Statement by

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before the

Medicaid Commission

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Good morning and thank you for once again inviting me to appear before the Commission. Reforming the Medicaid system—and ultimately the broader health care system—remains a high priority for governors and the National Governors Association (NGA).

Since I was here last, the Deficit Reduction Act of 2006 has been signed into law. Passage of the DRA included many of the NGA and commission supported short-term recommendations that provide states with new tools to better manage their programs. To ensure the long-term sustainability of the program, however, further reforms are necessary.

In its current form, Medicaid—the $330 billion federal state safety net program that provides health care services to 58 million Americans—is unsustainable from both the state and the federal budget standpoint. Not only does Medicaid need additional reform but Congress needs to enact other health care reforms that will assist in taking pressure off Medicaid. Unfortunately Medicaid has grown 11 percent per year over the last 30 years. The growth rate has also fluctuated over time from a low of 2 percent in the early 1990s to 20 percent in the late 1980s.

From a state budget perspective it also has grown from about 11 percent of the average state budget in 1988 to 22 percent in 2006. While governors have worked hard over this period to maintain their commitment to both elementary and secondary education as well as higher education, Medicaid has been funded by slight reductions in those programs and major reductions in other state programs. If Medicaid continues this rapid growth, states will be in the unfortunate position of having to fund Medicaid by cuts in education, particularly higher education.

Given the changes taking place in the global marketplace education is the last area states should cut. We are definitely at a crossroads. If we do not bring the growth rate of Medicaid expenditures down dramatically we will not be able to appropriately fund education and thus we will not have the educated and skilled workforce that is necessary to compete in the international economy in the twenty first century. The cost of not competing will be reductions in the real wages and real incomes of most Americans. The bottom line is that our children may be the first generation of Americans that will have a lower standard of living than we do.

Medicaid spending over the last five years has been driven by a 40 percent increase in case load and a 4.5 percent per year increase in the health care price index. As we look to the future, the case load growth will continue to be a problem as long-term care is the most expensive portion of Medicaid and the over 65 population will be the faster growing cohort. In addition, due to the high cost of health care and the pressures of the international marketplace, the private sector is likely to continue to reduce their coverage, particularly for individuals below 200 percent of poverty. For this reason the focus of reform should be to reduce the rate of health care cost increases to be more in line with the average CPI.

Recommendations for Reform

In developing your recommendations for the long-term sustainability of the Medicaid program you should follow the following principles:

- The focus should be on lowering the growth over time as opposed to one-time changes that merely lower the base.

- Only policies that reduce the cost of the program to both the federal government and the states should be considered. Policies that shift costs between the two levels of government should be off the table.

- Policies should focus on making Medicaid look more like other health care programs that are provided by the private sector, where appropriate. For healthier, higher income beneficiaries, Medicaid needs to become integrated into the rest of the health care system.

- Incentives should be realigned so that states can reap the savings from innovative approaches that generate savings for both states and the federal government.

- Policies that enhance quality, price transparency and adoption of electronic health care records should be adopted as they will both increase quality and reduce costs over the long run. Pay for performance is an integral part of this strategy.

- Medicaid should also be utilized to accelerate the adoption of quality, price transparency and the electronic medical records by all health care providers.

- Alternative more cost-effective policy tools that would assist individuals and employers in obtaining and maintaining private health insurance should be developed to slow the rate of growth of Medicaid.

In developing your recommendations you should consider two categories. First, those polices that focus on making Medicaid more cost effective. Second, additional policies that affect Medicaid indirectly by limiting its future growth or by enhancing broader concepts of health care quality. These are often more cost effective than Medicaid.

I. Making Medicaid More Cost Effective

There are a number of areas that the commission should consider making recommendations regarding the Medicaid program itself.

Long-term Care

As the Commission develops its final recommendations I urge you to include reforms in the area of long-term care. Medicaid has become the nation's largest payer of long-term care services, funding approximately 50 percent of all long-term care spending and nearly two-thirds of the costs for all nursing home residents. In the next seven years, 78 million baby boomers will begin turning 65 years old. Medicaid simply cannot continue to afford being the predominant provider of long-term care coverage for this population.

