MEDICAID TODAY: THE STATES' PERSPECTIVE

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE

HOUSE OF REPRESENTATIVES

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MEDICAID TODAY: THE STATES' PERSPECTIVE

WEDNESDAY, MARCH 12, 2003

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

The subcommittee met, pursuant to notice, at 10 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Barton, Upton, Deal, Burr, Whitfield, Norwood, Wilson, Buyer, Fletcher, Rogers, Tauzin (ex officio), Brown, Waxman, Towns, Pallone, Stupak, Green, Strickland, DeGette, John, and Dingell (ex officio).

Also present: Representatives Stearns, Davis, and Schakowsky.

Staff present: Chuck Capton, majority counsel; Steve Tilton, health policy coordinator; Eugenia Edwards, legislative clerk; Patrick Morrisey, deputy staff director; Bridgett Taylor, minority professional staff; Amy Hall, minority professional staff; and Nicole Kenner, minority staff assistant.

Mr. BILIRAKIS. The committee will come to order. Without objection, the committee will proceed to Committee Rule 4(e). That rule specifies that for purposes of opening statements, the Chair and ranking minority member of a hearing have 5 minutes each, and all other members receive 3 minutes. In response to members' concerns regarding the period for opening statements, any member, when recognized for an opening statement, may completely defer his or her 3-minute opening statement and instead use those 3 minutes during the initial round of witness questioning. Without objection, so ordered.

The Chair recognizes himself for an opening statement. Good morning. I am very pleased to welcome our distinguished guests here today. I would like to extend a special thank you, of course, to my home State Governor, Jeb Bush, and also to the other two Governors here with whom I have had the pride and pleasure of having served with here in the Congress, John Rowland and Bill—as I call him "Billy"—Richardson. I know they have taken a very keen interest in the topic of Medicaid, and I appreciate your willingness to work time into your busy schedule to be here with us today.

Clearly, each of you gentlemen has tremendous struggles in dealing with your budget crisis, implementing plans for homeland security, and dealing with the real risks of bioterrorism. These issues alone must occupy a great deal of your time.

I know that a large contributing factor to your budget woes is spending related to the Medicaid program. Therefore, it is critical for us to examine issues related to this program that has not seen any fundamental changes since its inception in 1965.

Medicaid is growing at astronomical rates, and Congressional Budget Office projections estimate total Federal spending on Medicaid to double—to double—over the next 10 years to $360 billion. This is an average growth rate of 8 percent, clearly outpacing inflation.

The Federal Government cannot sustain this rate of growth nor can State governments, and I hope that each of you will be able to address the impact of this kind of growth, coupled with already existing deficits, might have on each of your States.

Unfortunately, we have not done a very good job in policing this program the last few years. Today, I am announcing that this will be changing. Over the next several weeks and months, if need be, I plan to hold a number of hearings that will explore the entire Medicaid program. These hearings will help us determine where and how to focus our limited Medicaid resources. I would also like to state that this effort is not an attempt to erode the safety net, it is an attempt to strengthen it and ensure that it will remain firmly in place for future generations.

I am sure that each of you has been exploring alternatives to the problems you are facing in Medicaid. I know in some instances Governors have scaled back eligibility and coverage for some people. I know in other instances you have used the Section 1115 waiver process to address your unique concerns. I am hopeful that each of you will expand on some of the ideas that you have tried in your States to address your spending concerns. In particular, I am anxious to hear how flexible the Medicaid program is in allowing you to meet the needs of your State populations.

These issues of flexibility in coverage are ones that we need to discuss. I would like to say at the outset that I do not have—I do not have—any preconceived notions about the answers to these questions. I plan on exploring a variety of ideas—and I hope I speak for the entire committee when I say we don't have any preconceived notions. We plan on exploring a variety of ideas that will express our concerns with burgeoning Medicaid costs.

Last, I would like to commend the President for recognizing the need for Medicaid reform. He has requested $3.2 billion in new money—in new money—in his budget to help with the State fiscal crises and reform Medicaid. This is a very positive step and we will look critically at the President's proposal, but this hearing is not about the President's proposal—and I emphasize that, it is not about the President's proposal. This is an opportunity to hear from people on the front lines administering this program what they need from us to make it work better and more efficiently.

Again, thank you all for being willing to testify today, and I will recognize my good friend from Ohio, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. Thanks to the three Governors that are joining us. I want to acknowledge four individuals in our audience who are currently enrolled in Medicaid—Carolyn Chavan, Donna Lucero, Rose Spears, and Jeannette Morrisette Johnson.

