

MEDICAID REFORM: THE NATIONAL GOVERNORS ASSOCIATION'S BIPARTISAN ROADMAP

HEARING BEFORE THE COMMITTEE ON ENERGY AND COMMERCE HOUSE OF REPRESENTATIVES ONE HUNDRED NINTH CONGRESS

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(II)

CONTENTS

	Page
Testimony of:	
Huckabee, Hon. Mike, Governor, State of Arkansas; and Hon. Mark Warner, Governor, State of Virginia	21
Material submitted for the record by:	
Acevedo-Vilá, Hon. Anibal, Governor, Commonwealth of Puerto Rico, prepared statement of	74
Barton, Hon. Joe, letter dated July 5, 2005, to Gov. Mark R. Warner, enclosing questions from committee members, and responses to same ...	78
Kennelly, Barbara, President, National Committee to Preserve Social Security and Medicare, prepared statement of	76

MEDICAID REFORM: THE NATIONAL GOVERNORS ASSOCIATION'S BIPARTISAN ROADMAP

WEDNESDAY, JUNE 15, 2005

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The committee met, pursuant to notice, at 11:07 a.m., in room 2123 of the Rayburn House Office Building, Hon. Joe Barton (chairman) presiding.

Members present: Representatives Barton, Bilirakis, Upton, Stearns, Gillmor, Deal, Whitfield, Norwood, Cubin, Shimkus, Wilson, Shadegg, Pickering, Buyer, Radanovich, Bass, Bono, Walden, Ferguson, Rogers, Otter, Myrick, Murphy, Burgess, Blackburn, Dingell, Waxman, Markey, Brown, Rush, Eshoo, Stupak, Engel, Wynn, Green, Strickland, DeGette, Capps, Allen, Davis, Schakowsky, Solis, Baldwin, and Ross.

Also present: Representative Gingrey.

Staff present: Chuck Clapton, chief health counsel; David Rosenfeld, majority counsel; Jeanne Haggerty, majority professional staff; Brandon Clark, health policy coordinator; Eugenia Edwards, legislative clerk; Bridgett Taylor, minority professional staff; Amy Hall, minority professional staff; and Turney Hall, research assistant.

Chairman BARTON. The committee will come to order. Our witnesses today, Governor Warner and Governor Huckabee, are testifying in the other body and are going to be joining us shortly. So in the interim we are going to begin our opening statements. And, according to the rule we adopted at the beginning of this Congress, since this is a full committee hearing and we have two Governors, Mr. Dingell and I will each be recognized for 5 minutes to give our opening statements. Then, every other member who wishes to be recognized will be recognized for 1 minute to give their statement. And hopefully, by the time that happens, the Governors will be here and then we will go to their testimony and then our usual 5 minutes of questions per member, alternating between the minority and the majority. Any questions about that, anybody?

Mr. DINGELL. No questions, Mr. Chairman.

Chairman BARTON. Okay. So the Chair would recognize himself for an opening statement.

Good morning. Even though our two Governors, Governor Warner and Governor Huckabee are not here yet, we do want to appreciate their agreeing to testify before us on this important hearing.

We understand that there is the making of a bipartisan agreement amongst the Governors about what might be done to reform Medicaid. Under the aegis of the National Governors Association, today's witnesses have played a central role in bringing both Republican and Democrat Governors together to develop and support these innovative concepts for Medicaid reform. The Governors are before us today because Medicaid is in crisis. We have reached a point where there are just not enough taxes or taxpayer money to keep Medicaid going as we know it today.

Most States now spend more on Medicaid than they do on schools or anything else for that matter. Analysts predict in as few as 20 years, Medicaid will consume between 80 to 100 percent of all State budget dollars. That is an amazing statement. Without reform, Medicaid eventually will bankrupt every State in the Nation. The only alternative is the eventual collapse of the Medicaid program.

Here is a thought that comes from somebody that I probably wouldn't agree with too much. He is John Adams Hurson, a Maryland State legislator who is president of the National Conference of State Legislatures. Let me read to you what Mr. Hurson says. "I am a Democrat, a liberal Democrat, but we can't sustain the current Medicaid program. It is fiscal madness. It doesn't guarantee good care, and it is a budget-buster. We need to install a greater sense of personal responsibility so that people understand that this care is not free." I couldn't agree more.

The proposals that we will hear about this morning reflect the bipartisan views of the Nation's Governors. Governors know their State's programs and beneficiaries, what they can afford and what levels of benefits and services are most appropriate for those most vulnerable in their State populations. Governors have to struggle every day with Medicaid financing and service delivery. Governors also see the flaws in the current program. They seem to understand how many middle-class seniors hide their assets through creative accounting techniques so that they can get Medicaid to pay for nursing home care. They see how Medicaid pays too much for some prescription drugs. They also know how Medicaid's co-payment policies with rates that are frozen at 1983 levels, discourage beneficiaries from taking responsibility for their own healthcare decisions.

This knowledge has helped to shape many of our Governors' reform proposals. This will not stop critics from challenging these reforms, and that is the purpose of today's hearing, to hear their reforms and then have a review of them. Some will say that any change to the system they love will hurt the poor. Critics conveniently ignore the fact that the system is already changing as States try to avoid ruin. Between 2002 and 2005 all States reduced provider rates and implemented drug cost controls. Thirty-eight States have reduced eligibility, and 34 States have reduced benefits. This year hundreds of thousands of beneficiaries will lose Medicaid eligibility or face reduced benefits in States like Tennessee, Missouri, and Mississippi.

I think that it is time to do something because doing nothing hurts Medicaid patients every day. I, personally, would like to reform and save Medicaid. The Federal budget does need some help.

The State budgets desperately need help. Medicaid beneficiaries need help. I applaud our Governors and generally support the reforms that they are bringing before us. Medicaid is clearly in need of reform.

This committee is tasked by Congress in the budget resolution to reduce the growth of Federal spending. It is my job as chairman to try to help the committee come up with a bipartisan agreement that will do the very best that we can to meet that target. And as I said, I hope that we can do it in a bipartisan fashion.

Just as important, though, is the importance of simply saving Medicaid. The exercise that we discuss today is about much more than reconciliation; it is also about preserving the healthcare safety net that protects the Nation's poor. If we cannot make Medicaid more affordable to States and to the Federal Government, we will have to put the beneficiaries who depend on the program at grave risk.

I look forward to today's hearing. It is an important hearing. I might also say that this isn't the only hearing that we are going to do. This is the first of many hearings that we are going to have this summer as we move toward a Medicaid reform package in the fall.

[The prepared statement of Hon. Joe Barton follows:]

PREPARED STATEMENT OF HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY
AND COMMERCE

Good Morning. Let me begin by thanking Governors Warner and Huckabee, for appearing before the Committee today. We appreciate their willingness to testify about a new bipartisan agreement to reform Medicaid that has recently been developed by the National Governors Association. Today's witnesses played a central role in bringing Republican and Democratic governors together to develop and support these innovative concepts for Medicaid reform.

The Governors are here today because Medicaid is in crisis. We have reached a point where there just are not enough taxes or taxpayers to keep Medicaid going. States now spend more on Medicaid than they do on schools, or anything else, for that matter. Analysts predict that in as few as 20 years, Medicaid will consume 80 to 100 percent of all state dollars. Without reform, Medicaid eventually will bankrupt every state in the nation. The only alternative is the eventual collapse of the Medicaid program.

Here's a thought that comes from someone I probably wouldn't agree with much. He's John Adams Hurson, a Maryland state legislator who is president of the National Conference of State Legislatures. Let me read you what Mr. Hurson says: "I am a Democrat, a liberal Democrat, but we can't sustain the current Medicaid program. It's fiscal madness. It doesn't guarantee good care, and it's a budget buster. We need to instill a greater sense of personal responsibility so people understand that this care is not free." I couldn't agree more.

The proposals we will hear about this morning reflect the bipartisan views of the nation's Governors. Governors know their state's programs and beneficiaries, what they can afford and what levels of benefits and services are most appropriate for these vulnerable populations. Governors must struggle every day with Medicaid financing and service-delivery.

Governors also see the flaws in the current program. They seem to understand how many middle class seniors hide their assets through creative accounting techniques so they can get Medicaid to pay for nursing home care. They see how Medicaid pays too much for some prescription drugs. They also know how Medicaid's co-payment policies, with rates still frozen at their 1983 levels, discourage beneficiaries from taking responsibility for their health care decisions.

This knowledge helped shape many of the Governors' reform proposals. This will not stop critics from challenging these reforms. Some will say that any change to the system they love will hurt the poor. The critics conveniently ignore the fact that the system is already changing as states try to avoid ruin. Between 2002 and 2005, all states reduced provider rates and implemented drug cost controls; 38 states reduced eligibility; and 34 states reduced benefits. This year, hundreds of thousands

of beneficiaries will lose Medicaid eligibility or face reduced benefits in states like Tennessee, Missouri, and Mississippi.

We must do something because doing nothing hurts Medicaid patients every day. I want to save Medicaid. The Federal budget needs our help. The State budgets need our help. Medicaid beneficiaries need our help. I applaud the Governors and generally support the reforms they are bringing us. Medicaid is clearly in need of reform.

This Committee is tasked by Congress, in the budget resolution, to reduce the growth of Federal spending. We're going to do our best to meet that target, and I hope we can do it in a bipartisan matter. Just as important, though, is the importance of simply saving Medicaid. The exercise we discuss today is about much more than reconciliation—it is also about preserving the healthcare safety net that protects the nation's poor. If we cannot make Medicaid more affordable to States and the Federal government, we will have put the beneficiaries who depend on the program at grave risk. There are serious challenges facing Medicaid today and the program is clearly at a crossroads. We need to look for innovative, bipartisan solutions for the problems facing Medicaid in order to strengthen and improve the program. Medicaid beneficiaries deserve nothing less. So do America's taxpayers.

Chairman BARTON. With that, I would—

Mr. RUSH. Mr. Chairman? Mr. Chairman? Down at this end.

Chairman BARTON. Mr. Rush.

Mr. RUSH. Mr. Chairman, I would like just to speak out of order just for a moment. Since the last time the full committee has met we have had a death among our family. The chief of staff for Congressman Towns passed suddenly last week, and I would just ask that you would join me in a moment of prayer for her and her family and for our family because she was a fixture around this committee and around all of us. Brenda was loved by everybody. Brenda Pillors.

Chairman BARTON. I am honored to do that, and I think Mr. Dingell was going to speak to that too in his opening statement. But would we all just have a moment of silence, and those that believe in prayer, a moment of prayer. Amen. With that I would recognize the distinguished ranking member, Mr. Dingell.

Mr. DINGELL. Mr. Chairman, I thank you for the recognition, and I thank you also for holding this hearing on a very important, a very valuable question. I ask that I also be permitted to insert into the record a brief comment about Brenda Pillors, who was much loved on this side of the aisle and in the committee generally. She was chief of staff to our good friend, Mr. Towns, and she was quite a force for good within the Congress. She will be missed.

Chairman BARTON. Without objection.

Mr. DINGELL. Thank you, Mr. Chairman. As I said, Mr. Chairman, I thank you for this hearing. It is a very important question, and I welcome Governors Warner and Huckabee to us and thank them for their testimony today. We are interested in hearing about their Working Groups Preliminary Proposal to change Medicaid and how these changes will help them and other Governors with regard to fiscal problems. We have heard for a number of months the concerns of the States regarding their budgets and how much of each budget is consumed by Medicaid. These appear to be very legitimate concerns. I want the Governors to know that I am sympathetic to the financial bite that they face, but that we do need to have a perspective on one very important question; and that is how do we fix their problem within the broader healthcare system and yet take care of those for whom the Medicaid program is designed to be helpful?

Congress has tried to eliminate the problems or at least to alleviate this situation many times, including a major victory in June 2003 when we were able to provide the States with \$10 billion to assist them through the economic downturn by temporarily boosting the Federal Medicaid funding. But now we are going in the opposite direction. Congress is looking to cut \$10 billion from the Federal budget, keeping in mind that cutting \$10 billion in Federal funding for these programs equals a \$17.5 billion cut overall to Medicaid recipients because of the shared State-Federal financing of the program. That is a significant number.

The National Governors Association has come out strongly against the cost shift by the Federal Government that would place a still-greater financial burden on the States. This is a very legitimate concern. I wholeheartedly agree with the Governors and would support giving the States \$10 billion rather than taking it away. I believe that to be a more justifiable course. But we must also take care not to cost-shift the burden from the States to the backs of the poor and those who have the least capacity to address the problems that would occasion. Unfortunately, I am afraid that much of the NGA proposal will do just that: shift cost to the poorest and to the most vulnerable citizens who depend on this program and who have no hope of help elsewhere.

It appears that in the name of personal responsibility, the NGA proposal will make it much more difficult for children and pregnant woman to get needed services. Do we really need to set policies that will make it more difficult for a child diagnosed with diabetes to get insulin? Or to care of the problems of a pregnant woman who is desperate, alone, and destitute? In the end, we as a Nation will pay the financial and social costs of any complications that would result from such children being so treating.

The proposed cost-sharing increases and the benefit changes will result in many going with no services at all. I understand the NGA proposal would eliminate the Medicaid requirement that low-income children who are screened and diagnosed with health problems get the treatment they need. That would be a little bit like a case I saw when I went to a hospital and they told me, Dingell, there is good news here; women are going to be able to be tested for breast cancer. I said that is wonderful. Yes, they said, but there is a real problem; they are not going to be able to get the treatment because that is not in the program. The cost-sharing increases and benefit changes will probably, then, result in no services for many at all. I understand the concerns of the Governor, but we must inquire why are we turning our backs on people who have the greatest need?

Equally troubling is the proposal to take away from senior citizens, individuals with disabilities, pregnant woman, and children the ability to enforce their rights to promised benefits, which serves as a backstop to guarantee that they get the services they need. We should not kid ourselves. As I learned in the good Jesuit teachers' philosophy, rights without a remedy are no rights at all.

I understand this is a preliminary agreement between a group of Governors, which meant concessions were no doubt made on both sides. I am, however, curious; how many senior, how many people with disabilities, how many pregnant woman, how many children

were included in these negotiations? And what was done about the concerns that they expressed if they were heard? And where will these folks be when the leadership in this House decides that those health services will get cut while doling out tax cuts to the most fortunate amongst us. It is a sad day when the budget of the United States, as submitted by the Republican leadership, will require folks like the witnesses before us today to figure out how to hurt the people the least, rather than to help them the most.

Before I yield back, Mr. Chairman, I would like your attention because I have a question that the minority would very much like to ask you and our good friends on the majority side. I want to express the concern of the members on this side that we are not hearing today from those who would be most hurt by these proposals. I note that our colleagues in the other body are hearing today from experts on the perspectives of beneficiaries of providers. My question to you, Mr. Chairman, is will the committee be holding full and adequate hearings to obtain the testimony from beneficiaries and providers on those proposals before we go forward with \$10 billion in cuts to those who are going to get the cuts?

Chairman BARTON. The gentleman yield?

Mr. DINGELL. I yield to my good friend, of course.

Chairman BARTON. Today's witnesses are the Governors, but we are going to have a number of hearings. We always do. We will work with you and other interested members to make sure that we have a broad range of witnesses so that the issue is fully vetted before we move to a legislative solution.

Mr. DINGELL. That comment does you great credit, Mr. Chairman, and I thank you. I understand you to be telling me that we will then be hearing from representatives of the—

Chairman BARTON. We will—

Mr. DINGELL. [continuing] children, representatives of pregnant women, and others who are going to be affected by—

Chairman BARTON. I think we have established comity and trust, not just on this issue, but on all the issues. I am not aware that we have had a problem this year on any specific issue on short-changing the witness list. But this is an important issue, and as you pointed in your opening statement, there are many, many important principles in play here, and this committee will not move legislatively without creating a full record where all interested parties are a part of.

Mr. DINGELL. Mr. Chairman, if I may continue on my time, your record as chairman has been one of fairness and decency, and I want to express my appreciation to you for that. I have great hopes that we will see those superb tendencies at play here and that we will be able to get a record that will enable us to look at the concerns of everybody who is going to be affected by these matters. And with those remarks, Mr. Chairman, with great respect, I thank you.

Chairman BARTON. The last thing, Mr. Dingell, before we yield to Mr. Deal, as you know, because the reconciliation process, we will have a timetable to legislate sometime most probably in September. So we will do our fact-finding hearings this month and in July. There might be one final generic hearing in early September,

but we would move to a legislative markup sometime in September.

Mr. DINGELL. Thank you, Mr. Chairman.

Chairman BARTON. Okay. The distinguished subcommittee chairman, Mr. Deal of Georgia, is recognized for 1 minute.

Mr. DEAL. Thank you, Mr. Chairman. First of all, I want to thank the National Governors Association and the two Governors that we will hear from in just a few minutes, but also the staffs of that organization and the staffs of the individual Governors who have worked very hard on coming up with a bipartisan solution to this issue of Medicaid reform. And I also want to thank the staffs here on our committee who have been working in conjunction with them.

There are two things that I think need to be said about this. First of all is that this is, as we will hear from the Governors, a policy-driven debate. Certainly, finances play a part. At the Governors' level it is now consuming, for their part of Medicaid, more than they are spending on elementary and secondary education and continues to grow. This year it is costing a cumulative \$300 billion, and is projected over the next 10 years to be \$4.5 trillion in cost. But policy is what we will hear from the Governors in terms of policy changes, the kind of changes that I think all of us acknowledge need to be addressed.

I want to thank them for doing this on a bipartisan basis. I think the fact that they have done that is a challenge to us to deal with this issue likewise, on a bipartisan basis. Thank you, Mr. Chairman.

Chairman BARTON. Thank the gentleman. The Chair would recognize Mr. Brown, the ranking member of the Health Subcommittee, for 1 minute.

Mr. BROWN. Thank you, Mr. Chairman. I first ask unanimous consent to enter into the record statements from the consortium of America's dental providers, as well as the National Association of Community Health Centers.

Chairman BARTON. Without objection, so ordered.

[The material follows:]

June 14, 2005

The Honorable NATHAN DEAL
 Chairman
 Energy and Commerce Subcommittee on Health
 United States House of Representatives
 Washington, DC 20515

DEAR MR. CHAIRMAN: We write as organizations committed to equitable access to dental care with a broad range of experience in directly providing care and in working to ensure that dental care is available to Medicaid beneficiaries. To that end, we have attached these principles for dental Medicaid reform to assist you as you work to improve efficiencies in Medicaid.

As the Surgeon General highlighted in his 2000 report, Oral Health In America, oral health is an essential component of overall health. The report further states that dental disease is the single most chronic condition among children in America. Dental disease has also been linked in recent studies to other diseases such as cardiovascular disease and pre-term, low birth-weight babies.

Failure to treat dental problems can have serious human consequences and impose economic burdens on our health care system as people seek care in more expensive circumstances. Routine primary dental care saves money: When primary dental services are unavailable, families will often wait and seek care for their loved ones in hospital emergency rooms--where they may receive a temporary pain fix that

masks the worsening problem or emergency care that can cost as much as 10 times more than regular care in a dental office.

Lack of access to dental care has affected our national military readiness, with the Department of Defense reporting that 4 in 10 recruits have dental problems severe enough to preclude their immediate deployment.—

While Medicaid is a major source of oral health care, enrollment in Medicaid does not ensure receipt of oral health care services. Less than one percent of state Medicaid budgets are allocated to preventive oral health care. Only 7 states provide adult Medicaid dental benefits and only 20% of Medicaid-eligible children receive any type of dental care. A 2000 survey of state Medicaid program administrators found that 95% of respondents reported an access problem for lower-income children in need of dental care. Dental costs for children who receive preventive dental services early in life are 50% lower than costs for children who receive care after years of neglect.

Despite these problems, Medicaid has been innovative and has been a successful laboratory in some states for dental programs and policies that increase access to dental care for low-income and vulnerable populations. We stand ready to work with Congress in providing those best practice models as you seek to improve the Medicaid dental program.

Millions of low-income children and adults postpone needed dental care until health emergencies result from uncovered and untreated dental care. Your committee has the means for correcting the bias in Medicaid that favors expensive treatment in emergency rooms. We look forward to working with you and your committee in improving efficiencies in Medicaid by assuring regular access to routine and preventive oral health care.

Sincerely,

ACADEMY OF GENERAL DENTISTRY; ALLIANCE OF THE AMERICAN DENTAL ASSOCIATION; AMERICAN ACADEMY OF ORAL & MAXILLOFACIAL PATHOLOGY; AMERICAN ACADEMY OF PEDIATRIC DENTISTRY; AMERICAN ACADEMY OF PERIODONTOLOGY; AMERICAN ASSOCIATION OF DENTAL EDITORS; AMERICAN ASSOCIATION FOR DENTAL RESEARCH; AMERICAN ASSOCIATION OF ORAL AND MAXILLOFACIAL SURGEONS; AMERICAN ASSOCIATION OF PUBLIC HEALTH DENTISTRY; AMERICAN ASSOCIATION OF WOMEN DENTISTS; AMERICAN DENTAL ASSOCIATION; AMERICAN DENTAL EDUCATION ASSOCIATION; AMERICAN DENTAL HYGIENISTS' ASSOCIATION; AMERICAN STUDENT DENTAL ASSOCIATION; ASSOCIATION OF STATE AND TERRITORIAL DENTAL DIRECTORS; CHILDREN'S DENTAL HEALTH PROJECT; DENTAL TRADE ALLIANCE; THE HISPANIC DENTAL ASSOCIATION; AND THE PIERRE FAUCHARD ACADEMY.

(**Note:** A complete list of organizations that are supporting the statement of dental Medicaid reform principles will be forthcoming as other groups continue to sign on.)
Attachment

DENTAL MEDICAID REFORM CORE PRINCIPLES & POLICIES

Given that Medicaid beneficiaries are more likely to access care than similarly situated uninsured; Given that the dental services children and adults receive in Medicaid are cost-effective; Given that dental disease is the single most common chronic disease of children; Given that parents consistently cite dental as the number one unmet health need of their children; Given that poor oral health can affect a child's ability to learn and an adult's ability to obtain a job due to appearance; Given that untreated oral disease complicates medical conditions like diabetes and heart disease and may be associated with pre-term low-birth weight babies; Given that oral disease can jeopardize the health of Medicaid-eligible elderly and the disabled, affecting the health and well being of those living in nursing homes; Given that preventive and routine dental services save overall health care dollars by avoiding costly visits to the emergency room, the dental community agrees to the following principles and recommended policies:

Preserve the Federal Guarantee of Medicaid Coverage, Services and Consumer Protections

- Maintain a federal requirement for dental services for EPSDT Medicaid-eligible children¹, and extend medically necessary coverage to adults.

¹See *CMS Guide to Children's Dental Care in Medicaid*. October 2004. <http://www.cms.hhs.gov/oralhealth/>. The Guide was developed for the use of state Medicaid agencies, dental and other health care providers, and national, state and local policy makers involved in organizing and managing oral health care for children under Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) service.

- Ensure that preventive dental benefits are excluded from cost-sharing requirements.

Preserve the Federal Financing Role in Medicaid

- Maintain the current federal-state financing arrangement within Medicaid and reject proposals to establish caps on payments to states.
- Update the federal matching formula to address changes in state economics, and provide an enhanced match for dental services to ensure a state is able to adequately cover these services for Medicaid populations.
- Allow for flexibility within states without diminishing the existing federal-state partnership, which includes federal requirements and/or incentives to enhance program effectiveness.

Assure and Maintain Access to Care Through Adequate Provider Participation

- Provide incentives to states to adopt Medicaid models that mirror programs dental providers work with in the private sector, improve access for beneficiaries and facilitate providers' active participation in the Medicaid program.
- Ensure that dental providers receive fair and market-based compensation for services provided and that compensation is not decreased by cost-sharing requirements.
- Consider utilizing the private market to provide additional dental coverage options to higher-income Medicaid beneficiaries or populations not currently covered by the Medicaid program (e.g., optional dental health savings accounts), and ensure that any private insurance models offered to Medicaid beneficiaries provide comprehensive dental benefits.
- Maintain equal access provision in federal law to ensure that beneficiaries within Medicaid have access to dental services in the same way as beneficiaries in the private sector.²
- Support dental targeted case management programs that utilize Medicaid funds to capitalize on disease management.

Use the Medicaid Waiver Process to Foster Improvements and Innovation, Not to Eliminate Federal Protections or Reduce Benefits

- Ensure that medical necessity criteria does not restrict or eliminate coverage for oral health/dental care that meets professional standards and is clinically appropriate, as determined by a dentist.

Improve the Integrity of Medicaid

- Eliminate fraud and abuse within the program and ensure necessary oversight to determine adequate access to care is provided to beneficiaries.
- Ensure that the financing of the Medicaid program is sound and responds to market demands and state economic needs.

Recognize the Interdependence of Medicaid and the Public Health System

- Facilitate public-private partnerships that improve access for individuals who access oral health care through a safety-net provider. Such a partnership may result in private contracts between safety-net clinics and dental providers and academic dental institution clinics.
- Facilitate the establishment of school-linked programs.
- Encourage programs that value prevention and disease management (to reduce disease burden), are science and evidence-based and invest in strategies with strong potential for long-term savings through preventive care.

Mr. BROWN. Thank you, Mr. Chairman. I have concerns about NGA's proposal, as Mr. Dingell does, but at least they didn't set up a kangaroo court Medicaid commission that puts life-saving insurance on trial as if Medicaid is an evildoer. The NGA would cut costs in two ways: by reducing the price of healthcare and by reducing access to it. There is evidence that healthcare prices can come down with no ill effects. Drug makers earn three times the profit of other Fortune 500 industries. Drug prices, for instance, can come down.

There is not evidence that we can reduce Medicaid access without doing harm. Medicaid enrollees can't afford private health in-

²See *Healthy People 2010—Oral Health Goals and Objectives*. <http://www.healthypeople.gov/document/html/volume2/21oral.htm>.

insurance or higher-cost sharing. RAND's Health Insurance Experiment found that low-income Americans forsake essential care when cost-sharing is increased. Kaiser Family Foundation found that Medicaid beneficiaries already spend more of their income on healthcare than the rest of us do. Medicaid only covers medically necessary care. States can use prior authorization in case management to make sure of it. It is a myth that Medicaid enrollees receive more care than their counterparts in privately insured plans. They don't.

Medicaid is expensive because our demographics are shifting, because private insurance is eroding and—

Chairman BARTON. The gentleman—

Mr. BROWN. [continuing] because healthcare—

Chairman BARTON. The gentleman needs to sum up.

Mr. BROWN. I will. Thank you, Mr. Chairman. Let's not pretend that taking healthcare services away from vulnerable Americans is an ethical way to reduce a budget or to cover more people.

Chairman BARTON. Thank the gentleman. The gentleman from Florida, Mr. Bilirakis, is recognized.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I have a brief written statement to be made a part of the record and waive an oral statement.

Chairman BARTON. The gentleman yields back. The distinguished gentleman from California, Mr. Waxman.

Mr. WAXMAN. Thank you, Mr. Chairman. First of all, this hearing is prompted by a budget reconciliation, and I want to point out that budgets are moral documents. They reflect the values of our Nation, the priorities of our people, who wins and who loses. And I think we are required all of us to ask on a bipartisan basis what happens to the poor and the most vulnerable, especially the Nation's poorest children.

Today we are going to hear from the Governors. They have a very real perspective about the Medicaid program because so much of the costs of this program are dumped on them, rather than absorbed by the Federal Government. I think we ought to make sure that the changes we make in the name of reform are simply not shifting cost to others, particularly those least able to bear them. We should be sure that we are not putting barriers in the way of participation in Medicaid by the very people we are trying to reach and not to make changes that add to the numbers of uninsured in this country, rather than reduce the numbers of uninsured in this Nation.

We have a budget that I think is immoral. It gives tax breaks to billionaires, and yet calls for billions of dollars to be cut out of the program for the very poorest for their healthcare. Let us not go along with the priorities of that budget. Let us do what is necessary to make a healthcare program for the poor in this Nation really work.

Chairman BARTON. We thank the gentleman. Does the distinguished Subcommittee Chairman of Telecommunications, Mr. Upton, wish to make an opening statement?

Mr. UPTON. Waive.

Chairman BARTON. Waive. Does Mr. Stearns wish to make an opening statement?

Mr. STEARNS. Yes, I do.

Chairman BARTON. Mr. Stearns is recognized.

Mr. STEARNS. Thank you. Thank you, Mr. Chairman. I think we can have a bipartisan discussion on this. I think all of us remember the same type of thing was in play with welfare, and we were able to come together, both the House and the Senate and, finally, the President.

No one said it better than the Tennessee Governor, Phil Bredesen, who delivered the National Democratic address last Saturday when he said, "No. 1, everybody pays something,"—talking about his Medicaid plan and its reform—"imagine shopping at a store where nothing has a price tag and you never get a bill. All of us know you spend a lot more than you do now. But this is exactly how Medicaid works today. Until there is a little economic tension, until everyone has a little skin in the game, the system will continue to be inefficient." And I commend him for his statement, and I think that is appropriate for all of us to realize, that we need to reform Medicaid and make the people who are involved to also participate. Thank you, Mr. Chairman.

Chairman BARTON. And we thank the gentleman. Mr. Markey of Massachusetts.

Mr. MARKEY. Thank you. The Republicans want to cut taxes \$106 billion in this year's budget. That is why we are here—the \$106 billion tax cut. This is proportionately skewed toward the wealthiest. And so the price that has to be paid is, amongst other things, \$10 billion cut out of Medicaid to pay for the tax breaks for the wealthiest. One-third of all babies born in the United States today are on Medicaid. One-third of all babies. Two-thirds of all people in nursing homes are on Medicaid. Doesn't it make sense for the Republicans first to figure out what are our obligations to those babies and those seniors; then what is left over is a tax cut? But no. They decide that first they give the tax breaks to the wealthiest in the country clubs who have benefited the most, and then let us figure out how much we cut those babies and how much we cut Grandma in the nursing home. And that is what we are doing here today.

