# THE CONSEQUENCES OF OBAMACARE: IMPACT ON MEDICAID AND STATE HEALTH CARE REFORM

## HEARING

BEFORE THE

## COMMITTEE ON ENERGY AND COMMERCE
## HOUSE OF REPRESENTATIVES

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

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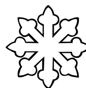

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# CONTENTS


| | Page |
|---|---|
| Hon. Fred Upton, a Representative in Congress from the State of Michigan, opening statement | 2 |
| Prepared statement | 3 |
| Hon. Henry A. Waxman, a Representative in Congress from the State of California, opening statement | 6 |
| Prepared statement | 31 |
| Hon. Joseph R. Pitts, a Representative in Congress from the Commonwealth of Pennsylvania, opening statement | 34 |
| Prepared statement | 35 |
| Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement | 38 |
| Hon. Cliff Stearns, a Representative in Congress from the State of Florida, prepared statement | 186 |
| Hon. Cathy McMorris Rodgers, a Representative in Congress from the State of Washington, prepared statement | 187 |
| Hon. Cory Gardner, a Representative in Congress from the State of Colorado, prepared statement | 189 |
| Hon. John D. Dingell, a Representative in Congress from the State of Michigan, prepared statement | 191 |
| Hon. Edolphus Towns, a Representative in Congress from the State of New York, prepared statement | 192 |
| Hon. Bobby L. Rush, a Representative in Congress from the State of Illinois, prepared statement | 193 |
| Hon. Eliot L. Engel, a Representative in Congress from the State of New York, prepared statement | 197 |
| Hon. Lois Capps, a Representative in Congress from the State of California, prepared statement | 201 |


## WITNESSES


| | |
|---|---|
| Gary R. Herbert, Governor, State of Utah | 41 |
| Prepared statement | 44 |
| Answers to submitted questions | 205 |
| Deval Patrick, Governor, Commonwealth of Massachusetts | 64 |
| Prepared statement | 67 |
| Answers to submitted questions | 210 |
| Letter to Mr. Cassidy, dated March 23, 2011 | 224 |
| Haley Barbour, Governor, State of Mississippi | 79 |
| Prepared statement | 81 |
| Answers to submitted questions | 227 |


## SUBMITTED MATERIAL


| | |
|---|---|
| Reports on The Benefits of Health Care Reform in Massachusetts, Mississippi, and Utah, March 2011, submitted by Mr. Waxman | 7 |
| Letter of February 3, 2011, from Kathleen Sebelius, Secretary, Department of Health and Human Services, to Governors, with Medicaid Cost-Savings Opportunities report, submitted by Mr. Waxman | 16 |
| Letter of February 24, 2011, from Marina L. Weiss, PhD, Senior Vice President, Public Policy and Government Affairs, March of Dimes, to committee leadership, submitted by Mrs. Capps | 115 |
| Statement of Pat Quinn, Governor, State of Illinois, dated March 1, 2011, submitted by Ms. Schakowsky | 125 |
| Statement of Service Employees International Union, dated March 1, 2011, submitted by Mr. Waxman | 130 |

Page

Statement of National Partnership for Women & Families, dated March 1, 2011, submitted by Mr. Waxman .... 132
Statement of the American Orthotic and Prosthetic Association concerning Medicaid, dated March 1, 2011, submitted by Mr. Waxman .... 133
Letter of March 2, 2011, from ACCSES et al. to Members of Congress, submitted by Mr. Waxman .... 143
Statement of the Pharmaceutical Care Management Association, dated March 1, 2011, with February 2011 report "Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs were Optimally Managed" by the Lewin Group, submitted by Mr. Bass .... 148
Letter of March 1, 2011, from Robert F. McDonnell, Governor, Commonwealth of Virginia, to Republican leadership, submitted by Mr. Griffith .... 177
Letter of February 28, 2011, from Nathan Deal, Governor, State of Georgia, to Mr. Gingrey .... 184

# THE CONSEQUENCES OF OBAMACARE: IMPACT ON MEDICAID AND STATE HEALTH CARE REFORM

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**TUESDAY, MARCH 1, 2011**

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

The committee met, pursuant to call, at 9:47 a.m., in room 2123 of the Rayburn House Office Building, Hon. Fred Upton (chairman of the committee) presiding.

Members present: Representatives Upton, Barton, Stearns, Whitfield, Shimkus, Pitts, Walden, Terry, Rogers, Myrick, Sullivan, Murphy, Burgess, Blackburn, Bilbray, Bass, Gingrey, Scalise, Latta, McMorris Rodgers, Harper, Lance, Cassidy, Guthrie, Olson, McKinley, Gardner, Pompeo, Kinzinger, Griffith, Waxman, Dingell, Markey, Towns, Pallone, Eshoo, Engel, Green, Capps, Doyle, Schakowsky, Gonzalez, Inslee, Baldwin, Weiner, Matheson, Butterfield, Barrow, and Matsui.

Staff present: Gary Andres, Staff Director; Michael Beckerman, Deputy Staff Director; Mike Bloomquist, Deputy General Counsel; Allison Busbee, Legislative Clerk; Howard Cohen, Chief Health Counsel; Marty Dannenfelser, Senior Advisor, Health Policy and Coalitions; Andy Duberstein, Special Assistant to Chairman Upton; Paul Edattel, Professional Staff Member, Health; Julie Goon, Health Policy Advisor; Todd Harrison, Chief Counsel, O&I; Sean Hayes, Counsel, O&I; Debbee Keller, Press Secretary; Ryan Long, Chief Counsel, Health; Jeff Mortier, Professional Staff Member; Monica Popp; Professional Staff Member, Health; Heidi Stirrup, Health Policy Coordinator; John Stone, Associate Counsel; Phil Barnett, Democratic Staff Director; Jen Berenholz, Democratic Chief Clerk; Stephen Cha, Democratic Professional Staff Member; Brian Cohen, Democratic Investigations Staff Director and Senior Policy Advisor; Alli Corr, Democratic Policy Analyst; Tim Gronniger, Democratic Senior Professional Staff Member; Purvee Kempf, Democratic Senior Counsel; Karen Lightfoot, Democratic Communications Director, and Senior Policy Advisor; and Karen Nelson, Democratic Deputy Committee Staff Director for Health.

Mr. UPTON. I would just note that some of the governors have been here in town for a couple of days. They are anxious to get back to their home States. We know that the airport is only minutes away, but because of that, we are going to be right on in terms of the clock, so expect a fast gavel for all of our members.

**OPENING STATEMENT OF HON. FRED UPTON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN**

Mr. UPTON. This month marks the 1-year anniversary of the President's signing into law a pair of controversial health care bills that are transforming the way Americans receive and pay for health care. We convene this hearing today to hear from the governors about what impact the health care law has had on their States thus far and what they believe to be the toughest challenges we face in implementing the President's health care reform package over the coming years.

Medicaid currently covers nearly 54 million Americans, and the Administration's chief health actuary has estimated that the Medicaid expansions included in the law could increase the Nation's Medicaid rolls by at least 20 million beginning in 2014.

While the President's health care reform package altered the relationship that the Federal Government has had with the States by requiring that States drastically expand their Medicaid populations, governors are also deeply concerned about the new unfunded mandates in the law and their impact on current State budgets.

The CBO estimates that these mandates and expansions will cost the States at least $60 billion but the States themselves estimate the cost to be nearly twice as much. Today I join members of the Senate Finance Committee to release the first comprehensive analysis of what the States themselves expect to spend as a result of the health care law and the results are sobering. Even using conservative estimates, the States expect to face an additional $118 billion in costs through 2023 as a result of the law's mandate.

Today's governors cannot afford to continue offering the same benefits in the same way to their existing Medicaid populations. However, the health care law puts them between a rock and a hard place. They cannot make eligibility changes in their options programs because the health care law freezes their current programs in place for years.

This hearing will be an opportunity to hear from three of the Nation's most thoughtful governors. Although as governors you are following very different roadmaps concerning health care reform, I believe that you can all agree that State innovation and flexibility are key.

[The prepared statement of Mr. Upton follows:]

**Opening Statement of the Honorable Fred Upton**
**Chairman, House Committee on Energy & Commerce**
**March 1, 2011**

This month marks the one-year anniversary of the President's signing into law a pair of controversial health care bills that are transforming the way Americans receive and pay for health care. We convene this hearing today to hear from Governors about what impact the health care law has had on their states thus far, and what they believe the toughest challenges will be in implementing the President's health care reform package over the coming years.

Medicaid currently covers nearly 54 million Americans, and the Administration's chief health actuary has estimated that the Medicaid expansions included in the law could increase the nation's Medicaid rolls by at least 20 million beginning in 2014.

While the President's health care reform package altered the relationship the federal government has with the states by requiring that states drastically expand their Medicaid populations, Governors are also deeply concerned about the new unfunded mandates in the law and their impact on current budget state budgets. The Congressional Budget Office estimates that these mandates and expansions will cost the states at least $60 billion, but the states themselves estimate the costs to be nearly twice that amount. Today I join members of the Senate Finance

Committee to release the first comprehensive analysis of what the states themselves expect to spend as a result of the health care law, and the results are sobering. Even using conservative estimates, the states expect to face an additional $118 billion in costs through 2023 as a result of this law's mandates.

Today, Governors cannot afford to continue offering the same benefits in the same way to their existing Medicaid populations. However, the health care law puts them between a rock and a hard place. They cannot make eligibility changes in their options programs because the health care law freezes their current programs in place for years.

This hearing will be an opportunity to hear from three of the nation's most thoughtful Governors. Although as Governors, you are following very different roadmaps concerning health care reform, I believe that you can all agree state innovation and flexibility are key. My hope is that by the end of today's hearing, we will have a better understanding of what this Committee can do to provide Governors the flexibility they need to create innovative health programs in a way that helps the people they serve, preserves quality, and reduces the financial burden on taxpayers.

I now yield one minute to the .....

Mr. UPTON. I yield now 1 minute to Mr. Barton.

Mr. BARTON. I thank you, Mr. Chairman, and I welcome our governors here, who right now are empty chairs but I am sure they will be here at the appropriate time.

Mr. BARTON. I am going to put my entire statement in the record, Mr. Chairman. Simply put, this is the same old story, just a new chapter. We have heard year after year that we need more flexibility for our Medicaid partners at the State level. My Governor of Texas has sent a letter that I will put in the record at the appropriate time, and he points out that in Texas alone, Medicaid is going to be 25 percent of the entire budget, and over the next 10 years it is going to cost an additional $27 billion in State matches to the Federal Government.

So this is a very good hearing. I look forward to listening to the three governors today and working with all governors of the 50 States to try to find a solution to help maintain this program and continue the benefit package but also find a way to impact the cost curve.

Thank you, Mr. Chairman, for the hearing.

Mr. UPTON. I yield the balance of my time to Dr. Burgess, 2 minutes.

Mr. BURGESS. I thank the chairman and I thank the governors for being here. I know it is an extra effort on your part. I do want to thank the chairman for his commitment to listen to the States in this exercise because it is so critical what happens at the State level.

Mr. BURGESS. There are a handful of people on this panel that have actually seen a Medicaid patient in their professional careers before coming to Congress. I am one of those. So when I point out the massive flaws in the system, it is not out of a lack of compassion but precisely the opposite. The Federal Government created this system to care for the poor and poorest in society but it has really now become an empty promise because oftentimes it is a bait-and-switch. The countercyclical nature of the program encourages growth in times of financial excess and then you are hit with maintenance of effort when the economy goes bad. Those with Medicaid find themselves unable to access services because Medicaid pays so much less than comparable services. Even Medicare pays better than Medicaid.

If we were to start fresh with a blank sheet of paper, what would it look like? Would it look like it does today? And really, very few of us on this side doubt that it would. Time after time, providers cite the lower reimbursement the paperwork as the two more important reasons for limiting their participation, and then we expanded the situation without improving it, so we made it worse. Here is the question: Why do we even still have Medicaid in 2014? The answer is, some people involved in the genesis of the law signed a year ago didn't care about how to provide the best care or how to coordinate or to get more people to purchase innovative insurance products. They needed to keep the CBO score down and that meant lumping everyone into Medicaid right at the last minute.

Mr. Chairman, I thank you for your indulgence. I will yield back.

Mr. UPTON. I would recognize the ranking member of the full committee, the distinguished gentleman from California, Mr. Waxman, for 5 minutes for an opening statement.

Mr. WAXMAN. Thank you, Mr. Chairman.

**OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA**

Mr. WAXMAN. Today we will hear the views of several of the Nation's governors on the impact of the Affordable Care Act and on the Nation's critical safety net health program, Medicaid. Medicaid and the ACA are both partnerships between the federal and the State governments. We share the responsibility for making these programs run efficiently and serve the needs of the populations that depend on them. So this can and should be a productive dialog. But in my view, that does not include re-litigating the Affordable Care Act.

ACA is already delivering important benefits: prohibiting insurance companies from rescinding insurance when someone gets sick, requiring coverage of preventive care for no cost, allowing young adults to stay on their parents' insurance up to the age of 26.

Three new reports we are releasing today highlight the benefits of the new law in the States represented by the three governors who will be testifying. They show, for example, that in Utah, 1.8 million residents are already receiving consumer protections against the worst abuses of the insurance companies. In Mississippi, over 30,000 seniors have already saved hundreds of dollars on high Medicaid drug costs, and I would like to ask, Mr. Chairman, that these reports, which show precisely how much the Affordable Care Act will help millions of Americans, be included in the record.

Mr. UPTON. Without objection.

[The information follows:]

**March 2011**

## The Benefits of Health Care Reform in Massachusetts

**Committee on Energy and Commerce, Democratic Staff**
**Henry A. Waxman, Ranking Member**

In March 2010, Congress passed and President Obama signed into law historic health care reform legislation, the Affordable Care Act. Millions of Americans are already benefitting from this law: insurers are no longer allowed to discriminate against children and others who are sick; small businesses are receiving billions of dollars in tax credits to provide health care coverage for their employees; and seniors are saving money on prescription drugs and receiving free preventive care through Medicare.

This analysis examines the benefits of the new law for Massachusetts and its residents. It finds:

- Massachusetts and its residents have already received **$270 million** in benefits under the new law and will receive **$9.3 billion** in benefits over the next ten years.
- Over **66,000** Massachusetts seniors have already received **$16.5 million** to help reduce prescription drug costs, and over one million seniors in Massachusetts will receive drug, preventive care, and other Medicare savings worth **$3.6 billion** over the next ten years.
- Up to **153,000** small businesses in Massachusetts have already earned as much as **$54 million** in health care tax credits and will receive **$1 billion** in tax credits over the next ten years.
- Over **570,000** Massachusetts households will receive **$4.7 billion** in tax credits and other federal assistance to help pay for health care over the next ten years.
- Community health centers in Massachusetts will receive over **$300 million** in new funding over the next ten years.

### Benefits for Middle Class Families

**Tax credits for health insurance.** Starting in 2014, the health reform law gives middle class families with incomes up to $88,000 for a family of four tax credits to help pay for health insurance. There are an approximately 570,000 households in Massachusetts that could qualify for these credits if they purchase their own health insurance or, in the case of households with incomes below 133% of poverty, receive coverage through Medicaid. These families, and the state Medicaid program, will receive $4.7 billion in tax credits and other federal health care assistance over the next decade.

### Benefits for Seniors

**Reducing drug costs for seniors.** In 2010, the health reform law provided a $250 rebate to Medicare beneficiaries who entered the Medicare Part D "donut hole" and lost coverage for their drug expenses. Over 66,000 Massachusetts seniors benefited from this provision, receiving $16.5 million in rebates. In 2011, seniors who hit the drug donut hole will receive 50% discounts on brand name drugs, and in subsequent years, this discount will increase until the donut hole is finally eliminated. A typical beneficiary who enters the donut hole will see savings of over $550 in 2011 and over $1,700 by 2020. Over the next decade, seniors in Massachusetts who hit the donut hole will save a total of $1.1 billion on drug costs.

**New preventive care benefits for seniors.** The health reform law improves Medicare by providing free preventive and wellness care, starting in January 2011. The law also strengthens the Medicare trust fund, extending its solvency from 2017 to 2029, improves primary and coordinated care, and enhances nursing home care. There are over one million Medicare beneficiaries in Massachusetts who are already benefitting from the provisions that provide for free preventive care. Over the next decade, these Medicare improvements will save Massachusetts seniors $2.5 billion.

**Benefits for Small Businesses**

**Tax credits for small businesses.** The health reform law provides tax credits to small businesses worth up to 35% of the cost of providing health insurance. There are up to 153,000 small businesses in Massachusetts that are eligible for this tax credit. These businesses have already earned as much $54 million in tax credits and will receive $1 billion in tax credits over the next decade.

**Employer assistance with retiree insurance costs.** The health reform law provides funding to encourage employers to continue to provide health insurance for their retirees. There are 162 employers in Massachusetts who are participating in this Early Retiree Reinsurance Program.

**Community Health Centers.**

**Assistance for community health centers.** There are 300 community health centers in Massachusetts that provide health care to the poor and medically underserved. Nationwide, the new law provides $11 billion in new funding for these centers. If the community health centers in Massachusetts receive the average level of support, the 300 centers will receive over $300 million in new assistance.

**Grants for Massachusetts and Health Care Providers**

The Affordable Care Act provides billions of dollars in new grant programs for states and health care providers to improve the health insurance market, reduce costs, and improve quality of care. Massachusetts and its health care providers have already received over $200 million in grants under the new law. This includes $1 million to detect, prevent, and roll back unreasonable insurance premium increases; $740,000 million for consumer assistance programs; $126 million to support groundbreaking biomedical research and reduce long-term growth of health care costs, $1.1 million for home visiting programs, and $14.4 million to support training of primary care doctors.

**Benefits for Massachusetts Taxpayers**

The health reform law reduces the nation's debt by eliminating waste, fraud, and abuse in the health care system, reducing the growth of health care costs, and preventing excessive profit-taking by private insurers. According to the Congressional Budget Office, the bill will reduce the deficit by over $200 billion over the next ten years and by over a trillion dollars in the decade after that. Repeal would eliminate these cost-cutting measures, adding more than $3,000 to the national debt for each American, including the 6.6 million residents of Massachusetts.

*This analysis is based upon the following sources: the U.S. Census (data on small businesses); the Centers for Medicare and Medicaid Services (data on Medicare and Part D enrollment and Medicare savings per enrollee); the Department of Health and Human Services (Affordable Care Act grants); the Health Resources and Services Administration (data on community health centers. Estimates of the total value of tax credits for families are extrapolated from statewide information on the percentage of families with incomes below 400% of the federal poverty level, the percentage of uninsured residents, and the estimated average tax credits received by middle-income families under the legislation. This estimate takes into account new federal assistance through Medicaid for individuals and families with incomes below 133% of the federal poverty level.*

March 2011

# The Benefits of Health Care Reform in Mississippi

Committee on Energy and Commerce, Democratic Staff
Henry A. Waxman, Ranking Member

In March 2010, Congress passed and President Obama signed into law historic health care reform legislation, the Affordable Care Act. Millions of Americans are already benefitting from this law: insurers are no longer allowed to discriminate against children and others who are sick; small businesses are receiving billions of dollars in tax credits to provide health care coverage for their employees; and seniors are saving money on prescription drugs and receiving free preventive care through Medicare.

Republicans in Congress have passed legislation to repeal the new law. Mississippi Governor Barbour has supported efforts to overturn the law, stating that "[t]he legislation would prove disastrous for Mississippi's economy, its budget, and its taxpayers." This analysis examines the benefits of the new law for Mississippi and its residents. It finds:

- Mississippi and its residents have already received almost **$70 million** in benefits under the new law and will receive over **$20 billion** in benefits over the next ten years.
- **1.5 million** Mississippi residents are already receiving protection from the consumer protections in the law, which prohibit annual and lifetime coverage limits, ban insurance rescissions, and provide safeguards against unreasonable rate increases.
- Insurance companies operating in Mississippi can no longer discriminate against **40,000 to 180,000** Mississippi children with pre-existing conditions and will be banned from discriminating against **480,000 to 1.3 million** Mississippi residents with pre-existing conditions.
- Over **30,000** Mississippi seniors have already received **$8.0 million** to help reduce prescription drug costs, and almost 500,000 seniors in Mississippi will receive drug, preventive care, and other Medicare savings worth **$1.7 billion** over the next ten years.
- **14,000** young adults age 26 and under have already obtained health insurance coverage under their parents' insurance plan.
- Up to **53,000** small businesses in Mississippi have already earned up to **$19 million** in health care tax credits and will receive **$350 million** in tax credits over the next ten years.
- Over **800,000** Mississippi households will receive **$14.1 billion** in tax credits and other federal assistance to help pay for health care over the next ten years.
- Health coverage will be extended to **315,000** uninsured Mississippi residents starting in 2014.
- Health care providers in Mississippi will save **$4.1 billion** in uncompensated care and community health centers in Mississippi will receive **$256 million** in new funding over the next ten years.

## Protections Against Insurance Company Abuses

**Prohibition on discrimination on the basis of pre-existing conditions.** Under the health reform law, insurance companies can no longer deny coverage to children with pre-existing conditions and will be banned from discriminating against adults with pre-existing conditions in 2014. There are 480,000 to 1.3 million residents of Mississippi with pre-existing conditions like diabetes, heart disease, or cancer, including 40,000 to 180,000 children. Repeal would allow insurance companies to refuse to insure these individuals if they seek coverage in the individual or small-group markets. The consequences would be particularly acute for the 100,000 to 260,000 individuals with pre-existing conditions who currently lack insurance coverage and who would be unable to purchase individual policies if the law is repealed.

**Prohibition on annual and lifetime coverage limits.** The health reform law prohibits insurance companies from imposing annual and lifetime limits on health insurance coverage. This provision protects the rights of everyone who receives coverage from their employer or through the market for private insurance. If this protection is repealed, insurers would be able to impose coverage limits on 1.5 million individuals in Mississippi with employer or private coverage.

**Prohibition on rescissions.** The health reform law prohibits insurers from rescinding coverage for individuals who become ill. Repeal would allow insurance companies to resume the practice of rescinding coverage for the 141,000 state residents who purchase individual health insurance.

**Benefits for Individuals and Families**

**Tax credits for health insurance.** Starting in 2014, the health reform law gives middle class families with incomes up to $88,000 for a family of four tax credits to help pay for health insurance. There are 810,000 households in Mississippi that could qualify for these credits if they purchase their own health insurance or, in the case of households with incomes below 133% of poverty, receive coverage through Medicaid. These families will receive $14.1 billion in tax credits and other federal health care assistance over the next decade.

**Health insurance for young adults.** The health reform law allows young adults to remain on their parents' insurance policies up to age 26. In Mississippi, 14,000 young adults have used this option to retain coverage through their parents' health insurance plan.

**Reducing the number of uninsured.** When fully implemented in 2014, the health reform law will extend coverage to virtually all Americans. In Mississippi, 315,000 residents who currently do not have health insurance are likely to receive coverage under the new law.

**Free preventative care.** The health reform law promotes wellness by requiring insurance companies to offer free preventive care as part of any new or revised policies they issue after September 23, 2010. Repeal would allow insurance companies to charge for these essential benefits, which would increase out-of-pocket costs for 325,000 Mississippi residents.

**Benefits for Seniors**

**Reducing drug costs for seniors.** In 2010, the health reform law provided a $250 rebate to Medicare beneficiaries who entered the Medicare Part D "donut hole" and lost coverage for their drug expenses. Over 30,000 Mississippi seniors benefited from this provision, receiving $8.0 million in rebates. In 2011, seniors who hit the drug donut hole will receive 50% discounts on brand name drugs, and in subsequent years, this discount will increase until the donut hole is finally eliminated. A typical beneficiary who enters the donut hole will see savings of over $550 in 2011 and over $1,700 by 2020. Over the next decade, seniors in Mississippi who hit the donut hole will save a total of $540 million on drug costs.

**New preventive care benefits for seniors.** The health reform law improves Medicare by providing free preventive and wellness care, starting in January 2011. The law also strengthens the Medicare trust fund, extending its solvency from 2017 to 2029, improves primary and coordinated care, and enhances nursing home care. There are 492,000 Medicare beneficiaries in Mississippi who are already benefitting from the provisions that provide for free preventive care. Over the next decade, these Medicare improvements will save Mississippi seniors $1.2 billion.

**Benefits for Small and Large Businesses and Health Care Providers**

**Tax credits for small businesses.** The health reform law provides tax credits to small businesses worth up to 35% of the cost of providing health insurance. There are up to 53,000 small businesses in Mississippi that are eligible for this tax credit. These businesses have already received $19 million in tax credits and will receive $350 million in tax credits over the next decade.

**Employer assistance with retiree insurance costs.** The health reform law provides funding to encourage employers to continue to provide health insurance for their retirees. There are 33 employers in Mississippi who are participating in this Early Retiree Reinsurance Program.

**Reducing the cost of uncompensated care.** The health reform law benefits hospitals and health care providers by covering more Americans and thereby reducing the cost of providing care to the uninsured. Over the next decade, the Affordable Care Act will reduce the cost of uncompensated care for Mississippi's health care providers by $4.1 billion.

**Assistance for community health centers.** There are 197 community health centers in Mississippi that provide health care to the poor and medically underserved. Nationwide, the new law provides $11 billion in new funding for these centers. If the community health centers in Mississippi receive the average level of support, the 197 centers will receive $256 million in new assistance.

**Grants for Mississippi and Health Care Providers**

The Affordable Care Act provides billions of dollars in new grant programs for states and health care providers to improve the health insurance market, reduce costs, and improve quality of care. Mississippi and its health care providers have already received over $40 million in grants under the new law. This includes $1 million to detect, prevent, and roll back unreasonable insurance premium increases; $1 million to plan for a new health insurance exchange that reduces costs and ends insurance industry abuses; $5.2 million for home visiting programs, HIV prevention, laboratory and health information systems, and health clinics and health centers; and $37 million for the "Money Follows the Person" demonstration project, which improves long-term care and provides new tools to help individuals in long-term care as they transition from institutions to the community.

**Benefits for Mississippi Taxpayers**

The health reform law reduces the nation's debt by eliminating waste, fraud, and abuse in the health care system, reducing the growth of health care costs, and preventing excessive profit-taking by private insurers. According to the Congressional Budget Office, the bill will reduce the deficit by over $200 billion over the next ten years and by over a trillion dollars in the decade after that. Repeal would eliminate these cost-cutting measures, adding more than $3,000 to the national debt for each American, including the 2.9 million residents of Mississippi.

*This analysis is based upon the following sources: the U.S. Census (data on insurance rates, small businesses, and young adult population); the Centers for Medicare and Medicaid Services (data on Medicare and Part D enrollment and Medicare savings per enrollee); the Department of Health and Human Services (uncompensated care, pre-existing conditions, and Affordable Care Act grants); the Health Resources and Services Administration (data on community health centers); and the Congressional Budget Office (estimates of the percentage of citizens with health insurance coverage under health care reform legislation). Estimates of the total value of tax credits for families are extrapolated from statewide information on the percentage of families with incomes below 400% of the federal poverty level, the percentage of uninsured residents, and the estimated average tax credits received by middle-income families under the legislation. This estimate takes into account new federal assistance through Medicaid for individuals and families with incomes below 133% of the federal poverty level.*

March 2011

# The Benefits of Health Care Reform in Utah

Committee on Energy and Commerce, Democratic Staff
Henry A. Waxman, Ranking Member

In March 2010, Congress passed and President Obama signed into law historic health care reform legislation, the Affordable Care Act. Millions of Americans are already benefitting from this law: insurers are no longer allowed to discriminate against children and others who are sick; small businesses are receiving billions of dollars in tax credits to provide health care coverage for their employees; and seniors are saving money on prescription drugs and receiving free preventive care through Medicare.

Republicans in Congress have passed legislation to repeal the new law. Utah Governor Herbert has supported efforts to overturn the law, stating that "every Utahn should be concerned about the impact of this legislation." This analysis examines the benefits of the new law for Utah and its residents. It finds:

- Utah and its residents have already received almost **$50 million** in benefits under the new law and will receive **$6.1 billion** in benefits over the next ten years.
- **1.8 million** Utah residents are already receiving protection from the consumer protections in the law, which prohibit annual and lifetime coverage limits, ban insurance rescissions, and provide safeguards against unreasonable rate increases.
- Insurance companies operating in Utah can no longer discriminate against **45,000 to 207,000** Utah children with pre-existing conditions and will be banned from discriminating against **416,000 to 1.1 million** Utah residents with pre-existing conditions.
- Over **20,000** Utah seniors have already received **$5.2 million** to help reduce prescription drug costs, and almost 270,000 seniors in Utah will receive drug, preventive care, and other Medicare savings worth **$930 million** over the next ten years.
- **11,700** young adults age 26 and under have already obtained health insurance coverage under their parents' insurance plan.
- Up to **62,000** small businesses in Utah have already earned as much as **$22 million** in health care tax credits and will receive **$410 million** in tax credits over the next ten years.
- Over **570,000** Utah households will receive **$4.8 billion** in tax credits and other federal assistance to help pay for health care over the next ten years.
- Health coverage will be extended to **216,000** uninsured Utah residents starting in 2014.
- Health care providers in Utah will save **$1.6 billion** in uncompensated care and community health centers in Utah will receive **$59 million** in new funding over the next ten years.

## Protections Against Insurance Company Abuses

**Prohibition on discrimination on the basis of pre-existing conditions.** Under the health reform law, insurance companies can no longer deny coverage to children with pre-existing conditions and will be banned from discriminating against adults with pre-existing conditions in 2014. There are 416,000 to 1.1 million residents of Utah with pre-existing conditions like diabetes, heart disease, or cancer, including 45,000 to 207,000 children. Repeal would allow insurance companies to refuse to insure these individuals if they seek coverage in the individual or small-group markets. The consequences would be particularly acute for the 70,000 to 196,000 individuals with pre-existing conditions who currently lack insurance coverage and who would be unable to purchase individual policies if the law is repealed.

**Prohibition on annual and lifetime coverage limits.** The health reform law prohibits insurance companies from imposing annual and lifetime limits on health insurance coverage. This provision protects the rights of everyone who receives coverage from their employer or through the market for private insurance. If this protection is repealed, insurers would be able to impose coverage limits on 1.8 million individuals in Utah with employer or private coverage.

**Prohibition on rescissions.** The health reform law prohibits insurers from rescinding coverage for individuals who become ill. Repeal would allow insurance companies to resume the practice of rescinding coverage for the 169,000 state residents who purchase individual health insurance.

**Benefits for Individuals and Families**

**Tax credits for health insurance.** Starting in 2014, the health reform law gives middle class families with incomes up to $88,000 for a family of four tax credits to help pay for health insurance. There are 570,000 households in Utah that could qualify for these credits if they purchase their own health insurance or, in the case of households with incomes below 133% of poverty, receive coverage through Medicaid. These families will receive $4.8 billion in tax credits and other federal health care assistance over the next decade.

**Health insurance for young adults.** The health reform law allows young adults to remain on their parents' insurance policies up to age 26. In Utah, 11,700 young adults have used this option to retain coverage through their parents' health insurance plan.

**Reducing the number of uninsured.** When fully implemented in 2014, the health reform law will extend coverage to virtually all Americans. In Utah, 216,000 residents who currently do not have health insurance are likely to receive coverage under the new law.

**Free preventative care.** The health reform law promotes wellness by requiring insurance companies to offer free preventive care as part of any new or revised policies they issue after September 23, 2010. Repeal would allow insurance companies to charge for these essential benefits, which would increase out-of-pocket costs for 385,000 Utah residents.

**Benefits for Seniors**

**Reducing drug costs for seniors.** In 2010, the health reform law provided a $250 rebate to Medicare beneficiaries who entered the Medicare Part D "donut hole" and lost coverage for their drug expenses. Over 20,000 Utah seniors benefited from this provision, receiving $5.2 million in rebates. In 2011, seniors who hit the drug donut hole will receive 50% discounts on brand name drugs, and in subsequent years, this discount will increase until the donut hole is finally eliminated. A typical beneficiary who enters the donut hole will see savings of over $550 in 2011 and over $1,700 by 2020. Over the next decade, seniors in Utah who hit the donut hole will save a total of $290 million on drug costs.

**New preventive care benefits for seniors.** The health reform law improves Medicare by providing free preventive and wellness care, starting in January 2011. The law also strengthens the Medicare trust fund, extending its solvency from 2017 to 2029, improves primary and coordinated care, and enhances nursing home care. There are 266,000 Medicare beneficiaries in Utah who are already benefitting from the provisions that provide for free preventive care. Over the next decade, these Medicare improvements will save Utah seniors $640 million.

## Benefits for Small and Large Businesses and Health Care Providers

**Tax credits for small businesses.** The health reform law provides tax credits to small businesses worth up to 35% of the cost of providing health insurance. There are up to 62,000 small businesses in Utah that are eligible for this tax credit. These businesses have already earned as much $22 million in tax credits and will receive $350 million in tax credits over the next decade.

**Employer assistance with retiree insurance costs.** The health reform law provides funding to encourage employers to continue to provide health insurance for their retirees. There are 30 employers in Utah who are participating in this Early Retiree Reinsurance Program.

**Reducing the cost of uncompensated care.** The health reform law benefits hospitals and health care providers by covering more Americans and thereby reducing the cost of providing care to the uninsured. Over the next decade, the Affordable Care Act will reduce the cost of uncompensated care for Utah's health care providers by $1.6 billion.

**Assistance for community health centers.** There are 45 community health centers in Utah that provide health care to the poor and medically underserved. Nationwide, the new law provides $11 billion in new funding for these centers. If the community health centers in Utah receive the average level of support, the 197 centers will receive $50 million in new assistance.

## Grants for Utah and Health Care Providers

The Affordable Care Act provides billions of dollars in new grant programs for states and health care providers to improve the health insurance market, reduce costs, and improve quality of care. Utah and its health care providers have already received over $20 million in grants under the new law. This includes $1 million to detect, prevent, and roll back unreasonable insurance premium increases; $1 million to plan for a new health insurance exchange that reduces costs and ends insurance industry abuses; $12.7 million to support groundbreaking biomedical research and reduce long-term growth of health care costs, $1.6 million for home visiting programs, and $3.6 million for health centers..

## Benefits for Utah Taxpayers

The health reform law reduces the nation's debt by eliminating waste, fraud, and abuse in the health care system, reducing the growth of health care costs, and preventing excessive profit-taking by private insurers. According to the Congressional Budget Office, the bill will reduce the deficit by over $200 billion over the next ten years and by over a trillion dollars in the decade after that. Repeal would eliminate these cost-cutting measures, adding more than $3,000 to the national debt for each American, including the 2.9 million residents of Utah.

*This analysis is based upon the following sources: the U.S. Census (data on insurance rates, small businesses, and young adult population); the Centers for Medicare and Medicaid Services (data on Medicare and Part D enrollment and Medicare savings per enrollee); the Department of Health and Human Services (uncompensated care, pre-existing conditions, and Affordable Care Act grants); the Health Resources and Services Administration (data on community health centers); and the Congressional Budget Office (estimates of the percentage of citizens with health insurance coverage under health care reform legislation). Estimates of the total value of tax credits for families are extrapolated from statewide information on the percentage of families with incomes below 400% of the federal poverty level, the percentage of uninsured residents, and the estimated average tax credits received by middle-income families under the legislation. This estimate takes into account new federal assistance through Medicaid for individuals and families with incomes below 133% of the federal poverty level.*

Mr. WAXMAN. The Affordable Care Act gives States a major role in its implementation. It allows great flexibility for States to run new health insurance exchanges and to continue to run their Medicaid programs, the subject of today's hearing.

At this time I would like to submit for the record a February 3rd letter from Secretary Sebelius describing the flexibility that exists in the Medicaid program, and without objection, Mr. Chairman——

Mr. UPTON. Again without objection.

[The information follows:]

**The Secretary of Health & Human Services**
**Washington, DC**

**February 3, 2011**

Dear Governors:

As the new year begins, officials at the Federal and State level are looking ahead to a period full of opportunities and challenges. I have had the opportunity to speak individually with many of you over the past few weeks, including many who are now assuming their new positions. Having served as a Governor, let me welcome you to one of the best jobs you will ever have.

In these conversations, I have heard the urgency of your State budget concerns. I know you are struggling to balance your budget while still providing critical health care services to those who need them most. I want to reaffirm the Obama Administration's commitment to helping you do both.

I also know that as you prepare your budget, your attention will turn to Medicaid. Medicaid is a major source of coverage for children, pregnant women, seniors and people with disabilities in every State. It has a unique role in our health care system, covering a diverse group of beneficiaries, including some of the most frail and vulnerable Americans. And it is the nation's primary payer for long-term care in nursing homes and outside of institutions. Medicaid is a Federal-State health partnership. The Federal government pays a fixed percentage or matching rate and sets minimum standards. States fund their share of program costs and have the lead on designing their programs beyond these standards, including what benefits are covered, how providers are paid, and how care is delivered.

In the last two years, the Administration has worked to ensure adequate support for States to manage their Medicaid and the Children's Health Insurance Programs (CHIP). One of the first actions taken by President Obama was to work with Congress on legislation to increase Federal support for the States in the form of an enhanced Federal match for Medicaid (known as the Federal Medical Assistance Percentage or FMAP). This enhanced FMAP was part of the American Recovery and Reinvestment Act and lasted through December 31, 2010. However, last year, at the request of many Governors, we worked with Congress to extend the enhanced FMAP policy through June 2011. Approximately $100 billion has been provided to States, and in 2009 alone, due to the enhanced FMAP, State Medicaid spending fell by ten percent even though enrollment in Medicaid climbed by seven percent due to the recession. In addition to this financial support, we have taken many other administrative steps to open up lines of communication with States, lower the paperwork burden States face in administering the program, and accelerate our review process for State plan amendments.

We recognize that many States are re-examining their Medicaid programs and looking for opportunities to meet the pressing health care challenges and better cope with rising costs. In light of difficult budget circumstances, we are stepping up our efforts to help you identify cost drivers in the Medicaid program and provide you with new tools and resources to achieve both

short-term savings and longer-term sustainability while providing high-quality care to the citizens of your States. We are committed to responsiveness and flexibility, and will expedite review of State proposals.

Starting immediately, the senior leadership from across the Department will be available to meet individually with your staff about plans that you may already have in mind. My team stands ready to come to your State to discuss your priorities and how we can help achieve them.

In the meantime, recent conversations suggest a lack of clarity about what flexibility currently exists in Medicaid. Some of you have asked whether I can "waive" the maintenance of effort requirements for people who a State has covered under Medicaid's "optional" eligibility categories and waivers. I note that the Affordable Care Act gives a State the flexibility to reduce eligibility for non-disabled, non-pregnant adults with incomes above 133 percent of the Federal poverty line ($14,500 for an individual) if the State has a budget deficit, although prior to June 30, this would mean the loss of the enhanced FMAP under the Recovery Act. I continue to review what authority, if any, I have to waive the maintenance of effort under current law.

However, States have substantial flexibility to design benefits, service delivery systems, and payment strategies, without a waiver. In 2008, roughly 40 percent of Medicaid benefits spending – $100 billion – was spent on optional benefits for all enrollees, with nearly 60 percent of this spending for long-term care services. The enclosed paper identifies a range of State options and opportunities to more efficiently manage Medicaid, many of which are underway across the country. Some of the key areas of potential cost savings are described briefly below:

- **Modifying Benefits.** While some benefits, such as hospital and physician services, are required to be provided by State Medicaid programs, many services, such as prescription drugs, dental services, and speech therapy, are optional. States can generally change optional benefits or limit their amount, duration or scope through an amendment to their State plan, provided that each service remains sufficient to reasonably achieve its purpose. In addition, States may add or increase cost sharing for services within limits (see attachment for details). Some States have opted for more basic benefit packages for higher-income enrollees (e.g., Wisconsin provides benefits equivalent to the largest commercial plan offered in the State plus mental health and substance disorder coverage for pregnant women with income between 200 and 250 percent of poverty). A number of States charge beneficiaries $20 for non-urgent emergency room visits or use cost sharing for prescription drugs to steer individuals toward generics or preferred brand-name drugs. To the extent States scale back low-value benefits or add fair cost sharing that lowers inappropriate use of care, savings can be generated.

- **Managing Care for High-Cost Enrollees More Effectively.** Just one percent of all Medicaid beneficiaries account for 25 percent of all expenditures. Initiatives that integrate acute and long-term care, strengthen systems for providing long-term care to people in the community, provide better primary and preventive care for children with significant health care needs, and lower the incidence of low-birth weight babies are among the ways that States have improved care and lowered costs. For example, children's hospitals adopting a medical home model to manage the care of chronically ill

children have accomplished impressive improvements in health and reductions in cost. One Florida children's hospital reduced emergency room visits by more than one-third, and reduced hospital days by 20 percent. These delivery models and payment strategies can be implemented by hospitals and States without seeking a Federal waiver, and we are exploring ways that we might provide further support for such initiatives.

In addition, the Affordable Care Act offers new Medicaid options that provide States with additional Federal matching funds. For example, States can now benefit from a 90 percent Federal matching rate for coordination of care services provided in the context of a health home for people with chronic conditions. Additionally, the Community First Choice Option, available in October, will offer States a six percent increase in the Federal matching rate to provide certain person-centered long-term care services and supports to enhance your efforts to serve beneficiaries in community-based settings.

- **Purchasing Drugs More Efficiently.** In 2009, States spent $7 billion to help Medicaid beneficiaries afford prescription drugs. States have broad flexibility to set their pharmacy pricing. We are committed to working with States to ensure they have accurate information about drug costs in order to make prudent purchasing decisions. As recommended by States, the Department is undertaking a first-ever national survey to create a database of actual acquisition costs that States may use as a basis for determining State-specific rates, with results available later this year. Alabama, the first State to adopt use of actual acquisition costs as the benchmark for drug reimbursement, expects to save six percent ($30 million) of its pharmacy costs in the first year of implementation. We will also share additional approaches that States have used to drive down costs, such as relying more on generic drugs, mail order, management relating to over-prescribed high cost drugs, and use of health information technology to encourage appropriate prescribing and avoidance of expensive adverse events.

- **Assuring Program Integrity.** According to the Department's 2010 Financial Agency Report, the three-year weighted average national error rate for Medicaid is 9.4 percent, meaning that $33.7 billion in combined Federal and State funds were paid inappropriately. The Federal government and States have a strong, shared interest in assuring integrity in every aspect of the program, and there are new options and tools available to States. Our Medicaid Integrity Institute is preparing a series of webinars for States to share best practices, learn about the potential cost savings created by the new program integrity provisions in the Affordable Care Act, and hear about initiatives underway in Medicare and the private sector that could be replicated in Medicaid. For example, to help your State identify providers who were terminated elsewhere, States will have access to a new Federal portal starting in mid-February to obtain this information from other States and the Medicare program. In addition, States will be able to use Federal audit contractors to save State funds and consolidate auditing efforts. States will also benefit from new, cutting-edge analytics, like predictive modeling, being developed to prevent fraud in the Medicare program. In 2010, the Departments of Health and Human Services and Justice recovered more than $4 billion in taxpayer dollars – the highest annual amount ever – from people who attempted to defraud seniors and taxpayers, and we want to continue to work closely with you to prevent and fight waste,

fraud and abuse in Medicare, Medicaid and CHIP. The President is committed to cutting the error rate in half by 2012.

Beyond these areas of flexibility that could produce short-term savings, we are actively moving forward in areas that could lower costs in the long run. In particular, we are focused on how to help States provide better care and lower costs for so called "dual eligibles," seniors and people with disabilities who are eligible for both Medicaid and Medicare. These individuals represent 15 percent of Medicaid beneficiaries but nearly 40 percent of all Medicaid spending. This population offers great potential for improving care and lowering costs by replacing the fragmented care that is now provided to these individuals with integrated care delivery models. The new Federal Coordinated Health Care Office has already released a solicitation for up to 15 States to receive Federal support to design new models for serving dual eligibles. We also plan to launch a Department-wide effort to reduce the costs of health care by improving patient safety in Medicare, Medicaid and throughout the private health care system, and States will be critical partners in this effort. We welcome other ideas on new models of care, including new ways to deliver care that encourage investment and yield savings.

To expedite these 2011 efforts, we will host a series of "virtual" meetings with State health policy advisors and Medicaid directors. In these sessions, we will share information about promising Medicaid cost-saving initiatives underway in one or more States that we are prepared to support and approve in other States on a fast-track basis.

This is just the beginning of a discussion on how we can help you better manage your Medicaid programs and navigate your budget crises. Please be assured that I am committed to working with you toward a sustainable and vibrant Medicaid system in ways that are responsive to the current challenges you are facing every day.

Sincerely,

Kathleen Sebelius

Enclosure

**Medicaid Cost-Savings Opportunities**
**February 3, 2011**

**Overview**

Medicaid is a large and diverse health care coverage program. Jointly financed by the States and the Federal government, in 2010, Medicaid covered nearly 53 million people and accounted for about 16 percent of all health care spending.[1] It accounts for 17 percent of all hospital spending and is the single largest source of coverage for nursing home care, for childbirth, and for people with HIV/AIDS.[2] It covers one out of four children in the nation as well as some people with the most significant medical needs.[3] While children account for most of the beneficiaries, they comprise only 20 percent of the spending. By contrast, the elderly and people with disabilities account for 18 percent of enrollees but 66 percent of the costs.[4]

Over the past three years, despite rising enrollment due to the economic recession, nationwide State spending on the Medicaid program dropped by 13.2 percent (equivalent to a 10.3 percentage point decline in the State share of the total costs of the program) as a result of the added Federal support provided to State Medicaid programs through the American Recovery and Reinvestment Act of 2009 (the Recovery Act).[5] In 2009 alone, due to this action, State Medicaid spending fell by 10 percent even though enrollment in Medicaid climbed by 7 percent due to the recession.[6] However, this enhanced Federal Medical Assistance Percentage (FMAP) support is set to expire on June 30, 2011. While State revenues are beginning to show signs of recovery, the upcoming State fiscal year could be especially difficult for States.

Against this backdrop, States are beginning to plan for 2014 when Medicaid will be simplified and expanded to adults and children with income up to 133 percent of the Federal Poverty Level (FPL) ($26,645 in annual income for a family of three in 2011). Benefits for most newly eligible adults will be comparable to that of typical private insurance. Significantly, almost all of the new Medicaid coverage costs will be borne by the Federal government. The Medicaid changes in the Affordable Care Act will also bring about major improvements in the program for States, health care providers, and low-income individuals. The Department of Health and Human Services (HHS), in collaboration with States, has been engaged in a multi-faceted process to accomplish these changes by 2014. The objective is to ensure that Medicaid functions as a high-performing program serving the needs of America's most vulnerable citizens and is a full partner with the Health Insurance Exchanges in achieving the coverage, quality and cost containment goals of the new law. Recent reports have found that the increased support for Medicaid, lower uncompensated care costs, and other provisions of the new law to tackle health care costs will produce savings to States as they become fully effective. In the short term, however, State budget pressures are forcing an immediate focus on this program whose enrollment has grown as job-based insurance declined due to the recession.

Now HHS is stepping up its efforts to help States consider policies that will improve care and generate efficiencies, in the short term and over time, as part of the larger imperative to tackle health care cost growth throughout the health care system. This paper identifies existing flexibility in the Medicaid program and new initiatives, many of which can be accomplished under either current program flexibilities or the new options under the Affordable Care Act.

**Existing Areas of Program Flexibility**

Over time, Medicaid has evolved to offer States considerable flexibility in the management and design of the program. States set provider payment rates and have considerable flexibility to establish the methods for payment, to design the benefits for adults, and to establish other program design features. In addition, States have the ability to apply for a Section 1115 waiver of other Federal requirements to adjust coverage and payment rules.[7]

**1. Cost Sharing**

In the Deficit Reduction Act of 2005, Congress gave States additional flexibility to impose cost sharing in Medicaid in the form of copayments, deductibles, coinsurance, and other similar charges without requiring States to seek Federal approval of a waiver. Certain vulnerable groups are exempt from cost sharing, including most children and pregnant women, and some services are also exempt. However, States may impose higher cost sharing for many targeted groups of somewhat higher-income beneficiaries, above 100 percent of the poverty level (the equivalent of $18,530 in annual income for a family of three), as long as the family's total cost sharing (including cost sharing and premiums) does not exceed five percent of their income.

States may impose cost sharing on most Medicaid-covered services, both inpatient and outpatient, and the amounts that can be charged vary with income. In addition, Medicaid rules give States the ability to use cost-sharing to promote the most cost-effective use of prescription drugs. To encourage the use of lower-cost drugs, such as generics, States may establish different copayments for non-preferred versus preferred drugs. For people with incomes above 150 percent of the poverty level, cost sharing for non-preferred drugs may be as high as 20 percent of the cost of the drug. The following table describes the maximum allowable copayment amounts for different types of services.

**MAXIMUM ALLOWABLE COPAYMENTS**

| **Services and Supplies (Cost Sharing Subject to a Per-Beneficiary Limit)**[a] | **Eligible Populations by Family Income**[b,c] | | |
|---|---|---|---|
| | **≤100% FPL** | **101-150% FPL** | **>150% FPL** |
| **Institutional Care** (inpatient hospital care, rehab care, etc.) | 50% of cost for 1st day of care | 50% of cost for 1st day of care, 10% of cost | 50% of cost for 1st day of care, 20% of cost |
| **Non-Institutional Care** (physician visits, physical therapy, etc.) | $3.65 | 10% of cost | 20% of cost |
| **Non-emergency use of the ER** | $3.65 | $7.30 | No limit |
| **Preferred drugs** | $3.65 | $3.65 | $3.65 |
| **Non-preferred drugs** | $3.65 | $3.65 | 20% of cost |

a. Emergency services, family planning, and preventive services for children are exempt from copayments. Cost sharing is subject to a limit of five percent of income.
b. Some groups of beneficiaries, including most children, pregnant women, terminally ill individuals, and most institutionalized individuals, are exempt from copayments except nominal copayments for non-emergency use of an emergency room and non-preferred drugs. American Indians who receive services from the Indian Health Service, tribal health programs, or contract health service programs are exempt from all copayments.
c. Under certain circumstances for beneficiaries with income above 100 percent of FPL, States may deny services for nonpayment of cost sharing.

Because Medicaid covers particularly low-income and often very sick patients, Medicaid cost sharing is subject to an overall cap. The Medicaid cost for one inpatient hospital visit averages more than $5,700 for blind and disabled beneficiaries.[8] Someone in very frail health, such as a beneficiary with advanced Lou Gehrig's disease, likely requires multiple hospital visits each year. If such an individual has four hospital stays per year and income amounting to 160 percent of poverty (about $23,000 for a family of two), without the cap he could be charged hospital cost sharing averaging up to $1,140 per visit. Total cost sharing is capped at five percent of income, so this beneficiary would not be required to pay the full 20 percent copayment for such a costly hospital stay, but could still face more than $1,100 in cost sharing per year.

**2. Benefits**

States have various sources of flexibility with respect to the design of Medicaid benefits for adults. For children, any limitations on services (either mandatory or optional) must be based solely on medical necessity; States are required to cover their medically necessary services.

**"Optional" benefits**. Medicaid-covered benefits are broken out into "mandatory" services, which must be included in every State Medicaid program for all beneficiaries (except if waived under a Section 1115 waiver), and "optional" services which may be covered at the State's discretion. Below is a table listing mandatory and optional services. While considered "optional," some services like prescription drugs are covered by all States. In 2008, roughly 40 percent of Medicaid benefits spending – $100 billion – was spent on optional benefits for all enrollees, with nearly 60 percent of this spending for long-term care services.[9]

**MEDICAID COVERED SERVICES**

| Mandatory Services (60% of Spending) | Optional Services (40% of Spending) |
|---|---|
| • Inpatient hospital services | • Prescription drugs |
| • Outpatient hospital services | • Clinic services |
| • Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services | • Physical therapy |
| • Nursing facility services | • Occupational therapy |
| • Home health services | • Speech, hearing and language disorder services |
| • Physician services | • Respiratory care services |
| • Rural health clinic services | • Other diagnostic, screening, preventive and rehabilitative services |
| • Federally qualified health center services | • Podiatry services |
| • Laboratory and X-ray services | • Optometry services |
| • Family planning services | • Dental services |
| • Nurse Midwife services | • Dentures |
| • Certified Pediatric and Family Nurse Practitioner services | • Prosthetics |
| • Freestanding Birth Center services (when licensed or otherwise recognized by the State) | • Eyeglasses |
| • Transportation to medical care | • Chiropractic services |
| • Smoking cessation for pregnant women | • Other practitioner services |
| | • Private duty nursing services |
| | • Other services approved by the Secretary[a] |

a. This includes home and community-based care and other community-based long-term care services, coverage of organ transplants, Intermediate Care Facilities for Persons with Mental Retardation (ICF/MR) services and other services.

