Laughter.]

Now, there was something wrong there.

Again, I think some at the top are okay. Maybe it is some of the entrenched bureaucrats inside who are afraid to do anything that is contrary to the written page. Again, that is why I echo 100 percent what Governor Barbour says. Just block-grant the money to us.

We are smart people. We understand our challenges uniquely in our States; we care about our people. You give us the money, and let us find the ways to find the solutions to our unique problems. And, if you need to cut us 10 percent to do it, I would take it. Give me a block grant, eliminate the strings. We will provide better services for less money if you will give us the flexibility we need.

Senator HATCH. And you are closer to the people to understand their needs, too.

Governor Barbour, you have the experience of being a former chair of the Republican Governors Association and now the policy chair of the Republican Governors Association. Can you tell us about the quality of care that Medicaid provides to beneficiaries under the current structure?

Now, you have outlined the seven points, but, if you care to add anything to that, what if any changes would you propose making to that Medicaid program structure today?

Governor BARBOUR. We have to improve the quality of care that people are getting, and we have to improve the outcomes.

Senator HATCH. Yes.

Governor BARBOUR. The spending, unfortunately, is not about quality and outcomes, it is about the number of services provided.

Senator, in Mississippi, if you are a Medicaid beneficiary, you get benefits—a package of benefits that is better than a State employee. The State employee health insurance program is not as rich in terms of services as our Medicaid beneficiaries get.

However, because Medicaid pays so much lower provider rates than health insurance does, we see a lot of doctors will not take but so many Medicaid patients, will not take new Medicaid patients, whatever. That is not unique.

GAO last week reported, nationwide, physicians participating in Medicaid and CHIP are generally more willing to accept privately insured children than new patients on Medicaid or SCHIP. Seventy-nine percent are accepting all privately insured children, but only 47 percent are accepting all Medicaid-insured children, according to GAO.

So what is the Obama administration policy going to be? They are going to start making the States pay higher provider fees. And we, in my State, we try to keep provider fees as high as we can afford because we know it improves access.

But you have to save money somewhere else, and so they are going to put this new rule they call the Access Rule in place, and then they are probably going to directly force us to pay the Medicare rate or higher for providers.

And the problem with that is it may bring some doctors back in, but it just makes the program that much less affordable for the State. We have to find the savings somewhere else. You know, gold does not grow on trees. We have to have balanced budgets. We have to live within our budget.

I will tell you, people in my State are tired of cutting higher education spending because we need the money for Medicaid. There is a balance that has to be struck here. And this is very concerning, that you see these numbers and you know that the result is going to be, "Well, you States just spend more money, and we will solve the problem."

Senator HATCH. Yes. Well, you know, when we did SCHIP, a lot of people do not recognize the "S" in SCHIP. And I was very pleased that you made it clear that the "S" meant block grants to the States.

When I designed that program, it was to have the States run it and have 50 State laboratories so we could pick and choose among the States what works and what does not work, look at other States, see if they have a better approach to it than we do, which is what both of you have been saying here today. And I made it very clear it was not an entitlement program either.

And one of the first things the Obama administration did was make it an entitlement program, another welfare program run mainly by the Federal Government. I mean, it just—I had to vote against it, which was heartbreaking to me at the time.

But Governor Barbour, let me just ask you this question. Washington is broke, with a $14.3-trillion national debt. If States were given less money—both of you have indicated this—if States were given less money, say under some form of a block grant, but given tremendous flexibility, how would that impact patient care? Could States do more with less if they had flexibility from Washington?

Governor BARBOUR. Absolutely. As I said in my testimony, many of us Governors understand the Federal Government has to save money. And this is a huge program, a 200-and-something billion dollar a year Federal program today.

Senator HATCH. Yes.

Governor BARBOUR. We will accept the Federal Government saving money and giving us less, but the only way we can do it is if we have the authority to make the reforms without Washington's permission. We will—you know, I will sign up for that tomorrow.

Senator HATCH. Fair enough.

Governor BARBOUR. But we have to have the flexibility.

Senator HATCH. You have also indicated, Governor Herbert, that you can do more with less.

Governor HERBERT. Again, I think it is——

Senator HATCH. You do not want to do more with less, but you could if you had the authority to do it.

Governor HERBERT. I think it is intuitive that the closer the government is to the people, the more efficient it becomes.

Senator HATCH. That is the way I feel, too.

Governor HERBERT. And so, giving more flexibility to us, and we, in turn, as States need to give more flexibility to cities and counties. That would be a much better way to deliver the system.

And that evolves to—again, the best delivery system is the private sector. We need to empower the private sector, which is where we do not have as much waste, where they are incentivized, that they are using their own dollars. And, you know, this free market system has made our country pretty great.

It will work in health care, too. We sometimes forget. We think this is a government mandate, so the government has to do it all. We need to see what we can do to get private providers more involved and the private sector competing in a free market system. Higher quality, lower cost. It works at Wal-Mart, it will work in health care.

Senator HATCH. This has been good. I have a final question for both of you. I am very appreciative of both of you taking this amount of time and helping the Finance Committee to understand this better, and I am going to make sure everybody gets this record.

I am concerned that Medicaid is failing patients and is a target for waste, fraud, and abuse. Almost everybody says it is. That is not because States are not doing their job. They are not doing a bad job; it is because Washington's bureaucracy has tied the States' hands for making meaningful changes and reforms.

And I think it is time to fix this program. We owe it to the taxpayers and the beneficiaries. We owe it to our grandchildren to reform our entitlement programs that will saddle them with this huge enormous government debt if we do not have the courage to act now. As ranking member on the Finance Committee, I am committed to getting this done, but I need your help as we undertake this critical effort.

Would both of you and others—hopefully you will talk to Democrats and Republicans, you know, as you go along. Would you commit to working with me and hammering out the details of the com-

prehensive Medicaid reform proposal? That is what I would like to do.

I know the States have great ideas, and that is what we did originally with CHIP that turned into another welfare program. I learned a real lesson on that one, I will tell you. I had to vote against the CHIP bill that they finally distorted under the Obama administration, you know.

Governor BARBOUR. Well, of course, Senator. We appreciate you and Chairman Upton's willingness to work with us.

Senator HATCH. Okay.

Governor HERBERT. Absolutely. And, again, we are just delighted that you would ask. That is something that needs to be done more often on this issue and other issues to see what the States' perspectives are.

Let me just conclude by saying this, Senator Hatch, if I could. The key thing here today, I think, that we have emphasized over and over again is that the States need flexibility. We need to partner with you. We have the same goals and objectives.

It is something we can do in a bipartisan way. We have demonstrated that in the past with welfare reform. There is no reason why we cannot do it with Medicaid and health care reform as we partner together.

The watchword is flexibility, but what we cannot have is a flexibility that is not flexibility. It reminds me—and I have used the phrase before—when Henry Ford said, "You can have any color of car you want as long as you choose black."

And we have a challenge here because we have some in Washington who say, "No, we are going to give you flexibility as long as you do it our way." And so we need to have true flexibility to be able to implement the programs in the best way we can, making sure the taxpayers' dollars are spent the best way, that we get the best and most efficient outcome.

If our hands are unleashed, we can do that; if our hands are tied or just one hand is tied behind our back, we will not be as efficient as we are capable of.

Senator HATCH. Thank you, Governor.

I want to thank both of you, both Governor Herbert and Governor Barbour. I recommend and commend each of you for your leadership and striving to make Medicaid work better for taxpayers and, of course, for patients.

I also appreciate those who have submitted statements, written testimony, on Medicaid reform. I know we have testimony from the Heritage Foundation, the Cato Institute, and the Galen Institute as well—all three very, very efficient and effective organizations.

It is time to fix the Medicaid program. We owe it to the taxpayers, we owe it to the beneficiaries, and we owe it to our grandchildren to reform our entitlement programs that will saddle them with enormous government debt if we do not have the courage to act now.

This hearing marks only the beginning of a concentrated effort to accomplish Medicaid reform. That is a task I am committed to as the ranking member of the Senate Finance Committee, and it is a task I have worked on with my counterpart from the House of Representatives, Chairman Fred Upton, and with the Nation's

Governors, and it is a task that I am going to continue to work on until it is complete.

I intend to be chairman of this committee, and I will not be happy until we get this mess straightened out. Together we can and we must develop a comprehensive and sustainable Medicaid reform.

Now, this hearing record will be held open for 2 weeks for additional statements or materials. I, again, want to thank the committee chairman, Senator Baucus, for calling this committee meeting here in Utah. It means a lot to me, and he means a lot to me, and we are going to work closely together.

And with that, we will keep the record open, and, of course, we will end this hearing at this time and recess until further notice. Thanks so much to both of you.

Governor HERBERT. Thanks.

Governor BARBOUR. Thanks.

[Whereupon, at 3:22 p.m., the hearing was concluded.]

APPENDIX

ADDITIONAL MATERIAL SUBMITTED FOR THE RECORD

Barbour Testimony: Salt Lake City, Utah

July 14, 2011

Senator Hatch and Members of the Committee, thank you for the privilege of being a part of this important hearing on Medicaid. Governors have unique and valuable perspectives on this complex entitlement program, and we appreciate your taking the time to discuss this effort during the Senate recess.

As debt reduction talks continue in Washington, it is fiscally irresponsible to add hundreds of billions in new costs to a Medicaid program that is already overburdened and unsustainable. We must address meaningful health care reform. The Patient Protection and Affordable Care Act (PPACA) has created widespread uncertainty.

Medicaid is strangling state budgets now and causing business owners to halt job creation and investment because they can't know their costs or obligations for PPACA employee health care. The job numbers last week emphasized it. The June unemployment rate stands at 9.2 percent, and the economy only created 18,000 jobs last month and 25,000 for the month before. Labor market recovery once again has not happened this summer, with job creation essentially flat for the second straight month.

States went into their budget seasons facing a combined shortfall of $86 billion, according to the National Conference of State Legislatures. The stimulus funding cliff and Medicaid mandates forced states to choose healthcare spending over other state priorities like education and public safety. On July 7, 2011, a chart in the Wall Street Journal indicated Medicaid comprises an average 22 percent of state budgets, followed by K-12 education (21 percent) and higher education (10 percent). A second chart demonstrated that K-12 and higher education each bore more than twice as many budget cuts as Medicaid during mid-year budget cuts in the last fiscal year, even though Medicaid comprises a larger share of the average state's budget.

Governors, in bipartisan fashion, have asked Congress for relief from onerous Maintenance of Effort requirements both in January and as recently this past Saturday. On July 9, Governors Gregoire and Heineman wrote on behalf of the nation's governors, "Budget challenges have driven many states to implement reductions in Medicaid programs and the severe limitations on further reductions posed by federal maintenance-of-effort requirements and the proposed access regulations, are causing state Medicaid spending to rise even faster without increased flexibility for governors to administer the program to best meet the needs of their individual states."

As Congress considers tightening its belt and reducing federal spending for Medicaid, remember to grant the flexibility states need to provide health care to the poor without overburdening taxpayers. Otherwise, states will be forced now to increase state taxes or reduce funding for education, transportation and public safety. If federal Medicaid spending is reduced — and flexibility from Washington's rules is not granted, the most likely, if not the only permissible, source of savings would be additional reductions in payments to doctors and hospitals. This

option would force states to run afoul of the proposed PPACA requirements regarding physician access. Washington is setting states up for failure.

Exacerbating the problem, CMS has failed to provide reliable guidance and direction on just about all of the PPACA changes. The most recent proposed regulations on exchanges is full of holes. The Administration needs to be honest with states and the American people about the federal government's own readiness to meet the requirements of PPACA.
In addition, recent information from CMS about setting Medicaid rates and access will burden states. What states need is freedom from Washington to focus on patients – not new mandates from Washington to fill out more paperwork. In addition, the delays in guidance about Health Information Technology initiatives hinder states' ability to begin the program. In fact, states are required to implement some mandates within weeks after CMS issues final regulations. This is unrealistic.

On May 23, 2011, Senator Hatch and Chairman Upton wrote the nation's governors and requested our input to modernize the Medicaid program. Senator Hatch, you wrote — and I quote, "We are concerned that the program is failing patients; is a target for waste, fraud, and abuse; and is bankrupting both state and federal governments." I agree. The program is broken and must be fixed.

Governors appreciate your reaching out to discuss needed health care reform. Such discussions never occurred during the debate of the PPACA despite multiple requests from governors to be included in discussions. In fact, as you might remember, governors from both parties were excluded from a White House-arranged meeting on February 25, 2010, at the Blair House to discuss health care reform. This meeting was pitched as a bipartisan, open and honest discussion about needed reform, yet governors, critical stakeholders in this infamous reform, were not present.

Unlike the bipartisan Personal Responsibility and Work Opportunity Reconciliation Act, or welfare reform of the 1990s, where governors and states were part of the solution, PPACA was an exclusive, partisan effort that expanded a broken system while placing billions of taxpayer dollars at risk every year. Americans are no closer to affordable health care with the passage of PPACA than they were before the debate began.

You and your colleagues here today have taken a different approach. In May, you requested governors' feedback on our challenges and sought ideas to make Medicaid better. As you suggested, Republican governors representing 29 states and 55.4 percent of the population submitted written recommendations on June 13. I appreciate the opportunity to share with you the challenges states face in implementing this complex program. Each governor faces a unique set of problems regarding Medicaid, making a one-size-fits-all solution impossible.

To that end, I am here today to discuss the Republican governors' seven guiding principles included in our June 13 response to you and Chairman Upton. We continue to believe that Governors must have the flexibility to make program adjustments in a timely manner, given our ever-changing economy. Governors are ready to work with Congress and the Administration to develop a better path, one that gives states greater leeway in determining how to provide safety net health care while allowing states to be good stewards of taxpayer dollars.

First, states and territories are best able to make decisions about the design of their health care systems based on their respective needs, cultures and values.

PPACA will add $26 billion in new administrative costs alone to Medicaid over the next decade. The high price tag will be split almost evenly with $14 billion to be paid by the federal government and $12 billion to be paid by the states. By 2019, administration costs are expected to reach $30.5 billion and continue growing at an annual rate of 5.2 percent. Such expensive red tape is not only onerous but unnecessary. Through greater flexibility in the management of Medicaid, states might be able to reduce substantially the hidden tax increase that forced expansion of the program will impose.

More simply and directly put: what works in Vermont, may not work in Mississippi; and what works in Arizona, may not work in Florida. We are all very different, both culturally and demographically, and should have the flexibility to deal with the health of our people.

The federal government's efforts to tie our hands do not account for state-specific needs, nor does it improve care. It simply imposes extra expense on taxpayers.

Second, states and territories also should have the opportunity to innovate by using flexible, accountable financing mechanisms that are transparent and hold states accountable for efficiency and quality health care. Such mechanisms may include a block grant, a capped allotment outside of a waiver, or other accountable and transparent financing approaches.

The FY2012 House Budget proposal recommends a federal block grant. As a governor, I appreciate the House putting this concept on the table. As Congress works to get federal spending under control, I understand that cuts must be made. Governors would be willing to accept cuts to their Medicaid programs if Congress would give us the flexibility to run our programs efficiently. We believe that we can run a quality Medicaid program at a lesser cost-saving the federal and state government's money.

In 2009, Rhode Island entered into a historic agreement with the Bush Administration where the State agreed to cap Medicaid spending for a five-year period (thus giving the federal government budget certainty) in return for the federal government granting substantially greater flexibility than Medicaid rules traditionally allow.

Rhode Island collapsed 11 different waiver programs under a single Global Waiver. That empowered state policy makers to create a consumer-centered health care delivery system that assures beneficiaries have access to services and supports more appropriate and most needed care in the least restrictive and most cost-effective setting.

Contrary to what some in Washington think, state lawmakers and policy makers are capable of making informed decisions. Rhode Island used the flexibility to begin rebalancing its long-term care system by offering more home- and community-based options for seniors and the disabled, mandated care coordination management to achieve better health outcomes and integrate service, and institute value-based purchasing approaches program-wide to ensure quality and access at a price taxpayers can afford. And Rhode Island managed to accomplish all of this, save approximately $100 million in two fiscal years without changing eligibility guidelines.

In return for total flexibility in managing my Medicaid program, I would agree to a block grant-type funding mechanism of the FMAP to Mississippi capped at, say, two or three percent per annual increase, or at one half of the average national increase, saving the federal government more than $100 million a year compared to the average increase in federal Medicaid costs nationally. I emphasize "total flexibility" to run our program, but note, since my state is about one percent of the nation, that deal nationally would save about $10 billion a year in federal spending. Since every state is different, states will have different opinions regarding the implementation of block grants, but such flexibility is critical, and the conversation regarding block grants needs to occur between Congress and Governors. What worked in Rhode Island may not be the solution in Mississippi, but it should be left to state policy makers -- who balance budgets and actually manage the Medicaid program -- to decide.

The status quo must be changed. The current process, which states are required to follow in order to make changes to their programs (either via a state plan amendment or a waiver), is time consuming, costly and challenging to navigate. States should not have to kowtow to CMS to request permission to do what is right for their unique situations. From a bureaucratic standpoint, CMS's process moves at a snail's pace. A state may wait months or years for CMS to approve or deny program changes for immediate needs.

