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TESTIMONY BEFORE THE HOUSE SUBCOMMITTEE ON HEALTH CARE, DISTRICT OF COLUMBIA, CENSUS, AND THE NATIONAL ARCHIVES

July 10, 2012

Jeffrey Colyer, M.D.
Lieutenant Governor, Kansas

Good morning, Chairman Gowdy, Ranking Member Davis, and members of the Subcommittee on Health Care, District of Columbia, Census and the National Archives. My name is Dr. Jeff Colyer. I have the privilege of serving the State of Kansas as Lieutenant Governor and I am also a practicing surgeon. It is an honor to be invited to visit with this very important committee today to discuss the impact of the Patient Protection and Affordable Care Act.

There are several reasons the ACA should be repealed. We need to start over before irreversible damage is done to patients, taxpayers, states or the fiscal health of the United States. The states are the crucible where we can best get results for our patients. I will summarize some of the problems and suggest some solutions that would lead us to a better, more stable healthcare system.

TRANSPARENT HEALTH CARE ECONOMICS

Twenty five years ago I was part of a team of analysts writing on Soviet military spending at London's International Institute for Strategic Studies. Then I never imagined I would relive Soviet style economics as a surgeon, patient, or policy maker in Kansas in the next millennium.

The Soviets claimed they spent only about one fifth of what the US did to produce a fantastic array of tanks, planes, and millions of men under arms--many times larger than the United States. The reality was closer to 15-18% of their GDP. Under Soviet central planning, the problem was that prices and costs had no relationship to production and real expenses. Nobody—the CIA, the DIA, the Brits, the French, even the Russians themselves, could price the Soviet military machine. The problem was that operation and production of a giant economy ignored economic reality by creating a massive bureaucracy to ensure "results." It was that economic absurdity that ultimately caused the collapse of the USSR.

As a surgeon I work in an industry that consumes 16% of the GDP but there is no pricing mechanism that connects transparent prices to consumers or services or to even basic accounting. It is a system dominated by monopolies and oligopolies. We produce the best health care in the world and yet the economics don't make sense. None of our economic signals align in the system.

Let me give you an example of how dysfunctional the economics of healthcare are on the micro-level. If I remove four moles covered by insurance, I have to send a claim form to get paid. I know the price I will be paid is roughly $175, but I have to submit a bill for $800. However the claim form price — and the accounts receivable on my books — by CMS regulations has to be the highest possible price -- $200 per mole -- a price I have never been paid in my 18 years of practice. The basic example is that the insurer might pay $100 for the first mole, $50 for the second, $25 for the third, and nothing for the fourth.

You can imagine how irrational the books are for any medical practice. Every patient thinks you are gouging them by charging $800 and then only getting paid $175. No wonder there is no competition in the market and prices are not related to outcomes. The basis of supply and demand is a transparent price signal and we don't have that in conventional medical care.

However if you do not have insurance for something like a hand injury, we can quote our patients the cost of surgery, hospital and anesthesia fees and even deal with complications before you decide to have surgery. The price signal and the outcomes are real and visible to everyone.

And then there are the "freakonomics" of Medicaid.

Right now a Medicaid recipient can only visit fewer and fewer doctors because many do not participate in the program. So patients often make a rational economic decision-- the least expensive option for them and the most expensive option for taxpayers-- the emergency room.

The state may spend thousands of dollars on care for diabetes and obesity, but there are no rewards for quitting smoking or losing weight which could cure the problem.

One problem is that Medicaid pays less than the actual cost of care so the cost gets shifted to commercial insurance. As commercial insurance rates increase, more people are forced or rewarded to rely on Medicaid. And getting off Medicaid back into the commercial market is even more expensive and daunting. It is a vicious cycle. This trend will be exacerbated by the ACA.

We have bureaucratized health care so much that it distorts health outcomes. In my own practice two thirds of my employees deal with bureaucracy and only one third are involved in direct patient care. The problem is that the Affordable Care Act further distorts markets and makes it difficult to focus on real results for real patients. There is no question healthcare is complex and expensive. However the ACA makes everything more complex and more expensive without connecting the economics of medicine to the real needs of real Americans.

MEDICAID

I would like to address the state-federal partnership of Medicaid. The State of Kansas has a long and proud history of caring for those in need. However, like many other states, Kansas has recognized the trajectory of the Medicaid program is unsustainable. States understand the program must be improved, and we need flexibility to take action. The passage of American Reinvestment and Recovery Act and PPACA, and particularly their inclusion of Maintenance of Effort provisions, have made flexibility a challenge to obtain.