**Amount, duration and scope of a benefit.** States have flexibility in the design of the particular benefit or service for adults, so long as each covered service is sufficient in amount, duration and scope to reasonably achieve its purpose.

**"Benchmark benefits."** States have broad flexibility to vary the benefits they provide to certain adult enrollees through the use of alternative benefit packages called "benchmark" or "benchmark-equivalent" plans. These plans may be offered in lieu of the benefits covered under a traditional Medicaid State plan. A benchmark benefit package can be tailored to the specific medical conditions of enrollees and may vary in different parts of a State.

Benchmark benefits coverage is health benefits coverage that is equal to the coverage under one or more of the following standard commercial benefit plans:

- Federal employee health benefit coverage – a benefit plan equivalent to the standard Blue Cross/Blue Shield preferred provider plan offered to Federal employees;
- State employee health benefit coverage – a benefit plan offered and generally available to State employees in the State; or
- Health maintenance organization (HMO) coverage – a benefit plan offered through an HMO with the largest insured commercial non-Medicaid enrolled population in the State.

States may also offer health benefit coverage through two additional types of benchmark benefit plans, Secretary-approved coverage or benchmark-equivalent plan coverage. Secretary-approved coverage is any other health benefits coverage that the Secretary determines provides appropriate coverage to meet the needs of the population provided that coverage. Benchmark-equivalent coverage is a plan with different benefits, but with an actuarial value equivalent to one of the three standard benchmark plans. Benchmark-equivalent packages must include certain services such as inpatient and outpatient hospital services, physician services, and prescription drugs.

States have the option to limit coverage for generally healthy adults to benchmark or benchmark-equivalent coverage. Other groups, including blind and disabled, medically frail, and institutionalized individuals can be offered enrollment in a benchmark plan, but they cannot be required to enroll in such a plan. To date, 11 States have approved benchmark coverage. States generally have used this option to provide benefits to targeted groups of beneficiaries, rather than having to provide these services to a broader group of people. For example, Wisconsin provides benefits equivalent to the largest commercial plan offered in the State plus mental health and substance disorder coverage for pregnant women with income between 200 and 250 percent of poverty.

**Opportunities for Medicaid Efficiencies**

Medicaid costs per enrollee, like those in the health system generally, are driven by utilization and payment rates, including rising prices, and to some degree by waste, fraud, and abuse. Medicaid costs are also uniquely driven by increased utilization associated with the complex cases and chronic illness prevalent among those enrolled in the program. The initiatives below aim to help States improve care and lower costs largely through changes in care delivery systems

and payment methodologies focused on the costs drivers in the program. We are developing a portfolio of approaches that would be combined with technical support and fast-track ways for States to implement the new initiatives and we remain open to other ideas that can improve care and efficiency. Most of these initiatives can be accomplished under current flexibilities under the program.

**1. Service Delivery Initiatives and Payment Strategies for Enrollees with High Costs**

Because Medicaid serves people with significant medical needs (including but not limited to "dual eligibles") and is the largest single payer for long term care, Medicaid expenditures are driven largely by the relatively small number of people with chronic and disabling conditions. For example, in 2008, five percent of beneficiaries accounted for more than half of all Medicaid spending and one percent of beneficiaries accounted for 25 percent of all expenditures.[10] Working to develop better systems of care for these individuals holds great promise not only to improve care but to reduce costs. Reducing the average cost of care by just ten percent for the five percent of beneficiaries who are the highest users of care, could save $15.7 billion in total Medicaid spending and produce a significant positive impact on longer term spending trends.[11]

Some initiatives focusing on high-need beneficiaries include:

- Care and payment models for children's hospitals to reorganize and refinance the way care is delivered for children with severe chronic illnesses. A number of children's hospitals are working to coordinate all primary care and specialized care needs of these children through a medical home model. For example, St. Joseph's Children's Hospital of Tampa reduced emergency room visits by more than one-third, and hospital days by 20 percent. The Arkansas Children's Hospital model is projected to reduce annual per child costs by more than 30 percent and reduce hospital admissions by 40 percent.[12] Even more importantly, the overall quality of life for these children can be dramatically improved through a medical home model of care.

- The "Money Follows the Person" demonstration grants extended and expanded under the Affordable Care Act. Currently, 43 States and the District of Columbia are using or planning to use these funds to help transition people from costly nursing home settings to more integrated community settings. HHS is currently exploring innovative ways for States to use these funds and welcomes State ideas. Promoting alternatives for home and community-based services reduces dependence on institutional care, improves the quality of life, and enhances beneficiary choice.

- Initiatives to change care and payment models to reduce premature births. Given that Medicaid currently finances about 40 percent of all births in the U.S., it has a major role to play in improving maternity care and birth outcomes. Early deliveries are associated with an increase in premature births and admissions to neonatal intensive care units (NICUs), which carry a high economic cost.[13] One factor contributing to premature births is an increase in births by elective cesarean section. Promising models to reduce premature births and medically unnecessary cesarean sections include adopting new protocols and using mid-level providers in an integrated care delivery setting to improve care coordination. In New York, one model of coordinated prenatal care reduced the

chances of a mother giving birth to a low-birth weight infant by 43 percent in an intervention group as compared with a group of women receiving care under standard practices.[14] In Ohio, a focus on lowering the rate of non-medically necessary pre-term cesarean deliveries has led to reductions in pre-term cesarean births and NICU admissions.[15] According to some analyses, a NICU admission increases costs ten-fold above normal delivery costs. These service delivery and payment initiatives can be accomplished without a waiver or demonstration.

- Promoting better care management for children and adults with asthma. About a quarter of all asthma-related health care spending is for hospital care, much of which could be avoided with better care management.[16] Successful models exist that involve nontraditional educators and patient self-management. A New York initiative focused on patient self-management and tailored case management reduced asthma-related emergency room visits by 78 percent.[17] A similar project in California reduced hospital admissions by 90 percent.[18]

- Initiatives to reduce hospital readmissions, which could improve care and lower costs. A recently published analysis shows that 16 percent of people with disabilities covered by Medicaid (excluding the dual eligibles) were readmitted to the hospital within 30 days of discharge. Half of those who were readmitted had not seen a doctor since discharge.[19] There is a significant body of evidence showing that improving care transitions as patients move across different health care settings can greatly reduce readmission rates. Interventions such as using a nurse discharge advocate to arrange follow-up appointments and conduct patient education or a clinical pharmacist to make follow-up calls has yielded dramatic reductions in readmission rates. One Colorado project, for example, reduced its 30-day readmission rate by 30 percent.[20] These practices can continue to be expanded in Medicaid, where the average cost of just one hospital admission for an individual with disabilities (excluding dual eligibles) is more than $5,700.[21]

- Implementing the new Health Homes option in the Affordable Care Act. This option offers new opportunities – and Federal support – to care for people with chronic conditions by providing eight quarters of 90 percent Federal match for care coordination services. Guidance to States has been issued (http://www.cms.gov/smdl/downloads/SMD10024.pdf), and HHS is establishing an intensive State-based peer-to-peer collaborative within the new Centers for Medicare & Medicaid Services (CMS) Innovation Center to test and share information about different models. The option, which was effective January 1, 2011, could result in immediate savings, given the enhanced match, as well as a path for learning how to establish effective care coordination systems for people with chronic conditions.

- Promoting Accountable Care Organizations (ACOs) that include Medicaid by bringing States into the planning and testing of ACO models that include, or even focus on, Medicaid plans and providers. CMS will work with States to ensure that States have ample opportunity to participate in these new models of care and benefit from any savings.

- Continuing to integrate health information technology. Health information technology (health IT) and electronic health information exchange are also key to driving down health care costs. Medicaid-financed incentive payments to eligible providers began in several States in January. HHS-funded health IT initiatives are underway in every State, providing implementation assistance and supporting improved care coordination. Additional Federal grants from the Office of the National Coordinator for Health Information Technology to support State-level initiatives will be awarded in February. (http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__hitech_and_funding_opportunities/1310).

**2. Purchasing Drugs More Efficiently**

Pharmacy costs account for eight percent of Medicaid program spending, with States spending $7 billion on prescription drugs in 2009.[22] While States have taken steps to reduce their pharmacy costs over the past decade, there is still strong evidence that many State Medicaid agencies are paying too high a price for drugs in the Medicaid program.[23] Recent court settlements have disclosed that the information most States rely upon to establish payment rates is seriously flawed. As a result, the major drug pricing compendium used by Medicaid State agencies will cease publication before the end of 2011, and States must find a new basis for drug pricing. We will work with States to help them manage their pharmacy costs and ensure their pharmacy pricing is fair and efficient:

- Provide States with a new, more accurate benchmark to base payments. A workgroup of State Medicaid directors and State Medicaid pharmacy directors has recommended a new approach to establishing a benchmark for rates, namely, use of actual average acquisition costs.[24] Alabama, the first State to adopt use of actual acquisition costs as the benchmark for drug reimbursement rates, expects to save six percent ($30 million) of its pharmacy cost in the first year of implementation. However, it is difficult and costly for each State to create its own data source for actual acquisition costs. States have recommended a national benchmark. In response, CMS is about to undertake a national survey of pharmacies to create a database of actual acquisition costs that States may use as a basis for determining State-specific rates. The data will be available to States later this year.

**3. Dual Eligibles**

There is great potential for improving care and lowering costs by ending the fragmented care that is now provided to "dual eligibles" – people who are enrolled in both Medicaid and Medicare. While only 15 percent of enrollees in Medicaid and Medicare are dual eligibles, four out of every ten dollars spent in the Medicaid program and one quarter of Medicare spending are for services provided to dual eligibles.[25] Fragmented care, wasteful spending, and patient harm are significant risks with two programs serving some of the most frail and medically needy people, each with its own sets of rules and disparate financial mechanisms. Just a few examples can explain the problem and suggest some of the solutions:

- When Medicaid programs invest in health homes and similar initiatives that can help people who are dually eligible avoid hospitalizations, Medicare realizes most of the savings since it is the primary payer for the cost of hospital care for these people.

- If Medicare seeks to reduce hospital costs and avoid preventable hospital readmissions, extensive discharge planning relying on the availability of community-based long-term care may be required. Those long-term care services, however, are largely driven and financed by Medicaid, not Medicare.

Except in a very small number of specialized plans covering only about 120,000 of the 9.2 million dual eligibles, people do not have a team of caregivers that direct and manage their care across Medicaid and Medicare and States do not have access to information about the care delivered across the two programs.

The Affordable Care Act establishes a new Federal Coordinated Health Care Office to focus attention and resources on improving care for dual eligibles. The Office, which was formally announced on December 29, 2010, will work with States, physicians and others to develop new models of care. In the short term, the Office will focus on the following initiatives that will have an immediate impact on States' ability to better manage care:

- Support State Demonstrations to Integrate Care for Dual Eligible Individuals. The Federal Coordinated Health Care Office recently announced that it will award contracts to up to 15 States of up to $1 million each to help them design a demonstration proposal to structure, implement, and evaluate a model aimed at improving the quality, coordination, and cost-effectiveness of care for dual eligible individuals. Through these initiatives, we will identify and validate delivery system models that can be rapidly tested and, upon successful demonstration, replicated in other States. Further investments from the new CMS Innovation Center are under review; this is a priority area for States and HHS. Additional areas of focus and opportunity are demonstrations to decrease transfers between nursing homes and hospitals and developing accountable care organizations to serve dual eligibles and other populations with complex health problems.

- Provide States with access to Medicare Parts A, B and D data. For several years State Medicaid agencies have been requesting access to Medicare data to support efforts to: (1) improve quality; (2) better coordinate care; and (3) reduce unnecessary spending for their dual eligible beneficiaries. CMS will make these data available to States in early 2011.

**4. Improving Program Integrity**

States and the Federal government share a common interest in ensuring that limited dollars are not wasted through fraud. According to the 2010 HHS Financial Agency Report, the three-year weighted average national error rate for Medicaid is 9.4 percent, meaning that $33.7 billion in combined federal and State funds was paid inappropriately. Our work on developing new ways to prevent fraud as well as some of the new tools created by the Affordable Care Act will bring additional options and resources to States to help them with their fraud prevention and detection efforts. No waiver or special demonstration is needed to move ahead on these initiatives.

- The Medicaid Integrity Institute provides free training to State Medicaid agency staff—it conducted 38 courses last year and trained 1,900 staff since February 2008. States participate as faculty, receive training, and help shape the curriculum. We are planning a special series

of web-based trainings for State Medicaid agencies to share best practices and inform States about new provisions of the law aimed at preventing fraud.

- The Affordable Care Act requires the screening of providers and provides States with new authority to help keep problematic providers from enrolling in Medicaid. The vast majority of Medicaid providers and suppliers participate in both Medicaid and Medicare, so Medicare provider screening actions in Medicare will also benefit Medicaid and CHIP programs. A significant value for States is expected. CMS will provide active support and assistance to States, including training of State Medicaid and CHIP program staff and best practice guidelines.

- New, cutting edge initiatives are being developed to prevent fraud in the Medicare program and will be shared with States to ensure that Medicaid gets the full benefit of Medicare advances in this area including analytics such as predictive modeling to identify patterns and examine high-cost problem areas across all types of care.

- CMS will be organizing new Payment Accuracy Improvement Groups with States grouped based on their shared interest in particular program integrity vulnerabilities. States with similar interests will work with CMS, as well as Federal contractors and other experts, to target issues and problem solve.

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[1] *2010 Actuarial Report on the Financial Outlook for Medicaid.* Office of the Actuary, Centers for Medicare & Medicaid Services (for enrollment data).*National Health Expenditure Projections 2009-2019.* Office of the Actuary, Centers for Medicare & Medicaid Services (for expenditure data).

[2] Kaiser Family Foundation 2010.

[3] Kaiser Family Foundation 2010.

[4] 2010 Actuarial Report on the Financial Outlook for Medicaid. Office of the Actuary, Centers for Medicare & Medicaid Services.

[5] CMS analysis of FY 2008-2010 Medicaid Budget and Expenditure System (MBES) data.

[6] Martin A. et al, "Recession Contributes To Slowest Annual Rate Of Increase In Health Spending In Five Decades," *Health Affairs*, 30(1): 11-22, January 2011.

[7] Section 1115 of the Social Security Act authorizes the Secretary of HHS to waive compliance with certain specified provisions of the law or to permit expenditures not otherwise allowed under the law in the context of an "experimental, pilot of demonstration project" that the Secretary determines is "likely to assist in promoting the objectives" of the program.

[8] CMS Analysis of Inpatient Hospital Spending for Blind/Disabled Non-Dual Medicaid Beneficiaries, FY2008, MSIS (Medicaid Statistical Information System), FFS only. Inpatient claim count is used as a proxy for inpatient admission count.

[9] ASPE Analysis of the Medicaid Statistical Information System (MSIS) data for 2008. Spending for mandatory and optional populations.

[10] CMS analysis of FY 2008 CMS MSIS data.

[11] CMS analysis of FY 2008 CMS MSIS data.

[12] November 2010 presentation by the National Association of Children's Hospitals.

[13] Tita, A., et.al. *The New England Journal of Medicine.* January 8, 2009 volume 360, No. 2, pages 11-120.

[14] Eunju Lee, et al. *American Journal of Preventive Medicine* 2009; 36(2):154–160).

[15] The Ohio Perinatal Quality Collaborative Writing Committee. A statewide initiative to reduce inappropriate scheduled births at 360/7–386/7 weeks' gestation. Am J Obstet Gynecol 2010;202:243.e1-8.

[16] American Lung Association. Trends in Asthma Morbidity and Mortality, January 2009.

[17] Hoppin, et al, August 2010. Asthma Regional Council.

[18] Hoppin, et al, August 2010. Asthma Regional Council.

[19] *Hospital Readmissions among Medicaid beneficiaries with Disabilities: Identifying Targets of Opportunity.* Center for Health Care Strategies, December 2010.

[20] Coleman EA, Parry C, Chalmers S, Min SJ. The care transitions intervention: results of a randomized controlled trial. *Arch Intern Med.* 2006 Sep25;166(17):1822-8.

[21] CMS Analysis of Inpatient Hospital Spending for Blind/Disabled Non-Dual Medicaid Beneficiaries, FY2008, MSIS (Medicaid Statistical Information System), FFS only. Inpatient claim count is used as a proxy for inpatient admission count.

[22] National health expenditures, historical tables. Includes state and local spending on Medicaid prescription drugs for 2009. https://www.cms.gov/NationalHealthExpendData/02_NationalHealthAccountsHistorical.asp.

[23] See for example, OEI-05-05-00240, Medicaid Drug Price Comparisons: Average Manufacturer Price to Published Prices, June 2005.

[24] *Post AWP Pharmacy Pricing and Reimbursement: Executive Summary and White Paper.* American Medicaid Pharmacy Association and the National of Medicaid Directors, June 2010. Accessed at: http://www.nasmd.org/home/doc/SummaryofWhitePaper.pdf.

[25] Kaiser Family Foundation. *Dual Eligibles: Medicaid Enrollment and Spending for Medicare Beneficiaries in 2007*, December 2010. Accessed at: http://www.kff.org/medicaid/upload/7846-02.pdf.

Mr. WAXMAN. It is no secret that States are having problems with their budgets and that the recession is a significant contributor. When unemployment increases, State revenues decline and more people rely on Medicaid and CHIP, and Medicaid has been working exactly as intended. Medicaid has enrolled an additional 6 million people during the recession, many who lost other forms of insurance when they lost their jobs. Medicaid is the final safety net for these families, but the program is still extremely efficient. As a matter of fact, Medicaid spending growth on a per-enrollee basis has been slower than increases in private health premiums.

What would be helpful here is to make Medicaid a program that automatically corrects for recessions and disasters with additional federal support so States are not stretched beyond their means at a time of economic stress when Medicaid enrollment grows to help people losing their jobs or in a crisis.

I want to highlight other important facts about the program. Medicaid covers 45 million low-income children and adults. It assists almost 9 million seniors and people with disabilities with Medicare costs. It covers 70 percent of nursing home residents and 44 percent of people with HIV/AIDS. It is the Nation's safety net program that helps those most severely in need. The program's benefit package responds to the needs of the population it serves, providing prenatal and delivery care, speech and occupational therapy, case management and community-based care that helps individuals with disabilities stay out of a nursing home. Medicaid offers States considerable flexibility in the management and the design of the program.

To be clear, there are aspects of the program we can improve. We can reduce costs for 9 million dually eligible beneficiaries, low-income seniors and disabled that are eligible for both Medicare and Medicaid. This group accounts for just 15 percent of total enrollment but 39 percent of total Medicaid costs.

Here is where the ACA helps the States. It establishes the Federal Coordinated Health Care Office to reduce the cost and increase the quality of care for the individuals. It established a Center for Medicare and Medicaid Innovation with a charge to identify and develop policies to improve care and cut costs.

These are the changes we need to concentrate on, not radical changes that will add to the number of uninsured. A number of governors have suggested a Medicaid block grant with no standards for coverage or care. This idea was discredited 30 years ago, and it will be discredited again. It will leave States with inadequate funding and remove the federal commitment to be a full partner. It will result in loss of coverage for the most vulnerable and severely disabled adults and children, people needing nursing home care, and poor children and families, and it will exacerbate unfair distributions of dollars among the States. Calls to block grant, cap or cut this program under the guise of flexibility and fiscal restraint are shortsighted.

I hope today we can concentrate on how we can work together to make our programs run better, not destroy them.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Waxman follows:]

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED TWELFTH CONGRESS

**Congress of the United States**

**House of Representatives**

COMMITTEE ON ENERGY AND COMMERCE

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**Opening Statement of Rep. Henry A. Waxman**
**Ranking Member, Committee on Energy and Commerce**
**"The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform"**
**March 1, 2011**

Today we will hear the views of several of the nation's governors on the impact of the Affordable Care Act and on the nation's critical safety net health program—Medicaid.

Medicaid and the ACA are both partnerships between the Federal and State governments. We share the responsibility for making these programs run efficiently and serve the needs of the populations that depend on them. So this can and should be a productive dialogue. But in my view that does not include relitigating the Affordable Care Act.

ACA is already delivering important benefits: prohibiting insurance companies from rescinding insurance when someone gets sick, requiring coverage of preventive care for no cost, allowing young adults to stay on their parent's insurance up to the age of 26, and more.

Three new reports we are releasing today highlight the benefits of the new law in the states represented by the three Governors who will be testifying. They show, for example, that in Utah, 1.8 million residents are already receiving consumer protections against the worst abuses of the insurance industry. In Mississippi, over 30,000 seniors have already saved hundreds of dollars on high Medicare drug costs. I'd like to ask that these reports—which show precisely how much the Affordable Care Act will help millions of Americans—be included in the record.

The Affordable Care Act gives States a major role in its implementation, it allows great flexibility for States to run new health insurance exchanges, and to continue to run their Medicaid programs—the subject of today's hearing. Some at the recent Governors' Association meeting have called to change Medicaid to a block grant to increase flexibility.

At this time, I would like to submit for the record a February 3rd letter from Secretary Sebelius describing the flexibility that exists in the Medicaid program and making a commitment to work closely with states on what changes they would like to make.

It is no secret that States are having problems with their budgets, and that the recession is a significant contributor. When unemployment increases, state revenues decline, and more people rely on Medicaid and CHIP.

And Medicaid has been working exactly as intended. Medicaid has enrolled an additional 6 million people during the recession, many who lost other forms of insurance when they lost their jobs.

Medicaid is the final safety net for these families. But the program is still extremely efficient. As a matter of fact, Medicaid's spending growth on a per enrollee basis has been slower than increases in private health insurance premiums.

What would be helpful here is to make Medicaid a program that automatically corrects for recessions and disasters with additional federal support so States are not stretched beyond their means at times of economic stress – when Medicaid enrollment grows to help people losing their jobs or in crisis.

I want to highlight other important facts about the program:

- Medicaid covers 45 million low-income children and adults.
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The program's benefit package responds to the needs of the population it serves, providing pre-natal and delivery care, speech and occupational therapy, case management, and community based care that helps individuals with disabilities stay out of the nursing home.

Medicaid offers States considerable flexibility in the management and design of the program. Within the confines of minimal federal protections, states design their benefits package, they determine coverage levels, and they set provider payment rates. They can get waivers of other Federal requirements to adjust coverage and payment rules—and many states have done so.

To be clear, there are aspects of the program we can improve. We can reduce costs for 9 million dually eligible beneficiaries—low-income seniors and disabled that are eligible for both Medicare and Medicaid. This group accounts for just 15% of total enrollment, but 39% of total Medicaid costs.

Here's where the ACA helps the states. It establishes the Federal Coordinated Health Care Office to reduce the costs and increase the quality of care for the duals. It established the Center for Medicare and Medicaid Innovation with a charge to identify and develop policies to improve care and cut costs.

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This idea was discredited thirty years ago, and it will be discredited again.

It will leave states with inadequate funding—and remove the Federal commitment to be a full partner.

It will result in loss of coverage for the most vulnerable—severely disabled adults and children, people needing nursing home care, and poor children and families.

It will exacerbate unfair distributions of dollars among the States.

Calls to block grant, cap, or cut this program under the guise of flexibility and fiscal restraint are short sighted.

I hope today we can concentrate on how we can work together to make our programs run better—not to destroy them, and not to turn our backs on the critical safety net provided by Medicaid, and the important new benefits that millions of Americans are and will receive under the Affordable Care Act.

Mr. UPTON. Thank you.

I would now recognize the chairman of the Health Subcommittee for 5 minutes, Mr. Pitts.

Mr. PITTS. Thank you, Mr. Chairman.

## OPENING STATEMENT OF HON. JOSEPH R. PITTS, A REPRESENTATIVE IN CONGRESS FROM THE COMMONWEALTH OF PENNSYLVANIA

Mr. PITTS. Right now, States across the Nation are struggling to balance their budgets and reduce costs without sacrificing the quality of care for their current Medicaid enrollees. Many States have already made deep cuts trying to achieve balanced budgets. But under the maintenance of effort provisions in Obamacare, if a State takes any action that makes eligibility for Medicaid more restrictive than the standards in effect for the State's program as of March 23, 2010, that State could lose all federal funding. If States can't change their eligibility criteria, governors are left with little flexibility and few choices but to cut payments to providers or cut other parts of the State budget, for instance education and transportation, in order to maintain federal Medicaid spending.

What does this look like for my home State of Pennsylvania? In an op-ed on USAToday.com, Pennsylvania Governor Tom Corbett today wrote, "Pennsylvania's Medicaid program, for example, has seen steady, unsustainable increases in the number of people it serves and the cost of those services. The Keystone State's Medicaid budget is growing at nearly 12 percent a year, while the Commonwealth's general revenues have grown by just 3 percent a year. It is a trend that simply cannot continue, but one that will be unavoidable as long as inflexible federal rules guide State policies."

A May 2010 Kaiser Family Foundation report found that by 2019, Pennsylvania's Medicaid rolls may grow by an additional 682,880 people and may cost the State an additional $2.041 billion over the 2014-2019 time period.

Many of our governors, including Governor Herbert of Utah and Governor Barbour of Mississippi, who are with us today, have already spoken out and asked the Secretary of Health and Human Services to relieve them of some of the restrictive healthcare-related federal mandates, including the maintenance of effort provisions. The responses they have received have not been encouraging.

So I look forward to hearing from our witnesses today and learning firsthand what the impact of Obamacare will be on State Medicaid programs and other State health programs. I am also interested in hearing their ideas to provide access to quality care for greater numbers of people, while keeping costs under control.

[The prepared statement of Mr. Pitts follows:]

**Rep. Joseph R. Pitts**
**Opening Statement**
**Energy and Commerce Committee**
**Hearing on "The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform"**
**March 1, 2011**

Thank you, Mr. Chairman.

Right now, states across the nation are struggling to balance their budgets and reduce costs without sacrificing the quality of care for their current Medicaid enrollees.

Many states have already made deep cuts trying to achieve balanced budgets.

But under the Maintenance of Effort (MOE) provisions in Obamacare, if a state takes any action that makes eligibility for Medicaid more restrictive than the standards in effect for the state's program as of March 23, 2010, that state could lose all federal funding.

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A May 2010 Kaiser Family Foundation report found that by 2019, Pennsylvania's Medicaid rolls may grow by an additional 682,880 people and may cost the state an additional $2.041 billion over the 2014-2019 time period.

To put into perspective what this increased Medicaid spending looks like to folks back home in the 16th Congressional District, $2.041 billion roughly equals the entire budgets of Pennsylvania's Departments of:

Agriculture, Community and Economic Development, Conservation and Natural Resources, Environmental Protection, Health, Insurance, Labor and Industry, Military and Veterans Affairs, Probation and Parole PLUS the entire budgets of the State Police, Attorney General's office, the Legislature, and the Judiciary.

Many of our governors , including Governor Gary Herbert of Utah and Governor Haley Barbour of Mississippi, who are with us today, have already spoken out and asked the Secretary of Health and Human Services to relieve them of some of the restrictive healthcare-related federal mandates, including the Maintenance of Effort provisions.

The responses they have received have not been encouraging.

I look forward to hearing from our witnesses today and learning firsthand what the impact of Obamacare will be on state Medicaid programs and other state health programs.

I am also interested in hearing their ideas to provide access to quality care to greater numbers of people, while keeping costs under control.

Thank you, I yield back.

Mr. PITTS. At this time I would like to yield 1 minute to Dr. Gingrey of Georgia.

Mr. GINGREY. Thank you for yielding.

New CBO numbers on Obamacare out in the news are definitely not good. Costs have increased by $460 billion in just 2 years and State Medicaid costs rose by 300 percent from $20 billion to $60 billion. Can States reform their programs or do a better job of screening out individuals who don't belong in the program in order to deal with these crushing costs? No, they can't. Obamacare expressly forbids them from making eligibility changes that might remove people who are illegally in the program until at least 2014. Well, can States afford to wait until 2014? Rhode Island sure can't. The city of Providence just sent termination letters to every single teacher it has, 2,000 in all, in order to give themselves as much budgetary flexibility as possible. In fact, 34 States and the District of Columbia have already cut K-12 education programs and 40 States have cut higher education over the last year due to budgetary problems.

So today this country is forced to stare at an inconvenient question: How can our children compete in the global economy without a quality education? President Obama has often said that we need to stick with this health reform proposal because it lets children up to age 26 stay on their parents' insurance policy. Well, Mr. President, when your economic policies make our college graduate children less likely to find a good job, they are going to need to stay on their parents' health policy, and I yield back.

Mr. PITTS. I yield at this time 1 minute to Ms. Blackburn of Tennessee.

Ms. BLACKBURN. Thank you, Mr. Chairman. Welcome to our witnesses.

Our chairman mentioned that the States were expecting the cost to be twice what the Federal Government had estimated. I would like to make everyone aware, we have had a test case for Obamacare. It was in the State of Tennessee. It was called TennCare. Costs were not twice what were estimated, they were four times what were estimated.

Mr. Chairman, our former Governor, Phil Bredesen, had a great article in the Wall Street Journal on this. I would like to submit it for the record, as well as "A history ignored" by Edward Lee Pitts from World magazine. This lays out what happens. TennCare ate up 35.3 percent of the State budget before it was addressed. There was no more money for higher ed, no more money for education. If you want a program that is going to eat up every dollar and is too expensive to afford, this is it.

I am looking forward to talking with our governors. Governor Patrick, looking forward to what you have to say about a failed program in your State, Massachusetts Care. Yield back.

Mr. UPTON. The chair will recognize for an opening statement the gentleman from New Jersey, Mr. Pallone, for five minutes.

Mr. PALLONE. Thank you, Mr. Chairman.

**OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY**

Mr. PALLONE. Today we meet again as our Republican colleagues continue their assault on the Affordable Care Act and the many positive benefits it offers Americans nationwide. The specific focus on Medicaid in this hearing has little to do with our newly enacted health reform legislation. It is simply an extension of Republicans' decades-long interest in undermining and ultimately dismantling the Medicaid program.

I point out that under Democratic leadership, the previous Congress understood the dire straits States were facing and granted significant federal relief through the Recovery Act to ensure that our safety-net programs could operate as they were designed to: to provide Medicaid coverage for vulnerable Americans when they need it most.

And this certainly should be contrasted with the recently passed Republican Continuing Resolution which achieves nearly one-third of its budgetary spending cuts by reducing critical aid for State and local governments. It is no surprise to anyone that the Medicaid rolls are expanding right now when the economy is contracting. Medicaid often expands and vice versa. In challenging economic times, if unemployment increases and incomes drop, fewer people receive health insurance from their places of employment and more individuals meet the eligibility requirements for Medicaid coverage.

Now, we have been hearing a lot about the need for flexibility in the Medicaid program. States already have broad latitude to design their Medicaid programs after meeting minimum health care coverage benchmarks. They may also apply for section 1115 Medicaid waivers to amend the program even further. But the flexibility my Republican colleagues seek seems more directed at destroying the Medicaid program than strengthening it. Block granting Medicaid is no panacea for States. It would threaten the fundamental tenet of the Medicaid program that it can expand and contract according to need. By changing the federal component of Medicaid from a fixed percentage to a fixed dollar amount, States could be left holding the bag with much higher bills in times of economic crisis. It could be truly catastrophic both for States and for the citizens who desperately require medical assistance.

And we should also be wary of proposals to raise cost sharing and copayments on low-income and working families in Medicaid. Numerous studies, including one conducted by Rand Health, found that even nominal copayments lead to a much larger reduction in the use of medical care by low-income adults and children and seriously compromise access to needed health care.

There are a lot more thoughtful ways to harness the costs of Medicaid than what our colleagues on the other side are proposing. The Affordable Care Act advances a commonsense philosophy regarding shared responsibility among individuals, employers, the federal and State government. The Medicare maintenance of effort to protect access to health care for the most vulnerable is the State's responsibility in the near term until full health reform is reached in 2014. After that, 100 percent of the costs of the Med-

icaid expansion included in health reform will be borne by the Federal Government and then phased down to 90 percent in 2020.

Furthermore, the Affordable Care Act enacted meaningful Medicaid reforms which slow the growth of health care costs for both States and the Federal Government. It promotes Medicaid demonstration projects that institute delivery system reform and finance State efforts to establish medical homes in Medicaid, which will improve care for those with substantial health needs. We also give the Federal Government and the States important new tools to fight fraud in Medicare, Medicaid, SCHIP and the State health insurance exchanges.

We need to think carefully about the profound devastation some of the Republican proposals on Medicaid would have on working families and the State health agencies that serve them. I have been here for a long time, and it is almost every year we see another proposal by the Republicans to dismantle Medicaid. They don't like Medicaid. I know that. But the bottom line is that Medicaid has been a much-needed lifeline for the 6 million people that enrolled in the program during this recession, many of whom did lose employer-sponsored health insurance.

I have a minute left, Mr. Chairman. I would like to yield that to the gentlewoman from Wisconsin, Ms. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman.

Right now across the country and particularly in my home State of Wisconsin, we are seeing the effect of unfortunate attacks by some of our Nation's governors on the values we hold dear. I am sorry that Wisconsin's Governor, Scott Walker, declined the Majority's invitation to be on this panel today. Governor Walker's budget adjustment bill would not only strip away workers' rights, it would also gut Wisconsin's Medicaid program. It violates Wisconsin's proud tradition of providing comprehensive health coverage for our most vulnerable citizens by potentially eliminating insurance coverage for 63,000 parents and 6,800 adults and reducing coverage for current and future enrollees.

But Governor Walker's dangerous budget plan is also fiscally irresponsible. While Walker has offered his proposal under the guise of repairing the State budget and saving money, the proposed Medicaid provision would not yield any savings this year. Instead, the plan would put the State at risk for losing billions of dollars in Medicaid funding at a time when it can least afford to lose this funding.

I stand in solidarity with my fellow Wisconsinites who have taken to the streets to oppose State plans that threaten the health, education and safety of the people of our great State.

I yield back.

Mr. UPTON. The gentlelady's time has expired.

At this point a quick thing. It is my understanding that the Democratic Steering and Policy Committee has approved Donna Christensen to be back with us, and even though the full caucus has not approved it yet, we welcome her back and we will view her as a member of the committee for all intents and purposes this morning, without objection.

I now recognize the following gentlemen for 1 minute each to introduce their governors: Mr. Matheson, Mr. Markey and Mr. Harper. Mr. Matheson.

Mr. MATHESON. Thank you, Mr. Chairman, for holding this hearing today.

I want to extend a thank you to my governor, Governor Herbert, for providing Utah's experiences with reforming our health care system. As many on this committee probably know, Utah is one of the few States that took the initiative before enactment of health care reform at the federal level to tackle reforms to our health care system at the State level. One in particular was the establishment of a health insurance exchange in Utah. Our State's experience can certainly testify to the flexibility States need in order to implement this law.

I appreciate Governor Herbert's participation at today's hearing. I want to extend him a warm welcome to our committee and look forward to his testimony and insight.

I yield back.

Mr. MARKEY. It is my pleasure to welcome Governor Deval Patrick from the great Bay State here to Washington.

In 2006, Massachusetts trailblazed the path for the health care reform we would see here on Capitol Hill just a few years later. Our outstanding governor has been the driving force behind successful implementation of the Massachusetts law.

In November of 2010, he was overwhelmingly reelected to a second term. Under his watch, an astounding 98 percent of Massachusetts residents and 99.8 percent of our children now have good, dependable health insurance. No other State comes close.

Just recently, Governor Patrick proposed new legislation to lower health care cost without cutting into our residents' quality of health care or access to services. His legislation focuses on quality of health care services over quantity, encouraging providers to better coordinate care for their patients. This means lower costs and healthier patients. Our experience in Massachusetts shows that far from being one size fits all, health care and reform efforts provide States with wide latitude.

I can't think of a better person than Governor Patrick to join us this morning to highlight the great work we have done in Massachusetts, and I look forward to his testimony. It is our honor to have you with us here this morning, Governor.

Mr. HARPER. I am honored to introduce one of today's witnesses, Governor Haley Barbour of Mississippi, who has made the tough decisions in Mississippi to make sure that we have a balanced budget, money in the bank, and has been a true leader on energy issues in this country. Governor Barbour has promoted a healthier Mississippi by supporting Let's Go Walking, Mississippi, along with First Lady Marsha Barbour. The program is discussed in schools across the State to show kids the importance of exercise and healthy meals.

Governor Barbour has worked diligently to protect the solvency of Mississippi's Medicaid program by controlling cost. Under his leadership, Medicaid changed its prescription drug program to better utilize generic drugs instead of more expensive brand-name drugs. He also promoted annual physicals for Medicaid bene-

ficiaries to detect health problems early by checking them for diabetes and high blood pressure and making sure they are taking the right medications.

But to truly understand Governor Haley Barbour, look no further than what happened in the aftermath of Hurricane Katrina to see what his leadership was about, what he and First Lady Marsha Barbour did. They didn't wait around, Governor Barbour didn't wait for somebody to come help him. He didn't wait for others. He didn't sit around and complain. He simply rolled his sleeves up and went to work, and the rest of America got to see what it takes to be a great leader.

Governor Barbour, we are honored to have you today.

Mr. UPTON. Thank you.

Governors, welcome. Take your seat at the table. We appreciate you submitting your testimony in advance. At this point we will recognize each of you for 5 minutes each, and we will begin with Governor Herbert from Utah. Welcome.

## STATEMENTS OF GARY R. HERBERT, GOVERNOR, STATE OF UTAH; DEVAL PATRICK, GOVERNOR, COMMONWEALTH OF MASSACHUSETTS; AND HALEY BARBOUR, GOVERNOR, STATE OF MISSISSIPPI

### STATEMENT OF GARY R. HERBERT

Mr. HERBERT. Well, thank you, very much. Good morning. I am Gary Herbert, Governor of the State of Utah. I would like to thank Congressman Upton and other members of the committee for your invitation to testify here today.

Let me begin by stating that I am a firm believer in the principles of Federalism embodied in the 10th Amendment. A balance of powers between the States and the Federal Government is not only right and proper, but essential to finding solutions to the complex problems we face today.

Justice Louis Brandeis famously described States as laboratories which can engage in "novel social and economic experiments without risk to the rest of the country."

In Utah, we began our health system reform efforts 5 years ago, long before the Patient Protection and Affordable Care Act arrived on the scene. The lessons we have learned in our experiments in health system reform can serve as a guide to other States as they begin their own reform efforts.

The Federal Government has taken the opposite approach with a one-size-fits-all decree. The governors, the very people responsible for shoehorning the details of this decree in our agencies and budgets, were never invited to the table to give our input or asked for our opinions when the act was proposed by the Obama Administration or debated in Congress. I find that frankly unconscionable.

The States can and should find their own solutions tailored to their own unique circumstances. In Utah, for example, a majority of Utah's uninsured population are employed. Most work for small businesses that do not offer health insurance benefits. Utah also has the youngest population in the country. Many of our uninsured are the so-called "young immortals" who have deemed traditional

health insurance coverage to be either unnecessary or too expensive.

In order for health systems reform to be effective in Utah, we had to respond to the needs of our small businesses and their employees. As part of our health system reform efforts, Utah small businesses have the option of using a defined contribution model. This model allows employers to manage and contain their health benefit expenditures.

With the creation of the Utah Health Exchange, Utah employees also benefit from expanded access, choice and control over their health care options. Employees can now purchase one of more than 100 plans currently offered through the exchange.

Our figures also show that 20 percent of businesses participating in the Utah Health Exchange are offering health benefits for the first time.

Just as Henry Ford offered his first customers a choice of any color car they wanted as long as they chose black, the Affordable Care Act allows States flexibility in implementing the act as long as they do it the way Washington tells them.

Another challenge for Utah is our increasing financial obligation for Medicaid. Even before the Affordable Care Act, Medicaid was already a large and growing part of the Utah State budget. In the 1990s, Medicaid took 9 percent of our general fund. In fiscal year 2010, it was 18 percent. By fiscal year 2020, it is estimated to exceed 30 percent of my general fund budget, and that is without the federally mandated expansion of the Affordable Care Act.

I have come to Washington to present solutions to help ease the burden on our State. First, I call upon the Administration to support an expedited appeals process to the Supreme Court for the health care litigation. States cannot be left with uncertainty in regards to the implementation of this act.

Second, I ask Congress to gives States flexibility to find health care solutions based on each State's unique needs, and third, we have also proposed specific solutions for reform. These reforms will require that the Center for Medicare and Medicaid Services support our waiver requests.

In the interest of time, I have included details of our recommendations in my submitted testimony but I will highlight just one example here today. In our efforts to be more innovative and efficient, we developed an approach which uses paperless technology to communicate with our Medicaid clients, reducing costs by the State of Utah as much as $6.3 million a year. With this flexibility in this one area alone, we estimate that all the States adopting this technology could save between $600 million and $1 billion per year.

Communicating by e-mail seems like a no-brainer. However, we waited for 8 months to hear from the Federal Government. When we did hear something, it was a denial, and in a bitter irony, the denial came by e-mail. Interestingly, when I raised the issue with President Obama just yesterday, I later received this note from Secretary Sebelius letting me know that we could now in fact proceed with a paperless process. While I appreciate this positive response, and I do, I have to ask myself two questions: first, why did it take a personal conversation between a governor and a President

of the United States to resolve this simple issue, and second, and even more important, why do we even have to ask for permission to make this logical cost-saving improvement?

For me, the situation illustrates what is wrong with the current partnership between the States and the Federal Government: a partnership that is one-sided and puts the States in a subservient role.

In conclusion, I emphasize again that real health care reform I believe will rise from the States, the laboratories of democracy, not from the one-size-fits-all approach imposed by the Federal Government. From the days of our pioneer forefathers, Utahans have been finding Utah solutions to Utah problems. I am here today to assert our right and our responsibility to continue to do so. Thank you.

[The prepared statement of Mr. Herbert follows:]

GARY R. HERBERT
GOVERNOR

STATE OF UTAH
OFFICE OF THE GOVERNOR

GREG BELL
LIEUTENANT GOVERNOR

**Governor Gary R. Herbert's Testimony to House Energy and Commerce Committee**
**March 1, 2011**

Good morning. I am Gary R. Herbert, Governor of the State of Utah.

I would like to thank Congressman Upton and the other members of the committee for your invitation to testify.

Let me begin by stating that I am a firm believer in the principles of Federalism embodied in the 10th Amendment.

States are not powerless agents of federal authority. I believe that – as Governor of the great State of Utah – I should take every opportunity to assert the rightful authority of our state to advance Utah solutions to Utah problems.

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

Justice Louis Brandeis famously described states as laboratories which can engage in "...novel social and economic experiments without risk to the rest of the country."

In Utah, we began our health system reform efforts five years ago, long before the Patient Protection and Affordable Care Act arrived on the scene. The lessons we've learned in our novel experiments in health system reform can serve as a guide to other states as they begin their own reform efforts. In fact, we have already been contacted by officials in numerous other states asking us to share our experiences with them.

The federal government has taken the opposite approach. The federal government decreed the one-size-fits-all law of the land, and has left to the states the details of how to shoehorn the Affordable Care Act's voluminous dictates and mandates into their agencies and budgets.

The Governors who are responsible for so much of the implementation of the Affordable Care Act were never invited to the table when it was being proposed by the Obama Administration or debated in Congress. I find that unconscionable.

Utah has repeatedly demonstrated we can find Utah solutions to Utah problems, particularly in the area of health care. Our health system reform efforts have been targeted to respond to Utah's unique business and demographic needs.

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Unlike many other states, a majority of Utah's uninsured population are employed. Most work for small businesses which do not offer health insurance benefits. Over 80% of Utah's businesses are small businesses, and less than 50% of Utah small businesses were offering health insurance coverage as of 2009. In order to reduce our uninsured population, we needed to make insurance coverage accessible to our state's small employers.

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

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

Years ago, most U.S. businesses made the switch from a defined benefit to a defined contribution model for their employee retirement benefits offerings. Incidentally, Utah is leading the nation by having moved our state employees toward a defined contribution retirement benefit, as well.

As part of our health system reform efforts, Utah small businesses now have the option of using a defined contribution model for their health benefit offerings. A defined health benefit left businesses with unpredictable and ever-escalating costs. Through access to Utah's new defined contribution market, employers can manage and contain their health benefit expenditures.

With the creation of the Utah Health Exchange, Utah employees also benefit from expanded access, choice, and control over their health care options. Rather than the traditional one-size-fits-all approach inherent in the defined benefit model, employees can now use the defined contribution from their employers to shop for health insurance tailored to their individual needs and circumstances. The Utah Health Exchange currently gives Utah small business employees more than 100 plan choices, all of which retain the pre-tax and guaranteed-issue advantages of traditional small group insurance.

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

We have used market principles to create a Utah solution to Utah's problems.

Governor Patrick and I hold the distinction of presiding over the only states in the nation with functional health insurance exchanges at this time.

The Commonwealth Connector in Massachusetts was designed to serve a business community and citizen population vastly different from what we have in Utah. Hence, our exchanges are constructed in vastly different ways.

The federal government simply should not be in the business of telling Utah, Massachusetts, Mississippi, or any other state how to run their current or future exchanges, or even force them to have an exchange.

The Affordable Care Act not only mandates exchanges for every state, but it gives the states little leeway in constructing exchanges that work for diverse needs and populations. Worse, the Affordable Care Act feigns a posture of giving flexibility to the states, while it's requirement are, in reality, quite rigid.

Just as Henry Ford offered his customers a choice of any color car they wanted as long as that color was black, the Affordable Care Act allows states flexibility in constructing their exchanges as long as they do it the way Washington tells them. Minimum Essential Benefit mandates, obligatory quality improvement activities for carriers, compulsory federal subsidy determination mechanisms; these are just some of the examples of the lack of flexibility of the new national health care program.

The next major problem in need of market forces is the state's Medicaid program. Medicaid is poised to wreak havoc on the state's budget for years to come, threatening our ability to fund critical services, such as transportation and education.

Even before the Affordable Care Act, Medicaid was already a large and growing part of the Utah state budget. Medicaid's share of the overall general fund has been growing and is projected to grow even larger, creating real problems for the state. In the 1990s, it was as low as 9%. In Fiscal Year 2010 it was 18%. By FY 2020, it is estimated to exceed 30%, without federally mandated expansion.

In this recession, Medicaid enrollment has skyrocketed. In December 2007, enrollment stood at 158,267 individuals. In December 2010, enrollment stood at 230,812 individuals, a 46% increase in 3 years.

The Affordable Care Act accelerates growth in Medicaid and compounds the budget pressure. The Act prohibits the normal state tools to control costs. It requires Maintenance of.Effort, meaning the state must participate at federally-dictated levels. The Act limits cost-sharing. The Act confiscates state pharmacy savings.

Perhaps worst of all, the Affordable Care Act dramatically expands Medicaid eligibility in 2014. Enrollment is projected to grow approximately 50% under the mandated expansion. The Act only pays for part of new costs, meaning states must cover the rest. In Utah, these new costs are estimated to be as high as $1.2 billion over 10 years.

I have come to Washington to present solutions to help ease the burden on our state.

First, I call on the Obama Administration to support an expedited appeals process to the Supreme Court for the healthcare litigation which has been decided by the lower courts. Along with 28 of my fellow Governors, I have sent a letter to the President asking for his support.

Second, I would ask that Congress exercise its authority to find legislative solutions to the onerous mandates imposed on the states by the Affordable Care Act.

Third, we have proposed specific solutions for reform. This will require that the Center for Medicare & Medicaid Services (CMS) support the waiver requests that we have or will be submitting. Our message is simple: To have any hope of success, Utah needs flexibility to make this mandated model work in our unique state for our unique demographics and needs.

Our reforms fall into four distinct areas: administrative simplification, provider incentives, patient accountability, and expand premium subsidy options.

The first example is in the area of administrative simplification. CMS sent us a memo that essentially requires us to use paper to communicate with enrollees in the program. In our efforts to be more innovative and efficient, we developed an approach which uses electronic technology to communicate with our clients, reducing costs by as much as $6 million a year.

If CMS allows Utah the flexibility we need to be efficient—in this one area alone—we estimate that all the states adopting this technology could save more than $600 million per year. This seems like a no-brainer. However, CMS has been slow to respond. Utah's simple request for this issue has been sitting with CMS since last July.

The second example highlights the need to change incentives for providers. We are also trying to get waiver approval for a comprehensive reform to the way we reimburse providers for Medicaid services. We should pay for value, rather than volume.

We are developing a home-grown solution to this problem. We want to contract with Accountable Care Organizations (ACOs) to move toward a more provider-based care model. These contracts will better align financial incentives for providers to keep people healthy instead of just providing services.

If we are allowed to proceed, this model will be a tipping point for the Utah market, and we expect to shortly see private insurance companies follow suit, benefitting and strengthening our overall health care system.

In conclusion, I emphasize again that real health care reform will rise from the states, not be imposed by the federal government.

From the days of our pioneer forefathers, Utahns have been finding Utah solutions to Utah problems. I am here today to assert our right and responsibility to continue to do so.

Addendum 1

# The Utah Health Exchange – A Brief Overview

The overarching philosophy of Utah's approach to health reform is that the invisible hand of the marketplace, rather than the heavy hand of government is the most effective means whereby reform may take place. The Utah Health Exchange is part of Utah's overall health system reform effort and is designed to enhance consumer choice and the ability of the private sector to meet consumer needs.

The Exchange formally opened in August 2009 for the individual/family product market as well as a limited launch for the small group market. A full launch of the small group market and a pilot version for the large group market took place in September 2010.

**What is the Exchange?**
The exchange is an internet-based information portal. It connects consumers to information they need to make an informed choice, and in many cases allows them to execute that choice electronically.

**Why do we need an exchange?**
Utah's approach to health system reform is to move toward a consumer-based system, where individuals are responsible for their health, health care, and health care financing. A major step in that direction is the development of a workable defined contribution system.

The Exchange is a critical component in moving towards a consumer-based system. For example, in order for a defined contribution system to function efficiently, consumers need a single shopping point where they can evaluate their options and execute an informed purchasing decision. For a consumer-based market to succeed, brokers, agents, employers, and individuals must have access to reliable information to allow consumers to make side-by-side comparisons of their options.

**What is the overall goal of the Exchange?**
The overall goal of the Exchange is to serve as the technology backbone to enable the implementation of consumer-based health system reforms.

**How does the Exchange accomplish that goal?**
To accomplish this goal, the Exchange has three core functions:

1. Provide consumers with helpful information about their health care and health care financing,

2. Provide a mechanism for consumers to compare and choose a health insurance policy that meets their families' needs

3. Provide a standardized electronic application and enrollment system

**Doesn't this exist already in the private sector?**

Addendum 1

It could be argued that the information that a consumer needs exists in the present system, however, in Utah we are missing two key elements. In order for consumerism to really take hold, we need to create a system where the information is available in a standardized format that allows comparisons and is located at a single shopping point.

**Why did Utah choose to go with an exchange model?**
Utah's approach to health system reform relies on the fundamental principles of personal responsibility, private markets, and competition. To promote competition in the health care system, consumers need three things – accurate and relevant information, real choice, and the opportunity to benefit from making good choices. The exchange model enhances private competition in the health care system by providing all three elements of increased competition. In addition to the benefits to the consumer, the exchange model also offers relief to employers who will no longer need to bear the full burden of running a health plan for their employees.

**What is unique about Utah's approach?**
Utah's approach to developing an exchange is unique in that it builds on existing technology instead of starting from scratch. This allows the state to incorporate and build on private solutions. Utah's approach is also designed to support the existing roles of entities in the health system, including insurers, producers, and health care providers.