This is not about reform, ladies and gentleman. This is about the Republicans paying for the tax break this year that they want to give to the wealthiest and taking the money away from those most in need in our society.

Chairman BARTON. Does Mr. Gillmor wish to make an opening statement?

Mr. GILLMOR. Thank you, Mr. Chairman. I have a statement I would like to enter into the record. But let me just make one brief comment on the really and detrimental effect growing Medicaid costs are having in Ohio. Despite efforts at cost containment, budget strategies, Medicaid expenditures in Ohio are increasing at twice the rate of State revenues. They now amount to more than \$10 billion. And to put that in perspective, that is 40 percent of the entire budget of Ohio, and it is the reason that you are having cuts in schools and in other areas of State government. And in fact that number is larger than Ohio's entire State budget in 1987. So I think it makes the case that there is reform needed. And I yield back.

[The prepared statement of Hon. Paul Gillmor follows:]

PREPARED STATEMENT OF HON. PAUL E. GILLMOR, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF OHIO

Thank you, Mr. Chairman for holding this important hearing. Furthermore, I welcome Governors Huckabee and Warner, and applaud the National Governors Association's initiative in bringing a bipartisan Medicaid reform roadmap before us for public consumption.

With a generation of baby boomers growing older, life expectancy on the rise, a shrinking labor force, and smaller family units, the demand for long-term care is likely to increase, producing an even further strain on our nation's Medicaid program. Absent future demographic realities, there no question that Medicaid is in dire need of transformation now.

Today, it is safe to say that a majority of states are experiencing skyrocketing Medicaid costs coupled with declining revenues. In my home state of Ohio, despite recognizing the reality of a broken system and enacting a number aggressive cost containment and budget strategies, Medicaid expenditures are increasing at twice the rate of growth of state revenues, amounting to a total \$10.5 billion. This figure represents over 40% of the state's general revenue fund spending and is larger than Ohio's entire state budget in 1987.

In response, the Ohio Commission to Reform Medicaid was formulated in December 2003, and earlier this January, they released their recommendations. As we speak, the Ohio state legislature is hard at work, making great strides to adopt the Commission's recommendations in an effort to again, root out Medicaid inefficiencies and stunt its growth.

With the evolution of Medicaid over the years, reform ideas have come and passed, or simply been swept under the rug. We must take hold of today's circumstances and remain committed with our governors to transforming our system into one of personal responsibility, quality, and efficiency, for our citizens that need it the most.

I look forward to the governors' testimony, again thank the Chairman, and yield back the remainder of my time.

Chairman BARTON. Gentleman from Chicago, Mr. Rush, wish to make an opening statement?

Mr. RUSH. Thank you, Mr. Chairman. Mr. Chairman, just as I did at the last Medicaid hearing back in April, I really must voice my disappointment with the premise of this hearing. I simply don't believe that Medicaid is in any need of reform, not when there are far more egregious examples of programs and policies that are in need of reform, and at the same time that don't disproportionately impact our most vulnerable populations.

It has been rather telling that this Congress's zeal for reform is always reserved for matters that affect poor and working people and never for the waste and abuse generated by the most privileged ranks of our society. Having said that, this committee is burdened with the unfortunate task of coming up with \$10 billion in savings in the Medicaid program.

And given this reality, I want to emphasize that it is my ardent position that absolutely none of the \$10 billion in savings should come from Medicaid beneficiaries themselves. If we are going to squeeze savings out of the program, then the burden should fall entirely on those parties and those interests that are best able to absorb these costs. Medicaid beneficiaries are some of the most vulnerable and needy populations in our country and thus, by definition, they are the least—

Chairman BARTON. The gentleman needs to—

Mr. RUSH. [continuing] able to bear the costs of these so-called Medicaid reforms. And I yield back the balance of my time.

Chairman BARTON. We thank the gentleman. Does Mr. Shimkus wish to make an opening statement?

Mr. SHIMKUS. I will pass.

Chairman BARTON. Does Mrs. Wilson wish to make an opening statement?

Ms. WILSON. Yes, Mr. Chairman. Thank you, Mr. Chairman, and thank you for holding this hearing. Over the last 4 years, every State in the Nation has cut eligibility, benefits, or payment rates—or all three—in Medicaid. And in general, the Federal Government has done very little to help the States with those difficult decisions. Yet the Governors have continued to get the beans to the barbecue. They have got to balance their budget, provide services, make tough decisions. And we have seen plenty of examples of where our failure to help them has cost them dearly.

Medicaid is set up to pay claims. It is not set up to improve anyone's health, and it is ripe for reform. It is now the largest healthcare program in the country, and it is one of the most complicated programs that we have in the Federal Government.

I appreciate the Governors being here today, and I also appreciate their efforts to develop bipartisan ideas to improve the health status of those who depend upon Medicaid, because that is what this debate is about. And the health status of people who are eligible for Medicaid is much lower than it is for the population as a whole. We should start asking why and start taking action to fix it. And I yield the balance of my time.

Chairman BARTON. We have one of our Governors here. Governor, welcome. We are in the process of opening statements, so we are going to continue that. And at the end of our opening statements, hopefully, Governor Warner will be here and we will be able to hear from you. The gentlelady from California, Mrs. Eshoo.

Ms. ESHOO. Thank you, Mr. Chairman, and good morning to everyone. On the issue of Medicaid, my entire public service has been—and previous to my service in the Congress was to strengthen it, to find ways to be smart in order to save dollars, afford people access to a much higher level of quality of care. In the county that I worked in we achieved that. We are still doing that. It became a model for the Nation.

Now, here in the halls of the Congress, I think that this whole debate really needs to be placed in the context of both a moral audit of our budget and our priorities, as well as a values audit. We are going to talk about all the things that need to be done in order to come up with this \$10 billion. Let me remind my colleagues—and this is not left, right, or center; it is a fact of our budget—we are spending a half a billion dollars a day in Iraq as we walk up and down the halls in the Congress. This is being driven by over a trillion dollars in tax cuts—

Chairman BARTON. The gentlelady needs to—

Ms. ESHOO. [continuing] where there has been room made—I am not going to stay for the rest of it, Mr. Chairman, because I am not going to support the \$10 billion cut. And the reason I am saying it is because we have, I believe, a moral deficit. If we are for—

Chairman BARTON. The gentlelady is 30 seconds over her time.

Ms. ESHOO. If we are for correcting this and looking for smart ways to take care of people, I will be a part of it. But I think there

is a real moral deficit in the Congress and in the budget, and I think it is an outrage.

Chairman BARTON. Okay. Does the gentleman from Georgia, Mr. Norwood, wish to make an opening statement?

Mr. NORWOOD. Thank you, Mr. Chairman. I will waive my opening statement.

Chairman BARTON. Okay, the gentleman from New Jersey.

Mr. FERGUSON. I do, Mr. Chairman.

Chairman BARTON. The gentleman is recognized.

Mr. FERGUSON. Mr. Chairman, thank you for holding this hearing, and I will continue the committee's work toward reforming Medicaid. It has been said many times in this committee and elsewhere, Medicaid is broken, it is hemorrhaging money, it is simply unsustainable in its current form, and, quite frankly, it is not serving those it was designed to serve in the first place.

Governor Mark Warner said this past April, "Medicaid at 53 million Americans is going to bankrupt all of the States, and indirectly, then, lead to further deficit problems at the Federal level and over the next decade." Our Governors recognize, Governor Warner recognizes that Medicaid is broken. It needs to be fixed. I look forward to their recommendations and their insights into what we can do to help make this program more efficient and more effective.

Over the next 10 years Medicaid is slated to cost \$4.5 trillion. It is already surpassing elementary and secondary education in most State budgets. And I will say, Mr. Chairman, that the problems that we face in Medicaid and the needs that we have to reform Medicaid have little to do with tax cuts; they have little to do with tax relief. It has everything to do with the fact that it is a government program that is simply not serving those it is meant to serve. And those one-third of babies born today who are on Medicaid, the two-thirds of those in nursing homes today who are on Medicaid, it is simply not serving their needs. That is why this program—

Chairman BARTON. Gentleman's—

Mr. FERGUSON. [continuing] needs to be reformed.

Chairman BARTON. [continuing] time has expired.

The gentleman from Michigan, Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman. I ask that my whole statement be made a part of the record.

Chairman BARTON. Without objection.

Mr. STUPAK. I just think the highlight in my State of Michigan, Medicaid accounts for 25 percent of the State's budget. The trouble in Michigan is an economy that is struggling to cope with a wave of manufacturing jobs being shipped overseas. Under Governor Jennifer Granholm growth in Medicaid spending has been held at a mere 1.5 percent per year, even though the Medicaid rolls have grown by 30 percent. That is evidence to me that Medicaid is flexible, and that Governor Granholm has done a great job of meeting this challenge.

The proposal we are going to hear today from the Governors calls for more flexibility in setting premiums, co-pays, and benefits offered. I think we need to look very carefully at the consequences of these options. When Oregon increased its premiums, its rolls dropped by 50 percent. That is an alarming statistic. With an aging

population and a weak economy, this is not the time to cut the safety net out from a population in need. So I hope we look very carefully at these proposals today. And with that, I will yield back my remaining 4 seconds.

Chairman BARTON. We thank the gentleman from Michigan. Gentelady from California, Mrs. Bono, wish to make an opening statement?

Ms. BONO. Thank you, Mr. Chairman. I will waive.

Chairman BARTON. Does the gentleman from Oregon wish to make an opening statement?

Mr. WALDEN. Thank you, Mr. Chairman, I do.

Chairman BARTON. Gentleman is recognized.

Mr. WALDEN. When I served in the Oregon legislature, I worked closely for a number of sessions on the creation of the Oregon Health Plan, an effort to expand Medicaid coverage to those who didn't have it by providing more preventive care and reaching out and trying to get the most use of the money so we could cover the most people. When we talk about this being a moral decision, I think it is.

And, Mr. Chairman, your Oversight and Investigation Subcommittee has held numerous hearings on Medicaid issues, and clearly, there are areas that require our involvement to reform Medicaid. In some cases we found, for example, that Medicaid paid up to \$5,336 for a drug that only costs a pharmacy \$88 to acquire. That is a waste of \$5,200 on one drug. Now, that is probably the worst example we found, but overall, we found that pharmacies' acquisition cost for generic drugs would be an average of nearly 66 percent below the average wholesale price. So, Mr. Chairman, I think there is room here, especially when Medicaid is still paying for drugs like Viagra for convicted sex offenders, to improve both the moral and fiscal standing of Medicaid. With that I return the balance of my time and ask that my full statement be entered into the record.

Chairman BARTON. Without objection, so ordered.

Does Mr. Engel wish to make an opening statement?

Mr. ENGEL. Yes, thank you, Mr. Chairman. Slashing funding to Medicaid is not a viable solution to greater budgetary problems. Just 2 years ago we gave States an additional \$10 billion and desperately needed FMAP funding. And this year we have been instructed in Energy and Commerce to cut Medicaid by \$10 billion at a time when our citizens need it most. Medicaid was intended to be elastic to respond to our changing populations in time of need. Parts of the NGA proposal worry me because it advocates raising premiums, deductibles, and co-payments, which could clearly make healthcare services unaffordable and out of reach for the Medicaid program's low-income population.

NGA calls it personal responsibility. But what about the low-income mother trying to care for her family by stretching her budget to cover housing, electricity, food, clothing, and now, increased cost-sharing and co-payments for medical care. I can assure you, these mothers are as familiar with personal responsibility and strapped budgets as any Governor in our Nation. I want to add my voice to those who say that the fact of the matter that tax cuts are a priority for this Congress and this Administration makes all the

other funding unavailable. And the root of the problem with Medicaid are the tax cuts, as is the root of the problem—all the other programs that we don't have enough money to adequately fund. So I thank you, Mr. Chairman. I look forward to hearing our witnesses.

Chairman BARTON. We thank the gentleman. The gentleman from Idaho wish to make an opening statement? Gentleman from California, Mr. Radanovich, wish to make an opening statement?

Mr. RADANOVICH. Thanks, Mr. Chairman. I waive.

Chairman BARTON. The gentleman from Texas, Dr. Burgess.

Mr. BURGESS. Mr. Chairman, in the interest of time, I will submit my statement for the record.

Chairman BARTON. All right. The gentlelady from North Carolina, Ms. Myrick.

Ms. MYRICK. No, I waive my time.

Chairman BARTON. Gentleman from Pennsylvania, Mr. Murphy.

Mr. MURPHY. Mr. Chairman, I will submit my whole statement for the record, but briefly, I just want to add that—

Chairman BARTON. The gentleman is recognized.

Mr. MURPHY. Thank you, sir. That with regard to this discussion, I am pleased that you are holding this hearing and the Governors are testifying, particularly because we need to change this discussion from who is paying to what we are paying for. What is incredible in America, our dirty little secret, is the amount of money we waste. And this has nothing to do with compassion. If we really want to talk about compassion, let us talk about what we waste. Every year in America from medical errors, every day in America, the number of deaths that occur is equivalent to a 747 flight going down. That is how bad it is. And a lot of these things are things Medicaid continues to pay for. If we have real compassion for our citizens, which we do, and I applaud the Governors for taking lead on it, let us stop the errors that are wasting money, that are causing deaths, that are causing more hospitalizations and more harm, and let us get down to the business of showing real compassion and fixing this for America. Thank you, Mr. Chairman.

Chairman BARTON. Okay. Gentleman from Maryland, Mr. Wynn, wish to make an opening statement?

Mr. WYNN. Thank you, Mr. Chairman. I will waive at this time.

Chairman BARTON. Gentleman from Texas, Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and I appreciate your holding the hearing on Medicaid reform and, again, having the Governors here, because Governors certainly have a large stake in Medicaid reform and deserve a seat at the table. Without a voice today are the folks who undeniably have the single largest stake in the Medicaid reform, and they are the beneficiaries. The beneficiary who would be most affected by the National Governors Association roadmap, particularly its benefit-targeting and cost-sharing proposals.

Medicaid was designed to provide healthcare to the most vulnerable populations that cannot afford healthcare, and frankly, do not have the means to share this cost. Faced with limited means and the cost-sharing requirements proposed by the NGA, Medicaid beneficiaries will likely avoid seeking necessary healthcare. The result would be poorer health outcomes, increased ER utilization, and

increased uncompensated care that would drive up health costs for all Americans.

In my State of Texas, the cost of treating the uninsured has caused the family insurance premiums to increase by \$1,500 in 2005. And make no mistake, Medicaid is the health insurer of last resort in our country, and if the NGA's Proposal takes away that safety net, then that population will go to our emergency rooms and continue to have uncompensated care. Mr. Chairman, I would like to have my full statement placed in the record.

Chairman BARTON. Without objection, so ordered.

Gentleman from Ohio, Mr. Strickland.

Mr. STRICKLAND. Mr. Chairman, Medicaid serves over 50 million low-income individuals per year, and that number continues to increase but at no fault of Medicaid, which actually provides services more cost-effectively than the private sector. The burden on Medicaid is increasing because people are losing their jobs, and therefore, their employer-sponsored health insurance. The burden on Medicaid is increasing because our population is getting older, and the elderly need long-term care. It would be an injustice not to put the Medicaid debate into a meaningful context.

We are searching for \$10 billion of savings in a program that serves the poorest, and spending one-half billion dollars a day in Iraq with no end in sight. We should search our hearts as we make these decisions. We sit here with salaries of more than \$150,000 a year. We have healthcare subsidized by the American taxpayer, and we are taking healthcare from the most vulnerable among us. It is a moral issue. Jesus said, "As often as you have done it unto the least of these, you have done it unto me." I yield back.

Chairman BARTON. The gentleman's time has expired. The Gentlelady from California, Mrs. Capps.

Ms. CAPPS. Thank you, Mr. Chairman, and welcome, Mr. Governor. Today we will hear proposals to change Medicaid. The advocates of these proposals will describe them as ways to improve Medicaid and expand its benefits. I heard this from the Budget Committee Chairman as well. Ultimately, the goal is to reduce costs. Reducing costs is a laudable goal, but only so long as it does not hurt the beneficiaries of the program. There are only two significant ways to cut costs in Medicaid: one is to kick people out of the program; the other is to eliminate covered benefits, which are already limited to services medically necessary. Medicaid beneficiaries are 28 million poor children, 16 million poor working parents, 6 million elderly and dying and disabled. They can't afford to pay more for healthcare. That is why they are on Medicaid. These approaches will add to the ranks of the uninsured. It will increase the amount of uncompensated care. Both are going to cost us a lot more in the long run. I yield back.

Chairman BARTON. Gentleman from Mississippi wish to make an opening statement? Okay. Gentleman from Maine, Mr. Allen.

Mr. ALLEN. Thank you, Mr. Chairman. I note that page one of the report of the Governors recognizes that the Medicaid program is extremely cost-effective compared to private sector healthcare. We are at an historic crossroads. Just 2 years ago Congress approved a \$10 billion FMAP increase. Now, we are facing a \$10 billion cut to Medicaid, even as the number of uninsured in our coun-

try has risen to 45 million. Cutting Medicaid would have a devastating impact on the most vulnerable in our society. It will unravel an already fraying health safety net jeopardizing support for providers like hospitals, clinics, doctors, and health plans that serve low-income people. With Medicaid funding half the Nation's nursing home care, cutting or block granting the program would jeopardize the quality of care provided to seniors and people with disabilities in the Nation's nursing homes. Maine will lose \$76 million over 5 years if this \$10 billion cut takes place. We need a better plan, and I hope you can help. Thank you.

Chairman BARTON. The gentlelady from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. Let us at least be honest today. This is not about money and it is not about reform. It is about priorities. And in this richest Nation in the history of the world, poor people, the most vulnerable people, are clearly not a priority for the Republican majority. We are not forced to make these cuts. We are doing it at the same time as we are giving billions of dollars in tax breaks to the wealthiest. In fact a trillion dollars in tax breaks to the 52,000 richest families in this country by eliminating the inheritance tax, while we are asking more of those who are already paying more out of their income for healthcare than we who are sitting right here. That is the reform—that we are going to ask these most vulnerable of Americans to pay more for healthcare than they do already. If we want to talk about reform, let us talk about provider abuse, or let us talk about waste. But what we are really talking about today in large part is taking money out of the pockets of persons with disabilities, low-income children, and pregnant women. This is wrong. I think we should start over and come up with a real plan for reform for Medicaid that provides our poor people what they need. Thank you.

Chairman BARTON. We thank the gentlelady. Does the distinguished whip of the committee, Mr. Shadegg, wish to make an opening statement?

Mr. SHADEGG. I waive.

Chairman BARTON. The gentlelady from California, Ms. Solis.

Ms. SOLIS. Thank you, Mr. Chairman, yes. I would like to commend you for having this hearing this afternoon, but I am also disturbed, because as you know, Medicaid provides healthcare coverage for over 50 million individuals currently. And 24 million of those are children. In fact one in three Latino children receives healthcare through Medicaid.

While plenty of Americans live without health insurance, programs like Medicaid are often the only means and only source of protection for families and children. Medicaid is so vital for many Americans and especially Latinos, fastest growing population, 9 million Latinos receiving healthcare through Medicaid.

We have all heard from our States about their cutbacks that they are proposing in their budgets. The impacts will be devastating on Medicaid, especially in the State of California. And at a time when States are seeing rising rates of Medicaid enrollment for children, we are proposing here to cut back. I think that is the wrong, wrong solution, and we need to come back at the table, organize, and make sure that we are more inclusive, and that we realistically

allow for States like California that have been able to meet unmet needs in a way that is very innovative, that we should really look at that and use that perhaps as a model. Yield back the balance of my time.

Chairman BARTON. The gentlelady yields back the balance of time. Chair comments that her outfit is the most photogenic yet on the monitor. That pink looks very good on television. I wouldn't recommend it. Does the gentlelady from Tennessee wish to make an opening statement?

Ms. BLACKBURN. Thank you, Mr. Chairman. Yes, I do, and I want to thank you for holding this important hearing. I also want to thank you for inviting my neighbors from Virginia and Arkansas, who are well aware of the many issues surrounding Tennessee. It is a decade-long Medicaid transformation, which is an expanded delivery system known as TennCare. And we have heard some about it this morning. And as you know, Tennessee is in the process of reducing our TennCare rolls by over 323,000 individuals. This program is based on unattainable expectations, poor cost estimates, and it has proven to be too much for our State's budget to bear. It is now over one-third of our State's \$26 billion budget. As I speak, the TennCare Bureau is mailing letters to enrollees throughout Tennessee notifying them of the dis-enrollment process. Having come from the State Senate in Tennessee to this position, I have all too familiar a working knowledge of the program.

I thank the chairman for addressing the issue before States are forced to take some of the same steps as Tennessee. I also appreciate the work of the Budget Committee and the resulting Budget Reconciliation Agreement that has brought the issue to the forefront. Without addressing needed reforms, the future of Medicaid is ominous. As Governor Warner mentioned earlier this year, and I quote him, "What is happening in Tennessee is a precursor to what is going to happen in every State in the country. It is just a matter of when."

Chairman BARTON. The gentlelady's time has expired.

Ms. BLACKBURN. Thank you, Mr. Chairman.

Chairman BARTON. The gentlelady from Wisconsin, Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman. I welcome today's opportunity to talk about Medicaid. And against the backdrop of continuous and repeated criticisms of the program, some of which are unfounded, I think it is important that we take a moment to focus on what Medicaid actually is. Medicaid is a last resort that prevents millions of Americans from joining the ranks of the uninsured. It is a safety net.

I also think it is important for us to remember that Medicaid truly serves a very low-income population. The current Federal poverty level for a family of four is \$19,350 a year. This is not a population that has additional resources to be able to afford increased co-payments or other cost-sharing mechanisms. I can imagine nothing worse than having to decide between the health of your sick child or food for your family.

Last, thank you, Mr. Chairman, for your earlier commitment to holding additional hearings on this topic that include the perspective of the beneficiaries.

Chairman BARTON. Does the gentleman from Michigan, Mr. Rogers, wish to make an opening statement? Okay. We are going to recognize Mr. Ross and give him additional time if he wishes to formally introduce his Governor to the committee.

Mr. ROSS. Thank you, Mr. Chairman. I would like to take this opportunity to thank the National Governors Association, the chairman-elect of the National Governors Association, Governor Mike Huckabee, from my own home State of Arkansas for being here with us today. Some people know this, some don't, but actually, not only are we from the same State, we are from the same hometown of Hope, Arkansas, both graduates of—

Chairman BARTON. Is everybody from Arkansas—

Mr. ROSS. [continuing] Hope High School.

Chairman BARTON. [continuing] from Hope, Arkansas.

Mr. ROSS. Well, there is about 10,000 of us, Mr. Chairman. Both graduates of Hope High School, although he graduated a few years before I did. We both worked at the same radio station growing up, and all I can figure out is while I was drinking from the water fountain by the library, he was drinking from the water fountain on the south side of the building because I am a "D" and he is an "R", but we do get along quite well, and I welcome him to the committee here today. When he finishes this term as Governor, he will be the longest-serving Governor at the current time in the Nation. And I had the privilege to get to know him when he was our lieutenant Governor and presided over the State Senate where I served for 10 years.

I would like to take this opportunity not only to welcome Governor Huckabee here today but to point out to this committee that Medicaid program is absolutely crucial to our home State of Arkansas. Recent numbers show that there are 717,000 Medicaid cases in our State. And, Mr. Chairman, to put that in perspective, that is one in five people in Arkansas that receive Medicaid. Over half the children in Arkansas are on Medicaid or have received Medicaid services in the last year, and close to 80 percent of Arkansas nursing home residents are paid for by Medicaid. I believe it is crucial that any changes or reforms to this program do not come at the expense of the necessary benefits that these individuals currently rely on. Any changes, any changes whatsoever that have the potential to shift these beneficiaries out of the program will only add to the number of uninsured and result in increased illnesses and higher healthcare cost.

And with that, Mr. Chairman, I want to thank you for giving me the opportunity today to introduce my Governor from my hometown of Hope, Arkansas, Governor Mike Huckabee.

Chairman BARTON. We see no other member who is a member of the committee present. The Chair is going to conclude the opening statements. The Chair would recognize Dr. Gingrey of Georgia who is not a member of the committee, but has asked to sit in and observe the hearing. He is not going to be allowed to ask questions, but we are appreciative of his presence.

We do want to welcome both of our Governors. We have Governor Huckabee of the great State of Arkansas and Governor Warner of the great State of Virginia. We are going to recognize Gov-

ernor Huckabee first since he was here first, and then Governor Warner.

I will say about Hope, Arkansas—I had a car break down in Hope, Arkansas on Bill Clinton Drive. I kid you not. And I went to the convenience store, and the lady that ran the convenience store took me to the auto parts store to pick up the part for the car and watched me try to fix it for 15 minutes and told me to get out of the way and she would fix it for me. And she did. And I told her that I was a Republican, and she said she didn't care. It was obvious that I didn't know what to do with my hands and she could make it happen. That is a true story on Bill Clinton Drive in Hope, Arkansas.

Now, Governor Huckabee, we do recognize you, sir. We are going to recognize you for such time as you may consume, which we hope will be less than 10 minutes. We are going to set the clock for 10 minutes. After we hear your testimony, we will recognize Governor Warner; then we will start the questions. We understand that you, Governor Huckabee, have to leave by 12:45. So welcome to the Energy and Commerce Committee. Your statement is in the record in its entirety, and we recognize you to comment on it. You have to push the little button to turn the microphone on. No, it is right on your microphone there.

Governor HUCKABEE. There we go.
Chairman BARTON. All right.

STATEMENTS OF HON. MIKE HUCKABEE, GOVERNOR, STATE OF ARKANSAS; AND HON. MARK WARNER, GOVERNOR, STATE OF VIRGINIA

Governor HUCKABEE. Maybe I need that lady that fixed your car to come turn this microphone on, Mr. Chairman. Mr. Chairman, thank you very much. And let me say a word of thanks to my friend, Congressman Ross from Arkansas. He and I do get along quite well, and it is a pleasure to work with him on issues there. From some of the comments it seems like Governor Warner and I and Congressman Ross and I get along a lot better than some of you guys do. Let me just say that.

But we are here today to present some proposals from some of the National Governors Association that really do represent not an ending point, but a beginning point, for how we can improve the quality of healthcare to the neediest citizens. We are not here to see if we can make it more difficult for people to get healthcare. We are not here to see if we can cut people off the rolls. We are not here to see if we can hurt people. Let me assure you, the last thing on earth any Governor wants to do is to hurt the people he has been elected to serve.

My wife and I participated in an activity for over two, almost 3 years where every single month we would go into the home and have dinner with a family who was on Medicaid. Why did we do that? Because we wanted to sit down and actually see and talk to them and ask them what problems do you have with the program? How would you fix it? How could you improve it? It was one of the most enriching experiences of our lives. The truth is, as a kid growing up, I wasn't many dollars away from being a person who would have been on Medicaid. The only reason I wasn't is because my

parents were too proud to have accepted it. They would have wanted to pay something in in order to access it.

Medicaid program is a great program. We are not here to criticize it. We are here to improve it. The fact is, it is a 40-year-old program. Next month will mark its 40th anniversary. For 40 years it has been a safety net, but a lot has changed in 40 years. 40 years ago the No. 1 song on the Billboard charts was the Beatles song "Help", probably a good anthem for today because that is why we are here, help. The top three television programs in America were "I Love Lucy", "Hazel", and "Bewitched". The average family income was \$5,900. A loaf of bread cost 21 cents. A gallon of gas cost 24 cents. A new Chevrolet cost \$2,350.

A lot has changed. Today, we are trying to run an MP3 health program on a 45 RPM standard. And we need to make some changes. We are here to present to you some changes that have come as a result of meticulous, tedious, and often very delicate work of 50 Governors, in particular, some 10 Governors who have worked very diligently on a taskforce, both Republicans and Democrats. What is remarkable about our proposals is that these discussions are not simply the consensus or even the work of a majority; they are the work of the unanimous consent of both Democrat and Republican Governors representing the full ideological spectrum, but all of whom share this common conviction: while we all want to continue helping the people of our States, we all recognize that the program, as it is currently designed, as it is currently administered, is unsustainable. We simply are asking for the opportunity to improve it, to reform it, to make it better.

There are 43 million Americans who don't have any coverage whatsoever. They are off the cliff. We want to make sure that with some reforms that we are presenting today, that it might be possible to better utilize the resources that you have and that we have so that rather than see how many people we can uncover, we can find creative ways to cover actually more people.

My colleague, Governor Warner, who has been an outstanding leader not only of the National Governors Association, but also of this effort, will be addressing some of the larger, broad-based concerns in a moment. But let me mention seven specific areas that I am going to touch upon ever so briefly that we are going to ask you to give us the opportunity to administrate.

Now, I would like to remind you that a few years ago there was a real concern when Governors brought welfare reform proposals to Congress. The attitude was this will be a race to the bottom. It will be a disaster if we give Governors that flexibility. Although people will be poorer than they have ever been, they will be just ruined. But the proof is that after having implemented those flexibilities in the very kind of programs we are asking you to give us with Medicaid reform, more people are at work and fewer are on welfare, and we have actually improved a system that was a hopeless nightmare for so many, many Americans. We ask you to give us that same consideration, recognizing that there are clear divides here in Congress.

But let me say emphatically we are not divided among the Governors. This is not simply a proposal that has strong majority presence among Governors and tepid acceptance on the part of the mi-

nority. This has unanimous support and strong support of all the Governors of all the States. That has not been an easy task to get us to that same place, and in part because Medicaid is not a program; it is 50 separate programs. And if there is one important message to get across to everyone across America is that it is not a one-size-fits-all. Every State plan is unique and different to that particular State. Even the reimbursements rates vary from State to State. And the components of what we consider to be the optional programs vary. That is why the reforms are delicate and difficult to come to. But these we have presented.