In June, the NGA wrote a letter to the Commission that outlined a combination of policies to slow the growth of Medicaid long-term care costs for seniors. To make Medicaid more cost effective, NGA recommends reforms that will further expand access to home and community based services and critically, reforms to facilitate coordination between Medicare and Medicaid for individuals eligible for both programs.

The DRA provides new flexibility for states to provide home and community based services to individuals through a state plan amendment; however, this flexibility is limited to individuals at or below 150 percent of the federal poverty level. To be effective, this flexibility should be expanded to allow states to provide these services to higher income individuals.

States and the federal government need increased ability to work together to provide improved care coordination for dual eligibles, those individuals eligible for both Medicare and Medicaid. A holistic approach to the treatment and care management of these individuals will provide improved quality of care as well as cost-savings. A critical first step would be to align the incentives between the federal and state government by allowing states to share in cost savings achieved through improved care management of this population. Further reforms are also necessary to improve the ability of CMS and states to develop models to integrate care. Such reforms should include giving states the option to integrate acute and long-term care benefits for dual eligibles through a state plan option; streamlining Medicare and Medicaid rules governing care for this population to allow for an integrated approach to care; and providing states with increased tools to enroll dual eligibles into an integrated care management plan.

Waiver Reform

The use of waivers in Medicaid has been an important tool for states to modernize state programs. The federal government has long offered states the opportunity to develop new models and create innovative programs through a Section 1115 Research and Demonstration Waiver. The federal government should develop a process that recognizes those 1115 Waiver programs that have demonstrated a history of solid achievement. Such a program could, for example, allow permanent adoption of the 1115 Waiver program in the State Plan. Other states should also be able to replicate the proven success of these models without having to apply for a waiver.

State and Federal Partnership

The Medicaid program is a state-administered program that is jointly funded by the states and the federal government. The partnership between the states and the federal government in running the Medicaid program is important to consider as you develop your final recommendations. Working together, states and the federal government can make progress towards Medicaid modernization, identify efficiencies and maintain the integrity of the program.

The DRA Medicaid reform effort was successful because of a shared commitment to promote policies that focused on enhancing and sustaining the program while also producing savings for both the federal government and the states. Identifying efficiencies in Medicaid is a shared goal for both states and the federal government. Such cost-savings are necessary to continue to fund an ever expanding program with limited funds.

Because Medicaid is funded through a matching system whereby the state administers the program through broad federal guidelines, there is a natural tension between the funding partners as the federal government reviews the state's management decisions and subsequently makes funding decisions. Limited state and federal funding exacerbates this tension as both partners manage their budgets and costs increase year after year.

These natural tensions are reflected in a number of administrative changes that CMS is advancing; but these proposed changes are nothing more than cost shifts to states that governors oppose. The proposed policies would reduce funding for Medicaid just as states are working to redesign their programs to utilize the reform tools contained in the DRA. As the Commission develops its recommendations I urge that you not support these policies and instead develop reforms that will continue to enhance and improve Medicaid while saving money for both the federal government and the states.

The administrative changes that are proposed include: a major reduction in allowable provider taxes; limits on payments to government providers; and changes to reimbursement policies for rehabilitation services as well as school-based administration and transportation. Not only would

the proposals shift cost to states, they would diminish long-standing, legitimate state funding mechanisms that CMS has previously approved.

Such changes in state plans would impose a huge financial burden on states and impede our progress in implementing the current reform options and continuing to look for further reforms that benefit both the federal government and states.

II. Indirect Reforms to Limit Growth and Increase Quality

There are also a number of reforms that could be enacted, which do not directly affect Medicaid but will increase quality and decrease costs indirectly.

Long-term Care Insurance
As outlined in our June letter, NGA supports a number of policies that aim to indirectly limit the growth of Medicaid long-term care spending. With the understanding that Medicaid can no longer be the chief financing mechanism for the nation's long-term care costs, NGA promotes policy solutions that encourage personal responsibility and discourage the reliance on Medicaid financed long-term care. NGA supports tax credits for the purchase of long-term care insurance (discussed in detail below); as well as other mechanisms to provide incentives for individuals to acquire insurance, including the option to convert portions of 401(k) and pension annuities into long-term care insurance.