The renewal of the Healthier Mississippi Demonstration Waiver is a good example of CMS's lethargic response to states' seeking to tailor their programs to meet the needs of their people. The Healthier Mississippi Waiver provides coverage for a segment of the aged and disabled population with incomes at or below 135 percent of the Federal Poverty Level (FPL) who are not eligible for Medicare and do not otherwise qualify for Medicaid. Medicaid began submitting its renewal documents in July 2009 and did not receive final approval until October 2010, 15 months later. And this was for renewal of an already successful program providing care to the elderly and disabled that only required minor adjustments to the original waiver.

My colleagues in other states have experienced similar interaction with CMS.

Texas's 1115 concept paper was submitted in April 2008 and negotiations broke down more than a year ago because CMS wanted them to spend more money and expand eligibility. Texas wanted to provide care for more low-income individuals in the private market.

One of the most visible and humorous examples of this bureaucracy is from my friend, Governor Hebert. After working with CMS for 9 months on a waiver and hearing no response, Utah received an email denying their request. Governor Herbert did not receive resolution until he personally lobbied the President back in February when the governors visited the White House. Should states have to go through such hurdles to manage their programs?

The nation has lost the benefits of innovation in the past few years. Look back to the creation of the state Children's Health Insurance Program. No one knows its history better than you, Senator Hatch. And no one deserves more credit for its creation than you. But SCHIP at the federal level was preceded by innovation by states--Florida, New York, and Pennsylvania. SCHIP is an overwhelmingly bipartisan and popular endorsement of state flexibility and capped federal allotments. Some of us dare to call this model for what it is--a block grant.

After the creation of SCHIP, the creativity of states was unleashed during the Bush years. Call the roll across the country and you will find innovation in states as diverse as Massachusetts, Rhode Island, Vermont, West Virginia, Florida, Kentucky, Tennessee, Indiana, Iowa, and Idaho. These were states led by Democrats and Republicans alike. Ask former governor, now Secretary of Agriculture, Tom Vilsack about his ideas on basic health insurance coverage. Ask Phil Bredesen how important flexibility granted by the Bush Administration was to his Administration. Now try to name states that have been granted innovative, comprehensive waivers during the current Administration,

Look at the expansion of home and community-based services during the Bush years. States accelerated the shift from institutional care to community based care because they were allowed to do so in their own way at their own pace.

Third, Medicaid should be focused on quality, value-based and patient-centered programs that work in concert to improve the health of our states' citizens and drive value over volume, quality over quantity, and, at the same time contain costs.

The Medicaid Program is broken from both a budget and health outcomes perspective. The growth in federal Medicaid medical service spending is unsustainable, increasing almost 8 percent annually during the past 10 years. In Mississippi, the PPACA will result in a massive expansion of Medicaid, which is projected to cost Mississippi taxpayers up to an additional $1.7 billion over the next decade despite little spending during the first four of those years. This increase will add 390,000 to 400,000 new individuals to Mississippi's Medicaid rolls, a two-thirds increase, meaning one-in-three Mississippians will be on the state's Medicaid program. With full implementation by 2020, PPACA will cost Mississippi's taxpayers $443 million a year, increasing our state Medicaid cost by half and far outpacing the growth of our revenues. The cost will only rise in subsequent years and the collective impact to states will be $118 billion through 2023.

In Mississippi we offer every Medicaid beneficiary a free annual physical exam. Very few accept our offer, and federal law prohibits us from requiring them to do so. In my state, we have some of the highest incidences of obesity, heart disease, diabetes and cancer. If we could require Medicaid beneficiaries to have an annual exam, it would allow for early detection and proper treatment, improving the quality of life for thousands of Mississippians. We also believe it would save money within a year or two. Preventive care is obviously important, so we are currently partnering with the Mississippi Healthcare Alliance, a physician-led organization that is helping us promote screenings and physical exams through community outreach and meetings with physicians. However, Medicaid programs should have the flexibility to require beneficiaries to get an annual exam to ensure our goal of promoting the use of primary and preventive care. As it stands, we cannot provide incentives to Medicaid recipients to encourage healthier behaviors without going through the infamous waiver process. States want to focus on patients and improve their programs. The problem is that Washington gets in the way.

Fourth, states and territories must be allowed to streamline and simplify the eligibility process to ensure coverage for those most in need, and states must be able to enforce reasonable cost sharing for those able to pay.

States should invest in technology and improved capabilities to determine eligibility; however, states should set their own eligibility thresholds. The dramatic expansion of states' Medicaid populations in 2014 will greatly worsen an already costly challenge: Tracking individuals and families.

For example, after I became Governor, Mississippi began requiring face-to-face redetermination of eligibility for most Medicaid beneficiaries. The face-to-face meeting allows Medicaid a one-on-one interview to educate and assist eligible beneficiaries with enrollment in programs. During the in-person interview, discussions take place with other household members and if they qualify for Medicaid services, they are enrolled. For example, a beneficiary may be offered information on our Mississippi Cool Kids Program, or, as you might know it, the Early Periodic Screening, Diagnosis and Treatment Program, which provides a comprehensive array of medically necessary services.

The state allows exceptions to the face-to-face redetermination for nursing home residents, foster care children, disabled children living at home and anyone home bound, such as an elderly adult in a home- and-community based waiver program. As a whole, this process has proven very successful. Mississippi has a 0.1 percent eligibility error rate, the third lowest in the country, compared to the national average at 6.74 percent. Taxpayers are paying an average of more than $6,000 for each person on Medicaid in Mississippi for a plan that is more generous than most private plans. I believe an annual review to ensure those receiving Medicaid benefits are truly eligible is in the best interest of both beneficiaries and taxpayers. We think it is important to provide the right services to the people, but note that the Maintenance of Effort provisions get in the way of other states implementing this policy at this time. Allowing states to implement what Mississippi has done ensures that care gets to those who truly need it. If the eligibility error rate fell from 6.74 percent to 1.74 percent, far above Mississippi's .1 percent, federal and state governments would save a combined $20 billion a year.

Secretary Sebelius noted in a February 23, 2011, letter that Congress gave states additional flexibility to impose cost sharing in Medicaid in the form of co-payments, deductibles, coinsurance and other similar charges without requiring states to seek federal approval or a waiver. However, this option is available only for the population above 133 percent FPL, or the optional population, not the mandatory population. Further, these federal regulations do not allow a provider to deny services to an individual on the basis of the individual's ability to pay. No cost-sharing measures can be imposed on the bulk of Medicaid enrollees.

The federal government should give states the flexibility to increase enrollee cost sharing and permit cost sharing for all enrollees. For example, more than half of Mississippi Medicaid recipients are children. When the federal government ties states' hands by not allowing cost sharing for children's care and guarantees service regardless of payment, cost-sharing measures become pointless.

Enforceable co-pays and steeper tiers of co-pays for all enrollees are examples of how Medicaid could incentivize beneficiaries to choose an equivalent service at a lower cost. It is important for consumers to have some personal responsibility for their own health care. For example, if a Medicaid enrollee wants a certain drug advertised on television that costs 10 times as much as a generic brand, which is its molecular twin, a state should be able to charge a $20 or $50 co-pay for the brand name drug and $1 co-pay for the generic drug, unless a doctor gives a medically necessary reason why the generic is unacceptable. A patient or a parent will choose the $1 route almost every time, resulting in the same quality of health care but at much lower costs for the taxpayer. This is done for Americans with private insurance every day.

Other states are working to shift their programs to more a preventative care mode. Utah has submitted a waiver which would allow them to increase copays for beneficiaries and move providers away from fee-for-service payment model. Louisiana is working on one waiver to create a coordinated care system (Coordinated Care Networks) and another waiver to combine care for at-risk children that includes Medicaid, Juvenile Justice and Education. My other neighbor, Alabama, has a state-of-the-art Maternity Care program that coordinates care for pregnant women. This program has saved Alabama taxpayers money and improved care. Governors could do much more with improved flexibility and better tools in our toolbox.

Senator Hatch, please remind your colleagues that the majority of Medicaid spending occurs because states have expanded eligibility and services beyond the federal entitlement. In response to state pleas for flexibility as states were confronted with their funding crises, CMS basically told states they can cut certain optional eligibility groups and optional benefits. That is true from a legal perspective but far from helpful. Prescription drugs are an optional benefit under federal law. Home and community based services are optional. To tell states that we can entirely remove optional eligibility groups but we cannot re-determine eligibility more frequently or be trusted with figuring out how much of a co-payment to charge to encourage use of generics rather than brand name drugs is misguided and short-sighted. We applaud your efforts to secure relief from the MOE. The statutory provision is difficult enough but the CMS interpretation which is even more restrictive than the law undermines the Administration's credibility when federal officials talk about flexibility.

Fifth, states and territories can provide Medicaid recipients a choice in their health care coverage plans, just as many have in the private market, if they are able to leverage the existing insurance marketplace through innovative support mechanisms.

States should have the ability to reward individuals for participating in health promotion or disease prevention activities without having to go through a third-party contractor, and we should look for ways to provide easier access to private insurance for Medicaid clients who would prefer to access the commercial market in lieu of Medicaid. Policy makers could consider allowing vouchers for Medicaid recipients.

The federal government doesn't need to tell states how to leverage the existing marketplace; they need to give us the tools and allow us the flexibility to design systems to enhance the private market through innovative support mechanisms - which may look different in all 50 states.

In Mississippi, I have supported a conservative, market-based health insurance exchange that does not include subsides or an individual mandate, much like that of Utah. We have more than 135,000 small businesses employees who could be served through such a mechanism, covering more people and providing a means for private coverage to follow the person, not the job.

Mississippi also has one of the most successful risk pools in the country, covering 3,600 individuals. Before PPACA passed, thirty-five states, including Mississippi, already operated high-risk pools covering more than 200,000 Americans. The federal government decided state risk pools weren't enough and through PPACA, allocated $5 billion and required new duplicated risk pools to be established. That subsidized program in theory would allow more people to switch to a less-expensive option. CBO predicted 200,000 people, who had been denied coverage because of pre-existing conditions, would be covered by the new federal risk pool between 2011 and 2013. They were wrong. As of April 30, 2011, there are a total of 21,454 individuals utilizing the federal high-risk pool and 75 of them are Mississippians.

Sixth, territories must be ensured full integration into the federal health care system so they can provide health care coverage to those in need with the flexibility afforded to the states.

Currently, Puerto Rico's federal share is only thirty five percent, putting a strain on the local budget that limits Puerto Rico's ability to offer the range of services States offer. Governor Fortuno tells me that Puerto Rico is also the only jurisdiction in the United States in which seniors are not automatically enrolled in Part B of Medicare, causing many seniors to opt into the program after the enrollment period ends, at which point they must also pay substantial late enrollment penalties. Puerto Ricans have a distinguished history of serving in the Armed Forces, but they are denied coverage in Tricare Premium, the best health policy for our men and women in uniform.

There is no justification for these disparities. The 3.8 million natural born US citizens in Puerto Rico deserve the right to have the same benefits of our national health care program, including having the flexibility to adequately implement a state health care program.

Seventh, states must have greater flexibility in eligibility, financing and service delivery in order to provide long-term services and support that keep pace with the people Medicaid serves. New federal requirements threaten to stifle state innovation and investment. In addition, since dual eligibles now constitute 39 percent of Medicaid spending, Medicare policies that shift costs to the states must be reversed and the innovative power of states should be rewarded by a shared-savings program that allows full flexibility to target and deliver services, which are cost effective for both state and federal taxpayers.

One way Mississippi wants to improve long-term care is a specialty-skilled nursing facility for children. There is a need in Mississippi for a specialty-skilled nursing facility for the care of medically complex and fragile children. The state wanted to use Civil Money Penalty Funds (CMP) as start-up money for the development of this specialty-skilled nursing facility for children. Prior to PPACA, states were not required to seek CMS approval to use CMP funds. With the passage of PPACA, the use of CMPs were expanded, but utilizing the funds now

requires CMS approval. Mississippi petitioned CMS to use the CMP funds for the specialty-skilled facility and the request was denied.

We know what we need, and we have a plan to get children who require ventilation services out of a hospital into a more home-like setting, but CMS is preventing us from getting there even though the money is in the CMP account to pay for it . This is just another example of CMS not allowing states to be innovative or granting the necessary flexibility to make each Medicaid program meet individual states' needs.

Another example of how the cost of the Medicare program is being shifted to states is in the Medicare Part D 'clawback'. States must pay a share of this Medicare benefit in addition to being required to pay for some drugs not covered in this program for those dual eligibles. In addition, Medicare only covers nursing home services if skilled care, such as active therapy, is needed and only for 100 days, not if the person just simply needs 24/7 care. The burden of nursing home care after the 100 days is borne by the state's Medicaid program.

Secretary Sebelius has opined that flexibility is at the states' disposal to control costs. Although there are avenues states currently can utilize to try to make changes to their programs, making these changes is often lengthy, time consuming and burdensome to states. CMS continuously tells states to be creative and flexible in developing new programs and implementing changes to existing programs to provide smarter care choices. However, all of these things require CMS approval. They shouldn't.

On Friday, July 8, Secretary Sebelius announced a demonstration project with states to address the challenge of serving our citizens who are eligible for both Medicare and Medicaid, the so-called "dual eligibles." At the state level, we know a great deal about the dual eligibles, we know they are among the most medically complex and poorest among us. The costs to provide them with the health care they need are no doubt expensive because it is not unusual to find they have 5, 10, even 15 different medical conditions. But they are also costly because no one is managing their care. They are typically on their own and face difficulties in navigating through the health care complex by themselves. "FFS" typically means fee-for-service. But it also means "fend for self." These are the least capable to fend for self. In addition to complex medical needs, when you look at the characteristics of the dual eligibles, 54 percent have no high school diploma compared to 22 percent of non-duals.

Changes to Medicare policies impact Medicaid as well because Medicaid fills the gaps in Medicare coverage by paying for premiums, cost-sharing, and additional benefits, most especially long-term care that Medicare does not cover. When Medicare acts, there is a reaction within Medicaid. The so-called "doc fix" that seems to perpetually vex the Congress has a spill over effect onto Medicaid. The proposal to raise the age of Medicare eligibility will keep millions on full Medicaid for a longer period of time. Washington needs to stop masking the full costs of its decisions by passing costs onto states.

The demagoguery of proposals to reform Medicare must stop as well. We know that Medicare meets only about 60 percent of a beneficiary's health care expenses which is why more than 90 percent of Medicare beneficiaries have some type of supplemental coverage, either through retiree benefits, private medi-gap insurance, or, all too often, Medicaid.

States and the federal government need to start a serious discussion about how best to serve the dual eligibles at the best value to the taxpayers.

Although the new Medi-Medi project is intended to address fraud and abuse by sharing data between Medicare and Medicaid, having the duals lends itself to abuse for providers to bill both Medicare and Medicaid for services. The Government Accountability Office (GAO) just recently highlighted the missed opportunities to combat waste, fraud, and abuse because no one is looking at Medicare and Medicaid data simultaneously. Once payment is made and out the door, you will never fully recover the taxpayers' money. If Congress is at all serious about significantly lowering the loss of funds due to improper payments, give us the Medicare data for the dual eligibles on a real time basis.

As a condition of eligibility, individuals should be required to apply for all Medicare benefits. This is commonsense. Medicaid is supposed to be the payer of last resort so individuals should be expected to make use of all other resources before turning to Medicaid. Mississippi does this now; it is in our state plan. However, it would be easier if this did not require federal approval.

CONCLUSION:

There are three primary factors that drive Medicaid costs for states – eligibility, provider rates and utilization of services. Recent federal actions, the MOE restrictions in PPACA and the proposed access regulations regarding provider rates, prohibit states from exercising any real ability to control two of the three factors. States have limited control over utilization through the prior authorization process, but I know every Governor here does not want to sacrifice an individual's health to ensure the solvency of the program. In addition, the Obama Administration is proposing a blended rate to fund the federal share and, in effect, the state share, of the Medicaid program. States will suffer under this plan because it simply shifts more costs to the states without giving states any flexibility to design their own programs. It is unrealistic and unfair to think that states can manage their Medicaid programs when the federal government permits the states no flexibility in designing and no flexibility in administering their programs while continuing to push the ever-growing costs for the program down to the states. At the end of the day, states will be saddled with a Medicaid program that is significantly different than the one states signed up for 40 years ago. States will be forced to pay higher rates to providers, states will be forced to enroll individuals who are significantly above the poverty thresholds, states will have less federal financial support and states will have no flexibility to control their own costs. In short, Mr. Chairman, the Administration's constraints regarding eligibility and provider rates at the expense of economy, efficiency and flexibility will lock states into an unaffordable and unsustainable health care system that is destined to fail.

United States Senator Orrin G. Hatch
Opening Statement
Senate Committee on Finance Hearing on
Perspectives on Medicaid from Select Governors

July 14, 2011

I want to begin today by thanking the Chairman of this Committee, my friend and colleague, Max Baucus, for scheduling this hearing today. Though Republicans and Democrats do not necessarily agree in the details, I think that there is some agreement that the nation's Medicaid program — as currently constituted — is unsustainable. The opportunity to hear from the nation's governors, the individuals on the ground who are responsible for administering this program, while also balancing their state budgets, is an important one.

Medicaid was originally created as a safety net program for the nation's poor. Fewer than five million individuals used Medicaid services in the program's first year. Today, however, nearly one in four Americans is on Medicaid, and half of those newly covered by PPACA will be on Medicaid. The liberal Center for American Progress tellingly wrote the other day that House Budget Committee Chairman, Paul Ryan's, Medicaid proposal would be bad for the middle class. That says it all. A program initially created to support the nation's destitute, has been transformed into a spending program for the middle class.