**What is a defined contribution market?**
When it comes to employment-based health insurance, Utah recognizes that the traditional approach to purchasing a group plan is not consistent with our underlying philosophies of health system reform. In 2009, Utah created a new defined contribution market for health insurance. In this market, employees choose their own insurance company, network, and benefit structure and employers simply decide how much to contribute toward the employee's policy. It is apparent that while this market greatly enhances consumer choice and competition among insurers, it is also a more complicated system with many more people needing information than in the traditional group market.

**What functions can the Exchange actually do now?**
At present, the Exchange is ready and able to support the new defined contribution market for Utah's small employers. The Exchange serves as the technology backbone that makes such an innovative market possible. The Exchange has the capacity to handle employer enrollment, communicating information to insurers about risk, compiling and displaying price information to employees, executing the employees' enrollment in their choice of plan, and facilitating the collection and distribution of premiums. The end result is that employees have the necessary information and purchasing power to make an informed health insurance choice.

In addition to supporting the defined contribution market, the exchange also supports consumer choice in the traditional individual market. In this regard, the primary role of the Exchange is to connect consumers with private companies that can help them identify and purchase the product they need. On the Exchange, consumers are given three options to shop for and buy a policy – use a private online shopping service, buy direct from a participating insurer, or search for an agent to get in-person assistance. Currently, there are four private online shopping services, five insurers and hundreds of agents available through the Exchange.

**Where will the Exchange take us in the future?**

Addendum 1

It is important to remember that a robust Exchange will be more than just a place to "apply for health insurance". While the initial focus of setting up the Exchange has been to establish a stable defined contribution market, this is just the first stepping stone in the process toward a consumer-oriented system.

In order to facilitate consumer choice in the long run, it is clear that the Exchange must provide information that is relevant to not only health care financing but also quality and transparency of the health care system. The Exchange will also evolve into a tool for patients to make better decisions about their health and health care by providing access to information about cost and quality and health and wellness.
The value of the Exchange is the sum of all its parts and each "part" is essential to the long term success of the Exchange and to the success of Health System Reform.

Addendum 2

# Medicaid Electronic Notification Proposal

**Program and Goals** – The Department of Workforce Services (DWS) is an integrated, one-stop service delivery agency that administers workforce programs, labor exchange, unemployment insurance, and eligibility for multiple social service programs – Medicaid, CHIP, SNAP, TANF, and Child Care. Through administrative modernization, DWS expects to reduce administrative costs by $9.2 million over the next 18 months.

**Electronic Notification** – The core of this effort is to move to a more automated, self-directed eligibility model using the new "myCase" system. Under the proposed system, customers will have easier and real-time access to services and case information, cycle times for determination will decrease and result in greater program integrity. The administrative savings come from three cost centers: 1) Electronic correspondence – the cost of a paper-based notice is currently $.52, which could be virtually eliminated, 2) Staffing – a more automated system will allow more determinations per worker, and 3) Reduced telephony costs.

**Summary of myCase** – myCase is an electronic customer interface launched in November, 2010. Currently, it is being used by over 50,000 customers and growing rapidly. Over 160,000 notices have been read online, with 2.5 million page views. Utah would like to be a national leader in the development of this eligibility model and its application to Medicaid.

**Federal Reaction** – FNS (who oversees the Food Stamps program, SNAP) has been supportive at the national regional level. DWS appreciates their support with both system development and the potential need for support on additional waivers and policy interpretations. Unfortunately, we have struggled to get permission from CMS for full implementation of electronic correspondence for Medicaid clients.

**Timelines** –

- July 1, 2010 waiver request sent to FNS
- July 12, 2010 electronic correspondence request letter sent to Department of Health (DOH) to be sent to the Regional CMS office.

Addendum 2

- Received waiver approval from FNS - December 7, 2010
- Received conditional support from CMS on December 14, 2010. The condition of the support would require DWS to send a paper notification with all eligibility decisions (resulting in no cost savings).
- Drafted response for CMS as a rebuttal on the conditions. DOH received the DWS rebuttal and sent the response on to regional CMS office.
- December 17, 2010, DOH notified DWS that there should be no further action taken on the request until the CMS Office of General Counsel reviewed and made a decision.
- December 17, 2010 - present, CMS (both the regional and national offices) have requested clarification and answers to questions, but there has been no word yet on a final decision from their Office of General Counsel.
- We have informed FNS that until we hear back from CMS, our electronic correspondence implementation is on hold.
- February 15, 2011 – Representatives from DWS and DOH participated in a joint call with CMS regional and national officials to review progress, address concerns, and request an expedited decision.
- At present, there has still been no response on this issue.

On February 26 we are slated to release new functionality into myCase. This latest release will include the electronic correspondence "opt in" for customers. We've postponed the release date three times and postponing it again would impact our costs, training, and roll out of other critical functionality. Each month the release is postponed hampers Utah's ability to reduce costs and deliver quality services to our customers in a 24/7 online environment. Our timeline is aggressive and we need an efficient process to meet these milestones.

We would like to work with CMS to quickly resolve the electronic correspondence issue and to develop a better process to expedite future potential waivers or permissions.

Addendum 3

# Utah Medicaid Reform Proposal

**Rising Medicaid costs threaten the stability of the budget** –In the 1990s, Medicaid expenses accounted for 9% of Utah's state budget. Currently, they account for 18% of the state budget and are projected to be well over 30% within the next ten years. Enrollment has increased 46% from December 2007 to December 2010.

**Obamacare will just make this worse** – In 2014, Utah Medicaid will be required to add another 100,000 people to the program, a 50% increase in enrollment. Enhanced federal funding for this group will run out within 10 years, costing the state an additional $1.2 billion.

Obamacare also takes away the key tools that states could have used to address the rising costs. It contains a maintenance-of-effort provision which prohibits us from rolling back some of the expansions to optional populations put in place during better economic times. It freezes cost-sharing arrangements with patients to the old levels, such as $3 co-pays for pharmacy and $6 for inappropriate use of the emergency room. It also confiscates all of the savings that we have generated through our preferred drug list program, costing us $6.3 million a year starting in 2010.

**Proposed reforms** – To get the costs under control and prevent a total collapse of the state budget, we have to change the way the program works. Utah is considering a proposal that would "fix" the bad incentives in Medicaid and restore some hope of cost control. The basics of the proposal are:

- Replace existing managed care contracts with Accountable Care Organization (ACO) contracts – Providers would be paid on a capitated basis in a way that brings the doctor and the patient into the mix (as opposed to the old HMO model where we pitted doctors against insurers.)
- Require contracted ACOs to meet performance standards, including using Medical Homes.
- Increase Patient Responsibility – Create a sliding scale copayment schedule for patients based on their income.

Addendum 3

- Budget management strategy – Peg the growth in Medicaid payments to the growth in state revenues. Use a Medicaid Rainy Day fund in good years to save up for the bad years.
- Expanding the Premium Subsidy Option – Allow Medicaid clients the option of taking a subsidy to purchase insurance through work or the Utah Health Exchange instead of being on Medicaid.

We may be able to do some of this under our existing waiver authority; however, we need the federal government to give us some additional flexibility in order to make these reforms successful. If we can test this model, there is a chance that we could provide insights that would help every state improve their Medicaid program, saving hundreds of billions of dollars in state budgets alone, not to mention the savings to the federal government.

**It's not just Medicaid** – We are proposing reforms to our Medicaid program that are part of a larger effort to address problems with the system. Most insurers recognize the fundamental problem of paying for volume instead of value. If Medicaid takes the lead on changing the way providers are paid, private insurers will follow, lowering overall costs system-wide.

## Addendum 4

# The Utah Health Exchange: A Look in the Rearview Mirror

Norman K. Thurston, Ph.D.
State of Utah Health Reform Implementation Coordinator
February 2011

**Preface** – Governor Jon Huntsman, Jr. was inaugurated in 2005 and stated that one of his priorities was to make health insurance available to more Utahns. Dr. David Sundwall, the executive director of the State Health Department was tasked to find staff resources to create a solution and I was asked to work on this project to help inform stakeholders and frame the debate.

Our first step was to organize a day-long health summit held at the University of Utah in May 2005. National experts were invited to inform policy makers and stakeholders about the latest national ideas on various health and insurance related problems. The goal of the summit was to form a consensus on which direction the Governor should take. One of the presentations was on a plan for a new helath care connector being negotiated in Massachusetts with a Republican governor and a Democratic legislature. We quickly realized that our approach would need to be different, but it might be possible to create a low-cost, Utah –based version that would focus on markets and private solutions and exclude the expansion of government programs.

With the support of many staff, legislators and governors, we have designed a revolutionary approach to health system reform in Utah. In this document I intend to give a reflection on the development and implementation of the Utah Health Exchange, a critical component of our overall plan for health system reform. I hope to highlight both the thinking behind our approach and the lessons learned.

**Genesis – Identifying the Underlying Problem**

While the focus of health system reform in Utah has grown to include several critical areas that are intended to bring more value into the system, at the outset the goal was to decrease the number of people without health insurance.

To help understand the problem, we analyzed detailed surveys of the uninsured and realized some commonalities. Most of the uninsured in Utah are in households with at least one working adult, who is often employed by a small business or if they are employed by a large business, they are part-time workers.

That raised the next question. Why do so few small businesses offer health insurance? Estimates indicated that in 2005 less than 40% of small businesses in Utah were offering health insurance as a benefit. A study of businesses in Utah showed us that the number one reason they choose not to offer a health benefit was the unpredictability of costs. Most small businesses are entrepreneurial and need to be able to project both revenues and costs out three to five years in order to make plans to achieve their profitability goals.

Addendum 4

To address these specific issues, we set out to create a new approach to the employee health benefit that would entice more employers to offer it and slow the decline in employers no longer offering coverage. Some of the critical aspects of the design of this new system include:

- Generate predictability of costs for the employer – Small employers need to be able to forecast with a fair degree of certainty what their labor costs will be. We needed a system that gives the employer the ability to predict costs more effectively than the current system allows.
- Preserve the tax benefit to both the employee and employer – The current tax code creates a huge disparity in treatment of health insurance that is purchased through an employer's group plan versus a policy purchased by an employee on their own. We needed to create a system that continues to allow both the employer and the employee to pay for health insurance with pre-tax dollars. This tax benefit could be as much as 45% of the cost of health insurance, considering state and federal income tax, payroll tax, and the phase-out of the earned income tax credit.
- Bringing the consumer back into the equation – One of the most powerful forces for change is an informed consumer. Traditionally, the employee has been excluded from critical conversations about benefits and prices for group health insurance. To bring competition, discipline, and innovation into the process, we need to give more of the control to the employee.

**Changing the Underlying Health Insurance Markets**

With these preliminary goals in mind, the first key element in setting up the new system was to develop an entirely new health insurance market in the State of Utah. At the time, we had four main private-sector markets – individual/family market, small group market, large group commercial, and self-insured. Our intent was to create a new defined contribution market that is modeled after the defined contribution approach to retirement benefits. The defined contribution approach to retirement addressed the same problem that employers had with predictability regarding their retirement benefits.

In this new market, employers would designate a contribution amount for each employee to use toward the purchase of health insurance. The employee would then be allowed to select from plans offered by participating insurers in the same way that they have control over how their defined retirement contributions are invested. In addition to giving the employer control over their benefit costs, this also has the advantage of giving the employee full control over their health plan. They can choose the plan that best suits their needs. The employee also now has skin the game, in the sense that if they choose a more expensive plan, they pay the difference, but they also perceive the savings from choosing a less expensive plan.

As soon as we started designing this new system, we recognized that the two biggest challenges in creating this new choice-oriented market would be the potential for adverse selection and the need for a technology tool to help consumers evaluate their options and make good choices.

Adverse selection is primarily a problem for the carriers, so we brought them together and gave them an opportunity to identify a solution for potential selection issues.

Their solution was to design and implement one or more risk adjustment mechanisms to ensure that the funds that flow to each carrier inside the Exchange more closely match the assignment of the risk. It turns out to be also a good move strategically. As we researched risk adjustment experiments, we found

that in most cases where they failed, the blame was placed on the entity that developed the risk adjuster. It is easy for an insurer to walk away from a failing risk adjuster that is designed by someone else. It's a lot harder for them to make that case when they themselves have designed it. In our system, if the risk adjuster needs to be modified or updated, the carriers have the ability to make those changes.

On the second issue, facilitating consumer choice, we looked to the consumer experience in other industries that have similar challenges. The easiest example to understand is the travel industry. Over the past twenty years, consumers have been given a significantly greater opportunity to use the internet to make travel plans and execute them online.

We found that there are several private companies that have developed technologies to help consumers navigate the complex decision-making process and get the outcome that best meets their needs. In our presentations, we often pointed to Travelocity as being a prime example of a pioneer in the world of web-based consumer support. We set out to find a solution for employees choosing health plans that replicated the Travelocity service concept.

**Using Technology to Facilitate Health System Reform**

As we contemplated moving forward with this new market, it became apparent that we would want to develop an internet portal that could serve as the technology backbone for implementing health system reform in the State of Utah. This concept grew into the Utah Health Exchange.

*Note: It should be remembered that an Exchange is a technology solution that is designed to facilitate the underlying health system reforms. In national discussions, people occasionally ascribe additional roles for exchanges, including such things as operating public programs, regulating markets, or even negotiating with carriers. While any of those goals could be a part of a state's underlying health reform, they should be thought of separately from the technology component, which is the real Exchange.*

In addition to providing a web-based solution for the new defined contribution market, the portal could also provide technology solutions for other aspects of health system reform. Specifically, if we were going to the trouble of developing a consumer choice module for employees in the defined contribution market, we could also make that same functionality available to individuals buying policies on the open market or employers shopping for traditional group policies. Similarly, this would create a great opportunity and need for us to provide consumers with solid information on cost and quality. Eventually, this core portal could be expanded to support other aspects of health system reform.

As we considered how to structure the portal, we decided to take a modular approach. Initial development would eventually concentrate on three modules:

1) The Consumer Information Module

2) The Individual Market Shopping Tool

3) The Defined Contribution Module.

After taking a realistic assessment of our capabilities and limited staff resources we decided to focus on the most critical component of the portal first – providing a workable solution for small employers. Because of that, the Defined Contribution Module was given the highest priority.

Addendum 4

We set a goal of having something ready for a few employers to test by the fall of 2009. To make that happen as quickly as possible, we used an RFP process to identify existing private market technology solutions that could be applied to this module. Through that process, we found that the consumer comparison and choice technology that we needed already existed in the private market place.

In the insurance industry, just like the travel industry, there are several firms that have already developed tools to support health plan choice that could be adapted to meet our goals and needs. At the end of the process, we awarded contracts to two private companies, bswift, and HealthEquity, to work together to form the core technology for Defined Contribution Module. bswift's area of expertise is in facilitating consumer choice and HealthEquity brings the tools needed to handle to flow of funds. As a bonus outcome from the RFP process we also identified ehealthinsurance.com as a partner for developing the Individual Market Shopping Tool.

With these three private partners on board, in the summer of 2009, we launched the portal and christened it the Utah Health Exchange (often referred to as the UHE or the Exchange). In its initial form, the Exchange was launched with both the Defined Contribution Module and the Individual Shopping Module.

Development of the Consumer Information Module has begun, but is still not ready for prime time. When it is complete, the Consumer Information Module will be a technology resource to provide consumers with more transparency about the entire health care system, including health care providers as well as insurers. It will be able to display information on cost and quality in a way that helps the consumer make decisions and choices.

**The Individual Market Shopping Tool**

The Individual Market Shopping Tool is the easiest component of the Exchange to explain. Once word got out that ehealthinsurance.com would be our partner in this module, several other private entities with similar capabilities approached us with a desire to get involved. Since it was our purpose all along to foster competition in the private market, we had no justification to exclude any qualified partner.

As is stands today, individuals coming to the Exchange to buy a policy can shop in three different ways:

1) Online Comparison Shopping – They can choose one of five companies that offer side-by-side comparison shopping web-sites.

2) Online Buy Direct Shopping – They can also buy direct from one of the five insurance company web-sites that offer individual policies for sale through the Internet.

3) Find a Broker – The Exchange also has a tool that allows individuals to find a store-front insurance producer nearby where they can get help in person.

It is important to note that the plans offered through this module are the same plans available through the individual market. Given that our individual market functions relatively well, there was no need for insurers or regulators to create new rules or restrictions on policies that could be offered.

Addendum 4

*Note: I should note one exception – as part of the health reform legislation, we raised the bar for carriers to deny coverage in the individual market. Under the new rules, individuals under 225% of average risk cannot be denied coverage.*

While this adds significant value for consumers by facilitating their interaction with private partners, it is not a cure-all. Products purchased through this module do not have the tax advantages of employer-sponsored plans. In the Utah individual market, these plans are not guaranteed issue plans, so consumers can be denied coverage. In that case, they are informed of their eligibility to participate in the federal or state high risk pools.

It's also critical to point out that these private partners do not charge the state for their services and did not receive any state development funds. They earn commissions just as they would through their normal line of business and do not increase the cost to consumers.

While this solution works very well for our current needs, we have to consider that as it stands today, the Affordable Care Act also contains several provisions that will create a significant disruption in our individual market and our Exchange approach might need some additional functionality to meet guidelines. We are currently evaluating the impact on our market and developing a contingency plan.

**The Defined Contribution Module**

The Defined Contribution Module is the most well-known and publicized module of the Exchange. This module was launched with a very aggressive timeline. We needed to have small employer beta test up and running by late summer, 2009, with a full launch for small employers in the fall of 2010. We were also asked to conduct a pilot program for large groups in 2011 to see if we could be ready to handle all large groups by the fall of 2011.

The limited launch that ran from the fall of 2009 through the full calendar year of 2010 resulted in a test group of eleven employers offering their employees a defined contribution health benefit. Having a relatively small number of participants was exactly what we needed to be able to test the technology and work out any bugs. We learned a lot in the process.

We have identified seven essential functions that need to be in place for a Defined Contribution Module to work.

1. Creation of Application Packets – The Exchange must be able to accept employer information electronically and create a basic application packet that can be sent to the insurance carriers for evaluation and acceptance. This packet needs to include employees' basic health information collected on an electronic version of the state's uniform health questionnaire.

2. Risk Assessment/Underwriting/Rate Setting – Once the employer packet is approved for participation in a defined contribution plan, the technology must facilitate communication with the insurance carriers in the underwriting and rate setting process. Rates received from the carriers must be posted so that employers and employees see the correct prices based on their group's risk. (In Utah, we use the same underwriting rules as in the traditional small group market, plus or minus 30% rate bands.) Once the pricing information is loaded, employers have any opportunity to review the rates and set the defined contribution amounts for the employees.

Addendum 4

3. Employee Shopping and Choice – Employees must be given an opportunity to come into the system, evaluate their options, and make their plan choice. While every component is critical, this is the one that makes or breaks the effectiveness of the Exchange. Our goal is to provide the consumer with the tools they need to evaluate their options and make an informed choice. The current technology allows employees to filter or sort based on type of plan, benefits structure, insurance carrier, the inclusion of a particular provider, price, and other elements. This is critical, because with over 140 possible plan choices, it can be an overwhelming experience to evaluate so much information and make a good choice. It is our belief that this is where technology makes the biggest difference.

4. Enrollment – Once the employee choices have all been executed, the technology must be able to create an enrollment file that documents which employees and dependents are enrolled in which plans. This information is then transmitted to the carriers so they can create accounts, print cards, and be ready to process and pay claims for their respective enrollees.

5. Eligibility Reporting – The system also needs to have the capacity to enroll new hires and make changes at other times, such as special qualifying events or terminations and communicate those changes to the carrier and report current and accurate eligibility information to inform other processes in the system, such as financial payments.

6. Financial Transactions – The system must make an accounting for the premium dollars. In this new market, there are more destinations for those dollars that in the traditional group plan. Most importantly, the premium dollars have to be risk adjusted and forwarded to the corresponding carriers.

7. Customer Service/Support – The last function to cover is a process for customer service and user support. Ideally, most employee needs would be served by their employer's producer, who would be fully aware of the functions of the Exchange and is licensed to make recommendations about plan choice. However, the Exchange needs to have the ability to provide information and support to all users. We are currently in the process of evaluating and redefining our approach to filling this role, but it is becoming apparent that this is more of a policy decision than a technology issue.

As mentioned earlier, one of the critical elements to make this new defined contribution market work is the ability to apply an effective risk adjuster and our approach was to turn that over to the participating carriers. In statute, we created the Utah Defined Contribution Risk Adjuster Board as the formal process for that to happen. This board is composed of carrier representatives, government representatives, and a representative from the business community.

The duty of the board is to develop a plan of operations governing the defined contribution market that addresses problems related to risk and protects the market from adverse selection. Since the details of the operation of this market are fairly dynamic as we continue to learn and adjust, I have left out many of the specifics. However, the current version of the plan of operations would have most of those details.

Similarly, the staff operating the Exchange frequently needs input on difficult operational and implementation issues. To provide additional support in a less formal setting, the Utah Health Exchange Advisory Board was created, composed of representatives from insurers, producers, community organizations, and government.

**Critical learning from the Defined Contribution Module Launches**

Addendum 4

We used the learning from the limited launch to improve the technology in preparation for a full launch in the fall of 2010. We have also learned a few important things in this full launch that have required us to plan additional improvements.

Perhaps the most important thing we have learned is that it is difficult to put together and manage all of the information needed in an employer application. In the traditional market, this is typically done by producers using a paper-based approach. When this is translated into an electronic format, there is still a tremendous need for the producer to be heavily involved in scrubbing the various components to ensure that everything is ready for submission.

Here are some of the other current issues and learning points from the launches:

1) Employee census – Businesses, especially small ones, are dynamic environments. During the course of a few weeks involved in processing the application, employees are hired, terminated, and become eligible or ineligible for benefits. The insurer has to know that they are basing their underwriting on the complete set of employees that are to be insured, yet this is a moving target. This is no different than what happens in the traditional small group market, but it is certainly something to take into account.

2) Employer Support – At the end of the process, many employers want assurance that the prices their employees will see in the Exchange are competitive with rates in the traditional market. In Utah, by statute, the plans inside the Exchange cannot be priced higher than the same plans outside the Exchange. However, this can be difficult to verify. Due to the nature of the Exchange, it's not easy to perform an apples-to-apples comparison with plans offered outside the Exchange. First of all, the exact plan that they may be considering outside the Exchange may not be one of the choices inside the Exchange. In addition, for reasons already mentioned about changing employee census, the rate quotes may not have been generated using the same employees. Finally, there is no way to predict what the employees will choose when given the choice.

3) Retrospective Risk Adjustment – In addition to the prospective risk adjuster, carriers may wish to do some back-end or retrospective risk adjustment. One of the challenges will be that claims information for employees in any given group could be housed across multiple carriers who may not be excited about sharing that information with each other. Fortunately, all of our participating carriers are also required to submit data to our All Payer Claims Database (APCD). So there is a single data source that has access to all of the claims related to Exchange participants. It stands to reason that the APCD could be a very useful tool in conducting retrospective risk adjustment for groups insured through the Exchange.

4) Engage Producers – The producers are the primary sales force for the defined contribution market. Rather than confronting and marginalizing them, it is better for everyone involved to engage them as early as possible in the process. An informed producer is likely to see how this new approach can benefit some or all of their existing clients as well as providing them a new sales tool to reach out to those small businesses that don't currently offer a benefit. Producers are also very helpful in guiding the development of the technology tools, ensuring that the process flows as intended, and watching out for errors or deviations in the system.

5) Premium Parity – In order to avoid a scenario where the defined contribution market is overloaded with high risk employers, it is essential that premiums for like products be the same inside and outside the

Addendum 4

Exchange. Initially, we did not have this requirement in the limited launch, and it became immediately apparent that this would be a problem. One of the specific areas of concern has to do with restrictions on renewal rates. In Utah, incumbent carriers face statutory limits on premium increases at renewal. When currently covered small employers look at the Exchange, carriers should not get a free pass to rate them up beyond these limits. In our current approach, if an employer is currently insured with a participating carrier, all carriers are restricted from assessing a risk factor higher than their renewal risk factor from their incumbent carrier.

6) Engage Insurers – When all is said and done, the insurers have every incentive to make this work. It represents an opportunity to increase enrollment, which will reduce cost-shifting as well as providing additional premium. To the extent that there are concerns about risk, it is the insurers who have the proper motivation to address them. With this in mind, we have given a fair amount of latitude to the insurers to bring their expertise to the table to help in the design and development of the system.

7) Private Solutions – We now realize that it was very effective for us to contract with companies that have existing technology solutions that could be applied to the needs of the Exchange. However, we have also learned that this partnership works best when the application of the technology is close to the core competency of the partner. It's better to engage additional partners whose core competencies meet the need at hand instead of trying to apply technologies beyond what they are intended to do.

8) Do a Beta-test – Maybe this is the most obvious thing that we only thought about once we were into the process. It is essential to a successful development to continually test the system during development. A beta-test with real participants was very informative and made a huge impact on our eventual outcome.

**Counsel for Other States**

**Can this be done faster using Utah as a template?** I am convinced that this is the case. Based on our experience, we know what legislative action is required, and we also know what critical functions need to be in place for the Defined Contribution Module to work. This isn't to say that it would take time to develop those functions, but we now know that most (if not all) of them are already developed in the private market. If states can be clear about their needs, it should be straightforward to build.

**What adaptations should states anticipate?** It was not easy to develop the data interfaces and communications between the exchange tools and the insurers. While insurers that are participating in our Exchange understand how to deal with that now, new insurers will need some time to get up to speed.

Mr. UPTON. Thank you.
Governor Patrick.

**STATEMENT OF DEVAL PATRICK**

Mr. PATRICK. Thank you very much. Mr. Chairman, Mr. Waxman, to all the members of the committee, thank you for the opportunity to be here today. Thank you, Congressman Markey, for the warm welcome and generous introduction. I am looking forward to discussing with you the impact on the States of the Patient Protection and Affordable Health Care Act and the next steps in implementing national health care reform. And thank you in advance, Mr. Chairman, for your understanding about my having to leave by 11:30 to catch a plane to get back home.

In the interest of time and with your permission, I will simply submit for the record the written testimony that we have provided and offer a shorter statement now.

As many of you know, the Affordable Care Act enacted last year is modeled in many respects on our reform measure in Massachusetts enacted in 2006. Our experience with our own reform in Massachusetts may forecast what other States may expect from national health care reform in a couple of respects.

Today, thanks to effective implementation of our 2006 reform legislation, more than 98 percent of Massachusetts residents have health care coverage today including 99.8 percent of our children. As the Congressman said, we lead the Nation in both categories. More people are getting preventive care instead of waiting until they have to go to the emergency room. Workers and their families no longer have to worry about a catastrophic illness forcing them into bankruptcy or being denied coverage because they are already sick. We have not had the problem of crowd out where companies have abandoned insurance plans for their employees in favor of publicly subsidized plans. In fact, the percent of private companies offering health insurance to their employees has increased from 70 percent before the bill was passed to 76 percent today.

We paid for expanded coverage just as we said we would: by delivering more care in primary care settings than in emergency rooms. In 2005, Massachusetts paid over $700 million for health care for the uninsured and underinsured. In 2010, we spent $405 million, nearly $300 million less. With 98 percent of our residents covered, universal coverage has increased State spending by about 1 percent of our total State budget. Overall, Medicaid represents 32 percent of annual State spending today and has grown about 2.7 percent per capita since our reforms were enacted.

Ours is a hybrid solution. Like the Affordable Care Act, it emphasizes private insurance purchased in the open market at competitive prices and service delivered by private clinicians. People choose their own doctors.

We still have challenges, of course. For example, even with the highest per capita ratio of primary care physicians to residents in the country, there are not enough primary care physicians. The wide variance in the reimbursement rates at provider hospitals is another challenge. But these are challenges all over the country. The point is, that in Massachusetts we stopped limiting our thinking to the same old two choices between a perfect solution or no

solution at all. We chose to try something and we moved, and it has worked.

The process of developing our reform measure is something I am proud of too and I just want to touch on very briefly. Then-Governor Mitt Romney, a Republican, working together with a Democratic State legislature, a Democratic United States Senator, Ted Kennedy, and a broad coalition of business and health care leaders, labor, patient advocates, came together to invent our reform bill and then stuck together to adjust it as we have gone along and to refine it. That bill was an expression of shared values of our belief that health care is a public good and that everyone in Massachusetts deserves access to it.

So for Massachusetts, the Affordable Care Act is familiar. Like our law, it improves health security for all our citizens. It takes a hybrid approach that leverages the best of government, nonprofits and private industry, and with President Obama's leadership, it was developed and supported by a broad coalition of stakeholders and advocates who understood that our public health and economic competitiveness demanded action.

The Affordable Care Act is also cost-effective. According to the Congressional Budget Office, the act will reduce the federal deficit by $124 billion through 2019 and by more than $1 trillion in the subsequent decade. So national health reform is an important piece of a responsible plan to improve our fiscal outlook for the long term.

Based on our experience at home, national health reform is also good for our economic competitiveness. Matt McGinity, the CEO of a small technology company in Natick, a town outside of Boston, bought health insurance through a program created by the Commonwealth Connector, which is our version of a health exchange. The program, called Business Express, is an online service to help small businesses easily shop for private health care and find the best possible value. Using Business Express, Matt was able to compare health plans side by side and avoid a 23 percent premium increase his current insurer was proposing. He and his employees saved $9,300. Now, that may not seem like much to many of you here but it is meaningful to Matt's company and to thousands of small businesses like it in our home State of Massachusetts.

I met a young entrepreneur recently who moved his business up to Massachusetts from Florida—I hope I am not upsetting anyone here from Florida in saying this—because with a young family he wanted to be able to start his venture without worrying that his children would not have health insurance. In other words, universal coverage has helped our competitiveness.

So I see my time is up. Let me just wrap up, and I hope we can get to what I feel is the nub of the issue, which is cost control, and cost control is a challenge all over the country in places that have a universal system and in those that don't, 130 percent premium increases over the last decade. We have some strategies that we have put in place and that we are pursuing in Massachusetts to get at that nationwide issue, and frankly, there are some elements of the Affordable Care Act that help us in that regard as well, and I look forward to your questions. Thank you very much, Mr. Chairman.

[The prepared statement of Mr. Patrick follows:]

Testimony of

Massachusetts Governor Deval L. Patrick

as prepared for delivery

before the

House Committee on Energy and Commerce

United States Congress, Washington, DC

Tuesday, March 1, 2011

Chairman Upton, Ranking Member Waxman and the Members of the Committee:

Thank you for the opportunity to appear before you today to discuss the impact of the Patient Protection and Affordable Care Act on states and the next steps in implementing national health care reform.

Like many successful federal programs, the origins of national health care reform can be found at the state level. In 2006 Massachusetts enacted a health care reform bill aimed at making health care universally accessible. Because that measure serves as

a model for national health care reform, it may be helpful for me to offer some insights on the impact of our reform in Massachusetts and the process by which it was devised and implemented.

Today, thanks to effective implementation of our 2006 reform legislation, more than 98 percent of Massachusetts residents have health care coverage, including 99.8 percent of our children. We lead the nation in both categories. More people are getting preventive care instead of waiting until they have to go to the emergency room. Workers and their families no longer have to worry about a catastrophic illness forcing them into bankruptcy, or being denied coverage because they're already sick. The percent of private companies offering health insurance to their employees is up to 76% from 70% before the bill was passed. Health care reform is doing exactly what it was designed to do: expanding access to quality health care to all our residents.

We paid for expanded coverage as we said we would, by delivering more care in primary care settings than in emergency rooms. In 2005, Massachusetts paid over $700 million for health care

for the uninsured and underinsured. In 2011, we spent $405 million – nearly $300 million less. With 98% of our residents covered, universal coverage has required about 1% more of our state budget in state spending. Overall, Medicaid represents 32% of annual state spending today and has grown about 2% per capita since our reforms were enacted.

The process of developing our reform measures is something I am proud of, too. Then-Governor Mitt Romney, a Republican, working together with a Democratic state legislature, a Democratic United States Senator, and a broad coalition of business, labor and health care leaders came together to invent our reform bill and then stuck together to adjust it as we implemented and refined it. That bill was an expression of shared values, our belief that health care is a public good and that everyone in Massachusetts deserves access to it.

Ours is a hybrid solution. Like the Affordable Care Act, it emphasizes private insurance purchased in the open market at competitive prices, and service delivered by private clinicians.

People choose their own doctors, and there remains a lot of choice. We still have challenges, of course. For example, we don't have enough primary care physicians. The wide variance in the reimbursement rates of provider hospitals is another challenge. But these are challenges across the country that are not caused by our universal care law. The point is that in Massachusetts we stopped limiting ourselves to the same old two competing choices: a perfect solution or no solution at all. We chose to try something and we moved. And it worked.

So, for Massachusetts, the Affordable Care Act is familiar. Like our law, it improves health security for all citizens. It takes a hybrid approach that leverages the best of government, non-profits and private industry. And with President Obama's leadership, it was developed and supported by a broad coalition of stakeholders and advocates who understood that our public health and economic competitiveness demanded action.

Getting people insured, having them receive their care in primary care settings as opposed to emergency rooms, is good. It's

also cost effective. According to the Congressional Budget Office, the Affordable Care Act will reduce the deficit by $124 billion through 2019 and by more than $1 trillion in the subsequent decade. National health reform is a critical piece of a responsible plan to control our national budget deficit and improve our fiscal outlook for the long term.

Based on our experience at home, national health reform is also good for our economic competitiveness. Matt McGinity, the CEO of a small technology company in Natick, outside of Boston, bought health insurance through a program created by the Commonwealth Connector, our version of the Health Exchange. The program, called Business Express, is an online service to help small businesses easily shop for private health care and find the best possible value. Using Business Express, Matt was able to compare health plans side-by-side and avoid a 23% premium increase his current insurer was proposing. He and his employees saved $9,300.

I met a young entrepreneur recently who moved his business up to Massachusetts from Florida because, with a young family, he

wanted to be able to start his venture without worrying that his children would not have health insurance. Universal coverage helps our competitiveness.

Federal reform is good for Massachusetts. It has given us an affordable way to extend the promise of coverage to Massachusetts residents who make between $33,000 and $44,000 a year, or families of four making $67,000 to $89,000 a year, by making those families newly eligible for tax credits that help them afford their premiums. And through the retooled Medicaid and Children's Health Insurance Program, Massachusetts taxpayers will save about $450 million a year while allowing us to provide better care to our youngest and more vulnerable residents.

The next frontier for Massachusetts and for America is cost control. The framers of our Massachusetts reform purposefully addressed access first and put cost control off. We can wait no longer. Spending on health care makes up 17.6% of all spending in the United States – one of the largest single sectors of our economy. In recent years growth in health care costs has outstripped growth in

GDP even as the share of Americans with health insurance has fallen. As spending on health care programs and emergency care grows, it weakens our ability to compete and slows job growth. Left unchecked, health care costs threaten our fiscal integrity and our ability to provide future generations with the same support that we have enjoyed. The generations before us made choices that preserved the critical services that we rely on. We need to follow their example and make responsible decisions on behalf of future generations.

So, while health insurance is universally accessible in Massachusetts, it is not yet universally affordable. My state is home to some of the world's best hospitals and health care providers, but our costs are far too high and they are growing at an unsustainable rate. The challenge of high health care costs is not unique to Massachusetts and has nothing to do with our health care reform. Escalating premiums, rising over 130% in America in the last decade, far outpacing the rate of economic growth or general inflation, are a challenge for businesses, governments and working families all over

the country. With due respect to the Committee, this is where the Congress needs to turn its attention now.

And just as we in Massachusetts have provided the national model for universal access, I believe we can crack the code on cost control.

As a near term solution to rising premium costs for small businesses, last April I directed the Division of Insurance to reject excessive increases in health care premiums. This led to agreements with insurers to limit their rate increases and put pressure on providers to hold down their rates. That move was not without its critics. But it had to be done. Not because health insurance companies are bad – they're not. Not because it was a permanent solution – it isn't. It had to be done because for all the good intentions and the broad consensus on the critical need to lower costs, the market wasn't doing it on its own. We needed something to prod the market forward. And it worked.

Last week, the Massachusetts Division of Insurance approved health insurance rates for this year. Now we are looking at single digit base rate increases – down from the twenty five to thirty percent increases that had become the norm and precisely the relief we sought by intervening last year.

Last summer, I signed legislation that made it possible for small businesses to form associations to pool their buying power when negotiating insurance rates with carriers, and mandated that insurers offer at least one select network product with premiums that are 12% lower than those without select networks. The legislation also required greater transparency in understanding the drivers of health care costs. These initiatives are being implemented right now.

Two weeks ago we launched the second phase of health care reform in Massachusetts, aimed at finally controlling costs and making health care as universally affordable as it is accessible. Right now, the current system rewards providers for the quantity of care they deliver, not the quality. For costs to come down, this has to change. We are working with the health care community in our state

to accelerate their transition to innovative, improved models for delivering health care. In these new models incentives will be realigned to reward integrated care under a more rational price structure that emphasizes wellness and lowers costs for everyone. Our goal is for integrated, cost-efficient caregivers to predominate in Massachusetts by 2015.

The Affordable Care Act actually supports our efforts to bring down costs. We are using the authority of the national reform to develop guidelines and incentives for more integrated systems of care. The Act is helping us coordinate care for individuals who are eligible for both Medicaid and Medicare and thereby bring cost savings to the Medicare program. And it builds on the movement toward patient-centered medical homes where primary care providers are paid to care for people and not just for 15-minute appointments.

The Affordable Care Act has helped bring health insurance within reach of thousands of Massachusetts small businesses through tax credits. It will supplement some things we are already doing to allow small businesses to buy their health insurance in

groups to increase their purchasing power. Just as our Massachusetts reform gives people freedom to move between jobs within the state without fear of losing health care, the Affordable Care Act permits that freedom across the Nation. It makes investments in the health care infrastructure that supports everything we do. And it reduces the deficit in the short run and over time. Just as our businesses rely on good roads, a modern electricity grid and access to broadband to thrive, having a strong health support system is another piece of the puzzle, making us an attractive destination for new businesses. The Affordable Care Act is good for America and deserves a chance to be implemented.

This is, above all, about people and what kind of country we want to live in. I remember meeting a young woman named Jaclyn Michalos, a cancer survivor who got the affordable care she needed to save her life through our Commonwealth Connector. She had no other way before Massachusetts health care reform. This is about people, not abstract policy or politics. I urge you to remember that.

The remaining challenge before us all is cost control and again I urge you to turn your attention to that. In my state, businesspeople from companies large and small, new and old, often tell me that health care costs are the single greatest obstacle to job growth. Massachusetts ranks 4th in total jobs created since December 2009 and we rank 6th in private sector jobs created since December 2009. Our unemployment rate is well below the national average. Hiring at the national level has already started to come around. But neither at home nor nationally can anyone be satisfied with where we are. The Affordable Care Act has some useful tools to help businesses and governments control costs. But on this front there is much more to be done. I hope you will support what we are trying to do in this area in Massachusetts and in other states, and that we can provide some useful models for further national reform.

Again, thank you for inviting me today. I look forward to extending the progress we've already made expanding access to health care and to working with you on making that care more affordable. I am happy to take any questions you might have.

Mr. UPTON. Thank you.
Governor Barbour, welcome.

## STATEMENT OF HALEY BARBOUR

Mr. BARBOUR. Mr. Chairman and members of the committee, first of all, thank you for asking. The first thing we want to say is thank you. When they were doing the Affordable Care Act, there was a big meeting at the White House of Members of Congress from both parties, and there were no governors, and so thank you to the committee, both Republicans and Democrats, for asking governors what we think.

I would like to associate myself with Governor Herbert's request that the cases from Florida and Virginia on the constitutionality of the federal act be expedited. It is in our interest to know the answer sooner rather than later, and the thing we fear the most is conflicting opinions from different circuits. We have already seen conflicting opinions at the district court level. Conflicting opinions from different circuits would just compound that problem. So for those of you who have any influence on that, we would like to get that question answered sooner rather than later.

I am delighted to be here with my friend Deval Patrick. Massachusetts has a State health insurance program that they are obviously happy with, and we think that is their right, and when Senator Kennedy and Governor Romney and then Governor Patrick, if that is what Massachusetts wants, we are happy for them. We don't want that. That is not good for us. We don't want that. We don't want community rating. We don't want extremely high mandatory standard benefits packages. So the point I am trying to make is, different States have different problems, we have different ideas, and while you may not believe it, some politicians obviously who act like you all love our constituents more than we do, believe it or not, we love our constituents as much as you all do and we want to do right for them but we want to do what we can afford and can sustain.

Medicaid is the second biggest item in my budget after education. We spend about 63 percent of the State budget on education, and Medicaid is the next biggest thing. However, Medicaid's growth before I was Governor, it was growing at 16-1/2 percent a year and we were cutting our community colleges and cutting our universities because the money was having to be diverted to Medicaid.

In my 7 years as Governor, we have reduced Medicaid expenditure growth to 4 percent. We have not changed eligibility with one exception. The people who we used to give pharmaceuticals through the Medicaid program who are dual eligibles now get their pharmaceuticals through Part D. So in full disclosure, I want to say that. The reason I do is because of this, because we have got the flexibility to do it, we reduced our pharmaceutical program's cost from $697 million annually to $279 million, a 60 percent reduction. A little bit of that came from Part D but primarily by going to generics. We are 78 percent generic now and the meds are great for people. If somebody has to have a brand name, we do that.

Flexibility to do that kind of stuff is critical for us. That is what we need. One of the things we were allowed to do my first year is,

our Medicaid roll had gone from 510,000 to 750,000 in 4 years. Forgive me for thinking maybe that wasn't the way it should have been. So we found out that the previous administration had not followed the federal rule that you have to require people to reestablish their eligibility annually. They weren't doing that. We require our beneficiaries to reestablish their eligibility annually in person, and a lot of people who probably had once been eligible for Medicaid but weren't anymore didn't come to try to requalify. We make exceptions for people in nursing homes, for disabled children, for people who are homebound because they are sick, but this is a benefit on average that is worth somewhere between $6,000 and $7,000 and we don't think it is a burden once a year to go to one of about 70 places just to reestablish your eligibility for this program. We do that for everybody.

What we would like is the ability while they are there to mandate that they take a physical. We offer at this meeting every Mississippi Medicaid beneficiary a health assessment, and hardly any of them take us up on it. We would like to be allowed, and we don't think we ought to have to ask for permission to make that mandatory. But there are a lot of things you have to get permission to do. Waivers are a problem you will hear from many people but I want to tell you, State plan amendments can be just as big a problem. We have a State plan amendment where they met the 180-day requirement to approve our State plan amendment but then it took them a year to approve the contract that was going to be part of the State plan amendment. That doesn't help.

Let me just make one other point about this, and I know my time is up but I think it is important. We have $7 million in Medicaid that comes from fines paid by nursing homes that had some violation. We have to get CMS's permission to spend that. We asked for permission to spend it to build a facility for the 20 to 25 very sick children, typically vent patients, that right now we have to put in the hospital, very expensive care, or send them out of State because the regular nursing home is really not set up to have 79 senior citizens and one 5-year-old. We were told well, you can do that if you remodel an existing building but you can't do it if you build a new building on our University Medical Center State hospital campus. Those kinds of things, we should not be required to ask permission to do those kinds of things, whether it is to save money or provide better care.

My time is up and I would be glad to take any questions.

[The prepared statement of Mr. Barbour follows:]

Chairman Upton, Ranking Member Waxman, and members of the Committee, thank you for the privilege of being a part of this important hearing on implementation of the Patient Protection and Affordable Care Act (PPACA). Governors have unique perspectives as we stand on the front lines of entitlement reform, and we governors appreciate your taking the time to hear our concerns and ideas.

On January 26, 2011, the Congressional Budget Office updated its baseline budget outlook which included a projection that this year's budget deficit will total a record $1.5 trillion. The President's Fiscal Year 2012 budget proposal released last month calls for a $1.6 trillion deficit.

Proving the point that healthcare reform did nothing to rein in entitlement spending, the January 26 report highlighted that spending on Medicare, Medicaid, and other mandatory federal health programs will reach $870 billion in 2011, or 5.8 percent of GDP. In CBO's baseline projections, spending for health programs more than doubles between 2011 and 2021, rising by an average of about 7 percent per year and reaching $1.8 trillion in 2021. On top of that, we all know these projections are unrealistically low, as they do not include major budget gimmicks such as the "doc fix" and CLASS Act.

Clearly, Americans are no closer to affordable healthcare with the passage of the PPACA than they were before the debate began. This law will greatly expand state Medicaid programs, pulling tax dollars from other necessary areas like education and law enforcement. Governors will soon be forced with the choice to either cut state spending in other priority areas or to

increase taxes to pay for the federally required expansion of the Medicaid program. The states need the flexibility and authority to craft innovative programs to provide medical care to our neediest citizens. But to do so, we need Congress to cut the red tape states must wade through to implement new programs and save money on what we already do. Through greater flexibility in the management of Medicaid, states might be able to reduce substantially the hidden tax increases that forced expansion of the program will impose. Our citizens should not have to wait years for agencies in Washington to green light new healthcare solutions. We need relief now.

Medicaid was established in 1965 to provide healthcare to the neediest among us – our poor and our elderly. However, the cost of Medicaid to the states has spiraled out of control. Medicaid is in serious need of reform, not expansion. It needs to cost less, not more. In Mississippi, over the last 10 years, program costs have doubled. However, during the four years under my predecessor, Medicaid costs went up nearly 16 percent a year. In my six years in office for which we have data, our Medicaid costs rose only 4 percent per year. If we had more flexibility, we could do more constructive things to reduce costs and provide quality care.

The Medicaid Program is broken from both a budget and health outcomes perspective. The growth in federal Medicaid medical service spending is unsustainable, increasing almost 8 percent annually during the past 10 years.

From a bureaucratic standpoint, CMS' process moves at a snail's pace. For a state to get approval of a waiver to meet its immediate needs, it may wait a year - or even two - for the bureaucrats to approve or deny such actions.

Despite all of this, instead of reforming the flawed program, the PPACA expanded a broken system. Governors are on the front lines to deal with the aftermath of this shortsighted effort.

Since I have become Governor, and before the PPACA, Mississippi has taken a number of concrete steps to enhance services and curb costs despite a rigid federal Medicaid system.

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

The state does allow exceptions to the face-to-face redetermination for nursing home residents, foster care children, disabled children living at home and anyone home bound, such as an elderly adult in a home-and-community-based waiver program. As a whole, this process has proven very successful. Mississippi has a 0.1 percent eligibility error rate, the third lowest in the country, compared to the national average at 6.74 percent. My view is taxpayers are paying an average of more than $6,000 for each person on Medicaid in Mississippi, for a plan that is more comprehensive than most private plans. An annual review to ensure those receiving Medicaid benefits are truly eligible is in the best interest of both beneficiaries and taxpayers.

Since I have been Governor, the Division of Medicaid has instituted a policy of prevention and wellness to encourage beneficiaries to utilize a medical home. Under the program, an individual can get care on a regular basis allowing the healthcare provider and beneficiary the opportunity to develop a relationship that fosters quality care. The goal of the program is to redirect existing dollars from a pay-for-service strategy to a wellness strategy, creating a healthier Mississippi. Beneficiaries are given one free annual physical examination, which does not count against their total number of doctor visits. This is done to establish a baseline health assessment in which to build beneficiaries' care around. Although Medicaid has offered this service for six years, very few beneficiaries in Mississippi use this important preventive care service. Having the flexibility and the ability to require an annual physical would assist the state in providing not only better preventative care and but also would result in a reduction of healthcare costs.

I will remind you that Medicaid cannot require beneficiaries to schedule an annual exam because the federal law prohibits us from doing so. In my state, we have some of the highest incidences of obesity, heart disease, diabetes and cancer. If we could require Medicaid beneficiaries to have an annual exam, it would allow for early detection and proper treatment, improving the quality of life for thousands of Mississippians. Preventive care is obviously important because the PPACA now requires coverage of certain preventative services. Medicaid programs should have the flexibility to require beneficiaries to get an annual exam to ensure our goal of promoting the use of primary and preventive care.

In 2005, the cost of prescriptions for the Mississippi Medicaid program was out of control. Pharmacy costs reached $697 million that fiscal year. We took action to rein in these

excessive costs. I can tell you in one year our drug costs went down from $697 million to $422 million in FY 2006. The next year, we saw a full year of savings when costs dropped further to $279 million, a nearly $420 million or 60 percent annual reduction.

We promoted the use of generic drugs by limiting the number of expensive brand-name prescriptions to two per month. These changes applied to Medicaid beneficiaries ages 21 and older. We reduced the maximum number of prescriptions allowed from seven to five per month. There were also cost savings from the Medicare Part D pharmacy program. .

Our efforts to encourage the use of generic prescriptions worked. In June 2010, the Mississippi Medicaid program was using generics at a rate of 78 percent – far more than the 46 percent utilization rate seen six years earlier.

Another area where states and the federal government could save tax dollars and improve health care is in long term care services. Mississippi's population between the ages of 55 and 64 increased by 10.2 percent from 2005 to 2009. Mississippi pays nearly five times more for each citizen placed in a nursing home, than it pays for the same individual to receive care at home near family and friends. In the current fiscal year, the estimated amount to add one nursing facility bed to the Medicaid program is $55,731, and that cost is expected to be $60,190 next year. In comparison, the cost to serve one person receiving home- and community based services, who meets the same criteria as those in a nursing facility, is $10,949 this year. In a few years when this group is in need of long-term care, the cost of a nursing home to the Medicaid program will far surpass the cost of receiving care at home.

How should you encourage more home and community care? First, let's make sure that those who are admitted to long term care facilities in lieu of home and community based services require the highest level of long term care. As you know, nursing facility services are federally mandated. Therefore, if a person meets the financial and functional/medical criteria for Medicaid-funded institutional care, they have an "entitlement" to that care. There is no such entitlement to Medicaid-funded home and community based programs although the functional/medical criteria for admission to these home and community based programs is the same as the criteria for institutional care. The admission requirements for home and community based care should be less stringent than the requirements for institutional care and the institutional requirements should be such that only those requiring the highest level of long term care need should be eligible. Over the past several years, despite difficult budget circumstances, we've gradually increased the number of persons served in our home and community based programs. Due to effective management of the Medicaid program and the savings produced over the last year, this year I have been able to authorize the addition of 6,200 more individuals to our Medicaid home and community based program. These individuals will be able to receive quality care in the setting they are most comfortable at less cost to Medicaid than institutional care.

In a February 3 letter sent from Secretary Sebelius to Governors, she writes of flexibility at the states' disposal to control costs. Although there are avenues states can utilize to try to make changes to their programs, making these changes is often lengthy, time-consuming and burdensome to the states. CMS continuously tells states, such as Mississippi, to be creative and flexible in developing new programs and implementing changes to existing programs to provide smarter care choices. However, all these things require CMS approval. They shouldn't.

For example, there is a need in Mississippi for a specialty-skilled nursing facility for the care of medically complex and fragile children. The University of Mississippi Medical Center is working with the Division of Medicaid to utilize Civil Money Penalty Funds (CMP) as start-up monies for the development of this specialty-skilled nursing facility for children. Nursing homes pay CMPs when they violate Medicare and/or Medicaid quality-of-care requirements. The PPACA expanded the use of CMPs. CMS has even said it provides greater flexibility to use those funds to support the quality-of-care and quality-of-life initiatives for those persons who must reside in a nursing home even for a short period of time. We want to do just that in Mississippi by developing a nursing home program specifically for these medically fragile children; however, we are required to get CMS approval. This process can take months, as CMS will refer our request to a team who will provide technical assistance. We know what we need, and we have a plan to get these very special children out of a hospital into a more home-like setting. We work with the parents to eventually allow them to go to their home. The steps CMS is requiring us to take are delaying our efforts to do just what they say they want us to do.

My Medicaid staff submitted a State Plan Amendment over a year ago to implement a Care Coordination Program. The Plan Amendment has been approved, but the comprehensive risk contract under the State Plan Amendment was submitted last spring and has yet to be approved. My staff has been in regular communication with CMS staff and was assured there were no problems with the contract. Yet in December, CMS made us aware of a possible problem, and then it took another month to get CMS to let us know what they consider the problem to be. It is impossible to make any meaningful changes to the Medicaid program when the process takes so long to approve a State Plan Amendment and has become increasingly burdensome on states.