Without flexibility to reform Medicaid to improve outcomes and reduce costs, Kansas will continue to see increases in Medicaid costs. From 2002-2008, Kansas Medicaid spending grew 33 percent, while enrollment increased 25 percent. This growth occurred as Kansas tax revenues remained strong. Since then, Kansas' Medicaid budget has ballooned from $2.4 billion in 2008, at the onset of federally mandated "maintenance of effort" requirements, to what will reach nearly $3 billion in 2013 without reforms.

To deal with these cost increases previous Administrations proposed tax increases, cut provider rates across the board, refused dental benefits, raised premiums, created long waiting lists, and even told Kansans that if they were over the age of 18 they were not eligible for heart transplants when their lives were on the line.

Those bureaucratic savings certainly did nothing to improve patient outcomes. The ACA creates even more bureaucracy and further restricts options a state may have at its disposal.

When Governor Brownback and I took office in January of 2011, the State of Kansas faced a $500 million budget deficit. This deficit was heightened by an increased caseload demand of $265 million for Medicaid recipients. Furthermore, the Kansas Medicaid program was in

disarray scattered across four cabinet agencies without a common budget, without health goals, and with few providers.

Governor Brownback and I made an important decision. Rather than cut people off or make massive across the board rate cuts, we would remake Medicaid. We covered the shortfall with highway funds and then began to remake the program to be consumer oriented, provide integrated care, and focus on saving money by actually getting better outcomes.

Two weeks ago, Kansas signed three contracts to provide integrated care for needy Kansans. In those contracts, we specifically insisted on no rate cuts for providers and that no one who is eligible for Medicaid be cut off. We originally estimated savings of $830 million over a five year period.

The signed contracts turned out better than our original estimates. Every Kansan on Medicaid can keep their doctor if they participate. They will have at least three choices of different plans that offer benefits like opportunity accounts and personalized health programs.

Projected savings are over one billion dollars (rather than $830 million) and, we added the following services:

1) Basic dental coverage
2) Coverage for heart transplants
3) Bariatric services for obesity
4) Created an offramp from Medicaid back to the commercial insurance market

In addition we are changing our focus to push preventive care and health outcomes. To make sure we have good behavior and achieve health outcomes, Kansas will hold back more than half a billion dollars unless they meet specific health outcomes—real results for real Kansans.

We are improving care in Kansas and saving money without hurting our most vulnerable. In other words if you let the states make decisions we can actually set and achieve goals for health outcomes, not cut providers, not throw people off the program, and actually increase benefits.

All of Kansas' reforms depend on CMS approval of our waiver request. And while tere are some avenues for state innovation, they are narrow paths. The State of Kansas is in the process of applying for a Section 1115 Demonstration project to implement a series of innovative reforms that were the result of nearly a year of public input.

As a state, we envision a future in which the federal government offers us the opportunity to meet a similar challenge. The first track of our proposed 1115 demonstration is not revolutionary on its own; the kind of authorities we are seeking have been approved in other states. However, the State of Kansas strongly feels that a global waiver, or more specifically a per capita block grant tied to health outcomes, would more effectively allow states to reflect the needs of their citizens. We have indicated our intention to pursue that after the first track has been

implemented. Our vision is the restoration or reinvention of a state-federal partnership that will provide a model for reform that honors the program's statutory goal of improving the health of Americans in the greatest need.

MEDICAID EXPANSION

For years Kansas was a leader in healthcare with lower insurance costs, one of the lowest rates of uninsured, and access to care. About a decade ago, our governor decided to try to cut our relatively low uninsured rate by dramatically expanding the Medicaid program.

In those days our uninsured rate was roughly 10%, commercial insurance covered nearly 70%, and the remaining 20% were in government programs. Ten years after that experiment began, commercial coverage collapsed to 59%, government programs exploded, and the number of uninsured ticked up despite billions in new Medicaid spending. Exactly the wrong trendlines for a stable healthcare system.

Kansas is attempting to create an offramp from Medicaid to more stable commercial insurance. We want to create incentives for jobs with benefits. We have implanted reforms to to reward individuals and businesses to voluntarily get off long term disability and rejoin the workforce. This will result in better health outcomes and less costs.