From what I can see, this is not only disastrous for federal and state taxpayers, but it fails beneficiaries themselves who are in a failing program.

There are four core features of Medicaid that show the need for significant reform. First, the impact of this program on federal spending has become a genuine problem. Over just the next ten years, the federal government will spend $4.6 trillion on the Medicaid program.

Second, Medicaid is now crowding out other critical needs in state budgets, such as education and law enforcement. Medicaid now represents 22 percent of state budgets, and the expansions of Medicaid in the health care law amount to an additional $118 billion burden on the states.

Third, it is not clear that all of this spending gets us the right results. Study after study shows incredibly poor outcomes for Medicaid beneficiaries, especially when compared to privately covered patients.

And finally, Medicaid is rife with fraud. Earlier this week, the Government Accountability Office — or GAO — issued a report concluding that we are not even able to accurately gauge the amount of fraud in Medicaid because we do not have the technological tools to track it.

There has to be a better way, and as the Ranking Member on the Senate Finance Committee, I am working every day to personally ensure that we get this program under control. As it currently exists, Medicaid threatens the fiscal integrity of the nation and the states, and it fails to provide an adequate quality of care to those who depend on it.

I believe that we already have an existing model for successful reform. In 1996 a Republican Congress and a Democratic President succeeded in one of the greatest reforms of a major entitlement program in our nation's history, when it took up welfare reform.

Medicaid is failing patients and is a target for waste, fraud, and abuse, not because the states are doing a bad job, but because Washington's bureaucracy has tied states' hands, preventing them from making meaningful changes and reforms that make sense at a local level.

Solutions for sustainable Medicaid reform will come from the states – not just Washington. My goal is to empower the states to design and implement innovative Medicaid solutions that work for states.

In May, along with House Energy and Commerce Committee Chairman Fred Upton, I wrote the nation's governors, asking for their ideas on Medicaid. A majority of the nation's governors responded with a request for flexibility and transparent, accountable budgeting.

Today, we have two of those governors today. I could not be more pleased that you are here to give us your perspective. My state's governor, Gary Hebert, has shown again that the Utah Way can be a model for other states. The success of Primary Care in Utah shows that states can create innovative and efficient solutions, if they are given some relief from Washington mandates.

And Governor Haley Barbour, as the Republican Governors Association's policy chair, has been leading the effort to put energy behind Medicaid reform.

This hearing is part of a collaborative process with the nation's governors to reform the Medicaid program. In my role as the Republican leader of the Senate Finance Committee – with responsibility for entitlement programs – I am determined that this process will end in a comprehensive Medicaid reform law.

I want to be clear though. For those on the ground in the states, this is not a Republican or a Democratic issue. Former Tennessee Governor Phil Bredesen has called Medicaid, "an obsolete and broken system."

I wish that I could say that I disagree. But the more that one looks at this program, the more clear it is that this program cries out for fundamental reform. Only then can we restore fiscal integrity to the federal and state governments, and only then can we deliver a higher level of care to those who depend on this system.

I look forward to the testimony of our esteemed witnesses, and I thank them for taking the time to share their experiences with us today.

Governor Gary R. Herbert's Testimony to the Senate Finance Committee's "Medicaid Field Hearing" - July 14, 2011

Good afternoon, I am Gary R. Herbert, Governor of this great State of Utah.

I would like to thank Senator Hatch for convening this hearing and for your invitation to testify. I would also like to welcome Governor Barbour to our state.

Let me begin by noting these governors are joining many others from around the country in our state this week for the summer meetings of the National Governors Association. We are colleagues who represent diverse states and diverse populations – and we all have our own unique challenges.

What we share, however, is the rightful authority to advance unique solutions to our unique challenges. I am a firm believer in the principles of Federalism embodied in the 10th Amendment - states are not powerless agents of federal authority.

A balance of powers between the states and the federal government is not only right and proper, but essential if we are ever to find solutions to the complex problems we face as Americans.

To solve those problems, it is critical for the federal government to provide states with the flexibility to find better ways to conduct our business. Simply put, the citizens of this great state deserve, and expect, that Utah challenges will be met with Utah solutions that address our unique demographics and dynamics.

One of our most significant challenges – and a challenge I know we share with other states that are represented by their governors here today – is the untenable growth of our Medicaid program. Medicaid is poised to wreak havoc on the state's budget for years to come, threatening our ability to fund other critical services, such as education and transportation.

In trying economic times, such as those we've experienced over the past several years, families increasingly rely on programs like Medicaid to get them through the rough patches. In May 2007, enrollment stood at 161,368 individuals. By last month – June of 2011 – enrollment had ballooned to 244,470 individuals, an increase of 51% in just 4 years.

As you might imagine, this growth has created a tremendous strain on Utah's budget. Medicaid growth rates have exceeded the state's annual revenue growth rates for the past two decades. Last year, the program's share of the overall general fund was 18 percent – more than double its share from the 1990s. And by 2020, it is estimated to exceed 30%, and that's without the federally mandated expansion of the program.

And it's not just increased enrollment driving up costs. The cost of delivering medical care is also to blame – partly due to health care inflation that is rapidly outpacing overall inflation, and partly due to a reimbursement structure that provides financial rewards overusing medical care.

We have a plan that addresses our unique challenges and will fundamentally change the way Medicaid services are delivered to Utah citizens

Our plan is patient-focused and provides for healthier people; it promotes individual responsibility and consumer choice; and it saves money by providing financial incentives to keep people healthy, not just to perform more tests and procedures on them.

It balances the policy demands of a growing program, with looking out for those who desperately need its services.

The plan is truly homegrown. It was crafted over the past several months by my administration and the Legislature, along with input from Utah citizens, health care providers and advocacy groups.

In order to make this work, the federal government needs to provide Utah with the flexibility to institute the plan.

Our solution has a number of distinct advantages over the current Medicaid service delivery model. Perhaps most importantly, is that it realigns financial

incentives for providers to deliver care in a manner that moves away from "billable events or services" and towards a focus on patient outcomes.

In other words, when it comes to the delivery of health care for Medicaid clients, we are going to stop paying for quantity and start paying for quality.

Our proposal replaces the current Medicaid Managed Care and fee-for-service models with a Medicaid Accountable Care Organization, or ACO, model. The model works by paying doctors and hospitals a lump sum to manage the care of a patient.

This offers the provider an incentive to work towards the best possible health outcome for each individual patient, and to move away from performing, and in turn billing for, services that may be medically unnecessary.

A centerpiece of this reform effort is the "Medical Home" concept. Each Medicaid client will have access to a primary care provider, or a group of primary care providers, who will not only deliver care, but will also coordinate their patients' care throughout the entire network of providers.

This new model will incorporate something that has been missing from Medicaid for quite some time: Consumer choice and individual responsibility

Not only will Medicaid clients have the choice to select from at least two Accountable Care Organizations, they will have the choice to opt out of the program all together and instead receive a subsidy to purchase private insurance.

Currently, individuals who are eligible for Medicaid do not have the choice to participate in the state's premium subsidy program. Our proposal allows an individual who is eligible for Medicaid to make their own choice: Enroll in the program, or opt to receive a premium subsidy and purchase their own insurance through the Utah Health Insurance Exchange or through their employer.

I am a firm believer that Medicaid recipients need to take more responsibility for the delivery of their health care – both in terms of outcomes and payments.

We know that better health outcomes lead to reduced health care costs. And we know that better health outcomes are often achieved by patients cooperating and complying with a recommended course of treatment.

Our plan allows Accountable Care Organizations to offer incentives to patients with chronic diseases who follow their recommended treatments. Such incentives could come in the form of limiting or waiving co-payments, or granting limited cash rewards or gift cards.

The state has nearly 20 percent of its budget, almost $1.8 billion, invested in this program. It's time to move away from the entitlement mentality that has gotten us into this situation by requiring recipients to shoulder a little more of the financial load.

Federal Medicaid co-payment limits were established at $3 back in the early1980's during an initial wave of Medicaid reform. Since that time, co-payment limits have increased by only 60 cents. You would be hard pressed to find a family in our state whose private insurance copayments haven't increased by 60 cents in the past year, much less the past 30 years.

Had that co-payment adjusted with inflation throughout the years, it would be the equivalent of about $11 today.

These onerous and archaic restrictions established by the federal government have put states on a path to financial ruin.

We're ready to change paths.

We're suggesting a modest increase from $3 to $5 for primary care co-payments. And to help ensure patients seek care in appropriate settings, clients visiting an emergency room for non-emergent care will be responsible for a $25 co-payment, rather than the current $6 amount.

We believe this will help reduce much of the unnecessary spending created by patients seeking primary care in the costly emergency-room setting.

I've heard the criticisms that we are placing an undue burden on a population that can little afford to shoulder it. And I'm not unsympathetic to the plight of those who truly would be unable to bear such a burden. Those with no income would still be exempt from the cost sharing. Additionally, our proposal grants

the Accountable Care Organizations the flexibility to waive co-payments, if they find it to be in the best interest of their patients' health outcomes.

Our intent is to implement these reforms in the state's four most populated counties on July 1, 2012.

This should give the Centers for Medicare and Medicaid Services (CMS) ample time to review our waiver and to work through any concerns.

The highest levels of leadership at CMS have been receptive and supportive of our efforts thus far. I would encourage those leaders to provide their staff with the flexibility they will need to make sure we are successful.

The ramifications of this reform effort extend well beyond the borders of our state. Not only could this model be the tipping point for Utah's public insurance program, but I believe private insurance companies will soon follow suit – in Utah, and across the nation.

This is where true health reform will rise from, from the "laboratories of democracy" that we call states.

In Utah, we know we're on the right track. Our health system reform efforts began five years ago, and the lessons we've learned are already serving as a guide to other states as they begin their own reform efforts.

Utah is unique in that a majority of our uninsured population is employed. Most work for small businesses which do not offer health insurance benefits. In order to reduce our uninsured population, we needed to make insurance coverage accessible to our state's small employers.

Utah also has the youngest population in the country. Many of our uninsured are so-called "young immortals", persons between the ages of 18-34 who are generally healthy and employed but who have deemed traditional health insurance coverage to be either unnecessary or too expensive.

In Utah, we have chosen a path of business- and consumer-oriented health system reform which responds to Utah's needs.

One of the tools we're using to help reduce our uninsured population is the Utah Health Insurance Exchange – one of just two exchanges operating in the nation.

The Exchange gives Utah small business employees more than 100 plan choices, all of which retain the pre-tax and guaranteed-issue advantages of traditional small group insurance.

The Utah Health Insurance Exchange is now fully operational. In its first month alone, the exchange helped more than 1,000 employees get health insurance they have chosen. Each month, enrollment continues to climb. Our figures show that 20% of businesses participating in our defined contribution market through the Utah Health Exchange are offering health benefits for the first time.

This is another example where we have used market principles to create a Utah solution for Utah's challenges.

These are the types of innovations Washington should be celebrating – not stifling.

If there is one thing the committee takes away from my testimony here today, and from the testimony you'll hear from Governor Barbour, it's that states are poised to act – but we need flexibility from Washington in order to do so.

Senator Jay Rockefeller
Statement for the Record
Senate Finance Committee Field Hearing
Perspectives on Medicaid from Select Governors
July 14, 2011

Mr. Chairman, we all agree these are very critical times for our nation. Every day many Americans face the challenge of providing for their families, maintaining their health and well-being and hoping that their elected leaders in Congress will stand as a voice for their families as we address the economy and the deficit. As usual when our nation is in the midst of these conversations, Medicaid has once again become a target – despite overwhelming proof of its effectiveness and its importance to our millions of people in our country.

After almost 50 years, Medicaid is still a life-saving part of our nation's health system – covering 40 percent of births (over 50 percent of births in West Virginia), 62 percent of long-term care, and, along with the Children's Health Insurance Program, 34 percent of the children in our country. Earlier this month, a landmark study by Harvard and MIT economists reinforced the fact that Medicaid is an essential life line for millions of Americans. In addition to being more likely to have regular doctor visits and get recommended preventive care (such as mammograms), Medicaid enrollees were 40 percent less likely to say that their health had worsened in the past year than those without insurance. The study found that those with Medicaid were protected financially as well – for example, they were less likely to borrow money to pay doctor bills. Medicaid is the health care program that helps states during times of crises – including after the September 11th attacks, Hurricanes Katrina and Rita, and the recent floods and tornados in the South and Midwest. And, Medicaid serves as an economic engine supporting millions of homegrown jobs at hospitals, nursing homes, community health centers, and doctor's offices in every single state.

The recent economic downturn demonstrates exactly why we need Medicaid to remain strong. Medicaid is the single largest source of federal revenue for the states, and it automatically expands during an economic downturn to assist families who lose their jobs and health insurance. Between 2008 and 2009, Medicaid enrollment rose 9.3 percent as people lost their jobs and their health insurance. The enhanced federal matching rate provided under the American Recovery and Reinvestment Act of 2009 and a subsequent six-month extension resulted in extra federal contributions of $100 billion to states through June 2011 to help them maintain their health coverage through Medicaid. With the expiration of that extra assistance, states simply cannot absorb drastic federal Medicaid cuts and the inevitable job loss that will follow. That is why the National Governor's Association has pointed out that "federal spending reductions for Medicaid will result in a direct cost shift to states, which will result in reduced

Medicaid expenditures, increased state taxes or reductions in K-12 education, transportation, and public safety funding."

Medicaid already accomplishes its goals very efficiently. Between 2000 and 2009, per beneficiary spending grew at 4.6 percent, compared to 7.7 percent growth in premiums for employer sponsored insurance. Yet we have seen far too many proposals over the last few months that, instead of strengthening this vital program, would arbitrarily cut federal spending by hundreds of billions of dollars – shifting costs to states, local governments, and beneficiaries, with devastating consequences. The House Republican budget, for example, would slash dizzying amounts of funding from the program – draining $770 billion in federal funding from the states by turning Medicaid into a block grant and repealing the historic coverage expansion under the health reform law. Under this plan, states would receive 44 percent less federal Medicaid money annually by 2021, and up to 44 million fewer people nationally would have Medicaid coverage compared to current law – dramatically increasing the burden of uncompensated care on the health centers, hospitals, nursing homes, and other institutions that rely substantially on Medicaid. More recently, we have seen proposals to for a "blended rate" that reduces federal Medicaid spending by as much as $100 billion, as well as a new proposal that would require up to $500 billion in cuts from vital health care programs like Medicare and Medicaid. I wholeheartedly oppose each of these proposals. While I am more than willing to have the conversation about how to improve Medicaid, I am concerned that in general, Congress tends to seriously focus on the Medicaid program only within the context of deficit reduction. With the exception of the health reform law, Congress has rarely focused on real ways to improve the program. Instead, the focus has most often been on cutting Medicaid, no matter what the consequences are. It is far past time that we stop using Medicaid as the scapegoat for our health care cost problem.

Finally, I must express my serious concerns about proposals to repeal the maintenance-of-effort responsibilities for states set forth in the health reform law. In light of the success of Medicaid and CHIP in covering children, I am particularly concerned with the devastating effects on children's coverage that would result from this proposal. According to the independent Congressional Budget Office (CBO), enacting this proposal would mean that:

- **By 2013, 400,000 people will lose their Medicaid and CHIP coverage.** Two-thirds of those dropped from coverage will be children.

- **Half of all states will end their CHIP programs by 2016**. One quarter of states are expected to end their program even earlier, in 2015, while remaining CHIP programs are expected to scale back coverage. For example, they could put children at risk of losing coverage by increasing the amount of red tape and bureaucracy, including waiting lists, that families must face when trying to enroll their children.

- **By 2016, the number of those expected to lose CHIP coverage will climb to 1.7 million people, with 700,000 left uninsured.** Less than two years after efforts to extend coverage to nearly 32 million uninsured Americans, this bill takes a step backwards by resulting in loss of coverage, a burden that will be borne disproportionately by children.

Repealing the maintenance-of-effort provisions would jeopardize the country's remarkable progress in covering children and unravel one of Congress's most successful bi-partisan initiatives. It would be extremely shortsighted to dismantle programs that are working so well, and the American people agree. Again and again, Americans say they do not want children to go without health care coverage or parents to go without long-term care. As middle class families lost jobs in the economic downturn, Medicaid and CHIP have kept their children covered. Middle class families quickly deplete their savings and resources when a child gets sick and has significant health care needs. It is Medicaid that helps most middle class families get care for their children with significant needs. And, middle class families know that despite their current economic security, they will not be able to pay for nursing home care for themselves or a loved one if they ever need it.

Some critics have contended that middle class families should not receive coverage through Medicaid. But these middle class families understand that if they or a loved one faces disability, disease, old age or some other life changing event, there may be nowhere else to turn to for affordable health coverage and long-term care. They understand that cuts to Medicaid would leave them not only at greater financial risk, but also in a situation where they have nowhere else to turn to protect their child or their parent's health. It therefore should not be surprising that 83% of Americans do not support major reductions in Medicaid.

Proposals to slash Medicaid and attack our most vulnerable fellow Americans are irresponsible. Instead, we should focus on and strengthen the provisions of the health reform law to improve the solvency and efficiency of Medicaid, including taking better care of dually eligible beneficiaries and eventually enacting real long-term care reform. Rather than seeking to tear Medicaid down, we should strengthen this important program for now and generations to come.