Last but certainly not least, the federal PPACA, if it goes into effect, will have a dramatic negative impact on Mississippi's budget for years to come. It is important to examine the potential costs of the substantial expansion of Medicaid on our financial future. I requested Milliman Inc., a consultant currently on contract with the Mississippi Division of Medicaid, to analyze the potential cost of the PPACA on the State of Mississippi.

Their findings are staggering. The PPACA will result in a massive expansion of Medicaid, which is projected to cost Mississippi taxpayers up to an additional $1.3 billion to $1.7 billion over the next decade despite little spending during the first four of those years. Milliman's analysis focused solely on the expansion of the state's Medicaid program and did not take into account the number of additional unfunded mandates contained in the law. Those mandates coupled with the changes in Medicaid will surely make those numbers even higher.

Of course, expansion of the Medicaid program will require the State to commit additional tax dollars to both staffing and service needs. Although the federal government will cover some of the additional costs of the expansion, there are numerous associated costs that are the responsibility of the State. As you know, the legislation tries to accomplish this goal by massively expanding states' Medicaid programs.

We expect more people to enroll in Medicaid rather than face federal fines for lacking private health insurance coverage. In 2014, the PPACA will significantly expand Medicaid eligibility thresholds to individuals with incomes of 138 percent of the Federal Poverty Level (FPL). The 138 percent of FPL population reflects the 133 percent of FPL eligibility level

indicated in the Act with the additional 5-percent allowance. This increase will add 390,000 to 400,000 new individuals to Mississippi's Medicaid rolls, a two-thirds increase, meaning one-in-three Mississippians will be on the state's Medicaid program. With full implementation by 2020, this will cost Mississippi's taxpayers $443 million a year, increasing our state Medicaid cost by half. That number will continue to rise in subsequent years.

This estimate considers all reform provisions related to the Medicaid expansion, including items such as increased administrative costs and shifting children from CHIP to Medicaid. Due to the PPACA's individual mandate to require an individual to have health insurance, the state expects a high participation rate by the newly eligible individuals in addition to people who are currently eligible for Medicaid but not enrolled. This high participation rate is reflected in the cost analysis by Milliman.

Further, within a few years, we will see more Americans on government health care and fewer businesses offering health care coverage. The new law will hurt small businesses – the backbone of the American economy. Employers who do not offer adequate insurance will be fined thousands of dollars. And who decides whether an insurance plan is adequate? The folks in Washington. To stay in business, we will see employers drop healthcare insurance coverage, cut wages or hire fewer workers, or all three. That's certainly not the answer to curing our economic troubles.

States need flexibility now, and we can't wait. State tax revenues from every source are still well below 2008 levels and will continue to lag behind the national economic recovery especially if skyrocketing gasoline prices hurt the economy as in 2008. Although nearly every

state is required to enact a balanced budget, according to the Fall Fiscal Survey of States report, 11 states are reporting nearly $10 billion in budget gaps that must be closed by the end of fiscal 2011. In addition, fiscal 2012 and fiscal 2013 also represent significant challenges for states as the funding provided by the expiration of American Recovery and Reinvestment Act, or stimulus dollars, will no longer be available. Although not all state budget offices have completed forecasts, so far 23 states are reporting $40.5 billion in budget gaps for fiscal 2012, and 17 states are reporting $40.9 billion in budget gaps for fiscal 2013. Many states continue to cut their general fund spending. In Mississippi, I've had to cut spending $700 million, including 9.4 percent in cuts of General Fund spending in Fiscal Year 2010. States must live within their means and balance their budgets. The infusion of federal stimulus funds for state budgets, which included a number of Maintenance of Effort provisions and ended with steep cliffs, has delayed the inevitable need for governors to plan for each state's fiscal reality. But the time is now.

Given these dire budget situations across the country, and even in normal fiscal times, our systems can't support the broad PPACA Medicaid expansion now or in the future. States need the ability to be incubators of reform. People who say there is only one way to do conservative healthcare reform are missing the point of state-based health reform.

There has been much discussion lately among both Republican and Democratic governors regarding the Maintenance of Effort requirements set forth both in ARRA and PPACA. A letter was sent to Congressional leadership which outlined how MOE requirements freeze state governments' ability to adapt the state-administered Medicaid programs to changing populations or economic conditions. The MOE should be stricken both for income and eligibility

standards and methodologies and procedures. While this is not as bad for my state as many others, states should be allowed to manage their programs for their unique populations.

Eliminating the MOE requirements should be coupled with the ability to develop new financing structures and to tailor benefit packages. For example, in Mississippi approximately 65 percent of beneficiaries are pregnant women and children. Although states are allowed to constitute their benefit packages, CMS dictates each covered service must be sufficient in amount, duration and scope to reasonably achieve its purpose. When states try to tailor a benefit package, CMS uses this definition as a crutch and will not allow any changes. An alternative would be to give children, their mothers and pregnant women a voucher to purchase private insurance. This would benefit the recipient by providing increased choice and improved access to providers, and states would see a reduction in costs due to coverage and administration efficiencies.

Secretary Sebelius also noted in her letter that Congress gave states additional flexibility to impose cost sharing in Medicaid in the form of co-payments, deductibles, coinsurance and other similar charges without requiring states to seek federal approval or a waiver. The problem is federal regulations do not allow a provider to deny services to an individual on the basis of the individual's ability to pay. In addition, no cost-sharing measures can be imposed on many Medicaid enrollees, including children.

The federal government should give states the flexibility to increase enrollee cost sharing and permit cost sharing for all enrollees. For example, more than half of Mississippi Medicaid recipients are children. When the federal government ties states' hands by not allowing cost

sharing for children and guarantees service regardless of payment, cost-sharing measures become pointless.

Enforceable co-pays and steeper tiers of co-pays for all Medicaid enrollees are examples of how Medicaid could incentivize enrollees to choose an equivalent service at a lower cost. For example, when a Medicaid enrollee may want to get a certain drug that they saw advertised on television that costs 10 times as much as a generic brand that is its molecular twin, a State should be able to charge a $50 co-pay for the brand name drug and a $1 co-pay for the generic drug, unless a doctor gives a medically necessary reason why the generic is unacceptable. A patient or a parent will choose the $1 route almost every time, resulting in the same quality of health care but much lower costs for the taxpayer.

Without such common-sense solutions, States are often forced to arbitrarily limit services or cut provider reimbursement rates to control costs. These approaches are not ideal, but they are often the only path the federal government allows.

In return for total flexibility in managing my Medicaid program, I would agree to a block grant-type funding of the FMAP to Mississippi capped at, say, two or three percent per annual increase, saving the federal government more than $100 million a year compared to the average increase in federal Medicaid costs nationally. I emphasize "total flexibility" to run our program, but note, since my state is about one percent of the nation, that deal nationally would save at least $10 billion a year in federal spending.

As to a state health insurance exchange, we oppose the mandate of a one-size-fits-all exchange. In my state, we are pushing forward with a conservative, market-based exchange that

does not include subsidies or an individual mandate, much like that of Utah. The federal government doesn't need to tell us how to do it.

In the PPACA, the federal government mandates creation of a temporary high-risk pool to subsidize individuals with pre-existing conditions. Thirty-five states, including Mississippi, already operate high-risk pools covering roughly 200,000 Americans. The federal government decided the state risk pools weren't good enough so the PPACA allocated $5 billion and required new duplicative risk pools be established. This subsidized federal program, in theory, would allow people to switch to a less expensive option.

The federal government was wrong. As of February 1, there are a total of 12,437 individuals utilizing the mandated federal high-risk pool, 58 of these are Mississippians. Remember the states are already operating successful risk pools covering 200,000 individuals. The Mississippi risk pool, which is touted as a national model, covers 3,600 individuals.

Americans are not any closer to quality, affordable health care coverage than they were two years ago. Obamacare not only will increase already rising health care costs, but also will require major tax increases to pay the states' portion of the costs.

And the fundamental problem remains that States are tasked with running insurance programs but are prevented from using the basic principles of insurance and the free market to provide quality care at the lowest possible cost. With flexibility from the federal government's straight jacket of rules and regulations, States can design Medicaid programs that show compassion for both the enrollee and the taxpayer.

Mr. UPTON. Thank you all. We will ask questions alternating between sides until you all have to get on your planes to go back again. We appreciate you being here.

Governor Herbert, you mentioned that in Utah you have nearly 100 different exchanges that folks are able to participate in. Has your State examined how any of those would still be around when the Affordable Care Act would be fully implemented?

Mr. HERBERT. Well, it is uncertain. The hope is that we would be able to maintain our exchange even during the implementation of the Affordable Care Act as part of the discussion right now for States to do their own exchange or the Federal Government will come in and do one for you. I think that because we got an early run on this that we are probably going to be able to maintain. We have 100 plans and a number of different providers, and it is growing, and small businesses for the first time are finding a way to provide a benefit package of health care.

So our exchange is working the way we thought it would work. It has only cost us about $500,000 to $600,000 to set it up, and so we only have about three people on staff that are running it. So it is a very different approach than Governor Patrick's, and I am not saying it is the approach, it is an approach, and I would just echo what Governor Barbour said. You know, all States ought to have opportunities to find the solutions to the problem and so ultimate flexibility is probably what we need, and I think we will find solutions to the health care issue that represent the demands and needs of our own respective States.

Mr. UPTON. Now, as I understand it, many of your plans are health savings accounts, HSAs. Does your State anticipate seeking a waiver to try and keep those alive then?

Mr. HERBERT. We don't have health savings accounts that have been put into place or at least in any dramatic form right now with our health exchange. What we have provided really is a defined contribution as opposed to a defined benefit where the small business people now can identify how much money will you put towards health care. Then the consumer takes that money, goes to a portal of information and then shops for whatever is best for them in their own individual interest, and it introduces private competition as people search for their business and try to compete, and it puts the consumer in control of that money, and so it is similar to health savings accounts. It allows the consumer to spend the money as they see fit as opposed to how the insurance company sees fit or the business sees fit. There is not a third-party purchaser now and it is not a one size fits all for the individual.

Mr. UPTON. Last question. Governor Herbert, Governor Barbour, as you look at expanding the Medicaid population up to 138 percent, how is your State going to be able to pay for your State's share of that expansion?

Mr. HERBERT. Well, again, the eligibility requirement going up is going to cost my State an additional $1.2 to $1.3 billion over the next 10 years, and for a State the size of Utah, that is real serious money, and the only way we can afford to do that is, we are going to have to cut from some other program, whether it be education or health and human services and other areas of transportation needs that we have in a fast-growing State or raise taxes, which

will probably have a dampening effect on our fragile recovering economy. So the options are not good for us with that request.

Mr. UPTON. And Governor Barbour, how would you respond to that?

Mr. BARBOUR. It is going to take a very big tax increase. The federal act would require us to increase the rolls by about two-thirds from about 600,000 people, 20 percent of our population, to a million, a third of our population, and because the costs are back-loaded, you know, the first few years there is very little cost, a billion three to a billion seven over 10 years, but by year 10, it will be $443 million is the estimate. Four hundred and forty-three million dollars is a gigantic increase in our taxes but that is what it would cost us.

Mr. UPTON. Yield the balance of my time to Mr. Guthrie.

Mr. GUTHRIE. Thank you, Mr. Chairman. Thank you for yielding. That is the question I was going to go for.

Just 3 years ago, I was a State legislator trying to make the budget balance, and if you looked at Kentucky's pie, Medicaid kept getting a bigger piece of it, and we had to take it out of higher education. Tuition rates are higher, other things are higher in Kentucky because of the growth of Medicaid, and now Governor Beshear has said essentially what you said. He said, "I have no idea how we are going to pay for it." That is a quote. And what is this going to do to education or other issues? I know Governor Herbert touched on it a little bit but Governor Barbour, alphabetically we can go—I just have a few seconds but what this is going to do to your State budgets if we don't give you——

Mr. BARBOUR. Because we can't run a deficit, we either have to raise taxes or cut spending for other things or more likely do both.

Mr. GUTHRIE. Governor Herbert?

Mr. HERBERT. Our increase, as I think I had mentioned earlier, is that for us it will be a 50 percent increase in Medicaid eligibility. So it is a dramatic increase in our budget, and again the $1.2 to $1.3 billion additional cost has got to come from someplace. Either you raise taxes or you cut services. It is that simple. And as a State legislator, you know the challenge that is. We are all having challenges with our budgets today. It is a very difficult time and this just adds to the problem.

Mr. GUTHRIE. Does it affect Massachusetts differently, Governor?

Mr. UPTON. Excuse me. My time is expired. I would yield to the ranking member of the full committee, Mr. Waxman, for 5 minutes.

Mr. WAXMAN. Thank you, Mr. Chairman. Thank you, Governors, for your testimony.

It seems to me in both your oral presentation and your written testimony there are some common themes that I think we all can agree on. We must continue to make Medicaid a better program. By innovating, we can provide better quality of care while also reducing costs, and I think we need to work together to achieve that goal.

But we also know nationally that certain populations have greater health care needs than others. Children are half of Medicaid's beneficiaries but they are only 25 percent of the cost. Adults including pregnant women make up 23 percent of beneficiaries but 13 percent of the cost. Individuals with disabilities make up 19 per-

cent of the population but 44 percent of the cost, and seniors make up 10 percent of the beneficiaries but 23 percent of the cost, and this is the same for all three of your States. Children and adults make up the largest share of the Medicaid enrollees but they are only a fraction of the cost. That is why it doesn't make sense to cut back eligibility for adults and children.

First, cutting back eligibility for adults and children will save the State some money but not very much because these populations are not where the money is. Secondly, uninsured low-income kids and adults use the emergency rooms more than they would if they were insured and had a source of primary care. But the real problem is that the cost of that care is now going to be shifted to the emergency room, the physicians that staff it, the hospitals that operate it, or onto the people themselves who won't be able to get the services. The costs, like the people, don't just disappear once eligibility is terminated. They are just taken off the federal and state treasuries and shifted onto local community hospitals, physicians. That is really inefficient and unfair.

So where is the money in Medicaid? Over half of the spending is for seniors and the disabled, and cutbacks on the disabled and seniors are unthinkable as these are some of the most vulnerable and medically needy in our society. So I have come to the conclusion we have to be smarter, we have to do things better, and under the Affordable Care Act, we can. For example, under the Affordable Care Act, we are already helping States and providers create demonstrations to structure and implement new delivery models to reduce costs and improve care for the dual eligibles, as Governor Barbour pointed out. That is the most expensive population of seniors and disabled.

Governor Patrick, I heard you touch on delivery system reform in your opening statement. Can you talk about why you decided that expanding coverage and improving the quality of care are the right direction for us to move in as opposed to cutting back on eligibility?

Mr. PATRICK. Thank you for the question, Congressman. First of all, I just wanted to say that as we have implemented and expanded coverage, our universal plan over the last 4 years, we have also increased spending on public education every single year to the highest level in the history of the Commonwealth because that is another values choice that we have made.

And for us, the discussion about whether to try to insure everyone or not is a question about what kind of Commonwealth we want to live in, and I would suggest that the discussion about how to do that nationally is also about what kind of country we want to live in. The question of cost is a question that is with us, that is facing small businesses and working families whether we have Affordable Care Act or not, whether we have Medicaid or not, and that is what we have focused on. That is our next chapter in health care reform, and frankly, we get some tools through the Affordable Care Act to help us with that.

It turns out—and I would be interested—I know I am not supposed to be asking the questions but Dr. Burgess, I wonder if this——

Mr. WAXMAN. Please don't.

Mr. PATRICK. What is that?

Mr. WAXMAN. Please don't because I only have limited time. But your idea is to hold down costs by innovating in the delivery system——

Mr. PATRICK. Exactly.

Mr. WAXMAN [continuing]. Not cutting people out of the program.

Mr. PATRICK. Exactly.

Mr. WAXMAN. Now, Governor Herbert——

Mr. PATRICK. I was just going to say that what we have learned from clinicians, from medical professionals is that more integrated care is actually better care for the patient in terms of quality but a lower-cost care as well, and so realigning the incentives so that we are paying for quality of care rather than quantity of care is where we are trying to move now.

Mr. WAXMAN. Thanks.

And Governor Barbour, I have a quick question to ask you. We have some areas of agreement as well, support for medical homes, which is also authorized by the Affordable Care Act, but I want to focus on the eligibility cuts right now. You promoted the idea of flexibility that would allow you to cut eligibility. So my question for you is the following. Do you intend to cut eligibility for the inexpensive adults and children, possibly flooding your emergency rooms, without reducing the cost substantially, or do you plan to cut off seniors and the disabled since that is where the bulk of the Medicaid spending is?

Mr. BARBOUR. Thank you, Congressman Waxman, for asking. As I said in my testimony, I reduced the cost increase of Medicaid from 16½ percent per annum to 4 percent. We didn't do it by changing eligibility except when the Federal Government set up Medicare Part D, there was no reason for us to have a pharmaceutical program anymore to duplicate that. It is a very small part of the savings.

You are right. Children cost us about 1,000 bucks a year. Our average beneficiary costs us between $6,000 and $7,000 a year. That is where the savings are. The savings are in managing. We can give these people better care at the same time but we shouldn't have to come up here and kowtow and kiss the ring to get the permission from Washington to do that to try to help our people. That is what we are saying. And sir, we would be willing to make this deal with you: Give us a block grant with total flexibility and we will say limit the increase in our FMAP payment to half of the national average, whatever it is, and we will take that in a heartbeat.

Mr. WAXMAN. Thank you.

Mr. UPTON. The chair recognizes the gentleman from Texas, Mr. Barton, for 5 minutes.

Mr. BARTON. Thank you, Mr. Chairman. It is good to have you three governors here. This is kind of deja vu. We did this 6 or 7 years ago. Governor Barbour was a big part of that at the time.

We have a new governor down in Georgia, Nathan Deal, who is a former subcommittee chairman of the Health Subcommittee of this committee, and when he was subcommittee chairman and I was full committee chairman, we passed an amendment that gave the States the right to actually verify eligibility, verify citizenship. We didn't say that States couldn't cover illegal aliens but we said

if you wanted to restrict your benefits for Medicaid to U.S. citizens or legal residents, we gave you the right to do that. Our friends on the Democrat side changed that verification program to basically self-affirmation: if you say you are eligible, you are eligible. Governor Barbour, would one reform of Medicaid that we should consider be going back and giving States the right to actually verify citizenship before their extended Medicaid benefits?

Mr. BARBOUR. Yes, sir.

Mr. BARTON. Governor Herbert, what is your——

Mr. HERBERT. Absolutely. I think that would just make sense.

Mr. BARTON. Governor Patrick?

Mr. PATRICK. I think we do it already.

Mr. BARTON. You think you do it already? Well, I would like to see your program then because if you do, you are the only State in the Nation that does, so I appreciate that.

There has been quite a bit of talk in the last Congress of States beginning to opt out of Medicaid because it just gets too expensive. What would the tipping point be if we don't change the current health care law? Where would States begin to seriously think about opting out? At what point in their budget? In Texas, for example, 25 percent of the State's budget is for Medicaid. In some States it is higher than that and in some States it is lower. Do the governors have a taskforce on this issue, and if so, what discussion has been about where States begin to seriously think about opting out? Again, we will start with Governor Barbour and just go right down the line.

Mr. BARBOUR. I do notice that I am on Governor Patrick's left, but I realize to you all I am on the right. That makes me feel better. I think it makes Deval feel better too.

Mr. BARTON. At least you all can joke about it. That is a good thing.

Mr. BARBOUR. I can't imagine Mississippi opting out of Medicaid. We are a poor State. It is an important program. We just want to run it better. We want to run it better for the taxpayers. We want to run it better for our beneficiaries. We can control the cost much, much better, and if the Federal Government would give us more flexibility or just make it where we didn't have to go ask for permission like Governor Herbert was talking about for 8 months to do something very commonsensical, we could, and that is in your budget interest too. So I am not an opt-out advocate and I am just being forthright about it.

Mr. BARTON. Governor Patrick?

Mr. PATRICK. Congressman, as I said in my opening statement, we are so far down this path. The Affordable Care Act is very familiar to us in its framework because we have reform measures in Massachusetts that are very like it, so this is not so scary to us. I think there is a bigger question here that goes beyond Medicaid and goes to the private payers as well, and that is, as I said earlier, the escalating costs in insurance premiums that have been with us all over the country, certainly all over the Commonwealth, and that is where we have concentrated our time. We get some additional tools because of the act to get at that, and I would just say respectfully, it would be wonderful to work with the Congress on that

larger issue because I think that is enormously important for our competitiveness economically.

Mr. BARTON. Governor Herbert?

Mr. HERBERT. Well, thank you, Congressman. I think it is like asking the question, which straw will break the camel's back, and we don't know which one will break the camel's back. We keep piling it on and eventually we are going to have some serious back strain. You know, in Utah, again, we are doing pretty well with health care. President Obama, in fact, has used Utah as an example as he has advocated for better health care. We have good quality health care at lower cost in Utah, comparatively speaking, to other States. So our system really has been working pretty well.

Mr. BARTON. So you all don't see any State really in your experience thinking about opting out?

Mr. BARBOUR. You said opt out of Medicaid?

Mr. BARTON. Medicaid. That is correct.

Mr. BARBOUR. I don't.

Mr. HERBERT. We have no plans to opt out of Medicaid. Our concern is really the increasing costs of Medicaid and the majority costs to Utah for the Medicaid expansion are coming from the healthy low-income adults.

Mr. BARTON. Mr. Chairman, my time is about to expire. I am going to submit for the record a question for them to expand on the constitutionality of federal mandates that the States have to pay, and there are a lot of federal mandates in this Medicaid expansion that beginning in 2014-2016, the States have to do it and they have to pay for it, and I would like a response in terms of the constitutionality of that question, but I will put that in writing.

Mr. UPTON. Great. Thank you. If you can respond quickly, that will be great.

The chair would now recognize the gentleman from the great State of Michigan for 5 minutes for questions, Mr. Dingell.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy.

Gentlemen, welcome. I am delighted to see you, Governor Barbour. We are old friends and have been on the same side and opposite sides of many questions together. Governor Patrick, welcome to you, we are proud of what you are doing up there in Massachusetts. Governor Herbert, welcome to you also.

Mr. HERBERT. Thank you.

Mr. DINGELL. Gentlemen, very quickly. I note, Governor Patrick, you have had firsthand experience in implementing a State-level reform law and that you support the federal law and find that it would work well with your statutes up there. Is that right?

Governor Barbour, I gather you, my old friend, have a different view. You supported overturning the law. Am I correct?

Mr. BARBOUR. That is correct, Mr. Chairman.

Mr. DINGELL. And Governor Herbert, I gather you have also supported overturning the Affordable Care Act. Is that right?

Mr. HERBERT. We have joined the lawsuit in Florida.

Mr. DINGELL. Now, gentlemen, I want to see where we are. We have embarked upon a great challenge and upon a great testing of our national will and capability here, and so let us go through some of these things. In the case of Mississippi, Governor Barbour, you are aware that health insurance can no longer discriminate against

180,000 children in Mississippi with preexisting health conditions, and you are also aware that as a result of the Affordable Care Act, about 53,000 businesses in your State, as in other States, will be eligible for $350 million in new health care tax credits, and Governor, you are also aware that a million and a half residents of your fine State are benefiting from consumer protections in the Affordable Care Act such as prohibit annual and lifetime coverage bans and limits banning rescissions and provides safeguards against unreasonable care increases.

And you, Governor Herbert, thanks to the Affordable Care Act, find that 20,000 seniors in Utah have already received $250 rebates from high Medicare drug prices as a matter of relief, and again, in Utah, the Affordable Care Act now permits 270,000 Medicare recipients in Utah to receive free preventive care, and in Utah again, I note that the uncompensated care costs borne by Utah hospitals and health care providers will be protected against over a billion dollars in the next decade. And also that in Utah the Affordable Care Act, there are over 200,000 otherwise uninsured State residents that will be able to afford and to obtain affordable health coverage.

Now, gentlemen, we have all this before us, and I am trying to understand. If you could assist me, starting with you, Governor Herbert, remember I don't have very much time left. What are we going to do to replace these benefits if we repeal them? How are we going to make whole the categories of persons that I have just mentioned who will be significantly benefited?

Mr. HERBERT. Well, I think, as Governor Barbour has mentioned, that we really do care about our people in our State and we will find solutions.

Mr. DINGELL. That is not an issue, Governor. I don't want to get into that debate. It is not a proper debate.

Mr. HERBERT. OK. It seems like the approach from Washington is do it our way or it won't get done. Again, Utah has good health care, has had good health care. I just, I guess, come from the position that as we look to those who need the benefits and we define what those benefits are, there is nobody that can define them better than the governors and the people in the States. So the eligibility, the benefits, that ought to be received, we can help define that better than anybody I think else, certainly better than people in Washington.

Mr. DINGELL. Governor, I apologize. I have 58 seconds to share between your two colleagues.

Mr. BARBOUR. Chairman Dingell, thank you. A couple points. Most of our small businesses won't qualify for those subsidies. However, the standard benefits package that we expect to be put on us will cause many of our small businesses that today struggle to provide health insurance to their employees will drop that health insurance because the standards benefits package is going to drive the cost so high. As far as the preexisting condition, we recognized this issue in Mississippi long before Haley Barbour was governor. And for about 15 years, we have had a pool, a risk pool for people with preexisting conditions. It has about 3,600 people on it right now, and that is about average, as you can imagine. People move into it, and then when their preexisting exclusion expires,

they move out. The federal risk pool has 58 people, even though the cost is less, the premium is lower, and so this is just an example of something that, I don't know, I am told 35 States have a risk pool like us or similar risk pool. There are things that we do, can do, and we are doing them and we think we should be allowed to make those decisions instead of having community rating, high mandatory benefits package, increase the cost of health insurance in our State. That is our concern.

Mr. DINGELL. Governor, I just want to hear a word from Governor Patrick.

Governor?

Mr. PATRICK. Well, we see a tremendous amount of flexibility in the Affordable Care Act today. We see some further benefits in terms of federal tax credits for the next tier of people we are trying to reach. We see some tools to help us get at the dual eligibles, which as a number have mentioned and I know my colleagues agree is a particularly expensive part of the health care system, and we see some flexibility to try new things in terms of payment delivery systems and payment reform, which is where the real pickup is, not just in Medicaid but for the health care cost system generally. So for us, this is a good bill and one worth fighting for.

Mr. DINGELL. Mr. Chairman, I thank you for your courtesy.

Mr. UPTON. The gentleman from Illinois, Mr. Shimkus, 5 minutes.

Mr. SHIMKUS. Thank you, Mr. Chairman. Mr. Chairman, I want to submit a rundown of the State of Illinois's issue. I don't want to go through it, but I want to submit that for the record.

Thank you, Governors, for coming. I see Utah and Mississippi both run about a $700 million deficit right now, this is what I am being told, where Massachusetts has a billion-dollar deficit. You all have balanced-budget amendments. Illinois is $13 billion in the hole. Do you believe that the Obamacare gives you the flexibility to address changes in Medicaid to help get such a large budget deficit under control? Yes, sir, just each one.

Mr. HERBERT. In Utah, our structural imbalance, we have no deficit. We have a structural imbalance—we used some one-time money, we are not borrowing it—is about $200 million. But this clearly, the cost to us as we move forward with the Affordable Care Act will throw that out the window.

Mr. SHIMKUS. So it doesn't give you the flexibility to meet your budgetary needs?

Mr. HERBERT. Well, again, it doesn't give us the flexibility. I guess the definition is how flexible is flexibility. You know, there are some flexibilities in it, but again, if we have to maintain maintenance of effort, if we have to in fact use the——

Mr. SHIMKUS. I am going to try to get through. I don't want to be disrespectful but I want to get—Governor Patrick?

Mr. PATRICK. Yes.

Mr. SHIMKUS. You think it does give you the flexibility?

Governor Barbour?

Mr. BARBOUR. Well, of course, the difference is, I don't have his State health care system. Under ours, it would drive up my cost. It would absolutely make a very large tax increase necessary. But

more importantly, it will drive up the cost for health insurance for the individuals and the businesses that buy health insurance.

Mr. SHIMKUS. Thank you. And Illinois is $13 billion in debt. That is our financial position in the State of Illinois. If members of the Congressional delegation would write you a letter saying hey, Governor, we know you have issues, can you get with your health and services people and let us start talking about how we can jointly help solve this problem, would you as a governor be open to a letter by members of the Congressional delegation to address your concerns? Governor Herbert?

Mr. HERBERT. Absolutely.

Mr. SHIMKUS. Governor Patrick?

Mr. PATRICK. I am not sure I understand the question but we have been working closely with our delegation.

Mr. SHIMKUS. Well, this is Medicaid. We have a large role in the Medicaid delivery system. We are partners with you. If your Members of Congress said we want to help you, would you say yeah, come on?

Mr. PATRICK. I never said no when our Members of Congress——

Mr. SHIMKUS. Thank you.

Mr. BARBOUR. The answer is yes. I think to her credit, Christine Gregoire, who is the chairman of the National Governors, a Democrat, by the way, is trying to do just that, and the fact that you all are having governors here is encouraging.

Mr. SHIMKUS. Just for the record, November 2009, we sent a letter to our Governor and we have yet to get a response, one that has $13 billion in debt based upon Medicaid.

I want to address really quickly some cost issues. If we are going to try to help contain cost, EMTALA, which is the emergency room law that anyone who walks in the door has to receive care, even though it is not an emergent issue, if we address EMTALA and were able to triage and push people to urgent care, that would be a reform at the federal level, would that help you control cost?

Mr. HERBERT. I think it would. It needs some analysis by experts in our State but I think so.

Mr. SHIMKUS. Governor Patrick?

Governor PATRICK. Yes, I think it could, and we have been taking those very steps.

Mr. SHIMKUS. Thank you. Yes. Great.

Mr. BARBOUR. I would urge you to give us permission for us to do something rather than telling us how to do it.

Mr. SHIMKUS. Great. What about, Obamacare had—when we were talking about saving costs, it was $50 billion of savings if we would move on tort reform, lowering cost, $50 billion which could have gone to pay some of the expensive costs. Would tort reform be a good way to hold down costs, Governor Herbert?

Mr. HERBERT. Absolutely.

Mr. SHIMKUS. Governor Patrick?

Mr. PATRICK. In the bill I referred to earlier, which is our next phase of health care reform, we have included tort reform in that, yes.

Mr. BARBOUR. My first year as Governor, we passed the most comprehensive tort reform in the country. It doesn't just help cost,

it improves the quality of care because we had doctors leaving to get away from lawsuit abuse and so it is more than cost.

Mr. SHIMKUS. Last question. In federally qualified health clinics, we give them Tort Claims Act protection. If we are providing health care, Medicaid dollars, federal dollars, if we provided Federal Tort Claims Act protection for practitioners who are receiving federal dollars, would that help drive down cost, Governor?

Mr. HERBERT. I think so, yes.

Mr. PATRICK. I don't know how to answer that.

Mr. SHIMKUS. Well, it is a tort reform issue, so——

Mr. BARBOUR. Under our State tort claims act, the university hospital and all, they have caps under the law and it does help.

Mr. SHIMKUS. Thank you very much. Yield back my time.

Mr. UPTON. The chair would recognize the gentleman from New Jersey, Mr. Pallone, for 5 minutes.

Mr. PALLONE. Thank you, Mr. Chairman.

I wanted to go back to Governor Patrick because I know that in response to Mr. Waxman you were basically talking about how more quality care or improving coverage and quality care actually lowers costs, and I really believe that if you cover more people, you give them quality care, then ultimately you save the system more money, and at the risk of being critical of the Republicans, I am going to be anyway, you know, I just think it is ironic, because if you go back a few years, you had people like Governor Romney who were advocates for universal coverage because it saved money in the long run. I remember when the second George Bush was present, he was a big advocate for expanding community health centers. Now we see the Republicans in their Continuing Resolution cutting community health centers. Even the FMAP that gave more money to the States, that was a big thing with the Republicans too. Peter King introduced the legislation back in 2003, long before the Democrats were even doing it. But now we see the opposite. We see, you know, Republicans backtracking and saying that they don't support these efforts to expand coverage and provide the community health centers with funding.

I want to ask you two things, Governor Patrick. One is, if you just want to expand a little, because I don't think you had a chance, on what Congressman Waxman asked about, you know, what Massachusetts did to expand coverage and how that actually improves quality, makes for healthier people, and in the long run lowers costs. Maybe you could just spend a minute or two or that.

Mr. PATRICK. Thank you for the question, Congressman. The simple fact is that more people in Massachusetts today get their primary care in primary care settings than in higher-cost emergency room settings, and that means system costs are smoothed, and it is a simple principle of insurance that the more people who are insured, the more you spread the risk. That also moderates cost. But premium cost, which is, you know, the provider rates, although there is variance, they have increased faster than inflation in Massachusetts and everywhere else in the country. This has nothing to do with universal care. This has to do with the way we incent, if I may use that as a verb, the incentives for how we pay for health care. Right now we pay for the number of times you are in and out of an office, the number of tests that are run and not

the quality of that care, and managing that care closely, particularly for those high-cost chronically ill people, has been shown to be better care for the individual but also lower cost.

So what we have in the Affordable Care Act are tools we didn't have in our own health care reform and that we are building on with a new piece of legislation I filed 2 weeks ago to realign these incentives and get at systemwide costs, and that is good, not just for the State and for local budgets but that is good for business budgets and for working families.

Mr. PALLONE. I appreciate that. And again, I didn't hear Mr. Barbour criticize Mitt Romney but I know he gets a lot of criticism and he was the one that basically came up with this idea. He was a governor at the time, in any case.

Now, I wanted to ask about community health centers because this is another case. When I was here and the second George Bush was President, he really pushed for community health centers, opened more of them, you know, this was going to be our answer for people who didn't have coverage. Now we see in the C.R. community health centers I guess are cut by $1.3 billion relative to the President's request, and that would roll back critical expansions to community health centers. In your State, Massachusetts, you would lose nearly $5 million in community health center funds which are being used to provide care for nearly 90,000 of your residents. I had a community health center that was funded in the Recovery Act wrote me a letter saying now that they would have to close the door if the C.R. becomes law.

So, you know, how is your State going to fare if these funds are cut off? I mean, community health centers are a way, if we don't have Medicaid or the Medicaid gets cut back, people at least can go there. It is another backup.

Mr. PATRICK. No, I understand the question, Congressman. It is a worry for us. We have a broad and deep network of community health centers, and frankly, the community health centers like the community hospitals tend to be lower-cost settings for primary care than the wonderful downtown teaching hospitals that we have, and for our system to work and I think for a universal system to work, we have to have more community dispersion in where people get their primary care. So we very much are watching and involved in trying to assure that just as we keep up our end of the bargain in terms of our support for community health centers, that the Congress does as well.

Mr. PALLONE. Thank you.

Mr. UPTON. Mr. Pitts, 5 minutes.

Mr. PITTS. Thank you, Mr. Chairman. Thank you, Governors, for coming.

Mr. Barbour, you mentioned that a couple years ago you started a new program for persons to individually sign up for eligibility. I didn't hear after that first year requiring individuals to sign up personally, what happened to your rolls? What percentage was the effect of that?

Mr. BARBOUR. Congressman Pitts, it was a combination of 60,000 more people working in my State, Part D, but our program, we reduced the rolls from 750,000 to 580,000.

Mr. PITTS. That is about 20 percent?

Mr. BARBOUR. About 20 percent, that is right, and again, there is nobody who is not getting health care. There were a lot of people who weren't eligible.

Mr. PITTS. Now, under the maintenance of effort requirement in the new law, can you continue that program of having people individually sign up for eligibility?

Mr. BARBOUR. It is my understanding that we can.

Mr. PITTS. That you can?

Mr. BARBOUR. Yes, sir.

Mr. PITTS. Can you elaborate on your State's experience in dealing with the CMS bureaucracy and your attempts to be granted Medicare waivers? Do you find the CMS bureaucracy helpful and cooperative? Do you find their decision-making process timely? Do you find their actions too burdensome? Would you elaborate?

Mr. BARBOUR. My experience over 7 years as being Governor is there are a bunch of nice people who work there, they work hard. I have actually been up to their headquarters a few years ago to go through a really kind of complicated issue. But for whatever reason, it is slow, and I am told that the average waiver takes a year. I have been through personally in the last 15 months a State plan amendment and contract that took 15 months and at the end of 15 months it was approved except they told us you can't do the part that actually helps. You know, they didn't approve that part of the contract. These are things that we shouldn't have to come up here and ask for. We ought to have the flexibility to run the program. But I don't think it is because they are not good people or they are not working hard. It is just the process is long and drawn out.

Mr. PITTS. Thank you.

Mr. Herbert, you mentioned an anecdote. Could you elaborate on your dealings with CMS bureaucracy?

Mr. HERBERT. Well, again, I have already given the example of wanting to go paperless, which again I think most people here can see that is kind of what we are about today, and it is a voluntary basis so you don't have to do it, it is not mandated but it would save us about $6.3 million. But after 8 months we were getting nowhere. I actually came to meet with CMS and to get things moving. We couldn't understand why we were getting a denial, and the denial being sent by e-mail we thought was just ironic. That kind of got things moving but it was really the conversation yesterday with President Obama that allowed us to finally get this logjam removed and do something that is just sensible.

But we have other waivers out there that we want to look at that would allow us to in fact put together a Medicaid rainy-day fund to help us slow down the costs that are rising in Medicaid, to start providing fee for service to payment for healthy outcomes, not just for procedures, to incent on the right side of the health care equation. But that will require some waivers from CMS to allow us to go forward. So again, we will come up with ideas, other States will come up with ideas but we need to have the ability to have this dialog and get some waiver to allow us to find efficiencies in the system.

Mr. PITTS. Thank you.

Mr. Patrick, during the debate on the Obamacare law, the proponents of the law stated passing the bill would get people to stop

using the emergency room for their care. In Massachusetts, do Medicaid patients visit the ER more or less than those with private insurance?

Mr. PATRICK. About the same.

Mr. PITTS. I have a study September 2011 paper by Douglas Holtz-Eakin suggesting that from July 2007 through March of 2008 Medicaid patients visited the ER at a rate more than three times those with private insurance. Do you think that figure is in the ballpark?

Mr. PATRICK. No, that figure it not current. It is about the same, and the total population has gone down. We started implementing health care reform, Congressman, in 2007, at the beginning of 2007, so we have had a little bit more than 4 years of getting at that, and total utilization in the ER for primary care has gone down in both the private payer and public payer.

Mr. PITTS. The half minute I have left I will yield to Dr. Cassidy.

Mr. CASSIDY. Thank you.

Mr. PATRICK. Congressman, I am sorry, if it is all right, do you mind if I also say something about our experience with CMS?

Mr. PITTS. Go ahead.

Mr. PATRICK. I would just like to—you know, we have negotiated now two waivers with CMS in order to do our own experiment, and I want to say that our experience has also been a very deliberate, sometimes feeling tedious experience with the current Administration and the Administration before. Now, when we have raised these issues in the past, they have expressed what I think is the perennial concern, which is that they know that they also have—just as much as we want flexibility, they know that we have to be accountable. But if there is a way to smooth that out, I think that is something that we would love to work together.

Mr. PITTS. Thank you.

Mr. UPTON. The gentleman's time is expired. I would recognize the gentleman from Massachusetts, Mr. Markey.

Mr. MARKEY. Thank you, Mr. Chairman.

Mr. Patrick, Governor Barbour said that he could accept a deal where his State received 50 percent of the Medicaid money they receive today, and he could live with that deal.

Mr. PATRICK. I will take his 50 percent.

Mr. MARKEY. What would be the impact in Massachusetts if there was a 50 percent cut in the Medicaid funding that went to the State in terms of the impact on the health care of our residents?

Mr. PATRICK. Well, I think that would jeopardize universal care. I mean, that would be profound for us.

Now, we are working very hard, just to repeat myself, to get system costs down, the cost of care down, because that is important not just for Medicaid but across the economy, and as we gain those savings, that is good for the Federal Government just as it is good for those small businesses that are in the private market. But, no, we are not looking for that.

Mr. MARKEY. No, Governor——

Mr. BARBOUR. Congressman Markey, if I may, what I said was, we would take 50 percent of the increase, not that we would cut our total FMAP in half, just when the increase came we would take

only half as much. So I am glad you said that because I hope others didn't understand what I said that way.

Mr. MARKEY. Half of the increase?

Mr. BARBOUR. Thank you for clearing that up.

Mr. MARKEY. I think that is important for everyone to hear. Mississippi is more than willing to accept that money.

The next question is, Governor Barbour spoke about how he felt that the private sector would not insure as many of its employees under this kind of a system. What has the experience in Massachusetts been?

Mr. PATRICK. That phenomenon I understand is called crowd out, and actually, I will tell you when I was looking at this, you know, I have spent most of my life in the private sector, so when I was looking at this when it was being debated, it seemed to me a business could make a rational decision to stop offering health care for their employees and say, you know, you go on the publicly subsidized. It has actually been the opposite result in Massachusetts. There are more businesses offering employees health insurance today than before our health care reform went into effect.

Mr. MARKEY. So it has actually gone up, not down, in terms of the businesses providing health insurance?

Mr. PATRICK. Correct.

Mr. MARKEY. Now, what about your work with the insurance itself to contain costs? How has that proceeded since the bill has been implemented?

Mr. PATRICK. Well, our work with the insurers has proceeded on a parallel course, not necessarily because of the Affordable Care Act meaning, you know, we have been seeing small businesses, and I suspect everybody here does, who are seeing their commercial activity pick up and then they get that increase in their premium at 2030, 50 percent in some cases, and they can't see a way to add that one or two employees, and that is important for us because 85 percent of the businesses in our Commonwealth, as you know, Congressman, are small. So if they don't start hiring, we don't get a recovery. It is as simple as that. And so we engaged with the insurers about a year ago using existing State authority to disapprove excessive rate increases, and we did just that, and then we had a tussle and everybody eventually got to the table, and what were 20 and 30 and 40 percent increases last year are single digit base rate increases this year. But that is a step. It is a temporary step. What we need more to the point is comprehensive payment reform and delivery system reform, which is what we are moving on now and what is accelerated frankly by provisions in the Affordable Care Act.

Mr. MARKEY. Now, there are some who say that universal health care harms the economy, leads to higher unemployment, hurts the bond rating of a State. What has been the experience in Massachusetts?

Mr. PATRICK. Well, our budgets have been responsible, balanced and on time for each of the last 4 years and we are working with the legislature to assure that again this year. Our bond rating started out strong, has remained strong through the recession and just recently was upgraded from AA to AA positive outlook. I think we are the only State since 2007 in the country that has had an

improved bond rating, and as I said, we have continued to invest in public education at the highest levels in the history of the Commonwealth.

So I will also say, our unemployment rate is about a point and a half below the national unemployment rate but we are not satisfied. We still have to drive that down. But when I talk to those small businesses who are concerned about their premium increases, they appreciate that we have these additional tools now to be able to get at that, and as I said, I meet entrepreneurs who say that the security that comes from universal care in our State is a factor in their decisions to invest in Massachusetts, and we welcome that.

Mr. MARKEY. So contrary to public impression, Massachusetts unemployment rate is down, the bond rating is up, the budget is balanced and we have 98 percent of the people with——

Mr. PATRICK. And we have got more work to do but I am very proud of where we are.

Mr. MARKEY. And you have done a great job. Thank you, Governor.

Mr. UPTON. The chair recognizes Mr. Walden for 5 minutes.

Mr. WALDEN. Thank you very much, Mr. Chairman. I want to thank the governors for being here today. My home State of Oregon has tried to innovate over the years. I was majority leader of the Oregon legislature when we implemented the Oregon health plan. I have been a small employer for 22 years and we paid for health insurance premiums for our workers, and I spent about 5 years on a community nonprofit hospital board, so I have sort of been on every seat at the table on health care reform trying to figure out how to make it more affordable and available.

One of the things I recall from my days on the hospital board was the shift that occurs to the private sector insurance side when the government doesn't reimburse enough, and that especially is true, I believe, on Medicaid, that it is probably the least reimbursement, so you have cost shifting going on from Medicaid and Medicare onto the private sector, which drives up then the insurance costs paid for by those who are trying to provide it, the small employers of America who, Governor Patrick, you expressed sympathy for. I am led to believe, and correct me if I am wrong, but the Commonwealth Fund has said that Massachusetts has the highest average family premiums in the country. Is that still the case?

Mr. PATRICK. I don't believe it is but I will say that we have trended about a point or so higher than the escalation even nationally over a decade.

Mr. WALDEN. But as you have tried to bring everybody into the pool, your costs have continued to escalate beyond the original projections, right?

Mr. PATRICK. No, not beyond the original projections, with due respect, Congressman, but the issue of premium increases is a problem, as I say, all across the Commonwealth and all across the country.

Mr. WALDEN. Governor Barbour, I know that my senior Senator, Ron Wyden, and Governor Patrick, your Senator, Scott Brown, have teamed up to gives States more flexibility if they have their own plans. The President yesterday seemed to embrace that con-

cept, and I would be curious to hear from all three of you, does that go far enough? Is it helpful to give you that earlier out at 2014? And if not, what should we be doing?

Mr. BARBOUR. Of course, the devil is in the details, but the thing that concerns me, the things that are in the statute we are told the States will still have to do, and Governor Patrick has been talking about how costs didn't go up and he didn't have people drop insurance. Well, Massachusetts already had a very, very expansive mandatory standard benefits package. Most States, particularly rural States, don't, and if we get saddled with the standards benefits package like Massachusetts, that is why our employers will drop coverage because their premiums will skyrocket. So if it doesn't give us relief from that and similar things, it is really not much help.

Mr. WALDEN. Governor Herbert?

Mr. HERBERT. Well, again, as I mentioned earlier, how flexible is flexible, and clearly there is not absolute flexibility. This is not a block grant, do it as you see fit. Maintenance of effort still required. The essential benefit package stays the same. The eligibility for Medicaid still is there. So if we get the outcomes that we, the Federal Government, say to the State, then you have got flexibility, and that really is not flexibility.

Mr. WALDEN. Governor Patrick?

Mr. PATRICK. I think from a policy point of view, Congressman, the act or the bill, we are probably indifferent to it because as I said, we are so far down the path, and we have so much flexibility under our existing 1115 waiver and there is plenty of flexibility in the act.

Mr. WALDEN. So then I want to go to another topic. There are some reports out in the last day or two and over time about the waste and fraud both in Medicare and in Medicaid, upwards of 10 percent of the program the GAO and the IGs have said is a result of waste. I met with some physicians in my district, an ambulance operator in another part of the State of Oregon who talked about some of the fraud and waste they saw occurring in Medicaid where somebody would feign a problem, call an ambulance, they would get to the emergency room so they could actually go to a shopping center nearby, and Medicaid gets to pay for it, and I heard that from three separate instances. What are you doing and is the Federal Government doing enough to get at that? We are talking, 20, 30, 40, 50, $60 billion perhaps annually in waste and fraud identified by the GAO and others.

Mr. BARBOUR. One of the things we have done is, we try to manage the program. We have reduced our error rate to 3.47 percent, which is the fourth lowest in the country. Our eligibility error rate is now one-tenth of 1 percent. Just by reducing our error rate as we have, we are saving the people of Mississippi tens of millions of dollars on Medicaid. If you got the national rate down to ours and got the national rate of Medicare down to ours, it would be tens of billions of dollars that the taxpayers would save just by managing the program.

Mr. WALDEN. I think I am out of time, unfortunately. I would welcome your responses perhaps in writing afterwards but my time is expired.

Mr. UPTON. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman.

First, I want to mention again, and I know here that the health reform is not necessarily Obamacare. This committee spent many years dealing with health care, and as was said earlier, whether it be expanding community-based health clinics or the hours we spent over the last 2 years drafting that legislation.

The testimony today sounds like the States want the Federal Government to write them a blank check and allow them to be left to their own devices to manage their health care programs without any guidance from the folks here in Washington who are going to have to vote for the money on how the federal tax dollars should be spent. I spent 20 years as a Texas legislator, State house and senate, and sat on that side many times and watched what happened, and let me give you some examples of what may not work.

In 2003, Texas experienced a budget crisis much like we see now. At the time the State decided to drop 175,000 children off the SCHIP rolls because they couldn't come up with the State match. The State of Texas gets about 65 percent of federal dollars for SCHIP enrollment and about 70 percent of federal dollars for Medicaid enrollment. The Texas Medicaid provides coverage at only minimum levels required by federal law for those eligible populations. Texas Medicaid eligibility is granted for 6 months and recipients must reapply and continue to meet all the eligibility requirements, but the problem is, every 6 months they have to show up down at our State Department of Human Services. Texas has been trying since 2008 for a section 115 waiver but it was even denied in 2008 by President Bush because it wanted to shift Medicaid eligibility of individual into private plans, and I know those private plans are going to have to make a profit to be able to do that so we will end up with scarce Medicaid dollars going to profit instead of going to help cover our poorest citizens. We have not recovered from the SCHIP disaster in 2003 and Texas still has the highest uninsured rate in the country, and I am a strong supporter of mandated 12 months' continuous eligibility to prevent the States from using children oftentimes as budgetary pawns.

Governor Patrick, can you explain the benefits you see in the Medicaid program under health reform?

Mr. PATRICK. Well, first of all, Congressman, I agree with almost all the observations you make in terms of how we experience it in Massachusetts with the one exception of the private insurance. Our health reform is a hybrid so we emphasize private insurance including for Medicaid recipients, and so it is very much a market-based kind of solution, I guess is what I am trying to say, which may be why I keep coming back to the point about how across the market whether for private or public payers, we have to focus on increased costs and what is happening with premiums and what that is doing to our competitiveness. This program has worked very, very well in Massachusetts. The fact that we have over 98 percent of our residents insured today with reliable health care and that that has been maintained and improved even during a time of enormous economic uncertainty I think is something I am very proud of and I think has been a real help for us in our own recovery.

But the broader question of the cost of health care, not the cost of Medicaid, with due respect, that is a secondary question. The cost of health care for which in this country we spend 17.6 percent of what we spend has got to be addressed, and the Affordable Care Act gives us some tools to do that and we are trying some others on the State side as well.

Mr. GREEN. Let me let the other governors answer because, like I said, I have been on both sides of the coin and there were times that we could bring down some Medicaid programs in Texas back in the 1980s and we would get 80 percent federal funding and only come up with 20 percent yet we still couldn't do it in the State. So Texas does not have a rich Medicaid program by any means. So both Governor Barbour and——

Mr. BARBOUR. First let me say, I don't mean any offense, but PPACA doesn't come out too good in my accent of the name of this law, P-P-A-C-A. So I didn't mean any offense by referring to it as Obamacare, it is just easier for me to say.

Mr. GREEN. I understand. It works well on Fox for my Republican colleagues but it is really the Affordable Health Care Act, and we name things crazy but it is called health reform. That is the easiest thing.

Mr. BARBOUR. Yes, sir.

Mr. GREEN. And I don't have any problem with your accent from where I come from.

Mr. BARBOUR. Well, I figured if there was one guy here who would understand, it would be you.

I would just say that we are concerned about keeping provider rates sufficiently high that they will see our Medicaid patients.

Mr. UPTON. Mr. Terry.

Mr. TERRY. Thank you, Mr. Chairman, and with my accent, I still call it Obamacare too. It is easier.

My question is for Governors Herbert and Patrick, very quickly. The State exchange issue I think is an interesting issue and how States when you do it yourselves can be a lot more innovative. Particularly I want to ask Governor Herbert, because Nebraska and Utah are similar in population and demographics, would it be beneficial in a State exchange to have the opportunity to combine with other States and form a regional? I will let you go first and then Governor Patrick.

Mr. HERBERT. Yes, I think it would be. I think you will increase purchasing power and the ability to have more competition and the consumer will have more options and better options for their own unique needs. Again, without beating a dead horse here, it is not a matter of is my approach better than Governor Patrick's approach. Again, Mitt Romney is a friend of mine. In fact, we looked at the Massachusetts model when we started out. It just didn't work for Utah. It was not in Utah's best interest so we picked a different pathway. There are probably pros and cons of both of them. It is not a matter of I am right and he is wrong or vice versa. But as we work together as States, we can probably find solutions. We talk about, it is a little hard to define what is the health care reform message, what is the issue. I don't think the public generally understands. Is it universal access, universal coverage, is it quality of care, is it affordability? It is probably all of the above.