First, changing the prescription drug aspect by making the program more transparent and insuring that whatever reforms we have are not at the expense of the local pharmacist, who, in many cases, is the only point of service health provider in rural communities. All stakeholders in the prescription drug pharmacy issue should have a stake in helping to reform it, including the pharmaceutical companies, as well as the pharmacist and the State government. But the system is hopelessly and irreparably broken because it is non-transparent and is a system of gaining in the pricing structure that makes it impossible to appropriately administer. Give us the tools that any CEO managing a healthcare program would ask for, to better price those prescription drugs. That is what we ask for. We don't ask for you to give us the ability to cut people off, but to manage the resources so that people are getting the drugs they need at a price that makes sense.

Second, changes in the asset policy. There is a growing concern that many people are able, particularly those with great wealth because they can hire the best accountants and attorneys to shift their assets, to spin down and divest themselves so that they can become Medicaid eligible for long-term care. There needs to be reforms in that.

A third thing, modifying Medicaid's cost-sharing rules. I realize this is a sticky wicket for many. But let me assure you that many of our States have some serious evidence-based background in having some co-payment based on some services. We were able to actually reduce the number of uninsured children by more than 39 percent and lead the Nation, as a State of Arkansas, by expanding coverage to children but by having a very modest co-pay. We are not asking for families to have an undue burden. The burden would not exceed more than 5 percent of family income. What we have found—and, again, we have an 8-year record to base it on—is that families welcome the opportunity to be able to have some stake in the game and a sense of pride. And in addition to that, more importantly, we have been able to contain some of the unusual utilization when people go needlessly to the emergency room instead of waiting the next day to the clinic like I have to do on my State health plan.

The fourth is creating a benefit package flexibility. This simply allows States to perform targeted services in a more effective way.

The next proposal deals with developing comprehensive waiver reform. Waivers are complicated, they are often convoluted, they sometimes mean that rather than to expand services or to operate more efficiently, we spend months if not years trying to get permission to do something that would make, frankly, your budget easier,

but more importantly, would provide care to people who have nothing right now.

A very important area is judicial reform. And, frankly, this is foundation and fundamental to virtually everything else we are going to ask for. Right now, if we make reforms in our State plan, chances are we are going to get sued. We will go to Federal court, and two things will happen: the first thing is, the Department of Health and Human Services will abandon us and leave us to our own, not even so much as filing a Friend of the Court Brief; and the second thing that happens, we lose the lawsuit. We need some opportunity to deal with both the consent decree issue for States, as well as being able to make sure that if the Federal Government gives us permission and authority to do something, they at least will stick with us when we are sued over having done what they agreed to support.

And then to make some reforms in the way that the commonwealths and territories are created. Our colleagues who govern the territories are at an extraordinary disadvantage when it comes to the Medicaid program, and some of them are paying now as much as 80 percent of the cost, more than any of us as States, are paying. And while this is not a huge budgetary issue, it is a critical reform issue that needs to be addressed for the most vulnerable citizens of that State.

Mr. Chairman, we welcome your questions and the opportunity to engage in the debate with you today and the discussion, but we certainly come primarily with a sense of anticipation, excitement, and real hope that you will hear from those of us who administer these programs in our States and knowing that it is not our intention to see if we can hurt people. It is our intention to see what we can do to help people that we do care for. Thank you.

Chairman BARTON. Thank you, Governor Huckabee. Before we recognize Governor Warner, we have a distinguished visitor with us today. Congressman Brown's daughter is with us from Brooklyn. She is a graduate of Swarthmore College; she is a union organizer; she speaks fluent Spanish; she is here today to help her father in some discussions with some Central American dignitaries. If Emily would stand up and let us recognize her. We are always glad to have talent on the dais, even when it is—

Mr. BROWN. Especially when it exceeds out.

Chairman BARTON. [continuing] behind us. We want to recognize you, Governor Warner. We appreciate the strong work you have done on this issue. You, I believe, headed the taskforce of the Governors on this and have spent quite a bit of time on it. Congressman Boucher is not here to formally welcome you to committee, but I know that he speaks very highly of you. And were he here, he would tell you what a great job you have been doing as Governor of Virginia. So we also recognize you for such time as you may consume. We have set the clock at 10 minutes.

STATEMENT OF HON. MARK WARNER

Governor WARNER. Thank you, Mr. Chairman, and I will try not to take that full 10 minutes so that we can get into the question discussion. Let me also apologize for being a bit late. Your colleagues on the Senate side kept me a little bit longer with some

questions. We have been doing this tag-team effort today. And let me start by thanking my colleague and partner in this effort, Mike Huckabee, although, after hearing Mr. Ross' comments, is it actually the case if you are from Hope as well and Mike Huckabee—is every Arkansas elected official from Hope, Arkansas—

Chairman BARTON. That was what I asked before you got here.

Governor WARNER. But Mike Huckabee has been a great partner, and I want to reinforce what he has already said. This has been a long process to get to this document. We have had, literally, over 35 Governors and/or their Medicaid directors actively engaged in putting this document together. And none of the other Governors—while some of the others haven't fully participated—no one has opted out. So we truly do have a bipartisan proposal before you. It is a proposal that we all recognize is geared at making not only Medicaid more efficient, but also making sure that those Americans, both on Medicaid and equally important, those 45 million Americans without healthcare and those Americans on the edge who still have some form of health insurance that may be on the verge of being dropped onto the Medicaid rolls have a more efficient system.

Now, let me just again—Mike mentioned what he and Janet have done. Let me just put a little bit of my very briefly personal background. Before I became Governor, long before I was even involved in politics, one of the things I am proudest of, I started a healthcare foundation in Virginia back in 1992 when there were a million Virginians without healthcare, public/private initiative. We have helped 600,000 Virginians get healthcare. Great success story. Problem is, 2005, 13 years later, we still have a million Virginians without healthcare. So grappling with this issue is something that is terribly important.

Well, one of the things that I have been proudest of is during my tenure as Governor, we have taken our State, which had one of the worst records of signing up children for children's health insurance and aggressive changed the way we enlisted kids. We have actually even lowered the co-pays and eliminated in some case on this initiative. And now, we are up to 97 percent of our eligible kids being signed up and have recognized by Kaiser as—during the budget trough as one of the most effective States.

But even with those actions I want to echo what my colleague has already said; Medicaid as it is currently structured is not sustainable over the long haul, and we must find ways to improve the program. In Virginia in 1990 the Commonwealth was spending \$1 billion on Medicaid expenditures. Into this budget cycle we are going to be spending \$5 million. Now, I wouldn't mind that fivefold increase if we had actually substantially improved coverage or improved the quality of care. But too many times, unfortunately, we have not improved coverage or substantially increased payments to providers or expanded services. So we believe, as Governors—and let me give you a couple starting points since—when we started on the Senate side I started with the broad overview.

First, we believe this debate should be policy-driven and not budget-driven. And that has been the bipartisan consensus of the Governors. We strongly continue to oppose caps or a block granting of this program. This is a Federal-State partnership that should

continue. But we do recognize that we are going to need some additional efficiencies, that we are going to need some additional flexibility. Governor Huckabee went through some of the specific items.

Again, in terms of framing the problem very briefly, Medicaid expenditures now—and we went back and forth with some of your Senate colleagues on this—combined State and Federal Medicaid expenditures in aggregate outpace education expenditures, K-12. In some States, I believe Missouri, Tennessee, we are looking at 30, 33 percent of total State expenditures being driven on Medicaid. We in Virginia are down still about 15 percent because we are a very, very low reimbursement State. But we can see the increase lines.

And why is this happening? Well, we have seen, obviously, that Medicaid is increasingly serving a number of low-income, frail seniors, people with mental and physical disabilities. And this population, while it is only about 25 percent of our total caseload, drives about 70 percent of the costs.

Dual eligibles, one of those cost shifts that has kind of taken place over years, now make up about 42 percent of total Medicaid spending. We have seen increase in caseloads, and we are proud of the fact that we have upgraded our SCHIP program and what Mike has done with his program covering kids in Arkansas. But we are also seeing a series of other cost shifts going. We are seeing increasing numbers of employers decide to no longer provide health insurance, and in some cases, actually encouraging their workers to go on Medicaid rolls.

And in terms of long-term care, as Governor Huckabee mentioned, we cannot continue to be—with the baby-booming generation heading toward retirement—Medicaid cannot continue to be the single-largest by a manyfold factor provider of long-term healthcare insurance for, in some cases, two-thirds of our senior population.

So what we have laid out for you today is kind of a dual approach. And this is a starting point, let me make clear, not the ending point. Medicaid reform cannot be done in isolation as if it is some island inside the healthcare system. We have to look at this in an overall context. But at least in the short-term, not only in terms of some of the efficiency or reforms we are talking about, but we also think they need to be coupled with certain areas of reinvestment and certain other areas where we can prevent increasing populations from falling upon the Medicaid rolls. And let share with you some of those in fact non-Medicaid-related goals.

First—and I know folks on both sides of the aisle talk about this repeatedly, but it is my hope, as somebody who has spent 20 years in the technology industry, that we can move from talk to action, that we can finally bring the power of information technology to our healthcare system. It is remarkable in 2005 that we still don't have electronic medical records, that we have not used the efficiencies that IT have brought to every other sector of our economy, to the, what, 14, 15 percent of our economy that is made up in healthcare.

Second, we are open to looking at what we hope would be Federal tax credits for employers and employees, particularly on the employer side for small business, to create at least some modified

benefit package that can be available on the private insurance side so that folks on that margin that either fall in the uninsured category or are about to fall in the uninsured category can have some form of private health insurance that they can purchase. And we think we ought to be looking at stretching a little bit on purchasing pools and other tools to get the aggregate numbers we will need to provide health insurance for these individuals who otherwise, through no fault of their own, may fall upon the Medicaid rolls.

And third, we must change the whole framework on the long-term care debate. And part of that means changing the mindset of young folks when they start thinking about buying health insurance or life insurance, that they also purchase long-term care insurance. We would, again—I know that there is proposals on the House side, there are proposals on the Senate side to look at tax credits for incentives to purchase long-term care insurance. We support those.

We are also looking at other tools so that we can both with carrots and sticks look at this asset transfer issue in a broader context. At least in Virginia, we don't know how much of this, in an abuse way, is going on. But we do know it is kind of an all-or-nothing situation where too many middle-class adults are finding ways to perhaps dispose of Mom and Dad's assets before they go into a nursing home so they can be eligible for Medicaid. We have got to think about it in a different way. One of the things we are putting forward, for example, is the notion of reversed mortgages, reversed mortgages with an ability to keep at least some equity in your home that could be passed on to your heirs and perhaps use some of that other equity that has been built up to actually provide in-home care or other non-nursing home type care.

These are all tools that we think we need to move forward on outside of the kind of four walls of Medicaid if we are going to at least take a step toward making sure that this reform effort is really not budget-driven simply, but is actually policy-driven and driven at the goal of improving the quality of healthcare for our most vulnerable citizens. Thank you, Mr. Chairman.

[The prepared statement of Hon. Mike Huckabee and Hon. Mark Warner follows:]

PREPARED STATEMENT OF GOVERNOR MARK R. WARNER, CHAIRMAN AND GOVERNOR MIKE HUCKABEE, VICE CHAIRMAN, NATIONAL GOVERNORS ASSOCIATION

Mr. Chairman and distinguished members of the Energy and Commerce Committee. Thank you for requesting that we testify today on ways to address the significant challenges confronting the Medicaid Program. Today we are releasing a preliminary policy paper that outlines the recommendations of the National Governors Association for Medicaid Reform. The recommendations represent work by eleven governors on a Medicaid Working Group with additional input by most governors, including their Medicaid Directors. These recommendations are preliminary in that we will continue the working group over the next year so that we can complete our work and provide Congress and the administration with further clarifications of our policy as well as our further recommendations. We also look forward to working with the Medicaid Commission and have offered Secretary Leavitt the NGA Center for Best Practices to assist him in the Commission's work.

It is also important for us to stress the fact that we see today's release of policy recommendations as the beginning, not the end, of the process. We hope that both your committee and your staff will be willing to work closely with NGA and the working group governors as you develop policies to make the nation's public health insurance programs more efficient, accountable, and responsive. Given that this working group will continue, it will be able to not only provide you with more detail

on our recommendations, but also comment on alternative approaches you wish to discuss.

THE PROBLEM

It is difficult to overstate the impact of Medicaid on state budgets. It now represents about 22 percent of the average state budget and is a larger percentage than all elementary and secondary education. If you add health care spending for state employees and other programs, state health care spending totals about one-third of all spending, and is equal to spending on all education—elementary, secondary and higher.

The problems of Medicaid are three fold. First is that the Medicaid program is increasingly serving populations with very serious and expensive health care needs. Low-income frail seniors, people with HIV/AIDS, ventilator-dependent children, and other individuals with serious mental and physical disabilities represent only about 25 percent of the Medicaid population, but account for more than 70 percent of Medicaid's budget. The average cost of providing health care to seniors and people with disabilities is more than six times the cost of providing care to pregnant women and children. Medicaid provides expensive chronic care and long-term care services that are largely unavailable anywhere else in the health care system. Meanwhile, those who are dually eligible for both the Medicare and the Medicaid Program account for 42 percent of total Medicaid spending. Demographic trends suggest that these cost pressures will continue to increase.

Second, the caseload has increased 40 percent over the last five years. While much of this growth has been in the relatively healthy populations of pregnant women, children, and families—an influx of 15 million beneficiaries in a five year period presents a fundamental challenge to states.

The caseload has been rising as the percentage of people under age 65 covered by employer-sponsored health care is falling dramatically. At first this was due to declines in U.S. economy, but it has continued as the economy recovered because fewer of the new jobs being created offer health insurance. Small businesses in particular are finding it increasingly more difficult to afford health insurance for their employees. Families that are losing coverage are concentrated among low-income individuals primarily below 200 percent of poverty.

The population of seniors and people with disabilities, who already account for 70 percent of Medicaid's \$330 billion annual budget, will grow considerably over the next 20 years. Specifically, the over age 65 population will grow 64 percent, by 2020 and the over age 85 population will grow 3.1 percent per year over the next two decades. The Congressional Budget Office estimates that over the next ten years, growth in the elderly and disabled populations will comprise practically all of the Medicaid caseload growth.

However, since Medicaid is the primary safety net, unless something is done, the case load will continue to grow in the high single digit rate and perhaps even higher over the next two decades as increasing costs shift individuals from private coverage to Medicaid, or to the growing ranks of the uninsured.

The third problem is that the consumer price index for health care has been increasing 2 to 3 times the average price index. Medicaid, like all insurers, has been faced with these rising costs. It is the combination of these problems—caseload growth and health inflation—that makes Medicaid unsustainable in the short-run let alone the long-run.

THE VISION

The policies that are outlined in our paper do not represent comprehensive health care reform. Medicaid, however, is inextricably linked to the rest of our health care system and its payers. Consequently, the scope of our paper is wider than the existing Medicaid program as it focuses both on populations that may become Medicaid eligible as well as some underlying cost drivers in the overall health care system. In terms of Medicaid itself, this paper offers important short-term reforms that will help modernize, streamline, and strengthen this vital program.

The recommendations to make Medicaid more efficient and effective were not developed to generate any particular budget saving number. Instead, they were developed as effective policies that would maintain or even increase health outcomes while potentially saving money for both the states and the federal government.

The non-Medicaid recommendations had three goals. First, to increase quality and health outcomes by applying modern technology and accountability to our health care system. Second, to develop alternative, more effective policy tools that would assist individuals and employers to obtain and maintain private health insurance as opposed to having these individuals become Medicaid eligible. Third, to improve

financing and delivery of long-term care by developing incentives for quality private long-term care insurance products, community-based care, innovative chronic care management, and alternative financing approaches. Specific health care policies are organized around four objectives:

1. Reforming Medicaid
2. Enhancing quality and containing costs in the overall health care system
3. Strengthening employer-based and other forms of private health care coverage
4. Slowing the growth of Medicaid long-term care

REFORMING MEDICAID

The paper outlines several areas of reform which gives states additional flexibility to streamline their programs.

1. **Prescription Drug Improvements.** The current system is flawed and must be replaced. A number of policy changes must be enacted that will help decrease costs and improve quality and efficiency of care. The goal of reducing both state and federal expenditures will require policy changes that impact all segments of the pharmaceutical marketplace, including (but not limited to) increased rebates from manufacturers, reforms to the Average Wholesale Price (AWP), policies that increase the use and benefit of more affordable generic drugs, and tiered, enforceable co-pays for beneficiaries. States must have additional tools to properly manage this complicated and critical benefit.

2. **Asset Policy.** While Medicaid remains a vital source of long-term care coverage for many individuals who cannot receive that care elsewhere, there is growing concern that many individuals are utilizing Medicaid estate planners or other means in order to shelter or transfer assets and therefore qualify for Medicaid funded long-term care services. Medicaid reform must include changes that increase the penalties for inappropriate transfers, restrict the types of assets that can be transferred, and encourage reverse mortgages, as well as other policies that encourage individuals and their families to self-finance care rather than rely on Medicaid.

3. **Cost Sharing.** Medicaid's cost-sharing rules, which have not been updated since 1982, prevent states from utilizing market forces and personal responsibility to improve health care delivery. These provisions should be modified to make Medicaid look more like the State Children's Health Insurance Program (SCHIP), where states have broad discretion to establish (where appropriate) enforceable premiums, deductibles, or co-pays. As in SCHIP, there should be financial protections to ensure that beneficiaries would not be required to pay more than 5 percent of total household income (no matter how many family members are enrolled in Medicaid) as a critical balance to this proposal. For higher-income households (for example, those above 150 percent of the federal poverty level), a 7.5 percent cap should be applied.

4. **Benefit Package Flexibility.** Medicaid's populations are very diverse, ranging from relatively healthy families and children to the frail elderly, to individuals with serious physical and developmental disabilities. The types of services and supports needed by these populations are quite different, yet the Medicaid benefits package remains "one-size-fits-all." Many states have found that the flexibility built into the SCHIP program allows for greater efficiencies without compromising quality of care. Extension of this flexibility to services for appropriate Medicaid populations would allow states to provide more targeted services while managing the program in a way that prevents sweeping cuts in the future.

5. **Comprehensive Waiver Reforms.** Waiving various portions of the federal Medicaid statute has become the norm—rather than the exception—for states. Reforms are needed to increase efficiency and reduce costs, increase the ease with which states obtain current waivers, expand the ability to seek new types of changes, and change the federal statute to eliminate the need for many waivers altogether.

6. **Judicial Reforms.** The right of states to locally manage the optional Medicaid categories is clearly defined in both policy and law, and the federal government should remove legal barriers that impede this fundamental management tool. Also, U.S. Department of Health and Human Services officials should have to stand by states when one of their waivers is questioned in the judicial system and should work with states to define for the judiciary system that any state has a fundamental right to make basic operating decisions about optional categories of the program.

7. **Commonwealths and Territories.** The federal Medicaid partnership with U.S. commonwealths and territories has become increasingly unbalanced over a period of years, to the extent that some of the jurisdictions are financing over 80 percent of their Medicaid costs, and many of the Medicaid expansions such as transitional medical assistance are not available. The imbalance affects quality of care issues and creates increased financial stress. Medicaid reform needs to include a re-

view of the current relationship and the development of a pathway that moves to a rebalancing of this partnership.

ENHANCING QUALITY AND REDUCING COSTS OF THE OVERALL HEALTH CARE SYSTEM

We must increase the efficiency, productivity and quality of the entire health care system and believe that states are able to tailor solutions unique to their cultures, institutions and health care markets, but large enough to experiment with system wide reform. Accordingly, Congress should establish a National Health Care Innovations Program to support the implementation of 10 to 15 state-led, large-scale demonstrations in health care reform over a three- to five-year period. States would serve as the lead entity for these demonstrations, but they would have to partner with the private sector. Some of these demonstrations would be for statewide provider networks while others would be for networks in major metropolitan areas. Using information technology to control costs and raise quality would be a core objective of these demonstrations. The financing of these demonstrations should not come at the expense of Medicaid funding.

STRENGTHENING EMPLOYER BASED AND OTHER FORMS OF HEALTH CARE COVERAGE

Governors recommend a federal refundable health care tax credit for individuals as well as an employer tax credit for small employers. There is also a recommendation for the federal government to fund state alliances or purchasing pools which in combination with individual tax credits and the utilization of the S-CHIP benefit package for additional populations should also help create more competition in the health care marketplace. Finally, there is a recommendation to develop a catastrophic care/reinsurance model to address unsustainable "legacy costs."

SLOWING THE GROWTH OF MEDICAID LONG-TERM CARE

The paper includes a number of recommendations on assisting individuals in the purchase of long-term care insurance through the use of federal tax deductions and credits as well as by enacting long-term care partnership legislation. Finally, there are recommendations to address home- and community-based care and chronic care management.

STATE CONTRIBUTION TO THE MEDICARE DRUG BENEFIT

While Medicare beneficiaries have some guarantees, that on January 1, 2006 the Medicare program will begin in providing them with a drug benefit, states do not have the same guarantee that the fiscal burden will be lifted.

In some states, contrary to clear congressional intent, the phased down state contribution (clawback) provision will actually cause states to spend more in Medicaid. In addition to their mandatory clawback payment, some states will also face increased costs from the administrative burdens of the new law.

Mr. Chairman, let me again thank you for the opportunity to appear before you. The nation's Governors look forward to working with you closely to begin the process of reforming the Medicaid program. As currently structured it is unsustainable.

MEDICAID REFORM

A PRELIMINARY REPORT FROM THE NATIONAL GOVERNORS ASSOCIATION

June 15, 2005

Medicaid is the nation's largest health care program, providing health and long term care services to 53 million low-income pregnant women, children, individuals with disabilities and seniors. It is a vital health care safety net and provides important services to those who can get care from no other source. Medicaid coverage has also played a critical role in reducing the number of the uninsured, currently estimated at 45 million nationwide.

Medicaid spending, however, has increased dramatically over the last five years driven by a 40 percent increase in caseload and a 4.5 percent per year increase in the health care price index, strengthening the impetus for reform. Comprehensive Medicaid reform must focus both on reforming Medicaid and on slowing both the number of low-income individuals and elderly becoming eligible for Medicaid. Medicaid will always have an important role as the health care safety net, but other forms of health care coverage must be strengthened to ensure Medicaid's financial sustainability. Enhancing the quality of care and containing costs are also critically

important. Governors believe that Medicaid reform must be driven by good public policy and not by the federal budget process.

The Vision

The policies that are outlined in this paper do not represent comprehensive health care reform. However, the scope is wider than the existing Medicaid program as it focuses both on populations that may become Medicaid eligible, as well as some of the underlying cost drivers in the overall health care system. In this sense it can be viewed as Medicaid plus health care reform. The various policies that are recommended are linked by a number of themes that underline this reform package. First, there are a number of incentives and penalties for individuals to take more responsibility for their health care. Second, moving to a more flexible benefit package for non elderly, non disabled Medicaid populations as well as for individuals who gain access through the individual health care tax credit will reduce costs while increasing total access. Third, the creation of state purchasing pools, that would use the combined leverage of public programs (offering a common S-CHIP-type benefit package) and individuals using the health care tax credit should strengthen the ability of small purchasers to gain more competitive rates in the health care marketplace. Fourth, technology and other state innovations are focused on reducing the long-run costs. Fifth, there are a number of policies designed to reduce reliance on Medicaid coverage. Finally, the paper includes a number of potential short-run policy changes as well as long-run structural changes that will improve the US health care system.

Specific health care policies are organized around these five objectives:

1. Reforming Medicaid
2. Enhancing Quality and Reducing Costs in the Overall Health Care System
3. Strengthening Employer-Based and Other Forms of Private Health Care Coverage
4. Slowing the Growth of Medicaid Long-Term Care
5. State Contribution to the Medicare Drug Benefit

1. Reforming Medicaid

Medicaid now covers 53 million Americans and the program is expected to spend a total of \$329 billion in combined state and federal funds in 2005. While the Medicaid program is extremely cost effective compared to private sector health care, the existing program structure is inflexible and the benefits are not necessarily consistent with the needs of the various populations. This paper focuses on both short-run flexibilities that could help states realize incremental savings and a major restructuring that would be necessary to make the program sustainable over the long-run.

Long Term Restructuring

Although Medicaid is the largest health care program in the nation, generalizations about the program are difficult to make, because it operates so differently in each of the states and territories. In addition, Medicaid is even more complicated than 56 different programs, because within each state, Medicaid plays a number of very distinct roles while serving a number of very distinct populations.

Medicaid essentially has three major functions:

- It provides comprehensive primary and acute care coverage for everyone who is eligible for the program (low income children, parents, seniors, and people with disabilities);
- Some Medicaid beneficiaries also qualify for comprehensive long term care services, depending on their needs; and
- Medicaid also helps finance services for people with chronic and disabling conditions such as HIV/AIDS, severe mental illness, and MR/DD. Each of these populations relies on Medicaid for support that they cannot receive elsewhere, and Medicaid restructuring must consider their unique needs and circumstances.

Although Medicaid does serve these three major roles, it also serves other functions such as a source of funding for uncompensated care in hospitals, and as a supplement to Medicare for low-income beneficiaries for whom it pays cost sharing and wraps around for various services in addition to long-term care.

Medicaid is serving many roles in the health care system. All of these roles could be improved upon by a greater focus on wellness and health promotion as opposed to simply "sick-care" treatment. These goals can be achieved by relying more heavily on care management and coordination.

- For low-income, but relatively healthy individuals who rely on Medicaid as a health insurance product, Medicaid should be transformed into a more

mainstreamed, S-CHIP type program that could be coordinated with state and federal tax credits.

- For individuals with disabilities who have no other recourse than to rely on Medicaid, reforms should encourage more consumer choice and benefit packages that improve the quality of their care where possible, but not jeopardize their stability of care.
- A new national dialogue is needed to confront the issues of an aging population and the potential sources of funding for end-of-life care. The easiest solution may be to incorporate long-term care services into Medicare, but an alternative approach could be to link long-term care funding to Social Security, or broader pension reforms or other changes to solidify the link between personal responsibility and end-of-life care.

What is clear is that Medicaid can no longer be the financing mechanism for the nation's long-term care costs and other costs for the dual eligibles. Approximately six million Americans are dually eligible for full Medicare and Medicaid benefits, and another one million receive financial assistance to cover out-of-pocket costs, such as co-payments and deductibles. These individuals represent a small portion of Medicaid's 53 million person caseload, and despite the fact that they are fully insured by Medicare, they still consume 42 percent of all Medicaid expenditures. Compared to other Medicare beneficiaries, dual eligibles are sicker, poorer, more likely to have chronic health conditions, and at higher risk for institutional care.

The details of this restructuring, however, are beyond the scope of this paper. The nation's Governors will continue to work on this issue and will be providing further detail.

Short-Run Flexibilities

A. Prescription Drug Improvements—States and the federal government have long suspected that Medicaid overpays for prescription drugs. The President's budget proposes to set federal ceilings on the prices that states pay for prescription drugs. The proposal would change the current system, whereby states purchase drugs based on the Average Wholesale Price (AWP). States have long been concerned that manufacturers have been inflating this number and that Medicaid has therefore been overpaying for drugs for many years. The President's proposal would establish a new price target for states, the Average Sales Price (ASP) that would be defined by law, subject to Federal audit, and lower than AWP. States would be allowed to reimburse pharmacies no more than ASP plus six percent (to account for dispensing fees and other costs) for all generic and brand name drugs.

Governors believe that the burden of reducing Medicaid expenditures for prescription drugs will require a multi-prong approach and should include savings proposals that affect both drug manufacturers and retail pharmacists, as well as increase state utilization management tools that decrease inappropriate prescribing and utilization. It is critical that states maintain and enhance their ability to negotiate the best possible prices with the industry.

There may be benefits of using ASP or other calculations as a reference price, because increased transparency of drug costs can serve to decrease total costs, especially if there is more flexibility with respect to dispensing fees (they should not be tied to a percentage of the cost of the drug dispensed, for example.)

This proposal should be modified in several ways:

- *Increasing the minimum rebates that states collect on brand name and generic prescription drugs to ensure lower total costs that would not solely impact pharmacists nor create disincentives to provide generic drugs where appropriate. Medicaid's "Best Price" provision should not be eliminated in exchange for this;*
- *Requiring that "authorized generics" be included in the Medicaid rebate calculations. An authorized generic is a brand product in different packaging that some manufacturers distribute through a subsidiary or third party at the same time that a true generic is launched by a generic manufacturer. This product is essentially a brand product at a cheaper price, but it violates the Hatch-Waxman 180 day exclusivity protection for generic manufacturers, and because CMS does not include these products in the Medicaid rebate calculations, it results in hundreds of millions of dollars in lost revenue for state Medicaid programs.;*
- *Forcing discounts on the front end of drug purchases rather than waiting an average of six months (not including dispute time) to receive rebates;*
- *Using closed formularies to drive beneficiary utilization and decrease costs similar to those that will be used by Medicare Part D plans;*
- *Giving states additional tools such as tiered co-pay structures to encourage greater utilization of generic drugs;*

- *Enacting stronger sanctions (including criminal penalties) for companies and individuals that fail to accurately report ASP (or whatever new methodology is adopted);*
- *Allowing states to join multi-state purchasing pools and to combine Medicaid with other state-funded health care programs to improve leverage; and*
- *Allowing managed care organizations to access Medicaid rebates directly for the Medicaid populations that they serve.*

B. Asset Policy—

Asset Transfers. There is concern that many individuals are utilizing Medicaid estate planners in order to shelter assets and therefore qualify for Medicaid funded long term care services. Examples of such estate planning approaches include:

- *Sheltering assets in trusts, annuities and other financial instruments that are then deemed as “not available to the Medicaid beneficiary;”*
- *Converting “countable assets” under the law into “exempt assets”; and*
- *Transferring assets through joint bank accounts or other means to close relatives.*

Under current law, when an individual applying for Medicaid has transferred assets within the three year “look-back” period, the amount of those transfers are used to calculate a period of ineligibility for Medicaid. This period of ineligibility is determined by dividing the total amount of the assets transferred by the average monthly cost of nursing home care in a given service area. For example, if an asset worth \$40,000 is transferred during the look-back period and the average costs of nursing home care is \$5,000 per month, then the individual would be subject to an eight-month waiting period to receive Medicaid eligibility. This period of ineligibility, however, begins on the date of the actual transfer of the asset, and by the time the person actually applies for Medicaid, that period has often expired.