COMMUNICATIONS

ObamaCare's Medicaid Mandate

Remarks by
Michael F. Cannon
Director of Health Policy Studies
Cato Institute[1]

Before the
Senate Finance Committee Field Hearing
Salt Lake City, Utah

July 14, 2011

Mr. Chairman and members of the committee, I am grateful for the opportunity to submit these comments to you today.

The "Patient Protection and Affordable Care Act" of 2010 imposes serious burdens on American taxpayers, consumer, employers, and state governments. It is an obstacle to job creation and better, more affordable health care for everyone – particularly those at the margins of society. There is quite literally nothing that Congress can do to improve the cost, quality, or security of health insurance and medical care so long as this law, known commonly as "ObamaCare" remains on the books.

The law's Medicaid provisions will prove the most burdensome to state governments.

The Medicaid Mandate

States can scarcely afford their Medicaid programs as they existed before ObamaCare became law. Medicaid outlays are among the largest, if not the largest, item in state budgets. Yet ObamaCare imposes on states an onerous "maintenance of effort" requirement that effectively robs states of their ability to manage their Medicaid programs in order to contain spending.

ObamaCare further requires all states to expand Medicaid eligibility, by 2014, to all individuals in households with incomes below 138 percent of the applicable federal poverty threshold. The law promises that the federal government will initially fund the entire cost of these new enrollees, but it also promises that federal funding will fall over time. Since the penalty for not expanding a state's Medicaid program is the withdrawal of all federal Medicaid funds, this mandate is essentially coercive. Moreover, Congress and President Obama are already considering reducing the federal contribution, which would make this mandate even more costly to states.

ObamaCare's Medicaid mandate will impose significant costs on states, principally because individuals who are already eligible for the program, but not enrolled, will begin to enroll in 2014. My Cato Institute colleague Jagadeesh Gokhale projects that in the first 10 years of operation (2014-2023), ObamaCare will mandate that Florida, Illinois, and Texas spend roughly an additional $20 billion *each* on their Medicaid programs, that Oklahoma spend an

additional $11.4 billion, that Nevada spend an additional $5.4 billion, and that New York spend an additional $53 billion. Compared to prior law, state Medicaid spending will increase by 17.1 percent in Florida, 28.1 percent in Illinois, 45 percent in Nevada, 16.5 percent in New York, 35 percent in Oklahoma, and 12.9 percent in Texas over the first 10 years of full implementation.

On a per-taxpayer basis, ObamaCare's Medicaid mandate is also highly inequitable. "For every $1 in costs imposed on each working-age Texas adult," Gokhale writes, "Floridians and New Yorkers will pay about $1.50, Illinoisans will pay $3.60, while Californians will save a small amount (about 3 pennies)."

Zero Evidence of Cost-Effectiveness

ObamaCare imposes these burdens on states without any evidence that expanding Medicaid is a cost-effective way of improving the health or financial security of low-income households.

Supporters of the law the have recently seized upon the results of the Oregon Health Insurance Experiment, which found that when government transfers $3,000 from taxpayers to a Medicaid enrollee, it somewhat benefits the enrollee in terms of reduced financial strain and self-reported health. Supporters claim that these modest benefits justify ObamaCare's Medicaid mandate, but the OHIE does not provide the vindication they seek.

- First, despite being eligible for Medicaid, 13 percent of the control group had private health insurance — suggesting that on some dimension, Medicaid's eligibility rules are already too broad.

- Second, the OHIE extended coverage to the most vulnerable population of uninsured Americans, yet produced only modest improvements in health and financial security. At higher income levels, where individuals have greater baseline access to health insurance and medical care, the benefits of expanding coverage are likely to be smaller and the costs (to the extent that crowd-out is higher at higher income levels) will be greater.

- Third, For Medicaid to be cost-effective, it must produce benefits *and* do so at the same or a lower cost than alternative policies. The OHIE only establishes that after one year, there are modest benefits to expanding Medicaid to the most vulnerable among the uninsured. It tells us next to nothing about the costs of producing those benefits, which include not just the transfers from taxpayers but also any behavioral changes on the part of Medicaid enrollees, such as reductions in work effort or asset accumulation induced by this means-tested program. Nor does it tell us anything about the costs and benefits of alternative policies. Indeed, other policies are likely more cost-effective than expanding Medicaid. Health economists generally agree that discrete programs promoting highly effective treatments (for hypertension, diabetes, etc.) could produce health gains as large as expanding health insurance would, but at far less expense. Reducing taxes could plausibly reduce financial strain to a similar degree by expanding job creation.

- Finally, the OHIE illuminates an unflattering feature of the debate over ObamaCare. In 2010, Congress and President Obama vastly expanded Medicaid without knowing what benefits it might bring or waiting for the results of the one study that might tell them what taxpayers would get in return for their half a trillion dollars. The law's supporters seek to cajole doctors into practicing evidence-based medicine, yet they themselves dove head-first into evidence-free policymaking.

States Need to Cut Medicaid, Not Expand It

States and the federal government cannot afford ObamaCare's Medicaid mandate. The money simply isn't there. Indeed, states should be cutting Medicaid enrollment rather than expanding it. The evidence shows there are millions of people enrolling in Medicaid who don't need taxpayer subsidies to obtain coverage, and experience shows that Medicaid cuts will not be as painful as some might think.

Economists of all political stripes acknowledge that Medicaid crowds out private health insurance, which provides better access to medical care. Jonathan Gruber, a Massachusetts Institute of Technology health economist and sometime consultant to the Obama administration, has estimated that, in effect, as many as six out of every ten enrollees added to Medicaid and similar programs would otherwise have had private coverage. Put differently, these programs cover four uninsured Americans for the price of ten — a lousy deal even by government standards.

Gruber's MIT colleague Amy Finkelstein finds that Medicaid also crowds out private long-term care insurance. For those who qualify, the value of Medicaid's nursing-home and related benefits is two-thirds that of a typical private long-term care policy. Medicaid thereby reduces the marginal benefit of private insurance to just one third of the marginal cost. Consumers therefore choose, quite rationally, not to purchase private coverage.

President Obama elides the existence of crowd-out when he implies that every single senior receiving Medicaid's nursing-home benefits "wouldn't be able to afford nursing home care without Medicaid." That's simply not true. An entire cottage industry of elder-law attorneys has emerged to help seniors qualify for Medicaid without spending down their wealth.

All of which means that if states reduce eligibility for their highest-means enrollees, many will obtain private coverage themselves. These include the patients of a Louisiana ob-gyn who, The New York Times reports, have private coverage through an employer but enroll in Medicaid when pregnant to avoid the co-pays.

How many former Medicaid enrollees would obtain private coverage if states reduced their rolls? It depends. But consider two examples. In 1996, Congress eliminated Medicaid eligibility for many non-citizen immigrants. Coverage among non-citizen immigrants actually increased — the opposite of what one might expect — because non-citizen immigrants responded to the cuts by obtaining jobs with health benefits. In 2005, Missouri cut 100,000 people from its Medicaid rolls. The number of adults with health insurance fell, but by a smaller amount than the number cut from the Medicaid rolls, because private insurance filled part of the

gap. With children, the news was even better. Missouri cut loose one fifth of all low-income children enrolled in Medicaid, yet the coverage rate among low-income children did not change. Private insurance filled the entire gap.

Private insurance may not fill as much of the gap today as it did when there were more jobs available. One step that could help spur job creation would be to repeal ObamaCare, which includes individual and employer mandates that are increasing the cost of private insurance at the same time they are reducing job opportunities for low-skilled workers. Repeal would also eliminate the government price controls that have destroyed the market for child-only health insurance in some 20 states; restoring those markets would fill even more of the gap.

All sides agree that balancing federal and state budgets is impossible without restraining Medicaid spending. The first step is to eliminate ObamaCare's Medicaid mandates. The second step is to block-grant federal Medicaid funding to the states. Medicaid block grants would give states the incentive and the flexibility to target their programs at the truly needy who can't obtain coverage on their own.

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U.S. Senate Finance Committee
Field Hearing

"Perspectives on Medicaid from Select Governors"

Sen. Max Baucus, Chairman
Sen. Orrin Hatch, Ranking Member

July 14, 2011
Utah State Capitol
Salt Lake City, UT

Submission for the U.S. Senate Finance Committee record from
Grace-Marie Turner
Galen Institute

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U.S. Senate Finance Committee
Field Hearing
"Perspectives on Medicaid from Select Governors"

Submission for the record from
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I would like to commend the committee for traveling to Salt Lake City to hear testimony from governors about the huge impact that Medicaid has on their state budgets. States are desperate to find savings to get their budgets in balance. Medicaid spending has nearly doubled over the last decade, and for many it consumes the first or second biggest share of state expenditures, threatening education, public safety, and transportation programs. Decades of expansion of what is now the largest single health program in the country are finally catching up. Former Virginia governor and now-Sen. Mark Warner (D-VA) says, "Long before Social Security goes bankrupt, Medicaid is going to bankrupt all the states."

Under the Patient Protection and Affordable Care Act (PPACA), as many as 25 million people will be added to Medicaid nationwide. Chief Medicare Actuary Richard S. Foster anticipates that by the end of this decade, 84 million people will be on the program.

Many see Medicaid as the foundation for the government-run health program of the future. But Medicaid is arguably the worst health care program in the country. It is riddled with waste and fraud, and it offers a generous benefits package on paper but pays doctors so little that many can afford to see only a few Medicaid patients, and this relegates patients to long waits in hospital emergency rooms to get even routine care.

Governors have told Washington in every way they can they need flexibility in order to improve the program and better manage Medicaid spending. In January 2011, 33 governors and governors-elect wrote to President Obama and congressional leaders requesting "flexibility and relief" from the "excessive constraints placed on us by healthcare-related federal mandates."[1] States say they need to trim their Medicaid rolls now — partly because of the faltering economy and partly because stimulus funding that initially helped many of them pay for the added enrollment has ended.

And, while Health and Human Services Secretary Kathleen Sebelius has responded by sending her agency's Medicaid experts to the states to help them explore options to trim Medicaid spending, she is still urging states to do everything they can to keep Medicaid enrollment at current levels before the health law's changes take effect in 2014.[2]

Senate Leadership

Governors are rightly concerned that Washington's rules and red tape impede efforts to not only get costs under control but also to improve care delivered through the program. Sen. Orrin Hatch of Utah, Ranking Member of the Senate Finance Committee, and Rep. Fred Upton of Michigan, Chairman of the House Energy and Commerce Committee,

underscored those concerns when they sent a letter this spring to the governors about the quality of care in Medicaid programs, quoting a study that shows "Medicaid patients were nearly 50 percent more likely to die after heart surgery than patients who had either private coverage or Medicare."[3]

They also expressed alarm about fraud, waste, and abuse in Medicaid, and the cost of Medicaid that "is bankrupting both federal and state budgets." They asked governors to give them "feedback on both the challenges you have faced" and "your ideas on how to make Medicaid work better."

The committee's field hearing in Utah to hear directly from the governors is further evidence of your commitment to work with them in modernizing the program.

Three other senators — Sens. Richard Burr of North Carolina, Tom Coburn of Oklahoma, and Saxby Chambliss of Georgia — have introduced legislation to reform Medicaid by giving states more flexibility and creating new incentives to improve the quality of care in the program.

They start by giving governors their first request — repealing the maintenance of effort requirement that forces them to keep Medicaid enrollment high even as health spending is squeezing other state services.

Their "Medicaid Improvement and State Empowerment Act" would give "health grants" to states to provide coverage for low-income Americans and give states more flexibility to provide care that suits the needs and resources of their states and not the dictates of Washington bureaucrats. The bill would also maintain current payments for acute care for patients who are dually eligible for Medicare and Medicaid and the disabled.

The Medicaid Dilemma

Some states have been lured into expanding Medicaid enrollment — originally designed to provide health care to the lowest-income Americans — well into the middle class because Washington pays at least half of the cost. The more people the states cover, the more money they receive from Washington. Conversely, whenever they try to turn down the federal spigot, they lose two or more federal dollars for every dollar they cut.

Sen. Joe Manchin (D-W.V.) understands the challenges of the states and wants to give them more flexibility, based on the model of initiatives he introduced when he was governor. "If you are a healthy person who is financially challenged — and you need help from the state, then you're going to have some responsibilities to meet," he explained.[4] He offered rewards to encourage Medicaid recipients to keep appointments and comply with treatment recommendations coupled with the loss of some benefit privileges for those who refused.

Block Grants to the States

States must go through time-consuming and bureaucratic appeals to Washington to get permission to make changes to Medicaid. This leads to waste, inefficiency, and a program that has few other options but the crude tools of price controls to try to rein in spending. PPACA did little or nothing to reform what is arguably the worst health care program in the country — and the largest, with more than 50 million people enrolled. In many states, it pays doctors so little that Medicaid's rich benefits package is little more than a paper promise for care.

There is growing interest among the governors in giving states much greater flexibility in running their Medicaid programs through block grants, global waivers, and other programs to give them more control over spending.

But there is pushback, including a study released by the Kaiser Family Foundation in May 2011, with researchers from the Urban Institute, which is highly critical of the block grant plan.[5] The study concludes that if the health law was repealed and states were given block grants for Medicaid, state spending would increase between 45 and 71 percent to offset the loss of federal dollars or 44 million people would be without coverage as a result of the changes.

This study uses exaggeration as a scare tactic. As this committee hearing shows, the Congress is clearly ready to work with the states to make sure that changes to Medicaid work for both the citizens of the states as well as federal taxpayers.

Rhode Island has proven that a global waiver, which works much like a block grant, can work to protect enrollment and to save taxpayers money. Giving states greater flexibility is the key to greater efficiency in Medicaid spending so that states can modernize their programs to fit the needs of their citizens and match the resources available in their individual states.

Rhode Island developed and received approval for a global Medicaid waiver in January of 2009. In exchange for significantly more flexibility in managing its Medicaid program, it received an aggregate budget of $12.075 billion dollars through 2013. The state had — and still has — the latitude to preserve coverage and services for those with the greatest need and to re-tool benefit packages to ensure coverage for the maximum number of beneficiaries within established budget constraints.

State officials were confident that with the ability to operate the program with less onerous federal rules, they would not exceed the cap.

They were right. The rate of growth in Medicaid spending was cut in half from over 8 percent to 3 percent in the first 18 months the program was in operation. At its expenditure rate as of last year, Rhode Island was on track to spend approximately $9.3 billion of the allotted $12.075 billion, while maintaining enrollment levels.

"Rhode Island shows that more money is not the solution," according to former Rhode Island health and human services secretary Gary Alexander. "The answers are comprehensive reform and freedom from onerous federal mandates."

The Kaiser report referenced above gives virtually no consideration to the important efficiencies that could be gained by better managing and coordinating care for the 20 percent of patients who consume 80 percent or more of Medicaid's resources. States closer to their citizens have demonstrated in Rhode Island, Vermont, Indiana, and elsewhere that significant improvements in care are possible while saving taxpayers money – if the federal government will allow them the freedom and flexibility to design their programs to make them more efficient.

The Kaiser report assumes that spending for Medicaid continues to rise at the rate of 8.2 percent a year. And it assumes that nearly 76 million people will be on Medicaid under current law. Governors are telling Congress they cannot afford this rate of spending for a program that is going to swell by tens of millions of new recipients.

At some point, we must recognize the reality that change is not only inevitable but essential. The question is whether or not the political leaders closest to the people will be able to make finely tuned changes or whether the program remains rigid and inflexible, requiring more and more cuts to provider payments as fewer and fewer Medicaid recipients are able to find physicians to see them.

The States and the Health Reform Law

There is strong resistance in the majority of starts to the demands of the new health reform law. They are ordered to expand Medicaid to levels that many say could bankrupt them and to set up new health exchange bureaucracies lest the federal government sweep in and do it for them.

Medicaid Expansion. Beginning in 2014, the new law requires states to expand Medicaid to cover up to 25 million more people. Under the new law, people under age sixty-five who have incomes below $14,400 for an individual and $29,300 for a family of four (133 percent of the federal poverty level) would be eligible for the program. Total federal and state Medicaid spending will skyrocket, going from $427 billion to $896 billion between 2010 and 2019.

Federal taxpayers will pick up 100 percent of the cost for this expansion until 2016, and then the federal matching payment begins to drop to 90 percent.

Even with this assistance, the governors estimate the cost of the law's Medicaid expansion will be $118 billion over 10 years — almost twice the Congressional Budget Office's estimate.[6] A joint Congressional Committee report released by Senator Hatch and Representative Upton, titled "Medicaid Expansion in the New Health Law: Costs to the States," contains a state-by-state analysis of the law's financial impact.

"Governors of both political parties were clear when Congress was debating the $2.6 trillion health law that they could not afford a massive expansion in Medicaid," said Sen. Hatch. "With this report, we see the true cost to states, who are already facing a collective $175 billion budget shortfall, of this unsustainable expansion... It's time for Congress to peel this program back by putting states, not the federal government, back in charge."

Until now, states have basically decided how much people can make and still be on Medicaid, with different categories for eligibility. With the expansion, many governors fear that adding millions more people to their Medicaid rolls will cripple their state budgets. Medicaid is already consuming a huge share of their revenues. Medicaid will inevitably take money away from spending on education, transportation, public safety, and other programs — and in many states, it already is.