The President's Block Grant would freeze Federal funding for optional coverage and benefit placing the health of millions of Americans at risk. Thank you all for joining us.

To truly appreciate the impact of the President's Block Grant proposal, we will obviously need to hear from those who will be directly affected by it. I would ask, Mr. Chairman, you schedule a hearing that features current Medicaid beneficiaries and providers who serve the program.

This is "Cover the Uninsured Week," an initiative sponsored by the Chamber of Commerce and Families, U.S.A. Their message is simple: 41 million Americans are uninsured. It hurts working families, the public health, and the economy. I am assuming it was similar logic that prompted the President, during his State of the Union Address, to name health care for all Americans as one of his top three domestic policy goals.

Our mantra when it comes to the uninsured should reflect the oath that all doctors take—"First, do no harm." That means preserving the advances made by Medicaid, Medicare, and the State Children's Health Insurance Program. Together, these programs serve 90 million Americans, one-third of our population. We can't build a solid structure if we allow the foundation that is Medicaid, Medicare and SCHIP to crumble.

Medicare, Medicaid and SCHIP typically cover individuals who are disenfranchised from the health insurance system. They either live in poverty and can't afford insurance, or they are medically uninsurable, which means insurers refuse to cover them. Before Medicare, 50 percent of seniors had no health insurance. Before Medicaid, virtually every low-income child and every low-income disabled American lacked coverage.

Medicare, Medicaid, and SCHIP have helped lift millions of seniors out of poverty and have given children a fighting chance at a healthy, productive life. If we forsake these commitments, the number of uninsured inevitably swell.

In regard to Medicaid, the President's Block Grant—excuse me—Block Loan approach is premised on the notion "a little fiscal discipline and a dose of flexibility will put the brakes on Medicaid spending." The problem is Medicaid costs are not rising because Medicaid is inefficient or inflexible. The myth that public programs like Medicare and Medicaid are less efficient than private insurance, is just that. It is a myth.

According to a study released yesterday, Medicare costs have been growing more slowly than that of private insurance for the last 30 years. Medicaid costs for children and non-elderly adults are growing at half the pace of private health insurance premiums. Put another way, private health insurance plans would have to cut their annual premium increases by half to rival Medicaid growth rates. Pretty good for an entitlement without responsibility, to borrow one of the terms of endearment our friends Governor Bush and Governor Rowland used in referring to Medicaid. It would be difficult to accuse State Medicaid programs of profligate spending on children and non-elderly adults. The same holds true for spending on the elderly and the disabled.

I understand Governor Rowland is cracking down on long-term care eligibility abuses, but I am sure even he would agree these abuses have a relatively small impact overall.

If anyone can produce evidence that elderly and disabled Medicaid beneficiaries are systematically receiving care they don't need, or the States are paying providers too much for that care, I would like to see the evidence. What beneficiaries are getting too much coverage? What benefits should we not be providing? Tell us.

And while I think we can certainly find common ground when it comes to Medicaid flexibility, increased flexibility is not going to enable States to reduce Medicaid spending appreciably. Medicaid costs are increasing because our population is aging and because health care costs, particularly drug prices, are rising in both the public and the private sector. Medicaid costs should grow because Medicaid fulfills a societal need that is growing. If we abandon Medicaid beneficiaries when actual and projected costs don't line up perfectly, then we will be fully responsible for increasing the number of uninsured. So much for the President's coverage goal.

There are responsible steps we can take to ease the pressure on State budgets and protect beneficiaries. We can adopt the administration's proposal to increase the Medicaid rebates required from drug makers. We can pass a meaningful prescription benefit. We can Federalize the qualified Medicaid beneficiary program. But our top priority must be to help State Medicaid programs weather the current budget crisis so that beneficiaries don't lose coverage.

Peter King, Republican from New York, and I have introduced legislation to provide a temporary increase in Federal matching funds. The bill would provide $70 million to Connecticut, $217 million to Florida—not in form of a loan tied to a Federal funding cap jeopardizing the future of Medicaid, but through direct assistance to protect coverage for current beneficiaries. I understand Governors Rowland and Bush oppose this legislation. Apparently they don't need help weathering enrollment increases associated with economic downturn and the unanticipated explosion in prescription drug costs.

Governor Rowland just cut 23,000 low-income adults from Medicaid. Governor Bush plans to cut 20,000 elderly and disabled individuals from Medicaid next year. I guess some are more entitled, Mr. Chairman, to public dollars than others. You can't eliminate a societal need by ignoring it. Medicaid is too important for that.