The President’s budget proposes to change the rules regarding penalties for individuals who transfer assets in order to become eligible for Medicaid long term care. The proposal would begin that penalty period on the date that the individual enters the nursing home or becomes eligible for Medicaid, whichever is later.

This approach should be encouraged and a number of other similar approaches should be explored around assets transfers to prevent estate planners from simply moving to alternate schemes. Other approaches to address inappropriate transfers could include:

- *Increasing the look-back period from three years to five years (or longer);*
- *Limiting the amount and types of funds that can be sheltered in an annuity, trust or promissory note*

In all cases, these changes should be federal requirements, although there should be ability to “opt-out” of the federal guidelines if the state can prove that existing policies would meet the intent of the law. Furthermore, there should be some resource threshold, e.g., \$50,000 and indexed in future years, below which assets transfers would be exempted, as well as policies in place to protect individuals with dementia or others at risk of being exploited.

While this approach should provide some savings by preventing inappropriate transfers, state officials will need many more tools in order to fully address the growing long-term care crisis in the Medicaid program. Many of these other approaches are addressed in the long-term care section below.

Reverse Mortgages. This is another tool that could help prevent individuals with considerable assets from depending upon Medicaid. According to the U.S. Census Bureau, 81 percent of seniors own their homes and 73 percent own them free and clear. This represents \$1.9 trillion in untapped home equity that is currently exempted from Medicaid’s eligibility calculations. According to the National Council on Aging, 48 percent of America’s 13.2 million households age 62 and older could get \$72,128 on average from reverse mortgages, and “in total, an estimated \$953 billion could be available from reverse mortgages for immediate long term care needs and to promote aging in place.”

This proposal would create an incentive and a new allowance for individuals to pursue reverse mortgages in order to pay for long-term care services (in addition to private long term care insurance, which is currently allowed). Any person who obtained a reverse mortgage under this proposal would be able to shelter \$50,000 (or some other appropriate amount that would be indexed to inflation) in equity from their house without incurring penalties. Other incentives to encourage reverse mortgages should be contemplated. Broader use of reverse mortgages would be both an effective way to reserve Medicaid funding for those who have truly exhausted all of their other means, and a way to provide more consumer-directed options for seniors to choose from in developing their own long-term plan of care. The number of individuals currently on Medicaid who own their own homes is relatively small and this proposal would not likely affect them, so immediate savings would be limited. How-

ever, the major impact of this proposal would come from restraining the future growth of the program and in fostering a greater sense of personal responsibility with respect to end of life financial planning.

Other similar approaches could include requiring some form of family contribution to the costs of long-term care. Similar methods of “deeming” family income are utilized by states in their child support systems and might not be difficult to implement for Medicaid. In any case, provisions should be made to allow individuals to pass along some portion of their assets/resources to family members without incurring penalties. This would allow the balancing of both the needs of an ownership society with the responsibility of family to provide for the care of their loved ones.

C. Cost Sharing—Current law prohibits co-payments for some populations; for some services like family planning and emergency care; restricts co-pays, where allowed, to a maximum of \$3; and ultimately treats cost sharing as unenforceable if the beneficiary cannot or will not pay. These rules, which have not been updated since 1982, prevent Medicaid from utilizing market forces and personal responsibility to improve health care delivery.

A new vision for cost-sharing should make Medicaid look more like S-CHIP, where states have broad discretion to establish any form of premium, deductible, or co-pay for all populations, for all services, and could make them enforceable. As in S-CHIP, financial protections to ensure that beneficiaries would not be required to pay more than 5% of total family income (no matter how many family members are in Medicaid) are a critical balance to this proposal. For higher-income households (for example, those above 150% FPL) a 7.5% cap could be applied, as under the current HIFA waivers.

States would have broad latitude to waive these types of cost-sharing for any populations or services that it determines would be negatively impacted by such policies. The purpose of increased cost sharing is not to restrict access to necessary medical care, but to allow individuals to contribute to the costs of their own health care as much as possible. These new policies would be monitored and evaluated heavily and if the evidence shows that increased cost-sharing harms appropriate access, the policies should be revised.

D. Benefits Package Flexibility—The Medicaid program is viewed as the health care program for the poor, but it neither serves all poor people, nor are all of the beneficiaries below the federal poverty level. Medicaid’s populations are very diverse, ranging from relatively healthy families and children to the frail elderly, to individuals with serious physical and developmental disabilities. The types of services and supports needed by these populations are quite different, yet the Medicaid benefits package remains “one-size-fits-all.”

Many states have found that the flexibility built into the SCHIP program allows for greater efficiencies without compromising quality of care. Extension of this flexibility to services for appropriate Medicaid populations would allow states to provide more targeted services while managing the program in a way that prevents sweeping cuts in the future.

Medicaid reform should include the ability to offer a different level of benefits, using S-CHIP as a model, to certain Medicaid beneficiaries, such as those for whom Medicaid serves as a traditional health insurance program. This discussion extends beyond the traditional distinction between “mandatory” and “optional” populations, which are arbitrary distinctions when it comes to the need for health care services. This would include an improved ability to set benefit limits and cost sharing amounts, do employer buy-in programs, eliminate retroactive eligibility periods, and establish different benefit packages for different populations or in different parts of the state. Medicaid can be improved by focusing more on improving health outcomes rather than adhering to a sometimes-arbitrary list of benefits mandates (that are often the result of effective lobbying by provider interest groups).

Many relatively healthy kids and families are technically mandatory, and many of the optional populations, such as the Medically Needy, are among the frailest in the program. Reform must therefore acknowledge that there are people served by Medicaid that need a comprehensive package of benefits. For more medically fragile populations, changes in the benefit package should be made to encourage more chronic care management and other services that can improve health outcomes and reduce costs.

E. Comprehensive Waiver Reforms—Waiving various portions of the federal Medicaid statute has become the norm, rather than the exception for states. HHS officials routinely describe that they consider thousands of state waivers every year. Yet, despite all this action, states must still jump through significant hoops in order to make relatively minor changes to their Medicaid programs, and often, major changes are simply outside the scope of the current waiver authority. Reforms are needed to increase the ease with which states get current waivers, expand the ability

to seek new types of changes, and change the federal statute to eliminate the need for many waivers altogether.

The most commonly waived portions of the Medicaid statute are those requiring that beneficiaries have “freedom of choice” of provider, and that services be comparable, statewide, and consistent with respect to amount, duration, and scope.

- The federal statute should change to reflect these commonly waived and antiquated provisions by allowing states to innovate in these areas through the state plan amendment process.
- Similarly, 1915(b), 1915(c) and PACE waivers should be administered through the state plan process, not waivers. It is critical in this scenario that these waivers retain the basic protections of the waiver, such as the ability to control costs and utilization common to the 1915(c) waivers. The state plan amendment process should include check boxes for typical waived items so that States could continue to target these services on the issues of comparability, statewideness, and amount, duration, and scope. States would realize cost savings because services would be implemented sooner and States would reduce administrative costs associated with waiver development, cost effectiveness/budget neutrality, reporting, and the waiver amendment/renewal process.
- In addition, streamlining the waiver process for all states that choose to pursue larger reforms and innovative programs would be a helpful improvement.
- Allowing states to easily receive approval to try an approach already tested successfully in other states would be one improvement.
- Automatically converting a waiver to a state plan after the first renewal would be another, as would a consistent 5 year approval/renewal period.
- Many promising innovations in Medicare/Medicaid integration or care coordination are never implemented because of outdated notions of siloed budget neutrality requirements. The requirement for budget neutrality should be waivable at state option and the statute should also allow for states to consider savings to the Medicare and other federal programs when considering the impact of Medicaid changes.
- States that wish to make substantial improvements to their Medicaid programs may find that some portions of the statute are not waivable at all. States should be allowed to apply for “superwaivers” that envision much broader changes than can be achieved under the current 1115 waiver structure. Such waivers should allow states to develop effective programs that meet the unique needs of their citizens.

The State of Arizona has operated its Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), through a Section 1115 waiver, since the inception of Arizona’s participation in Medicaid in 1982. There are many lessons to be learned to reduce costs from Arizona’s experience. All Medicaid eligible persons are enrolled into managed care plans that AHCCCS contracts with using competitive bidding to maximize market forces. Market forces drive quality while holding down costs. Several states have demonstrated success with this model, and others should look to it to contain costs.

F. Judicial Reforms—The right of states to locally manage the optional Medicaid categories is clearly defined in both policy and law, and the federal government should remove legal barriers that impede this fundamental management tool. To that end, Congress and HHS should authorize states to rightfully make basic operating decisions about optional categories of the program.

Federal judicial actions have sometimes become a means by which the judicial branch makes decisions about Medicaid programs that should be left in the hands of state elected officials and competent program managers. If the management of the Medicaid program is being handled in a manner that is consistent with legislative and congressional intent, the court system should not become involved.

These court actions sometimes conflict with the policy positions of state and local officials and go beyond addressing the specific problem that was the basis of the initial lawsuit. These court actions fit into two broad categories:

- Consent decree cases
- Court decisions based on a specific case that have an adverse affect on the state Medicaid program as a whole

These court decisions can remain in place for decades and institutionalize the policies of elected officials who have long since left office. For example: Arkansas cannot make any change in fees paid to physicians without going back to court to remain in compliance with a consent decree entered into between the state and the Arkansas Medical Society in 1993. These court actions also create an environment where state time and resources that could be spent on the greater good of the whole program go toward reducing the impact of the specific court decision.

Federal reforms are needed to constrain the broad ability of judicial decrees in Medicaid cases that clearly impede state innovation and reform. In a time of shrinking resources and growing demand it is not realistic to ask states to manage these complex programs with court decrees overriding sound management decisions.

These court decisions and the subsequent legal actions that follow, increase administrative costs and divert valuable resources that could be far better spent on services to clients.

G. Commonwealths and Territories—The federal Medicaid partnership with U.S. commonwealths and territories has become increasingly unbalanced over a period of years, to the extent that some of the jurisdictions are financing over 80 percent of their Medicaid costs, and many of the Medicaid expansions such as transitional medical assistance are not available. The imbalance affects quality of care issues and creates increased financial stress. Medicaid reform needs to include a review of the current relationship and the development of a pathway that moves to a rebalancing of this partnership.

2. Enhancing Quality and Controlling Costs in the Overall Health Care System

America's current health care system is ripe for improvement and states are ready to take the lead in helping drive change. States are small enough to tailor solutions unique to their cultures, institutions and health care markets, but large enough to experiment with systemwide reform. States can also partner effectively with health care providers, insurers, and purchasers to lead large scale pilot projects.

We must increase the efficiency, productivity, and quality of our entire health care system, which will increase the opportunities for reasonable coverage expansions. Like welfare reform a decade ago, states can play a lead role in driving this transformation through demonstration projects in partnership with the private sector.

Accordingly, Congress should establish a National Health Care Innovations Program to support the implementation of 10 to 15 state-led large-scale demonstrations in health care reform over a 3-to-5-year period. Using information technology to control costs and raise quality would be a core objective of these demonstrations. States would serve as the lead entity for these demonstrations, but they would have to partner with the private sector. Some of these would be for statewide provider networks while others would be for networks in major metropolitan areas. They would focus on:

- deploying information and communications technology, including interoperable electronic health records (EHRs) accessible to all participating providers and patients, to improve services;
- improving quality of care, including disease prevention and management, through establishment of evidence-based practices, measuring outcomes, and pay-for-performance programs;
- using innovative strategies to cover many of the Americans who currently lack health benefits;
- empowering consumer choice through price transparency, quality reporting, and financial incentives; or
- reducing malpractice incidents and improving adjudication of malpractice claims.

Each demonstration project would be selected through competition and encouraged to demonstrate multiple innovations. All projects would need to emphasize the goal of increasing cost-effectiveness and, to the extent possible, improving health care quality.

For a more comprehensive discussion on this issue, see the NGA white paper on health care reform demonstration programs.

The financing of any of these solutions should not come at the expense of Medicaid funding.

3. Strengthening Employer-Based and Other Forms of Private Health Care Coverage

Between 2001 and 2003, the proportion of Americans under the age of 65 covered by employer-sponsored health care dropped from 67 percent to 63 percent. While some of this reduction could be cyclical due to the economic downturn, many argue that the increase is more structural, as the U.S. economy is becoming more service and small business oriented and more competitive in the ever more global marketplace. Several policies could assist in reducing the number of individuals losing health care coverage. The financing of any of these solutions should not come at the expense of Medicaid funding.

A. Individual Health Care Tax Credit—A refundable tax credit could be developed that would be available to all low-income individuals below some income threshold, e.g., \$3,000 for a family of four with incomes below \$25,000, which is phased-out

at income levels of \$60,000. This credit would be a premium subsidy that could be paid directly to a health care plan by the U.S. Department of the Treasury. Unlike the trade assistance program that targets unemployed workers, eligible workers that could receive tax credits could have their employers deduct payments from wages and send them directly to the U.S. Treasury who would combine those funds with the tax credit, confirm eligibility, and forward the payment directly to the health plans.

To increase the use of the tax credit, the federal government could also mandate presumptive eligibility so that individuals would have to opt out as opposed to opting into the system. It is critical that this subsidy be set at the appropriate level. If it is too low, there will be few individuals who could use it; and if it is too high, then it would be an incentive for businesses to stop providing employer-paid health care. It is also critical that the level have the appropriate relationship with any credit for small employers. The credit would be available for all individuals who meet the income criteria and are not participating in an employer-paid or public program. Individuals who qualify for both Medicaid and the tax credit would be able to choose between the two. States should also be allowed to enhance the tax credit. One option would be to allow states to use disproportionate share funds for the enhancement.

Because this is a refundable tax credit it is reflected in the federal budget as an outlay as opposed to a reduction in revenues. This opens up the potential option for the states to apply for a waiver that would allow the funds to come directly to the states based on a plan that would maximize health care access. For example, the Michigan Third Share program, which has equal amounts paid by employers, employee, and government, could utilize these funds for the government share. Such a waiver option would allow individual states to tailor the funds to their unique labor force and health care marketplace. Such a tax credit also equalizes tax treatment of all individuals with regard to health care. This tax credit can also be designed to allow individuals to buy into the S-CHIP benefit or to otherwise require that the credit only be viable when used to purchase some basic, threshold benefit, as defined by the state. It is difficult to determine how many individuals would use a tax credit of this nature.

B. Employer Tax Credit—A new employer tax credit would be developed for small firms, i.e., up to 100 workers. The employer tax credit would be about \$200 per individual or the amount necessary to make the federal contribution necessary to enact this policy the same as that necessary to enact the individual tax credit. The policy rationale is to equalize the tax treatment between the individual tax credit and the employer-based tax credit. Unlike the Administration's proposal, it would not be restricted to employer contributions to Health Savings Accounts. The employer tax credit would be restricted to only workers below a given wage rate. The amount of the credit, the targeting, and the relationship to the individual tax credit are key in order to support the employer-based system, as opposed to providing incentives for employers to reduce coverage. Also, the state should be able to designate the minimum benefit package to be eligible for the tax credit. This credit would be reflected as a reduction in revenues to the federal government.

C. State Purchasing Pools—The federal government would make grants to states to create state purchasing pools. In the past, states have experimented with purchasing pools, but most have failed because they were never large enough to avoid risk-selection and ended up becoming high risk pools that were subsidized. Specifically, there was a financial incentive for healthy individuals to obtain their insurance outside the pool. Currently, the Federal Employees Health Benefit Program (FEHBP) and the small firm purchasing alliance in California (now called Pac Advantage) are existing purchasing pools. Permitting states to develop an SCHIP benefit package for their non-disabled, non-elderly Medicaid population, and including the same benefit package for the individual health care tax credit, should allow them to create a large enough pool (mostly in metropolitan areas) to negotiate effective rates.

To avoid adverse risk, states should be allowed to mandate that both populations be part of the purchasing pool. States will need the discretions to design their purchasing pools. This will include health plan qualifications, underwriting, rating rules, and enrollment rules. The pool could be the mechanism for Medicaid women and children, SCHIP, state employees, COBRA options, and the tax credit as well as any private firm, particularly small business that purchases health care in the state. This could have the added benefit of stabilizing the individual and small group market. Such a large pool could also maximize consumer choice. The President's budget includes this proposal.

D. Catastrophic Care/Reinsurance Model to Address Unsustainable "Legacy Costs"—Numerous employers in the U.S. have been consistent, reliable partners

with their employees on health insurance coverage, yet their ability to continue providing this coverage to retirees (“legacy costs”), current employees, and their families—amidst rising national health care costs—is becoming a distinct competitive disadvantage. Catastrophic care, chronic diseases, and serious illnesses contribute significantly to the overall cost of health care and should be addressed. While more attention and resources must be focused on wellness and disease management programs as well as best practices to ensure quality care, some bold options that offer uniquely American solutions for our American legacy cost challenges are needed. The following are two concepts to consider—one that is employer pools and another that is insurance pools. A hybrid could also be considered.

One option is to create a reinsurance pool whereby employers and other payers would be reimbursed by the federal government for part of the cost of catastrophic medical bills of their employees. To be involved in this program, employers could be required to provide health care coverage equivalent to a benchmark plan to all of their employees and/or provide preventive and disease management programs to better manage care and improve quality and care.

Another option to explore more fully is a national “Healthy Mae,” as Senator Frist refers to it. The senator believes that a “Healthy Mae” model, fashioned after Fannie Mae, would help insurers more broadly share risk, reduce administrative costs, and create a vibrant secondary market for health insurance just as the U.S. has done for home mortgages. Potentially a publicly-chartered private insurer, “Healthy Mae” could help create a big secondary market for health insurance and would reduce the financial burden on employers when their workers’ medical bills rise above a certain threshold. “Healthy Mae” would be designed to give buyers access to a more stable insurance market—which presumably would feature lower rates that could keep more people covered.

4. Slowing the Growth of Medicaid Long-Term Care

Medicaid has quietly over the years become the nation’s largest payer of long-term care services, funding approximately 50 percent of all long-term care spending and nearly two-thirds of all nursing home residents. With the anticipated demographic changes, the potential liability for future long-term care costs can only grow. While Medicaid reforms over the past twenty years have focused on improving the long-term care benefit (eliminating the institutional bias, encouraging consumer-directed care, etc), new efforts need to focus on how to encourage personal responsibility and discourage the reliance on Medicaid financed long-term care. Ultimately, a new national dialogue is needed to confront the issues of an aging population and the potential sources of funding for end-of-life care.

The following two policies could help slow the growth of elderly enrollment in Medicaid.

A. Tax Credits and Deductions for Long-Term Care Insurance—Currently, about 28 states provide deductions or tax credits for long-term care insurance. The federal government currently allows tax deductions for the purchase of insurance, but only if the premium amounts exceed 7.5 percent of an individual’s adjusted gross income. Only 11 percent of the population age 65 and older and 8 percent of those between ages 55 and 64 have a long-term care policy in effect.

The potential impact of deductions and tax credits is very different, since they impact quite different income groups. The deduction is more effective in stimulating the purchase of long-term care insurance since it is more valuable to younger, higher-income individuals in higher tax brackets. Because these individuals may allow policies to lapse and because they are less likely to enroll in Medicaid, they do not provide the maximum possible relief to Medicaid per lost dollar in federal tax revenues. On the other hand, tax credits can be better targeted to lower-income individuals who have a higher probability of becoming Medicaid eligible. This will lead to more relief in Medicaid spending. A December 31, 2001 report by ABT Associates indicated that Medicaid saves \$1.16 and \$2.67 respectively in 2025 and 2050 for every dollar lost due to federal tax credits. Tax deductions do not break even. A combination of a significant tax credits, e.g., \$2,000, and a small deduction, e.g., \$200, might be the most effective in lowering Medicaid costs. States, through their capacity as regulators of insurance, set minimum standards and other guidelines for any such policy that could be obtained through the tax credit.

The Treasury should also develop some mechanism so that individuals can receive the credit when they pay the premium to avoid the long delay between payment and reimbursement via annual tax submissions. Tax credits are particularly effective to the federal government as well as states due to the potential Medicaid savings. Because this credit focuses on the very expensive population in long-term care, potential Medicaid savings are significant. The federal government may also want to mandate that all firms who provide 401(k) and other pensions provide an option to

convert a portion of an annuity into long-term care insurance. This tax credit would be reflected as a revenue reduction in the federal budget. As of 1998, there were \$9.5 trillion in qualified retirement plans, some portion of which could ultimately be used for long term care financing.

B. Long Term Care Partnerships—Four states (California, Connecticut, Indiana, and New York) have been operating promising partnerships between Medicaid and the long-term care insurance industry. Although their approaches differ, the basic concept is that individuals who purchase private insurance and exhaust its coverage would be allowed to access Medicaid and still protect some of their assets. There are two basic approaches that the four states utilize—the dollar-for-dollar model and the total asset protection model. In the dollar-for-dollar model, beneficiaries are able to keep personal assets equal to the benefits paid by the private policy. In the total asset model, all assets are protected after a threshold for years of coverage has been crossed, typically three or four years. In both cases, Medicaid becomes the payer when the partnership policy benefits are exhausted. States are projected to realize savings because Medicaid becomes the payer of last resort, not the first.

Federal law prohibits the expansion of these partnerships beyond those four states, but 17 states have passed enabling legislation allowing them to begin such a program should the federal prohibition be repealed, and several others are currently exploring that option. While long-term care partnerships do not promise a silver bullet for Medicaid's long-term care crisis, they can be a key part of the solution, and therefore all states should be allowed to participate.

In addition to tax treatment and other incentives for the purchase of long term care insurance, there are ways to improve the delivery of long term care services for individuals who remain covered by Medicaid. Those include both increasing the focus on home and community-based alternatives to institutional care as well as strengthening the chronic care management components of both Medicare and Medicaid.

C. Improving Access to Home and Community-Based Care. The long-term care policies advocated by NGA should also include reforms to the Medicaid program that produce better health outcomes for beneficiaries and result in greater efficiencies for both the federal government and states. Such reforms should give states more tools to encourage home and community-based care and could include the elimination of the requirement for a waiver for home and community based care as discussed in the section on waiver reforms and in the current NGA policy on Long Term Care (HHS-28).

D. Improving Chronic Care Management. The long-term care policies advocated for by the Governors should include reforms that encourage better care for the chronically ill populations in Medicaid. Although this is a small population, they demand a large portion of the available resources. States should be rewarded for program improvements that produce savings for both Medicaid and Medicare, particularly through improved chronic care management, by sharing savings evenly with states in the form of enhanced FMAP on a year-to-year basis. States should have the authority to provide financial incentives for care management methods that save money and improve outcomes outside of the targeted case management benefit.

5. State Contribution to the Medicare Drug Benefit

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) was designed to deliver a federal pharmacy benefit to Medicare beneficiaries. It was also designed to ease state Medicaid programs of their responsibility for providing pharmacy benefits to those eligible for both the Medicare and Medicaid programs—the dual eligibles.

While Medicare beneficiaries have some guarantees that on January 1, 2006, the Medicare program will begin providing them with a drug benefit, states do not have the same guarantee that their fiscal burden will be lifted. In some states, contrary to clear congressional intent, the Phased-Down State Contribution (clawback) provision will actually cause states to spend more in Medicaid in fact, a handful of states are projecting that they will never see any financial relief in prescription drug costs from the MMA than they would have in the absence of the law. In addition to their monthly clawback payments, states will also face increased costs from the administrative burdens of the new law. While state Medicaid programs operate with administrative costs far below those of private insurers, states have been forced to trim their program overhead even further in order to protect scarce resources for the care that their beneficiaries need. Tracking, calculating, and reporting clawback payments, as well as the other duties that resulted from the MMA, present substantial new administrative tasks [as well as potential costs] for Medicaid programs.

Integrating Medicaid's coverage with the drug coverage provided by the separate prescription drug providers will be a difficult undertaking for states. The clawback

provisions should not be a further financial burden on states as they work to focus on the coordination of care that is central to the spirit of the Medicare Modernization Act.

Chairman BARTON. We thank you, Governor. The Chair is going to recognize himself for the first 5 minutes of questions. Because we have so many members here, which is a good thing, the Chair is going to be fairly strict about the 5-minute rule.

Just so that we make sure we understand the main points, I would like either Governor Huckabee or Governor Warner to summarize the main, principal recommendations of your report, just, you know, one, two, three, four, five. Either one of you.

Governor HUCKABEE. Mr. Chairman, the first one is dealing with the prescription drug improvements primarily to make the system more transparent. The current system is based on an idea of average wholesale price. It really is built on acquisition cost plus a dispensing fee; then, there is a rebate that is given back to the States, which States negotiate. The whole issue of an average wholesale price is a complete misnomer. It is neither average nor wholesale. It is a complete fabrication. No one knows what the real drug costs are, and there is no real capacity or authority of the States to negotiate best price. Our State attempted to that, got sued, and lost. That is one of the issues—

Chairman BARTON. I hate to stop a Governor in mid-sentence, but my time is limited. So your first recommendation is just to change the drug pricing system—

Governor HUCKABEE. Yes.

Chairman BARTON. [continuing] do you have a specific recommendation or just that it needs to be changed?

Governor HUCKABEE. Well, no, sir, it is in the full context of what we have given in the 13-page document that—

Governor WARNER. Let me just add on this very briefly on the drug pricing issue, and it is obviously enormously complex. We feel that some of the initial proposals, particularly that came from the Administration, disproportionately put the issue of the savings coming out of the hides mostly of local pharmacists. We think it ought to be—if there are going to be savings it ought to be borne by not only the pharmacists in terms of the dispensing fee, but it also ought to be dealt with a little bit by Pharma.

We ought to also look at stronger policies to incent generic use. We ought to look as well, for example, one of the things the Governors are concerned about, and well, this backs into the Medicare drug benefit, and I know that folks don't want to revisit that, but we have States like Virginia that, through our use of a preferred drug list, have negotiated, for example, \$35 million worth of savings. We have negotiated a better price than we are going to be able to have under the new drug benefit. And with the "clawback" provision, we are going to not get those benefits.

Chairman BARTON. Right. Well, I agree with that. In fact I have asked that the Pharmacy Association to come up with a drug-pricing plan that they are supposed to give to me in the next 2 weeks. So No. 1 is drug pricing. What is your second general recommendation?

Governor HUCKABEE. Let me skip down to the issue of judicial reform because without it, none of these others probably will work

anyway because we will be tied up in court trying to get them dealt with. We would ask that Congress and the Health and Human Services authorize the States statutorily to make some basic operating decisions about components of the program. We need that authority in statutory law because right now, every time we try to make any type of changes, whether it is done through an 11.15 waiver or whatever, we end up getting sued. We are in a protracted court battle, we lose, and what could have been a modest cost can become an extraordinary cost. We are looking for assistance in that and also a reform to the idea of consent decrees, which sometimes can last as long as 20 years and four Governors and administrations down the road.

Chairman BARTON. Okay.

Governor WARNER. We are looking as well—I mean, we raised the issue, for example, on asset transfer both looking at tightening rules on asset transfers in terms of look-backs, for example, but also balancing that with an approach on reversible mortgages that would allow some equity being passed on and tax incentives, tax credits to look at the purchase of long-term care. We see those as a coupling, for example.

Chairman BARTON. Okay.

Governor HUCKABEE. We would mention the cost-sharing rules. Once again, it is not in order to deny benefits to people, but so that people could be empowered and have some sense of personal responsibility in the benefits that they receive. Again, a limitation with a capitation on how much they would actually have to spend.

Chairman BARTON. So cost-sharing means some sort of an increased co-pay?

Governor HUCKABEE. Right.

Chairman BARTON. Okay. That is four. Are those the main ones?

Governor WARNER. No, I think we have also looked at a modified benefit package. Now, again, we recognize that if inappropriately implemented, this could—particularly for mandatory populations—cause enormous concern. But what we have seen with—I think the benefit, for example, of some of the SCHIP programs, if we can find a modified benefit package that could be applied in a quasi-Medicaid role, particularly to some folks who are on the verge of falling onto Medicaid, we could substantially move the ball forward. But we need some flexibility there.

Chairman BARTON. Okay. My time is about to expire, so I have got one final question. What sort of mechanism do you want to establish with this committee as we move toward legislating on this in September? How do we communicate with the Governors? Through you two or is there a taskforce or—

Governor WARNER. We have a taskforce, Mr. Chairman. We would ask that you communicate through us and then our staff who has worked very diligently. We have not only NGA staff, but a whole group of Medicaid directors who will be happy to work with your and your staff. Again, what we are, as—particularly, the Medicaid directors, these are the folks on the frontline have to implement whatever policy change you bring about. They are critically important to this process, and I think it would be a great value to you as you put together your legislation.

Chairman BARTON. And my final question, does the National Governors Association support Federal legislation this year on Medicaid?

Governor HUCKABEE. Yes, sir.

Governor WARNER. We recognize that at least in terms of the budget reconciliation, you have gotten numbers out there, although some of your Senate colleagues were indicating that they thought that not all of those dollars needed to necessarily come from the Medicaid program—

Chairman BARTON. I am not asking a specific number, but Governor Huckabee said you do. Governor Warner—

Governor HUCKABEE. We look forward—we recognize we are going to have to see some changes in the Medicaid program—

Chairman BARTON. I take that as a yes?

Governor HUCKABEE. Yes, sir.

Chairman BARTON. Okay. Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Governor Huckabee, thank you. Governor Warner, thank you for joining us. Governor Warner, when you became Governor of Virginia, you took over an SCHIP program that simply wasn't working very well. Virginia had at that point premiums of \$15 per child up to \$45 per family per month on SCHIP recipients. Those premiums seemed to, from your later actions—it was believed those premiums cost thousands of kids to lose coverage. When you took office you eliminated the premiums; you referenced earlier that was one of your proudest accomplishments since more children were covered. So I think this—in my mind it shows two things; one, that cost-sharing, even on relatively higher-income people in SCHIP quickly cause people to fall into the ranks of the uninsured; and second, because of the changes you made on the other end if you will, simplifying eligibility, reducing co-pays, you were successful in getting a lot more needy children in the program. I think you recognized that cost-sharing by your actions could be a barrier to participation. Given that experience, I wonder why you are now lending your support to a policy of cost-sharing for children even below the poverty level. This is the group we most want to reach. This is also the group that costs the States the least to cover than any other. I don't think anyone blames children because they don't cost much typically—blames children for the budget problems of Medicaid. Explain to me why, in light of your experience and your policy changes and your success in Virginia, explain to me why you are supporting this policy.