Medicaid Expansion Hurts the Most Vulnerable

Even before the health law was enacted, the dean and CEO of Johns Hopkins Medicine, Edward Miller, warned that putting millions more people on Medicaid would lead to overwhelming demand for medical centers like his that treat a large number of low-income patients.

Dr. Miller wrote a commentary article in *The Wall Street Journal* in December 2009 entitled "Health Reform Could Harm Medicaid Patients."[7] He warned that this large Medicaid expansion could have "catastrophic effects on those of us who provide society's health-care safety-net."

Hopkins serves tens of thousands of poor, disadvantaged people, including 150,000 people in Maryland's Medicaid program.

Hopkins has worked very hard to create programs to provide quality care, ranging from routine care at clinics to sophisticated hospital treatment for patients with serious and complex medical problems.

"The key fact is that for years the state did not cover all the costs [of] our Medicaid program," Dr. Miller wrote. Johns Hopkins lost more than $57.2 million treating Medicaid patients between 1997 and 2005. The state had added thousands more people to Medicaid "whose costs were not completely covered by the state." Then Maryland expanded Medicaid *again* to cover more people, and Johns Hopkins lost another $15 million in just the first nine months. There is just no way the system can handle the huge wave of new patients that is coming with this Medicaid expansion.

Given time, Dr. Miller says, Hopkins could work with other medical facilities to create a system of care for thousands more patients. But if up to 25 million more people are added to the Medicaid rolls nationwide beginning in 2014, it could completely overwhelm the safety-net system among his and other hospitals and clinics around the country. And given Medicaid's abysmally low payment rates, it is unlikely that private doctors will be able to afford to take much more of the exploding caseload.

Massachusetts Offers Lessons for Other States

Massachusetts is a canary in the coal mine for health reform and offers a lesson for other states. Before the state enacted its own version of reform in 2006, it had the highest health costs in the country. But health costs continue to soar in the Bay State, and Medicaid spending is already choking its budget. Today, three-fourths of the people who have become insured as a result of the Massachusetts law are getting taxpayer-subsidized coverage, through either Medicaid or its version of an exchange.

A recent report on the status of Massachusetts' health care reform efforts said, "Medicaid is gobbling up more and more of the state budget, a trend that has been going on for many years. . . . [It's] devouring new state revenues and leaving other services in areas like public safety, human services, education and local aid, subject to continuing budget cuts."[8]

A separate report shows that hundreds of millions of dollars that were supposed to go to improving public schools in Massachusetts have instead gone to pay for expensive health insurance for teachers.[9] The rise in health insurance premiums has "completely consumed the increased appropriations for education and then some," according to the report from the Boston Foundation. "These cost increases are huge, and they're affecting kids."

Further expansion of Medicaid severely stresses what should be a safety-net program. This is not reform. Why would we put so many people into a program where patients already have such a difficult time getting care?

A Program Plagued by Fraud

Many are asking why we would dramatically expand a program that is so plagued by fraud. *The New York Times* ran a series of articles in 2005 exposing the astonishing corruption and waste in New York State's Medicaid program[10]:

- A Brooklyn dentist — who has since been indicted — billed for 991 fillings, cleanings, and other dental procedures supposedly done in one day in 2003, costing Medicaid a total of $63,967. That dentist's payments from Medicaid that year totaled $5.4 million.

- The state paid $316 million for private ambulance transportation for Medicaid patients. It paid $36 for a taxi trip that would cost $2 on a bus — in a city that has the country's best public transportation system.

Experts estimate that at least 10 percent and likely much more of the $45 billion New York State spent on Medicaid in 2005 was stolen or wasted.

The average cost per Medicaid patient in the state is $10,600 a year. That's enough to buy a good private health insurance policy, even in New York's incredibly expensive market.

The series got the attention of former governor George Pataki, who quickly appointed an independent inspector general to track fraud and abuse in the state Medicaid program. In the three years leading up to 2009, the unit recovered nearly $660 million and landed hundreds of convictions and millions in restitution in New York. But it's still just the tip of the iceberg. Medicaid has too long been at the bottom of the priority list for policy makers and investigators.

Taxpayers and the recipients who rely on Medicaid need this safety-net program to be moved to the top of the health reform priority list.

The Exchange Dilemma

Governors are also in a dilemma about what to do regarding the health exchanges required under the new health law. So far, only 10 governors have signed legislation to get the exchange machinery moving. States such as California were among the first to pass legislation to begin setting up the exchanges, but its budget woes have taken center stage for so long that there has been little action to follow up. Gov. Rick Scott of Florida has barred any action by state employees or any spending to set up the exchanges pending a decision in the lawsuit his state is leading to challenge the health law in the courts. In Indiana, Gov. Mitch Daniels believes he is obligated to set up a bare-bones infrastructure as a firewall so his successor isn't faced with the prospect of having the federal government move in and create an exchange in 2013 if Indiana is unprepared.

The majority of states are doing as little as possible. They don't want to waste time, money, and resources in setting up the exchange bureaucracies if the law is declared unconstitutional. Voters in other states have approved or are preparing ballot initiatives to block implementation of the law's individual mandate. Other states think that it is very likely that implementation will be delayed simply because there is so much to be done, and it seems almost impossible that states could get the exchange bureaucracies ready for the 2013 deadline to show meaningful progress to HHS.

These exchanges will be extraordinarily complex, requiring integration of a vast amount of information from residents, employers, health insurers, and the state on a monthly basis to determine eligibility for health insurance subsidies. Then they must have a huge regulatory structure in place to make sure health insurers follow an avalanche of new rules. Few states have the expertise to get this done.

Many governors believe that this time, money, and energy should be spent on meaningful reform that suits their needs and resources. Some are considering the lightly regulated Utah Exchange model for an insurance marketplace.[11] Others are looking at Gov. Daniels' Healthy Indiana program as a model for coverage expansion, providing an HSA-like health benefit for lower-income uninsured people.[12] The key, once again, is state control.

More People Flooding to the Exchanges

McKinsey & Company conducted a detailed survey of 1,300 employers, which showed a significant percentage of companies will drop health insurance after the exchanges become available in 2014.[13]

The McKinsey survey found that 30 percent of employers overall will definitely or probably stop offering health insurance to their workers. However, among employers with a high awareness of the health reform law, the share increases to more than 50 percent. I conclude this will mean as many as 78 million workers and their families will lose the health insurance they now get at work.[14] Many of them will be forced into the government-run health insurance exchanges.

There was strong pushback from the White House about the survey's findings. The administration believes that employers will be more, not less, likely to offer health insurance under the new health overhaul law. They cited a study by Urban Institute researchers, which concluded that small employers will be more likely to offer health insurance as a result of the health law.[15]

These conclusions defy evidence, trends, and common sense. Small business owners across the country — and all employers — are considering paying the $2,000 fine for not providing health insurance rather than up to $10,000 for federally prescribed health insurance for each worker.

In a study last year, Douglas Holtz-Eakin, a former director of the Congressional Budget Office, estimated that the CBO underestimated the law's impact on job-based health insurance.[16] He says that the incentives in the law will drive 35 million more workers out of employer plans and into subsidized coverage, and that this would add about $1 trillion to the total cost of the health law over the next decade. McKinsey's survey implies that the cost to taxpayers could be significantly more.

McKinsey released the survey questions, methodology, and data, putting to rest questions about the objectivity.[17]

Other facts supporting moves to the exchanges:

- The share of Americans with employer-sponsored insurance dropped from 69 percent in 1999–2000 to 61 percent in 2008–2009.[18] This is part of a larger trend that the health law will accelerate.

- An Associated Press story from last fall included quotes from a Deloitte consultant saying that "I don't know if the intent was to find an exit strategy for providing benefits, but the bill as written provides the mechanism."[19] The head of the American Benefits Council claimed the law "could begin to dismantle the employer-based system."

- A PricewaterhouseCoopers survey of employers found that nearly half of all employers "indicated they were likely to change subsidies for employee medical coverage" thanks to the law.[20]

- Former Tennessee Gov. Phil Bredesen in a commentary said that Tennessee could drop coverage for its state employees, pay the $2,000 per employee penalty to the federal government, give their workers cash raises to compensate for the loss in health benefits, and still come out at least $146 million per year ahead.[21]

There are huge costs and great uncertainty about the impact of the sweeping mandates sand spending under the new heath law. Health costs already are increasing, and the costs to taxpayers could explode.

Modernizing Medicare: Are ACOs the Answer?

There is great interest in ideas to help contain costs throughout the health sector by instituting policies and programs that will lead to better coordinated, more efficient health care delivery. Many see Medicare as a driver in these changes because it pays for such a large share of medical care through its outmoded fee-for-service model.

Many supporters of the new health law point to Accountable Care Organizations as the answer to constraining future health costs. ACOs are supposed to be the innovative new idea that will move our health sector toward better coordinated care in Medicare, thereby lowering health costs.

No one argues that Medicare needs to be modernized and that seniors would benefit from coordinated care. Traditional Medicare relies on an antiquated design of entitlements to thousands of government-approved medical products and services under a system of government-established price controls. It is a program full of gaps, inefficiency, and waste, and it desperately needs to be modernized.

Those who are feverishly working to implement the new health overhaul law believe that the government will be able to reorganize the $2.7 trillion health sector and make it more efficient without harming the quality of care. They believe this even though the federal government has never been able to control costs in the price-controlled, micro-managed health programs it has been running for nearly a half century.

Nonetheless, their faith in government-run health care is what led them to embrace this untested new idea for ACOs.[22]

ACOs are a concept created by a number of academic researchers. The idea is to create new organizations in which doctors and hospitals would work more closely together. They would voluntarily create new legal entities that ACO advocates say will be more "accountable" for providing care in doctors' offices, hospitals, and other care settings. Physicians and hospitals would share the revenue and keep some of the savings if they can provide the care at less cost than what traditional Medicare would pay.

In the 1990s, when managed care, particularly HMOs, was dominant, there was a backlash, and Congress considered passing what was then known as a patients' bill of rights to prevent HMOs from unfairly denying care to their enrollees.

Ironically, ACOs strongly resemble the managed care plans of the 1990s. They are expected to provide all of the medical care a patient needs within a budget, and if they do so while cutting costs, they can keep part of the savings as a profit. There will, of course, be a very strong incentive for the plans to find ways to provide less care to patients. In many cases this may eliminate wasteful care, but patients are very likely to see it as a form of rationing, which they will resist.

At least as conceived by its authors and as written in law, there is no requirement at all that Medicare patients have to give consent to be enrolled in an ACO. Here is what the law says:

> (c) ASSIGNMENT OF MEDICARE FEE-FOR-SERVICE BENEFICIARIES TO ACOS.—The Secretary shall determine an appropriate method to assign Medicare fee-for-service beneficiaries to an ACO based on their utilization of primary care services provided under this title by an ACO professional described in subsection (h)(1)(A).

In plain language, this means that the government will have the authority to "assign" Medicare beneficiaries to ACOs without necessarily even telling them or asking their permission. They can make the assignment based entirely on whether or not a patient's primary doctor has decided to work through an ACO. If the doctor signs up with an ACO, the doctor's patients will go along, whether they want to or not.

ACO advocates have designed it this way on purpose. They are worried that asking seniors to make a choice for themselves will mean that many of them would decline to participate in ACOs if asked. They won't trust them.

But forcing seniors into ACOs without their consent is a terrible way to run a program. It will create resentment and fear once seniors figure out what is going on with their health care. The only way ACOs can control costs is by steering patients to some specialists and not to others or denying access to some tests, treatments, or medicines. That kind of restricted choice, without the consent of patients, is bound to create tensions.

It's unlikely to work anyway. The ACOs don't take away seniors' right to see whatever doctor they choose. The ACOs will just give their primary doctors an incentive to refer them to some specialists but not others. There is no penalty for Medicare patients if they don't stick with the ACO. But most people follow their doctor's recommendations, and that is what the government is counting on.

ACOs are likely to become one more failed government experiment. They can't possibly deliver significant savings without altering how patients experience the Medicare

program. But if Medicare patients see the ACOs as denying them care without their consent, they will rebel.

They aren't the only ones rebelling. When HHS released the proposed regulations for ACOs, the six pages of legislative text in the health law creating ACOs exploded into 429 pages of regulations about how they must work.[23]

Moving toward local control is the solution, but all of the solutions in the new health law move more and more power and control to bureaucracies in Washington.

Conclusion

Clearly, the answer is not more rules from Washington that dictate how, to whom, and under what circumstances health care will be delivered. We need – in Medicare, in the private health sector, and in Medicaid – more flexibility, more transparency, and better incentives to provide affordable, quality care.

There is growing interest among the governors in giving states much greater flexibility in running their Medicaid programs through block grants, global waivers, and other programs to give them more control over spending.

Medicaid spending has nearly doubled over the last decade, and for most states, it consumes the first or second biggest share of state expenditures, threatening education, public safety, and transportation programs.

The reality is that change is not only inevitable but essential. The question is whether or not the political leaders closest to the people will be able to make finely tuned changes or whether the program remains rigid, driven by ever more inflexible rules from Washington.

The states can be the power centers in charting a new path to redesign their Medicaid programs to provide better services at lower costs. The committee's field hearing in Utah to hear directly from the governors is further evidence of your commitment to work with them in modernizing the program and finding creative ways to get spending under control.

Grace-Marie Turner is president of the Galen Institute, a non-profit research organization focused on market-based ideas for health reform. She is a co-author of *Why ObamaCare Is Wrong for America* (Broadside/HarperCollins, 2011).

ENDNOTES

[1] Letter to federal leaders from Republican Governors Association, January 7, 2011, http://www.rga.org/homepage/gop-governors-ask-feds-to-ease-healthcare-mandates/.

[2] Marilyn Werber Serafini, "Sebelius Squad's Mission: Medicaid Savings," *Kaiser Health News*, February 22, 2011, http://www.kaiserhealthnews.org/stories/2011/february/22/obama-administration-dispatches-medicaid-savings-squads-to-states.aspx?referrer=search.

[3] Letter to governors from Senator Orrin Hatch and Representative Fred Upton, May 23, 2011, http://republicans.energycommerce.house.gov/Media/file/Letters/052311medicaidltrgovernors.pdf.

[4] Joselyn King, "Manchin Defends Medicaid Program," *The Intelligencer/Wheeling News-Register*, September 30, 2010, http://www.theintelligencer.net/page/content.detail/id/542279.html.

[5] John Holahan, Matthew Buettgens, Vicki Chen, Caitlin Carroll, and Emily Lawton, "House Republican Budget Plan: State-by-State Impact of Changes in Medicaid Financing," The Kaiser Commission on Medicaid and the Uninsured, The Henry J. Kaiser Family Foundation, May 2011, http://www.kff.org/medicaid/upload/8185.pdf.

[6] Senator Orrin Hatch and Representative Fred Upton, "Medicaid Expansion in the New Health Law: Costs to the States," March 1, 2011, http://energycommerce.house.gov/media/file/PDFs/030111 MedicaidReport.pdf.

[7] Edward Miller, "Health Reform Could Harm Medicaid Patients," *The Wall Street Journal*, December 4, 2009, http://online.wsj.com/article/SB10001424052748703939404574567981549184844.html ?mod=djemEditorialPage.

[8] Michael Norton and Kyle Cheney, "Medicaid Costs Surge Past $10 Billion, Devouring Uptick in Tax Receipts," *State House News Service*, December 13, 2010, http://www.statehousenews.com/cgi/as_web.exe?rev2010+D+15040366.

[9] Michael Levenson, "Health Costs Sap State Aid for Schools," *The Boston Globe*, December 9, 2010, http://www.boston.com/news/education/k_12/articles/2010/12/09/health_care_costs_sap_aid_for_massachusetts_schools/.

[10] Clifford J. Levy and Michael Luo, "New York Medicaid Fraud May Reach into Billions," *The New York Times*, July 18, 2005, http://www.nytimes.com/2005/07/18/nyregion/18medicaid.html?_r=2.

[11] "An Overview of the Utah Health Exchange," http://business.utah.gov/site-media/page-media/files/An_Overview_of_the_Utah_Health_Exchange_final.pdf.

[12] "About the [Healthy Indiana] Plan," http://www.in.gov/fssa/hip/2344.htm.

[13] Shubham Singhal, Jeris Stueland, and Drew Ungerman, "How US Health Care Reform Will Affect Employee Benefits," *McKinsey Quarterly*, June 2011, http://www.mckinsey.com/~/media/McKinsey/dotcom/US%20employer%20healthcare%20survey/us_health_benefits.ashx.

[14] Grace-Marie Turner, "No, You Can't Keep Your Health Insurance," *The Wall Street Journal*, June 8, 2011, http://online.wsj.com/article/SB10001424052702304432304576371252181401600.html.

[15] Stacey McMorrow, Linda J. Blumberg and Matthew Buettgens, "The Effects of Health Reform on Small Businesses and Their Workers," June 2011, Urban Institute, http://www.rwjf.org/files/research/72530quickstrike201106.pdf.

[16] Douglas Holtz-Eakin and Cameron Smith, "Labor Markets and Health Care Reform: New Results," American Action Forum, May 2010, http://americanactionforum.org/files/LaborMktsHCRAAF5-27-10.pdf.

[17] "McKinsey & Company Benefits Package Decision Maker Study," McKinsey & Company, June 20, 2011, http://www.mckinsey.com/~/media/McKinsey/dotcom/US%20employer%20healthcare%20survey/Employer_healthcare_survey-final_questionnaire.ashx.

