Statement of
Governor Mark R. Warner, Chairman
Governor Mike Huckabee, Vice Chairman

before the

Committee on Energy and Commerce

U.S. House of Representatives

on

MEDICAID REFORM

on behalf of the

National Governors Association

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

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

The Problem

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

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

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

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

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

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

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

The Vision

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

The recommendations to make Medicaid more efficient and effective were not developed to generate any particular budget saving number. Instead, they were

developed as effective policies that would maintain or even increase health outcomes while potentially saving money for both the states and the federal government.

The non-Medicaid recommendations had three goals. First, to increase quality and health outcomes by applying modern technology and accountability to our health care system. Second, to develop alternative, more effective policy tools that would assist individuals and employers to obtain and maintain private health insurance as opposed to having these individuals become Medicaid eligible. Third, to improve financing and delivery of long-term care by developing incentives for quality private long-term care insurance products, community-based care, innovative chronic care management, and alternative financing approaches. Specific health care policies are organized around four objectives:

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

Reforming Medicaid

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

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

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

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

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

services while managing the program in a way that prevents sweeping cuts in the future.

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

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

7. **Commonwealths and Territories**. The federal Medicaid partnership with U.S. commonwealths and territories has become increasingly unbalanced over a period of years, to the extent that some of the jurisdictions are financing over 80

percent of their Medicaid costs, and many of the Medicaid expansions such as transitional medical assistance are not available. The imbalance affects quality of care issues and creates increased financial stress. Medicaid reform needs to include a review of the current relationship and the development of a pathway that moves to a rebalancing of this partnership.

Enhancing Quality and Reducing Costs of the Overall Health Care System

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

Strengthening Employer Based and Other forms of Health Care Coverage

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

Slowing the Growth of Medicaid Long-term Care

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

State Contribution to the Medicare Drug Benefit

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

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

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