Another key provision in PPACA that affects states is the expansion of Medicaid. Designed as a mandate, this expansion, even though now optional, potentially poses high costs to the states. While some have characterized the expansion population as a free service to states, quite the opposite is true. The Congressional Budget Office estimated that over the next decade the expansion will cost states $73 billion. While some federal observers may suggest this cost is negligible, in the world of balancing budgets, these costs will be challenging for states to maintain. States already stymied by expansive interpretations of "maintenance of effort, " which remains in place in the ACA, have to consider the long-term implications.

These are important decisions for many citizens and each state is going to have to weigh the specific advantages and disadvantages for their citizens and the long term solvency of their state. Knowing the quality of governors and legislatures across the country, I know these decisions will not be taken lightly.

PRIVATE INSURANCE

Despite the promises from President Obama that premiums would decrease and access would increase, we have not seen that happening in Kansas. However since the passage of the Affodable Care Act, the percentage of people covered by private insurance continues to fall in Kansas, while premiums everywhere increased.

Kansas private insurance – employment-based and other private insurance – currently comprises the source of health insurance for 59% of all Kansans. A decade-long downward trend in employment-based insurance continues, and ACA policies only exacerbate the pressures on the private market.

A simple but powerful example is what happened to the child-only health insurance policy market in Kansas. Prior to the implementation of the ACA, four insurance companies offered child-only policies in Kansas. It was a relatively small but important market. In the fall of 2010, faced with uncertainty about how regulators would allow them to manage risk while still honoring the law's requirements to not deny coverage based upon pre-existing conditions, the companies stopped writing new child-only policies.

In 103 of Kansas' 105 counties, that meant no child-only policies were available, as a result of the ACA. Only one insurer in the Kansas City area continued to sell the policies, but in just two counties.

True to form, the State responded the next year by adopting legislation to allow children under 19 otherwise unable to obtain coverage to gain coverage through Kansas' high-risk pool, operated by the Kansas Health Insurance Association. It was a state solution, yes, but one forced upon the state by an unintended but still predictable consequence of the federal law.

While more mandates are to come, the private insurance market has registered the effects of the ACA in other ways. Private market premiums spiked in 2011. Nationally, the average family insurance premium increased 9 percent, the largest increase in six years.

The private insurance requirements of the federal law are another example of "Washington knows best" policy making. The outcome will be less choice, which in almost every kind of market ultimately means less value and higher cost.

HEALTH CARE SOLUTIONS

There is a better way of improving healthcare in Kansas and the United States. It is naïve to think that one huge piece of legislation will solve a complicated problem like healthcare. We need to continually improve and work on it. And the best way is to do it in continuous incremental reforms on the state and federal levels. Today I want to make some alternative suggestions that would allow Kansas to be more responsive to our citizens needs.

Our state of Kansas has lots of innovative providers, patients, insurers, and technology specialists. We believe we can better solve this using Kansas solutions and working with our neighboring states. We should repeal the ACA. But if it is not replaced a series of waivers and state compacts could greatly improve healthcare. Let me list a few.

1) Restore the traditional power of the individual states to regulate and manage health insurance. Allow states to determine insurance mandates, regulation, and competitive markets.
2) Allow states to quickly form compacts that will increase competition, lower costs, improve coverage in both private and government funded programs. Allow portability across states.
3) Allow everyone access to portable individual or group polices that can be financed by a combination of individuals, employers, and government.
4) Revise Medicaid so that instead of pages and pages of mandates, a state has complete flexibility in program design and implementation. While money would be "block granted" the federal-state partnership would focus on agreed health outcomes on the macro level not micro level program management. Allow some Medicaid participants to participate in the private market.
5) Encourage state coverage pools for pre-existing conditions as well as uninsurable pools. Federal funds could be redirected to cover the most needy. Standard open enrollment and qualifying events mechanisms could be used.
6) Allow insurers offer products that allow the consumer to create Personalized Benefit Designs.
7) Create provider price transparency to allow cost comparison and incentivize consumers to utilize cost effective options. Align actual prices with providers, insurers, consumers, and programs.
8) Encourage disability income insurance and allow it to be paired with health insurance plans to protect consumers from bankruptcy and severe economic hardship.
9) Allow states to opt out or have complete flexibility on exchanges. Allow states to use other mechanisms to provide subsidies where appropriate.

Mr. Chairman, thank you very much for the opportunity to visit with you today.

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