"Details Regarding the Survey Methodology," McKinsey & Company, June 20, 2011, http://www.mckinsey.com/en/US_employer_healthcare_survey.aspx.

"McKinsey & Company Benefits Package Decision Maker Study: Survey Results," McKinsey & Company, June 20, 2011, http://www.mckinsey.com/en/~/media/McKinsey/dotcom/US%20employer%20healthcare%20survey/Employer_healthcare_survey-tables.ashx.

[18] Paul Fronstin, "Tracking Health Insurance Coverage by Month: Trends in Employment-Based Coverage Among Workers, and Access to Coverage Among Uninsured Workers, 1995-2009," Employee Benefit Research Institute, http://ebri.org/pdf/notespdf/EBRI_Notes_06_June-11.HITrends-Annuity.pdf.

[19] Ricardo Alonso-Zaldivar, "Employers Looking at Health Insurance Options," Associated Press, October 25, 2010, http://www.foxnews.com/us/2010/10/25/employers-looking-health-insurance-options/.

[20] "Health and Well-Being Touchstone Survey Results: May 2011," PricewaterhouseCoopers LLP, May 26, 2011, http://www.pwc.com/en_US/us/hr-management/assets/PwC_2011_Health_and_Wellbeing_Touchstone_Survey_Results.pdf.

[21] Philip Bredesen, "ObamaCare's Incentive to Drop Insurance," *The Wall Street Journal*, October 21, 2010, http://online.wsj.com/article/SB10001424052702304510704575562643804015252.html.

[22] Grace-Marie Turner, James C. Capretta, Thomas P. Miller, Robert E. Moffit, *Why ObamaCare Is Wrong for America*, New York: Broadside Books, an imprint of HarperCollins, 2011.

[23] "Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations," Department of Health and Human Services, Centers for Medicare & Medicaid Services, 42 CFR Part 425, http://www.kaiserhealthnews.org/Stories/2011/March/31/~/media/Files/2011/ACO%20Proposed%20Rule.pdf.

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CONGRESSIONAL STATEMENT

Saving Medicaid: A Path to Comprehensive Medicaid Reform

Statement before
Committee on Finance
United States Senate

July 14, 2011

Nina Owcharenko
Director, Center for Health Policy Studies
The Heritage Foundation

My name is Nina Owcharenko. I am the Director or Health Policy Studies at The Heritage Foundation. The views I express in this testimony are my own, and should not be construed as representing any official position of The Heritage Foundation.

The Medicaid program is failing. This joint federal–state health program for the poor is fueling the federal entitlement crisis, bankrupting state budgets, and delivering substandard care to enrollees while crowding out private health insurance options for many. Moreover, the enactment of the Patient Protection and Affordable Care Act (PPACA) only accelerates these problems.

The PPACA expands Medicaid eligibility to new populations without fundamentally addressing the program's existing problems. The expansion is expected to add between 17 million and 25 million more people to the Medicaid rolls. Moreover, the PPACA is dependent on this massive Medicaid expansion to reduce the number of uninsured by half, reenforcing the argument that the new health care law is based on a government health care model.

Instead of making these problems worse, Congress needs to start over—beginning with repealing the new health care law. Then it must offer a path forward to fixing Medicaid. This long-term plan should include putting Medicaid on a federal budget, mainstreaming working families into private coverage, and preserving a true safety net for the most vulnerable in society.

Fueling the Federal Entitlement Crisis

In 1970, five years after the creation of Medicaid, 14 million Americans were enrolled in the program, and total (federal and state) spending was $4.7 billion.[1] Today, one in five (or approximately 60 million) Americans have been enrolled at some point in the program, and total (federal and state) expenditures were projected to reach $404 billion in 2010, according to the Chief Medicare and Medicaid Actuary.[2]

According the Chief Actuary, under PPACA, Medicaid spending will increase at a rate of 8.3 percent over the next 10 years. Total Medicaid expenditure is estimated to skyrocket to $840 billion by 2019—more than double what it spends today—and enrollment will reach close to 80 million by 2019.[3]

Combined with Medicare and the new health care subsidy in PPACA, these government programs will consume 9.2 percent of GDP by 2030.[4] This means that for every dollar generated, over 9 cents goes to government health care.

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[1] U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services, Office of the Actuary, *2010 Actuarial Report on the Financial Outlook for Medicaid*, December 2010, at *https://www.cms.gov/ActuarialStudies/downloads/MedicaidReport2010.pdf.*

[2] *Ibid.*

[3] *Ibid.*

[4] Spending Projections from Congressional Budget Office, *CBO's Long-Term Budget Outlook*, June 2011, at *http://www.cbo.gov/doc.cfm?index=12212.*

Bankrupting State Budgets

At the state level, the Medicaid program is straining already tight budgets. State Medicaid spending is growing faster than other key state priorities and is projected to consume 22 percent of total state spending in 2010, surpassing total state spending on primary and secondary education.[5]

Unlike the federal government, practically all states are required to balance their budgets. Therefore, states must find ways to *meet* their budgets. With limited flexibility, states typically resort to one of three choices: Reduce provider payments, cut or limit benefits, or readjust eligibility. However, Congress recently restricted the ability of states to make any eligibility changes in their program as a condition for receiving additional federal assistance through the stimulus packages.

Under PPACA, uncertainty remains for the states. Not only did Congress extend the restriction on making eligibility changes (even as a means for weeding out ineligible individuals), but the funding schemes claiming to "protect" states still shift costs to the states. The federal enhanced matching rates are only for "new" populations and decline over time from 100 percent to 90 percent.

Heritage Foundation analysts estimated that, when taking into account the added administrative costs, "the Medicaid expansion will increase state obligations by just under $33.5 billion for federal fiscal years 2014 through 2020."[6] As noted, total Medicaid spending will skyrocket to $840 billion by 2019, of which the Chief Actuary estimates that the state share will reach $328 billion by 2019.[7]

More Government Dependence, Less Private Coverage

Yes, projections estimate that between 17 million (based on the Congressional Budget Office)[8] and 25 million (based on the Chief Actuary's updated figures)[9] more people will be on the Medicaid program. However, an important question to keep in mind is the number that will join the Medicaid rolls due to the "woodwork" effect, by which

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[5] National Governors Association and National Association of States Budget Officers, "The Fiscal Survey of States," Spring 2011, at *http://www.nasbo.org/LinkClick.aspx?fileticket=yNV8Jv3X7Is%3d&tabid=38.*

[6] Edmund F. Haislmaier and Brian C. Blase, "Obamacare: Impact on States," Heritage Foundation *Backgrounder* No. 2433, July 1, 2010, at *http://www.heritage.org/Research/Reports/2010/07/Obamacare-Impact-on-States.*

[7] U.S. Department of Health and Human Services, *2010 Actuarial Report on the Financial Outlook for Medicaid.*

[8] Douglas W. Elmendorf, Director, Congressional Budget Office, "CBO's Analysis of the Major Health Care Legislation Enacted in March 2010," statement before the Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, March 30, 2011 at *http://republicans.energycommerce.house.gov/Media/file/Hearings/Health/033011/Elmendorf.pdf.*

[9] Richard S. Foster, Chief Actuary, Centers for Medicare and Medicaid Services, "The Estimated Effect of the Affordable Care Act on Medicare and Medicaid Outlays and Total National Health Care Expenditures," testimony before the Committee on the Budget, U.S. House of Representatives, January 26, 2011 at *http://budget.house.gov/UploadedFiles/fostertestimony1262011.pdf.*

individuals who are eligible but not enrolled will now join due to the individual mandate, and the "crowd out" effect, as a result of which, because of the expanded role of Medicaid, individuals previously with private coverage will instead be enrolled in Medicaid.

It is certain that PPACA will make more people dependent on government for their health care rather than the private sector.

Delivering Substandard Care

These fiscal issues facing Medicaid are compounded by the failure of the program to deliver quality care to those who are on the program. A major contributor to the quality issue is access. A recent *New England Journal of Medicine* study surveyed Medicaid patients' access to specialists. It found that 66 percent of those who mentioned they were covered by Medicaid/CHIP were denied appointments, while only 11 percent with private coverage were denied.[10] This study follows similar studies that looked at access to dental and psychiatric care.[11]

A recent Government Accountability Office (GAO) study found similar access issues. In its recent report, GAO found that "more than three times as many participating physicians—84 percent—experience difficulty referring Medicaid and CHIP children to specialty care as experience difficulty referring privately insured children—26 percent."[12]

Finally, while some studies show that Medicaid can improve care compared to not having any health care, there are others that show Medicaid's shortcomings in delivering quality care, especially when compared to privately insured individuals. A recent University of Virginia study found that Medicaid patients were more likely to die in the hospital than were the uninsured and the privately insured.[13]

PPACA apparently acknowledges this access issue by requiring states to increase the payment rates for primary care physicians to Medicare levels. The federal government provides an increase in the federal matching rate to cover these higher payment rates. However, the enhanced federal match is only temporary. As Heritage analysts point out, this creates yet another dilemma for the states. When the enhanced federal funding goes away, states will have several unappealing choices: Either find the funding to keep payments at their higher rates, and also likely raise payments to other groups of physicians who were not provided special treatment, or reduce primary care payments back to their original levels and jeopardize already limited access.

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[10] Denise Grady, "Children on Medicaid Shown to Wait Longer for Care," *The New York Times*, June 15, 2011.
[11] *Ibid.*
[12] U.S. Government Accountability Office, *Medicaid and CHIP: Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care*, GAO-11-624, June 30, 2011, at *http://www.gao.gov/products/GAO-11-624*.
[13] Damien J. LaPar *et al.*, "Primary Payer Status Affects Mortality for Major Surgical Operations," *Annals of Surgery*, Vol. 252, No. 3 (September 2010), pp. 544–551.

Leading with the States

It is clear that designing a one-size-fits-all approach to health care reform is riddled with problems. No two states are alike: Each state has its own underlying coverage issues and challenges that go even beyond Medicaid. Therefore, states should take the lead in developing state reforms that meet their unique needs and will test the virtues of consumer, market-based solutions.

Within Medicaid today, states should maximize their existing authority and flexibility to engage in initiatives such as premium support for private coverage, meaningful cost-sharing based on income, and utilization of proven private-sector care management tools. Moreover, states should aggressively pursue existing (albeit laborious) waiver authority to demonstrate and exercise broader, innovative reform ideas.[14]

In addition, several proposals grant states additional flexibilities that would not require the extensive federal negations in exchange for replacing the current open-ended federal matching rate with a fixed capped amount, and still other proposals envision states pursuing broader reforms that go beyond Medicaid.[15]

Under all these scenarios, states would be able to test varying models that support consumer, market-based solutions. Similar to welfare reform, this process of state experimentation will enable states to learn from each other, adapt successful models, identify federal barriers, and lead the way to a better health care solution that reflects the differences across the country.

More Reform Still Needed

However, even more should be done. The Heritage Foundation's *Saving the American Dream* fiscal plan rethinks Medicaid as we know it.[16] It begins with repealing the PPACA. A solid consumer, market-based health care system cannot be built on a flawed foundation. Then it puts federal Medicaid spending on a real budget along with other anti-poverty programs.

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[14] Nina Owcharenko, "State Medicaid Reform After Obamacare," Heritage Foundation *WebMemo* No. 3062, November 16, 2010, at *http://www.heritage.org/Research/Reports/2010/11/State-Medicaid-Reform-After-Obamacare.*

[15] See "The Path to Prosperity: Restoring America's Promise," Fiscal Year 2012 Budget Resolution, Committee on the Budget, U.S. House of Representatives, at *http://budget.house.gov/UploadedFiles/PathToProsperityFY2012.pdf*, and S. 1031, The Medicaid Improvement and State Empowerment Act, at *http://coburn.senate.gov/public/index.cfm/pressreleases?ContentRecord_id=f78e0cfe-8c8f-49fc-a895-e9f131dabb79&ContentType_id=d741b7a7-7863-4223-9904-8cb9378aa03a&Group_id=7a55cb96-4639-4dac-8c0c-99a4a227bd3a.*

[16] Stuart M. Butler, Alison Acosta Fraser, and William Beach, eds. *Saving the American Dream: The Heritage Plan to Fix the Debt, Cut Spending, and Restore Prosperity* (Washington: The Heritage Foundation, 2011), at *http://www.savingthedream.org/about-the-plan/plan-details/SavAmerDream.pdf.*

Next, it mainstreams healthy moms and kids out of the failing Medicaid program and into the private market to buy the kind of coverage that best suits their needs. In conjunction with insurance reforms based on choice and competition, these families will have the same coverage options and similar federal assistance available to them as other working families enjoy under this new plan.

Finally, it reorganizes "traditional" Medicaid into a safety net for those who are truly vulnerable in society—the frail, elderly, and disabled—and provides the states with the flexibility and tools to deliver value to their patients and taxpayers.
PPACA ignores the serious problems facing Medicaid. It will increase federal spending by federal taxpayers, shift unknown costs onto state taxpayers, further challenge already limited access issues, and reenforce a two-tiered health care system, locking more of the poor out of private coverage and into government-run health care.
The Heritage Foundation's *Saving the American Dream* fiscal plan offers a better future for America, Medicaid, and those who depend on it.

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Healthcare Accountability Through Payment Efficiency

By Jim Ribelin

7/27/2011

I. BUILDING CRISIS OF EPIC PROPORTIONS

I would like to thank the Senate Field hearing for the ability to submit the following information regarding the healthcare industry's needs to be able to fully develop the necessary infrastructure for the automation of healthcare payments, thereby making our nation's healthcare system more accountable for every penny being spent in both the private and public sectors.

I am Jim Ribelin, founder and former CEO of HERAE, LLC. , a San Diego based company with dynamic provider-facing healthcare payment automation services. I'm now a private consultant.

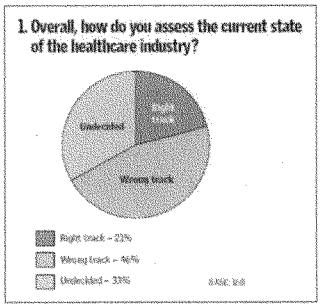
In December of 2010 I was invited to provide expert testimony at the first NCVHS sub-committee hearing for CMS on electronic remittance advice (ERA) and electronic funds transfer (EFT) for the healthcare industry.

Since being asked to provide expert testimony in Washington regarding healthcare payment automation I have been working with current members of the 112th Congress on additional "guard rail" legislation that will benefit the industry by targeting the annual healthcare waste and fraud contained in the U.S. healthcare system.

It is eye opening, to say the least, when you think that 80-90% of the healthcare cash distributed from payers (government and private) to healthcare providers ($1.6 billion each year) is paid out with paper checks![1] Especially surprising, in an environment today where consumers use bill pay 70%[2] of the time over writing paper checks and 73%[3] of the time use debit or credit cards to spend money, the healthcare industry is 80-90% paper checks.

A population growing in size and age coupled with an ever increasing demand for quality of life have created the perfect storm in which the country will soon be overwhelmed as it cannot deliver the healthcare obligations it has promised and at the same time remain financially solvent. The following facts paint a troubling picture:

- The average per capita cost of healthcare grew 6.19% over the 12 months ending February 2011. While this was one of the slowest healthcare growth rates in years, it is a growth rate that is still more **than triple the growth in overall inflation.**[4]
- Recent changes suggest the Medicare hospital insurance fund will be exhausted in 2024 - five years earlier than last year's estimate.[5]
- **21% of the 2010 federal budget**, or $732 billion, goes to fund Medicare, Medicaid, and the Children's Health Insurance Program (CHIP).[6]



Healthleaders Media Survey 2011

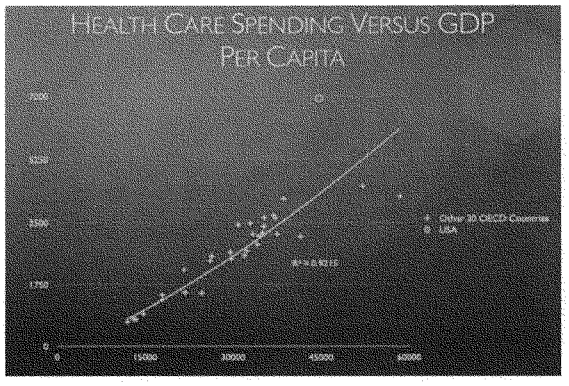
[1] Emdeon's website www.ushealthcareindex.com
[2] Source: "2009 Online Banking and Bill Payment Forecast: Active Users Grow While Bank Bill Pay Overtakes Biller Direct," Javelin Strategy & Research, January 2010
[3] Source: "The Survey of Consumer Payment Choice," Federal Reserve Bank of Boston, January 2010
[4] S&P Healthcare Composite Index as reported by Yahoo - http://finance.yahoo.com/news/US-Healthcare-Costs-Rise-619-prnews-1643018320.html?x=0&.v=1
[5] Medicare Trustees Report as reported by USAToday - http://www.usatoday.com/news/topstories/2011-05-13-2916218767_x.htm
[6] Center on Budget & Policy Priorities http://www.cbpp.org/cms/index.cfm?fa=view&id=1258

- Nearly two-thirds of this amount, or $452 billion, goes to Medicare, which provides health coverage to around 47 million people today; this amount is set to explode as millions of baby boomers reach the age of eligibility.[7]
- Both Medicaid and CHIP require matching payments from the states where healthcare costs have already caused states extreme financial burdens. Some states may go bankrupt under this weight.
- Without innovation to find better ways to deliver and pay for healthcare obligations our Federal government is faced with stark choices: raise taxes by $12,072 per household or eliminate every other government program. This does not even take into account increased state taxes necessary to avoid insolvency in state healthcare programs like Medicaid.[8]
- Funding all promised benefits solely on the back of income taxes would require raising the 35% income tax bracket to at least 77% and raising the 25% tax bracket to at least 55%.[9]
- Total spending on healthcare is now at 17.6% of gross domestic product (GDP) with estimates of 25% in 2025, 37% in 2050, and 49% in 2082.[10]

This rapid growth in the demand for and cost of healthcare forces the government, healthcare providers, insurance companies and consumers to seek alternatives to avoid the impending train wreck.