Governor WARNER. Let me try to explain that. First of all, we found a program that was clearly not working in Virginia. We made not only the changes in terms of co-pays, but I think more important, the changes in terms of co-pays were some of the regulatory changes we made in terms of the administrative burden that a family had to go through in terms of signing up for our famous program, our SCHIP program, or our Medicaid circumstance. It was not a problem of co-pays, I don't think, driving people away; it was a problem of we had such administrative hurdles to get folks signed up in the first place, we thought they needed to be signed up. We have done that; 97 percent of the kids have signed up.

I think looking at the co-pay issue, for example, the fact that on certain Medicaid populations we are looking at \$1 to \$3 maximum

co-pay that hasn't changed since the early 1980's. I believe even a Congressional study has seen that moving those slightly up to the \$3 to \$5 range or in that parameter makes some sense. I am open to that. I am also open to some modified co-payment scale if there is, for example, a misallocation, a mis-utilization of how people access the healthcare system. You know, I have seen the different studies out there. I can tell you in Virginia I am not sure we know how much misuse of, for example, the emergency room is. We have made some changes there. For example, we don't reimburse if folks go into the emergency room and the hospital determines it is not an emergency room warranted visit. We only reimburse them at a doctor office level as opposed to an ER visit. These kind of tools, which I think help diminish any potential misuse of the system are terribly important.

I also think the notion of some minimal increase in co-pay, particularly in that \$1 to \$3 range that has been not changed, to my understanding, since the early 1980's bears consideration.

Mr. BROWN. So why did you eliminate the \$15 up to \$45 per family—

Governor WARNER. What we eliminated at the front end was we wanted to make it as easy as possible for children in Virginia to sign up for our SCHIP program, and we were very successful with doing that.

Mr. BROWN. I appreciate the other things you did, but now you are saying that that premium you eliminated, and now you are saying well, maybe that premium wasn't a particular barrier—

Governor WARNER. Well, I would say that most of our finding was that the premiums were not potentially as much of a barrier, and I am not saying I am ready to re-implement those premiums. I am saying that when you have got, for example, in some procedures a \$1 to a \$3 level maximum co-pay that hasn't changed since the early 1980's that some moderate readjustment of that ought to be on the table. Yes, sir, I do.

Mr. BROWN. I think that we all agree about some of the administrative burdens on families and we need to help States eliminate such burdens, but report after report after report shows that cost-sharing does in fact deter enrollment. Oregon implemented a plan of \$6 to \$20 cost-sharing, the premium significantly less than Virginia, more than the \$1 to \$3, and nearly 50,000 people lost coverage. I mean I admire what you have done in Virginia and how you have made that program work better. I just think that that kind of premium that some people in this committee suggest can in fact deter children from enrolling.

Governor WARNER. But you are taking one subset of a host of programs that are underneath the umbrella of Medicaid. From this Governor's standpoint, I would like to have the flexibility to look at some areas where we could look at potential increase in co-payments. I am also very anxious to look at other areas where in terms of inappropriate utilization of the healthcare system, there could be a higher co-pay if you inappropriately utilize. Now, again, I think—and you may have better studies than I, but I spend an awful lot of time on this—you know, there is a lot of smoke around what level of inappropriate utilization goes on in our healthcare system. I don't know. I would like to find out. But if it is out there,

I would like to squeeze it out of the system so, again, those dollars can be redirected to expanding coverage for those folks who really need it.

Mr. BROWN. One more comment, Mr. Chairman, if I could. I did choose one subset, as you say, Governor, but the subset is maybe the single least expensive part of Medicaid. And I would like perhaps both of you to submit to us which cases you think we should have premiums and what they should be. I don't believe—if your report could be a little more specific, your recommendations. Thank you very much. Thanks.

Mr. DEAL [presiding]. Governor Warner, welcome. You didn't get to hear some of the opening comments, and perhaps we can debunk some of the comments that some of my colleagues on your side of the aisle—

Governor WARNER. I can take the recording home and listen to it—

Mr. DEAL. Okay. One of those is that you are picking on the most vulnerable. We have heard some of that in the response to Mr. Brown's questions about co-pays. But has the experience been that in waivers that have been granted to States that you have in fact been able to expand coverage rather than subject those who are the most vulnerable to any kind of criticism or elimination from participation? Would you comment on that?

Governor HUCKABEE. Mr. Chairman, I would be happy to. It is exactly the waivers that have given us the ability to put a safety net under people who didn't have it. That is one of the concerns that as Governors we have about Medicaid. It provides extraordinary coverage for a few, but it provides nothing for many. And if we had the flexibility to put that net under more people rather than to put an extraordinary net, maybe more net than is even needed under some, then that would be a great improvement on the system. That is exactly what we did in our State. When I became Governor one of the most impassioned pleas I heard early on was all the uninsured kids. We created a program called KIDS FIRST. Congressman Ross helped us do that as a member of the State legislature. When we did that what we found was with small co-pays—we didn't even have a premium, just very minimal co-pays—but it added over the years some 280,000 kids into insured coverage who had nothing before. Their benefit package matched that of what State employees had. And it has made a dramatic difference. And here is what we found: people utilized the services that they needed, but they didn't over-utilize. They were responsible with it, and they appreciated it. And it saved the lives of a lot of children and it has made it possible so that a single mom's greatest nightmare was not that her son was going to break his arm on the playground and she wouldn't have the ability to make the rent payment next month because that safety net was there.

We are not asking for the ability to hurt people. We are asking for the capacity to make it so that this program, a good program, can be run more efficiently in the same way that any person administering a benefits package would hope to do.

Governor WARNER. Mr. Chairman, let me just add again, since we are staying on the children's program, what we found in Virginia was with the waiver, we were suddenly able to no longer

have this administrative nightmare of two doors. If you didn't go through the right—if you had one level of eligibility, you went through the Medicaid door; if you had another level of eligibility, you went the SCHIP door. And what we were finding are these families don't remain fluid. Some months they may be qualifying for Medicaid; some months they may be qualifying for our SCHIP program. They were, in effect, being thrown off the rolls because we didn't have the administrative flexibility to make sure there was only one door. Now, in my mind that was a huge mistake. And the fact that we have now—Kaiser Foundation is recognized as having one of the highest sign-up rates of any State in the country because we have had some of that administrative flexibility. I think kids are better served.

Mr. DEAL. As my time is expiring as well, let me just tell you how much I appreciate the work that your association has done and your staff has done. There has been, in opening comments, the intimation at least that the reason we are here today is driven by the Federal budget numbers. Am I not correct that the Governors Association undertook what has now led to your recommendations far before we ever knew what the budget numbers at the Federal level were going to be? And would you briefly outline for us when this all started and the degree of participation that you have had from the various Governors in this effort?

Governor HUCKABEE. Congressman, I have been Governor since July 1996, and I can tell you Medicaid discussion has been on the table every time two or more of us get together. Over the past year we have become very focused on it to a degree of actually creating the taskforce long before the Federal budget numbers ever came about. What we did hope for, frankly, was that we would have policy first, then budget numbers. Frankly, we wanted to establish that there would be the social agenda, what it was we were trying to accomplish. Then, look at the program that would best accomplish it, and then, see what it would cost. The fact that we are being driven more by budget is not our decision necessarily, but we bring you not so much the numbers; that is, we feel, something Congress has to grapple with. We are bringing you ideas that we believe will improve the system. CBL will have to score the numbers and determine exactly what it is, although we think that there are efficiencies—I am not going to use the word savings; I think that is the wrong word—efficiencies to be had by better expenditures of monies. But the fact is, under the current system this program is unsustainable for the State level. We can't print money like you do, and that is why we come with a sense of real crisis with the Medicaid program.

Governor WARNER. And I would simply add to what Governor Huckabee has said we have also laid before you ideas of reinvestment. That is why this is a policy-driven document and not—and we have been very clear from the outset. We started last fall with the working group that this was going to be policy-driven. It was the message we continued to try to bring up to you; it should not be budget-driven. We have looked at ways where yes, we may be able to find some savings, but also ways where we think there needs to be reinvestment, or the problem is going to be worse in the coming years.

Mr. DEAL. I commend you and the efforts of your group. I think what you have done is historic. I now recognize Mr. Waxman for questions.

Mr. WAXMAN. Thank you, Mr. Chairman. Governor Warner, I have read some of your past statements where you have spoken out eloquently about the responsibility of the Federal Government to bear the State, Federal responsibilities for making sure that all Americans have access to healthcare. And I am puzzled by why your reform proposal that the Governors Association is bringing forward to us today is so timid in suggesting that the Federal Government has a responsibility to do more. You have said nothing about picking up the cost of dual eligibles. You have not suggested adjustments in the matching rate to help counteract the effect on the Medicaid rolls and State budgets with unemployment increases. You haven't asked that we eliminate the 2-year waiting period before Medicaid covers the disabled. You have a very timid statement about the clawback problem in the drug benefit. You haven't noted the problems resulting from the decline in the matching rate. So you are ready to ask for co-payments from poor children, yet you are not willing to come here and say that the Federal Government ought to stand together with the States to meet more of its obligation.

Governor WARNER. Well, Congressman—

Mr. WAXMAN. Can you explain that to me?

Governor WARNER. Well, I would be happy to. First of all, I would be happy to share with you—and we will have staff do that later today—the position that NGA has maintained over the years on dual eligibles. We think this is one of the cost shifts that has taken place, never was legislated—

Mr. WAXMAN. Is that part of the proposal for the National Governors—

Governor WARNER. We continue to—

Mr. WAXMAN. [continuing] Association on Medicaid?

Governor WARNER. We have never revoked or moved away from our proposal that the question of dual eligibles needs to be on the table, that it is what is driving—as my statistics earlier—40 percent of our cost are related to dual eligibles, something that broke the Federal-State compact that was with—

Mr. WAXMAN. Governor Huckabee, is it your understanding also—

Governor WARNER. Let me just go ahead and finish the two other points that you asked us to address.

Mr. WAXMAN. Please do, but I have a limited time and some I would ask—

Governor WARNER. One—

Mr. WAXMAN. [continuing] that I have 5 minutes to do in—

Governor WARNER. All right.

Mr. WAXMAN. [continuing] put the time in.

Governor WARNER. If there was an issue on FMAP, we were appreciative of the effort a couple years back, but if you want to reopen that, that would be, again, welcome. And the question—

Mr. WAXMAN. Governor, I am going to have to interrupt you—

Governor WARNER. Is it a question of the clock—

Mr. WAXMAN. No, I am going to interrupt you because it is my time. I am looking at a proposal of the National Governors Association that was submitted to us. I don't see these in this proposal. If they are long-standing proposals by the National Governors Association, then we ought to take that into consideration as well. And I am pleased to hear, and I gather, Governor Huckabee, you stand with him in saying that those are also proposals that you would back for us to take advantage of?

Governor HUCKABEE. Absolutely. Those are long-standing proposals, Congressman. I think that what we would want to emphasize today, these are the proposals that have the unanimous consent of all the Governors. There are a lot of things that individual Governors would strongly urge, but this is a group of proposals that has bipartisan, unanimous—

Mr. WAXMAN. Right.

Governor HUCKABEE. [continuing] support, and that is why we are presenting these. Not everything needs to be done, but at least—

Mr. WAXMAN. Some of the others may not have unanimous support?

Governor HUCKABEE. No, I think they have the complete support of the NGA, it is just that—

Mr. WAXMAN. Governor Warner—

Governor HUCKABEE. [continuing] they are not new.

Mr. WAXMAN. Excuse me. Governor Warner, you have shelled out for us an ideal for healthcare that the States can buy a package that is less than a comprehensive package of insurance in order to make ends meet. In one State we know that the Governor proposed that the outpatient care be covered, but not the inpatient care. States would be allowed to do that. You suggested that tax credits ought to be available so parts of insurance coverage could be available to other people as well. Is your vision of the future for healthcare in this county that people go out and buy policies to cover just a few of things that might be needed, but not to be protected from the overall healthcare costs of hospitalization or whatever the future may need? First question. Second question, you said this is not a policy-driven proposal. Why aren't the Governors saying to us if you can reduce the cost for prescription drugs, you ought to be able to reinvest that money back into Medicaid? Instead, the proposal we have is if you can reduce and we can reduce with you the cost of the Medicaid program either in prescription drugs or narrowing the benefits or making the elderly have to pay more, get reverse mortgage, et cetera, we are putting that money back into the Federal Treasury. \$10 billion is what our goal is so that we can put it back into the Treasury to pay for other priorities like tax cuts for billionaires. It is hard for me to believe that this isn't budget-driven when we don't really provide for the money that is saved to be reinvested in the program. So I would like you to address those—

Governor WARNER. Well, first—

Mr. WAXMAN. [continuing] two questions.

Governor WARNER. [continuing] of all, I would say that we actually have put in very strongly this is a policy-driven—I think you

got it reversed—this is a policy-driven document, not a budget-driven document, No. 1—

Mr. WAXMAN. No, I beg to differ. I think you have got it reversed, Governor.

Governor WARNER. Well, this is not the format of the Nation's Governors in terms of laying this out. No. 2, we have also put in place incentives that we think need to be in place to insure that people don't fall onto the Medicaid rolls. No. 3, whether it is long-term care insurance, whether it is other tax credits to provide some level of a private sector product that can be purchased. No. 3, I come back to your initial question, Congressman Waxman. I want to make sure that every Virginian and every American has the best healthcare possible. What I am looking at right now in a State of 7.4 million people after a fivefold increase in Medicaid spending, after a healthcare foundation that has done more—that I am proud to have started—done more to take care of the needs of the uninsured than any healthcare foundation I have seen around the country. I am looking 10 years later still at a million Virginians without healthcare.

Chairman BARTON. Gentleman—

Governor WARNER. One of the things we have got to grapple with is how folks don't—as Governor Huckabee said—fall off that cliff into no coverage at all. And we think—

Chairman BARTON. The gentleman's time—

Governor WARNER. [continuing] we have laid out some—

Chairman BARTON. [continuing] has expired. I understand the frustration because we all want to ask a lot more questions and we will—I assume, Governors, that you will take questions in writing for the record? Because I am sure a lot of members—5 minutes is very insufficient. The Chair is going to recognize out of order Mr. Norwood of Georgia for one question to Mr. Huckabee because I understand that Mr. Huckabee has to leave and Mr. Norwood had a specific question for Governor Huckabee.

Mr. NORWOOD. Well, it is really a point of clarification. My question is basically if we were to write the National Governors Association, who do we write and whose point of view do we get back? Do we get back Governor Huckabee's? Do we get back the National Governors Association point of view? Because if you are speaking with one voice, you have a very powerful voice in my opinion. But if I am going to get today one answer from Governor Huckabee and a different answer from Governor Warner, then I get confused a little bit. And I am not going to be able to ask Governor Huckabee questions, so are you unified in your position on Medicaid and can we expect an answer back from the National Governors Association? Because I am going to send you a bunch of questions because I won't get to ask them.

Governor HUCKABEE. Congressman, I think that is what we bring to the table today is complete unity among the Governors, Democrat, Republican, north, south, east, west, male, female. It is an unusual situation that we have worked hard to achieve. And if you talk to the National Governors Association, you are going to get a very strong, unified voice. That is why we are limiting our discussion to the things upon which we agree, not to the things for which we could not yet find agreement, but we are still working to-

ward it. There are many issues yet that we want to resolve. We have not gotten there. But we have gotten this far. And these are the issues that we can come to you with and say that from the left and from the right, Governors across America have not only accepted, but agreed upon and endorse and support and ask for your partnership in making them happen.

Mr. NORWOOD. Mr. Chairman, I thank you for that. I can tell you I will be very supportive if you are unified, and I think this committee will be too.

Chairman BARTON. Governor Huckabee, do you have to leave now or can you stay a little bit longer.

Governor HUCKABEE. Congressman—Mr. Chairman, I am afraid I do have to leave. I am—

Chairman BARTON. Congressman is fine. I am a Congressman.

Governor HUCKABEE. But I do have to preside with another NGA meeting this afternoon, but you are in good hands, and he speaks with the voice of unity and authority for the National Governors Association.

Chairman BARTON. We appreciate your attendance and we look forward to working with you.

Governor HUCKABEE. Thank you, Congressman.

Chairman BARTON. Chair would now recognize Mr. Bilirakis of Florida for questions.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I think we are all—or most of us in any case are grateful to these people for all their hard work over a period of months and years. Governor Warner, we are agreed, I suppose, that Medicaid's original mission or their current mission is to provide basic healthcare to those who can least afford it. Isn't that correct?

Governor WARNER. Yes, sir.

Mr. BILIRAKIS. Okay. In the written testimony—and you have said it so many times here; I am not sure how many people were listening—that your recommendations make Medicaid more efficient and effective, were not developed to generate any particular budget-saving number. You said they were policy-driven as against budget-driven, that this all started long before we started with this budget reconciliation. It is unfortunate, to be perfectly honest with you, I know we had a taskforce here on this committee working on discussing Medicaid reforms and meetings and that sort of thing in the last Congress. We didn't have budget reconciliation or \$10 billion or anything of that nature that was budget-driven. And people on this committee refuse to believe that, what are you going to do? But you said that instead they were developed to maintain or even increase health outcomes while potentially saving money through efficiencies for the States and the Federal Government. So the bottom line is that we don't change the original mission, which is providing basic healthcare to those who can least afford it. But as a result of efficiencies and some flexibility and some of the things that you have requested that we make that plus. By plus meaning you have indicated increase health outcomes, possibly add additional people to the rolls. Is that correct?

Governor WARNER. What we are talking about is if we can find savings, if we can make this system more efficient, that if we can end up, again, through some of the tools we have used, for exam-

ple, incentives on long-term care, find ways to have folks not fall or wait later in life until they fall on the rolls of Medicaid, that improves the health outcome of that individual and our country at all and obviously our States in terms of serving the people that need it.

Mr. BILIRAKIS. And in addition to the efficiencies and whatnot, you hope to reach that same result by focusing more on—using the words of your report—wellness and health promotion, as opposed to simply sick care treatment. Isn't that correct?

Governor WARNER. That falls clearly into the category of overall healthcare reform, which has to be—

Mr. BILIRAKIS. Yes.

Governor WARNER. [continuing] we have laid out first steps here, but getting into preventive care and wellness care, absolutely critical. It has not been the direct focus of this piece.

Mr. BILIRAKIS. Your executive committee consists of nine Governors. I believe—

Governor WARNER. Eleven Governors were participating in the working group; over 35 Governors have either themselves been involved or their Medicaid director has been involved. The other roughly 15 Governors, there has not been a single Governor that has said hold on here; I am opting out of this. So you do have back to Congressman Norwood's position. And there has been back and forth. You have the Nation's Governors coming before you with ideas that they have reached consensus on.

Mr. BILIRAKIS. So all of these Governors, Republicans and Democrats basically agree on this concept and reaching the result that I have already indicated, which is basically hold the line to the basic mission originally and add to it through wellness and possibly treating additional beneficiaries and that sort of thing. Now, would that breakdown have been how close in terms of Republicans versus Democrats?

Governor WARNER. Well, sir, the thing is Medicaid is not a single program. There are 50 separate Medicaid programs.

Mr. BILIRAKIS. Yes.

Governor WARNER. They vary dramatically. What you find mostly where the disagreement would come along would not be based on Republican versus Democrat; it would be based on what level of reimbursement levels you were able to provide within your respective States.

Mr. BILIRAKIS. Yes. Up here, as you have already heard, it is—

Governor WARNER. We may be the last—

Mr. BILIRAKIS. [continuing] Republican versus Democrat.

Governor WARNER. [continuing] bipartisan game in town.

Mr. BILIRAKIS. Yes, amen to that. Well, I just find it hard to understand why, you know, everybody here doesn't sort of agree that you have tried awfully hard to do this on a policy-driven, non-partisan type of a basis without hurting current beneficiaries and with the idea of adding additional ones and additional health outcomes, as well as, of course, wellness preventative care. It amazes me, but that is the way life is up here unfortunately. Thank you very much, Governor Warner, for all your hard work. Thank you, Mr. Chairman.

Chairman BARTON. Thank the gentleman. The gentleman from Massachusetts, Mr. Markey, is recognized for 5 minutes.

Mr. MARKEY. Thank you, Mr. Chairman, very much. Welcome, Governor.

Governor WARNER. Thank you.

Mr. MARKEY. Mr. Governor, we have 34 million Americans who live in poverty in America. 14 million children live in poverty in America. 13 million Americans live in abject poverty. That is half of the poverty rate. In other words, rather than \$19,000, it is \$9,500. Abject poverty. So under this proposal the Governors will have the ability to raise the fees for these poorest people. Now, I don't know what the incentive would be to raise the fees for the poorest people other than to pay for the tax cuts that the Republicans want for the wealthiest people in our society. In other words, the tax break for them comes from a tax increase, a fee increase for those people living in abject poverty, \$9,500 a year for a family of four and for the 13 or 14 million children who live in poverty in our country. So that is a budget decision. Because it doesn't seem to make any sense to me that you would want to raise the fees on the people—the children living in poverty. They already are the worst-treated citizens in our country. So isn't it really a budget-driven decision that you are making since you would never want to increase the fees for those people. And it is really not a policy decision because there really is no policy justification for increasing the fees for the poorest people.

Governor WARNER. Let me first of all say that, you know, in Virginia we actually—and some of you actually may have read about it—we put together a bipartisan coalition a year ago to deal with our tax code, to deal straight up with paying for what Virginians wanted in terms of level of service.

Mr. MARKEY. Has Governor Huckabee done that too?

Governor WARNER. Governor Huckabee has done it as well. Many Governors in both parties have stepped up and dealt with their States' finances.

Mr. MARKEY. So, again—

Governor WARNER. Let me—

Mr. MARKEY. [continuing] let me just say have you all agreed that you are not going to raise the fees for the poorest—

Governor WARNER. Congressman, what we have said is—matter of fact, Congressman Brown raised the point earlier—when we in Virginia tried to actually expand our children's health initiative, we actually cut back on co-payments so we could expand the program along with some of the administrative changes we have made. But to somehow say that the co-payment issue that in some areas has not moved from \$1 to \$3 since the early 1980's should somehow remain sacrosanct forever, respectively, I disagree. I think we need to look at that tool. We need to look—

Mr. MARKEY. But you do—again, Governor, you do understand that the only reason you would have to consider it is that the Republicans are going to cut—

Governor WARNER. Actually—

Mr. MARKEY. [continuing] \$10 billion, and it is actually going to be more than that as the years go on, that this is just this year's installment on that because of the huge tax breaks for the wealthy.

So in other words, if I can ask you this, would you, rather than have the tax break and rather than being here talking about your policy recommendations in the context of their tax break that requires this \$10 billion cut, would you prefer there be no cuts in Medicaid from the Federal Government and they reduce the tax break by the \$10 billion that is being required to be cut out of Medicaid? Would you prefer not to have that tax break?

Governor WARNER. Congressman, we would prefer not to see substantial cuts in Medicaid. That has been—

Mr. MARKEY. No, but will you—

Governor WARNER. Let me—

Mr. MARKEY. No, I understand, but it is important for us from the Governors' perspectives—

Governor WARNER. And I would like to give you that Governors' perspective, and the Governors' perspective is we want to minimize the cuts in Medicaid. What we also—

Mr. MARKEY. But there is no need for cuts in Medicaid if—

Governor WARNER. Sir, let me just say that we spend for every dollar, at least in Virginia, you put forward, we match it dollar for dollar. Now, if you are going to suddenly say we are going to take and pay 100 cents on the dollar in terms of all Medicaid costs, have at it. But in Virginia we have seen our State Medicaid costs go from \$1 billion to \$5 billion in the last 15 years. I make the choice because we don't have the luxury of not balancing a budget. Our numbers have to add up at the end of the year, and we have to make—

Mr. MARKEY. No, but I—

Governor WARNER. [continuing] decisions each year, and Medicaid is the largest single increase in our—

Mr. MARKEY. But do you think, Governor, that we should be talking about increasing Federal aid for Medicaid from a Federal level rather than decreasing Federal aid for Medicaid to you to minimize these difficult choices that you have to make to actually increase the fees for the children in abject poverty. That is the decision you are being forced to make, and you are making it—

Governor WARNER. No, what we are making is the statement—you are saying that—

Mr. MARKEY. I am asking whether or not you would want—do you want Congress not to give the tax break that requires the cuts in Medicaid that forces even more difficult decisions upon you and the other Governors? Do you oppose those tax breaks?

Governor WARNER. No, we put forward the position that said we would oppose—we were not looking, clearly, at any Medicaid cuts. You came up with a \$10 billion number. Our hope is that you will find some ways to spread that out amongst other programs or other areas. But we also, irrespective—let me make clear, though—irrespective of your current budget debate, Medicaid, as it is currently structured, is not sustainable over the long haul.

Mr. MARKEY. Well, let me—

Chairman BARTON. The gentleman—

Governor WARNER. From a State's standpoint—

Mr. MARKEY. You have—

Chairman BARTON. The gentleman's time has expired. I know it is frustrating, but it has expired. We now go to Mr. Upton for 5 minutes.

Mr. UPTON. Thank you. Thank you, Mr. Chairman. I applaud you and Chairman Deal for hosting this hearing. And, Governor Warner, I want to say thank you, as well, for your fine work with the Governors Association.

I know that our delegation sat down with our Governor a couple months ago, I guess, and we pledged to work in a bipartisan basis with Governor Granholm to try and make sense out of program that clearly today is not working. And you all made the very distinct point that doing nothing is not an option because it is simply not sustainable. And the demographics show that. The increase in the ages above 64 years old, and, again, for those growing over 80 years old, those percentages, the increase that are demanding Medicaid services, it clearly is not working today.

And I also thought that the Tennessee Governor's statement on Saturday as part of the response to the President's radio address was pretty much right on message. And he talked about the work that he has been a part of with regard to the Governors' plan that you all presented to us this morning. And I would agree strongly with the judicial reforms that you talked about. I might just ask my chairman does that mean we have to get the Judiciary Committee involved in our process as part of reconciliation, Mr. Barton, and do we have to get the Judiciary Committee to be involved, or can we just steal their turf and do it on our own?

Chairman BARTON. Well, we will try to steal their turf—

Mr. UPTON. All right—

Chairman BARTON. [continuing] on our own but—

Mr. UPTON. [continuing] that is good to me—

Chairman BARTON. But if they need to be involved, they will be.

Mr. UPTON. The question that I have for you, Governor Warner, what else can we do to create better personal responsibility for those demanding Medicaid? You talked a little bit about a small increase in the co-pay, something that has not gone up in more than 20 years. Are there some incentives that we can do to decrease smoking, better diet plans, a number of things that we might want to think about for preventative healthcare that you all took a look at as part of your report?

Governor WARNER. Absolutely. All of those are tools that we have to use. I mean I have got communities in Virginia where 20 percent of the kids in junior high are obese and Type II diabetes candidates. It is a ticking time bomb. I had Medicaid expenditures of \$400 million a year that are directly related to even non-alcohol and drug, but other lifestyle-related disease, Type II diabetes, hypertension. There has got to be a preventative aspect of this, and we have started somewhat, but we need to do more, and I think that is probably the case in every State.

Mr. UPTON. You know, one of the things as it relates to Michigan, last year is an example—this is in my opening statement I submitted for the record—Michigan's Medicaid program financed 40,000 births, 40 percent of the total number of births in the State. Is that about right for Virginia as well?

Governor WARNER. We are about that number, and one of the things we did recently—and, again, this is the kind of investment we think that needs to be part of—investment to save over the long haul—we recently, in this past year, expanded the quality of care to our prenatal care and actually raised to I believe 175 percent of the poverty level covering expectant mothers.

Mr. UPTON. You talked a little bit in your statement about expanding purchasing pools. We have had an issue in the Congress here the last couple of years to do that for small businesses called AHP, Associated Health Plans, and it is my understanding that we are likely going to have that legislation up on the House floor perhaps as early again as next month. Is that something that you all took a look at?

Governor WARNER. We did not take a look at AHPs specifically. I am not going to weigh in on those. I do think we all know that the lack of success sometimes that takes place with the purchasing pools is the adverse selection that takes place as younger firms or folks with younger employees opt out, and you have got to find ways to incent and even potentially mandate the ability to get the numbers together so that you can drive your insurance cost down.

Mr. UPTON. Our Governor shared her frustration with our delegation with a lack of the asset forfeiture items that a number of Governors have. Should we penalize those States that don't have a workable plan in that regard?

Governor WARNER. Are you talking about asset transfer here in terms of—

Mr. UPTON. Right.

Governor WARNER. [continuing] seniors? What we have tried to put together—and it is trying to strike a balance here—because I don't think any of—I can only speak for Virginia—I am not sure any of us know how much of inappropriate asset transfer is going on. But what we do have is a system, whether we like it or not, I believe, that encourages people to gain the system with it. Again—

Mr. UPTON. Let—

Governor WARNER. [continuing] let me just finish. And what we have tried to say here is while there needs to be perhaps stricter look-backs and other tools, we have to couple that with other incentives to purchase long-term care insurance, allows people to maintain some equity to their house to pass on, the reverse mortgage ideas and others. We need a series of both incentives and, yes, penalties to make sure that we are fair about dealing with folks as they go into long-term care situations.

Mr. UPTON. Thank you. My time is expired.

Chairman BARTON. Gentleman from Illinois, Mr. Rush, is recognized.

Mr. RUSH. Thank you, Mr. Chairman. Governor, thank you so much for your questions. I am going to ask you a series of questions, and hopefully, you will be able to answer them all. And I am going to ask them in their entirety before you answer. I would appreciate it if you would concur with me.