We are tracking it here with the Affordable Health Care Act probably just in one narrow area of accessibility. I don't know that it helps with the cost control measures.

Mr. TERRY. I appreciate that answer.

Governor Patrick and then Governor Barbour.

Mr. PATRICK. I am really interested in that idea, Congressman. We have about 220,000 people who get their coverage through our Connector, our version of the exchange. I think that compares to about 1,500, am I right, in Utah?

Mr. HERBERT. About a thousand.

Mr. PATRICK. So it is a slightly different scale because we made different choices, and I agree with my colleague, Governor Herbert. I am not sure that every State in the context of the exchange needs to make the same choices but I think that flexibility is allowed under the Affordable Care Act. I am very intrigued about how we do more regional pools because, frankly, economically, our people are moving regionally. And the idea of having portability of their care I think is very responsive to their needs.

Mr. TERRY. I appreciate that.

Mr. BARBOUR. Congressman Terry, I just wanted to briefly comment on your question. My State senate has passed an exchange bill for 3 years running and the house has not. Both of them have passed a bill this year. We want an exchange. We don't want—ours wouldn't be anything like Massachusetts'. It would be market voluntary and modeled on Utah's so there are—I just wanted you to know, even some of us that don't have the exchanges think that they are useful but not the way the federal act would require it.

Mr. TERRY. All right. Dr. Burgess, may I yield a minute to you?

Mr. BURGESS. Thank you, Mr. Chairman. Governor Patrick had a question for me and Mr. Waxman was so rude, he wouldn't yield time to you, so I will be happy to yield Mr. Terry's time to you to ask you the question.

Mr. PATRICK. Thank you, Dr. Burgess. I am good. No, you know, seriously, Mr. Chairman has changed. I am going to have to step away in order to get a plane, so unless you have a question for me, Dr. Burgess, I don't want to——

Mr. BURGESS. Well, I was dying to answer your question and I didn't want to leave the audience unfulfilled with you unable to ask me a question.

Mr. PATRICK. Thank you very much. If it is appropriate, Mr. Chairman, if there are other questions after I have to leave that members may have, I would be happy to respond in writing. I just have to make this plane.

Mr. PITTS. [Presiding] The chair thanks the gentleman for——

Mr. BURGESS. Let me just, in the remaining time I have, one of the issues that we lost out on in this health care reform was the issue of liability reform. I know I have over the years interviewed several doctors from Massachusetts who looked to move to Texas, even before we fixed the problem there. How are you dealing with this within your State?

Mr. PATRICK. I mentioned earlier that we filed health care reform two in Massachusetts, which is the next chapter. It is really around cost control and cost containment, and there is a feature of this which is tort reform. It is not because we have found analytically

that defensive medicine is a big contributor to health care costs but it is a contributor, and so we used a model actually from Michigan, which is not caps, it is an apology and prompt resolution model. It has been piloted at Mass General Hospital in Boston, and they have had fantastic results. So it is a model that works for us and I am looking forward to working with the legislature.

Mr. PITTS. The gentleman's time is expired. The chair thanks Governor Patrick for coming.

Mr. PATRICK. Thank you very much, Mr. Chairman.

Mr. PITTS. And you will respond in writing to any questions?

Mr. PATRICK. I would be happy to, yes, and I hope everyone will please excuse my——

Mr. PITTS. I thank the Governor and excuse him. The time now goes to the gentlelady from California, Ms. Capps, for 5 minutes.

Mrs. CAPPS. Thank you, Mr. Chairman, and I had a really good question for you, Governor Deval. I am sorry that you are leaving. No, I understand. If there is a way you could stay, I would appreciate it. But you have been an excellent testifier.

Mr. PATRICK. Can you try to do it quickly?

Mrs. CAPPS. Yes, if you can sit back down. I am not going to make you miss your plane.

Mr. PATRICK. Congresswoman, your answer was supposed to be "No, Governor, I totally understand that you have to——"

Mrs. CAPPS. Well, I have other questions to ask your colleagues. First of all, thank you very much for coming. We seem to be using this opportunity to scapegoat Medicaid because the real bottom line is that some people just don't like this health care law, but you have been a success story in reducing the number of uninsured and helping everyone who wants to get any access to the health care system. My other questions are going to be about children. Your State has the lowest rate of uninsured children in the Nation with over 95 percent in the State having health insurance. I think that is really an achievement. And I want just to ask you, and you can be quick and then run off. I don't want you to miss your plane. But what is the role that Medicaid has played in this?

Mr. PATRICK. Well, it has been enormous. The proportion of children insured today is actually 99.8 percent, and——

Mrs. CAPPS. That is stunning. I just want it to be on the record. Just say it again.

Mr. PATRICK. Well, 99.8 percent of Massachusetts children have health insurance today, and I am very, very proud of that. Now, Governor Barbour made a point which is true, that children are relatively inexpensive to cover and it is a very efficient kind of coverage for Medicaid. It has made a big difference for us.

Mrs. CAPPS. Thank you. We are worried about you catching your plane, and I do appreciate your taking the time.

I wanted to ask unanimous consent as I continue my question—thank you, Governor——

Mr. PITTS. Without objection.

Mrs. CAPPS [continuing]. To insert a letter from the March of Dimes for the record, which explains the importance of the Medicaid program for women and children, and I ask unanimous consent if that could be entered.

Mr. PITTS. Without objection, so ordered.

Mrs. CAPPS. Thank you.
[The information follows:]

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The Honorable Fred Upton
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
US House of Representatives
Washington, DC 20515

The Honorable Henry Waxman
Ranking Member
Committee on Energy and Commerce
2322A Rayburn House Office Building
US House of Representatives
Washington, DC 20515

February 24, 2011

Dear Chairman Upton and Ranking Member Waxman:

As your Committee prepares to hold a hearing with governors to discuss Medicaid and related provisions in health reform, the March of Dimes would like to emphasize the importance of this program in providing coverage for maternity and pediatric care. The mission of the March of Dimes, to improve maternal and child health by preventing birth defects, preterm birth and infant mortality, can best be achieved if all women of childbearing age, infants and children have access to health insurance that meets their needs. According to the Institute of Medicine, health coverage is the single most important factor that determines whether or not a child receives medical care when they need it, and also plays a key role in access to maternity care.

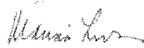
As you know, Medicaid currently finances approximately 41 percent of births annually and serves as the source of health insurance for almost 30 million — 1 in 4 — children nationwide. Children with special healthcare needs in particular rely upon the Medicaid program to cover critically needed health services. For example, approximately 48 percent of hospital stays for preterm infants were financed by Medicaid and nearly half of hospital stays for infants with birth defects were covered by Medicaid in 2007. Medicaid also supplements private insurance to provide "wraparound" coverage for millions of children with special healthcare needs whose medical care exceeds what the private plan is able to cover.

During the deliberations over the Affordable Care Act, the Foundation's 3 million active volunteers and staff in every state advocated for stability in Medicaid eligibility levels as one of several important mechanisms for maintaining progress already made in providing coverage for some of the nation's most vulnerable women and children. We are deeply concerned that weakening or repeal of the provisions that promote maintenance of coverage goes forward, as has been proposed by some, millions of pregnant women, infants and children will be at risk of becoming uninsured. For those with ongoing health care needs – such as women who have experienced a prior preterm birth and children with birth defects or medical conditions associated with prematurity – loss of health coverage could be devastating.

All of us at the Foundation understand that the health reform law is imperfect, and we have repeatedly offered to work with Members of the Committee to identify areas where improvements can and should be made. We also recognize and support the goal of finding cost efficiencies in the health care system that reduce costs for families, insurers and for publicly supported health programs. However, such proposals must not cause individuals to become uninsured or to lose coverage for essential medical care that meets their health needs. As you might expect, this is a particularly critical concern for women with high risk pregnancies and children with special healthcare needs, for whom a loss, gap or reduction in coverage could result in long term disability or even death. We look forward to hearing from Governors and Members of the Committee about their proposals and to working together to improve access to quality, affordable and meaningful coverage for women and children in every state.

Once again, thank you for the opportunity to submit our comments for the hearing record, and please know that all of us at the March of Dimes look forward to working closely with you as the Energy and Commerce Committee engages in oversight hearings and legislation on strengthening Medicaid and other issues central to the health of women of childbearing age, infants and children.

Sincerely,



Marina L. Weiss, Ph.D.
Senior Vice President, Public Policy
and Government Affairs

march of dimes

Mrs. CAPPS. Governor Barbour, I understand that you have said in your remarks that you support the repeal of the Medicaid State responsibility requirements, the maintenance of efforts requirements in the Affordable Care Act. When it comes to infant mortality, that means babies dying during childbirth or in the first few months of life. Our Nation has a very abysmal record among countries of the world. We rank 46th among all the nations of the world. Now, when it comes to the United States, Mississippi has the highest rate of infant mortality of any State in the United States, 10.7 infant deaths per 1,000 live births. Now, if Congress eliminated the Medicaid maintenance of efforts, you would have the flexibility to reduce Medicaid coverage for pregnant woman and infants up to age 1 from the current level of 185 percent of federal poverty line to 133. Mississippi also has the highest rate of preterm births of any State in the United States and again, our country doesn't do well on this topic so I am not trying to pick on Mississippi, but nearly 19 percent of live births in Mississippi are preterm. Now, preterm infants are at a much greater risk of health complications, newborn death and even higher health care costs. I am one who believes that our country's infant mortality rate is a national disgrace. Even during the Bush Administration in 2006, an HHS fact sheet stated that programs to improve access to prenatal and newborn care could help prevent infant mortality, and it specifically cited Medicaid.

So if I could ask you a yes or no question, do you agree with this assessment by the Bush Administration that Medicaid can help us address infant mortality?

Mr. BARBOUR. A little bit.

Mrs. CAPPS. A little bit? All right.

Mr. BARBOUR. That is correct. I mean, most of—ma'am, if I could respond?

Mrs. CAPPS. Of course.

Mr. BARBOUR. The biggest problem we have in my State is we have an extremely high rate of illegitimacy. We have a lot of children being born to mothers who are themselves in bad health——

Mrs. CAPPS. That is another piece.

Mr. BARBOUR [continuing]. Maybe because of life choices like drugs——

Mrs. CAPPS. Absolutely.

Mr. BARBOUR [continuing]. Alcohol, and it is not the health care system that is the principal driver here.

Mrs. CAPPS. But actually if these mothers received adequate prenatal care, some of these underlying issues could be addressed, and that is another feature——

Mr. BARBOUR. Yes, ma'am, and we offer it for free——

Mrs. CAPPS [continuing]. Of Medicaid——

Mr. BARBOUR [continuing]. For up to 185 percent, yes, ma'am.

Mrs. CAPPS. But now you will have the flexibility——

Mr. BARBOUR. A lot of them don't take it.

Mrs. CAPPS. Well, that is another issue, but the flexibility to raise it is going to make it tempting for States to do something that will be in the long run costly, costly not only in lives but also to the bottom line of the State's budget.

Mr. BARBOUR. The majority of all the people on Medicaid in Mississippi are children or pregnant women, and it is up to 185 percent of poverty. We are not interested in lowering it, but the biggest problem with our sick children at birth, low-weight birth is not the health care system.

Mr. PITTS. The gentlelady's time is expired.

Mrs. CAPPS. I yield back.

Mr. PITTS. The chair recognizes the gentleman from Pennsylvania, Dr. Murphy, for 5 minutes for questions.

Mr. MURPHY. Thank you, Mr. Chairman, and welcome, Governors. Good to see you again.

I want to go over a couple things about Medicaid expense in your State. In my State, Pennsylvania, Governor Corbett estimates that about 600,000 will eventually be $150 million per year. Do you both have estimates in your States of what those numbers might be of an additional Medicaid expense from this bill?

Mr. BARBOUR. When it is full out, $443 million in year 10.

Mr. MURPHY. So that is what it will be.

Mr. BARBOUR. One year.

Mr. MURPHY. Sir?

Mr. HERBERT. And ours is $1.2 billion over 10 years. It is a 50 percent increase in our numbers.

Mr. MURPHY. So that is the full cost of Medicaid in both your States, or that is in addition?

Mr. BARBOUR. That is the increase.

Mr. HERBERT. That is the increase out of our general fund.added onto Medicaid, and it is going to cost the State an additional $100 million to

Mr. MURPHY. Now, we also know that the Congressional Budget Office, which admittedly can only deal with the data they are given, they are not allowed to surmise or assume anything, but based upon the data they were given when this bill passed, they estimate about 9 million low-income employees would lose coverage due to some of the exemptions that occur, but Lewin Group now says it could be as high as 85 million, and some questions are that if employers are fined $2,000 per employee for not offering qualified health insurance, that it might actually serve as an incentive to expand those numbers up to that upper level of 85 million or so. So are your numbers that your States have based upon some of these higher or lower numbers? I am just curious in terms of the actual population you think might pick up. How confident are you on the accuracy of those numbers, that might it even be higher?

Mr. HERBERT. Well, I don't know the numbers that you have given there but our estimates are based on the fact that we are going to have to increase eligibility up to 133 percent of poverty. We are not covering that much in Utah.

Mr. MURPHY. I see.

Mr. HERBERT. And the essential benefit package would have to be changed and modified and enriched, and so we are going to have to give more and so that is going to add to the cost.

Mr. MURPHY. My question is, what happens, if anybody has looked in your States, if more employers drop their coverage and put people on Medicaid?

Mr. HERBERT. Well, if more employers drop their coverage, then clearly the eligibility will entice people to use Medicaid as the insurer and so our numbers will go up. I don't know what the percentage of that would be.

Mr. MURPHY. Governor Barbour?

Mr. BARBOUR. I am concerned that we underestimate the actual increase in cost, but as I said earlier, we have a lot of small businesses that offer insurance to their employees right now that won't meet what we fear the standard benefits package will be, and for a lot of people, they will just pay the $2,000.

Mr. MURPHY. Let me ask you then another area, because some of the talk has been, should—and I know, Governor Barbour, in your testimony and your written testimony too you talked about the delays in getting waivers taken care of, the delays in responses that are interminable. You mentioned things about the medical school and you talked about physical exams, the requirement is not there. If this money came to the States in the form of a block grant and said if you could design Medicaid the way you would want to do it—granted it was designed in 1965, and that was back in the era when a hospital that had an X-ray machine on wheels was considered pretty modern—but if you could redesign it, would your States want that authority? Do you think you could modernize things and deliver better health care quality to more people at a lower cost? Do you think you could?

Mr. BARBOUR. We think we would have a better fit for our State, we could move more toward an insurance kind of model, but we don't think it would just be better quality care, we could save you money. As I said at the beginning, we would take a 50 percent reduction in the annual increase, and that is a lot of money over time in savings for the American taxpayers. If we could cut the rate of Medicaid spending going up in half, and we would be willing to have a block grant and us take that risk.

Mr. MURPHY. Well, let me ask specifically then in terms of one of the things you mentioned, Governor Barbour, in your testimony about requiring Medicaid patients to have an annual medical exam. What benefits would you feel that would have in terms of improving quality?

Mr. BARBOUR. Well, for so many people, they would just have a better understanding, particularly older people would have a better understanding of what their health risks were and are. They would learn more. We would try to give them a briefing about their medicines, but they could get much farther along on that, but for a lot of them, they would find out things they don't know. If you go to the emergency care for your care, that is the worst place for primary care. It isn't just expensive, it is not designed for primary care. So it would help these people, a lot of people, have a better quality of life.

Mr. MURPHY. Governor Herbert, how about in your State? What about Utah?

Mr. HERBERT. Well, again, I think we can do it better. I would advocate for States to be able to be the innovators and creators of success. You know, it boils down to me just the simple principle, do you trust the States, do you trust the governors to do this, and some of you do and some of you don't. Some of you are a little

drawn aside about turning the reins over to the States, and I think we have proven the ability to in fact provide good service. We balance our budgets. We are out there growing the economy. We are doing things that we need to be doing in our respective States with our own respective different demographics. I have a young State. Our median age is only 28.8 years of age. I have a whole different demographic to deal with on health care than other States that may have a more aging population. So again, that is why I think let States and governors deal with it. I think that would find success that we otherwise would not have.

Mr. PITTS. The gentleman's time has expired.

Mr. MURPHY. Thank you.

Mr. PITTS. The chair recognizes the gentleman from Pennsylvania, Mr. Doyle, for 5 minutes.

Mr. DOYLE. Thank you, Mr. Chairman. It was interesting to hear from Governor Patrick about the economic impact of health care coverage in Massachusetts. It seemed to me that while we all know that providing our most vulnerable Americans access to health care will save individual families from extreme economic hardship due to medical costs, there is apparently also a larger economic role that health care coverage plays. Looking at the Massachusetts model after they rolled out their extensive plan, the number of uninsured shrank to an impressive 2.7 percent statewide, and uncompensated care costs went down by 38 percent. That hardly seems like a failed health care program to me. In 2009, nationwide uncompensated care costs were $40 billion. If Massachusetts is an example of the nationwide effect, we are talking about a potential savings of $15 billion as we lower the rate of uninsured in the country.

Similarly, it seems to me that cutting back on Medicaid and leaving more people without any type of insurance is shortsighted at best and more likely flat-out dangerous. As we all know, $1 cut from Medicaid means $2.33 cut from the State's economy.

You know, it is discouraging to me that the majority continues to spend time arguing taking away health care from our most vulnerable when what we really need to focus on is creating jobs and incentivizing economic growth. In my State of Pennsylvania, where the uninsured rates are nearly 20 percent, we could save hundreds of millions of dollars adopting the Massachusetts model, hardly, in my opinion, a failed health care model.

Mr. Chairman, I want to yield the balance of my time to Mr. Weiner for questions.

Mr. WEINER. I thank the gentleman.

Mr. Barbour, perhaps you and I should both have those white things they have at the U.N. so you could understand my Brooklyn accent and I can understand yours.

Mr. BARBOUR. We would need an interpreter.

Mr. WEINER. But I just want to ask you a couple of questions. I didn't hear you respond, the governors respond, about this question about tort reform. You don't want federal tort law to supplant and supersede State tort law, certainly, right?

Mr. BARBOUR. I thought the question was, what happened when we did this in our State, and it has been very, very, very beneficial.

Mr. WEINER. Would you agree, I assume you would, that you want State law to supersede federal law? You don't believe there should be a federal tort law, do you?

Mr. BARBOUR. I think in federal cases, I think there ought to be a federal tort law, if it is about federal law.

Mr. WEINER. Mr. Barbour, as you know, there is no such thing as a federal tort right now.

Mr. BARBOUR. Well, if you go into federal court in Mississippi and a case arises in the State, State law prevails. We wouldn't want to change that.

Mr. WEINER. If I can take back my time, medical malpractice is a State law. Are you aware of that?

Mr. BARBOUR. That is correct.

Mr. WEINER. OK. So you don't want federal law to supersede State medical malpractice tort law?

Mr. BARBOUR. Not in State cases.

Mr. WEINER. I didn't think you did. Can I ask you this question? From the conversation we are having here, you would think you have any additional costs at all before 2017. Are you both aware that you don't, you have no additional costs before the year 2017?

Mr. BARBOUR. That is why I said, sir, when I was trying to say what the costs were, they are so back-loaded.

Mr. WEINER. Right. Let me ask you this question. Do you anticipate in the future Mississippi will have more or fewer poor people with you as governor?

Mr. BARBOUR. It depends on the national economy. As long as we have got the economy we have got now, we are going to have——

Mr. WEINER. I am just curious because——

Mr. BARBOUR. We are going to have more——

Mr. WEINER. No, I understand, but is it your policy, Governor, to reduce the number of poor people in your State?

Mr. BARBOUR. The policy of our State is to grow the economy and have more people working.

Mr. WEINER. Is that a yes, sir?

Mr. BARBOUR. It should be the result.

Mr. WEINER. It is more or less a rhetorical question. Of you endeavor to have fewer poor people. That would make you a more successful governor, maybe even a candidate for higher office. If you have fewer poor people, wouldn't your Medicaid costs go down?

Mr. BARBOUR. Well, when we added 60,000 employees my first 3 years as governor, yes, sir, people went off the rolls. Our Medicaid costs——

Mr. WEINER. Right. So for your——

Mr. BARBOUR [continuing]. Were better under control.

Mr. WEINER. So if after 2017 you have fewer poor people than today, your Medicaid costs will go down, won't they?

Mr. BARBOUR. Well, no, they will actually go up because we are going to put all these people on Medicaid under the Affordable Care Act that are not——

Mr. WEINER. All right. I will put it this way.

Mr. BARBOUR [continuing]. That are not on it now.

Mr. WEINER. Well, let me put it in terms of the law. Under the Affordable Care Act, people eligible will have, a family of four making $30,000 a year will be the maximum coverage under the in-

crease under the Affordable Care Act starting in 2017 when the Federal Government stops absorbing 100 percent and absorbs 95 percent of that. If your number of poor people goes down a sufficient amount if you are a good governor and your number of poor people goes down, your Medicaid costs will go down, won't they?

Mr. BARBOUR. The definition of "poor" and eligible for Medicaid are two different things. The number of people eligible for Medicaid will go up.

Mr. WEINER. Thirty thousand for a family of four will be the new limit. If it goes down and you do a good job as governor, fewer poor people, lower Medicaid. I would endeavor that——

Mr. PITTS. The gentleman's time has expired.

Mr. BARBOUR. Not compared to today, Congressman.

Mr. WEINER. Well, that is exactly the number I gave you is the new law.

Mr. PITTS. The gentleman's time is expired. The chair recognizes the gentleman from Texas, Dr. Burgess, for 5 minutes for questions.

Mr. BURGESS. I thank the chairman for the recognition.

I thank you both for being here. I just wanted to clear up your concern about what we call this law, and I was too. In fact, I spent a long night before the Rules Committee trying to get the word "affordable" struck from the title on a germaneness issue because I couldn't see how "affordable" was germane to the bill in front of the Congress, but I wasn't allowed to proceed with that. So we are stuck with what it is called.

Governor Herbert, you referenced the need to expedite the Supreme Court review of the constitutional challenge to this law that was passed just less than a year ago. Now, when Judge Vincent in Florida issued his opinion just a few weeks ago, he said that injunctive relief was not necessary, that his declaratory judgment was all that was required because officers of the Federal Government would comply with the wishes of the court. Now, was he not correct in that statement?

Mr. HERBERT. Well, he may be, he may not be. That is still yet to be determined. The process is not completed yet. I know some States are taking the position that he is in fact accurate on injunctive relief. Others are saying it is not. And so for me as a State speaking for Utah, it is kind of like we are sitting on some shifting sands. We don't really know.

Mr. BURGESS. Because under normal circumstances, it would be likely June of 2012 before that Supreme Court ruling would occur. If I am to understand things correctly, officers of the Federal Government are not complying with the spirit of the law in that implementation of the law is still proceeding at a fairly rapid rate so this thing will be down the road another 18 months, and then if it is struck down, you will be asked to unwind under a court order, unwind all of the things that have occurred under the Affordable Care Act and it will be difficult to dissect out what you were doing with the State exchanges before the law went into effect and now what has been struck down by the Supreme Court. Is that correct?

Mr. HERBERT. That would be correct. Again, the uncertainty is really a problem for us to know which way to go and what to do.

Mr. BURGESS. Again, I really do thank both of you for being here and there are so many things that could come up.

In your written testimony, Governor Herbert, you talked about you wanted to get to a point where you pay for value. Now, are you aware that Donald Berwick, the head of Centers for Medicare and Medicaid Services, has testified that he too wants to go to a system that he pays for value? Have you two communicated on this point? Because he is the federal head of the Medicaid program.

Mr. HERBERT. He and I haven't. There may be some communication with our staff and our Medicaid people but he has not talked to me.

Mr. BURGESS. It seems to me that there is the common ground. Now, you also talked in your written testimony about what the accountable care model—I am sorry—the ACO model may be for Utah, and I don't disagree with that. The rules, unfortunately, that were due last September on accountable care organizations are still pending so it is kind of like the dog ate my homework over at HHS. We haven't got that to you yet. How are you able to proceed with this without the certainty of what the federal rules will be?

Mr. HERBERT. Well, it is very difficult. In fact, as mentioned earlier about the high-risk pool, and we had to wait about 6 weeks trying to get questions answered on high-risk pool and whether we should implement. We already had one in the State. Part of the Affordable Care Act requires a federal high-risk pool. But the answer came back, we can't answer that question, we haven't had a chance to read the bill.

Mr. BURGESS. Governor Barbour, you had some interesting comments about the high-risk pool at the National Governors Association on Sunday. Could I get you to quickly summarize those, about the number of people——

Mr. BARBOUR. Well, there may——

Mr. BURGESS [continuing]. That you were covering and the number that are covered now?

Mr. BARBOUR. It makes Governor Herbert's point about the need for a quick decision by the Supreme Court because we were required to create a second high-risk pool in Mississippi to comply with this law, even though we had had one since the mid-1990s. It insured 3,600 people. And we were forced to add another one and now in the course of however long it has been in effect, 58 people have signed up when they could have just taken our high-risk pool and not forced us to have another one.

Mr. BURGESS. The simplicity could be absolutely stunning in that, and actually Nathan Deal and I last year had legislation to try to do that but it didn't fly, unfortunately, with the Affordable Care Act.

Let me just point out, Representative Weiner's comments about the State sovereignty on medical liability. There is of course a federal program called Medicare, and Medicare is equally administered across all of the States without regard to State sovereignty. Would it be possible to set up a medical liability system within Medicare, within that federal program, say, perhaps, patterned after the Federal Tort Claims Act that is in effect for the federally qualified health centers that could provide some relief to your practitioners on medical liability costs?

Mr. BARBOUR. Yes.

Mr. HERBERT. I think so. It is an interesting idea, and I am not an attorney, I don't play one on TV, so I don't know if I can comment on that.

Mr. PITTS. The gentleman's time has expired. The chair recognizes the gentleman from Washington, Mr. Inslee, for 5 minutes for questioning. I am sorry, Ms. Schakowsky for 5 minutes.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

Illinois Governor Quinn has sent a statement from Illinois that outlines the many benefits of the Affordable Care Act. Among other things, he points out that the Medicaid expansion will cover 700,000 new adults who will have health insurance coverage, many for the first time in their adult lives. He adds, "The Affordable Care Act is helping to make comprehensive health insurance affordable and accessible to all Americans while providing the flexibility to allow governors to implement innovative policies that benefit the citizens of each unique state. In Illinois, we do not see the Affordable Care Act as an alternative or distraction to the urgent need for jobs and economic growth. We saw the law as a vital part of our economic recovery."

Mr. Chairman, I ask unanimous consent that Governor Quinn's full statement be included in the hearing record.

Mr. PITTS. Without objection, so ordered.

Ms. SCHAKOWSKY. Thank you.

[The information follows:]

# Statement of Governor Pat Quinn to the House Energy and Commerce Committee Hearing on "The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform."

March 1, 2011.

Thank you for this opportunity to share with the committee my perspective on, "The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform." While the title of today's hearing may be an attempt to denigrate the Affordable Care Act, we in Illinois are proud that the President's name is associated with the landmark legislation that courageously addresses one of the most vexing problems facing our nation.

I regret that my schedule did not permit me to address this committee in person this morning. I hope these brief written remarks can help the committee better understand the many ways that the Affordable Care Act is helping to make comprehensive health insurance affordable and accessible to all Americans, while providing the flexibility to allow governors to implement innovative policies that benefit the citizens of each unique state.

In Illinois, we do not see the ACA as an alternative or distraction to the urgent need for jobs and economic growth. We see the law as a vital part of our economic recovery.

In July, I appointed a Council on Health Care Reform Implementation. This Council, comprised of several state agencies responsible for various aspects of implementing the ACA, held open meetings throughout our state. Business owners, both large and small, testified about the urgent need to solve soaring health care costs. They described in sobering detail how they were forced to delay business expansion and hiring due to crippling premium increases. One witness described the horrendous choice of either firing a loyal, highly competent employee whose spouse had cancer, or watching health insurance premiums soar to unaffordable levels. Citizens described their horror at learning their insurance policy was canceled just as they were diagnosed with a debilitating chronic disease. Even insurers acknowledged the challenge of competing in a dysfunctional insurance marketplace and overwhelmingly encouraged an exchange administered within the state.

The unifying theme heard at the Council's meetings was that the ACA must be implemented quickly, efficiently and fairly.

We are doing this in Illinois.

We have seen more than 1,000 people with preexisting conditions receive health coverage through our new Illinois pre-existing condition insurance program. That means that 1,000

Illinois citizens, who previously could not find an insurance company to cover them at a price they could afford, have gained the health coverage they deserve.

We have seen more than 130,000 Illinois seniors receive $250 rebate checks in the mail to help cover the costs of prescription drugs. We have seen health plans cover immunizations, mammograms and other important preventative care procedures without charging the high deductibles and copayments that once served to deter consumers from routine checkups.

Thanks to the ACA, a student graduating from college in Illinois today remains covered under his parent's health insurance policy. And a sick child cannot be denied health coverage because she has a preexisting condition.

The ACA is already providing the state of Illinois with the tools and resources necessary – including nearly $300 million in grants to community health centers and other public and private stakeholders – to provide more Illinois citizens with crucial health care benefits and consumer protections at an affordable price.

The ACA has already accomplished so much in its first year. We look forward to its full implementation when it will offer desperately needed relief through:

- Tax credits for more than 150,000 small businesses to make health insurance more affordable
- Lower payments for prescription drug costs by closing the donut hole for 1.8 million older adults and people with disabilities.
- Reductions in Medicare premiums by ending the overpayments to Advantage plans.
- Provision of health insurance for more than 200,000 uninsured due to pre-existing conditions.
- Tax credits for 1 million Illinois residents to make insurance more affordable, bringing more than $16.4 billion to the state over five years.
- Reduced family health insurance resulting from the transparency of the health insurance exchange

The ACA will also benefit the state as a regulator by giving us the responsibility and authority to:

- Prohibit insurance companies from excluding coverage for pre-existing conditions.

- Review and approve extravagant premium rate increases.
- Require insurers to report appropriate data to determine the appropriateness of rate increases.
- Implement local versions of additional essential consumer protections.
- Prohibit rescissions, other than for fraud.

As a health insurer, Illinois is benefiting based on the federal subsidy for retired state employees whose costs exceed $15,000 per year.

And as a payer, Illinois will greatly benefit by the full federal funding of Medicaid expansion for approximately 700,000 new adults who will have health insurance coverage, many for the first time in their adult lives.

There are a host of new options for Illinois to consider to more efficiently organize and deliver health care to its publically covered population. The new Medicaid state plan options and demonstration programs will enable Illinois to slow that all-important growth curve to assure our Medicaid costs are under control.

I want to leave the committee with the full understanding that I approach health care as a right. I believe everyone in this country has a right to affordable and comprehensive health care that suits their individual needs.

While state resources are ever so limited, I see the costs associated with this law as an investment that will create jobs and provide essential health coverage for Illinois citizens.

Ms. SCHAKOWSKY. Governor Barbour, you have talked about the reason that infant mortality rates, et cetera, are up in Mississippi and also you were talking about in terms of Medicaid we have people pull up at the pharmacy window in a BMW and say they can't afford their copayment. Well, first of all, let me say that the Federal Government has made fraud in Medicare and Medicaid a top priority and has for the first time really put resources into doing that. But would you say that Mississippi uniquely? Because other States, it is really provider fraud that is the bulk of the fraud that goes on in Medicare and Medicaid asking for reimbursements of care that really wasn't given or prescription drugs. Would you say in your State it is your people who are defrauding the big problem in fraud?

Mr. BARBOUR. Congresswoman, my understanding is that that is not considered fraud, that in the federal rules if a person says they can't afford to pay the copayment, the provider can't challenge it, and of course, the sad thing about that for us is, the State doesn't save any money, it is the provider who gets shorted, but I report that because providers report it to me. It is not my understanding that that is, quote, fraud under the federal law. We have really done a good job of tamping down on our error rate, including fraud.

Ms. SCHAKOWSKY. So it is really people trying to—you know, it is about poor people or not-so-poor people trying to cheat the system that has been the big problem?

Mr. BARBOUR. We certainly had a problem at one time of people who were not eligible being on the program, and it was the State's fault because the State was not following the rules, but do we have provider fraud? Yes, ma'am, we do, and we also have waste from providers as well.

Ms. SCHAKOWSKY. Which all of us, I think, agree we have to go after.

You know, in Illinois we get a 50 percent match of federal dollars in our Medicare program. Mississippi gets almost 75 percent match. Utah gets about 71 percent match. As a matter of fact, for federal spending, Mississippi gets $2.02 back for every dollar in federal taxes it pays. Utah gets about $1.07. Illinois gets about 75 cents back. So we don't do as well as you do.

But do you not think that the fact that 75 percent of the dollars, for example, Governor, comes from the Federal Government that maybe the Federal Government has some right to set some parameters, or no?

Mr. BARBOUR. Sure, the Federal Government should have some right to set some parameters. I think the Federal Government overruns the program by far. I don't think that is unique to Mississippi. We get 75 cents because we are the poorest State in the country. We would love to trade with Illinois and be a much richer State and get a smaller percentage, but for us, the beauty is, you all would save a lot of money if you would let us manage the program and reduce our costs. You would get $3 out of 4 of the savings.

Ms. SCHAKOWSKY. Well, actually, I wanted to mention that with Governor Herbert. You were talking about your support for federalism and the pitch to let Utah be Utah, but actually Medicaid already gives you a great deal of flexibility in designing your pro-

gram. You can design your delivery system. You can set payment limits. You can do cost-sharing limits and benefits, and even prescription drugs are optional. So what are you saying? Just completely hands off, the Federal Government should not have a right to set some sort of limits?

Mr. HERBERT. Well, clearly you have a right, and I respect that right. It is a matter of, is there a better way? I think we ought to be more coequal partners in discussions of what the process is. I stipulate that the intention and objections of Medicaid and the health care reform act are designed to help the people. We all want that same goal. What we differ about is process.

Ms. SCHAKOWSKY. And yet both of you say you would rather see it repealed, right?

Mr. BARBOUR. The PPACA? Yes, ma'am.

Mr. HERBERT. I believe that parts of it are unconstitutional. I don't think we want to have an unconstitutional law on the books.

Mr. PITTS. The gentlelady's time is expired.

Our time is limited. The governors' time is limited. We want to thank the governors for their testimony. It has been an excellent panel. Before we adjourn, we have a couple of housekeeping items. The chair recognizes the ranking member, Mr. Waxman, for a unanimous consent request.

Mr. WAXMAN. Mr. Chairman, we have had letters from many different groups supporting maintaining Medicaid eligibility. We have a statement from the SEIU opposing repeal of the maintenance of effort and requirements of the ACA for Medicaid. I would like to have that as part of the record.

Mr. PITTS. Without objection, so ordered.

[The information follows:]

March 1, 2011

On behalf of the more than 2.2 million members of the Service Employees International Union (SEIU), I am writing in regards to the upcoming Energy and Commerce hearing entitled, "The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform." We hope that the Committee will provide a balanced perspective on Medicaid and identify policy solutions to help states during these difficult economic times while ensuring that those most vulnerable receive the health care services provided by this critical program. This program is important not only to the millions of low-income Americans who receive benefits but also to the economy of each state where Medicaid supports thousands of health-related jobs.

MARY KAY HENRY
International President

ELISEO MEDINA
International Secretary-Treasurer

MITCH ACKERMAN
Executive Vice President

GERRY HUDSON
Executive Vice President

BRUCE RAYNOR
Executive Vice President

DAVE REGAN
Executive Vice President

TOM WOODRUFF
Executive Vice President

The Patient Protection and Affordable Care Act (PPACA) was a critical step in ensuring that everyone has access to affordable, accessible, quality health care. For the first time in history, families will be eligible for subsidies to help pay for premiums and out of pockets expenses will be capped. Medicaid will be expanded for people up to 133% of the federal poverty level starting in 2014. States will receive 100% federal funding for 2014-2016 and will phase down to 90% in 2020, where they will remain. The PPACA also requires states to maintain Medicaid and CHIP eligibility standards that were in place when the PPACA became law until 2014 (in the case of adults) or 2019 (in the case of children).

Medicaid has been a key source of health coverage stability for millions of our nation's low-income children and families, seniors, and people with disabilities. It covers as many as 62 million low-income Americans over the course of a year, including one of every four children in the country and the 2014 expansion will be a key component in realizing the PPACA's goal of near-universal health coverage.

This year, states are facing daunting fiscal challenges. Recent estimates indicate that 2012 is shaping up as states' most difficult budget year on record. Thus far, some 44 states and the District of Columbia are projecting budget shortfalls totaling $125 billion for fiscal year 2012. While states are anticipating significant shortfalls in the coming year, their options for addressing those shortfalls are dwindling. The fact that enhanced federal match for Medicaid that has been available since October 2008 will end this June is a significant factor underlying projected deficits.

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Some of our nation's Governors have recently claimed that the expansion of Medicaid will result in increased costs to the states and that new regulations under PPACA are burdensome. Further, some have proposed to repeal important protections such as the maintenance of effort (MOE) in the face of budget challenges. These claims and proposals represent a dangerous attack on the Medicaid program as well as health reform more generally. While there is

no doubt that state budget problems are serious and warrant attention, the immediate fiscal crisis should not be used as cover for those whose real motive is to undo the gains of the Medicaid program and impede the implementation of the PPACA. SEIU firmly believes that the MOE requirements in the PPACA should not be overturned---repealing the MOE and lowering eligibility standards would simply trade short-term savings for long-term costs and would result in seniors, children, and people with disabilities losing critical health care they need.

We also hope that Congress and the Administration will work together to help states bridge the gap between their current fiscal challenges and the new federal support and opportunities that will become available in 2014. One way this could be accomplished would be to modify the current formula that governs Medicare Part D payments that states must send to the federal government (the Medicare Part D "clawback") in order to make it morefair to states and provide short-term fiscal relief.

We urge Members of the Committee and Congress to oppose any efforts to weaken stability protections in Medicaid and identify viable ways to find relief for the states.

For Immediate Release
March 1, 2011

Contact: Freya Riedlin
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## Medicaid – A Lifeline for Women and Families

***Statement of Debra L. Ness, President, National Partnership for Women & Families***

"We urge members of the House Energy and Commerce Committee – and all lawmakers at the federal and state levels – to remember that Medicaid provides essential, life-saving services to tens of millions of vulnerable women and families who otherwise would go without health care.

A staggering 50 million Americans now qualify for Medicaid, many of them direct or indirect victims of the punishing recession and jobless recovery. Three in four adult Medicaid beneficiaries are women. They need reliable health care services during this time of enormous need.

Medicaid covers the poorest and sickest people in our nation, financing essential care over the spectrum of women's lives, from family planning and maternal health services to nursing home care. It is the only source of health care for millions of vulnerable older women with multiple health problems, covering the home and community-based services and long-term care that they urgently need.

We understand the fiscal challenges facing lawmakers and the country, but this essential safety net program should be protected. We urge lawmakers to resist all arbitrary cuts to Medicaid, and instead to invest in prevention as well as the payment and delivery system reforms that can cut costs and improve the quality of care."

# # # #

*The National Partnership for Women & Families is a non-profit, non-partisan advocacy group dedicated to promoting fairness in the workplace, access to quality health care and policies that help women and men meet the dual demands of work and family. More information is available at www.nationalpartnership.org.*

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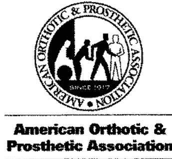


**Statement**

**of**

**The American Orthotic and Prosthetic Association**

**Before the**

**U.S. House of Representatives Committee on Energy and Commerce**

**Concerning**

**Medicaid and Orthotics and Prosthetics Coverage**

**March 1, 2011**

330 John Carlyle Street, Suite 200, Alexandria, Virginia 22314 • Phone (571) 431-0876 • Fax (571) 431-0899 • www.aopanet.org

Mr. Chairman and members of the committee, the American Orthotic and Prosthetic Association (AOPA) is pleased to have this opportunity to provide this statement for the record concerning why Medicaid coverage of orthotics and prosthetics is vital and sound health and economic policy. Orthotic and prosthetic professionals serve patients in need of artificial limbs, orthotics (orthopedic braces) and pedorthics (shoes and shoe inserts). AOPA estimates that our businesses provide patient services worth more than $3.45 billion annually.

The American Orthotic & Prosthetic Association (AOPA), founded in 1917, based in Alexandria, Virginia, is the largest non-profit organization dedicated to helping orthotic and prosthetic (O&P) businesses and professionals navigate the multitude of issues surrounding the delivery of quality patient care. With nearly 2,000 members, AOPA serves the O&P profession with advocacy before the Federal Government, and the resources to ensure high quality patient care in order to protect patients.

While we understand the economic crisis states face concerning their Medicaid budgets, we believe it is important to understand that some benefits are vital to ensuring a patient's ability to participate in the every day activities of working Americans. Orthotics and prosthetics are just such benefits. It is a false economy to cut these benefits because in the long run, evidence shows that to not provide coverage will cost more in medical care.

About our Patients

Our patients can be as diverse as a small child with spina bifda who needs customized orthotic bracing to the veteran who's lost a limb in war. In addition, the number of patients who loose a limb because of the effects of a chronic disease continue to increase. Some specifics:

- There are approximately 1.7 million people with limb loss in the United States (excluding fingers and toes);
- There are more than 185,000 new amputations performed each year in this country. The prevalence rate is approximately 4.9 per 1,000 persons;
- The incidence rate was 46.2 per 100,000 persons with dysvascular disease, 5.86 per 100,000 persons secondary to trauma, 0.35 per 100,000 secondary to malignancy of a bone or joint;
- The birth prevalence of congenital limb difference is roughly 25.64 per 100,000 live births;
- The prevalence rate of amputees is highest among people aged 65 years and older ~ 19.4 per 1,000.
- According to the American Diabetes Association, the risk of losing a foot or leg is 15–40 times higher for people living with diabetes than for those without the disease. More than 80,000 diabetes-related lower limb amputations are performed every year in the U.S., the International Diabetes Federation reports. Another 30 thousand limb amputations result annually from Peripheral Vascular Disease.

In addition, for seniors, Medicare coverage includes orthotic and prosthetic care.

The need to reduce budgets quickly does not promote calm, educated debate about sound health policy. More often the debate has focused on the concept that we don't have the luxury of caring about the long term economies and what matters is will removing a benefit save the state money in the current budget year.

AOPA has monitored the actions by the states to address the resulting economic realities of this storm, and the formidable challenge of balancing their state budgets in this environment.

State Efforts to Cut Medicaid Orthotic and Prosthetic Benefits is Not Sound Policy

To date Arizona has cut benefits has eliminated orthotic and prosthetic benefits under Medicaid for those over 21. These changes impact individuals particularly those who suffer from chronic conditions such as multiple sclerosis, cerebral palsy, and spin bifida. California and Nevada are also considering similar budget proposals.

Non-mandatory Medicaid benefits, including the benefits orthotic and prosthetic coverage are often referred to as "optional benefits." However, for an amputee restoring their mobility and returning to employment is not – in any sense -- optional. It is clear sections 1902 and 1905 of Title XIX allows states some flexibility to structure the benefits provided under their state plan and states also can obtain waivers for more flexibility. However, to reduce or exclude orthotic and prosthetic benefits is not necessarily sound health or economic policy. To not ensure that an individual can regain use of an arm or leg with a prosthetic or a customized orthotic limits an individual's ability to return to work, be a productive tax-payer.

However, studies demonstrate that orthotic and prosthetic coverage can actually decrease state health care costs. For example, Colorado found that the physical and mental health benefits derived from the ability to exercise, work, and participate in other activities of daily living with the assistance of orthotic or prosthetic devices result in fewer physician visits and medical/surgical claims. That study demonstrated savings gained from coverage were greater than the cumulative cost of providing the care through state-covered insurance benefits.

Kendra Calhoun, the CEO of the Amputee Coalition, the largest group representing amputees across the U.S. stated "….[when states] took the time to look at the facts and figures, have found that enabling patients to regain their mobility pays significant dividends, amounts saved that far surpass the costs of the care. We worry that some states, like Arizona, don't seem to have done their homework. "

A truly responsible fiscal policy should look to the long term – even when faced with an immediate crisis. By not looking to the long term, states disadvantage individuals with amputations and limb impairments when they could become part of the solution by returning to the workforce.

States Requiring Coverage for Orthotics and Prosthetics in Private Insurance

Ironically, many states have recently considered bills to assure that private health Insurance must offer orthotic and prosthetic coverage on the same terms as they do for other medical or surgical coverage, if they offer orthotic and prosthetic

coverage and 19 states have enacted some form of insurance parity for orthotics and prosthetics. In conjunction with consideration of legislation several states commissioned their own studies on the cost/benefits and time frames for offering orthotic and prosthetic care.

For example, Virginia's Joint Legislative Audit and Review Commission gathered data directly from insurers. This study showed projections of the costs of providing O&P care—somewhere between $0.02 and $0.08 per member/per month (PMPM). The Virginia study (Evaluation of Senate Bill 931, Joint Legislative Audit and review Commission of Virginia's General Assembly) found:

- The availability of prosthetic devices can improve the physical and psychological functioning of persons with amputations, injuries and congenital physical disabilities by enabling them to exercise and perform other activities of daily life. In addition, most amputees with prostheses return to some form of work and show a reduction in secondary conditions that can result from their disability.

- Amputees who have access to prosthetic devices show a reduction in the secondary conditions caused by increased sedentary lifestyle, have decreased dependence on caretakers, and a reduced chance of additional medical complications leading to further amputations.

- The more sedentary lifestyle (of patients without access to appropriate orthotics and prosthetics) may lead to an inability to maintain employment, an increased reliance on caretakers, an increased likelihood of experiencing depression and increased morbidity.

In Colorado, according to a study by the Colorado Department of health Care Policy and Financing Medical Policy and Benefits first year expenditures for private insurance coverage. First year expenditures [for orthotic and prosthetic coverage] expenditures were a total of $373,964, serving 381 clients and net savings documented for one-half of the benefit's first fiscal year are $195,482. Across the balance of the population, the net savings would result in an estimated amount of $448,666 for the entire year in other medical services because of the prosthetic and orthotic benefit.

Orthotic and Prosthetic Coverage in the Private Health Insurance Market

AOPA recently surveyed its providers across the country asking them about the prevalence of coverage in large employer plans and by individual plans. Two-thirds of respondents said that major employer health insurance plans cover O&P services over 80 percent of the time, with the composite national average being at least 75 percent for these employer plans.

Approximately 35 percent of the providers nationally said 80 percent or more of smaller/individual plans provide O&P coverage. Approximately 50 percent of

providers nationally found that between 60 and 80 percent of individual plans in their area provided an O&P benefit. The composite number for coverage is between 67 and 70 percent of smaller/individual health insurance plans across the country offer an O&P benefit. However this may vary regionally. For example, the Philadelphia and Southern New Jersey area which includes greater Philadelphia Metro area, on average 60 to 80 percent of insurance plans - both large employer plans and the smaller/individual coverage plans—currently include O&P coverage.

Another source of information is a study released in February by the Society for Human Resource SHRM studies small employers (those with between 100-499 employees), and large employers (those with over 5,000 employees. That study shows that the majority of small and large employers provide coverage for orthotics and prosthetics. Of the small employers, 70 percent responded that their company does offer prosthetic and orthotic benefits, i.e., artificial limbs and customized orthopedic bracing. Of the large employer plans, 75 percent reported offering O&P coverage. Nearly three-quarter of employers surveyed (72 percent) with either 100 to 499 employees (small) or 5000 and above employees (large) have health plans for employees that currently include coverage of this benefit. Large organizations with 5000 and above employees (75 percent) were slightly ahead in coverage of artificial limbs and custom orthopaedic bracing as were publicly owned for-profits (79 percent), non-profits (73 percent) and government agencies (79 percent).

Other Federal Programs

Perhaps the most visible government funding in the area of prosthetics is through the Department of Veterans Affairs (VA). An example of this federal investment in prosthetic research is the VA's launched of a three-year optimization study of an advanced prosthetic arm that was developed with funding from the Defense Advanced Research Projects Agency (DARPA). In addition, the VA is exploring the use of leading-edge technology such as robotics and nanotechnology to design and build lighter more functional prosthesis. This research over time helps all amputees.

Conclusion

As the studies cited, demonstrate the costs of providing orthotic and prosthetic coverage can help achieve savings in the long term. The cost of not providing Medicaid coverage for orthotic and prosthetic coverage should not be viewed through the lens of a short–term budget number.

Given the current state of coverage for these benefits in both Medicare, and the trend in states to require some coverage for orthotics and prosthetics, reducing Medicaid benefits in this area only serves to penalize those who need the benefits the most. In addition, to reduce these benefits is to deny over time Medicaid beneficiaries the benefits of federal resources invested in research to improve orthotics and prosthetics. Therefore, it is counter intuitive to make that investment and deny Medicaid beneficiaries coverage.

We appreciate this opportunity to provide this statement in the hearing record, and would be pleased to answer any questions.

March 1, 2011

United States House of Representatives
Washington, DC 20515

Dear Member of Congress:

Since their inception, Medicaid and the Children's Health Insurance Program (CHIP) have been key sources of health coverage stability for millions of the nation's low-income children and families, seniors, and people with disabilities. In economic downturns, Medicaid and CHIP play a critical role in maintaining access to necessary health care for children and, in some instances, parents. Low-income seniors have been able to turn to Medicaid for help with Medicare premiums and for needed long-term services and supports. People with disabilities have looked to Medicaid for help with the services they need to continue to be active members of their communities. All told, over 50 million people rely on Medicaid and CHIP for access to critical health care services that they could not otherwise afford.

In the Affordable Care Act, Congress recognized the important role these programs play in our nation's health coverage structure. One important provision of the Act ensures stable Medicaid and CHIP coverage by requiring states to hold steady on Medicaid and CHIP eligibility until 2014 for adults and 2019 for children. To date, these stability protections have worked exactly as intended, preventing states from reducing Medicaid and CHIP eligibility as well as from adding red-tape barriers to enrollment just when people need help the most.

But now, some of our nation's Governors are seeking to eliminate this important protection in the face of budget challenges. While there is no doubt that these state budget problems are serious and warrant attention, taking health care away from millions of American seniors and children is the wrong response. What the Governors propose would undercut the remarkable gains we've made in recent years in insuring our nation's children and imperil the availability of long-term services and supports for seniors and people with disabilities. This outcome would be in direct opposition to our nation's goal of reducing the number of uninsured. Moreover, cutting Medicaid would threaten the fragile economic recovery, since cuts to Medicaid translate into significant cuts in state business activity and jobs.

The economic and health care security of millions of Americans is at substantial risk if the stability provisions in the Affordable Care Act are weakened. We therefore urge you to stand firm and vigorously oppose any efforts to weaken these provisions. Our organizations are ready to work with you, with CMS and with state government to find smarter, more efficient ways to respond to state budgetary problems.