Reverse Mortgages
To facilitate the use of reverse mortgages as a means of financing health care, reforms should be made to relieve seniors of the upfront costs of applying for such loans. For those seniors that are applying for Medicaid, 1) reforms should be made to allow such costs be assumed into the annual payout of the mortgage; and 2) Federal Medicaid matching funds should be available for states to pay for upfront costs if the equity from the reverse mortgage loan is going towards the cost of healthcare.

New Programs
Reforms are needed to establish ways to support and strengthen the current level of long-term care services provided outside of Medicaid. The NGA also supports the establishment of new programs, such as a federally funded respite program, to support “informal” caregivers that currently provide care to individuals that would otherwise look to Medicaid for their care.

Health IT and Quality
Governors recognize that without a robust information technology infrastructure at the hospital, provider, and community levels, improvements in disease management, consumer empowerment, medical error reporting, and health care quality are nearly impossible. Such innovation will make the whole system more efficient and effective. States can play a lead role in driving this transformation through demonstration projects in partnership with the private sector.

NGA urges the commission to include in its final recommendation the establishment of a National Health Care Innovations Program to support the implementation of information technology to control costs and raise quality in Medicaid. States are small enough to tailor solutions unique to their cultures, institutions and health care markets, but large enough to experiment with system wide reform. States can also partner effectively with health care providers, insurers, and purchasers to lead large scale pilot projects. Through such demonstrations, states will be able to adopt policies such as price transparency and be able to

afford to use pay-for-performance and other quality measurement tools that are now being utilized throughout the rest of the health care system.

Tax Credits

At the federal level, tax credits and deductions are underutilized resources that would provide incentives for more Americans to purchase both health and long-term care insurance. Such incentives will be critical to both expand and sustain private insurance and therefore slow the growth of Medicaid.

The June NGA letter to the Commission discusses the potential impact of deductions and tax credits for purchasing long-term care insurance. NGA supports a combination of a significant federal tax credit, e.g., $2,000, and a small deduction, e.g., $200 for individuals as an incentive to purchase long-term care insurance.

The NGA also supports the use of tax credits as an incentive for both individuals and employers to purchase health insurance.

For individuals, a refundable tax credit could be developed that would be available to all low-income individuals below some income threshold, e.g., $3,000 for a family of four with incomes below $25,000, which is phased-out at income levels of $60,000. This credit would be a premium subsidy that could be paid directly to a health care plan by the U.S. Department of the Treasury. Unlike the trade assistance program that targets unemployed workers, eligible workers that could receive tax credits could have their employers deduct payments from wages and send them directly to the U.S. Treasury who would combine those funds with the tax credit, confirm eligibility, and forward the payment directly to the health plans.

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

Because this is a refundable tax credit it is reflected in the federal budget as an outlay as opposed to a reduction in revenues. This opens up the potential option for the states to apply for a waiver that would allow the funds to come directly to the states based on a plan that would maximize health care access. For example, the Michigan Third Share program, which has equal amounts paid by employers, employee, and government, could utilize these funds for the government share. Such a waiver option would allow individual states to tailor the funds to their unique labor force and health care marketplace. Such a tax credit also equalizes tax treatment of all individuals with regard to health care.

For employers, a new tax credit would be developed for small firms, i.e., up to 100 workers. The policy rationale is to equalize the tax treatment between the individual tax credit and the employer-based tax credit. The employer tax credit would be restricted to only workers below a given wage rate. The amount of the credit, the targeting, and the relationship to the individual tax credit are key in order to support the employer-based system, as opposed to providing incentives

for employers to reduce coverage. Also, the state should be able to designate the minimum benefit package to be eligible for the tax credit. This credit would be reflected as a reduction in revenues to the federal government.

State Purchasing Pools

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

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

Conclusion

In closing, I ask that you consider these further reforms in your final report. As you finalize your recommendations, I also ask that you take seriously the task of slowing the growth rate of Medicaid expenditures. Working together, states and the federal government can and must ensure the long-term sustainability of the Medicaid program.