I want to ask you more about the asset transfers that will restrict access to nursing home care. And I understand that research indicates that even before the 1993 Omnibus Reconciliation Act ex-

tended the look-back for transfers of assets to trust to 60 months, the establishment of trusts by people who could have used them to avoid Medicaid spend-down was extremely rare. Indeed, most trusts are established by the wealthy, and I think you will agree, to avoid paying taxes. And my first question is can you tell me why it is okay for wealthy people to give their entire estate to their children when they die while somehow it becomes a problem that people who need nursing home care, most of whom have very little wealth, can't keep anything? It seems to me that the Medicaid spend-down may possibly be the last estate tax left standing. In your testimony you stated that Medicaid reform could include changes that restrict the types of assets that are being transferred and increase penalties for inappropriate transfers. Can you be more specific and outline to this committee which assets that are being transferred that need more restrictions? And then also, as I understand it, older people can shift from being healthy to needing long-term care in a very short period of time following a stroke or fall, for example. And I know that many grandparents want to help their children and their grandchildren with purchasing their first home or getting a college education and the like. Do Governors support a policy that will go after grandparents who, without any awareness that a nursing home was in their future, pay for part of their children's college education? Do the Governors support a policy that would allow the State to go after a grandchild in college? Or do Governors support a policy that will allow the State to go after parents struggling to save for their own retirement if their own mother or father needed nursing home care but was unable to pay? So could you answer those questions?

Governor WARNER. I would be happy to, sir. First of all, what we are looking at is trying to ensure that seniors have a better quality of long-term care. We are looking at, in terms of the issue of wealthy versus non-wealthy, I think if there is misuse or inappropriate use of the system, it obviously needs to be applied fairly, equally. But I come back to the basic point, what I believe we have right now is a system that basically is all or nothing.

Mr. RUSH. Governor, is there a profile of someone who is abusing the system? Is there a profile that currently exists now? Who abuses the system?

Governor WARNER. Congressman, what I am concerned about is the fact of how I deal in a State where increasing numbers of seniors don't have virtually any options. Their only option is to spend all the way down before they go into a nursing home facility, or in some cases if they have the right counsel, can figure out a way to have any financial responsibility. We are trying to strike a balance here. And I believe that not trying to strike a balance, to simply continue to allow what seems to be a mini-growth industry in itself of ways to—and I think it is disproportionately used actually by more wealthy individuals, candidly, because they have the more sophisticated legal counsel and accountants and others who allow this to happen. In the long run, again, continues to diminish the resources we have available at the Federal level or the State level to provide the kind of quality long-term care that we need.

Now, asset transfer alone isn't going to solve the problem. It has got to be coupled, as I said, with significant incentives to encourage

people to purchase long-term care insurance. I mean we have a problem that is not going to go away with the baby-boomer generation heading toward retirement. In my State 65 percent of the people in nursing homes, they are on Medicaid. With a trajectory of a cost increase that is not going to diminish, we have to find a way to grapple with this issue.

Chairman BARTON. The gentleman's—

Mr. RUSH. I can understand your problem, and I understand your point, but I just don't see where they are going to be able to afford it, even long-term—

Governor WARNER. Well, that is why we are saying that if you can find a way so that folks—particularly in terms of their house—can preserve a piece of that equity so they don't have to totally dispose of it. And what the right number is, I am not sure. But there ought to be some way to preserve that so you can absolutely find that way to pass on some—you have worked all your life, and your largest asset is your house and you want to pass something on to your kids, you ought to be able to have that. But what we have got right now is, in effect, an all or nothing.

Chairman BARTON. The gentleman's time has expired. The gentlelady from New Mexico, Mrs. Wilson.

Ms. WILSON. Thank you, Mr. Chairman. And, Governor, thank you for being here and thank you for your leadership on this issue. I think it is a tremendous contribution to the body of work that has been done on Medicaid.

My colleague from Massachusetts who was here briefly before talked about budgets for Medicaid. And I think we need to be clear about this. Over the next 5 years under the Federal budget we are going to increase Medicaid spending by \$215 billion. That is a 7.1 percent annual increase over the next 5 years. We have got Tennessee dis-enrolling 300,000 people on Medicaid, the Governor of Alabama having real declines in Medicaid spending this next year, every State in the Nation struggling to meet the needs of their people because, as you mentioned and Governor Huckabee did as well, you don't print the money. Can Virginia sustain a 7.1 percent annualized growth rate in Medicaid?

Governor WARNER. That is, again, one of the reasons why we have said we have got to deal with this issue now. It is going to get exponentially worse over the next decade with the aging population, with increasing populations who are at a young age now. For example, just the obesity-related issue on Type II diabetes, we have got to get a handle on it. Now, that does not mean—and what I find somewhat frustrating is this—it is all or nothing, or somehow it is all about cuts or it is all about somehow being against the people who are in need. What we have tried to strike is a good faith effort to find ways to make the system more sustainable over the long haul, reinvest in areas where we can hopefully have folks not fall upon the Medicaid rolls over the long-term, either through long-term care insurance, through purchasing of some level of healthcare insurance in a modified benefit package. Because, again, your basic question is in most States it is much more than a 7 percent increase. You can't sustain it.

Ms. WILSON. Thank you. And I really appreciate your focus on letting policy drive the budget here. I know you have got to come

up with a budget that balances. But one of the things that frustrates me about Medicaid is that we don't look at whether it improves anybody's health. And it wasn't set up to improve anybody's health. It was set up to pay the bills. And I wonder if in Virginia you have looked at or whether the NGA has looked at what is the health status of people who depend upon Medicaid, and how does that compare to folks who have private health plans, or, more broadly, the population?

Governor WARNER. Well, we have started to look at how we can better manage toward healthier outcomes. I mean we have some preventative care programs we have put in place. You know, arguably, some folks who we move to, you know—HMO-modeled Medicaid in some areas as well that at least arguably are making the case that they are managing toward a better health outcome. I think you also have to recognize, though, that to take a Medicaid population that by definition is disproportionately poor and has other chronic problems that may not—you know, to compare that apples to apples with a middle-class population that is buying traditional health insurance and a large corporate structure, that is not a fair comparison.

Ms. WILSON. No, and I don't think it is either, but I think we do need to look at the apples to apples comparison, because I am not sure it is there. And in particular, with respect to that and the efforts you are making on trying to shift toward prevention and the management of chronic disease and getting a hold on obesity and so forth, are you awarded at all from the Federal Government in terms of reimbursement rates or anything for improving—

Governor WARNER. No, we don't—

Ms. WILSON. [continuing] the health—

Governor WARNER. [continuing] have an incentive system that encourages good behavior on the basis of the States.

Ms. WILSON. So from your State's Medicaid director, there is no help at all from the Federal Government if you show results?

Governor WARNER. To my knowledge, and I am glad I am here, we have no incentive reimbursement level that encourages the States to take on these initiatives. And, again, let us be candid with each other. Part of the problem is we are going to have to have a willingness and a dedication from you guys on the Congressional side and us on the Governors' side to make long-term investments in this type of preventive care. You cannot turn on the preventive care program day one and see results in 6 months. And when you have got the very real choices that we have to make about what level of care in terms of just dealing with the acute population, it is a balancing act. My hope would be, we would be able to move toward that preventive chronic disease management, these kind of investments, but we are going to need to kind of lock arms on this and be willing to acknowledge that the results are not going to happen overnight.

Ms. WILSON. Governor, thank you, and I look forward to continuing to work with you.

Chairman BARTON. We expect a series of votes in the next 15 to 20 minutes. We are going to get as many questions in, as many members in, and we will come back. What is your schedule?

Governor WARNER. I actually am going to use the same excuse that Mike Huckabee used a few moments ago. You know, in about another 15 or 20 minutes I am going to need to move on. I have got another session up here on the Hill.

Chairman BARTON. We have about an hour's worth of questions. Any way we could.

Governor WARNER. Let us compromise at a half-hour.

Chairman BARTON. All right. Mr. Stupak.

Mr. STUPAK. Thank you. And, Governor, thank you for being here. The issue really isn't—as Ms. Wilson indicated, we are putting more money into Medicaid—we are putting enough money in to meet the needs of the clientele we are trying to serve. So even though we may be putting more money in the next couple years, it is not meeting the needs we see. In my State of Michigan we see a 30 percent increase, and yet Jennifer Granholm has been able to keep our increase cost for Medicaid at 1.5 percent. So we do have to get smarter on the way we do that. On top of not meeting the needs, we are also expected to come up with \$14.7 billion over the next 5 years. That is what we have been instructed by the Budget Committee to make \$14.7 billion cuts over the next 5 years. So my concern, and I am sure you weren't here for my opening, but I highlight a point in Michigan—in fact yesterday, the Michigan legislature did a couple of things. It goes to flexibility and I want to ask you a little bit about it. The State Senate voted to make some Medicaid patients pay a \$5-per-month premium. The budget also calls for a \$10 co-pay for brand name drugs where there is a generic equivalent and a \$25 co-pay for non-emergency room visits. The House bill would eliminate 43,000 people on Medicaid recipients in Michigan including all 19- and 20-year-olds and relatives who raise family members—Medicaid eligible children. It sounds like there is a lot of flexibility in the Medicaid program already, but I am hearing the Governors saying we need more flexibility. In what way?

Governor WARNER. In terms of—and I can't speak to the Michigan-specific situation; perhaps you have already gone through the waiver process to grant you that flexibility—but I can assure you that to—

Mr. STUPAK. So that is unusual amongst the States?

Governor WARNER. To get an answer out of CMS on a timely basis to get a waiver through continues to be an issue.

Mr. STUPAK. So you want to move the waiver—

Governor WARNER. We want—

Mr. STUPAK. [continuing] provision quicker.

Governor WARNER. [continuing] to look at the waiver situation on a quicker basis, we want to encourage greater use of generics, we want to look, as I indicated, on the whole drug pricing issue in a much more aggressive way than has been done so far. I didn't get a chance to, but I would like to retake issue with one of your colleague's earlier comments. We very specifically raise the unfairness of the Federal Medicare drug benefit that actually penalizes States—

Mr. STUPAK. Correct.

Governor WARNER. [continuing] on the clawback who have, subsequent to 2003, done a better job of negotiating drug prices than the Federal Government. That doesn't make any sense.

Mr. STUPAK. I was going to ask you that. That was one of my questions. Your proposal mentioned the clawback provisions of the Medicare Modernization Act that requires States to begin making payments to the Federal Government in 2006 in exchange for Medicare-covering prescription drugs for dual eligibles. So what is the true cost of a clawback to a State like yours?

Governor WARNER. It varies by State. With the loss of our renegotiated prices that we received from our PDL with the administrative costs that are being put upon the system where there is no transition help put in, we see it pretty much as a negative, at least in the short run. And I think, again, it will vary by State. Some States will do all right; some States will not. But it seems strange that an issue that is supposed to help in the long haul deal with pharma costs actually increasing the costs in many cases.

Mr. STUPAK. Sure. Can some of these problems with the clawback—I mean Michigan is one that really kept their rates really low for prescription drugs. Is there anything we can do other than Congressional action that could relieve you from that clawback provisions in there?

Governor WARNER. We have heard talk that there may be some ability to invest some in the administrative transition. We have seen—the short answer is I don't know. My hope would be that those States who have negotiated a better price over the last 2 years, if you move the cut time from 2003 up to 2005—

Mr. STUPAK. Sure.

Governor WARNER. [continuing] that would at least allow us to implement the deals that we have negotiated. Again, I have spent—

Mr. STUPAK. Right, because you—

Governor WARNER. [continuing] 3 years in—

Mr. STUPAK. [continuing] have been penalized—

Governor WARNER. [continuing] government; I have spent 20 years in business. If I have got a good deal that I have already cut, it seems a shame to take that deal away from us.

Mr. STUPAK. Absolutely. You did a good deal and you are being penalized underneath a Medicare bill. Let me ask you about—and I want to get into this a little bit—the cost-sharing proposal. There has been a lot of talk—in fact Governor Huckabee mentioned about when the program started cost was only this much and gas was 24 cents and things like that, but the cost that is being paid here by the recipients, it is 5 percent of the service, and the service certainly has gone up. I mean with the service in 1982, that is the provision we use, 1982. You say they haven't gone up since then. But certainly, the cost of hospitalization from 1982 is different from 2005, so those costs have also gone up for the recipients.

So if the Governors' proposal is a cost-sharing—would allow greater cost-sharing similar to what we have in CHIPS, I am concerned if the proposal for Medicaid is being similar to what is allowed in CHIPS, in reality your proposal appears to be much more onerous than the CHIPS requirements. Because children below 100 percent, of course, are not in CHIPS, and you said earlier there are

more people below the poverty line. And for those in CHIPS with income between 100 and 150 percent of the poverty line, cost-sharing is limited to nominal amounts. So it appears to me that if you retain all of these protections from SCHIP, for example, would impoverish seniors—because you were just talking about that with Mr. Rush—in nursing homes. Would they be exempted from these new cost-sharing requirements?

Governor WARNER. What we are saying is—

Chairman BARTON. This is the gentleman's last question, and then we are going to go to Mr. Norwood.

Governor WARNER. [continuing] and, again, the issue here, remember Medicaid populations vary in our State—

Mr. STUPAK. Sure.

Governor WARNER. [continuing] we are very, very strict in terms of our eligibility requirements. Other States are Medicaid eligible up to 300 percent of poverty. We are saying that there ought to be some flexibility there. Now, you ought to have the caps, particularly for those 100 percent and below no more than 5 percent of their total income. There needs to be—what I have looked at, again, are some of these \$1 to \$3 levels. You alone have—or Congress or one of the Congressional entities has done their own study. If you simply bump those from \$3 to \$5, there are some savings. Do I think you are going to find enormous savings here? No. If we can simply partially dispel the notion that there is gross over-utilization, I think by having slightly higher co-pays, that is a step in the right direction as well.

Mr. STUPAK. Okay.

Governor WARNER. We don't know at this point. There are lots of studies on both sides. But I don't think you are going to see a lot of Governors go out, particularly in some of our most meaty populations, those 100 or 150 percent and below in poverty and suddenly put in SCHIP-type \$15 or \$25 co-pays.

Mr. STUPAK. Well, I just want to say—

Chairman BARTON. All right—

Mr. STUPAK. [continuing] like—

Chairman BARTON. [continuing] all right.

Mr. STUPAK. [continuing] Oregon, 50 percent increase drop and people dropped out once they raised the premiums—

Chairman BARTON. The gentleman's time has expired. We are going to go to—

Mr. STUPAK. Thank you, Mr. Chairman.

Chairman BARTON. [continuing] Mr. Norwood. We are going to give him 4 minutes because he did get to ask a question of Governor Huckabee.

Mr. NORWOOD. I also passed over my opening statement too.

Chairman BARTON. Well, a lot of other people did. Four minutes.

Mr. NORWOOD. Governor, thank you sincerely for your work you are doing. It is a pleasure to see adults at work trying to solve a policy problem rather than getting it so political. And I hope this committee can do the same thing.

I have two questions so I will try to get them both answered if I can. I was wondering what the NGA proposes to do in respect to taking people off Medicaid that really shouldn't be there? Specifically, I refer to illegal aliens, but I also refer to the millionaires

that were on the program who have done away with all their assets perhaps legally, perhaps not. This would restore the program to, I think, its original design, to serve as a safety net for people, citizens in this country who are most vulnerable. I know that you had problems in your State of Virginia. We have had problems in our State of Georgia. The strain of illegal aliens on your public infrastructure, as well as your criminal justice system.

Now, I am concerned that we don't know the resources that we are expending on this particular segment of the population. We have limited resources, obviously, and we have no idea of the level of Medicaid dollars being used to benefit illegal aliens at the State level. Or do you have an idea in your State what it is costing you?

Governor WARNER. Well, sir, we already have a policy to not provide Medicaid benefits to undocumented persons, and the legislature moved forward on that, even broadened that this year. In terms of the question, again, Congressman Rush is not here, one of the things that I don't think we know is—Congressman Rush asked for that giving the prototype of someone who is misusing the asset transfer; well, I don't know if the millionaires out there are doing that. But if they are out there doing that when I am seeing poor seniors not being able to get the kind of long-term care they need, we ought to put a stop to that. And what we are simply saying is that has to be on the table as we look at this. And, again, I keep coming back to it is not an either/or. It is yes, looking at asset transfers, but coupling that with incentives to purchase long-term care insurance, an ability to recognize that folks, particularly modern-income folks ought to be able to pass on some assets to their kids, and trying to do this in a more ration process than we have done so far.

Mr. NORWOOD. Well, you can go through nursing homes and figure this thing out just a little bit. And I don't know about your State. It is illegal to put illegal aliens on Medicaid, but you got to ask the question, I hope you are doing that in Virginia?

Governor WARNER. We are doing that.

Mr. NORWOOD. We are not doing that real well in some places. Now, one last question. How would the Governors' proposals work to give us some comfort or some assurance that core benefits, those preventive care benefits—and I admit dental is one of them that is important to me—they have a huge impact on health and well-being, and basically, many times are cost-effective. How do we assure ourselves that we won't—or does your program keep from eliminating those because of the budgetary crisis?

Governor WARNER. Congressman, those are the issues we face every day because it oftentimes does not break down to eliminating the benefit. It turns into a situation where the reimbursement level may be so low that the provider decides to opt out. That was an issue that we ran into recently in Virginia where we were losing so many of our OB-GYN's in rural communities. So, again, I would love to paint all this as black and white, but what we are trying to say is we want to put in place a system that encourages preventive care, we want to find efficiencies, but at the same time, we have got to recognize that right now, with the increasing populations, a lot of it driven by long-term care costs, we are not able

to do all the preventive activities because we have got to deal so much with just dealing with acute care.

Chairman BARTON. Gentleman's time has expired. The gentleman from Florida, Mr. Davis, 5 minutes.

Mr. DAVIS. Governor, good to see you again. I certainly applaud your leadership on this issue, in particular, on education issues, and you certainly aren't afraid to stick your head out of the foxhole here because you get shot at when you do.

I think what is going to advance this conversation is going to be a more specific understanding as to how this newly gained discretion could be used, or in the minds of some people, abused. I would like to ask you about a specific example that is taking place in my home State of Florida. I understand it may be taking place in your State and others. And it is a limitation on the ability of physicians to prescribe psychotropic drugs to people with mental health issues. Florida has adopted a policy, which is being described as a "fail-first" policy where a physician has to prescribe the least costly alternative, and only if and when that fails can the physician then move on to something that may be more medically appropriate. I would like to ask you if this is something that you are aware of? Is it happening in Virginia or something similar to it? Is it taking place in the other States besides my State?

Governor WARNER. I am vaguely familiar with what is happening in Florida, and I know kind of pushing the edge of the envelope on a series of Medicaid-related issues in Florida. And this is an area above my pay grade in terms of the technical definition of which drugs are in or out. But when we dealt with our PDL list, we did not include these drugs on our PDL list, and we have left that flexibility with the docs.

Mr. DAVIS. Are there any other States—

Governor WARNER. And I am not sure if there are any other States. We could try to find out and get back to you on that.

Mr. DAVIS. Would you care to express an observation or opinion as to the merits of the type of approach I have described where the physician is forced to prescribe something least costly and it has to fail before something that might be more medically appropriate could be prescribed?

Governor WARNER. Well, we chose not to go that route in Virginia based on our Medicaid folks, my Health and Human Services secretary, and working with the drug industry. So we chose not to pursue that and that is the way we are going to stay in Virginia. But let me say there may—because a case was made the medical necessity and the differentiation between drugs in this category, psychiatric drugs were so important that you couldn't substitute. On the other hand, there are areas where we can—

Mr. DAVIS. Right.

Governor WARNER. [continuing] increase generic use. There are other areas, and I mean not to leave—just so that I make sure that I can at least get shot at by everybody in the whole universe, you know, we also have got to look at generics as well as we see drugs rotate off of the brand name list, now, we have got to be careful the drugs don't move from a \$1 down to 80 cents and suddenly they get called generic and we haven't really realized the full benefits. I mean—

Mr. DAVIS. Right.

Governor WARNER. [continuing] Canada, for example, has been very out there on defining generics. Everybody has got to come to the table on this issue on drug pricing.

Mr. DAVIS. I agree with you generally. I want to cite you this specific example, which, obviously, you are not prepared to defend today—as an example of what is some of the concern here. It is not clear to me how many State could defend taking such a position of “fail-first” for psychotropic drugs. As Florida and many States have worked very hard to deinstitutionalize our mental health patients and try to keep them healthy, as well as the entire community healthy, and this type of Medicaid approach has been adopted.

I would also like to ask you in what little time I have left if there has been any discussions you have been involved in or the NGA has been involved in in terms of how much benefit there is to be achieved in further nursing home diversion, more emphasis in terms of Medicaid coverage of home healthcare, adult daycare, alternatives to institutional settings that might not only improve the quality of life for our seniors and disabled, but actually be a more cost-effective use of Medicaid.

Governor WARNER. I sure have—actually with Governor Kempthorne on a commission that is chaired by former Senator Kerry and former Speaker Gingrich looking at this issue. And I can just give you my personal view, and I think I speak for most Governors is we strongly urge at looking at these alternatives. Matter of fact, one of the things we have included in our plan is incentives to encourage more home-based care, more adult daycare, alternatives to nursing home care. And honestly, having sat down with some of the folks in the nursing home industry, I think they would not be opposed to that appropriate continuum of care if, again, we match it with the type of approach that we make the mindset in this country that when you buy life insurance, health insurance, you also got to go ahead and buy long-term care insurance.

Mr. DAVIS. Right. Has there been any discussion—

Chairman BARTON. Let this be the last question.

Mr. DAVIS. [continuing] about the States collectively engaging in regional compacts to pool their purchasing power to negotiate discounts in the pharmaceutical industry, and are there Federal obstacles to your doing so? And if you don't have time to fully answer that, I would certainly like to hear the answer—

Governor WARNER. Well, the short answer is yes, there are obstacles, particularly driven by the fact that we can't even get the benefits that we have already negotiated with the new Medicare direct benefit coming along. And then second, in terms of purchasing pools, we think they ought to be expanded, but you have got to have some ability to manage the adverse selection where the younger employees or the firms with the younger employees opt out.

Chairman BARTON. The gentleman's time has expired. The gentleman from Michigan, Mr. Rogers.

Mr. ROGERS. Thank you, Mr. Chairman. Thank you, Governor. Thanks for taking a little extra time today. And as you can see by the tone of the questions, it is going to be a difficult decision for all of us to get there, and we appreciate your leadership. To have

all the Governors come together and say we need more flexibility in a system that has 1,500 waivers, I mean this is a system that has not worked well for the States. And to have the courage to stand up and say give us the flexibility that we need and we will put a product out there that takes care of the disabled, that takes care of the needy elderly, that takes care of the needy populations in America is pretty exciting. And it is going to take that kind of leadership to get, I think, through this committee. And your help in that is going to be very, very important.

I want to talk about a couple of things. HSA is a great example. That is an innovation that is working in the marketplace. We have seen about 40 percent of the over a million people who have signed up for these things never had access to healthcare before. Pretty powerful thing. You have called, in the NGA's recommendation, a national Healthcare Innovations Program where you would go out in 10 to 15 large demonstration projects. Can you just talk a little bit about how you envision—what the kind of things you would like to see that tackle?

Governor WARNER. Well, let me give you my particular bias as somebody who spent 20 years in the technology industry before I transferred to this interesting business. The fact that we don't have the power of IT in the largest sector of our economy, that we have not used information technology to bring any kind of efficiency should be an embarrassment to all of us. The fact that we don't have electronic medical records and that we have not—to bring a true electronic medical record to the table on a State or regional basis, we have got to have resources, but also some ability to change the behavior folks that—whether it is providers and others, whether they have got legacy systems or the fact that they just don't want to change how they operate, we have got to change. And that will require not only the State, that will require the Feds; that will require hospitals, insurers, Pharma, local doc providers to come to the table. We need to move past talking about this, which we have been talking about for 10 years and actually start making it happen.

Now, there are some demonstration projects; there have been—I can point to a system in Central Virginia, our VCU Health System has gone a long way, but it is still a closed system. We have got to make it on a much broader basis. That would be a prime example.

I think purchasing pools is another example where we are going to have to let some folks, a la welfare reform, try things. I know there will be some consternation about mandatory purchasing pools where if you try to include various groups inside, you can't opt out. So that we can get the aggregate numbers we need to try to be able to purchase the level of healthcare that is provided from both the—you know, and you might be combining Medicaid populations with currently privately covered populations. But we ought to try that. Again, from both sides where we have been so far is we can't be afraid to shake this system up because, again, I come back to some of the questions I have heard from some of the members. There is no Governor—because we are the first folks people turn to if there is a healthcare—there is no Governor that doesn't want to increase the quality of healthcare for the most vulnerable of our citizens.

Mr. ROGERS. So——

Governor WARNER. But we have to be able to recognize that even if we defer this debate for a year or two, it is not going away, and let us go ahead and sit down together and try to work through it.

Mr. ROGERS. And that is a very good point. You are not going to let those people fall through the cracks. You are going to do everything that you can, and I believe you. And the Governors came out and said they are going to establish enforceable premiums, deductibles, and co-pays. You are not doing that to exclude people from the system, are you? Do you want to have a co-pay that excludes somebody from participating or are you trying to say that people need to participate in the healthcare delivery system in America? We need to apply consumerism so that everybody is invested in the solution. That is the way I understood——

Governor WARNER. We need to understand that there is a sense of personal responsibility, but we also have to recognize there are many people on Medicaid who are so poor that they have extraordinarily limited resources. And that is why, again——

Mr. ROGERS. But if we gave the——

Governor WARNER. [continuing] I am taking the notion——

Mr. ROGERS. [continuing] State the flexibility, you could make that determination of what that ought to look like. But in some cases you would recommend that somebody should pay a co-payment, even if it is a nominal fee. Is that correct? That is the way I understand this——

Governor WARNER. That is what we are looking at, but recognizing that there needs to be some caps, because there are—I think there is also going to be—let me be clear here. One of the things I think this would move toward, I think it would dispel the notion that this is somehow to save your Medicaid; this is not. There will be some perhaps marginal savings here. And if we can do that and dispel the notion a little bit that there is great abuse going on, let us have at it.

Chairman BARTON. The gentleman's time——

Governor WARNER. But——

Chairman BARTON. [continuing] has expired.

Governor WARNER. [continuing] it is not a silver bullet.

Chairman BARTON. The gentleman's time has expired. The distinguished ranking member of the full committee, Mr. Dingell of Michigan, is recognized for 5 minutes.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy. Welcome, Governor. I am pleased that you are here with us. Governor, a series of questions. You noted that the Governors 11 in number and others had an input. Were representatives of children's groups included in the development of the proposal?

Governor WARNER. Congressman, we worked with our Governors, we worked with our Medicaid directors——

Mr. DINGELL. Yes, but Governor, with all respect, time is very limited. Were representatives of the children's groups included in the development of——

Governor WARNER. No, that is why this was the National Governors Proposal.

Mr. DINGELL. Now, were representatives of the disability community or seniors groups included in the development of the proposal?

Governor WARNER. Well, I guess what I would take some issue with is saying that somehow Governors and/or Medicaid—

Mr. DINGELL. Governor, this—

Governor WARNER. Can I answer your question?

Mr. DINGELL. [continuing] is a search for fact, and I am just asking a yes or no. And I say so with all respect, but I have 4 minutes remaining and—

Governor WARNER. Right. The—

Mr. DINGELL. [continuing] I have a lot of questions—

Governor WARNER. [continuing] answer is this is the National Governors—the people who were involved in this proposal were the National Governors—

Mr. DINGELL. Okay.

Governor WARNER. [continuing] Nation's Governors, their Medicaid directors, and their health—

Mr. DINGELL. So, then, I assume the answer is no?

Governor WARNER. I have said who was—

Mr. DINGELL. Okay.

Governor WARNER. [continuing] involved.

Mr. DINGELL. Now, were representatives of the physicians groups, nursing groups, hospital groups, representatives of nursing homes included in the development of the program?

Governor WARNER. The Nation's Governors, the Medicaid directors, and their health advisors were involved in this.

Mr. DINGELL. And so you are having to tell me again that the answer is no?

Governor WARNER. No.

Mr. DINGELL. Now, I have some other questions here, Governor. And, again, I apologize for being so brusque because I have great respect for you, but I have got to get certain questions and the answers in the 3 minutes and 22 seconds remaining. Your proposal has been called tiered benefits. And then it has had other names applied to it. I want to know if this proposal will provide beneficiaries with the flexibility in a way which is intended to save the States money, or is it intended to accomplish other purposes?

Governor WARNER. No, what we are geared at is recognizing that we have to meet, at least in my State, 50 cents of every dollar that is spent in Medicaid to make sure that we can yes, save resources, but also our proposal is to encourage reinvestment in areas such as Federal tax credits for long-term care, for purchasing of health insurance for those folks so they won't fall onto the Medicaid rolls.

Mr. DINGELL. Now, the Medicaid law requires that payments must be made only for medically necessary treatments. The only way I can figure that you would save money, then, is by taking away benefits who currently need and are using them. Am I incorrect in that assumption?

Governor WARNER. Well, no, what I think there remains a question, and I can tell you how we addressed it in Virginia. Is there inappropriate use? If you have a, you know, the classically cited example of the head cold that shows up at the emergency room four times in the same month. I don't think that happens enormous amounts of time, but if it does happen, I need a tool to make sure that we prevent that from happening—

Mr. DINGELL. Now, I assume—

Governor WARNER. [continuing] and don't reimburse—

Mr. DINGELL. [continuing] that you have—

Governor WARNER. [continuing] our hospitals at the—

Mr. DINGELL. I assume that under existing law you may address that problem, may you not?

Governor WARNER. We may—

Mr. DINGELL. Is there anything—

Governor WARNER. [continuing] address it—

Mr. DINGELL. [continuing] inhibiting you—

Governor WARNER. We may address it, but if there was a way that allowed us a differential co-pay on the fourth visit to the emergency room, that is a tool I would like to see.