Sincerely,

ACCSES (formerly the American Congress of Community Supports and Employment Services)
Alliance for a Just Society
Alliance for Children and Families
American Academy of Family Physicians
American Academy of Pediatrics
American Association for Geriatric Psychiatry
American Association of People with Disabilities
American Association of University Women
American Association on Health and Disability
American Cancer Society Cancer Action Network

American Counseling Association
American Dance Therapy Association
American Diabetes Association
American Federation of State, County and Municipal Employees
American Heart Association
American Music Therapy Association
American Network of Community Options and Resources
American Nurses Association
American Occupational Therapy Association
American Psychiatric Association
American Psychological Association
American Public Health Association
American Society on Aging
Anxiety Disorders Association of America
Asian & Pacific Islander American Health Forum
Association of Asian Pacific Community Health Organizations
Association of Professional Chaplains
Association of University Centers on Disabilities
Attention Deficit Disorder Association
Bazelon Center for Mental Health Law
Center for Community Change
Center for Medicare Advocacy
Child Welfare League of America
Children and Adults with Attention-Deficit/Hyperactivity Disorder
Children's Defense Fund
Children's Dental Health Project
Children's Health Fund
CLASP
Clinical Social Work Association
Coalition on Human Needs
Colon Cancer Alliance
CommonHealth ACTION
Community Access National Network
Community Action Partnership
Community Organizations in Action
Consumer Action
Corporation for Supportive Housing
Cystic Fibrosis Foundation
Defeat Diabetes Foundation
Disability Rights Education & Defense Fund
Easter Seals
Families USA
Family Voices
First Focus
Health Care for America Now!
Hemophilia Federation of America
HIV Law Project
HIV Medicine Association
Leadership Conference of Women Religious
Learning Disabilities Association of America
Lutheran Services in America

Medicare Rights Center
Mental Health America
MomsRising
National Academy of Elder Law Attorneys
National Advocacy Center of the Sisters
National Alliance on Mental Illness
National Asian Pacific American Women's Forum
National Assembly on School-Based Health Care
National Association for Children's Behavioral Health
National Association for Home Care & Hospice
National Association for Pediatric Nurse Practitioners
National Association for Rural Mental Health
National Association of Area Agencies on Aging
National Association of Community Health Centers
National Association of Council for Children
National Association of County Behavioral Health & Disability Directors
National Association of County Human Services Administrators
National Association of Nutrition and Aging Services Programs
National Association of Social Workers
National Association of State Head Injury Administrators
National Center for Law and Economic Justice
National Committee to Preserve Social Security and Medicare
National Council for Community Behavioral Healthcare
National Council of Jewish Women
National Council of Women's Organizations
National Council on Aging
National Down Syndrome Congress
National Foundation for Mental Health
National Health Law Program
National Immigration Law Center
National Korean American Service & Education Consortium
National Latina Institute for Reproductive Health
National Multiple Sclerosis Society
National Network of Public Health Institutes
National Partnership for Women & Families
National Physicians Alliance
National Respite Coalition
National Senior Citizens Law Center
National Senior Corps Association
National Spinal Cord Injury Association
National Women's Health Network
National Women's Law Center
NETWORK: A National Catholic Social Justice Lobby
Nine to Five, National Association of Working Women
Paralyzed Veterans of America
Partnership for Prevention
PHI
Prescription Policy Choices
Project Inform
Raising Women's Voices for the Health Care We Need
RESULTS

School Social Work Association of America
Service Employees International Union
Shriver Center
Sugar Law Center for Economic & Social Justice
The AIDS Institute
The Arc of the United States
The Children's Partnership
The Every Child Matters Education Fund
The National Alliance to Advance Adolescent Health
The National Consumer Voice for Quality, Long-Term Care (formerly NCCNHR)
The Patients' Union
Treatment Access Expansion Project
Treatment Action Group
Union for Reform Judaism
United Cerebral Palsy
United Spinal Association
Voices for America's Children
WhyHunger
Wider Opportunities for Women
Witness Justice
Women of Reform Judaism

Mr. WAXMAN. And I did want to take a second or two to talk about the Medicaid citizen documentation. I think the statement by Mr. Barton was incorrect. States have two ways to establish whether someone is an actual citizen. One could be submit a name, Social Security number, date of birth, then go to the Social Security Administration for verification, and if the Social Security records match, the individual meets the documentation requirements. As of February, 33 States including Mississippi and Michigan have elected this option. In the alternative, a State can require an individual provide either a U.S. passport or a birth certificate and a driver's license or other photo ID. In no case may an individual self-declare citizenship or legal immigration status.

Thank you, Mr. Chairman.

Mr. PITTS. Without objection, so ordered.

The gentleman, Mr. Bass, would like to insert for the record a study on how to reduce Medicaid drug prices, and Mr. Griffith from Virginia has a letter from the Governor of Virginia to insert in the record. Without objection.

[The information follows:]

PHARMACEUTICAL CARE MANAGEMENT ASSOCIATION

**Testimony of**
**Pharmaceutical Care Management Association**
**Submitted to the**

**UNITED STATES HOUSE OF REPRESENTATIVES**
**COMMITTEE ON ENERGY AND COMMERCE**

*Hearing on Medicaid and State Health Care Reform*
**March 1, 2011**

The Pharmaceutical Care Management Association (PCMA) is the national association representing America's pharmacy benefit managers (PBMs), which administer prescription drug plans for more than 210 million Americans with health coverage provided through Fortune 500 employers, health insurers, labor unions, Medicare, Medicaid, and the Federal Employees Health Benefits Program (FEHBP). PCMA appreciates the opportunity to submit written testimony to the Committee on Energy and Commerce related to state Medicaid drug benefits.

PBMs achieve savings for the federal government as well as thousands of different employer and health plan clients who have differing needs and resources available to finance health benefits. However, all PBM clients – private and public sector alike – share the goals of wanting benefits that provide great access to prescription drugs, are affordable and, in the case of the private sector, help retain and recruit top-notch personnel.

Pharmacy benefit managers (PBMs) typically reduce drug benefit costs by 30 percent[1] for public and private payers by encouraging the use of generic drug alternatives, negotiating discounts from manufacturers and drug stores, saving money with home delivery, and using health information technology like e-prescribing to reduce waste and improve patient safety. Prior to the advent of these tools, there was no system wide approach to fully address the real dangers and costs of misuse, overuse, or under-use of prescription drugs. In the Medicare Part D program, research cited by the Centers for Medicare & Medicaid Services (CMS) notes that strong Part D plan negotiations have been a key driver in the benefit, which is now expected to cost taxpayers $373 billion over ten years, a 41 percent drop from the initial cost estimate of $634 billion for 2004-2013.[2] Unfortunately, with few exceptions, most states have largely unmanaged prescription drug benefits for their Medicaid program.

As the Committee looks at issues related to the growing Medicaid population and rising costs associated with this coverage, there is a proven option that would result in significant savings for each state. Instead of painful elimination of benefits and cuts to hospitals and doctors, governors could simply end Medicaid's practice of paying more than other programs for pharmacy benefits and adopt practices reflective of those used in Medicare Part D and commercial plans.

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[1] PricewaterhouseCoopers, "Medicare Part D: An Assessment of Plan Performance and Potential Savings," analysis prepared for the Pharmaceutical Care Management Association, January 2007
[2] Statement of Paul Spitalnic, CMS Office of the Actuary, "Medicare Part D Premiums Going Up by $1 in 2011," Walker, Emily. August 19, 2010.

A state-by-state analysis from The Lewin Group finds that on average Medicaid pays higher pharmacy rates, uses fewer generics than other programs and that states and the federal government together could save more than $30 billion over the next decade by transitioning to more efficient approaches used by Medicare Part D plans and the commercial sector, including union and state employee plans. This would save, for example, Michigan about $150 million, Illinois about $613 million, California about $2.1 billion, New York about $2.3 billion, and Texas $1.2 billion, over the next decade. The federal government could save more than $20 billion, and states an additional $12 billion collectively.

In fact, both New York and New Jersey recently announced plans to shift to a more modern pharmacy benefit management approach similar to that described in the study, projecting a combined savings of $391 million.

In most states, state legislators or government officials determine how much Medicaid pays drugstores for each prescription filled (dispensing fees) and ingredient costs (the reimbursement for the cost of the actual drug). This has become a highly political and inefficient process. As a result, in virtually every state, Medicaid is pharmacy's best paying customer--paying more than Medicare Part D and commercial plans. In comparison, on average, Medicaid pays nearly every other provider well below Medicare and commercial rates.

In January of 2008, the Inspector General of the Department of Health and Human Services reported that on average, state Medicaid plans pay more than $2.00 more in dispensing fees than Medicare Part D.[3] If states mirrored the operations of Part D, their Medicaid programs could improve generic utilization and negotiate better pharmacy payments directly with chain drugstores and the drug wholesalers that represent independent pharmacies. For example, a July 2010 report done by the American Enterprise Institute found that of the top 20 brand drugs dispensed in the Medicaid program for which there is a generic available, Medicaid wasted an average of $96 per prescription by not dispensing the generic.[4]

Recent polling finds that voters prefer to reduce Medicaid spending by more efficient pharmacy management over cutting benefits for patients or payments to doctors and hospitals. Voters also want Medicaid to stop paying higher pharmacy costs than other programs while also using fewer generics.

Considering the savings, support, and immediacy associated with this reform, the easiest way for states to reduce spending in Medicaid without cutting benefits – or slashing hospital or physician payments – is to modernize pharmacy benefits and start using cutting-edge marketplace tools to negotiate lower rates and increase the use of generic medications.

On behalf of the Pharmaceutical Care Management Association and our members, we look forward to working with the Committee to develop ways in which to improve administration of Medicaid pharmacy services, saving both states and the federal government money while still keeping benefits clinically appropriate and ensuring beneficiary access to needed medications.

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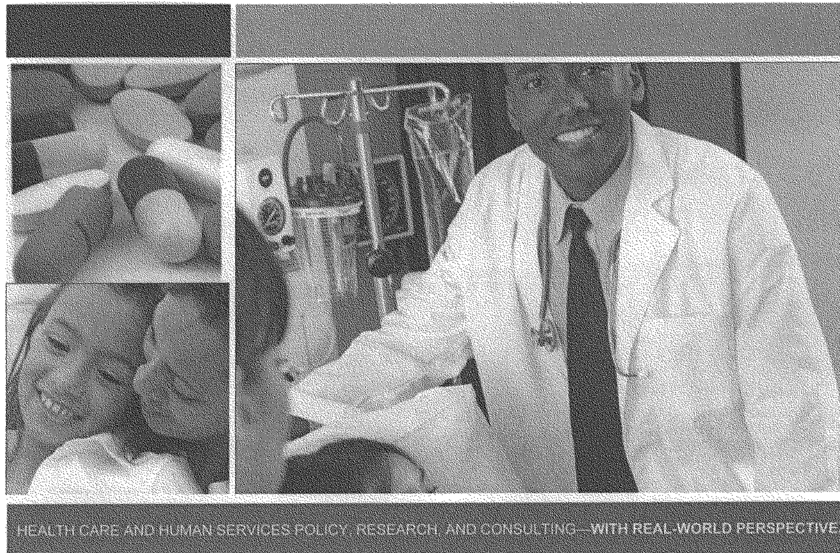
[3] Office of the Inspector General, "Review of the Relationship Between Medicare Part D Payments to Local, Community Pharmacies and the Pharmacies' Drug Acquisition Costs." A-06-07-00107. January 2008

[4] Brill, Alex "Overspending on Multi-Source Drugs in Medicaid" American Enterprise Institute. July 21, 2010




**Potential Federal and State-by-State Savings if Medicaid Pharmacy Programs were Optimally Managed**

February 2011

**Commissioned by the Pharmaceutical Care Management Association**

**Prepared by:** Joel Menges
Shirley Kang
Chris Park

## Table of Contents

I. EXECUTIVE SUMMARY ..... 1
Savings Opportunities Exist In Four Key Areas ..... 1
States With High Dispensing Fees Also Often Pay High Ingredient Costs ..... 2
Estimated Federal and State Medicaid Savings ..... 2
Estimates Reflect Changes Involving AMP and AWP Drug Price Benchmarks ..... 2
Rebates from Brand Name Manufacturers Have No Impact on Pharmacy Ingredient Cost Reimbursements or Dispensing Fees ..... 4
Conclusion ..... 4

II. INTRODUCTION ..... 5

III. SAVINGS ESTIMATE DERIVATION ..... 8
A. Reduced Dispensing Fees ..... 8
B. Reduced Ingredient Costs ..... 8
C. Increased Generic Dispensing Rate ..... 10
D. Decreased Utilization ..... 10
E. Increased Administrative Costs ..... 11

IV. TEN-YEAR SAVINGS ESTIMATES ..... 12

V. THE ROLE OF MANUFACTURER REBATES ..... 14

VI. RELATIONSHIP BETWEEN DISPENSING FEES, INGREDIENT COSTS AND GENERIC DISPENSING RATES ..... 15

VII. STATE-SPECIFIC SAVINGS ESTIMATES BY ELIGIBILITY CATEGORY ..... 17

VIII. FEDERAL AND STATE SHARE OF SAVINGS ..... 21

APPENDIX A. BASELINE PHARMACY COSTS, CY2011 ..... 23

APPENDIX B. SCATTER DIAGRAM ASSESSING CORRELATION BETWEEN HIGHER PAYMENTS TO PHARMACIES AND GENERIC DISPENSING RATES ..... 24

## I. Executive Summary

While discussions about Medicaid prescription drug costs have often focused on the rebates received from brand name drug manufacturers, this study explores how more efficient pharmacy benefits management -- apart from rebates -- could save Medicaid an additional $33 billion over the next decade.

Medicaid has become an outlier as one of the nation's few remaining pharmacy benefits programs that is mainly administered by public agencies using a fee-for-service (FFS) delivery model. In this model, which accounts for 73% of Medicaid pharmacy expenditures, dispensing fees, ingredient costs, and benefits management activities are determined by state officials. In most other programs, pharmacy reimbursements are determined through negotiations between pharmacy benefits managers (PBMs) and drug retailers.

Though states often use pharmacy benefits administrators (PBAs) to make their FFS program models operate more efficiently, states do not typically allow such organizations to negotiate payment terms directly with pharmacies. In contrast, Medicare Part D plans, Medicaid managed care organizations (MCOs), and state employee plans typically use PBMs to negotiate dispensing fees and ingredient cost reimbursements. PBMs negotiate directly with chain drug stores and indirectly with independent drug stores through drug wholesalers that collectively negotiate on their behalf.

The experience of Medicaid MCOs indicates that Medicaid pharmacy benefits can be more actively managed without compromising quality or access to medications for the unique and vulnerable populations that Medicaid serves. Likewise, widely varying payment levels—and per member per month (PMPM) costs—among state Medicaid fee-for-service programs serving similar populations suggest that substantial room exists to improve efficiency in most states.

### Savings Opportunities Exist In Four Key Areas

While Medicaid FFS programs and costs vary greatly state-by-state, we identified four key areas where pharmacy benefit management could generally be improved:

**Generic Drug Dispensing:** Medicaid FFS is less effective at encouraging the dispensing of generic drugs in place of brands. The generic dispensing rate in Medicaid FFS averages 68%, compared to an average 80% generic dispensing rate in Medicaid MCOs. While some of this difference is attributable to demographic differences between the Medicaid FFS and MCO populations, much of the generic dispensing difference persists when looking *within* each demographic subgroup.

**Dispensing Fees:** At $4.81 per prescription, the national average dispensing fee that Medicaid FFS programs pay to retail pharmacies is more than double the average dispensing fees paid by Medicare Part D payers, Medicaid managed care organizations (MCOs), or health plans in the commercial sector.

**Ingredient Costs:** The rate at which retail pharmacies are reimbursed for the actual medication ingredients (pills, capsules, etc) is also higher, on average, in Medicaid FFS programs than in Medicare Part D or the commercial sector.

**Drug Utilization:** The number of prescriptions dispensed per person is typically higher for similar demographic subgroups in Medicaid FFS programs than in Medicaid MCOs for similar demographic subgroups due to less effective controls on polypharmacy, fraud, waste, abuse, and other factors in the FFS setting.

### States With High Dispensing Fees Also Often Pay High Ingredient Costs

Contrary to conventional wisdom, we did not find that Medicaid FFS programs with low dispensing fees paid high ingredient costs. On the contrary, we found that many state programs paying high dispensing fees often also paid high ingredient costs. Likewise, we found no relationship between pharmacy reimbursement levels and the generic dispensing rate among Medicaid FFS programs, suggesting that benefits management rather than pharmacy reimbursement most strongly influences the generic dispensing rate.

### Estimated Federal and State Medicaid Savings

If all state Medicaid programs used a market-based approach such that dispensing fees, ingredient costs, drug utilization, and generic drug dispensing were brought in-line with norms for state employee health plans, Medicare Part D, and Medicaid MCOs, we estimate:

- Medicaid FFS prescription costs could be reduced by approximately 15%
- Combined federal and state savings to the Medicaid program would total $32.7 billion over the next decade
- Per member per month (PMPM) costs for Medicaid FFS pharmacy benefits could be reduced by $12 in 2012 under optimal management

In constructing our model we used data published by the Centers for Medicare and Medicaid Services (CMS) provided by individual state Medicaid programs. Estimated savings vary greatly from state to state and depend on the volume of prescriptions paid for in the FFS setting and how actively each individual Medicaid program currently manages pharmacy benefits (see Exhibit ES-1). Active pharmacy benefit management would incur higher administrative costs, but these costs would not outweigh the substantial savings opportunities and have been accounted for in our estimates. Our model, however, does not estimate specific impacts that would be associated with greater care coordination, clinical specialty pharmacy management, or the use of mail-service pharmacies.

### Estimates Reflect Changes Involving AMP and AWP Drug Price Benchmarks

Our savings estimates take into account recent changes to drug price benchmarks that influence pharmacy ingredient cost reimbursement levels in some cases. Recent changes to the determination of Federal Upper Limits (FULs) using the Average Manufacturer Price (AMP) may result in lower pharmacy ingredient cost reimbursement for some generic drugs in some states, so to be conservative we have not assumed that more active pharmacy management would result in any ingredient cost savings for FUL drugs in any state.

**Exhibit ES-1. Estimated Savings if Medicaid Pharmacy Programs Were Optimally Managed (Figures represent ten-year timeframe CY2012-CY2021)**

| State | Federal Share of Net Savings | State Share of Net Savings | 10 Year Total Net Savings, 2012-2021 |
|---|---|---|---|
| Alabama | $541,589,986 | $212,693,864 | $754,283,850 |
| Alaska | $123,277,462 | $92,518,227 | $215,795,688 |
| Arizona | $0 | $0 | $0 |
| Arkansas | $333,582,219 | $97,833,858 | $431,416,077 |
| California | $2,664,470,481 | $2,102,278,271 | $4,766,748,752 |
| Colorado | $145,129,408 | $92,104,295 | $237,233,703 |
| Connecticut | $195,163,881 | $172,490,345 | $367,654,226 |
| Delaware | $60,468,563 | $57,138,977 | $117,607,540 |
| District of Columbia | $51,606,201 | $20,541,747 | $72,147,948 |
| Florida | $832,251,989 | $472,600,872 | $1,304,852,861 |
| Georgia | $558,368,644 | $265,978,908 | $824,347,552 |
| Hawaii | $6,784,074 | $3,320,416 | $10,104,490 |
| Idaho | $138,704,585 | $45,072,321 | $183,776,906 |
| Illinois | $804,866,203 | $613,459,114 | $1,418,325,317 |
| Indiana | $413,221,714 | $213,536,536 | $626,758,250 |
| Iowa | $265,600,337 | $115,936,750 | $381,537,087 |
| Kansas | $104,786,220 | $62,038,990 | $166,825,210 |
| Kentucky | $489,938,125 | $173,966,438 | $663,904,563 |
| Louisiana | $879,404,642 | $280,728,542 | $1,160,133,184 |
| Maine | $124,678,825 | $60,777,993 | $185,456,818 |
| Maryland | $196,475,409 | $171,141,358 | $367,616,767 |
| Massachusetts | $87,191,071 | $87,880,524 | $175,071,595 |
| Michigan | $304,054,861 | $149,518,302 | $453,573,163 |
| Minnesota | $114,704,650 | $102,194,619 | $216,899,269 |
| Mississippi | $280,410,076 | $66,449,179 | $346,859,255 |
| Missouri | $559,461,818 | $281,744,973 | $841,206,791 |
| Montana | $54,131,730 | $17,138,337 | $71,270,067 |
| Nebraska | $99,486,235 | $49,575,402 | $149,061,637 |
| Nevada | $58,357,006 | $37,057,311 | $95,414,317 |
| New Hampshire | $28,623,415 | $21,459,624 | $50,083,040 |
| New Jersey | $271,482,125 | $248,960,390 | $520,442,515 |
| New Mexico | $9,922,916 | $1,806,984 | $11,729,900 |
| New York | $2,289,876,858 | $2,271,962,894 | $4,561,839,751 |
| North Carolina | $1,338,796,858 | $578,706,077 | $1,917,502,934 |
| North Dakota | $48,423,763 | $19,695,075 | $68,118,838 |
| Ohio | $638,373,638 | $351,241,692 | $989,615,330 |
| Oklahoma | $370,950,440 | $154,599,115 | $525,549,555 |
| Oregon | $76,014,671 | $36,835,822 | $112,850,493 |
| Pennsylvania | $224,596,327 | $164,502,469 | $389,098,796 |
| Rhode Island | $12,701,582 | $8,156,214 | $20,857,795 |
| South Carolina | $510,973,952 | $175,730,508 | $686,704,460 |
| South Dakota | $67,541,553 | $30,319,022 | $97,860,575 |
| Tennessee | $410,240,570 | $173,319,372 | $583,559,943 |
| Texas | $2,600,124,983 | $1,186,927,145 | $3,787,052,128 |
| Utah | $107,339,203 | $29,932,965 | $137,272,168 |
| Vermont | $73,796,325 | $50,408,289 | $124,204,614 |
| Virginia | $209,806,945 | $152,536,246 | $362,343,191 |
| Washington | $136,396,587 | $112,023,642 | $248,420,229 |
| West Virginia | $314,304,332 | $94,833,184 | $409,137,515 |
| Wisconsin | $267,986,623 | $161,999,644 | $429,986,267 |
| Wyoming | $35,929,608 | $23,774,779 | $59,704,387 |
| **US TOTAL** | **$20,532,369,685** | **$12,167,447,620** | **$32,699,817,305** |

Note: Nearly all of Arizona's Medicaid prescriptions are paid for by the managed care organizations (MCOs) contracting with the State. Given the Arizona MCOs' many years of experience managing the pharmacy benefit on a full-risk basis, we assume that further pharmacy benefits management savings are not attainable in this state.

In addition, a 2009 legal settlement resulted in a lowering of the Average Wholesale Price benchmark, which is commonly used in calculating pharmacy ingredient cost reimbursement for brand name drugs. While most commercial sector plans adjusted their ingredient cost formulas to minimize the impact on pharmacies, most Medicaid programs did not. This dynamic has been accounted for in our estimates.

### Rebates from Brand Name Manufacturers Have No Impact on Pharmacy Ingredient Cost Reimbursements or Dispensing Fees

The statutory and supplemental rebates paid to Medicaid by brand name manufacturers are determined separately from pharmacy dispensing fees and ingredient costs. This means that manufacturer rebates have no impact on the savings that more active management of dispensing fees and ingredient costs could achieve. Though improved management of drug utilization increases generic drug dispensing (and thereby reduces the use of brand drugs and the related rebate income they generate for states) the net savings to Medicaid FFS programs would still be large, as reflected in our savings estimates.

### Conclusion

Over the past decade, many Medicaid FFS programs have placed emphasis on maximizing drug manufacturer rebates while less actively managing other aspects of the pharmacy benefit relative to what occurs in the private sector. If Medicaid pharmacy programs used approaches employed by Medicare Part D, Medicaid MCOs, state employee health plans, and the commercial sector to determine dispensing fees, ingredient costs, drug utilization, and generic drug dispensing, approximately $33 billion in overall savings could be achieved during the next decade.

## II. Introduction

States continue to face extreme fiscal pressure to achieve Medicaid savings. Most states have experienced a massive influx of new Medicaid enrollees during the past three years as a result of the recession. While the Federal government has increased its financial support to states during this timeframe, as of July 2011 the enhanced Federal Medicaid match rates will revert to "normal" levels. When it does, states will see their share of Medicaid expenditures increase substantially, while revenues are likely to remain depressed.[1] In addition, the eligibility expansion provisions of the Affordable Care Act (ACA) will result in an enormous influx of new enrollees (more than 16 million persons nationally are projected). Nearly all of the costs for these new enrollees will initially be paid by the Federal government, but states will be strained to take on the added administrative burden of the expansion and pay their share of the costs.

In this environment, state Medicaid programs need to consider all available opportunities to reduce Medicaid costs in a manner that is not detrimental to the impoverished beneficiary population the program serves. Several opportunities exist in the area of pharmacy costs. Over the past several years, Medicaid fee-for-service (FFS) pharmacy programs have expanded their cost management of prescription drugs, but most FFS programs still have not achieved the same level of pharmacy benefits management as found in either Medicare Part D, Medicaid MCOs, or the commercial sector.

Medicaid FFS programs commonly reimburse pharmacies more for dispensing fees and ingredient costs than do MCOs and Part D plans. Additionally, Medicaid MCOs have demonstrated lower utilization and higher generic fill rates than in the Medicaid FFS setting.[2] Medicaid FFS programs could achieve substantial savings if they were to move toward the reimbursement and utilization levels found in Medicaid and commercial MCOs and Medicare Part D plans. Improving management of the FFS pharmacy benefit would likely entail more austere pricing policies as well as stronger management of the Medicaid FFS pharmacy benefit as typically occurs in the private sector. While there would be new costs associated with increasing management functions, the potential savings would more than offset these new administrative costs.

To estimate the potential impact of increased pharmacy benefit management in the Medicaid FFS setting, we modeled the impact of moving Medicaid FFS to levels typically found in Medicaid and commercial MCOs and Part D plans in four key areas: dispensing fees, ingredient cost, generic fill rates, and utilization. Additionally, we calculated an offsetting increase in administrative costs associated with more active benefit management activities. We modeled these changes in a step-wise fashion so that the savings attributable to that step reflect the impact of changes made in prior steps. For example, the savings estimated for improving the generic mix reflect the decrease in dispensing fees and ingredient costs made in prior steps. The estimated share of overall savings attributable to each benefits management component are summarized in Exhibit 1. Nationwide, the largest single component of the estimated savings

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1 Kaiser Commission on Medicaid and the Uninsured, "Hoping for Economic Recovery, Preparing for Health Reform: A Look at Medicaid Spending, Coverage and Policy Trends," September 2010.

2 Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-for-Service and Capitated Setting, Lewin Group, 2003 (funded by Center for Health Care Strategies)

(47%) would be derived from greater use of generic medications. Lowering payments to pharmacies for both dispensing fees and ingredient costs would collectively yield 40% of the overall savings (with dispensing fees creating the largest *price* savings opportunity). The remaining 13% of the savings would accrue through reductions in the volume of prescriptions in the FFS setting.

Exhibit 2 conveys state-specific Medicaid baseline information on fee-for-service (FFS) pharmacy costs, pharmacy payment levels, and generic utilization. Exhibit 2 also presents the estimated savings from optimal management of FFS pharmacy benefits. Nationwide FFS pharmacy costs are estimated at $18.3 billion in CY2012 (after rebates are collected[3]). Overall, we estimate that Medicaid could realize a net CY2012 savings of $2.6 billion if FFS prescriptions were optimally managed. Such optimal management is estimated to reduce Medicaid FFS prescription drug costs by approximately 15%.

**Exhibit 1. Share of Overall Benefits Management Savings by Component, Across 10-Year Timeframe CY2012-CY2021**

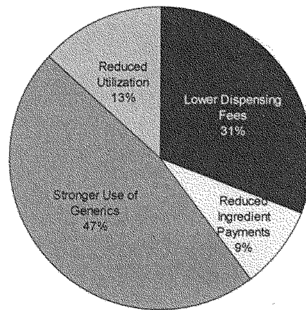


Exhibit 2 presents baseline pharmacy statistics and potential CY2012 savings for each state. States have vastly different baseline FFS pharmacy costs due to the size of their Medicaid programs and the degree to which they use capitation contracting with managed care organizations (MCOs) which includes a pharmacy "carve-in" approach. States also have differing maximum percentage savings opportunities depending on their current dispensing fee and ingredient cost structures, and their existing brand and generic mix of Medicaid medications. The savings figures are expressed in net terms to account for the impacts of Medicaid's large rebates.

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[3] Figures shown in this document generally represent net Medicaid costs and cost savings after rebates are collected. Rebates now represent approximately 40% of initial Medicaid payments to pharmacies. Thus gross pharmacy costs are considerably higher. We have presented only net costs except in the case of per member per month (PMPM) data because PMPM cost statistics are traditionally focused on the initial payments being made to pharmacies.

**Exhibit 2. State-Specific Medicaid FFS Pharmacy Expenditures and Savings Opportunities**

| State | % of Total Rx Costs in FFS Setting | Medicaid FFS Dispensing Fee | Generic Dispensing Rate | % Savings from Optimal Rx Benefits Management | Net Savings from Optimal Rx Benefits Management, 2012 |
|---|---|---|---|---|---|
| Alabama * | 100% | * | 72% | 18.1% | $60,228,367 |
| Alaska | 100% | $7.46 | 64% | 21.7% | $17,636,453 |
| Arizona ** | 1% | $2.00 | 0% | 0.0% | $0 |
| Arkansas | 100% | $5.51 | 66% | 14.2% | $32,750,788 |
| California | 76% | $7.25 | 64% | 19.0% | $380,873,331 |
| Colorado | 83% | $4.00 | 69% | 9.8% | $16,686,692 |
| Connecticut | 100% | $3.15 | 64% | 11.0% | $31,250,369 |
| Delaware | 59% | $3.65 | 67% | 12.0% | $10,395,627 |
| District of Columbia | 100% | $4.50 | 67% | 17.9% | $6,202,639 |
| Florida | 71% | $3.73 | 67% | 12.4% | $99,168,293 |
| Georgia | 52% | $4.63 | 67% | 17.4% | $69,037,036 |
| Hawaii | 56% | $4.67 | 79% | 12.3% | $691,455 |
| Idaho | 100% | $4.94 | 68% | 17.0% | $13,550,994 |
| Illinois | 100% | $4.27 | 73% | 13.1% | $111,857,318 |
| Indiana | 100% | $4.90 | 73% | 12.2% | $53,960,616 |
| Iowa | 100% | $4.57 | 69% | 16.5% | $28,781,116 |
| Kansas | 63% | $3.40 | 67% | 10.6% | $14,184,388 |
| Kentucky | 80% | $4.87 | 73% | 14.2% | $54,266,177 |
| Louisiana | 100% | $5.77 | 64% | 16.0% | $92,372,081 |
| Maine | 100% | $3.35 | 65% | 12.9% | $15,725,867 |
| Maryland | 41% | $3.31 | 62% | 12.9% | $31,005,971 |
| Massachusetts | 56% | $3.00 | 77% | 5.4% | $15,921,464 |
| Michigan | 45% | $2.75 | 67% | 10.3% | $36,795,008 |
| Minnesota | 46% | $3.65 | 72% | 10.9% | $18,514,773 |
| Mississippi | 100% | $4.37 | 71% | 11.3% | $25,387,412 |
| Missouri | 76% | $4.09 | 71% | 14.2% | $71,913,520 |
| Montana | 100% | $5.04 | 71% | 11.3% | $4,933,241 |
| Nebraska | 100% | $3.27 | 75% | 10.7% | $11,386,486 |
| Nevada | 76% | $4.76 | 71% | 10.7% | $7,087,982 |
| New Hampshire | 100% | $1.75 | 70% | 5.4% | $3,887,877 |
| New Jersey | 62% | $3.73 | 63% | 12.5% | $45,104,577 |
| New Mexico | 5% | $3.65 | 70% | 8.9% | $571,334 |
| New York | 100% | $4.13 | 63% | 15.1% | $411,615,383 |
| North Carolina | 100% | $5.05 | 65% | 19.0% | $150,337,202 |
| North Dakota | 100% | $5.29 | 69% | 19.7% | $4,921,642 |
| Ohio | 39% | $3.70 | 71% | 9.6% | $86,980,666 |
| Oklahoma | 100% | $4.15 | 70% | 11.2% | $42,566,846 |
| Oregon * | 43% | * | 71% | 8.3% | $8,955,460 |
| Pennsylvania | 24% | $4.00 | 70% | 10.4% | $32,975,428 |
| Rhode Island | 46% | $3.40 | 71% | 19.6% | $1,559,716 |
| South Carolina | 85% | $4.05 | 65% | 17.2% | $53,634,426 |
| South Dakota | 100% | $4.75 | 68% | 18.1% | $7,367,152 |
| Tennessee | 100% | $2.74 | 47% | 10.2% | $45,600,589 |
| Texas | 100% | $7.50 | 69% | 19.0% | $272,613,603 |
| Utah | 100% | $3.90 | 73% | 9.7% | $9,574,517 |
| Vermont | 100% | $4.75 | 64% | 16.0% | $11,260,858 |
| Virginia | 49% | $3.75 | 73% | 14.5% | $27,635,251 |
| Washington | 66% | $4.75 | 76% | 8.4% | $20,931,842 |
| West Virginia | 100% | $4.38 | 67% | 14.2% | $33,361,338 |
| Wisconsin | 58% | $3.76 | 65% | 13.6% | $36,880,813 |
| Wyoming | 100% | $5.00 | 69% | 16.5% | $4,307,317 |
| **US Total** | **73%** | **$4.81** | **68%** | **14.5%** | $2,645,209,301 |

* Alabama and Oregon recently adopted a payment model whereby pharmacies are paid at their average acquisition cost plus a dispensing fee of more than $10.00. To the extent these initiatives lower net prices, less savings will be achievable in these two states than the figures indicated in the right-hand column. Roughly 65% of Alabama's total potential savings and 30% of Oregon's were projected to occur through reductions in the unit prices paid to pharmacies.

** Since nearly all of Arizona's Medicaid prescriptions are paid for by the MCOs with which the State contracts, we assume that further pharmacy benefits management savings are not attainable in this state.

## III. Savings Estimate Derivation

The starting point for our analyses involved drawing upon publicly available CMS Medicaid pharmacy data on FFS expenditures for brand and generic medications in each state.[4] The most recent year's FFS costs (2009 for nearly all states) were trended to CY2011. These baseline costs and usage figures are shown in detail in Appendix A. These figures exclude Medicaid prescriptions purchased by Medicaid MCOs, and represent the amounts paid to pharmacies prior to the receipt of rebates from drug manufacturers.

The assumptions used to estimate the savings from each pharmacy cost management technique are described below, along with an overview of how these assumptions were derived.

### A. Reduced Dispensing Fees

On average, Medicaid FFS programs pay pharmacies a dispensing fee of $4.60 for brand drugs and $4.90 for generic drugs, more than twice the amount paid by private sector health plans. For states with Medicaid FFS dispensing fees above average Medicare Part D dispensing fees, we assumed that under PBM management the Medicaid dispensing fees will decrease to the typical Medicare Part D levels (estimated at $1.90 for brand drugs and $2.20 for generic drugs).[5]

### B. Reduced Ingredient Costs

The rate at which retail pharmacies are reimbursed for the actual medication ingredients (pills, capsules, etc) is also higher, on average, in Medicaid FFS programs than in Medicare Part D or the commercial sector. The ingredient cost reimbursement amount is computed based on either a published price benchmark, such as Average Wholesale Price (AWP), or on a fixed price per unit, such as a Maximum Allowable Cost (MAC). Pharmacies earn revenue on the difference or "spread" between their acquisition cost and ingredient cost reimbursement amount. This revenue source is often greater than revenues from dispensing fees.

Many Medicaid FFS programs pay higher ingredient costs to pharmacies for brand and generic drugs than do other programs.[6] Our model projects that if Medicaid FFS programs more actively managed their pharmacy benefits, ingredient costs would go down due to the negotiated pharmacy price reductions for both brand and generic drugs.

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[4] Available Online: http://www.cms.gov/MedicaidDrugRebateProgram/SDUD/list.asp. Data for Indiana, Ohio, Tennessee and Wisconsin were derived from a separate source (CMS MSIS website data) given that the baseline FFS costs in the first source were found to be incomplete for purposes of future trending - often due to a recent adoption of a pharmacy carve-out model within the state's Medicaid managed care program.

[5] "Memorandum Report: Medicare Part D Pharmacy Discounts for 2008, OEI-02-10-00120," DHHS Office of the Inspector General, November 2010.

[6] "Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid," DHHS Office of the Inspector General, February 2009; "Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid," DHHS Office of the Inspector General, February 2009; CMS Medicaid Pharmacy Reimbursement Information, Available Online: <http://www.cms.gov/Reimbursement/>, Accessed July 2010.

For brand drugs, we estimated that the AWP "discount rates" (the payment amounts negotiated below full AWP pricing levels) for some states will increase to reflect brand discount rates for Medicare Part D and commercial MCO plans. While prior data have shown Part D and commercial plans reimburse approximately 16% off of AWP, the recent reductions made in the calculation of AWP has changed the current discount rates.[7] Many Part D and commercial plans did not alter their reimbursement rates in lock-step with the AWP reductions, so the discount rate has decreased for many plans. Lewin's analysis of proprietary Part D data found average discount rates of approximately 13% off of AWP, which we used for our benchmark. For states with a brand AWP discount rate below 13%, we brought them up to 13%; we did not make any changes to the brand discount if a state's current brand AWP discount is higher than 13%.

Most Medicaid FFS programs have multiple pricing points for generic drugs and generally choose the lower of: 1) Federal Upper Limit (FUL) amount, 2) State Maximum Allowable Charge (MAC), 3) discount off of AWP, 4) usual and customary charges. Several OIG reports have shown Medicaid reimbursement for generic drugs to be well above that of Part D and commercial plans.[8] For generic drugs on the FUL list, the OIG reported that states paid in aggregate an estimated 84% more than Part D. However, the recent change in the FUL calculation to be no less than 175% of AMP will likely bring these drugs closer to those of other payers.[9] As the new FULs will likely bring generic ingredient cost down on several drugs, we have not assumed any additional savings would occur for drugs on the FUL list as reimbursement for several of these drugs will be reduced regardless of a state's actions. Approximately 53% of Medicaid FFS generic drug expenditures were for drugs on the FUL.[10]

For drugs not on the FUL list, there would still be opportunities to bring Medicaid generic ingredient costs in line with other payers. The OIG's analysis on a selection of top generic drugs found that the average Medicaid pharmacy reimbursement amount exceeded Part D by at least 10% for the majority of drugs in their sample, with the median being 17% higher than Part D. Using this information, we took a conservative approach and estimated that states could reduce generic ingredient costs up to 10% for generic drugs not on the FUL list. We used the states' published AWP discounts for generic drugs as a proxy to indicate their current aggressiveness

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7 "2009-2010 Prescription Drug Benefit Cost and Plan Design Report," Pharmacy Benefit Management Institute and Lewin analysis of proprietary Part D data.

8 "Comparing Pharmacy Reimbursement: Medicare Part D to Medicaid," DHHS Office of the Inspector General, February 2009; "A Comparison of Medicaid Federal Upper Limit Amounts to Acquisition Costs, Medicare Payment Amounts, and Retail Prices," DHHS Office of the Inspector General, August 2009

9 The OIG found that the AMP-based FUL amounts for ingredient costs under the DRA-mandated method (never implemented due to an injunction) were slightly less than average Part D payments. With the new definition of AMP and formula for determining FULs projected to increase FULs over the DRA amounts, it is likely that the new FULs will be at or above average Part D payments.

10 Coster, John, "Trends in Generic Drug Reimbursement in Medicaid and Medicare", *US Pharmacist*, 2010; 35(6)(Generic Drug Review suppl):14-19; US Government Accountability Office, "Medicaid Outpatient Prescription Drugs: Second Quarter 2008 Federal Upper Limits for Reimbursement Compared with Average Retail Pharmacy Acquisition Costs," GAO-10-118R Medicaid Federal Upper Limit, November 30, 2009.

on generic pricing.[11] We applied up to a 10 percentage point increase on generic AWP discount rates, on a sliding-scale basis, to the state's current level of generic drug reimbursement. We estimated a greater increase in generic discount for states currently with lower generic discount rates. For example, a state with a 5% generic AWP discount rate would move to 15%; a state with a 50% generic AWP discount rate would move only slightly to 51%. We applied these savings only to the estimated generic drug ingredient costs on drugs not on the FUL list (on average, 47% of the generic drug ingredient costs).[12]

### C. Increased Generic Dispensing Rate

Medicaid MCOs have consistently demonstrated a generic dispensing rate several percentage points above that achieved directly by Medicaid FFS programs for the Temporary Assistance for Needy Families (TANF) and Supplemental Security Income (SSI) populations.[13, 14] While generic dispensing rates have been several percentage points higher for TANF subgroups than for SSI subgroups due to the different mix of medications used, all available data indicates that MCOs have used more generics than the FFS setting for *both* subgroups.

MCOs tend to have more restrictive PDLs and enforce them more diligently. Most state FFS programs have preferred drug lists but their content is politically changeable and it is generally easier to get the non-PDL medications prescribed in FFS than in the MCO setting. MCOs are better able to remain focused on clinical and cost dynamics with regard to their PDL content and exception processes.

We modeled the savings on a sliding scale in each state. Each state was moved from its observed baseline generic dispensing rate to a target of 70-80%. States with lower generic fill rates were assumed to make greater improvements. For example, a state with a generic dispensing rate of 65% was shifted to 70%; a state with a 70% generic dispensing rate was shifted to 73%.

### D. Decreased Utilization

Medicaid MCOs have additionally demonstrated a lower prescription utilization rate than Medicaid FFS programs with similar demographic subgroups.[15] There are several causes for unnecessary and inappropriate prescription usage including fraud, prescription drug abuse,

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[11] CMS Medicaid Pharmacy Reimbursement Information, Available Online: <http://www.cms.gov/Reimbursement/>, Accessed July 2010.

[12] US Government Accountability Office, "Medicaid Outpatient Prescription Drugs: Second Quarter 2008 Federal Upper Limits for Reimbursement Compared with Average Retail Pharmacy Acquisition Costs," GAO-10-118R Medicaid Federal Upper Limit, November 30, 2009. We used the 53% reported in the US Pharmacist article and state-level information on FUL drugs from the GAO report to estimate state-level ingredient costs for non-FUL drugs.

[13] Programmatic Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs, The Lewin Group, 2007 (funded by Association for Community Affiliated Plans)

[14] Comparison of Medicaid Pharmacy Costs and Usage Between the Fee-for-Service and Capitated Setting, The Lewin Group, 2003 (funded by Center for Health Care Strategies), page 7.

[15] Programmatic Assessment of Carve-In and Carve-Out Arrangements for Medicaid Prescription Drugs, Lewin Group, 2007 (funded by Association for Community Affiliated Plans)

inefficient prescribing, and other factors. Collectively these problem areas seem to be more pronounced in the Medicaid FFS setting than in a more closely managed environment. While we have evidence of rather large-scale usage rate differentials between the Medicaid FFS and Medicaid managed care settings, we have conservatively assumed a 3% decrease in utilization from PBM management practices (relative to FFS) for this report.

### E. Increased Administrative Costs

These changes in reimbursement and utilization management will require an increase in administrative functions and oversight. We assumed that payments to external contractors (or increased operating costs if the state "self-performs" the enhanced pharmacy management functions) would represent 3%of gross pharmacy costs.

## IV. Ten-Year Savings Estimates

Savings estimates were initially derived for calendar year 2010. These figures were then projected forward across a ten-year timeframe CY2012 - CY2021 using the following assumptions.

An annual pharmacy cost trend factor of 2.18% was used to estimate the regular growth of annual Medicaid FFS spending. This percentage is a "roll-up" of additional assumptions regarding population growth and general inflation in pharmacy costs and usage. The trend factor also includes an assumption that the use of capitated MCOs will steadily increase in the Medicaid program (which reduces the amount of FFS pharmacy spending that is available for enhanced management).

The ten-year projections also factor in expected Medicaid enrollment growth created by the coverage expansion features of the Affordable Care Act (ACA). The increased FFS pharmacy costs anticipated to accompany the ACA's Medicaid coverage expansion were derived through the following steps:

- Lewin Group estimates of the size of the Medicaid expansion population in each state were drawn upon as a starting point.
- Total pharmacy costs for each expansion enrollee were estimated based on observed pharmacy costs for selected covered adults in Tennessee. This state already provides coverage to a large population of adults that is demographically similar to the Medicaid expansion population that will enroll in most other states.
- FFS pharmacy costs were derived based on the degree to which Medicaid TANF costs in each state were paid via capitation or via FFS during 2008.
- The Medicaid expansion population was estimated to enroll 50% in the initial year (CY2014) and to be fully enrolled from CY2015 onward.

Exhibit 3 presents the net savings estimates across the 10 year timeframe 2012-2021. These net savings are estimated to be $32.7 billion across CY2012 - CY2021, with nationwide annual savings starting at $2.6 billion in CY2012 and reaching $3.7 billion in CY2021.

Exhibit 3.
Nationwide Annual Savings if Medicaid Pharmacy Were Optimally Managed, 2012-2021

| Calendar Year | Total Savings |
|---|---|
| 2012 | $2,645,209,301 |
| 2013 | $2,702,821,959 |
| 2014 | $2,976,671,958 |
| 2015 | $3,261,168,728 |
| 2016 | $3,332,196,983 |
| 2017 | $3,404,772,233 |
| 2018 | $3,478,928,173 |
| 2019 | $3,554,699,228 |
| 2020 | $3,632,120,577 |
| 2021 | $3,711,228,164 |
| 10 Year Total, 2012-2021 | $32,699,817,305 |

Note: Figures from CY2014 forward include the estimated impacts of Medicaid enrollment expansion related to the recently enacted health reform legislation.

On average, we estimate that a savings of approximately 15% is achievable if Medicaid pharmacy programs used approaches employed by Medicare Part D payers, Medicare MCOs, state employee health plans, and the commercial sector to determine dispensing fees, ingredient costs, drug utilization, and generic drug dispensing.

## V. The Role of Manufacturer Rebates

It is important to note that Medicaid receives statutory rebates from pharmaceutical manufacturers that substantially lower the program's net costs per prescription. However, these rebates are determined separately from pharmacy dispensing fees and ingredient costs, and occur regardless of levels set for these pharmacy payments. Rebates do not diminish or otherwise impact the savings that are achieved from dispensing fee savings and ingredient cost reductions.

Improved management of *drug mix* - pushing utilization towards medications that are clinically appropriate but which offer Medicaid the lowest net cost - often represents the largest-scale savings opportunity for states. However, since rebates are often largest (in percentage and raw dollar terms) on relatively high-cost medications, the savings created by moving usage from a $100 brand drug to a $30 generic drug needs to be derived net of rebates. (There are some instances where the brand rebate is so large that the lowest net cost involves using the brand medication, for example.) The estimates in this document are therefore all conveyed on a net cost basis, after accounting for rebates. In general, pharmaceutical rebates are estimated to average 40% of initial prescription drug spending under the Affordable Care Act's (ACA) enhanced rebate provisions, and this level of rebates has been applied to the utilization reduction savings component in our calculations.

# VI. Relationship Between Dispensing Fees, Ingredient Costs and Generic Dispensing Rates

We found a positive correlation between dispensing fees and ingredient costs, with states having relatively high dispensing fees also having fairly low average ingredient discounts.

Thus, several states were high-end payers to retail pharmacies for both dispensing fees and ingredient costs.

Lewin examined the state-by-state statistical data to assess:

- whether dispensing fees and ingredient payments appeared to be correlated in some fashion; and
- whether states with relatively high dispensing fees (and relatively high ingredient payments for generics) were achieving a relatively high use of generic medications.

We found no evidence of such a correlation in either case, although with regard to the first issue there are many states with high payment levels for *both* dispensing fees and ingredient costs.

Exhibit 4 shows that the average usage of generics was almost constant when states were grouped by their different dispensing fees. Similarly, Exhibit 5 shows that the use of generics did not vary when states were grouped by their published ingredient discount levels.

**Exhibit 4. Relationship of Dispensing Fees to Generic Dispensing Rates**

| Dispensing Fee Range | Number of States | Average Generic Dispensing Rate | Average Ingredient Discount |
|---|---|---|---|
| $5.00 + | 10 | 67.3% | 12.3% |
| $3.50 - $4.99 | 30 | 69.5% | 14.1% |
| < $3.50 | 10 | 66.4% | 14.7% |
| **Total** | **50** | **68.5%** | **13.8%** |

**Exhibit 5. Relationship of Ingredient Discounts to Generic Dispensing Rates**

| Ingredient Discount Range | Number of States | Average Generic Dispensing Rate | Average Dispensing Fee |
|---|---|---|---|
| 16% + | 10 | 68.5% | $4.14 |
| 12% - 15.9% | 27 | 68.0% | $4.17 |
| < 12% | 13 | 69.4% | $4.76 |
| **Total** | **50** | **68.5%** | **$4.81** |

Appendix B presents a scatter plot showing each state's generic dispensing rate, its dispensing fee, and its ingredient discount percentage relative to AWP. This diagram visually shows the absence of any correlation between making higher up-front payments to pharmacies and achieving a relatively high use of generics in return.

We also assessed whether there was greater use of generics in states that utilized a higher dispensing fee for generics than they used for brand drugs. Again, no correlation was found. Among the nine states that paid a higher dispensing fee for generic drugs than for brands, the average generic dispensing rate was 65% versus 69% in all states where the same dispensing fee was used for both brand and generics.

## VII. State-Specific Savings Estimates by Eligibility Category

This section calculates state-specific savings by major eligibility category. Per member per month (PMPM) savings have been derived for each of the following eligibility groups (all of which exclude Medicare/Medicaid dual eligibles given that these individuals' pharmacy costs are paid for by the Medicare program):

Blind/Disabled

Children (non-disabled)

Adults (non-disabled)

Foster Children

The PMPM analyses portray baseline (gross) costs and cost savings, since PMPM pharmacy cost assessments are typically conducted focusing on the initial amounts paid to the pharmacies, not the state's net prescription drug expenditures after accounting for manufacturer rebates. Baseline FFS pharmacy costs by state and eligibility category are shown in Exhibit 6 for CY2012. Nationwide, the majority (62%) of Medicaid FFS pharmacy costs are incurred by the Blind/Disabled subgroup. This is due to two factors: first, the Blind/Disabled subgroup experiences very high per capita pharmacy costs; second the TANF population is enrolled in Medicaid MCOs more fully than is the Blind/Disabled population in many states.

Baseline PMPM FFS costs are shown for CY2012 in Exhibit 7. PMPM pharmacy costs for each eligibility subgroup vary considerably – national averages are $273 for the Blind/Disabled, $28 for TANF Children, $55 for TANF Adults, and $82 for Foster Care Children.

Estimated potential PMPM savings against the FFS baseline are shown in Exhibit 8 for each state for CY2012. The PMPM savings average $41 for the Blind/Disabled subgroup, $4 for TANF Children, $8 for TANF Adults, and $12 for Foster Care Children.