II. MARKET SIZE AND BUSINESS MODEL

Every year in the U.S. approximately $2.5 trillion in cash moves from government and employers, through healthcare insurance companies and by patients, to providers of healthcare. Just how big is $2.5 trillion a year?



It's 4 times the size of all of the cumulative costs of the Afghan and Iraq war since 2001. It's over 4 times the size of the annual defense department budget.

How does the U.S. healthcare spend compare in terms of dollars and outcomes, to other places around the world?

The U.S. spends nearly twice as much per-capita on health care than other industrialized nations without a corresponding gain in outcomes, according to the Organization for Economic Co-operation and Development (OECD). The U.S. ranks 20th in life expectancy and has the third highest infant mortality rate.

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[7] Center on Budget & Policy Priorities http://www.cbpp.org/cms/index.cfm?fa=view&id=1258
[8] The Heritage Foundation http://www.heritage.org/research/reports/2008/03/a-guide-to-fixing-social-security-medicare-and-medicaid
[9] The Heritage Foundation http://www.heritage.org/research/reports/2008/03/a-guide-to-fixing-social-security-medicare-and-medicaid
[10] Congressional Budget Office - http://www.cbo.gov/ftpdocs/87xx/doc8758/MainText.3.1.shtml

The U.S. also has high levels of obesity (over 32% of the population compared to 20% globally), with a significant effect on healthcare spending. When compared with five similar industrialized nations, the U.S. ranks at the bottom on all key measures, except for tobacco usage.

Relative ranking	Australia	Canada	Germany	New Zealand	United Kingdom	United States
Life expectancy	1	2*	4	3	4	6*
Infant mortality rate (per 1000 live births)	2	2*	1	4	4	6*
Tobacco consumption	3	2	6	4	5	1
Obesity (%)	3*	2	1	4*	5	6*
Avoidable deaths (Per 100,000)*	1	2	3	4	5	6
Health expenditures per capita, 2005	$3,128**	$3,326	$3,287	$2,330	$2,724	$6,401

All information is taking from 2005 OECD data unless otherwise noted.
*2000, 2003-2005 World Health Organization Data. Avoidable deaths is defined as deaths caused by treatable conditions left undetected and/or untreated.
**2004 OECD data.
Source: Organization for Economic Cooperation and Development, World Health Organization, analysis by PricewaterhouseCoopers' Heath Research Institute

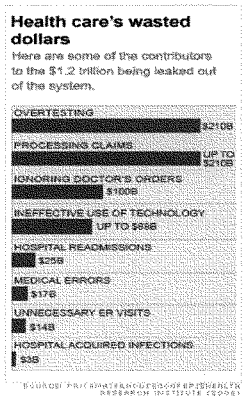
So does all of our excessive spending really help or has it simply become a way of doing business? It appears, like in other sectors of our GDP and in government spending, the U.S. healthcare industry has simply become bloated and inefficient in its annual spend. The industry will be compelled to find efficiencies, eliminate waste, cut-off fraud and spend every healthcare dollar more wisely.

III. INDUSTRY REQUIRES ELECTRONIC PAYMENTS

Much of the recent discussion around saving healthcare has been focused on either reducing costs or leveraging Healthcare Information Exchanges (HIEs) or Accountable Care Organizations (ACOs). While required, neither of these approaches alone is enough. Cost cutting alone will not work: As the demand for healthcare services increase, reducing the price paid for these services will only create shortages of the very healthcare professionals and services needed. And while a tremendous investment has been made in the creation of HIEs (over $30 Billion in the US) there is very little evidence that simply making patient information available has any impact on either quality or cost of care. So what is missing?

The Healthcare industry has largely ignored the efficiencies created by focusing on the way consumer goods and services are paid for electronically. Consider some metrics of potential savings:

- Healthcare waste and utilization inefficiencies are $420 billion a year[11]
- Fraud costs as much as $234 billion on an annual basis[12]
- Of the roughly $1.8 trillion dollars in annual healthcare payments each year from payers (government & commercial



[11] Source: PricewaterhouseCoopers' Health Research Institute report "The price of Excess", April, 2008
[12] Source: Reuters/Huff Post Health http://www.huffingtonpost.com/2011/04/13/health-care-fraud_n_848691.html

payers) to providers, **90% are paid by paper checks at a cost of between $5-$9 per transaction**[13]

The key to unleashing these potential savings starts with the ability to eliminate paper payments and effectively promote the adoption of electronic remittance advice (ERA) and electronic funds transfer (EFT) for healthcare. ERA was part of the 1996 HIPPA administrative simplification act, yet was flawed and ineffective in promoting electronic payments in healthcare.

A. Who's Writing The Checks?

If you break down the annual healthcare spend by who's paying out all that money:

- Medicare - $502 billion (20.2%)
- Medicaid - $374 billion (15.0%)
- Private Insurance Companies - $801 billion (32.2%)
- Patients - $299 billion (12.0%)
- Other (premiums, research, etc.) - $432 billion (20.5%)[14]

It's readily apparent the bulk of the annual healthcare spend is by the federal government (where typically 90% of all Medicaid funding is federal based, the remaining is state matching funds); $876 billion or 35.2% of every dollar.

B. Market Growth

The healthcare market is growing. With an aging population and medical procedures that are becoming more expensive, market estimates show the growth in healthcare spending to continue for decades.

The average per capita cost of healthcare services covered by commercial insurance and Medicare grew 5.77% over the 12 months ending in March 2011. While this reflected a nearly year-long deceleration of cost growth because of the current recession, according to Standard & Poor's Healthcare Economic Indices, healthcare cost growth from the +6.17% in annual growth posted in February, and +6.31% in January 2011 still outpaced inflation 3-to-1.

IV. LEGISLATIVE BACKGROUND

Again, the key to unleashing these potential savings starts with the ability to eliminate paper payments and effectively promote the adoption of electronic remittance advice (ERA) and electronic funds transfer (EFT) for healthcare. ERA was part of the 1996 HIPPA administrative simplification act, yet was flawed and ineffective in promoting electronic payments in healthcare

The Patient Protection and Affordable Care Act (PPACA) was signed into law on March 23, 2010. Among its many provisions, it contains a blueprint for full electronic adoption of ERA and EFT in the

[13] Source: Emdeon's website www.ushealthcareindex.com and CMS NCVHS Sub-Committee.
[14] All Figures: National Health Expend Data Tables, CMS website (https://www.cms.gov/NationalHealthExpendData/downloads/tables.pdf)

healthcare industry, achieved by mandating deadlines and financial consequences for several key milestones in the adoption process. Adoption of a *fully reconciled* electronic payment system will begin in 2012 and be complete by January 1, 2014. Highlighted below are the main pieces of the legislation that drive electronic payment adoption:

Modifies existing Social Security Act to require Healthcare Provider and Supplier Payments to use Direct Deposit or Electronic Funds Transfers (EFTs).

Section 1104, Paragraph b2 - TRANSACTION STANDARDS; OPERATING RULES AND COMPLIANCE): modifies the Social Security Act (**42 U.S.C. 1320d2**) to provide for Direct Deposit and EFT.

Modifies Section 1173A to call for standardized electronic administrative transactions and state that standards should be comprehensive, efficient and robust, requiring minimal augmentation by paper transactions or clarification by further communications.

Modifies Section 1173A to require paper versions of standardized transactions to comply with the same standards as fully compliant, equivalent electronic transactions, and to enable electronic funds transfers, in order to allow automated reconciliation with the related healthcare payment and remittance advice.

Modifies Section 1173B to stipulate that all financial transactions involving Medicare must be made electronically, by EFT, and calls for standardization of EFT transactions.

Mandates the adoption of standard Operating Rules for EFT and Health Care Payment and Remittance Advice Transactions:

Section 1104, Paragraph g4, Sub-Paragraph ii – ELECTRONIC FUNDS TRANSFERS AND HEALTH CARE PAYMENT AND REMITTANCE ADVICE: Mandates automated reconciliation of the electronic payment with the remittance advice.

Operating Rules must be adopted not later than July 1, 2012, in a manner ensuring that they are effective not later than January 1, 2014.

Payers will need to begin adopting a payment delivery system that allows for automated reconciliation by July 1, 2012, and full adoption by January 1, 2014.

Section 1104, Paragraph j4 – IMPLEMENTATION: Any health plan that fails to certify and document their compliance by December 31, 2013 will be assessed a penalty fee of $1 per covered life per day until it complies with the operating rules law, with payment required by November 2014.

V. ERA & EFT LEGISLATION RECOMMENDATIONS

While the sections outlined above are a good start for a fully electronic healthcare payment system, a lot of work must still be done to ensure that we create the *right* system, one that will reduce payment costs and inefficiencies as much as possible and set the stage for the detection of healthcare waste and fraud through the electronic payment system. Additional legislation is needed to help drive this process. My recommendations are as follows:

A. The Electronic Remittance Advice or ERA

Make electronic payments required for the entire industry

This was the vision 15 years ago with the passing of the 1996 HIPPA legislation and the mandate for electronic data interchange (EDI) transactions for healthcare.

Mandate, through federal legislation, electronic payments as the distribution method for claims payments for all insurance companies (payers), to providers through distribution of the electronic remittance advice transaction (ERA also known as the HIPAA 835 transaction) and electronic funds transfer (EFT). Require compliance by the same deadline of January 1, 2014 with the same penalties for non-compliance already outlined in Section 1104.

Create a uniform ERA standard across the industry

Regardless of any other outbound formats offered, payers must issue a new Standard ERA File Format as a method of delivery that must be available to providers upon request or as the default delivery format standard.

Explicitly define a single official 835 standard template for use in healthcare transactions.

Mandate that both payers and providers are able to receive and process this standard 835 format.

Require billing system vendors to build into their products the ability to accept this standard 835 form

Require that billing systems vendors provide an all-payer mechanism for providers to accept the 835 adjustment, remark and reason codes contained in the new Standard ERA File Format. There should be no option to create a unilateral approach.

This standard should be something similar to the existing Medicare ERA file format, with its delimiters, as issued by CMS. Many provider billing systems have addressed this payer format and it is widely used in the market today.

Force all parties to use the same delimiters for US healthcare transactions. In this case, segment elements are separated by a "*", sub-elements by a ":", and segment terminators by a "~", as Medicare has designated.

Mandate that third party vendors be able to upload the new ERA standard format

Any company that sells services to providers that include the ability to create an outbound electronic file for the submission of claims on the providers' behalf must be able to upload the new Standard ERA File Format. Failure to do so would result in significant penalties to companies that do not comply.

Such companies (billing services, practice management systems, etc.) must also ensure and comply to supporting regular updates to WEDI/HIPAA mandated adjustment, remark, and reason codes as

part of software maintenance to ensure providers have no issues related to uploading and posting ERA records.

Prohibit the forced bundling of disparate transaction formats under one vendor

No entity, whether from the banking, healthcare or any other industry, can mandate that providers must use one vendor in terms of the collection or distribution channel of the 835 healthcare transactions. This will allow for a free market in terms of both pricing and innovation around the transaction's unique needs. In other words, the needs for a provider around ERA and EFT transactions is much different than 837 claim submission, or the real time needs of patient eligibility. Healthcare payment transactions were never bundled when delivered by paper, and there is no need to bundle them as the industry changes to electronic payments. In fact, forced bundling reduces marketplace competition, variable pricing and service quality choice for payers and providers.

Give providers the power to choose the way they receive the standard ERA

Provider ERAs and EFTs are delivered to an approved entity selected by the provider. This includes the ability of the provider to have ERAs and EFTs delivered to different approved entities, or multiple approved entities.

Create the infrastructure for data requirement definition across the industry

Establish a regulatory group (new healthcare payment regulatory group or HPRG) to provide minimal data requirements necessary to support ease of use of remittance documentation to providers. The result of such changes will allow providers a reduction in effort and training related to multiple payer nuisances of data content, and will allow all constituents to focus on remittance details for payment business purposes.

Protect confidential patient information by mandating that it be handled by certified clearinghouse entities

Any company that handles the ERA transaction must be certified as a HIPAA compliant healthcare clearinghouse (an example of a certification organization of this type would be EHNAC), on an annual basis, to be able to continue to handle the ERA transaction. The inclusion of PHI in the ERA makes this recommendation necessary to protect sensitive patient information contained in the transaction file.

Create comprehensive capitation standard

Many of the issues causing confusion in healthcare payment distributions are related to PLB segment used in 835 records today. One such issue occurs when payers are transmitting capitation payments to providers. Since the rules for claim submission will undoubtedly result in capitation encounters being submitted to payers, a standard is needed to enforce that all encounter claims submitted be returned with the capitation payment. This will result in simplification and automation of capitation auditing and the reduction of the effort needed to reconcile the payment.

If a payer is sending payments to a provider related to capitation arrangements, the payer must send all encounter submissions with the ERA record to reduce the administrative burden for reconciliation of such payments. If a provider does not submit encounters, then the resulting ERA payment would only provide the PLB adjustment value in correspondence with the 835 balancing rules.

If a payer is sending payments to a provider related to capitation arrangements, the payer must send all encounter submissions with the ERA record to reduce the administrative burden for reconciliation of such payments.

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835 Records must balance

This is currently a significant issue. Data submitted by payers is not accurate or does not follow the EDI standard for proper balancing. These errors result in additional effort for all parties to determine if the payment is accurate, if billing system issues have occurred, or if the 835 file has been corrupted in another way. Providers should be able to reject unbalanced 835 records, and the originating payer should be subject to financial penalties.

Mandate that all ERA/835 records that are transmitted with balancing errors result in a fine to be paid by the original payer of the 835 record.

Allow providers to reject unbalanced transactions and demand a resubmission of a transaction with the error corrected as well as payment of interest for the claims contained in the resubmitted 835.

Payers must provide a service that allows for submission and tracking of such requests and provides for a turnaround time to correct that is narrow and provides accrued interest to the provider until resolved.

If a provider finds the file contains an error, a file error bonus must be paid to that provider for 1% of the transaction value or $25.00, whichever is less, using the next unrelated transaction submission. Such fine will be noted in the PLB segment. Failure to pay such violations will result in a submission to HPRG and notification on the payers NPID record.

B. The Electronic Funds Transfer or EFT

EFT and ERA transactions must be re-associated prior to transmission

Any payer that distributes ERA and EFT files must deliver these two unique transactions to the provider, either directly or through some third-party mechanism, re-associated. For definition purposes, re-associated means that there can be no doubt that a specific ERA file corresponds to a specific EFT payment, and that they both match in terms of total claim payment dollars. Our legislation recommendation does not address how the re-associated information is provided; only that such payments are coordinated and delivered on the same day. Providers would have the ability to choose the method of delivery (bank, vendor, etc.) that best suits their business needs.

Preserve key tracing information as the EFT record travels through the ACH network from payers to providers

Require changes to Receiving Depository Financial Institutes (RDFI) to preserve addenda trace number information and provide it in human readable presentation format (bank websites, bank statement memo notes) to providers for simplified verification of EFT payments. Such a change may require a modification to NACHA operating rule 4 subsection 4.4.3. Such a rule hampers the ability for addenda record information to be made available automatically, and on the same date of settlement, to support a provider's ability to view and double check re-association records. An added delay to addenda record information simply adds to the inefficiency and to the manual daily effort required to resolve re-association efforts. Without such RDFI cooperation, innovations in healthcare could be hampered with payment delays as a result of the provider, or provider's vendor of choice missing key re-association information to assist with the re-association process.

Prohibit the inclusion of confidential patient information in EFT records unless they are handled by a certified clearinghouse

Allow payers to submit 835 records without PHI to ODFI vendors for provider payment distribution. The removal of PHI information and use of the 835 header record for payment purposes ensures that payers send exact payment record details through both channels without PHI over-exposure as a result of using multiple distribution channels, but does not limit the provider's ability to choose value-add vendors for ERA/EFT receivership. This will allow payers to reduce their EFT implementation costs, and ensure that the same trace information is available for reconciliation and coordination of ERA information by the RDFI or provider vendors.

DFI constituents may receive 835 records for transmitting healthcare payments to providers. Payers are only required to send header level information (no PHI claim information) to create an ACH transaction. DFI groups can add optional services for validation of payments before delivery, but only at a payer's request and only if the DFI is certified as a HIPAA compliant clearinghouse entity.

In the case of a payer sending consolidated payments to the ODFI (multiple ERA payments to a single provider), the payer will submit payments using EDI 820 transactions with RMR loops that include TRN values.

Real-time payment language should be added to allow payers to evolve from batch payment to real-time if they so desire.

Allow payers to correct payment mistakes via Debit EFT

Provide an effective window of both notification of pending withdrawal and tolerable boundaries related to claim submission dates for payers to issue a withdrawal request via Debit ACH. This will allow payers the ability to request refunds past this date, but through debit authorization.