Mr. DINGELL. Under existing law you have the capacity to address fraud, waste, abuse, misuse of the system by beneficiaries, do you not?

Governor WARNER. I don't believe we have all the tools that would make this system—

Mr. DINGELL. I am going to—

Governor WARNER. [continuing] the best possible—

Mr. DINGELL. [continuing] submit a letter to you, Governor, because the points you are making are very good and I want to find out about that particular question. Does the NGA proposal allow States to cut nursing home benefits to people with incomes below \$7,000 a year?

Governor WARNER. That is not our intent. That is not my intent.

Mr. DINGELL. Does the NGA proposal allow States to cut medically necessary services needed by children and families whose income is under \$12,000 a year?

Governor WARNER. That is not our intent. That is not my intent.

Mr. DINGELL. Okay—

Governor WARNER. Matter of fact, we have taken—let me just again—you missed the earlier part of my presentation. And matter of fact, Virginia has dramatically expanded its children health program and been recognized by Kaiser as one of the most successful in the country.

Mr. DINGELL. Governor, don't take my comments as being critical or hostile. They are simply a quest for facts. Does the NGA proposal allow States to cut pregnancy-related services to pregnant woman?

Governor WARNER. In Virginia we actually expanded that coverage this year.

Mr. DINGELL. I would note that in Virginia, a Medicaid beneficiary living in Alexandria, Virginia, with two children can only have \$384 a month in income to still qualify for the program. In Arkansas, a person with two children on welfare, TANF, would have no more than \$204 a month in income to still qualify. Is there any way you can—

Chairman BARTON. This will have to be the gentleman's—

Mr. DINGELL. [continuing] at those levels, Governor?

Chairman BARTON. This will be the gentleman's last question.

Mr. DINGELL. I thank you, Mr. Chairman. Governor, you have my apologies if I have offended you.

Governor WARNER. I just wanted to try to give factual answers to your questions.

Chairman BARTON. Do you want to answer his last question?

Governor WARNER. No, in both of those cases, again, earlier we cited the fact that in Virginia what we did, particularly for expansion of our SCHIP program was we cut back on any co-payments so we could expand our program.

Chairman BARTON. Gentleman from Oregon, Mr. Walden.

Mr. WALDEN. Thank you very much, Mr. Chairman. Governor, thank you and thank you to your colleague who has had to leave for excellent work in this effort. I want to follow up on the issue of co-pays that my colleague from Michigan raised. We wrestled with this when I was in the Oregon legislature and we were implementing the Oregon Health Plan and talked about the idea of co-pays. And one of the issues that came up was a concern about collectability of them. Have you all looked at that? Because even—

Governor WARNER. Yes.

Mr. WALDEN. [continuing] if it is \$2 or \$3, we were hearing testimony that said docs, others are going to end up eating it because they are just not—

Governor WARNER. Right.

Mr. WALDEN. [continuing] going to get paid. Do you have a mechanism you are kicking around?

Governor WARNER. We are still trying to sort through that because it was and is an issue.

Mr. WALDEN. Okay. All right. We also heard testimony in those days, and this was quite a while back, that co-pays might help in the sense of trying in some way to get people to actually keep their appointments. Some of the medical community found that some Medicaid patients would make appointments and not keep them at a higher rate than others. Have you found that to be the case?

Governor WARNER. That has been our experience as well.

Mr. WALDEN. And are you looking from—

Governor WARNER. But whether the co-pay—

Mr. WALDEN. Yes, I don't know if—

Governor WARNER. [continuing] system has changed that behavior in keeping appointments, I can't speak to that. I don't know.

Mr. WALDEN. Is your—

Governor WARNER. But it is one of the things we ought to find out.

Mr. WALDEN. Well, that is what I wondered. Is your taskforce looking at that as an issue that the—

Governor WARNER. We have not at the gubernatorial level. I think the Medicaid directors have discussed this. But at the gubernatorial level we haven't drilled down to that level.

Mr. WALDEN. Okay, because that was an issue we kept hearing about too, and, you know, I am one of them who says just because a law has been on the books 40 years doesn't make it untouchable. We should use the latest in technology; we should think outside the box and say how do we make this the best possible system given the budget constraints we are given?

One of the other issues that comes up is the Federal law EMTALA that requires emergency rooms, hospitals—

Governor WARNER. Right.

Mr. WALDEN. [continuing] you go in there, you get care. And there has been some talk, some ideas kicked around about giving

some relief there to say if you are not truly an emergency case, the ER room should have the ability to refer you, then, perhaps to a public clinic or elsewhere. Have you all looked at the implications of that law and policy?

Governor WARNER. You are asking me not only to stick my head out but get it chopped off three different ways but—

Mr. WALDEN. That is why it is so nice you are there and I—

Governor WARNER. No, we have not looked at that specifically, but let me tell you what we have done. We have said that if a hospital provides, as they should, provides that care and it was an inappropriate use, for example, of the ER, that we will only reimburse at a doctor visit rate rather than an ER visit rate. And so we have incented—and, again, this is something that a lot of States haven't done yet. The hospitals are trying to put in place now, you know—

Mr. WALDEN. But can that—

Governor WARNER. [continuing] a better screening process so the person still gets care—

Mr. WALDEN. Right.

Governor WARNER. [continuing] but we have shifted some of the burden over to the hospitals to try to—

Mr. WALDEN. Well, that is why I wondered—

Governor WARNER. [continuing] push them toward the clinic as opposed to the ER.

Mr. WALDEN. And help me on this one. Do they have the authority under Federal law to make that move—

Governor WARNER. No, I don't—

Mr. WALDEN. [continuing] to push that—

Governor WARNER. One, I don't know the answer. Two, I think—

Mr. WALDEN. Okay.

Governor WARNER. [continuing] they do not. But three, what we have simply used is our—

Mr. WALDEN. Well, yes, you just push the cost onto—

Governor WARNER. Right.

Mr. WALDEN. [continuing] them, but as a bigger picture is that a law. Okay. One we probably should take a look at. I don't know whether it is you or Governor Huckabee talked about the issue we have looked at in the Oversight and Investigations Subcommittee on AWP versus ASP, average wholesale—

Governor WARNER. Right, right.

Mr. WALDEN. [continuing] price versus average sales price. We have found some extraordinary disparities, and really what appears to be, and I am sure there are those that can educate me on a different manner, but perverse incentive when a drug goes generic to actually keep the price high to maintain market share. Have you found that?

Governor WARNER. I can't speak to that specifically, but I am concerned about this notion of as drugs fall into that generic category that the fact that they are sometimes—they have kept prices artificially high, which is not fair or right. We are starting to look at other countries, what Canada has done and others, about trying to—

Mr. WALDEN. You might want to go—

Governor WARNER. [continuing] better to find generics.

Mr. WALDEN. I know you have lots of time and nothing to read, but you might want to get the transcripts from some of our hearings on this issue. It was pretty phenomenal, people testifying under oath what happens in that system.

Governor WARNER. Mr. Chairman, I will listen to everybody's opening comments first on that transcript before I—

Chairman BARTON. Yes, sir.

Governor WARNER. [continuing] listen to that.

Mr. WALDEN. Yes, cut right to the witnesses, believe me. The final issue, given your experience in community healthcare, I am curious about—we have held some oversight hearings on the expansion of the federally qualified healthcare facilities. I have seen them firsthand in my district, incredible work they are doing. Do you see this community health center concept as a reliever and an effective and affordable reliever that may actually hold down cost of Medicaid?

Governor WARNER. I think it is one of the tools. We have got I think 41 community healthcare centers. We also have the largest number of free clinics of any State in the country. And, again, one of the things that goes back to why I am pushing part of this process and pushing reforms that some may say, you know, oh, my gosh, you know, how are you willing to even consider these? Because I see the 1 million Virginians who don't have anything who access healthcare on an episodic basis through free clinics who have no permanent medical home at all, and they are the ones who are really getting stuck by our system and, you know, to again say that, you know, we are not willing to at least look at how we can fix Medicaid. And somehow we are going to put off the greater problem, the 45 million plus Americans who don't have any healthcare coverage at all for another day just isn't fair or right. And we can—

Chairman BARTON. Gentleman's time has—

Governor WARNER. [continuing] do this at the same time expand some level of care, that is in the best interest of this—

Chairman BARTON. Gentleman's time has expired. The Gentlelady from California, Ms. Capps.

Governor WARNER. I am going to have to make this the last—

Chairman BARTON. Well, if you could do one more on each side, Ms. Capps and the long-suffering Dr. Burgess. Do two more? They both have been here the whole time.

Ms. CAPPS. Thank you, Mr. Chairman. Thank you, Mr. Governor, for your testimony. I listened very carefully to it. And there is an elephant in this room, no partisan pun intended, which you referenced with respect to pharmaceutical costs, but exploding costs of healthcare are the bottom line across the board everywhere. For example, the growth in the cost of premiums for private insurance programs has risen 12 percent per year, twice as fast as the growth of increased costs for Medicaid as one example. And I hope there is a chart that is going to be lifted up so that you can see it.

[Chart]

Ms. CAPPS. There is a version for you.

Governor WARNER. With my eyes, that is about a perfect range—

Ms. CAPPS. Is that a good range for you? I would like to focus on with your time as a percentage of income, Medicaid beneficiaries out-of-pocket medical expenses, as you can see, are substantially larger than those with private insurance. And, for example, in 2002 poor adult Medicaid beneficiaries' incomes under \$797 a month spent 2.4 percent of their incomes on medical expenses. Privately insured adults with incomes over twice the poverty levels, incomes more than \$1,595 a month spent less than 1 percent. And this proposal about co-pays and increasing the out-of-pocket costs for Medicaid beneficiaries could be categorized as nothing more than a tax on the poor for being sick or trying to stay healthy. Many of those Medicaid beneficiaries have extending circumstances that make it tougher for them to stay healthy, labor work, repetitive motion, and those with disabilities, it goes on and on. It seems to me that what we are considering is increasing taxes on those who can least afford it when they are sick. And this is, you know, something that you are proposing. I want to ask, given that the poor are already paying much more out of pocket for their care on average than affluent families, you know, how will they manage to do this? They don't get a discount at the tax pump, low-income families don't get a discount when they buy school clothes for their kids or a discount at the grocery store or a discount on their rent. And we have seen difficulty this year with gasoline prices, heating, fuel costs, housing costs, how can we expect that they are going to be able to pay?

And my real topic that I want you to address in addition to those concerns of mine, we have, as part of our crisis, an exploding number of people without health insurance as people become unemployed, as more and more employers are eliminating health insurance because they can't afford it, small businesses and others. Now, you are making the case and your association that your desire for flexibility is to keep more people insured. I would like to hear how you propose to do that.

Governor WARNER. Great. Well, first of all, you know, someone who has, you know, spent enormous amounts of time trying to make sure—going back to our Children's Health Initiative—that we—

Ms. CAPPS. Yes.

Governor WARNER. [continuing] sign up more kids, I have seen these studies. I have seen other studies as well that have the opposite result. I do know this on just kind of a baseline; Congress set as a co-pay level \$1 to \$3 in the early 1980's. I think some being willing to give some flexibility to have some marginal increase to that, \$3 to \$5, \$3 to \$6 is what I believe your own study looked at. I am willing to have that on the table. Let me assure you, we have, unfortunately, many parts in Virginia still where folks are struggling every day to get by. But what I also feel very strongly about is that what you were asking me to when I have to match 50 cents on every dollar and I have got to make—you know, again, I come back to my point I made earlier—I have got to make a budget balance—

Ms. CAPPS. All right.

Governor WARNER. [continuing] and another editorial comment, we have dealt with taxes in a way to make sure that—

Ms. CAPPS. Yes.

Governor WARNER. [continuing] we can pay our bills—

Ms. CAPPS. Let me ask you one more—

Governor WARNER. No, please—

Ms. CAPPS. [continuing] question.

Governor WARNER. [continuing] let me finish here. And I feel that same level of concern for somebody who makes \$50 over the Medicaid eligibility line who has nothing.

Ms. CAPPS. I so much—

Governor WARNER. And that is—

Ms. CAPPS. [continuing] agree—

Governor WARNER. [continuing] exactly why I am saying, you know, I have changed on this. It may not be a perfect on the employer/employee tax credit to at least have them purchase some level of a—

Ms. CAPPS. I hear you.

Governor WARNER. [continuing] modified benefit package that may look like an SCHIP package. I think it—

Chairman BARTON. I want to—

Governor WARNER. [continuing] makes sense—

Ms. CAPPS. I—

Governor WARNER. [continuing] when we try—

Chairman BARTON. The gentlelady's time has expired and we still have five members that haven't asked questions. And the Governor is only going to let one more go. I am going to ask Dr. Burgess—I am going to recognize him, but I would hope that he would at least allow Mr. Engel to ask one question, because Mr. Engel was here at the gavel and has waited the whole time, and it is not probably going to have a chance to have his own time. So I am going to recognize—okay, the gentleman yields his first 2½ minutes to Mr. Engel. Two and a half minutes.

Mr. ENGEL. Thank you. I will speak very fast. Welcome, Governor. It is nice seeing you hear rather than on a plane. And I have been listening to your testimony, and no wonder people think you are a rising star. I just want to quickly say that the Medicaid discussion, there is no denying that budgetary numbers are playing a major role, and I think what you have heard from many of us, particularly on this side of the aisle is that we feel the priorities are misdirected in this Congress, that if we didn't have these huge tax cuts for wealthy people there would be more money to share for the Medicaid program with the States.

I would like to just say two things and then ask you to comment in some—and I thank my colleague, Mr. Burgess, for yielding to me. What bothers me is there are a million people living with HIV/AIDS. New York is one of the epicenters of that unfortunately. If we are going to say that under current Medicaid standards the beneficiary could be charged up to \$3 per prescription, in the case of an individual that might be taking multiple drugs might be \$45 a month, it really would impact very, very negatively on these people. I am wondering if you could talk about that.

And also, Governor Huckabee had mentioned the changing of the ability to have redress in the courts, and that bothers me because if you take a State like California, the State wasn't screening kids for lead poisoning and people went to court and changed that. The AIDS epidemic, Missouri refused to provide coverage for AIDS

drugs; they went to court and lost. If you take that away, I am afraid that we are going to have a lot of problems. So if you can comment to anything I have said, I would appreciate it.

Governor WARNER. I appreciate your comments and very briefly, at some level you have to hope and expect the Governors are going to bear some level of responsibility and not, you know, put someone who has AIDS and be able to have them so restrict their drugs they can't get the therapy they need. There has to be, again, some balance here. I think that most Governors have not, you know, when we have been granted flexibility in the past have not abused it. There are exceptions, but I think for the most part they will do the right thing.

I think in terms of—we have tried to draw very, very narrowly the question on judicial reform. And I understand your concern. There was a number of us that were concerned on some of the consent decree.

Chairman BARTON. Dr. Burgess—

Mr. ENGEL. Thank you.

Chairman BARTON. [continuing] last 3 minutes.

Mr. BURGESS. Governor, thank you very much for being with us today. It has really been a fascinating discussion that we have had. Quickly, what have you done in Virginia to keep employers from dropping out of the private insurance when you have expanded coverage in your SCHIP and your Medicaid program? You said you brought 95 percent of children into the fold, and we have a problem back in Texas with some employers dropping out of the insurance coverage when that happens.

Governor WARNER. Well, again, we have relatively low eligibility standards again, so that it is not—we are serving children that we think desperately need it. I think you raise a bigger question, which is if you are going to provide some incentive, and what we propose, for example, a tax credit that might go toward small businesses or might even go toward employees to be able to purchase some form of private health insurance, how do we not turn that into an incentive for employers to drop coverage? And if you asked me 2 years ago I would have said, and that is the reason why I don't support that tax credit approach. What I am saying 2 years later with what I see of this taking place anyway, with what I see with increasing caseloads, with what I see with these increasing costs, we have got to try to find a way to sort through to not tip the balance so the people actually no longer provide the health insurance. But for those who are on the edge, there ought to be an employer contribution, but somehow craft something to try at least in the middle. That is not a very good answer, not very articulate, but I hope you know what I am—

Mr. BURGESS. I do, and in fact at the risk of oversimplifying, I see three populations on the Medicaid system, the truly medically destitute, medically frail who are going to need the big—

Governor WARNER. Full boat.

Mr. BURGESS. [continuing] safety net that Mr. Huckabee was talking about. And then you have got, of course, the long-term care issue that does have to be dealt with. And in between you have got the patients that I used to see in my medical practice, basically pregnant moms who need help paying for insurance. And they don't

need the same kind of safety net that the medically frail and indigent need. So I certainly welcome your concept, whether we call it vouchers, premium support, or tax credits, I am absolutely in favor of that, and I would like to see us be able to expand that and offer the whole panoply, HMO, PPO, EPO, HSAs, whatever, to that segment of the population and let them choose what best fits their needs.

Finally, in the last few seconds I have, I couldn't help but think as I watched both of you up here, we are seeing a preview of the debates of 2008, and I hope you do remember that you are the last bipartisan game in town, and we will keep the tone as great as we have seen it this morning. It was truly something to watch, both of you together. Thank you.

Governor WARNER. Thank you.

Chairman BARTON. We have five pending votes on the floor. We are going to adjourn the hearing. Unfortunately, Mr. Ross and Ms. Myrick and Mr. Shimkus aren't going to be able to ask verbal questions, but they will be given the opportunity on the written record.

We want to thank you, Governor. We will be working with your taskforce and the Governors Association. This committee is a bipartisan committee, and we intend to report a bipartisan Medicaid reconciliation package sometime this fall. This hearing is adjourned.

Governor WARNER. Thank you, Mr. Chairman.

[Whereupon, at 2 p.m., the committee was adjourned.]

[Additional material submitted for the record follows:]

PREPARED STATEMENT OF GOVERNOR ANIBAL ACEVEDO-VILÁ, COMMONWEALTH OF PUERTO RICO

MEDICAID REFORM: THE NATIONAL GOVERNORS ASSOCIATION'S BIPARTISAN ROADMAP

The federal Medicaid partnership with U.S. commonwealths and territories has become increasingly unbalanced over a period of years...The imbalance affects quality of care issues and creates increased financial stress. Medicaid reform needs to include a review of the current relationship and the development of a pathway that moves to a rebalancing of this partnership.

National Governor's Association
Policy Position
EC-16. Medicaid Reform Policy

The National Governors Association Policy Position EC-16 recognizes the imbalance that has developed over a period of years in regard to the Federal Medicaid partnership, the Commonwealth of Puerto Rico and the U.S. territories.

I would like to take this opportunity to add my support to the NGA policy and to put forward interim steps that begin to address this imbalance.

In 1968, three years after the start of the Medicaid program, Congress established a \$20 million limit on the level of federal Medicaid that would be available to the Commonwealth of Puerto Rico. At that time Federal Medicaid costs, nationally, totaled \$1.1 billion. The Commonwealth matching assistance percentage (FMAP) continued at the 50 percent level; however, the Federal cap meant that there was no reimbursement for expenses to Puerto Rico once the Commonwealth expended \$40 million. From time to time, Congress has raised the cap, but has never reviewed the cap in terms of healthcare or fiscal policy.

Currently, the Commonwealth of Puerto Rico's effective FMAP rate approximates 18 percent. If the 1968 cap had been authorized to grow at the same rate as Medicaid grew nationally, Federal support for Medicaid in Puerto Rico would now approximate \$1.7 billion, as opposed to the current Federal support of \$219 million. In the states, federal Medicaid support approximates \$330 per month per participant as compared to federal support in Puerto Rico of about \$20 per month per participant. If Puerto Rico's 1968 Medicaid cap had increased as the Medicaid program

increased, nationally, the average monthly Federal contribution would be about \$173 per participant, still a fraction of average Federal support.

These are the challenges the Commonwealth's healthcare community confronts while operating in an economy where the cost of living is no less than many metropolitan areas in the states, and all of the Federal regulatory requirements governing healthcare facilities and providers are the same in Puerto Rico as they are in the states.

As Congress moves forward with its review of Medicaid, I would urge that the Committees consider adhering to four principles in terms of addressing Medicaid in Puerto Rico:

1. It is in the interest of both the Federal Government and the Commonwealth that the existing healthcare gap between the Island and the states does not grow any greater, and that measures need to be taken to narrow this gap.
2. Federally mandated expenses resulting from Federal consent decrees and U.S. Justice Department enforcement actions should be reimbursed outside of the cap.
3. Critical healthcare needs, particularly for children, persons with disabilities and the frail elderly, need to be considered as strategic healthcare investments, with the Federal contribution coming outside of the cap.
4. The Federal investment in Puerto Rico's healthcare must be safeguarded and efforts and initiatives, particularly in technology, that can safeguard the Federal investment and make the healthcare system more productive should be encouraged and supported.

In addressing the first principle of not allowing the healthcare gap between the Island and the states to grow any further, I believe that there are three actions which the Committee can take this year that would be meaningful in starting to address the current imbalance:

1. *Family Opportunity Act (FOA) (HR1443, S183)*. The FOA, as drafted, effectively precludes Puerto Rico from participating, as the cap on Medicaid reimbursement will prevent any Federal participation. If Congress enacts FOA this year, it is essential that Puerto Rico be permitted to participate in this program and the New Freedoms Initiatives must be placed outside of the cap, so that families and children with disabilities in Puerto Rico are not left behind.

2. *Transitional Medical Assistance (TMA)*. The Congress requires Puerto Rico to meet all of the same work standards of the Temporary Assistance to Needy Families (TANF), but the Commonwealth is not authorized to participate in TMA. TMA is recognized as one of the most critical elements in the success of moving families from welfare to work. When Congress reauthorizes TANF and TMA, it is essential that Puerto Rico be authorized to participate in and receive reimbursements for TMA so that it is in a stronger position to meet its TANF obligations.

3. *Adjustment Factor*. From 1998 to 2003, Federal support for Medicaid increased nationally 65 percent while Federal support for Medicaid in Puerto Rico increased 30 percent. The disparity in the growth rate is an issue that must be addressed this year, because each year that it is delayed, there is increasing pressures on the Commonwealth's healthcare system and fiscal strength. I urge the Committee to amend the provisions related to the annual adjustment for the Puerto Rico's Medicaid cap so that the adjustment is no less than the percentage increase in the national Medicaid program. This can be an important step in addressing the overall healthcare gap. It will also be consistent with actions Congress took in regard to the Medicare Modernization Act where the annual adjustment to the Commonwealth's block grant is based upon the annual growth of Medicare Part D.

These three steps start to lay the foundation to address the current imbalance. By including Puerto Rico in the two authorizations and adopting an adjustment policy that reflects changes in the program nationally, Congress will put into practice the principle of not permitting the imbalance of the Commonwealth/Federal Medicaid partnership.

I urge the Committee to consider these proposals as you move forward with budget reconciliation and I am certainly available to work with the Committee to find solutions which start to realign the current imbalance of the Commonwealth Medicaid partnership with the Federal government.

When Congress considers long term comprehensive Medicaid reform, I urge the Committee to examine the issues I raised previously, including:

1. *Impact of Consent Decrees*. The Commonwealth is under two consent decrees initiated by the US Justice Department requiring the expenditure of funds that are eligible for Medicaid reimbursement, but not eligible for a Federal match in Puerto Rico. My fellow Governors are concerned about the impact of the consent decrees since they are required to pay between 20 and 50 percent of their costs (Federal Medicaid financing the balance). I am particularly concerned as the Commonwealth

is not authorized to receive any additional reimbursements for eligible Medicaid costs resulting from the enforcement action of the U.S. Justice Department, and is required to absorb 100 percent of the costs.

2. *Critical Needs.* Critical healthcare needs, particularly for children, persons with disabilities and the frail elderly must be assessed with consideration given to possible support for strategic healthcare needs investments and should be viewed in the context of Medicaid reform to insure that these vulnerable populations are adequately served. One simple way to begin to take care of these critical needs and to begin to narrow the existing gap would be a new policy that would place the Federal contribution of Medicaid coverage outside of the existing cap for every child born after a date certain. This way, we begin to take care of our children first, and we tackle the existing gap in a slow, but steady fashion.

3. *Safeguards and Technology.* The Federal investment in Puerto Rico's healthcare must be safeguarded. Efforts and initiatives needed to protect that investment and make it more productive should be encouraged and supported. While technology development has been encouraged in the states with as much as 90 percent reimbursements for improvements, the Commonwealth has not been authorized to receive similar support. The President's initiative on "interoperable health information technology infrastructure" is an opportunity to make great strides in the quality and productivity of the Commonwealth's healthcare system, that can pay dividends to both the Federal government and Puerto Rico, provided the Commonwealth is authorized to access Medicaid funding for the development of these systems, in a manner similar to the states.

As Congress moves forward with comprehensive Medicaid reform, I encourage the Committee to follow the guidance of the NGA policy where it recommends that Medicaid reform "needs to include a review of the current relationship and the development of a pathway that moves to a rebalancing of this partnership." The cap established in 1968 is grounded in neither healthcare nor economic policy. The result is an effective FMAP for Puerto Rico of approximately 18 percent, a rate that could not be sustained in any jurisdiction.

The Commonwealth of Puerto Rico has a long history and strong commitment to providing comprehensive healthcare in its communities, and that commitment is not going to change. However, meeting that goal and fulfilling the Federal statutory requirements such as Early and Periodic Screening, Diagnosis and Treatment (ESPD), and Health Insurance Portability and Protection Act (HIPPA), Federal Court rulings such as *Olmstead* and *Cedar Rapids*, and meeting the Federal regulatory requirements of Health Resources and Services Administration and the Center for Medicare and Medicaid Services without a more balanced Federal partnership creates inordinate financial pressure that has an impact on the type of healthcare provided.

As the Committee moves forward with budget reconciliation I would urge establishment of the principle that the current Commonwealth/Federal Medicaid partnership should not develop any further imbalance, and that this goal can be accomplished by enacting the three proposals I have outlined. Secondly, in terms of comprehensive long term Medicaid reform I urge the Committee to examine the current Commonwealth/Federal Medicaid partnership with the objective of establishing a more balanced partnership, particularly in light of the healthcare needs, consent decrees and opportunities for technological advances.

Working together, sharing ideas, examining the effects of current policy, I believe that we can establish a pathway to rebalancing the Commonwealth/Federal partnership, a pathway that makes economic sense for both the Federal government and the Commonwealth.

PREPARED STATEMENT OF BARBARA KENNELLY, PRESIDENT NATIONAL COMMITTEE TO PRESERVE SOCIAL SECURITY AND MEDICARE

Mr. Chairman and Members of the Committee: Chairman Barton, Ranking Member Dingell, and members of the Committee, I appreciate your leadership in holding this hearing on the future of Medicaid—a program of vital interest to our nation's seniors.

Over the next few months, Congress will be considering a number of changes to Medicaid, likely involving substantial cuts to the program. On behalf of the 4.6 million members and supporters of the National Committee to Preserve Social Security and Medicare, I strongly urge you to oppose cuts to the Medicaid program.

For the past forty years, the Medicaid program has played a crucial role in our country's health care system by providing public health insurance for low-income Americans. The program protects those that are among the most medically and eco-

nomically vulnerable—children, adults, disabled individuals, and seniors—who do not have access to or cannot afford private health insurance. According to the Congressional Budget Office, in 2005 Medicaid will provide health coverage to 58.5 million people (including 5.4 million senior citizens and 9.2 million disabled individuals)¹.

Older Americans benefit from an array of important services provided by Medicaid, such as: hospitalization, physician services, long-term care, prescription drugs, clinic services, prosthetic devices, hearing aids, and dental care. While seniors represent only 9 percent of Medicaid's enrollees, they receive over a quarter of Medicaid's expenditures. Seniors receive a larger share of Medicaid's expenditures because they require more frequent and expensive medical attention. The Kaiser Family Foundation estimates that in 2003 the Medicaid program spent almost \$13,000 per senior.²

Senior citizens also benefit from Medicaid because of its leading role in our nation's long-term care system. The program's spending accounts for 43% of our nation's total spending on long-term care. For example, Medicaid provides vital financing for nursing homes, which rely on the program for about half of their total funding. Further, nearly 60 percent of all nursing home residents receive Medicaid. The fiscal year 2006 budget resolution passed by Congress targets the Medicaid program for billions of dollars in reconciled cuts over the next five years. The National Committee strongly opposes any cuts or funding caps to the Medicaid program. Cutting the program or imposing caps on federal payments to the states would disproportionately hurt seniors by ending coverage for millions of beneficiaries and/or shifting rising health care costs on to state governments that are already struggling to meet the needs of an aging population.

It is impossible to make meaningful reforms to the Medicaid program without examining the flaws in our nation's health care system. The growth in Medicaid spending is symptomatic of the larger problems with health care, such as: growing health care costs, skyrocketing prices of prescription drugs, declining employer-sponsored health care coverage, and the increasing number of the uninsured. Despite these daunting facts, Medicaid's overall growth rate is significantly lower than that of private health insurance premiums (6.9 percent for Medicaid versus 12.6 percent for private insurance premiums)³.

About twenty-two percent of National Committee member households have incomes below \$15,000 per year and many are eligible for Medicaid benefits. Our members know that the program's financing structure has proven highly successful in responding to difficult economic times because it guarantees coverage to all those who are eligible. Therefore, we believe it is essential to preserve the current structure of the Medicaid program.

Thank you for giving me this opportunity to discuss Medicaid and to share the National Committee's views on the program before this Committee. As always, I look forward to working with you on the host of issues impacting America's seniors.

¹ Congressional Budget Office. "Fact Sheet for CBO's March 2005 Baseline: Medicaid and the State Children's Health Insurance Program". Washington, D.C.: March 2005.

² Kaiser Commission on Medicaid and the Uninsured. "The Medicaid Program at a Glance." The Henry J. Kaiser Family Foundation. Washington, D.C.: January 2005.

³ These figures refer to the average growth rate per enrollee for acute care from FY2000-2003. For additional information, see John Holahan and Arunabh's article "Understanding The Recent Growth In Medicaid Spending, 2000-2003" from the January 26, 2005 edition of Health Affairs.