**Exhibit 6. Estimated Baseline Medicaid FFS Pharmacy Costs by Eligibility Category, CY2012**

| State | Estimated 2012 Total $ | | | | |
|---|---|---|---|---|---|
| | Blind/Disabled | Children | Adults | Foster Care Children | Total |
| Alabama | $352,946,008 | $156,216,033 | $33,853,812 | $10,674,196 | $553,690,050 |
| Alaska | $75,808,071 | $27,262,779 | $27,769,747 | $4,606,543 | $135,447,139 |
| Arizona | $0 | $0 | $0 | $0 | $0 |
| Arkansas | $211,023,428 | $139,366,127 | $24,006,517 | $9,146,853 | $383,542,925 |
| California | $2,492,361,695 | $271,502,655 | $467,606,414 | $107,026,027 | $3,338,496,790 |
| Colorado | $162,384,429 | $56,815,195 | $40,808,804 | $23,548,637 | $283,557,065 |
| Connecticut | $271,287,105 | $92,396,083 | $103,754,536 | $8,112,613 | $475,550,337 |
| Delaware | $50,901,576 | $22,766,427 | $68,368,696 | $2,830,038 | $144,866,737 |
| District of Columbia | $48,042,649 | $353,646 | $7,624,843 | $1,726,970 | $57,748,108 |
| Florida | $910,997,340 | $238,149,738 | $142,314,827 | $41,302,576 | $1,332,764,480 |
| Georgia | $578,414,836 | $23,910,583 | $14,004,592 | $46,009,822 | $662,339,833 |
| Hawaii | $9,054,924 | $92,139 | $239,040 | $9,651 | $9,395,754 |
| Idaho | $88,102,893 | $26,934,324 | $14,993,144 | $3,006,044 | $133,036,403 |
| Illinois | $704,512,657 | $377,574,143 | $271,414,720 | $69,260,783 | $1,422,762,303 |
| Indiana | $365,910,971 | $196,105,095 | $140,967,834 | $35,972,782 | $738,956,682 |
| Iowa | $154,467,875 | $72,465,965 | $48,138,386 | $16,214,077 | $291,286,303 |
| Kansas | $171,669,588 | $15,480,390 | $5,100,154 | $31,182,930 | $223,433,061 |
| Kentucky | $408,219,118 | $134,911,322 | $77,814,634 | $16,548,255 | $637,493,328 |
| Louisiana | $498,089,955 | $346,888,378 | $99,354,138 | $18,766,169 | $963,098,640 |
| Maine | $91,097,033 | $33,444,496 | $72,911,351 | $5,804,369 | $203,257,249 |
| Maryland | $266,559,163 | $72,803,099 | $30,536,298 | $29,314,741 | $399,213,302 |
| Massachusetts | $330,373,003 | $56,544,682 | $108,163,022 | $580,771 | $495,661,477 |
| Michigan | $357,634,716 | $116,095,976 | $83,588,387 | $38,621,605 | $595,940,684 |
| Minnesota | $224,837,769 | $22,866,595 | $24,662,246 | $9,710,286 | $282,076,897 |
| Mississippi | $217,857,468 | $115,855,934 | $36,171,688 | $5,331,016 | $375,216,107 |
| Missouri | $611,868,174 | $145,058,255 | $57,482,585 | $30,807,353 | $845,216,367 |
| Montana | $45,050,930 | $12,372,737 | $11,696,505 | $3,732,542 | $72,852,714 |
| Nebraska | $73,773,337 | $61,940,568 | $23,126,396 | $19,129,523 | $177,969,823 |
| Nevada | $88,382,863 | $6,115,766 | $6,493,859 | $9,710,235 | $110,702,722 |
| New Hampshire | $53,814,127 | $42,530,899 | $18,303,176 | $4,961,969 | $119,610,172 |
| New Jersey | $552,433,118 | $12,811,404 | $15,184,285 | $20,597,905 | $601,026,711 |
| New Mexico | $6,348,285 | $1,830,390 | $2,534,651 | $43,050 | $10,756,376 |
| New York | $2,478,591,458 | $605,270,130 | $1,419,762,584 | $44,825,693 | $4,548,449,865 |
| North Carolina | $704,869,682 | $355,481,160 | $227,512,460 | $31,073,453 | $1,318,936,756 |
| North Dakota | $21,001,803 | $10,005,740 | $8,632,371 | $1,981,745 | $41,621,659 |
| Ohio | $1,175,454,416 | $100,113,434 | $78,959,631 | $148,278,626 | $1,502,806,106 |
| Oklahoma | $336,285,436 | $221,871,326 | $59,838,923 | $16,683,603 | $634,679,288 |
| Oregon | $120,052,556 | $11,697,511 | $37,442,690 | $10,537,137 | $179,729,893 |
| Pennsylvania | $372,484,854 | $67,699,028 | $64,627,323 | $23,787,174 | $528,598,379 |
| Rhode Island | $12,695,423 | $118,789 | $208,755 | $206,244 | $13,229,211 |
| South Carolina | $262,238,434 | $151,800,163 | $90,474,866 | $14,771,278 | $519,284,741 |
| South Dakota | $31,251,196 | $21,326,908 | $10,044,955 | $5,243,821 | $67,866,880 |
| Tennessee | $371,736,632 | $206,949,104 | $148,672,553 | $17,645,138 | $745,003,427 |
| Texas | $1,229,112,328 | $893,207,566 | $156,726,698 | $113,285,749 | $2,392,332,340 |
| Utah | $87,931,736 | $27,096,665 | $39,731,253 | $9,947,870 | $164,707,525 |
| Vermont | $39,906,122 | $18,592,361 | $54,523,041 | $4,235,857 | $117,257,381 |
| Virginia | $201,061,918 | $51,873,577 | $25,933,145 | $38,605,185 | $317,473,825 |
| Washington | $361,256,748 | $18,903,373 | $22,038,157 | $12,857,089 | $415,055,366 |
| West Virginia | $272,844,798 | $67,549,704 | $42,225,444 | $9,466,536 | $392,086,481 |
| Wisconsin | $272,234,260 | $53,214,936 | $107,424,163 | $20,426,794 | $453,300,153 |
| Wyoming | $20,845,569 | $13,368,384 | $5,800,239 | $3,383,030 | $43,397,222 |
| **US Total** | **$18,846,080,471** | **$5,795,601,681** | **$4,679,568,535** | **$1,151,532,353** | **$30,472,783,039** |

Note: Figures in Exhibits 6-8 represent gross (pre-rebate) payments to pharmacies.
Savings estimates derived throughout this report, conversely, are net of all collected rebates.

Exhibit 7. Estimated Baseline PMPM Medicaid FFS Pharmacy Costs by Eligibility Category, CY2012

| State | 2012 Base PMPM | | | | |
|---|---|---|---|---|---|
| | Blind /Disabled | Children | Adults | Foster Care Children | Total |
| Alabama | $256 | $51 | $57 | $97 | $107 |
| Alaska | $442 | $24 | $78 | $71 | $77 |
| Arizona | $0 | $0 | $0 | $0 | $0 |
| Arkansas | $223 | $28 | $57 | $109 | $60 |
| California | $304 | $27 | $57 | $55 | $118 |
| Colorado | $314 | $24 | $55 | $176 | $75 |
| Connecticut | $546 | $29 | $82 | $85 | $94 |
| Delaware | $301 | $25 | $88 | $96 | $77 |
| District of Columbia | $297 | $27 | $63 | $58 | $178 |
| Florida | $283 | $24 | $38 | $70 | $76 |
| Georgia | $228 | $27 | $57 | $82 | $157 |
| Hawaii | $475 | $28 | $57 | $94 | $352 |
| Idaho | $310 | $19 | $70 | $73 | $67 |
| Illinois | $271 | $19 | $44 | $73 | $48 |
| Indiana | $302 | $27 | $57 | $92 | $161 |
| Iowa | $309 | $27 | $34 | $103 | $62 |
| Kansas | $321 | $21 | $38 | $167 | $141 |
| Kentucky | $261 | $38 | $77 | $95 | $101 |
| Louisiana | $284 | $39 | $50 | $124 | $75 |
| Maine | $296 | $26 | $73 | $108 | $77 |
| Maryland | $257 | $26 | $43 | $112 | $82 |
| Massachusetts | $109 | $25 | $53 | $115 | $67 |
| Michigan | $313 | $24 | $51 | $78 | $74 |
| Minnesota | $311 | $23 | $53 | $84 | $124 |
| Mississippi | $178 | $29 | $57 | $75 | $63 |
| Missouri | $430 | $47 | $65 | $86 | $147 |
| Montana | $333 | $23 | $78 | $77 | $84 |
| Nebraska | $368 | $37 | $68 | $115 | $75 |
| Nevada | $303 | $27 | $57 | $85 | $149 |
| New Hampshire | $325 | $32 | $79 | $111 | $68 |
| New Jersey | $510 | $27 | $36 | $63 | $261 |
| New Mexico | $46 | $27 | $57 | $12 | $42 |
| New York | $377 | $24 | $63 | $57 | $82 |
| North Carolina | $315 | $32 | $71 | $111 | $78 |
| North Dakota | $317 | $26 | $62 | $74 | $67 |
| Ohio | $196 | $27 | $57 | $83 | $117 |
| Oklahoma | $289 | $28 | $37 | $68 | $58 |
| Oregon | $343 | $27 | $103 | $75 | $140 |
| Pennsylvania | $216 | $38 | $70 | $76 | $111 |
| Rhode Island | $206 | $27 | $57 | $17 | $162 |
| South Carolina | $229 | $29 | $42 | $69 | $59 |
| South Dakota | $253 | $23 | $51 | $88 | $52 |
| Tennessee | $183 | $26 | $52 | $84 | $58 |
| Texas | $262 | $32 | $36 | $132 | $64 |
| Utah | $361 | $28 | $61 | $94 | $83 |
| Vermont | $312 | $26 | $93 | $120 | $80 |
| Virginia | $196 | $27 | $45 | $153 | $85 |
| Washington | $305 | $27 | $30 | $55 | $145 |
| West Virginia | $302 | $33 | $97 | $96 | $113 |
| Wisconsin | $133 | $27 | $39 | $41 | $62 |
| Wyoming | $299 | $26 | $60 | $84 | $60 |
| **US Total** | **$273** | **$28** | **$55** | **$82** | **$83** |

**Exhibit 8. Estimated PMPM Pharmacy Benefit Management Savings Against Baseline Medicaid FFS Pharmacy Costs, by State and Eligibility Category, CY2012**

| State | 2012 Base PMPM Savings | | | | |
|---|---|---|---|---|---|
| | Blind/Disabled | Children | Adults | Foster Care Children | Total |
| Alabama | $39 | $8 | $9 | $15 | $16 |
| Alaska | $75 | $4 | $13 | $12 | $13 |
| Arizona | | | | | |
| Arkansas | $32 | $4 | $8 | $16 | $9 |
| California | $57 | $5 | $11 | $10 | $22 |
| Colorado | $36 | $3 | $6 | $20 | $9 |
| Connecticut | $75 | $4 | $11 | $12 | $13 |
| Delaware | $41 | $3 | $12 | $13 | $11 |
| District of Columbia | $50 | $5 | $11 | $10 | $30 |
| Florida | $42 | $4 | $6 | $10 | $11 |
| Georgia | $39 | $5 | $10 | $14 | $27 |
| Hawaii | $48 | $3 | $6 | $9 | $36 |
| Idaho | $53 | $3 | $12 | $12 | $11 |
| Illinois | $35 | $2 | $6 | $9 | $6 |
| Indiana | $39 | $4 | $7 | $12 | $21 |
| Iowa | $51 | $5 | $6 | $17 | $10 |
| Kansas | $42 | $3 | $5 | $22 | $18 |
| Kentucky | $35 | $5 | $10 | $13 | $14 |
| Louisiana | $46 | $6 | $8 | $20 | $12 |
| Maine | $45 | $4 | $11 | $16 | $12 |
| Maryland | $38 | $4 | $6 | $16 | $12 |
| Massachusetts | $6 | $1 | $3 | $7 | $4 |
| Michigan | $41 | $3 | $7 | $10 | $10 |
| Minnesota | $36 | $3 | $6 | $10 | $14 |
| Mississippi | $20 | $3 | $6 | $8 | $7 |
| Missouri | $56 | $6 | $8 | $11 | $19 |
| Montana | $37 | $3 | $9 | $9 | $9 |
| Nebraska | $38 | $4 | $7 | $12 | $8 |
| Nevada | $34 | $3 | $6 | $10 | $17 |
| New Hampshire | $26 | $3 | $6 | $9 | $5 |
| New Jersey | $75 | $4 | $5 | $9 | $38 |
| New Mexico | $5 | $3 | $6 | $1 | $4 |
| New York | $65 | $4 | $11 | $10 | $14 |
| North Carolina | $55 | $6 | $12 | $19 | $14 |
| North Dakota | $56 | $4 | $11 | $13 | $12 |
| Ohio | $22 | $3 | $6 | $9 | $13 |
| Oklahoma | $35 | $3 | $5 | $8 | $7 |
| Oregon | $34 | $3 | $10 | $7 | $14 |
| Pennsylvania | $24 | $4 | $8 | $9 | $13 |
| Rhode Island | $35 | $5 | $10 | $3 | $27 |
| South Carolina | $40 | $5 | $7 | $12 | $10 |
| South Dakota | $44 | $4 | $9 | $15 | $9 |
| Tennessee | $23 | $3 | $7 | $11 | $7 |
| Texas | $45 | $6 | $6 | $23 | $11 |
| Utah | $38 | $3 | $6 | $10 | $9 |
| Vermont | $54 | $5 | $16 | $21 | $14 |
| Virginia | $27 | $4 | $6 | $21 | $11 |
| Washington | $24 | $2 | $2 | $4 | $11 |
| West Virginia | $46 | $5 | $15 | $15 | $17 |
| Wisconsin | $20 | $4 | $6 | $6 | $9 |
| Wyoming | $47 | $4 | $9 | $13 | $9 |
| **US Total** | **$41** | **$4** | **$8** | **$12** | **$12** |

## VIII. Federal and State Share of Savings

This section portrays the degree to which net savings on prescription drugs (after manufacturer rebates are taken into account) will accrue to each state government versus the Federal government. The share of overall savings between state and the Federal governments is driven by Federal matching rates. We have assumed the Federal match rates will revert to "normal" levels during the 2012-2021 timeframe, given that under current law the enhanced Federal match rates will be discontinued effective July CY2011.

Due to the Affordable Care Act (ACA), the Medicaid expansion population will be funded almost entirely by the Federal government. Therefore, we assumed the pharmacy savings attributable to the Medicaid expansion population during 2014-2021 will be 100% Federal savings.

There are also some complexities between the Federal and state match regarding "clawback" provisions of the ACA related to drug manufacturer rebates. These dynamics have not been factored into our estimates and will have only a minor impact on the share of the savings yielded from enhanced pharmacy benefits management activities.

The estimated ten-year savings in each state, and the Federal and state share of those savings, is presented in Exhibit 9. The Federal government would realize the majority of the savings (62% on average nationwide), since its matching rate is at least 50% in each state. State fund savings from strengthened Medicaid FFS pharmacy benefits management practices would nonetheless be very large in magnitude, particularly in consideration of the fiscal environment confronting nearly all state governments. The ten-year state fund savings potential exceeds $2 billion in California and New York, exceeds $1 billion in Texas, and exceeds $100 million in 22 other states.

**Exhibit 9. Estimated Ten-Year Pharmacy Benefits Management Savings Against Baseline Medicaid FFS Costs, Showing State and Federal Share of Savings, CY2012-CY2021**

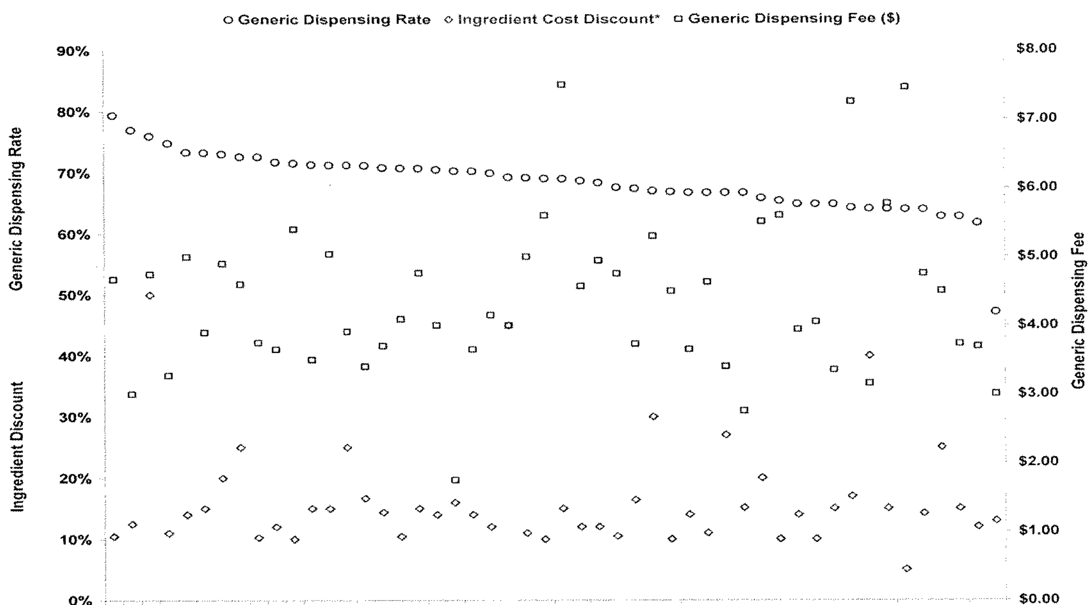
| State | 10 Year Total Net Savings, 2012-2021 | Regular Federal Match Rate (Existing Medicaid) | Federal Share of Net Savings (%) | Federal Share of Net Savings | State Share of Net Savings |
|---|---|---|---|---|---|
| Alabama | $754,283,850 | 68.01% | 71.39% | $541,589,986 | $212,693,864 |
| Alaska | $215,795,688 | 52.48% | 56.61% | $123,277,462 | $92,518,227 |
| Arizona | $0 | | | $0 | $0 |
| Arkansas | $431,416,077 | 72.94% | 76.86% | $333,582,219 | $97,833,858 |
| California | $4,766,748,752 | 50.00% | 55.25% | $2,664,470,481 | $2,102,278,271 |
| Colorado | $237,233,703 | 50.00% | 60.08% | $145,129,408 | $92,104,295 |
| Connecticut | $367,654,226 | 50.00% | 52.73% | $195,163,881 | $172,490,345 |
| Delaware | $117,607,540 | 50.21% | 51.27% | $60,468,563 | $57,138,977 |
| District of Columbia | $72,147,948 | 70.00% | 71.35% | $51,606,201 | $20,541,747 |
| Florida | $1,304,852,861 | 56.83% | 63.05% | $832,251,989 | $472,600,872 |
| Georgia | $824,347,552 | 65.10% | 67.43% | $558,368,644 | $265,978,908 |
| Hawaii | $10,104,490 | 56.50% | 66.12% | $6,784,074 | $3,320,416 |
| Idaho | $183,776,906 | 69.87% | 74.90% | $138,704,585 | $45,072,321 |
| Illinois | $1,418,325,317 | 50.32% | 56.05% | $804,866,203 | $613,459,114 |
| Indiana | $381,476,268 | 65.93% | 68.39% | $262,094,024 | $119,382,245 |
| Iowa | $381,537,087 | 63.51% | 68.98% | $265,600,337 | $115,936,750 |
| Kansas | $166,825,210 | 60.38% | 62.53% | $104,786,220 | $62,038,990 |
| Kentucky | $663,904,563 | 70.96% | 73.48% | $489,938,125 | $173,966,438 |
| Louisiana | $1,160,133,184 | 72.47% | 75.44% | $879,404,642 | $280,728,542 |
| Maine | $185,456,818 | 64.99% | 66.97% | $124,678,825 | $60,777,993 |
| Maryland | $367,616,767 | 50.00% | 53.05% | $196,475,409 | $171,141,358 |
| Massachusetts | $175,071,595 | 50.00% | 49.83% | $87,191,071 | $87,880,524 |
| Michigan | $453,573,163 | 63.19% | 66.61% | $304,054,861 | $149,518,302 |
| Minnesota | $216,899,269 | 50.00% | 52.55% | $114,704,650 | $102,194,619 |
| Mississippi | $346,859,255 | 76.29% | 80.38% | $280,410,076 | $66,449,179 |
| Missouri | $841,206,791 | 64.51% | 66.27% | $559,461,818 | $281,744,973 |
| Montana | $71,270,067 | 68.53% | 75.24% | $54,131,730 | $17,138,337 |
| Nebraska | $149,061,637 | 60.56% | 66.09% | $99,486,235 | $49,575,402 |
| Nevada | $95,414,317 | 52.64% | 60.28% | $58,357,006 | $37,057,311 |
| New Hampshire | $50,083,040 | 50.00% | 56.39% | $28,623,415 | $21,459,624 |
| New Jersey | $520,442,515 | 50.00% | 51.91% | $271,482,125 | $248,960,390 |
| New Mexico | $11,729,900 | 71.35% | 83.67% | $9,922,916 | $1,806,984 |
| New York | $4,561,839,751 | 50.00% | 50.17% | $2,289,876,858 | $2,271,962,894 |
| North Carolina | $1,917,502,934 | 65.13% | 69.31% | $1,338,796,858 | $578,706,077 |
| North Dakota | $68,118,838 | 63.75% | 70.35% | $48,423,763 | $19,695,075 |
| Ohio | $989,615,330 | 63.42% | 65.75% | $638,373,638 | $351,241,692 |
| Oklahoma | $525,549,555 | 67.10% | 70.20% | $370,950,440 | $154,599,115 |
| Oregon | $112,850,493 | 62.74% | 66.85% | $76,014,671 | $36,835,822 |
| Pennsylvania | $389,098,796 | 54.81% | 57.39% | $224,596,327 | $164,502,469 |
| Rhode Island | $20,857,795 | 52.63% | 60.05% | $12,701,582 | $8,156,214 |
| South Carolina | $686,704,460 | 70.32% | 73.97% | $510,973,952 | $175,730,508 |
| South Dakota | $97,860,575 | 62.72% | 68.36% | $67,541,553 | $30,319,022 |
| Tennessee | $583,559,943 | 65.57% | 87.09% | $410,240,570 | $173,319,372 |
| Texas | $3,787,052,128 | 60.56% | 67.85% | $2,600,124,983 | $1,186,927,145 |
| Utah | $137,272,168 | 71.68% | 77.56% | $107,339,203 | $29,932,965 |
| Vermont | $124,204,614 | 59.45% | 59.42% | $73,796,325 | $50,408,289 |
| Virginia | $362,343,191 | 50.00% | 57.07% | $209,806,945 | $152,536,246 |
| Washington | $248,420,229 | 51.52% | 54.52% | $136,396,587 | $112,023,642 |
| West Virginia | $409,137,515 | 74.25% | 76.53% | $314,304,332 | $94,833,184 |
| Wisconsin | $429,986,267 | 60.21% | 62.25% | $267,986,623 | $161,999,644 |
| Wyoming | $59,704,387 | 50.00% | 59.16% | $35,929,608 | $23,774,779 |
| **US Total** | $32,454,535,323 | **58.08%** | **62.26%** | **$20,381,241,995** | **$12,073,293,328** |

## Appendix A. Baseline Pharmacy Costs, CY2011

| State | 2011 FFS Rx Reimbursement | | | 2011 FFS Rx Scripts | | |
|---|---|---|---|---|---|---|
| | Brand | Generic | Total | Brand | Generic | Total |
| Alabama | $394,250,595 | $147,637,139 | $541,887,735 | 2,375,986 | 5,973,081 | 8,349,068 |
| Alaska | $78,922,265 | $53,637,717 | $132,559,982 | 362,218 | 643,002 | 1,005,220 |
| Arizona | $0 | $0 | $0 | - | - | - |
| Arkansas | $288,982,365 | $86,385,058 | $375,367,423 | 1,643,686 | 3,165,193 | 4,808,879 |
| California | $2,753,907,069 | $513,427,181 | $3,267,334,250 | 12,336,101 | 22,151,313 | 34,487,414 |
| Colorado | $217,320,675 | $60,192,161 | $277,512,836 | 999,645 | 2,248,514 | 3,248,159 |
| Connecticut | $376,586,576 | $88,827,053 | $465,413,629 | 1,911,195 | 3,408,484 | 5,319,679 |
| Delaware | $116,699,273 | $25,079,522 | $141,778,795 | 629,570 | 1,262,635 | 1,892,206 |
| District of Columbia | $45,114,447 | $11,402,716 | $56,517,164 | 215,901 | 435,620 | 651,521 |
| Florida | $1,135,737,595 | $168,618,020 | $1,304,355,615 | 4,859,794 | 10,030,041 | 14,889,835 |
| Georgia | $553,142,795 | $95,078,772 | $648,221,567 | 2,610,131 | 5,230,197 | 7,840,327 |
| Hawaii | $7,045,583 | $2,149,894 | $9,195,476 | 25,727 | 99,168 | 124,895 |
| Idaho | $109,669,206 | $20,531,428 | $130,200,634 | 542,856 | 1,171,197 | 1,714,053 |
| Illinois | $1,113,299,362 | $279,135,705 | $1,392,435,067 | 6,541,253 | 17,350,303 | 23,891,556 |
| Indiana | $625,908,363 | $97,296,908 | $723,205,271 | 2,486,099 | 6,739,690 | 9,225,789 |
| Iowa | $244,214,095 | $40,863,224 | $285,077,319 | 1,342,965 | 2,941,186 | 4,284,151 |
| Kansas | $183,730,695 | $34,939,725 | $218,670,420 | 720,962 | 1,443,319 | 2,164,281 |
| Kentucky | $479,160,920 | $144,743,764 | $623,904,684 | 3,007,443 | 8,282,184 | 11,289,627 |
| Louisiana | $712,986,194 | $229,583,283 | $942,569,477 | 4,033,918 | 7,177,591 | 11,211,509 |
| Maine | $175,479,953 | $23,444,717 | $198,924,670 | 1,062,090 | 1,955,984 | 3,018,074 |
| Maryland | $304,682,101 | $86,021,673 | $390,703,774 | 1,082,670 | 1,745,146 | 2,827,816 |
| Massachusetts | $383,307,071 | $101,789,013 | $485,096,084 | 1,874,014 | 6,278,369 | 8,152,382 |
| Michigan | $506,152,892 | $77,084,873 | $583,237,765 | 2,350,182 | 4,699,337 | 7,049,518 |
| Minnesota | $224,515,281 | $51,548,938 | $276,064,218 | 1,001,395 | 2,541,868 | 3,543,263 |
| Mississippi | $267,541,603 | $99,676,494 | $367,218,097 | 1,540,225 | 3,809,825 | 5,350,051 |
| Missouri | $650,115,928 | $177,084,025 | $827,199,952 | 3,220,939 | 7,768,991 | 10,989,930 |
| Montana | $52,571,613 | $18,728,191 | $71,299,804 | 260,791 | 645,309 | 906,101 |
| Nebraska | $135,617,813 | $38,558,452 | $174,176,264 | 700,828 | 2,084,214 | 2,785,042 |
| Nevada | $88,499,332 | $19,843,680 | $108,343,011 | 374,608 | 902,747 | 1,277,355 |
| New Hampshire | $95,761,440 | $21,299,152 | $117,060,592 | 462,776 | 1,093,395 | 1,556,171 |
| New Jersey | $462,067,065 | $126,148,315 | $588,215,380 | 2,167,290 | 3,651,024 | 5,818,314 |
| New Mexico | $8,700,630 | $1,826,466 | $10,527,096 | 40,519 | 95,612 | 136,131 |
| New York | $3,810,717,623 | $640,778,652 | $4,451,496,276 | 19,580,270 | 33,032,611 | 52,612,881 |
| North Carolina | $1,055,482,753 | $235,339,886 | $1,290,822,638 | 5,748,271 | 10,859,038 | 16,607,309 |
| North Dakota | $32,761,096 | $7,973,366 | $40,734,463 | 181,885 | 405,096 | 586,981 |
| Ohio | $1,261,923,056 | $208,849,621 | $1,470,772,678 | 6,281,091 | 15,212,591 | 21,493,682 |
| Oklahoma | $534,811,995 | $86,338,632 | $621,150,627 | 1,638,741 | 3,807,588 | 5,446,330 |
| Oregon | $143,588,227 | $32,310,590 | $175,898,817 | 575,027 | 1,427,839 | 2,002,866 |
| Pennsylvania | $441,250,820 | $76,080,092 | $517,330,912 | 2,277,308 | 5,433,030 | 7,710,338 |
| Rhode Island | $10,908,571 | $2,038,649 | $12,947,220 | 253,065 | 624,150 | 877,215 |
| South Carolina | $438,277,123 | $69,938,678 | $508,215,801 | 1,554,056 | 2,862,281 | 4,416,336 |
| South Dakota | $54,464,946 | $11,955,302 | $66,420,247 | 269,019 | 560,724 | 829,743 |
| Tennessee | $583,298,500 | $145,824,625 | $729,123,125 | 3,424,030 | 6,908,063 | 10,332,093 |
| Texas | $1,822,064,765 | $519,273,234 | $2,341,337,999 | 9,780,449 | 21,757,305 | 31,537,754 |
| Utah | $117,970,728 | $43,225,933 | $161,196,661 | 622,020 | 1,706,988 | 2,329,008 |
| Vermont | $97,089,134 | $17,668,819 | $114,757,953 | 511,565 | 907,218 | 1,418,783 |
| Virginia | $245,550,616 | $65,156,019 | $310,706,635 | 1,346,212 | 3,563,736 | 4,909,949 |
| Washington | $336,729,545 | $69,478,608 | $406,208,153 | 1,610,940 | 5,100,337 | 6,711,276 |
| West Virginia | $317,423,734 | $66,305,132 | $383,728,866 | 1,974,146 | 4,007,930 | 5,982,076 |
| Wisconsin | $366,036,547 | $77,601,177 | $443,637,724 | 2,552,967 | 4,708,613 | 7,261,580 |
| Wyoming | $34,854,404 | $7,617,774 | $42,472,178 | 169,067 | 379,120 | 548,187 |
| **US Total** | **$24,496,894,975** | **$5,326,338,049** | **$29,823,233,024** | **123,133,908** | **260,288,796** | **383,422,703** |

Source: CY2009 CMS website data. Available Online: <http://www.cms.gov/MedicaidDrugRebateProgram/SDUD/list.asp>. Lewin trend factors used to estimate 2011 costs and usage.

## Appendix B. Scatter Diagram Assessing Correlation Between Higher Payments to Pharmacies and Generic Dispensing Rates




Note: FFS Medicaid Programs Ranked by Generic Dispensing Rate (GDR). Arizona excluded because nearly all Medicaid beneficiaries are in managed care.

526583

*COMMONWEALTH of VIRGINIA*

*Office of the Governor*

Robert F. McDonnell
Governor

February 14, 2011

The Honorable John Boehner
Office of the Speaker
H-232 The Capitol
Washington, DC 20515

The Honorable Mitch McConnell
361-A Russell Senate Office Building
Washington, DC 20510

Dear Speaker Boehner and Senator McConnell:

Congratulations on your efforts to begin restoring the American people's confidence in our representative democracy. The nation's desire to return to its values of individual responsibility, competitive markets, and limited and more effective government is clear. Applying these principles in the legislative process will lead to significant economic growth and job creation.

In Virginia, as I have said publicly many times through multiple venues, including recent testimony before Congress, we firmly believe that the Patient Protection and Affordable Care Act (PPACA) is flawed and sections are unconstitutional. I signed legislation prohibiting mandates on individuals to purchase health insurance, and the Commonwealth was the first state to file suit challenging the constitutionality of PPACA. As you know, we were also the first state to have a successful ruling to that effect by a federal District Court. There has now been a second in Florida. We are joining with the majority of states to urge the Administration to seek a quick review and ultimate resolution of this issue by the United States Supreme Court in order to save time and money, and create finality and certainty.

While Virginia is opposed to PPACA, we also recognize that our health care system can be improved. Virginia, like all states, does not get the full value that we should from our health care expenditures. This results in a decrease of access to care which in-turn increases the burden on the safety net and taxpayers. Additionally, it adds expense for our businesses, limits our ability to attract international business, and makes our products more expensive. Our economic viability depends in part on reining in the costs associated with health care.

The complex web of new programs, agencies and bureaucracies created by PPACA is stifling. The lack of flexibility, rigid maintenance of eligibility (MOE) requirements, and flood

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The Honorable John Boehner
The Honorable Mitch McConnell
February 14, 2011
Page 2

of mandates will drive the cost of Medicaid up an additional $2 billion by 2022. This is on top of a program in Virginia that has already grown 1600% since 1985, from about $230 million to $3.4 billion, and now consumes 20% of the total state General Fund budget. Governors around the country, in both parties, are grappling with the unsustainable, unfunded burdens PPAÇA will put on the states if it is not stricken or repealed.

As we look ahead to your stated goal of repeal and replacement of the Patient Protection and Affordable Care Act, we must remember that health system reform remains a critical issue for states. Virginia, along with her sister states, needs certainty about what is both expected and permitted in order to plan carefully and invest wisely. Any federal health system reform must provide states maximum flexibility in order to carry out reforms consistent with their own values, financial climate, and needs of their citizens. The best national framework for health reform will improve the health of our country and strengthen the competitive position of our businesses while saving our taxpayers resources.

For these reasons, I created the Virginia Health Reform Initiative (VHRI). The purposes of VHRI are to implement PPACA in the least burdensome and bureaucratic manner for Virginia, while recommending other innovative healthcare solutions that meet the needs of Virginia's citizens and government. The Initiative will ensure that meaningful reform is achieved throughout the Commonwealth. There is a desire to see that the health care delivery system as a whole is positively impacted as a result of the work accomplished through the initiative. From insurance and payment reforms to how care is delivered, the initiative will work with stakeholders to reduce costs and improve quality. Just as Virginia is leading the opposition to PPACA, we believe we can also help lead the nation by establishing a model of innovative state based health reform.

The initial work of Virginia's Health Reform Initiative suggests a way forward for Congress. **Our country must change how it purchases both insurance and health care if we are to make sustainable improvements in our delivery system.**

**Health Care as a Marketplace**

From Adam Smith, we learned that markets require willing buyers and sellers, price transparency, and few barriers to entry into the marketplace. **Health care is probably the sector of our economy in which market forces are most limited.** Rather than continuing towards a single payer system that is the inevitable result of the requirements, incentives, and penalties in the PPACA, Congress should focus on enabling individuals and organizations to both purchase and provide services with full knowledge of pricing and value provided.

**Congress could offer individuals tax deductions equivalent to employer deductions and allow them to select their own healthcare funding plan without financial penalty.** The relentless increase in demand and cost for health care is caused by the separation between the buyer and the payer both in purchasing insurance and care. An important opportunity to increase accountability is to encourage individual markets for the purchase of products to fund health and health care services. When individuals choose for themselves, there is less need for "protection"

in the form of regulation and mandates on employers. Giving business the option of moving healthcare costs off their balance sheets should improve their competitive position. Employees should see an increase in their wages and the knowledge of the full cost of their insurance policy will encourage healthier behavior.

**Market-based reform must encourage development of markets in insurance products.** Individuals should be able to aggregate in a number of ways to obtain their policies. The **health benefit exchange** concept has some merit, but should not necessarily be an exclusive franchise in each state. Each state should have maximum flexibility to develop or encourage the development of private sector exchanges or use some other mechanism to create a better insurance market. In Virginia, it is possible that more than one exchange may arise in order to meet the needs of various markets.

Congress must **break the stranglehold of the federal payment system** by transforming the payment mechanisms mandated for Medicare and Medicaid by the Centers for Medicare and Medicaid Services (CMS). Price controls stifle innovation and do not work in any area of the economy. Many options for payment reform exist. To the extent that the federal government purchases services, it must pay for value and not volume. Moving away from price controls and toward a defined contribution methodology would allow for implementation of best practices and reward the effort and increased expense of adding value at every stage of the health care delivery and financing system. **Providers must be rewarded for the value they produce.** Continuing the current top down system in both Medicare and Medicaid will drive the nation towards an ineffective, "lowest common denominator single payer system."

**Medicaid Concerns**

Virginia's Medicaid program is the second largest program in Virginia's state general fund budget. The non-stimulus federal match rate for Virginia is 50 percent (this rate goes back into effect on July 1, 2011). In state fiscal year 2012, the Medicaid budget is 20.7 percent of the state only portion of the budget of $16.0 billion. In state fiscal year 2010, the total Medicaid expenditures were $6.55 billion (both state and federal funds) which provided health care to a monthly average of over 800,000 Virginians and more than one million individuals over the entire year.

**Over the past ten years, the number of people enrolled in the Virginia Medicaid program has increased more than 39 percent and spending has grown by nearly $4 billion (state and federal).** The three key drivers have been a concerted outreach to enroll more children, increases in the number of aged and disabled individuals enrolled in home and community based waiver programs, and most recently, the cyclical impact of economy. This enrollment growth has occurred despite the fact that Virginia's eligibility criteria are among the strictest in the nation.

Even prior to the passage of PPACA, **Medicaid growth was unsustainable.** If implemented as currently written, both in numbers of beneficiaries and in size of expenditures, Virginia Medicaid will expand significantly. New enrollees is estimated to be between 270,000

(lower bound estimate) to 425,000 (upper bound estimate) at an increased cost of $1.5 billion to $2.2 billion in state funds between 2010 and 2022.

Until the Supreme Court strikes down PPACA or Congress successfully repeals it, **states have a need for specific and immediate relief from certain provisions in the PPACA.** Such relief is related to Medicaid requirements and numerous other federal regulations that inhibit competition in the insurance and health care markets.

First, among these needs is an **easing of the requirements for Maintenance of Eligibility (MOE).** During the 2010 session, Virginia's General Assembly enacted changes to the eligibility determination process. PPACA was enacted before those necessary changes became effective. For example, Virginia also needs to address loopholes in the Medicaid "spend down" process. PPACA provides no flexibility for these reasonable changes. With excessive restrictions on what must "stay the same," one of the only places in which Virginia can achieve Medicaid savings is through cuts to Medicaid providers. We value the providers who accept Medicaid as a payment source. Flexibility within MOE requirements and broader waivers would afford all states the opportunity to innovate, try new deliveries, options, and protect identify other cost savings measures.

Moreover, the **methodology for determining Medicaid eligibility** is expensive and time consuming. PPACA has complicated what already exists in requiring different methodologies for eligibility determination for those who are currently eligible and those who will be newly eligible January 1, 2014. This is cumbersome and wasteful yet could be corrected if there was only one set of criteria. This issue is further complicated by the need to integrate Medicaid eligibility with the proposed health benefit exchanges.

One potential proposal to increase efficiency and reduce fraud and abuse in Medicaid is to **standardize and automate the eligibility processes for Medicaid and other social service functions.** Permitting states to receive a 90% administrative match for expanding consumer facing portals for identity verification, eligibility determination, and case management will be useful so long as the systems follow the Medicaid Information Technology Architecture (MITA) and are interoperable.

Finally, current regulation limits the amount of cost sharing that can be required of individuals who receive Medicaid. Given that economic incentives play an important role in controlling human behavior and choices, **states should have the flexibility to use appropriate cost sharing methods in the form of copayments and deductibles in all plans.**

**Other Areas of Concern and Consideration**

PPACA seemingly attempted to provide tax deductions for small businesses who aim to purchase health insurance for their employees. The bill falls extremely short in defining "small business" yet it identifies an algorithm that is so complex it fails to incentivize small businesses from hiring outside of the family or paying a competitive wage for those that they do. It is likely

that the deduction will be overlooked by most small business owners as there is no incentive for businesses to seek qualification for the tax deduction.

Congress should encourage states to **develop innovations in service delivery** to meet the needs of individuals through both the public and private sectors. Opportunities should be made available for states to develop effective and efficient solutions that fit local needs and best utilize local capacity. The budgeted CMS Innovation Funds should be available for state projects and not simply limited to existing organizations. In what might be the best option to keep states the laboratories of democracy, states could receive a block grant to create and maintain their own programs without penalty. Over time this would save the federal government money.

**Existing rules and regulations concerning Medicare and Medicaid need to be reassessed to consider their impact on availability and cost of services.** Requirements related to site of care and when, how, and by whom services can be delivered create barriers to entry into the market. This hinders innovation in service delivery and payment reform. Appropriateness and safety should be assessed from outcomes obtained and not so often by regulation of inputs.

Insurance reforms are a major component of PPACA. Unfortunately, states have already been asked to enforce provisions without the opportunity for their legislatures to consider their appropriateness. **Implementation of insurance reforms should be delayed until states have an opportunity to bring their laws into conformity and new mandates should be delayed until the issue of constitutionality is resolved.** Significant costs are now being incurred that may be wasted if the law is stricken or changed. Individuals and employers are already seeing an increase in premiums due to PPACA.

**Medical loss ratio requirements should likewise be delayed** until the regulations are well established and no unintended consequences can be assured. States should be given the flexibility to determine if and how to regulate insurers in their jurisdictions. As it exists, this mandate will inevitably limit the ability of insurers to provide new and innovative programs that are necessary to help "bend the curve" of healthcare costs.

**The concept of health benefit exchanges may have merit, but the timeline in PPACA is too aggressive.** Even if the federal rules were established (they are not) and states knew how best to proceed, it is unrealistic to expect that exchange technology will be perfected by January of 2014. The two exchanges that exist today are extremely different and neither is likely to be the optimal solution. Federal funding is essential if states are to avoid defaulting into the undesirable "federal option" but it is equally important that the regulations be issued as soon as possible if a delay is to be avoided.

As you consider the repeal and replace strategy for PPACA in Washington, this letter has highlighted the following items that need immediate modification to reduce cost, confusion and bureaucracy in the states.

The Honorable John Boehner
The Honorable Mitch McConnell
February 14, 2011
Page 6

1. States must be permitted to expand Medicaid in their own way via innovative programs to provide high value programs to their citizens.

2. Relief from the strict Medicaid Maintenance of Eligibility (MOE) requirements is essential to allow states to provide an equitable benefit.

3. Replacement of the new and old eligibility determination with one standard process which will increase efficiencies in the system.

4. Ensure that federal funds are available to support the federal mandates that are not repealed.

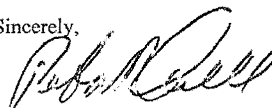
5. Delay Medical Loss Ratio requirements until regulations are well established and unintended consequences can be identified.

6. Delay the implementation of health benefit exchanges in order for federal rules to be established prior to states proceeding with the development of their own system without specific guidance.

The Virginia Health Reform Initiative is already moving down a road that is seeking how to shift the health care paradigm towards one that values individual responsibility, competitive markets, and realizes limited but effective government. I encourage you to use the opportunity ahead of you to make positive steps for the great people of our Commonwealth and Nation. You hold the power to help restore sound principles and effective governance to Congress. We must reform our health care delivery system and I encourage you to take the ideas presented in this letter as a few steps toward achieving that goal.

I along with the Secretary of Health and Human Resources, Dr. William A. Hazel, Jr., MD, will be happy to answer any questions you may have. Thank you for taking the time to read this letter and I look forward to working with you in the days ahead.

Sincerely,



Robert F. McDonnell

RFM/wah
cc: The Honorable Paul Ryan
Virginia Congressional Delegation
The Honorable William J. Howell
The Honorable Thomas K. Norment, Jr.
The Honorable Richard L. Saslaw

Mr. GINGREY. Mr. Chairman?

Mr. PITTS. Dr. Gingrey?

Mr. GINGREY. I have a letter also from our former colleague, Governor Nathan Deal of the State of Georgia, who has some very interesting comments in his letter. I would like to submit it for the record.

Mr. PITTS. Without objection, that will be inserted in the record.

[The information follows:]

STATE OF GEORGIA
OFFICE OF THE GOVERNOR
ATLANTA 30334-0900

Nathan Deal
GOVERNOR

February 28, 2011

The Honorable Phil Gingrey
U.S. House of Representatives
442 Cannon House Office Building
Washington, D.C. 20515

Dear Congressman Gingrey:

I am writing with regard to the Maintenance of Effort (MOE) requirement with respect to Georgia's Medicaid program and the significant challenge that this federal requirement is placing on the state of Georgia.

At a time when governors across the country are struggling to balance their budgets, the federal government is insisting on tying our hands as it relates to management of one of our state's most costly programs. State and federal governments must work together to remedy this situation; Secretary Sebelius, the Congress and President Obama should remove Maintenance of Effort requirements currently in place. Ensuring our ability to provide healthcare services to our most vulnerable population in the state of Georgia requires flexibility, and that is not provided under current law.

As a result of current MOE requirements, my SFY 2012 Budget Recommendation includes a reduction in Medicaid provider reimbursement of 1% and the elimination of coverage of "optional" benefits, including adult dental, vision and podiatry coverage. Additionally, my recommendation increases member co-pay amounts for covered services to the allowable nominal amount as a result of the limited options under current law. These very difficult decisions stem from austere budget times and stringent federal regulations. Provision of flexibility in our Medicaid program would significantly improve the budgetary landscape and would help us avoid these cuts in service.

As Governor, I call upon members of the Georgia Delegation, the Energy and Commerce Committee, the Secretary of the Department of Health and Human Services and the President to remove the deleterious MOE requirements on Georgia's Medicaid program that are hampering our ability to manage the program effectively.

As the former Chairman of the House Energy and Commerce Committee's Subcommittee on Health, I look forward to the opportunity to testify on the challenges my state faces with management of our Medicaid program.

Respectfully,

Nathan Deal

Nathan Deal

Mr. PITTS. Members will have 10 legislative days to submit questions for the record. I ask that the witnesses please respond promptly to these questions. Without objection, so ordered.

The hearing is now adjourned.

[Whereupon, at 12:08 p.m., the committee was adjourned.]

[Material submitted for inclusion in the record follows:]

Medicaid Cost to States
Opening Statement
Rep. Cliff Stearns
March 1, 2011

I want to thank Chairman Upton for holding this Hearing on the "Consequences of Obamacare: Impact on Medicaid & State Health Care Reform." When the Democrats passed this egregious bill last year, they failed to consider the full impact of this burdensome law. Not only are businesses being punished with new taxes and new regulations such as the 1099 requirement, but also states will be punished with the expansion of Medicaid.

The Patient Protection and Affordable Care Act (PPACA) will push 16 million more individuals onto Medicaid. Since Medicaid is a federal-state partnership, states will be forced to shoulder the hidden cost of the health care law. Many states are already operating under tough financial constraints and have difficulty meeting the Maintenance of Effort requirement under PPACA. They will have a very difficult time meeting the additional demands of 16 million more Medicaid individuals.

In my state of Florida, the expansion of Medicaid under PPACA will place an additional 2.1 million Floridians onto Medicaid in addition to the 2.93 million currently on Medicaid. Florida will double their Medicaid enrollment under PPACA and 25% of Florida's population will be on Medicaid. Today, Florida spends $19 billion on Medicaid. Over the next ten years, Florida will be forced to spend an additional $12.8 billion due to the Medicaid expansion.

Additionally, I would like to include a letter from Florida Governor, Rick Scott. Governor Scott details the current fiscal problems that the Medicaid expansion will cause.

This is a large burden for any state as Medicaid is the single largest expense for most states. Expanding the Medicaid program is fiscally reckless. While we need to reform the health insurance markets, PPACA was the wrong type of reform that will lead to more spending and lower quality care for Floridians.

**Statement of Congresswoman McMorris Rodgers**

**The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform**

**March 1, 2011**

Thank you Mr. Chairman for holding this important hearing. No one disagrees that the sentiments expressed by the Governors attending the National Governors Association Winter Meeting was a cry for help. These sentiments demonstrate that the Medicaid program is irreparably flawed. What once was a safety net for our nation's most vulnerable has had now been turned into an entitlement program that actually has the perverse incentive of expanding the federal net for individuals who would otherwise be covered by private or employer-sponsored health care.

The recession has hit hardworking families hard and as a result states have witnessed a record number of families enroll in Medicaid, particularly in the last several years. These increased rolls come at a time when states are facing budget shortfalls totaling $175 billion through 2013. The State of Washington has already made significant cuts to its Medicaid programs eliminating dental and vision coverage for beneficiaries. These cuts total $500 million, but yet the State still faces significant shortfalls of $5.7 billion over the next two years. Now, on top of these deficits, states will see expanded rolls and unfunded mandates totaling approximately $60 billion.

As we will see today, the health care reform act makes unsustainable changes to the Medicaid program, permanently changing the relationship between states and the federal government and skewing the incentives on which the program was founded. This change comes at a significant cost to states and the federal government – OMB projects

federal spending on the Medicaid program to reach $4.4 trillion over the next 10 years. Last week, I heard directly from Governor Gregoire that the state needs flexibility – flexibility of eligibility, flexibility to determine services, and flexibility with provider reimbursements. I look forward to hearing from our witnesses and working with them to restore the appropriate federal-state relationship that was originally intended.

**Opening Statement of the Honorable Cory Gardner**

**““The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform”**

**March 1, 2011**

Mr. Chairman, in this fiscal year the state of Colorado will face a $1.1 billion shortfall. During my time as a state legislator, I reviewed countless ways that we could shrink the size of our budget, yet not at the expense of the people of Colorado. Governors throughout the country are tasked with cutting spending and programs, yet the federal government has been expanding and creating new programs. The bill for this will fall directly on the states. The Affordable Care Act passed last year will force states to expand their Medicaid eligibility requirements and place the cost of this expansion directly on state budgets.

While working in the Colorado State Legislature, I opposed a state level health reform bill that created a provider fee in order to support the rising cost of Medicaid. This act shifted more cost to the consumers and increased federal spending. The federal government is supposedly tasked with matching this provider fee. However, it is estimated that federal matching funds could run out by 2016. Then what happens? If the federal government can no longer provide state matching, this then creates another unfunded mandate that Coloradoans simply cannot afford.

Colorado was forced to institute the provider fee in order to keep Medicaid afloat in the state and in order not to sacrifice coverage for those who need it. This hearing allows us the opportunity to examine what will truly happen to states with a massive expansion of Medicaid. In Colorado, Medicaid accounts for approximately 19 percent of the state's budget. According to the Kaiser Family Foundation, by 2019, my state will see a 47.7 percent increase in Medicaid enrollees as compared to the estimated national average of 24.7 percent. Mr. Chairman, the Colorado budget will be crippled once all the cost of this expansion is shifted back to the states.

This hearing will also focus on the maintenance of effort requirement. The maintenance of effort does not allow states the flexibly to alter Medicaid eligibility requirements in order to combat the budget shortfalls. If states do, they will lose all federal funding. These draconian measures do not provide states with any options. We are here today to examine these problems, and to begin to create real solutions to provide affordable coverage to the America people.

I thank the witnesses for being here, and I yield back the balance of my time.

Statement from Representative John D. Dingell
House Committee on Energy and Commerce
"The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform"
March 1, 2011

Today's hearing is cloaked in the need to help States manage their Medicaid programs in light of health care reform and budget shortfalls, yet once again injects political posturing into the process of this Committee.

The new Majority has made no secret of its goals to repeatedly attack the very goal of health care reform – providing affordable care for all Americans. Yet as they attack the health care reform law, they offer no real solutions to address the problems they perceive in its implementation.

The Department of Health and Human Services has shown a clear willingness to work with the States as we prepare to expand Medicaid in 2014. The Secretary has outlined the flexibilities available to Governors to meet their Medicaid obligations, and has made available her senior leadership to meet with the staffs of any Governor that wishes to reexamine their Medicaid programs.

Medicaid is and will continue to be a major source of health coverage for seniors, people with disabilities, children and pregnant women – our most vulnerable populations. Expansion of Medicaid eligibility is critical to providing coverage for millions of Americans who may not otherwise receive coverage.

Far too often when these individuals lose access to Medicaid, we know that the States are then left with the financial burden. In 2008 alone, States spent more than $17 billion on uncompensated care. The health care reform law strives to address this issue by providing States with additional federal resources and tools to make coverage affordable for the State and for its residents through the Health Insurance Exchanges, expanded Medicaid eligibility, grants and federal funding, to start. The Affordable Care Act also works aggressively to slow the growth of health care costs in Medicaid by restructuring health care delivery systems, reducing Medicaid prescription drug costs, and improving care for dual eligibles.

Improving Medicaid will result in better care for individuals and savings for the States. According to a recent study by the Urban Institute, States could save $70 billion or more by reducing uncompensated care costs and expanding access to Medicaid.

I understand under the current economic climate, increased Medicaid rolls are a concern, but fundamentally doing away with Medicaid by converting the program into to a block-grant program is not the answer. A block-grant program will not allow States the capacity to prepare or anticipate changes in their patient populations, and furthermore sets up a possible negative result in a loss of coverage and loss of benefits for beneficiaries.

I look forward today's dialogue with the nation's Governors and my colleagues in the Majority to how we can truly address the unpredictability of costs in Medicaid without jeopardizing the care of millions.

**Statement for the Record**

**Rep. Towns**

**March 1, 2011 hearing**

Chairman Upton, and Ranking Member Waxman, thank you for scheduling today's hearing on the Consequences of the Patient Protection and Affordable Care Act, and its impact on Medicaid and state health care reform. This is a timely subject that has far-reaching implications across the country, and I am pleased to be a part of the discussion.

I recognize that many states are requesting more flexibility from the federal government in running its Medicare and Medicaid programs. However, I remain concerned that if the federal government relaxes its eligibility criteria, many individuals will lose access to care.

For example, in its efforts to balance budgets, many states are making several unfortunate decisions, such as significantly cutting mental health budgets and programs. These cuts are extremely deep and ultimately will result in facilities closing their doors. This will cost jobs, as well as a lack of these extremely important services in primarily under-served communities. Ultimately, however, the most devastating result is the shifting of costs from mental health to other areas of the state budget. When individuals with severe mental health illness are left untreated, they will ultimately lose their homes and, if lucky, reside in homeless shelters that are paid for by states and cities, or worse, commit crimes and become incarcerated. It does states and communities no good to shift costs from one program only to magnify the effect and pick up equal or higher costs elsewhere.