Include in authentication security rules that providers agree to allow payers the ability to debit from their operating account when they submit a debit ERA record 2 business days before the ACH.

Allow payers to submit the BPR03 field with a debit flag, allowing for a debit ACH through their DFI vendor, after the notification period has been exceeded.

Allow accrued interest payable by the provider to the payer should the recapture transaction be unsuccessful because of insufficient funds.

Limit the total dollar volume per transaction to no more than $500.00 and limit each recapture transaction to one unique overpayment (no bundling).

Mandate proper certification for companies that handle EFT

Any company that handles EFT transactions should be certified to handle monetary transactions (an example would be SAS70 Type II certification), on an annual basis, in order to continue to handle the EFT transaction. The security of any systems that are involved, directly or indirectly, in the movement of money makes this recommendation necessary to protect the claim payment dollars being moved from originator to receiver.

Compliance Incentives

In an effort to drive early adoption of the new rules and to measure the impact and outcome, it is our recommendation that financial incentives be offered to both payers and providers who adopt distribution (payers) or receipt (providers) of ERA and EFT per these legislation guidelines.

Monetary incentives should be issued to payers and providers based on proven ability to distribute or receive ERAs and EFTs, fully re-associated, for 40%, 60%, 80% and 100% of their total business as compliance milestones on or before January 1st, 2013.

For each milestone of achievement, payers will receive an incentive of $ [formula based on payer total volume].

For each milestone of achievement, providers will receive an incentive of $5,000.

Similarly to other healthcare mandates such as electronic prescribing, adoption of ERA and EFT can be included in the next phase of meaningful use incentives for billing system vendors. Billing system vendors who handle automatically posting incoming ERA files for providers should be incentivized for compliance to these legislative recommendations with a one-time payment of $100,000. The deadline for participation in the incentive program should be proof of compliance by January 1st, 2012.

Because of these incentives, vendors accepting the incentive should be prohibited from charging medical providers for installation and/or usage of an ERA upload module.

CMS IDs Improper Payments, Top Regional RAC Issues

James Carroll, for *HealthLeaders Media* , July 27, 2011

The Centers for Medicare & Medicaid Services released a Recovery Audit Contractor update on July 15 that details the amount of overpayments and underpayments identified in the most recent quarter, as well as the total amount identified since the start of the national program.

In the Q3 FY 2011 update, CMS identified $233.4 million in overpayments and $55.9 million in underpayments with a total correction amount of $289.3 million—more than $100 million more than in the previous quarter.

The report shows that the figures identified by CMS continue to grow drastically; in the second quarter of fiscal year (FY) 2011, CMS identified $162 million in overpayments and $22.6 million in underpayments, with a total of $184.6 million in corrections.

While this brief CMS report is essentially self-explanatory, the figures within it are certainly telling, according to Kimberly Anderwood Hoy, JD, CPC,director of Medicare and compliance for HCPro, Inc.

"First quarter in FY2011 was more than all over FY2010 combined. You can really see the efforts being geared up when you look at this report, as each quarter goes up significantly more than the last."

In addition to the figures, the report also contains the top RAC issue per region for Q3 FY 2011. The issues are as follows:

Region A: Renal and urinary tract disorders (medical necessity)

Region B: Extensive operating room procedure unrelated to principal diagnosis (DRG validation/incorrect coding)

Region C: Durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) provided during an inpatient stay (Durable medical equipment)

Region D: Minor surgery and other treatment billed as inpatient (Medical necessity)

Some of these issues may not come as a surprise to many, but providers should take a closer look at some of the issues, says Donna Wilson RHIA, CCS, CCDS, senior director at Compliance Concepts, Inc., in Wexford, PA.

"After seeing the top issue in Region A, I reviewed the MS-DRG tables only to discover 'no MS-DRG entitled Renal and Urinary Tract Disorders.' However, I did find an MDC (Major Diagnostic Category) for 'Disease and Disorders of the Kidney and Urinary tract,' " she says. "Providers are left to wonder, what falls into this denial category: Simple urinary tract infections or simple urinary/renal procedures?"

"When it comes to the top issue in Region D," she continued, "regarding the medical necessity of minor surgical procedures, providers need to be cognizant of the correct patient status. Also, keep in mind the typical recovery period for these minor surgical procedures is usually 4-6 hours."

Region B switches gears from the other RAC contractors by finding success in denying the higher weighted MSDRGs 981-983. Coders should consider a second-level (prebill) review of any records grouped into MSDRG 981-983. Applying this best practice technique will ensure the claim is coded and/or sequenced correctly resulting in less denials, according to Wilson.

While none of the information in the report can be considered groundbreaking, it does serve as a reminder to the provider community that not only are RACs not going away, but they are expanding, so providers need to remain diligent and keep open all lines of communication.

"RAC's are taking advantage of their ability to run automated reviews around the clock on much less cost than a complex review not yielding big dollars. Just because a hospital is not getting record requests, don't assume that you are not being audited and losing money," said Elizabeth Lamkin, a partner atPACE Healthcare Consulting.

"Only front-end compliance and documentation can prevent these takebacks," she continued. "Each provider needs a coordinated and comprehensive approach to ensure that the financial and clinical departments are communicating to connect these dots. For instance, clinical department directors—especially in the outpatient department—should be informed on a regular basis if there are recoupments in their particular areas."

U.S. Senate Finance Committee
Field Hearing
"Perspectives on Medicaid from Select Governors"
Senator Max Baucus, Chairman
Senator Orrin Hatch, Ranking Member

July 14, 2011
Utah State Capitol
Salt Lake City, UT

Submission for the U.S. Senate Finance Committee
Record
From
Michael R. Sibbett, Retired Chairman
Utah Board of Pardons and Parole

I would like to welcome this Senate Field hearing to Utah. I am Michael Sibbett, retired Chairman of the Utah Board of Pardons and Parole. I am also Past President of the Association of Paroling Authorities International that represent all States and the US Federal Authorities, all of Canada, and some 40 other international countries. In my 15+ years judging criminals I have made over 130,000 decisions and have a deep understanding of the criminal justice system and of criminals. I have served in four Governor's cabinets and have worked with Senator Hatch on numerous criminal justice problems and solutions. I never thought I would be so involved in my retirement on an issue dealing with Medicaid and Medicare until I learned that the number one new criminal enterprise for organized crime was Medicaid and Medicare fraud.

When you have billions of dollars moving every month I could not believe there was not a better system set up with all the new technology to remove paper checks as this is the weak link for crime. I was extremely shocked to learn that approximately 90% of all medical payments are still being done by paper checks. If Congress ask for an accounting of the annual fraud loss the number is between $40-$50 billion every year. In addition to this loss the waste and abuse is over $100 billion annually and going up.

OIG is an independent, nonpartisan agency committed to protecting the integrity of more than 300 programs administered by HHS. Furthermore, DOJ has a criminal task force to collaborate with antifraud efforts as outlined in the Health Insurance Portability and Accountability Act of 1996, P.L. 104-191 (HIPAA). These joint criminal task force efforts have returned but a small % of loss from the public accounts. The frustration I share with many in the criminal justice community is the knowledge that if you manage the money on the front end you will not be chasing the money on the back end. Cowboy logic tells you to shut the barn door to keep a horse in if you don't want to waste time chasing the horse day after day after day. I have personally briefed CMS and ask them why they do not control payments better and why they don't get rid of paper checks with their response being "If Congress passes a law that requires them to do it then they would do it." Administrative rules and regulations will not solve this issue. We must have Congressional Legislation to address this issue. The model to use would be the credit card industry standard. This movement of money around the world is efficient and has a fraction of lost to abuse or fraud when compared to the health care industry.

I suggest a solution would be found by creatively destroying the current way healthcare contracts and pays itself by eliminating paper payments from the system and overlaying a financial healthcare network as the backstop for enforcement of efficiencies and cost containment. There will be those that would suggest that this is too complicated and unproven. It is not and has been done. If we are going to address an annual $100+billion dollar loss we need to reform the way healthcare contracts and pays for itself, putting into place a financial

healthcare network as a backstop, with teeth, to change how we do business within Medicare and Medicaid.

The Patient Protection and Affordable Care Act was signed into law on March 23, 2010. Among its many provisions, it contains a blueprint for full electronic adoption of ERA and EFT in the healthcare industry, achieved by mandating deadlines and financial consequences for several key milestones in the adoption process. Adoption of a *fully reconciled* electronic payment system will begin in 2012 and be complete by January 1, 2014. Highlighted below are the main pieces of the legislation that help drive electronic payment adoption:

- Modifies existing Social Security Act to require Healthcare Provider and Supplier Payments to use Direct Deposit or Electronic Funds Transfers (EFTs).
    - **Section 1104, Paragraph b2 - TRANSACTION STANDARDS; OPERATING RULES AND COMPLIANCE):** modifies the Social Security Act (**42 U.S.C. 1320d2**) to provide for Direct Deposit and EFT.
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        - **Modifies Section 1173B** to stipulate that all financial transactions involving Medicare must be made electronically, by EFT, and calls for standardization of EFT transactions.
- Mandates the adoption of standard Operating Rules for EFT and Health Care Payment and Remittance Advice Transactions:
    - **Section 1104, Paragraph g4, Sub-Paragraph ii – ELECTRONIC FUNDS TRANSFERS AND HEALTH CARE PAYMENT AND REMITTANCE ADVICE:** Mandates automated reconciliation of the electronic payment with the remittance advice.

- Operating Rules must be adopted not later than July 1, 2012, in a manner ensuring that they are effective not later than January 1, 2014.
- Payers will need to begin adopting a payment delivery system that allows for automated reconciliation by July 1, 2012, and full adoption by January 1, 2014.

- **Section 1104, Paragraph j4 – IMPLEMENTATION:** Any health plan that fails to certify and document their compliance by December 31, 2013 will be assessed a penalty fee of $1 per covered life per day until it complies with the operating rules law, with payment required by November 2014.

ERA & EFT Legislation Recommendations

While the sections outlined above are a good start for a fully electronic healthcare payment system, a lot of work must still be done to ensure that we create the *right* system, one that will reduce payment costs and inefficiencies as much as possible and set the stage for the detection of healthcare waste and fraud through the electronic payment system. I would recommend the following:

- **The Electronic Remittance Advice or ERA**
  - **Create a uniform ERA standard across the industry.**
    - Regardless of any other outbound formats offered, payers must issue a new Standard ERA File Format as a method of delivery that must be available to providers upon request or as the default delivery format standard. Furthermore, we recommend that this standard should be the existing Medicare ERA file format, with its delimiters, as issued by CMS. As many provider billing systems have addressed this payer format and it is widely used in the market today.
  - **Mandate that third party vendors be able to upload the new ERA standard format.**
    - Any company that sells services to providers that include the ability to create an outbound electronic file for the submission of claims on the providers' behalf must be able to upload the new Standard ERA File

Format. Failure to do so would result in significant penalties to companies that do not comply. Such companies (billing services, practice management systems, etc.) must also ensure and comply to supporting regular updates to WEDI/HIPAA mandated adjustment, remark, and reason codes as part of software maintenance to ensure providers have minimal issues related to uploading and posting ERA records. Finally, there would be a cap, by rule, on the amount a provider entity could be charged for the purchase and installation of modules supporting ERA uploading.

- **Prohibit the forced bundling of disparate transaction formats under one vendor.**
  - No entity, whether from the banking, healthcare or any other industry, can mandate that providers must use one vendor in terms of the collection or distribution channel of healthcare transactions (837, 270/271. 835, etc.). This will allow for a free market in terms of both pricing and innovation around each transaction's unique need. In other words, the needs for a provider around ERA and EFT transactions is much different than 837 claim submission, or the real time needs of patient eligibility. Healthcare payment transactions were never bundled when all paper, and there is no need to bundle them as the industry changes to electronic payments. In fact, forced bundling reduces marketplace competition, variable pricing and service quality choice for payers and providers.
- **Give providers the power to choose the way they receive the standard ERA.**
  - Provider ERAs and EFTs are delivered to an approved entity selected by the provider. This includes the ability of the provider to have ERAs and EFTs delivered to different approved entities, or multiple approved entities.
- **Create the infrastructure for data requirement definition across the industry.**
  - Establish a regulatory group to provide minimal data requirements necessary to support ease of use of remittance documentation to providers. The result of

such changes will allow providers a reduction in effort and training related to multiple payer nuisances of data content, and will allow all constituents to focus on remittance details for payment business purposes.

- **Protect confidential patient information by mandating that it be handled by certified clearinghouse entities.**
  - Any company that handles the ERA transaction must be certified as a healthcare clearinghouse (an example of a certification of this type would be EHNAC or CORE), on an annual basis, to be able to continue to handle the ERA transaction. The inclusion of PHI in the ERA makes this recommendation necessary to protect sensitive patient information contained in the transaction file.
- **Create comprehensive capitation standard.**
  - Many of the issues causing confusion in healthcare payment distributions are related to PLB segment used in 835 records today. One such issue occurs when payers are transmitting capitation payments to providers. Since the rules for claim submission will undoubtedly result in capitation encounters being submitted to payers, a standard is needed to enforce that all encounter claims submitted be returned with the capitation payment. This will result in simplification and automation of capitation auditing and the reduction of the effort needed to reconcile the payment. If a payer is sending payments to a provider related to capitation arrangements, the payer must send all encounter submissions with the ERA record to reduce the administrative burden for reconciliation of such payments. If a provider does not submit encounters, then the resulting ERA payment would only provide the PLB adjustment value in correspondence with the 835 balancing rules.
- **835 Records must balance.**
  - This is currently a significant issue. Data submitted by payers is not accurate or does not follow the EDI standard for proper balancing. These errors result in additional effort for all parties to determine if the payment is accurate, if billing system issues have occurred, or if the 835 file has been corrupted in another way. Providers should be able to reject

unbalanced 835 records, and the originating payer should be subject to financial penalties.

- **The Electronic Funds Transfer or EFT**
  - **EFT and ERA transactions must be reconciled prior to transmission.**
    - Any payer that distributes ERA and EFT files must deliver these two unique transactions to the provider, either directly or through some third-party mechanism, reconciled. For definition purposes, reconciled means that there can be no doubt that a specific ERA file corresponds to a specific EFT payment, and that they both match in terms of total claim payment dollars. Our recommendation does not address how the reconciled information is provided; only that such payments are coordinated and delivered on the same day. Providers would have the ability to choose the method of delivery (bank, vendor, etc.) that best suits their business needs.
  - **Preserve key tracing information as the EFT record travels through the ACH network from payers to providers.**
    - Require changes to Receiving Depository Financial Institutes (RDFI) to preserve addenda trace number information and provide it in human readable presentation format (bank websites, bank statement memo notes) to providers for simplified verification of EFT payments. Such a change may require a modification to NACHA operating rule 4 subsection 4.4.3. Such a rule hampers the ability for addenda record information to be made available automatically, and on the same date of settlement, to support a provider's ability to view and double check reconciliation records. An added delay to addenda record information simply adds to the inefficiency and to the daily effort required to resolve reconciliation efforts. Without such RDFI cooperation, innovations in healthcare could be hampered with payment delays as a result of the provider, or provider's vendor choice, missing key reconciliation information to assist with the reconciliation process.

- **Prohibit the inclusion of confidential patient information in EFT records unless they are handled by a certified clearinghouse.**
    - Allow payers to submit 835 records without PHI to ODFI vendors for provider payment distribution. The removal of PHI information and use of the 835 header record for payment purposes ensures that payers send exact payment record details through both channels without PHI over-exposure as a result of using multiple distribution channels, but does not limit the provider's ability to choose value-add vendors for ERA/EFT receivership. This will allow payers to reduce their EFT implementation costs, and ensure that the same trace information is available for reconciliation and coordination of ERA information by RDFI or provider vendors.
- **Allow payers to correct payment mistakes via Debit EFT.**
    - Provide an effective window of both notification of pending withdrawal and tolerable boundaries related to claim submission dates for payers to issue a withdrawal request via Debit ACH. This will allow payers the ability to request refunds past this date, but through debit authorization.
- **Mandate proper certification for companies that handle EFT.**
    - Any company that handles EFT transactions should be certified to handle monetary transactions (an example would be SAS70 Type II certification), on an annual basis, in order to continue to handle the EFT transaction. The security of any systems that are involved, directly or indirectly, in the movement of money makes this recommendation necessary to protect the claim payment dollars being moved from originator to receiver.

- **Financial Incentives**
    - In an effort to drive early adoption of the new rules and to measure the impact and outcome, it is recommended that financial incentives be offered to both the payers and providers who adopt the new rules before 2014.
    - Similarly to other healthcare mandates such as electronic prescribing, adoption of ERA and EFT can be included in the

next phase of Meaningful Use incentives for billing system vendors. The deadline for participation in the incentive program should be January 1, 2012.

- Because of these incentives, vendors should be prohibited from charging medical providers for installation and/or usage of an ERA upload module.

I respectfully submit these outlined legislative steps be considered by this Committee in your efforts to find a solution to both a criminal fraud and a pure efficiency solution of waste. I stand willing to assist in any way to this end urging a quick working group of staff to refine and improve these recommendations. Without legislative guiding this solution HHS/CMS and the States will have limited tools to address this issue of money.

Thank you for allowing me to submit my thoughts, and thank you for the service and leadership you provide to our great nation.

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