July 5, 2005

Governor Mark R. Warner
Executive Office Building, 3rd Floor
111 E. Broad St.
Richmond, VA 23219

Dear Governor Warner:

I am writing to thank you for appearing before the Committee on Energy and Commerce on June 15, 2005, to present testimony at our hearing entitled, "Medicaid Reform: The National Governors Association's Bipartisan Roadmap." Your testimony allowed Members of the Committee to gain a better understanding of this extremely important issue.

Pursuant to the Rules of the Committee, the hearing record remains open to permit Members to submit questions to witnesses. Attached are questions submitted by Members of the Committee. I would appreciate it if you could respond to these questions in writing and electronic format (Word or WordPerfect) no later than the close of business on Monday, July 18, 2005, in order to facilitate the printing of the hearing record.

Thank you again for your time and effort in preparing and delivering testimony before the Committee.

Sincerely,

Joe Barton
Chairman

Attachment

ENERGY AND COMMERCE COMMITTEE
 SUBCOMMITTEES
 Energy and Air Quality
 Health (Vice Chairman)

EDUCATION AND THE WORKFORCE
 SUBCOMMITTEES
 Select Education
 Workforce Protections (Chairman)

House Army Caucus
 House Rural Health Care Coalition
 Congressional Sportsman's Caucus

Charlie Norwood
 9th District, Georgia

Congress of the United States
House of Representatives

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June 23, 2005

Governor Mark Warner, Chairman
 National Governors Association

Dear Governor Mark Warner:

I want to first thank you for your and Governor Huckabee's testimony at the House Energy and Commerce hearing on the National Governor's Association (NGA) suggested reforms to the Medicaid program. As you know from my statements and questions posed at the hearing, I am encouraged by the bipartisan work the NGA has accomplished. However, I also have several concerns about the current structure of the Medicaid program which I would like the NGA to more fully address.

As you well know, Medicaid is jointly funded by both the federal and state governments and the current spending rate is unsustainable. This issue transcends political party and geography. Medicaid has grown to cover more than 50 million people nationwide at an astounding cost of \$300 billion each year. The program has become one of the most costly federal programs. It is also the most expensive program for every state.

Right now, Medicaid is structured in a way that makes the status quo unsustainable. While the federal government can continue spending at the same pace, the states, even those with the very best matches under the program, can't keep up. That means that some states, many of which have a mandate to balance their budgets, are cutting recipients off their programs.

Too often, folks up here in Washington think of reform as meaning some basic changes, but we have a profound opportunity to radically change how we think about providing Medicaid benefits. We also have the opportunity to do some real good for the neediest of our citizens in the process. In this light, I was wondering how the NGA would view a scrapping of the current match program with a replacement program that sees the federal government provide a baseline of care for a mandatory population. The federal government would set this mandatory population, as we do already and cover certain procedures. The states could then add to these services and expand those covered as each saw fit. How would the NGA react to such an approach?

In addition, I know something that has been stressed in the Medicaid reform debate, as well as the NGA report, is injecting more personal responsibility into the Medicaid program. This is something I absolutely agree with, but what is the firm policy that we in Congress can enact to reform Medicaid, preserve the safety net, and at the same time encourage as many people as are able to take more responsibility for their care, particularly their long term care?

This leads to my next question. Does the NGA believe that Medicaid is the best place to provide long term care? Assuming that long term care remains under the Medicaid program, we will need to reduce these costs. Obviously, moving more individuals to long term care insurance is a logical and reasonable solution. However, does the NGA believe it is feasible that any strategy to move a significant amount of long term care recipients or potential recipients to private insurance will be successful as long as Medicaid exists in its current form? What does the NGA think is the best means for us to encourage people to get long term care insurance? Finally, what would the NGA think of a federal mandate requiring that our citizens carry long term care insurance, as we do at the state level for motor vehicle insurance? In those cases where individuals could not afford the premiums of basic long term care insurance, the federal government could cover the cost. The resulting cost savings would be significant when compared to the current system, which sees people of all economic backgrounds qualifying for long term care coverage and the Medicaid program picking up the vast majority of the cost for such care.

Also, one of the points made in the NGA's report that caught my eye was a focus on judicial reform, which is something I'm very interested in. I was wondering if you could elaborate a little bit more on that and what exactly Congress can do to protect states that are seeking to enact reforms for the improvement of the system and our citizens.

Finally, as I'm sure you're aware, illegal aliens that abuse our public health sector are quickly becoming a major issue and one in which I have been actively engaged for some time. The growth in the number of illegal aliens affects all Americans, especially those who live in border states. While the problem begins at our borders, that is not where it ends. My state of Georgia is experiencing a tremendous strain on our social programs and public health infrastructure due to illegal aliens tapping into services meant for American citizens and legal aliens. This is allowed in spite of federal law explicitly forbidding any such practice.

I was wondering what the NGA proposes to do in respect to getting those off Medicaid who don't belong. Specifically illegal aliens, but also those few 'millionaires on Medicaid' we've heard about. This would restore the program to its original design as a safety net for America's most vulnerable. I'm very concerned that we don't know the resources we are expending on this segment of the population, and Medicaid reform is at its basic level a resource issue.

For this reason, I would like to know what steps you are taking to keep illegal aliens from receiving Medicaid benefits? Recent studies have shown that the number of

uninsured U.S. residents is often overstated because many of these individuals are illegal aliens. While I am aware that Medicaid is not supposed to benefit those illegally in our nation, we know that it certainly does. I respect your answer to this question during the hearing along that line of reasoning but we both should be able to realize that this does not match up with reality.

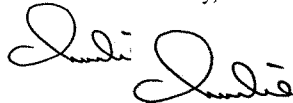
For example, a pregnant woman in labor who is apprehended at our border will receive a full range of care in a local hospital and her child will be eligible for Medicaid benefits. The program will end up picking up many of the costs associated with such treatment and there are plenty of other scenarios which are far less emotional that see non-citizens reaping the benefits of the Medicaid program. Since we do not ask persons seeking care if they are citizens, illegals can easily qualify for emergency care, obstetric services, as well as other services.

From unlimited Emergency Room access to those who have learned to manipulate state bureaucracies that do not properly enforce federal law, Medicaid benefits are going to absconders and away from America's needy. Of all these violations, the last is the obviously the most blatant disregard of federal law. The Centers for Medicare and Medicaid Services (CMS) has the responsibility to work with the states to see that the Medicaid program is implemented per federal law but in my opinion, has failed in this responsibility.

What can Congress do in conjunction with the NGA to crack down on this abuse and can the NGA even estimate the amount of Medicaid money spent on illegal aliens at the state level? With the number of individuals over age 85 expected to triple by 2050, and Medicaid spending continuing to force reductions in the number of beneficiaries at the state level, we cannot afford to have illegal aliens cheating the system and defying federal law.

I look forward to your response and thoughts to these important questions and suggestions. I want to once again thank you for your leadership and the efforts of the NGA to enter a collaborative discussion with Congress on this very important subject. If you have any questions, please feel free to contact me at (202) 225-4101.

Sincerely,

A handwritten signature in black ink, appearing to read 'Charlie Norwood', written in a cursive style.

Charlie Norwood

Member of Congress

A) Regarding your proposed approach to reforming the Medicaid program, like you, the Governors are interested in finding policy solutions to ensure that the program can continue to serve as a vital health care safety net for those who cannot get care from any other source. In response to your specific approach of eliminating the current matching approach in exchange for the federal government fully funding a "baseline of care for a mandatory population", it would be important to know more particulars about what populations and services would be included in the proposed baseline before being able to comment on the proposal. In addition to Medicaid reforms, Governors believe that reforms outside of the program must be made to address the issues of health care costs and quality, the erosion of the employer-sponsored market, and the nation's lack of a long-term care strategy. Such reforms would slow the number of low-income individuals becoming eligible for Medicaid to ensure future financial sustainability of the program.

The Governors' proposal puts forth a number of policy changes that would encourage individuals to take more responsibility for their care while still preserving the safety net. Related to long-term care, our proposal puts forth both short term solutions to relieve some of the burden of financing the long term care safety net (e.g. policies to reduce the use of asset transfers and make reverse mortgages a more viable financing option); as well as policies to encourage personal responsibility and self-planning for individuals' long-term care needs (e.g. tax credits and deductions for long-term care insurance and expansion of the Long Term Care Insurance Partnerships).

Governors are concerned that Medicaid has become the nation's *de facto* long-term care insurance plan. Medicaid now provides half of all long term care spending in the country and covers two thirds of all people in nursing homes. Medicaid is no longer just a safety net and policies must be enacted to encourage those with resources to self-finance their care and to support families who can provide care to their frail family members. The national debate on long term care must confront the growing need for long-term care services and the ability/willingness of people to plan ahead for that inevitability.

As you point out, the Governors are proposing that judicial reforms are necessary to allow states to manage their Medicaid program. The right of states to locally manage the optional Medicaid categories is clearly defined in both policy and law, and the federal government should remove legal barriers to that impede this fundamental management tool. To that end, Congress and the Department of Health and Human Services (HHS) should authorize states to rightfully make basic operating decisions about optional categories of the program. Currently, federal judicial actions have sometimes become a means by which the judicial branch makes decisions about Medicaid programs that should be left in the hands of state elected officials and competent program managers. If the management of the Medicaid program is being handled in a manner that is consistent with legislative and congressional intent, the court system should not become involved. When the courts are involved, HHS officials should have to stand by states in the judicial system, for example when one of their waivers is questioned, and work with states to define for the judiciary system states' rights to make basic operating decisions about optional categories of the program. Additionally, the Governors believe that federal reforms are needed to constrain the broad ability of judicial decrees in Medicaid cases that impede state innovation and reform. In a time of shrinking resources and growing demand it is not realistic to ask states to manage these complex programs with court decrees

overriding sound management decisions. These court decisions and the subsequent legal actions that follow, increase administrative costs and divert valuable resources that could be far better spent on services to clients.

Speaking to your concerns about the impact of illegal aliens on the Medicaid program, Governors agree that this population has an impact on the health care system as uncompensated care leads to higher costs for all payers. Currently, illegal aliens are not eligible for Medicaid and states are not enrolling such individuals into the program. We do not have any estimates of the amount of Medicaid money spent on illegal aliens at the state level, however. As you are aware, states neither set nor enforce immigration policy. The consequences of illegal immigration for the health care and social safety net are significant, but this is true regardless of whether Medicaid covers them or not.

**U.S. Representative Sue Myrick
Follow-up Questions to Governor Mark Warner
“Medicaid Reform: The National Governors Association's Bipartisan Roadmap”**

1. Governor Warner, can you please discuss your proposal to implement a closed, or limited, formulary in order to reduce drug costs? I understand the rationale for having restricted formularies, like those used in the Medicare Part D plans, but I'm concerned about some coverage groups- like the severely mentally ill. Many of these mental health patients, who are over-represented in the Medicaid population, sometimes need medicines that are rarely interchangeable for effective treatment. As you know, some states exempt certain psychiatric medications from preferred drug lists and other cost control policies. Do you think states should be able to exempt such drugs in the future? Has the NGA come to a consensus about how to deal with formularies for the most fragile patient populations?

A) The Governors proposal includes giving states the option of using a closed formulary to drive beneficiary utilization and decrease costs similar to those that will be used by Medicare Part D plans. As you mention, some states that currently have implemented preferred drug lists have chosen to exempt psychiatric medications. Decisions such as this should continue to be left up to individual states as they determine what works best in their Medicaid program. Governors recognize that the Medicaid program currently cares for frail patient populations. For more medically fragile populations, Governors are proposing changes in order to encourage more chronic care management and other services that can improve health outcomes. We recognize that shortsighted fixes can result in decreased Medicaid costs but greater increases in uncompensated hospital care. Governors have every incentive to ensure that medically necessary services are delivered appropriately and efficiently to those in need.

Questions from the Honorable John D. Dingell**The Honorable Mark R. Warner, Governor of Virginia****National Governors Association Executive Committee****June 15, 2005****Committee on Energy and Commerce****Hearing entitled: "Medicaid Reform: The National Governors Association's Bipartisan Roadmap"**

1. The National Governors Association (NGA) has said over the past few months that the Federal Government should not shift any more costs to the States. As I look at your proposal, however, it appears to me that what you are advocating is a cost shift to beneficiaries. Nearly 80 percent of children in Medicaid are in families earning less than 100 percent of the Federal poverty level (FPL) (\$1,069 a month for a family of two). Likewise, nearly 80 percent of individuals with disabilities on Medicaid have incomes of less than \$797 a month. Where will these individuals and families find the means to pay for care if Medicaid requires co-pays that they cannot afford?

A) The Governors' proposal recognizes that financial protections are a critical balance to the increased flexibility governing cost-sharing in the Medicaid program and propose that beneficiaries not be required to pay more than 5% of total family income (or 7.5% for higher-income households). Furthermore, states would have broad latitude to waive cost-sharing for any population or service that it determines would be negatively impacted by increased cost-sharing. The purpose of cost-sharing is not to restrict access to necessary medical care. The Governors propose that new cost-sharing policies would be monitored and evaluated heavily to evaluate the impact on beneficiaries, and if the evidence shows that increased cost-sharing harms appropriate access, the policies should be revised.

2. Should Medicaid reforms include both desirable efficiencies, such as cheaper prescription drugs, which produce savings, as well as initiatives that re-invest a portion of these savings to address program shortcomings? Do you agree that some of the high-priority investments the Congress should examine include:
 - (a) Helping to stop the reduction in Federal Medicaid matching funds that will hit more than 20 States next year without Federal intervention?
 - (b) Reducing the more than \$1 billion in costs that, according to CBO, States will face from additional administrative activities and "woodworking" effects from the Medicare prescription drug benefit?
 - (c) Helping to reduce the effect of the so-called "clawback" on States? As you know, the clawback requires States to pay back to the Federal Government a portion of the savings they would otherwise receive from low-income Medicare beneficiaries who are making the transition to Medicare for their prescription drugs.

- (d) Helping to finance the Family Opportunity Act, a program that would allow higher-income families to purchase Medicaid coverage for their severely disabled child, as a State option?
- (e) Helping to finance a State option to provide coverage to legal immigrant children and pregnant women?
- (f) Helping to ensure that the currently unspent CHIP dollars that were originally allocated to the States are not returned to the U.S. Treasury?
- (g) Ending the 24-month waiting period for individuals with disabilities before they qualify for Medicare?

A) The Governors believe that Medicaid reform should be driven by good public policy and not by an arbitrary budget number. If however, Medicaid reforms are enacted that provide greater than expected savings in Medicaid, it would be appropriate to also consider reinvestments that could help states further improve their programs. These reinvestments should consider the impact on state budgets.

3. Prevention should be a core precept of any health program, and is particularly important in the Medicaid program, since it results in overall savings to the healthcare system. For instance, we know that when low-income children receive preventive dental care, their costs are almost 40 percent lower than those who do not. Furthermore, when one compares the cost of managing symptoms related to tooth decay, it costs approximately 10 times more to treat Medicaid patients in the emergency room than these same patients in a dental office. Preventive dental services use less than one percent of the Medicaid budget, and there is a savings of nearly 40 percent per child by ensuring that they receive preventive dental services.
- (a) Current law requires States to provide dental benefits to all children in Medicaid. In fact, one of the problems with SCHIP is that not all States cover dental benefits. Does your “benefit flexibility” proposal include allowing States to eliminate dental benefits for children in Medicaid?
 - (b) Does your cost-sharing proposal call for charging higher co-payments for children’s dental services? How do we ensure that children continue to have access to these important services? Clearly increasing cost sharing would cause some children to lose access to dental care. Do you have an estimate of how many?

A) The goal behind the increased flexibility being sought in the Governors’ proposal is not to decrease use of appropriate services, but to be able to better manage state Medicaid programs in order to improve health care delivery. Governors recognize the importance of providing access to certain services, including preventive services for children such as dental care.

4. The NGA describes its cost-sharing proposal for Medicaid as similar to what is allowed in SCHIP. But the NGA proposal appears to be less protective of beneficiaries than SCHIP's requirements. Children below 100 percent of the FPL are not in SCHIP and thus are protected from any cost-sharing requirements. For those in SCHIP with incomes between 100 and 150 percent of the FPL, cost sharing is limited to nominal amounts.
- (a) Would the NGA proposal retain all of these protections from SCHIP? For example, would impoverished seniors in nursing homes be exempt from these new cost-sharing requirements?
 - (b) Would people with disabilities who have no income except for their Supplemental Security Income check be exempt from these requirements?
 - (c) Would pregnant women be exempt from any of the cost-sharing requirements?
 - (d) Would children in low-income families who are at risk of going without needed preventive care be exempt from these requirements?
 - (e) Would you limit cost sharing for children whose family earnings fall between the Medicaid income cutoff (generally 100 percent or 133 percent of the FPL for younger children) and 150 percent of the FPL, such as SCHIP does?
 - (f) It appears that the five or 7.5 percent cap in your proposal would only apply to cost sharing paid on Medicaid-covered benefits. But if the States are also cutting coverage for some benefits, that also will increase families out-of-pocket costs. Low-income families could end up paying much more than 7.5 percent out-of-pocket for health care. And, I would note, 7.5 percent of income for someone working 40 hours a week at \$12 an hour would mean that person's cost sharing would amount to four weeks of pay under the NGA proposal. Would your proposal allow the cap to apply to all cost sharing, whether or not the benefits are covered under Medicaid?

A) The Governors propose making the federal rules governing cost-sharing look more like SCHIP, where states would have broad discretion to establish any form of premium, deductible, or co-pay for all populations, for all services. The proposal recognizes that Medicaid beneficiaries should have financial protection from cost-sharing requirements. As in SCHIP, the Governors propose financial protections to ensure that beneficiaries would not be required to pay more than 5% of total family income. These limits are being proposed for all individuals in the Medicaid program with suggestion of a higher percentage of income limits (e.g. 7.5% limit) for beneficiaries with higher incomes (for example, those above 150% FPL). It is important to note that these cost-sharing changes are not being proposed as a requirement, but merely a framework for states to develop policies that meet the unique needs of their citizens. States would have broad latitude to waive these types of cost-sharing for any populations or services that it

determines would be negatively impacted by such policies. The intent behind the proposal is to allow states to better manage health care by encouraging necessary health care in the most appropriate setting.

5. The proposal of the Governors asks for “benefit flexibility” so they can provide Medicaid beneficiaries benefits similar to those in SCHIP. This seems to imply that the basic benefit protection for children, known as the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT), would be eliminated.
 - (a) Does the NGA reform proposal eliminate EPSDT for children -- a benefit that Secretary Leavitt said should not and would not be eliminated?
 - (b) If so, would all children lose these benefits? What benefits would be lost?
 - (c) How many children would be affected?
 - (d) What will poor children who lose this benefit do?

A) Governors believe that Medicaid reform should include the ability to offer a different level of benefits, using S-CHIP as a model, to certain Medicaid beneficiaries, such as those for whom Medicaid serves as a traditional health insurance program. Many states have found that the flexibility built into the SCHIP program allows for greater efficiencies without compromising care. The Governors do however acknowledge that there are people served by Medicaid that need a comprehensive package of benefits. For more medically fragile populations, Governors are proposing changes in the benefit package in order to encourage more chronic care management and other services that can improve health outcomes. The goal of this flexibility is to allow states to design their programs to reflect the very diverse Medicaid populations that range from relatively healthy children to those with serious physical and developmental disabilities. The types of services and supports needed by these populations are quite different.

6. (a) Proposals by the Governors and the President increase penalties on individuals who transfer assets and then qualify for Medicaid. Do the Governors support a policy that would go after grandparents who - unaware that a nursing home was in their future - paid for part of their grandchild’s college education or would the Governors’ policy allow for some commonsense exceptions to mandatory recovery either during the existing lookback period or during some longer period to the extent States were allowed to lengthen the lookback? If the Governors support certain exemptions, what kinds of transfers and what purposes should be exempted?
- (b) Currently, the state may not seek recovery from the assets of relatives of the individual needing nursing home care.

- (1) Do the Governors support a policy that would allow the State to go after a grandchild in college to recoup the money given by a relative now needing Medicaid nursing home care either during the existing lookback period or during some longer period?
- (2) Do the Governors support a policy that would allow the State to go after the assets of adults, either during the existing lookback period or during some longer period, if their own parents need nursing home care but was unable to pay?

A) The Governors believe that Medicaid's most important role is as a safety net program, providing health care and long term care services to people who have no other options. However, Medicaid now provides half of all long term care spending in the country and covers two thirds of all people in nursing homes. Medicaid is no longer just a safety net and policies must be enacted to encourage those with resources to self-finance their care and to support families who can provide care to their frail family members. It is understandable for seniors to want to pass along something to the next generation, but it is equally as important for public policy to encourage the next generation to similarly respect and care for seniors in return. The national debate on long term care must confront the growing need for long-term care services and the ability/willingness of people to plan ahead for that inevitability.

7. The cost of prescription drugs is one of the primary cost drivers in Medicaid, and has been growing at double-digit rates for several years. One area of the NGA interim Medicaid policy that shows great promise is the proposal to increase the rebate States would receive on the price of prescription drugs Medicaid buys.
 - (a) If Congress were to enact this proposal, how would States benefit? What do you think the impact of these proposals on state budgets would be?
 - (b) Some have said that increasing the rebate really does not benefit the beneficiaries because not all States require the rebate money to go back to the Medicaid program, thus allowing it to go to the general treasury. Do you believe that is a fair criticism?

A) It has long been understood at the state level, and increasingly accepted at the federal level, that the state Medicaid programs have been paying too much for prescription drugs. The base price upon which we reimburse, the Average Wholesale Price, is understood to be an inflated number that does not truly represent actual costs, and yet this has formed the basis of state reimbursements for 15 years. Reforms to this are needed as well as other avenues of federal and state savings least likely to negatively impact beneficiary access to health care. The statute generally requires that Medicaid receives the "Best Price" with respect to what other health care entities pay. In practice, this has not been the case; increasing the minimum rebate percentage would help ensure lower Medicaid costs.

Rebates to the states from pharmaceutical manufacturers should not be viewed as a separate funding stream or an added bonus to states, because they are merely a mechanism to ensure that the bottom

line prices that states pay for prescription drugs are as low as possible.

8. As you are aware, the Federal Government is slated to move some six million "dual eligibles" -- very low-income seniors and people with disabilities who are enrolled in both Medicaid and Medicare -- from Medicaid to Medicare drug coverage by January 1, 2006. All evidence suggests that this is going to be a difficult and complicated transition, particularly since it needs to be accomplished on a short timetable and many dual eligibles are ill-equipped to cope with significant change in their health care coverage.
- (a) What thoughts do you have on the implications of this transition for the low-income Medicare beneficiaries on Medicaid in your State?
 - (b) To what extent are your Medicaid agencies prepared to help facilitate this transition?
 - (c) Do you need additional assistance from the U.S. Department of Health and Human Services or Congress to help make the transition go smoothly?
 - (d) Are there additional steps that the Federal Government should be taking to help ensure that the transition to Medicare drug coverage for dual eligibles goes smoothly?

A) The extent to which The Congress can grant HHS the authority to share pharmacy utilization data as real time as possible between the PDPs and MAPDs and Medicaid agencies would be beneficial for the continued care coordination of the population (as it stands now, plans will not be required to share such data with states--and CMS is not permitted to share the utilization data that plans report to them with the states). Such data is used by states daily to intervene with disease and case management.

States would like to make contact with PDPs and MAPDs as early as possible to prepare for coordination of benefits and to make decisions about what drugs to provide to their beneficiaries that are not covered by some or all plans.

Clear communication with pharmacists will be essential--since many beneficiaries will have their first interaction with this new benefit at the pharmacy level. It is essential that pharmacists are educated and know who to contact to resolve confusion or disputes of beneficiaries.

Questions from the Honorable Jan Schakowsky
The Honorable Mark R. Warner, Governor of Virginia
The Honorable Mike Huckabee, Governor of Arkansas
On behalf of the National Governors Association

June 15, 2005

Full Committee Hearing entitled: "Medicaid Reform: The National Governors Association's Bipartisan Roadmap"

1. In my mind, your testimony makes the case that Medicaid is more important than ever because the private market is failing. As you point out, Medicaid is covering frail and expensive individuals whom the private market either refuses to cover or would cover at a cost that those individuals cannot afford. Your draft report also states that "the Medicaid program is extremely cost effective compared to private sector health care," and we know that per capita acute care costs for Medicaid rose 6.9% between 2000 and 2003, compared to 12.6% in the private sector where individuals are healthier.

Why, then, are you proposing that we increase reliance on the private market through tax credits, particularly in the individual market which we know discriminates against people with high health care needs through medical underwriting and which is the least cost-efficient of any form of coverage?

Are you proposing that the states share in the cost of these new tax credits for the purchase of more costly private insurance - or is it your intention that the federal government shoulder all the costs?

Have you prepared any analysis about the costs of covering individuals through Medicaid versus the cost of private insurance - not just in terms of state budgets but also in terms of overall costs? Do those analyses assume that cost-sharing and benefits would be comparable? Can you provide those analyses to this committee?

A) Governors believe that reforms outside of the Medicaid program must be made to address the issues of health care costs and quality, the erosion of the employer-sponsored market, and the nation's lack of a long-term care strategy. Such reforms would slow the number of low-income individuals becoming eligible for Medicaid to ensure future financial sustainability of the program. Included in these reforms are, as you mention, are policies that would encourage an increased reliance on the private market. For example, through small employer and individual tax credits for health insurance for low-income workers, individuals that would otherwise rely on Medicaid for coverage could afford private insurance; thereby reducing the burden on states and the federal government to fund such coverage. Also included in the Governors proposal is the establishment of state purchasing pools that would provide affordable insurance for individuals eligible for new tax credits to purchase health insurance

coverage.

Our proposal would rely on federal health care tax credits which could, at state option, be supplemented by additional state tax credits.

It is also important to consider that one cause of Medicaid's efficiency compared to the private sector is its provider reimbursement rates which are lower than private sector rates. While Medicaid is often justified at paying much lower rates, due to its nature as a safety net, this practice often has the compounding effect of shifting costs to the privately insured market as they increase rates to compensate. Strengthening employer-based and other forms of private health care coverage would provide greater overall reimbursements to providers and reduce the need for this cost shifting.

2. One of the questions that arise with the increased reliance on private insurance is that of regulation. If we are going to spend even more taxpayer dollars to subsidize private insurance, it seems to me that someone needs to be looking at the reasonableness of private health insurance premiums. Although the federal government would pay increased subsidies for the purchase of private health and long-term care insurance policies under your proposal, states would retain sole authority for insurance regulation.

Can you provide us with:

- The list of states that require prior approval of premium increases before they go into effect?
- The list of states that require review if premium increases are about a specified level? The number of states that have refund authority?
- The list of states that have the authority to order refunds if premiums are found to be excessive?

A) We do not have this information readily available, but enclosed is information from the National Association of Insurance Commissioners that should prove useful. There is a chart which depicts state rate filing requirements as well as a copy of the NAIC rating model for long term care insurance which almost half of the states follow. The rating model requires penalties for carriers that have ANY rate increases. (Enclosures)

3. Medicaid's administrative costs are low. Can you tell us how many states have loss-ratio regulations that limit the percentage of health insurance premium dollars that can go into administrative costs and profits, rather than the provision of patient care?

A) We do not have this information readily available. We would be happy to work with you and the National Association of State Medicaid Directors to further explore this issue.

4. You propose giving states the authority to increase cost-sharing with a family income cap of 5% or 7.5% for those with "higher incomes." Is it correct that the cap would apply only to Medicare covered services? Would costs for non-covered benefits be in addition to the cap? If Medicaid recipients do not have the means to pay for Medicaid cost-sharing, could providers such as physicians, hospitals, pharmacies and labs refuse to provide treatment under your proposal?

A) The Governors propose making the federal rules governing cost-sharing look more like S-CHIP, where states would have broad discretion to establish any form of premium, deductible, or co-pay for all populations, for all services. The proposal recognizes that Medicaid beneficiaries should have financial protection from cost-sharing requirements. As you mention, the Governors propose financial protections to ensure that beneficiaries would not be required to pay more than 5% of total family income. These limits are being proposed for all individuals in the Medicaid program with suggestion of a higher percentage of income limits (e.g. 7.5% limit) for beneficiaries with higher incomes (for example, those above 150% FPL). It is important to note that these cost-sharing changes are not being proposed as a requirement, but merely a framework for states to develop policies that meet the unique needs of their citizens. States would have broad latitude to waive these types of cost-sharing for any populations or services that it determines would be negatively impacted by such policies. The intent behind the proposal is to allow states to better manage health care by encouraging necessary health care in the most appropriate setting.

Also included in the Governor's proposal is the ability to make cost-sharing enforceable, which would allow where appropriate, providers to require beneficiaries to pay cost-sharing requirements. It is important to recognize again, here, that the idea behind such enforceable copays would be to steer beneficiaries to more affordable alternatives (e.g. generic drug or care in a physician office instead of an ER for non emergencies), not to prevent beneficiaries from accessing necessary, cost-effective care in the most appropriate setting.

5. We have ample evidence that increasing cost-sharing reduces utilization. Can you tell us, under your cost-sharing proposal, what percentage of the savings would come from lower utilization? We also know from the Rand and other studies that higher cost-sharing reduces utilization of both necessary and unnecessary care. Do you have any evidence as to how higher cost-sharing would affect access to necessary care? Do

you have any recommendations as to how to reduce unnecessary care without affecting access to necessary care?

A) The purpose of the proposed increased flexibility to allow Governors to use cost-sharing in the Medicaid program is not to restrict access to necessary medical care. The Governors propose that new cost-sharing policies would be monitored and evaluated heavily to evaluate the impact on beneficiaries, and if the evidence shows that increased cost-sharing harms appropriate access, the policies should be revised. Through the experience of managing a Medicaid program, states would be able to ensure that beneficiaries are accessing necessary services. Governors recognize that shortsighted fixes can result in decreased Medicaid costs but greater increases in uncompensated hospital care. States have every incentive to ensure that medically necessary services are delivered appropriately and efficiently to those in need.

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