In addition, some states are targeting Medicaid reductions through the prescription drug program. In Governor Barbour's testimony, he indicated that in FY2006 Mississippi was able to reduce drug costs from $697 million to $422 million, and subsequently to $279 million. Part of this effort was directly attributed to reducing the number of prescriptions allowed from seven to five per month. I am concerned that this approach directly interferes with the doctor-patient relationship. Rather than allow physicians and patients to determine a course of treatment, the Medicaid program in Mississippi makes this determination on their behalf. Cost savings are important, but if a patient is unable to afford stabilizing medications, then costs to the system as a whole are likely to up as they will ultimately resort to higher-priced treatments and hospitalization.

In our approach to strengthening our nation's healthcare system, let us always remember to take a well-balanced approach. We are a nation that cares for the sick and the elderly, and ensures that those who cannot afford healthcare are still provided access. As we look to reduce costs, let us not do this by simply limiting access to care. Let's instead look at how we can move forward together.

**Statement by the Honorable U. S. Rep. Bobby L. Rush**
**at the**
**U.S. House Committee on Energy and Commerce**
**on the**
**Hearing: "The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform"**

Tuesday March 1, 2011

Good morning.

I want to extend a very warm welcome to Governor Deval Patrick of Massachusetts, Governor Haley Barbour of Mississippi, and Governor Gary Herbert of Utah. Thank you for appearing before our committee today on such an important topic.

I am very disappointed by what we are going to debate today. First of all, national healthcare reform is one of the most important and historic pieces of legislation that Congress has ever passed. As the world's richest country, providing affordable healthcare services to as many Americans as possible should be our nation's foremost moral obligation.

Therefore, it is difficult to comprehend—after the historic healthcare reform legislation was signed into law to provide for nearly 46 million uninsured citizens and with 8.6 million of those being children—why on Earth we are trying to unravel what has taken us so many years to stitch together!

As we speak, these numbers are increasing. Since the start of the recession in 2009, more than 6 million individuals have enrolled in Medicaid. The vast majority of low-income individuals who will become eligible for Medicaid under health care reform do not have access to affordable, private health insurance coverage.

Unfortunately, but not unexpectedly, my Republican colleagues have shaded the truth again by saying Medicaid's expansion under the new health reform law will provide coverage to Americans who would have otherwise been covered by private insurance. This is simply not true. On the contrary, healthcare expansion will significantly reduce the numbers of low-income families that are uninsured and effectively increase access to care for many of this nation's vulnerable populations.

I am shocked that my colleagues are attempting to transform the debate over health care reform into a matter of "money." Maintaining good public health does not come with a price tag. Instead, we should be looking at the increased productivity and long-term fiscal and business-related savings that national health care reform will yield. Rather than continuing to fight to repeal or to significantly water down historic legislation that is now the law of the land, this Committee should be searching for ways to actually help states find ways to deliver affordable, high quality health care services to those Americans who desperately need it.

In my home state of Illinois, we are facing some very serious health care challenges. Medicaid cuts to hospitals, nursing homes and other providers will devastate the well-being of hundreds of thousands of Illinois citizens and our state's health-care delivery system. Our children and families will lose their health care in these challenging economic times as they face the grim prospect of job losses, home foreclosures, and increased discretionary spending of household budgets on rising food and transportation costs.

We simply cannot let these people and families down and it seems to me that dialing the clock back makes absolutely no sense at all.

I yield back.

# # #

**Rep. Engel Hearing Q&A**
**"The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform"**

I would like to thank the Governors for their time today. I understand that you face many challenges with your budgets these days and I appreciate you taking the time to be here.

The challenges that you face are great. Not only do you need to put forward a balanced budget, but you need to ensure that you are providing essential services for the residents of your states. I think it is possible to accomplish both goals without having to cut enrollment in your Medicaid programs.

My first question is for Governor Patrick.

As we all know, providing low-income Americans with meaningful, affordable health coverage improves quality of life and makes for a stronger, more effective work force.

I know states are worried about covering more people in Medicaid because of their budgetary situations.

But we should all be worried about what NOT covering people will do – how it would impact people's lives, not to mention state budgets.

The Institute of Medicine recently discussed what it means to an individual to be uninsured.

- Uninsured children are 20 to 30 percent more likely to lack immunizations, prescriptions, asthma care, and basic dental care.
- Uninsured children are also more likely than insured children to miss school due to health problems and to experience preventable hospitalizations.
- Uninsured adults are 25 percent more likely to die prematurely than insured adults.
- A high rate of uninsurance results in problems with access to hospital-based emergency services — including limits on inpatient bed capacity, outpatient emergency services, and the availability and timeliness of trauma care.

Some states have forged ahead – covering people in Medicaid even before the law requires them to do so, such as Washington, DC, Connecticut, Minnesota and my state of New York. Of course, Massachusetts made this calculus at a much broader level for its total population.

Governor Patrick, can you talk about what coverage has meant for the people of Massachusetts? And can you also give us some insight into the long term cost savings that your state will see as a result?

I believe that this hearing today is timely because many of you are currently drafting your budgets for the coming fiscal year. And though the economy has seen an improvement in recent months, much of which has to do with this Administration's policies, you still have high unemployment and therefore, low revenue.

But, I believe that there are creative ways to solve budget woes than to simply cut your way out of it. If you drop hard working American's from you Medicaid rolls, you end up costing yourself more in the long run.

In addition to the good work that Governor Patrick is doing in Massachusetts to cover over 98% of his residents, I would like to point out the creative thinking that is happening in my state, New York.

Just last week Governor Cuomo approved creative thinking measures that were recommended by a Medicaid Redesign Team. The team was comprised of stakeholders and experts from the state to work to reform the system and reduce costs. While I may not support all of the

recommendations made, the MRT was successful in finding ways to reduce costs while at the same time meet MOE requirements.

I would like to ask Governor Barbour, what more flexibility do you need? If states like Massachusetts and New York can partner with stakeholders across their states to find creative solutions, wouldn't you recommend that others do so? From what we know, you have many tools in your tool box. What more do you need?

**Statement of Rep. Lois Capps**
**"The Consequences of Obamacare:**
**Impact on Medicaid and State Health Care Reform"**
**Energy and Commerce Full Committee Hearing**
**March 1, 2011**

It is clear that all around the country, state budgets, like those of American families, are hurting.

And while we know that economic indicators point to recovery, for many, especially those in the lower income brackets, relief is still far away.

Today, we will hear from states that also must balance their budgets and make difficult decisions about what to save and what to cut.

These are difficult choices—in my state alone, we are facing a $26.6 billion dollar shortfall.

But I am concerned that the cuts that some are proposing, to safety net programs like Medicaid, will hurt those who need the assistance most.

The point of Medicaid is to ensure that those who need it most have access to health care, without passing those uncompensated costs to hospitals and localities.

The point of Medicaid is to ensure access to care so that individuals can get the treatments they need when they

first get sick and not wait until their illness is more severe, costly, and difficult to treat.

And while Medicaid is not perfect, with complex eligibility requirements and confusing categories of coverage…

The Affordable Care Act fixes this by making it clear that starting in 2014, those who have no other access and have incredibly low incomes will not have to sacrifice rent money for medications…

That parents who have lost their jobs can rest easy that their children can still see the doctor…

And that individuals with disabilities know their complex health care needs can be met affordably.

Knowing the importance of this program not only to the individuals it serves, but to the local economy that does not need to pick up the tab, it is difficult to hear some of our panelists making statements about gutting the program, kicking people out of it, or cutting it completely.

Moreover, it seems that those who call for these changes in Medicaid are also opposed to the Affordable Care Act, and have disparaged it whenever possible since before it even became law.

In this way, I worry that this hearing isn't really about Medicaid or the state health reform implementation.

Instead, it is a not-so hidden attack on a health reform law that is already helping so many by providing affordable and reliable access to care and protecting consumers from abusive insurance company practices.

And while we have listed the benefits that are already helping people many times in the 112th Congress, what those who oppose the law seem to deliberately overlook is that the Affordable Care Act has and will continue to bring money to States.

In California alone, over $430 million dollars in new grant funding have already been awarded.

Funding that goes towards helping individuals--from HIV prevention, to money that helps pregnant teen mothers finish high school ...

As well as grants that fund programs aimed at making the system better by cracking down on unreasonable premium increases, strengthening public health infrastructure, building or health care workforce, and enhancing ongoing efforts in the States and local communities to protect consumers from some of the worst insurance industry practices.

These grants address critical shortages, and provide vital services to the most vulnerable Americans, shoring up government budgets, and saving money.

The concern about states budgets should and must be addressed.

However, using the health reform law and the Medicaid programs as scapegoats to play politics doesn't help anyone.

I yield back.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED TWELFTH CONGRESS

# Congress of the United States

## House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
2125 RAYBURN HOUSE OFFICE BUILDING
WASHINGTON, DC 20515–6115

Majority (202) 225-2927
Minority (202) 225-3641

March 29, 2011

The Honorable Gary R. Herbert
Governor
State of Utah
350 North State Street, Suite 200
Salt Lake City, UT 84114-2220

Dear Governor Herbert:

Thank you for appearing before the Committee on Energy and Commerce Committee hearing on March 1, 2011, to testify at the hearing entitled "The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform."

Pursuant to the Rules of the Committee, the hearing record remains open for ten business days to permit Members to submit additional questions to witnesses, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and then (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Tuesday, April 12, 2011. Your responses should be e-mailed to the Legislative Clerk, in Word or PDF format, at Allison.Busbee@mail.house.gov.

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

Sincerely,

Fred Upton
Chairman

cc: The Honorable Henry A. Waxman, Ranking Member,

Attachment

The Honorable Michael C. Burgess, MD

1. **Texas Governor Rick Perry suggested changing how Medicaid is administered. He would like a formula based on the percent of the population living in poverty. Do you think changing the administrative requirements to be based off those who live in poverty would better represent the original intent of Medicaid and ensure coverage to those who need it most?** While this concept seems like a novel approach to federal funding, it certainly would require more study and analysis. Any changes to the federal funding formulas will have distributional implications, and may have unintended consequences that need to be carefully analyzed and studied. The one-size-fits-all definition of federal poverty does not necessarily reflect the realities of our diverse economies and populations. I would certainly be interested in continuing the dialog to look for improvements in how federal funds are allocated to states.

2. **One of the foundational problems of Medicaid is its countercyclical nature. Was the decision for the federal government to give states excess money during a recession for their Medicaid program and attach a maintenance of effort provision more damaging to their economy than allowing them to operate without the ARRA money?** For the State of Utah, the maintenance of eligibility attached to ARRA was relatively minor. However, I oppose the concept of maintenance of effort in general. In tough times, states should have the autonomy and flexibility to address fiscal challenges in a locally determined and fiscally responsible manner. One problem with federal handouts is that when states know the federal money is coming, they have a reduced incentive to make the tough decisions that really ought to be made in tough times. Adding a maintenance of effort requirement compounds the problem by not even allowing states who are willing to make the hard choices to do so.

3. **Medicaid has experienced historical growth over the past ten years with an annual growth rate of 4%. However, this rate pales in comparison to the projected 9.4% growth that Medicaid will experience in the next ten years under PPACA. How are your states preparing to deal with the exponential growth?** This will be a challenge for the State of Utah, as I am sure every other state. This year, our legislature passed and I signed Senate Bill 180 which outlines a fundamental reform of the Medicaid program in our state. Under this proposal, we would change the financial incentives so that providers will be focused on value instead of volume. The bill also contains provisions to help address the financing and funding of Medicaid moving forward. If this bill is successful, we could really see the cost curve bend because people are receiving appropriate care in the right time and place, which will save a lot of money. I sincerely hope that we can get the support of our federal partners to grant us the waivers we need to move forward.

4. **While enrollees in traditional fee-for-service Medicaid "can go to any doctor willing to participate in the program," scarce as those doctors may be; managed care enrollees can only see providers in their plans' networks.** In Utah, our managed care plans also contract with specific provider networks as part of their program to managed care and control costs.

5. **My state has a waiver program, STAR+Plus, that provides Medicaid managed care for acute care and long term care for part of the dual eligible population but for the general Medicaid population**

**does utilize managed care, and does so in a reasonable way that does advance care coordination. However, we are also monitoring the MCOs under Medicaid. Can you speak to your states experience with managed care and how you have dealt with the following:**

**a. Network access**

**b. Actuarial integrity of payment rates**

**c. Ensuring the encounter data (used for medical loss ratio MLR) or administrative cost data is accurate at all... and this is what ongoing rates are based on.**

. We have generally had a good experience with our Medicaid Managed Care Organizations (MCO). At present, our enrollees in the four most populous counties choose an MCO for their health care needs. Each of these MCO choices provides comprehensive networks with quality care. Enrollees can choose an MCO that uses either of the major hospital networks in the area. These MCOs provide a solid framework to build our future Medicaid program as envisioned by SB 180. As we make the transition from MCOs to ACOs, we anticipate seeing further bending of the cost curve as we provide proper incentives in the health care system.

The Honorable McMorris Rodgers

1. **Some say that the Medicaid program is irreparably flawed – that states are no longer focused on providing help to the individual, that the incentives are no longer aligned with the program's goals. So, while a repeal of the maintenance of eligibility is a necessary first step, it seems that it is a band aid for a larger underlying problem. Would you comment?** I believe that the traditional approach to provide care for the poor through Medicaid is fundamentally flawed. The current system ignores the importance of personal responsibility and consumer incentives and motivates providers to provide too much care. I firmly believe that the provisions of our Senate Bill 180 represent significant improvements over the current system. In the new system, we hope to have the flexibility to use cost sharing to align incentives for consumers and a new payment structure to provide incentives for providers to keep patients healthy and productive. As part of this system, we also hope to give consumers the option of using their public funds to buy private insurance either through an employer or on the individual market. I hope that the federal government will give us permission to make these changes so we can start to reap the benefits of re-aligning incentives.

2. **Last week I met with Washington's Democrat Governor Chris Gregoire who has been leading voice in the repeal of the Maintenance of Eligibility. But, she is also a strong advocate of giving states more flexibility in terms of eligibility standards, reimbursement standards, and the services a state provides. In fact, there is a proposal moving through the state legislature that the Governor has indicated she would approve that would limit growth based on eligibility group – rather than a cap on program funds – in return for greater flexibility. Do you believe this type of proposal has merit? Does it bring the focus of Medicaid back to covering the most vulnerable populations?** I would need to see more details and take some time to see if this would work for Utah. However, this might be a really good thing for some states, and I would hope that if Gov. Gregoire thinks it will work in Washington, she

should have the chance to do it. Right now, our efforts are focused on changing payments and incentives as I have mentioned previously to benefit our state's citizens.

The Honorable Charlie Bass

1. **Given the aggressive timeline that states are required to implement the Medicaid changes (July 1, 2013), are the Governors concerned about the states' ability to meet this timeline? What expectations does CMS have if the states don't meet the timeline?** I am very concerned about the Medicaid timelines in Obamacare. These represent big changes from the status quo, and it's really hard to predict how this will shake out. To make matters worse, there are a lot of areas where we need clarification or guidance from CMS and this information does not come easily, so I am not sure what their expectations might be. One example is that there is supposed to be a formula for determining federal funding depending on whether the person is eligible under the "new" or "old" rules, but it would be a huge administrative burden to have to run everybody through the system twice to figure out what the federal funds should be. While officials at CMS are aware of this problem, we do not have any clarity on how they will resolve this issue?
2. **In terms of the individuals cost of coverage, system and infrastructure changes, etc. there are state general funds intended to cover these costs. However, with the budget deficits and no funding set aside to cover staff salary and support that will be required once the changes are fully implemented, how do the Governors propose to pay for the extraneous (but essential) cost?** The federal government is supposed to pay for the increased administrative costs and for those who are eligible under the current rules for the first five years. But then the federal dollars phase down, and my staff is projecting a huge hit to our state budget when those funds dry up. The impact of a major required change in our Medicaid budget would have to be funded primarily out of existing priorities, such as higher education and transportation.

The Honorable Brian Bilbray

1. **Governor Herbert, this week in the House we will be voting to repeal the 1099 provision for businesses, which has received wide bipartisan support despite being signed into law less than a year ago. Utah and Massachusetts have a strong and growing medical technology industry. Another component of the law that has received strong criticism is the medical device tax. If this provision isn't repealed, how would this affect innovation and job creation in your states?** – Of course, any kind of tax on productivity will stifle growth. Placing a specific tax on an industry that is built around innovation and growth would seem to be counterproductive. I would like to see that tax repealed along with the 1099 provision and many others that in my view are harmful to state economies.

The Honorable Bill Cassidy

1. **FMAP theoretically pays more per recipient in poor state to compensate them that they have fewer resources to pay for themselves. For Example Mississippi's FMAP is 83% and Vermont's is 50%, yet the federal contribution is Vermont is $7,500 per recipient and in Mississippi it Is $3,000 per recipient. Clearly FMAP is not accomplishing its stated goal. What are your ideas to create equity in federal**

**payments?** There are always inefficiencies and problems when taxes are collected up to the federal level then redistributed back to the states. One of the issues is the strings that get attached along the way. The system also will have winners and losers, as some states will get back less than they put in. Not only does the FMAP formula create strange outcomes, but the current formula for DSH payments adds to the complexities of understanding the best way to use taxpayer money to help those in need. I do not have a detailed proposal at this point for revising the entire federal medical payment system, but I do support efforts to find better ways to do this. In particular, I would like to see more state autonomy and flexibility with far fewer strings attached. I believe that locally elected officials are much more likely to get it right than those who have to force a one-size-fits-all solution onto the states.

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED TWELFTH CONGRESS

# Congress of the United States

## House of Representatives

COMMITTEE ON ENERGY AND COMMERCE
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Majority (202) 225–2927
Minority (202) 225–3641

March 29, 2011

The Honorable Deval Patrick
Governor
State of Massachusetts
444 North Capitol Street N.W., Suite 208
Washington, D.C. 20001

Dear Governor Patrick:

Thank you for appearing before the Committee on Energy and Commerce Committee hearing on March 1, 2011, to testify at the hearing entitled "The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform."

Pursuant to the Rules of the Committee, the hearing record remains open for ten business days to permit Members to submit additional questions to witnesses, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and then (3) your answer to that question in plain text.

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

Sincerely,

Fred Upton
Chairman

cc: The Honorable Henry A. Waxman, Ranking Member

Attachment

<u>The Honorable Michael C. Burgess, MD</u>

1. ***Texas Governor Rick Perry suggested changing how Medicaid is administered. He would like a formula based on the percent of the population living in poverty. Do you think changing the administrative requirements to be based off those who live in poverty would better represent the original intent of Medicaid and ensure coverage to those who need it most?***

While we have not evaluated Governor Perry's proposal in detail, we believe the current methodology fairly supports states. As you know, the Federal matching rate for Medicaid services is calculated state-by-state based on each state's per capita income. Massachusetts receives a 50% federal match under this formula, which is the lowest rate possible under the Act.

2. ***One of the foundational problems of Medicaid is its countercyclical nature. Was the decision for the federal government to give states excess money during a recession for their Medicaid program and attach a maintenance of effort provision more damaging to their economy than allowing them to operate without the ARRA money?***

No. The enhanced federal matching rate under ARRA has allowed us to maintain eligibility and benefits at the very time when our residents have needed them most. During this period and for each year during my Administration, we have passed responsible, balanced and on-time budgets. We value the federal-state partnership on the Medicaid program, and have enjoyed a strong partnership with both Republican and Democratic administrations in Washington and in Massachusetts since our first 1115 demonstration waiver in 1995.

3. ***Medicaid has experienced historical growth over the past ten years with an annual growth rate of 4%. However, this rate pales in comparison to the projected 9.4% growth that Medicaid will experience in the next ten years under PPACA. How are your states preparing to deal with the exponential growth?***

Since our state's Health Care Reform law was passed in 2006, Massachusetts has increased the proportion of insured residents substantially. Today, over 98% of all our residents and 99.8% of our children have access to health insurance. We do not expect PPACA to dramatically increase our Medicaid expenditures, due to the scope and success of our existing Medicaid program. In fact, new funding available under PPACA may enhance our program and reduce our Medicaid expenditures. States that have not yet invested in universal coverage will have their additional expenses covered entirely under the Act during the transition.

4. ***While enrollees in traditional fee-for-service Medicaid "can go to any doctor willing to participate in the program," scarce as those doctors may be; managed care enrollees can only see providers in their plans' networks.***

   The question being posed is unclear. However, it is clear that fee-for-service rewards the amount of care (rather than the quality of care) and may actually contribute to the escalating cost of health care.

5. ***My state has a waiver program, STAR+Plus, that provides Medicaid managed care for acute care and long term care for part of the dual eligible population but for the general Medicaid population does utilize managed care, and does so in a reasonable way that does advance care coordination. However, we are also monitoring the MCO's under Medicaid. Can you speak to your states experience with Managed Care and how you have dealt with the following:***

   ***a. Network access***
   ***b. Actuarial integrity of payment rates***
   ***c. Ensuring the encounter data (used for medical loss ratio MLR) or administrative cost data is accurate at all.. .and this is what ongoing rates are based on.***
   ***d. Ensuring MCO's are living up to contractual obligations regarding networks, complaint***
   ***resolution, etc***

*a) Network access:*

The Medicaid managed care contracts have very clear network management, capacity and access standards and requirements. Managed care contracts are awarded on a regional basis and an MCO cannot serve a given region unless they have demonstrated that they are able to meet the access standards.

Moreover, the MCO Program management team has monitoring and reporting processes in place to monitor MCO performance including access and availability requirements. MCOs submit an annual network capacity report in accordance with MassHealth's reporting specs and format. Noncompliance can lead to corrective action including closure from serving in a region if the access falls below the contractual standards.

b) *Actuarial integrity for payment rates*:

All managed care rates are within actuarially sound rate ranges developed and certified by our actuary. The rates must also be approved by CMS.

*c) Ensuring the encounter data (used for medical loss ratio MLR) or administrative cost data is accurate at all . . . and this is what ongoing rates are based on:*

The MCO encounter data is used as the basis for developing the actuarially sound rate ranges. This encounter data undergoes standard edits for completeness and accuracy. In addition, our actuary reviews the data for its appropriateness for use in rate setting and makes adjustments where needed (such as completion factors and adjustments for subcapitation payments not reported in the encounter data).

*d) Ensuring MCO's are living up to contractual obligations regarding networks, compliant resolution, etcetera:*

The MCO contract management program unit assigns a contract manager to each contracted MCO. The manager's primary

responsibility is to ensure that contracted MCOs are in compliance with our requirements.

Monitoring is conducted via multiple channels, including regularly scheduled operations, programmatic and quality management workgroup and meetings. Additionally MCOs are required to submit reports for certain key elements to ensure that they are complying with contractual requirements.

**The Honorable McMorris Rodgers**

1. ***Some say that the Medicaid program is irreparably flawed - that states are no longer focused on providing help to the individual, that the incentives are no longer aligned with the program's goals. So, while a repeal of the maintenance of eligibility is a necessary first step, it seems that it is a band aid for a larger underlying problem. Would you comment?***

Medicaid is a values statement. I support it and for the people of Massachusetts it works. Our efforts to expand insurance coverage are enabled by a partnership between residents of the Commonwealth and their advocates, private insurance companies, health care providers, the state government, and the federal government through the Medicaid program. This partnership has been enormously successful in extending coverage and providing care to our most vulnerable citizens. Moreover, by working together, we have insured that our Medicaid program is aligned with the overall goals of Title XIX, while meeting the modern needs of our members.

2. ***Last week, I met with Washington's Democrat Governor Chris Gregoire who has been leading voice in the repeal of the Maintenance of Eligibility. But, she is also a strong advocate of giving states more flexibility in terms of eligibility standards, reimbursement standards, and the services a state provides. In fact, there is a proposal moving through the state legislature that the Governor has indicated she would approve that would limit growth based on eligibility group - rather than a cap on program funds - in return for greater flexibility. Do you believe this type of proposal has merit?***

***Does it bring the focus of Medicaid back to covering the most vulnerable populations?***

Our approach in Massachusetts has been to protect coverage and access to care for our vulnerable citizens while seeking program efficiencies that allow us to manage costs. The issue of health care cost growth is not a Medicaid issue; it is a medical system-wide issue. Having made health care universally accessible, we have shifted to focusing on making health care universally affordable. Meeting this challenge is bigger than Medicaid. It is critical to every working family, business, not-for-profit and municipality in the Commonwealth.

Accordingly, I have filed legislation in the Massachusetts legislature seeking to lower health care costs for all consumers by moving toward more integrated care models. Our proposals provide the health care industry both the incentives and the freedom to innovate and find lower cost ways to deliver better care. This effort will allow us not only to sustain coverage for our most vulnerable populations, but also cut costs for and improve the lives of all Massachusetts residents.

**The Honorable Edolphus Towns**

*I appreciate the work that your state has done under your leadership to provide access to quality care. I find it particularly impressive that almost 100% of your state's population is covered by health insurance, yet you have been successful at maintaining costs relatively stable.*

1. ***In your experience, how have costs been affected by increased coverage?***

Since our state's Health Care Reform law was passed in 2006, Massachusetts has increased the proportion of insured residents to over 98%, 99.8% of children. A 2009 Massachusetts Taxpayers Foundation report finds that new public spending for Commonwealth Care and MassHealth was largely offset by decreases in Health Safety Net (HSN) payments and other programs associated with a

high uninsured population.[1] The HSN pays acute care hospitals and community health centers for essential health care services provided to uninsured and underinsured Massachusetts residents. The study found that HSN payments declined as more residents obtained coverage through public and private sources. Expanded coverage has not been a "budget buster."

Massachusetts health reform has had a modest effect on private and public health care costs. The health reform law created a new private health insurance market for small businesses and individuals by merging these two markets. The cost of the merger is estimated to have increased premiums by 2.6% after adjusting for the higher premiums paid by individual subscribers due to their higher average ages.[2] However, health reform in Massachusetts is not generally recognized as a major factor in rising health care costs.

The fundamental issue of rapidly escalating premiums is independent of expanded coverage and is a national challenge. Provider price increases, price variation among providers, the fee-for-service payment method, and the absence of integration in the health system have been the major factors contributing to health care cost increases.[3] So, promptly after enacting our health reform law, we turned our attention to the critical issue of growing health care costs. Most recently, I filed legislation to lower health care costs for all consumers while providing the health care industry both the incentives and the freedom to innovate and find lower cost ways to deliver better care. I believe comprehensive, state-wide payment reform is the best approach to controlling costs throughout the health care system.

***2. How has the Massachusetts health program made small businesses in your state more economically competitive?***

[1] Alan G. Raymond, "Massachusetts Health Reform: The Myth of Uncontrolled Costs" *Massachusetts Taxpayers Foundation*. May 2009.
[2] Dianna K. Welch and Kurt Giesa, "Analysis of Individual Health Coverage in Massachusetts Before and After the July 1, 2007 Merger of the Small Group and Nongroup Health Insurance Markets" *Oliver Wyman*. June 2010. This report was produced for the Health Care Access Bureau of the Massachusetts Division of Insurance.
[3] "Massachusetts Health Care Cost Trends" Final Report. *Division of Health Care Finance and Policy*. April 2010.

Health care security and cost are the primary concerns of small entrepreneurs. First, under our reform, everyone has access to quality care; and I have met entrepreneurs whose decision to start their business in Massachusetts is directly related to the certainty they have that their young families will be covered while they get their venture up and running. Second, small businesses can now purchase health insurance through a program created by the Commonwealth Connector, Massachusetts' version of the Health Exchange. The program, called Business Express, is an online service to help small businesses easily shop for private health care and find the best possible value. Thanks to legislation I signed last summer, small businesses can now buy insurance in cooperatives with other small businesses, to aggregate their buying power and compete for better rates.

***3. How does the Affordable Care Act help residents of Massachusetts?***

Although our private insurance protections were already strong, the ACA has brought our residents additional protections, including prohibiting health insurers from having annual or lifetime limits on benefits and eliminating copayments for preventive services.

Massachusetts employers can also benefit from the small business tax credit that is available to some small employers that pay at least half of the cost of individual coverage for their employees. According to a Families USA and Small Business Majority report, 81,300 Massachusetts small businesses could be eligible for the small business health care tax credit.[4] Businesses are also taking advantage of the Early Retiree Reinsurance program.

Seniors and disabled individuals on Medicare who fell into the Medicare Part D coverage gap or "donut hole" receive a $250 credit to help with their prescription drug costs and will see continued benefits as the donut hole is phased out.

Massachusetts residents making between $32,000 and $43,000 a year, or families of 4 making $66,000 to $88,000 a year who currently

[4] "A Helping Hand for Small Businesses: Health Insurance Tax Credits" *Families USA and Small Business Majority*. July 2010.

are over income for our state reform programs, will be able to receive federal tax credits to purchase insurance through the Exchange.

Moreover, the state has received many grant, demonstration and design contract awards that will help improve and make more cost effective care to certain populations including those currently in institutions who could be served in the community with the necessary supports and individuals dually eligible for Medicare and Medicaid. We also look forward to applying for additional opportunities that the ACA offers to test new ways to pay for health care.

4. ***What suggestions do you have for lowering costs on the system?***

Just as we in Massachusetts have provided the national model for universal access, our state is also well positioned to become the national leader for effectively controlling costs, while sustaining or improving the quality of care. I filed comprehensive legislation earlier this year to establish a structure and process to facilitate significant reforms to the Commonwealth's health care payment and service delivery systems over the next three years.

The overarching goal of the legislation is to reward providers for quality, rather than volume. This will both improve the health of Massachusetts citizens and make health care more affordable. To accomplish this goal, the legislation encourages the growth of integrated care organizations (ICOs) comprised of groups of providers that work together to achieve improved health outcomes for patients at lower costs; and provides benchmarks, standards and guidance for the transition to integrated care and global payments. The legislation also allows our Insurance Commissioner to consider additional criteria when making the decision to approve or reject rate increase requests from both carriers and providers. In addition, the legislation reforms the medical malpractice system to make providers' apologies inadmissible as evidence and to establish a 180-day cooling off period before a party may initiate a lawsuit, in an effort to reduce so-called "defensive medicine."

5. ***What can the federal government do to work with states to strengthen health coverage and access, while lowering costs?***

To begin with, the passage of PPACA was the single most important change in federal health care law in a generation. I am proud of our efforts in Massachusetts, and to see that the federal law is modeled in large part based on our success here. Implementation of PPACA, with appropriate improvements based on further analysis and experience, is the best short-term step that the federal government can do to strengthen health coverage and access while lowering costs. Massachusetts has recently received several grants under PPACA that will allow us to continue this work in partnership with the federal government. Looking ahead, we are considering some of the flexibility options built into PPACA. We believe that Massachusetts has demonstrated the power of allowing states to innovate to achieve shared goals: expanding access to affordable health care for everyone in the United States. On cost control, we look forward to working with the Center for Medicaid and Medicare Innovation, created by the Affordable Care Act, on our efforts to lower costs while sustaining quality in the Massachusetts health care system.

Just as Massachusetts led the nation to a successful model for expanding health care access, I believe our experience going forward will inform that national discussion about containing health care costs and improving outcomes.

**<u>The Honorable Charles Gonzalez</u>**

1. ***At the March 3, 2011 hearing with Secretary Sebelius, Congressman Cassidy stated in his opening remarks that testimony from Governor Patrick at the March 1,2011 hearing was false. Could you please respond to Congressman Cassidy's claims for the record?***

Congressman Cassidy was wrong and I sent the enclosed letter to the Congressman on March 23, 2011 in response to his remarks, and would ask that it be made a part of the record.

**<u>The Honorable Charlie Bass</u>**

1. ***Given the aggressive timeline that states are required to implement the Medicaid changes (July 1,2013), are the Governors concerned about the states' ability to meet this timeline? What expectations does CMS have if the states don't meet the timeline?***

We have a good multi-agency team in place that is working to make the changes required by the ACA and we are on track to fully comply with the law.

Your question regarding decision making at CMS can best be directed to that organization.

2. ***In terms of the individuals' cost of coverage, system and infrastructure changes, etc., there are state general funds intended to cover these costs. However with the budget deficits and no funding set aside to cover staff salary and support that will be required once the changes are fully implemented, how do the Governors propose to pay for the extraneous (but essential) cost?***

Medicaid's federal-state partnership has always been essential to the effective functioning of the program. We look forward to working with CMS to ensure that all existing and new Medicaid requirements are implemented efficiently and compassionately. We are committed to funding all administrative expenses necessary to realize the goals of the ACA in Massachusetts.

<u>The Honorable Brian Bilbray</u>

1. ***Governor Patrick, this week in the House, we will be voting to repeal the 1099 provision for businesses, which has received wide bipartisan support despite being signed into law less than a year ago.***

   ***Utah and Massachusetts have a strong and growing medical technology industry. Another component of the law that has received strong criticism is the medical device tax. If this***

***provision isn't repealed, how would this affect innovation and job creation in your states?***

I am concerned about the medical device tax, as Massachusetts has a very robust medical devices industry and growth in this sector is something we have supported through our ten-year, $1 billion Life Sciences Initiative. Through the Life Sciences Initiative we have provided medical device and other biotech companies with working capital, tax incentives and workforce development support, while investing significantly in related research at our world-class academic institutions. I have invited medical device companies along on trade missions to China and other parts of the world to support the development of international partnerships. We will continue working with our partners in Washington to support, not corrode, our leadership in this important innovative industry.

Overall, I believe the health care law is highly beneficial to the people of America and our Commonwealth.

**The Honorable Bill Cassidy**

1. ***As opposed to your testimony, recent reports estimate that healthcare costs in Massachusetts have grown from 21% to 37% over the last 10 years. You are quoted as saying this is "unsustainable." There are reports that in 2009, recent immigrants were disenrolled from Medicaid to save costs. Last year the Boston Globe reported that dental benefits were "slashed" for hundreds of thousands of Massachusetts Medicaid beneficiaries, denying them access to their own dentists. If Medicaid is "unsustainable", why should it be expanded under PPACA?***

Respectfully, the Congressman is conflating two separate issues. Rising health care premiums are a serious national problem and the rate of growth across the country is indeed unsustainable. Denying universal access to care by repealing our health care reform (or the Affordable Care Act, for that matter) does nothing to address that problem. In fact, expanding access has actually helped us reduce the cost to the state of providing health insurance. All told, universal health care coverage has only added about 1% of the state budget to

state costs. Spending on the uninsured and underinsured through our uncompensated care pool is down by hundreds of millions of dollars.

As the experience of Massachusetts has demonstrated, Medicaid – in partnership with a robust private market – is a sustainable program for providing care to our most vulnerable residents. Over the last several years, we have made limited program changes that protect our eligibility standards and the vast majority of our services while administering the program efficiently in an environment of limited resources. I believe that these limited changes were the best options available to protect our members while allowing the Commonwealth to deliver on-time, balanced budgets throughout the second term. I have consistently supported the authority of states to have the flexibility to make such limited changes when necessary.

2. ***You also stated Massachusetts has not experienced crowd out with private employers dropping insurance and entering their employees into Medicaid. Professor Regina Herzlinger, of Harvard Business School, reports that enrollment in employer sponsored health insurance to decrease from 85% in 2003 to 78% in 2007. This belies your statement, how do you reconcile?***

Health care reform in Massachusetts was enacted in 2006. There has been no evidence of subsidized coverage "crowding out" employer-sponsored insurance. In fact, while national offer rates remained flat, 76% of Massachusetts employers were offering health insurance in 2009, as compared to 70% before the passage of our health reform.[5] Employer surveys show that nationwide 60% of employers offered health insurance in 2005 and 2009 compared to Massachusetts employers where offer rates climbed to 76% in 2009 from 70% in 2005. In addition, there is no evidence of public coverage crowding out employer sponsored insurance among non-elderly adults. The majority of working age adults continue to be covered by employer sponsored insurance. The percent of Massachusetts working age adults with employer sponsored

[5] Massachusetts statistics: Massachusetts Division of Health Care Finance and Policy, *Massachusetts Employer Survey*, 2009. National statistics: Kaiser/HRET, *Survey of Employer Sponsored Benefits*

coverage has increased from 66% in the fall of 2006 to 68% in the fall of 2009 according to the Urban Institute's (a nonpartisan economic and social policy research organization) Massachusetts Health Reform Survey of 2010.[6]

The absence of evidence of crowd out, like the evidence of expanded coverage being affordable, is not a matter of opinion but of fact. The single biggest issue facing not just our reform, but also the national economy, is rising health insurance premiums. Congress has helped us and other states with some of the tools in the Affordable Care Act. We look forward to working with the Congress to go further in addressing this challenge.

[6] Urban Institute, *Massachusetts Health Reform Survey*, 2010

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DEVAL L. PATRICK
GOVERNOR

TIMOTHY P. MURRAY
LIEUTENANT GOVERNOR

March 23, 2011

The Honorable William Cassidy
1535 Longworth HOB
Washington, DC 20515

Dear Congressman Cassidy:

I was deeply dismayed to learn about your remarks at a recent U.S. House Energy and Commerce Committee hearing which disparaged previous testimony I delivered regarding the impact of federal health care reform on Massachusetts. In your opening statement at the March 3, 2011 hearing on the FY12 budget for the U.S. Department of Health and Human Services, you characterized the information I presented related to emergency room visits, the impact of health reform on the private insurance market, and the cost of expanding access in Massachusetts as false. Having overseen the successful implementation of health care reform in Massachusetts, I fully stand behind the truth and accuracy of my testimony and am disappointed by your attempt to discredit my report on our experience to the Congress. Facts are facts and my testimony was a matter of fact, not opinion.

In Massachusetts, we re-directed funds that were previously utilized to pay for uncompensated care (i.e., uninsured patients receiving their care in emergency rooms) to help finance the cost of expanding access to insurance. This has allowed people to begin to receive better, more consistent care and has also turned out to be more cost effective. The attached survey (Massachusetts Health

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Reform Survey, 2006-2009, published in June, 2010) shows many of the cost effective advantages of health care reform. For instance:

[B]etween fall 2006 and fall 2009, non-elderly adults were more likely to have a place they usually go to when they are sick or need advice about their health (up 2.9 percentage points), more likely to have a general doctor visit (up 5.7 percentage points), and more likely to have a visit for preventive care (up 6.7 percentage points). They were also less likely to have unmet need for care (down 5.4 percentage points overall and down about 2 to 3 percentage points for each of the specific types of care examined) (page 12).

What this demonstrates -- although it seems like common sense to me -- is that when people have health insurance, they are more likely to have a usual place of care, more likely to have an appointment with their health care provider for a preventative care visit and less likely to have an "unmet need" for care. It still amazes me that some people do not see the simple, sensible truth in this -- we used the funds we previously used to pay the health care bill for the uninsured when they showed up in the hospital to give those uninsured folks access to insurance; once they have insurance, some percentage of them started seeing a doctor more regularly and taking better care of themselves. This is not only the right thing to do; it is the smart, cost effective thing to do.

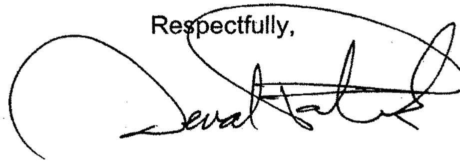
Data also show that more employers offer health care coverage in Massachusetts today than before the passage of health reform. The attached survey (Survey of Massachusetts Employers, page 4) of Massachusetts employers demonstrates that in 2005, 70% of employers offered coverage. By 2009, the percentage of employers offering coverage increased to 76%. This proves that health reform resulted in a 6% expansion -- not contraction -- of employer sponsored health insurance coverage in the Commonwealth.

The Honorable William Cassidy
March 23, 2011
Page Three

As it relates to coverage, there are now 410,000 newly insured in Massachusetts since outset of healthcare reform. The additional cost to the state of expanding coverage has amounted to approximately 1% of our budget. As I mentioned in my testimony, rising health care costs continue to be a problem that plagues our great nation. But, it is a problem that will exist regardless of whether we expand coverage. Just as Massachusetts led the way in 2006 by making access to health care universally available to all of our residents, we are now leading the way by using the tools made available to us through the Affordable Care Act to bend the cost curve.

In addition to the factual inaccuracies and misstatements contained in your remarks, I must take issue with the overriding sentiment you express toward health care reform. The question before us is not about who has the most cynical evidence to fill negative advertisements and influence the course of partisan debates. It's about what kind of society we want to live in and what we will choose to protect, invest in and pass on to future generations. We made a decision about what that society looks like in Massachusetts and made an important, successful step toward it. My testimony was intended to reveal some of these things we have learned in light of the similar federal proposal that was signed one year ago. I hope this letter will help clarify and underscore some of the specific points I addressed.

Respectfully,



Enclosures

FRED UPTON, MICHIGAN
CHAIRMAN

HENRY A. WAXMAN, CALIFORNIA
RANKING MEMBER

ONE HUNDRED TWELFTH CONGRESS

**Congress of the United States**

**House of Representatives**

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March 29, 2011

The Honorable Haley Barbour
Governor
State of Mississippi
P.O. Box 139
Jackson, MS 39205

Dear Governor Barbour:

Thank you for appearing before the Committee on Energy and Commerce Committee hearing on March 1, 2011, to testify at the hearing entitled "The Consequences of Obamacare: Impact on Medicaid and State Health Care Reform."

Pursuant to the Rules of the Committee, the hearing record remains open for ten business days to permit Members to submit additional questions to witnesses, which are attached. The format of your responses to these questions should be as follows: (1) the name of the Member whose question you are addressing, (2) the complete text of the question you are addressing in bold, and then (3) your answer to that question in plain text.

To facilitate the printing of the hearing record, please respond to these questions by the close of business on Tuesday, April 12, 2011. Your responses should be e-mailed to the Legislative Clerk, in Word or PDF format, at Allison.Busbee@mail.house.gov.

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

Sincerely,

Fred Upton
Chairman

cc: The Honorable Henry A. Waxman, Ranking Member,

Attachment

**The Honorable Michael C. Burgess, MD**

1. Texas Governor Rick Perry suggested changing how Medicaid is administered. He would like a formula based on the percent of the population living in poverty. Do you think changing the administrative requirements to be based off those who live in poverty would better represent the original intent of Medicaid and ensure coverage to those who need it most?

   *I am not familiar with Gov. Perry's proposal, so I cannot comment on it. However, as I understand it, the Medicaid program was originally designed for the lowest income populations, the elderly and the disabled. The Affordable Care Act departs from this original program design by greatly expanding the population that qualifies as low income. I think this is a mistaken fundamental shift in the Medicaid program and one that will be very expensive for American taxpayers.*

2. One of the foundational problems of Medicaid is its countercyclical nature. Was the decision for the federal government to give states excess money during a recession for their Medicaid program and attach maintenance of effort provision more damaging to their economy than allowing them to operate without the ARRA money?

   *I don't subscribe to the thought that you can buy your way out of a recession and that's what ARRA does. That said, as Governor I do what I can to help my state and if that means taking the money to shore up our budget, I'm going to do that especially since out taxpayers are paying their share of the*

*federal costs. Like most things the federal government gives you, ARRA came with strings attached. I do think the Maintenance of Effort (MOE) requirements should be eliminated because it ties states' hands and forces states to cut other essential programs like education or public safety to fund a one-size fits all Medicaid program. Lifting the MOE requirements will allow states to make difficult budget decisions in ways that reflect the needs of their residents.*

3. Medicaid has experienced historical growth over the past ten years with an annual growth rate of 4%. However, this rate pales in comparison to the projected 9.4% growth that Medicaid will experience in the next ten years under PPACA. How are your states preparing to deal with the exponential growth?

   *I am not sure states can adequately prepare for an expansion of this magnitude. As stated in my testimony, the expansion will cost Mississippi $1 to $1.7 billion over the next ten years and $443 million in year ten alone. States are facing a tremendous challenge and will have to make difficult choices as to what programs get funded. States will either have to cut programs or raise taxes.*

4. While enrollees in traditional fee-for-service Medicaid "can go to any doctor willing to participate in the program," scarce as those doctors may be; managed care enrollees can only see providers in their plans' networks.

   *Our new Medicaid care-coordination program, MississippiCAN, is reaching out to all providers to encourage them to enroll. The plans can pay no less*

*than what Medicaid pays and they may offer more benefits. We hope that will encourage providers to enroll.*

5. My state has a waiver program, STAR+Plus, that provides Medicaid managed care for acute care and long term care for part of the dual eligible population but for the general Medicaid population does utilize managed care, and does so in a reasonable way that does advance care coordination. However, we are also monitoring the MCO's under Medicaid. Can you speak to your states experience with Managed Care and how you have dealt with the following:

   a. Network access

      *Our new Medicaid care-coordination program, MississippiCAN, is reaching out to all providers to encourage them to enroll. The plans can pay no less than what Medicaid pays and they may offer more benefits. We hope that will encourage providers to enroll.*

   b. Actuarial integrity of payment rates

      *We retained Milliman, Inc., nationally renowned actuaries, to develop the rates that we pay our plans. Our plans are required to pay no less than the Medicaid rates and must cover at least the same level of benefits as our Medicaid program.*

c. Ensuring the encounter data (used for medical loss ratio MLR) or administrative cost data is accurate at all…and this is what ongoing rates are based on.

*Milliman is working with us to constantly analyze and update the rates.*

d. Ensuring MCO's are living up to contractual obligations regarding networks, complaint resolution, etc.

*We have a comprehensive contract monitoring tool to evaluate compliance with the contractual requirements as well as performance in achieving the intended health care outcomes and program efficiencies.*

**The Honorable McMorris Rodgers**

1. Some say that the Medicaid program is irreparably flawed – that states are no longer focused on providing help to the individual, that the incentives are no longer aligned with the programs' goals. So, while a repeal of the maintenance of eligibility is a necessary first step, it seems that it is a band aid for a larger underlying problem. Would you comment?

*Yes, the program is irreparably flawed and at its current rate of spending increases, the program is unsustainable. States need flexibility to design their programs in a way that best fits the state. What works in Maine may not work as well in Mississippi. Governors need short-term budget flexibility and long-term structural changes. In order to make the program*

*sustainable in the future, states will need innovative and solutions-based policies that address eligibility, benefits and financing. Repealing the maintenance of effort requirements addresses the short-term budget flexibility, but states must be given the ability to implement long-term structural changes. For example, trying to align the program back with the original goal of proving healthcare to the nation's most vulnerable citizens, by giving states the option*

2. Last week, I met with Washington's Democrat Governor Chris Gregoire who has been leading voice in the repeal of the Maintenance of Eligibility. But, she is also a strong advocate of giving states more flexibility in terms of eligibility standards, reimbursements standards, and the services a state provides. In fact, there is a proposal moving through the state legislature that the Governor has indicated she would approve that would limit growth based on eligibility group-rather than a cap on program funds- in return for greater flexibility. Do you believe this type of proposal has merit? Does it bring the focus of Medicaid back to covering the most vulnerable populations?

*I can't speak to her specific proposal for the State of Washington because what may work for Washington may not work best for Mississippi. But she is correct that states need flexibility to design their program in a way that works best for that state.*

**The Honorable Edolphus Towns**

1. Governor Barbour, you have proposed to cut funding for mental health by 7 percent, emphasizing the need to move toward home- and community-based

care and away from institutional care. I am concerned that your proposal does not include resources dedicated to that purpose. Instead, the proposal appears simply to cut institutional funding without providing resources for home-and community-based care.

a. This proposal could result in closure of some of the state's mental health facilities. Does your proposal include a plan for where the individuals who currently reside and receive treatment in these facilities will go? In what ways will your state work to develop programs and provide much-needed funding in these areas to ensure that individuals with mental health conditions receive the housing, care, and treatment that they need?

*I do support closing mental health institutions and moving toward more home and community based care. My state developed a program that has become a national model for delivering mental health services to individuals with serious mental health conditions. Our Mississippi Youth Programs Around the Clock, or MYPAC, has allowed hundreds of youth who are in critical need of mental health services to receive those services in the community instead of in an institution. We plan to expand the program again this year and my hope is that the State leadership will continue to expand and support the program after my term as Governor ends. In addition, I will sign a bill this year which begins to standardize services offered at the State's Community Mental Health Centers and ensures there is consistent among counties regarding these services.*

b. You have indicated in your written testimony that in FY2006 your state was able to significantly cut pharmacy cost by about $420 million. You did this partially by reducing the number of covered prescriptions from seven to five per month. I am concerned that this decision may have interfered with the doctor-patient relationship, and forced patients to simply forego taking needed, prescribed medications. Did you notice any change in other healthcare costs to Medicaid during that time? For example, did hospitalization rates go up because people did not have access to prescriptions?

*No, hospital utilization rates did not increase due to the reduction in covered prescription. Over this time period, hospital utilization rates remained the same or grew at the average rate. Hospital rates went up because Mississippi hospitals are reimbursed based on their costs and state law has prevented our Medicaid agency from making any changes to those payments. These provisions in state law have essentially required Medicaid to increase payments to hospitals by approximately 3% each year. In addition, to the reduction from seven to five drugs, beneficiaries are also limited to two brand and three generic drugs. Our pharmacy program expenditures have decreased, but that decrease is primarily due to the shift in market share from brand to generic drugs. When I became Governor, our generic utilization rate was 46%. Now, our generic utilization rate is 79%. Generics are cheaper than brand drugs and by shifting the market to generics, our program saves money and beneficiaries can still get the drugs they need.*

*We do not believe the reduction in the number of prescriptions for those Medicaid eligible persons interfered with the doctor to patient relationship. In fact, we found that many people were taking multiple medications for the same illness prescribed by multiple doctors. The reduction forced those patients to decide who their primary doctor would be and work with that one to assess all their drug needs, which resulted in many being taken off duplicate drug therapy. In addition, I signed a bill into law that strengthens the doctor-patient relationship by providing a step therapy or fail first protocol for medications when an insurer has restricted the use of certain medications. Physicians will now have a standard process to use to override that restriction.*

**The Honorable Bill Cassidy**

1. FMAP theoretically pays more per recipient in poor states to compensate that they have fewer resources to pay for themselves. For example, Mississippi's FMAP is 83% and Vermont's is 50%, yet the federal contribution in Vermont is $7500 per recipient and in Mississippi it is $3000 per recipient. Clearly FMAP is not accomplishing its stated goal. What are your ideas to create equity in federal payments?

   *Mississippi's FMAP rate is 83%, only because of the enhanced FMAP included in ARRA. It is normally 74%. Under FMAP, poor states get a higher percentage of the Federal Medicaid Assistance Percentages (FMAP),*

*and I support that policy. The expenditure per beneficiary depends on a lot of variables, including decisions made by the state.*

**The Honorable Charlie Bass**

1. Given the aggressive timeline that states are required to implement the Medicaid changes (July 1, 2013), are the Governors concerned about the states' ability to meet this timeline? What expectations does CMS have if the states don't meet the timeline?

   *Although I am worried about the timeline and the increased administrative burden healthcare reform places on the states, I am more concerned about the costs. As noted, this expansion will cost Mississippi between $1 to $1.7 billion over the next ten years and $443 million in year ten alone. States are in no position to accept any increased costs or additional administrative burdens to expand Medicaid. State general fund expenditures have dropped for the second year in a row. Many states cannot afford their current share of the Medicaid program, and they will also have to face a funding cliff whenever the stimulus-enhanced FMAP dollars are exhausted. States have already been forced to cut vital services with 30 states cutting education, 29 states cutting Corrections, and 28 states already cutting Medicaid. The expansion of Medicaid will force more cuts.*

2. In terms of the individuals cost of coverage, system and infrastructure changes, etc., there are state general funds intended to cover these costs. However with budget deficits and no funding set aside to cover staff salary

and support that will be required once the changes are fully implemented, how do the Governors propose to pay for the extraneous (but essential) cost?

*Unless the economy grows and revenues increase (without raising taxes), states will have to make difficult decisions about the essential state services that will be funded. When you are required to balance a budget each year, you must pull resources from one agency to fund another. Education and Medicaid will comprise more than 70% of our general fund budget next year and that number will increase when the full requirements of ACA come online. So, in order to fund the expansion in Medicaid, you are going to have to take something away from another state service.*