Mr. BILIRAKIS. The Chair thanks the gentleman. Under our rule, I would appreciate it if members would defer their opening statements as much as possible. Governor Bush, I know, has another appointment at something like 12:30. He has to leave between 12 and 12:30. It is just important that we all have an opportunity to question him. But in any case, I will recognize the members for 3 minutes, and hope that many of you will defer, and now recognize Dr. Norwood for 3 minutes.

Mr. NORWOOD. Mr. Chairman, I will defer my opening statement in order to gain my 10 minutes worth of questioning.

Mr. BILIRAKIS. Eight minutes worth of questions.

Mr. Pallone.

Mr. PALLONE. Thank you, Mr. Chairman. Mr. Chairman, time and time again, President Bush proclaims that our goal is high

quality, affordable health care for all Americans, and time and time again, Mr. Chairman, our President and the Republican leadership did not follow up their words with actions.

In this hearing today, I am sure we are going to hear that the President's Medicaid proposal expands access to health care, however, in reality this is a proposal that blackmails States into block granting Medicaid. By undermining access to care for the poor, the sick, and the disabled, the President's proposal weakens the health care safety net and, in my opinion, adds to the widening credibility gap that is putting him and the Republican leadership that support his proposal further out of touch with the American people.

By block granting a large portion of the Medicaid program, this proposal simply passes the buck on to hard-pressed States like my own, New Jersey. By shifting fiscal responsibility to States, the Medicaid Block Grant encourages States to limit their liability by capping enrollment, cutting benefits, and increasing cost-sharing for millions of low-income people.

Mr. Chairman, I think we need to strengthen not undermine the Medicaid program by supporting an increase in the Federal Medicaid contribution. Mr. Brown mentioned the legislation that he sponsored, that I have co-sponsored. That bill would provide a direct infusion to States of over $9 billion in 2003 alone. And I know States are always amenable to flexibility, but this kind of legislation is the type of Medicaid relief States desire, not a budget neutral block grant.

Now, I know it was mentioned that this is Cover the Uninsured Week, and it is very sad to me to see what has been going on. In the time of the Clinton Administration, we recognized the fact that there were a significant number of uninsured. We tried to establish new programs, expand Medicaid, establish the SCHIP program, do additional things through Medicare, and we even had additional proposals to try to bring more and more people through money infusion to the States, to try to reduce the number of uninsured.

The opposite is happening now under this administration. The number of uninsured goes up, and that is because in many cases the States don't have the money to continue with SCHIP, to cover not only the children but the adults, their parents, or even to expand it to include single adults. And I am afraid that what we are seeing today is the continuation of the Bush Administration policy that would simply say, "Look, we are not going to do anything," or "We can't do that much for the States, we have a budget problem, and so you are just on your own. We will give you a little more flexibility, but we are not going to give you the money so that you can expand and cover more of the uninsured." And it is very unfortunate. The States cannot handle this. In my own State of New Jersey, because of the budget crisis, there are going to be more and more people that are uninsured.

The only way that we are going to reverse this is for the States to give more money to the Federal Government, not to provide some flexibility that ultimately is nothing more than a block grant. The numbers show it. The facts show it. The number of uninsured are going up. They were going down before this administration took office. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The gentleman's time has expired. The gentlelady from New Mexico, Ms. Wilson.

Mrs. WILSON. Thank you, Mr. Chairman. I wanted to welcome all three of you here today, particularly Governor Richardson from New Mexico. You deal with now some of the things that I had to deal with in a previous life in dealing with children who are abused and neglected and in the custody of the State.

In New Mexico, we have one of the highest rates of uninsured of any other State in the Nation, and 70 percent of the people enrolled in Medicaid in New Mexico are children, many of them in the custody of the State, often physically healthy and emotionally a wreck. And the way Medicaid deals with those children is terribly important to our future and their access to health care.

I wanted to highlight the importance of some inter-relationships here between Medicare and Medicaid and the SCHIP program. The Federal Government sets the reimbursement rates for Medicare, and most States and private insurance companies tie what they pay to what Medicare pays, which is all set by the Federal Government, and New Mexico and a handful of other States get the short end of the stick because the Federal Government pays less in Bernlillo County, or Torrance County, or Sandoval County, than they do in Cook County or in Staten Island. We don't pay into Medicare based on where we live, and we shouldn't be denied access to health care because of where we live.

We need to add a prescription drug benefit to Medicare, and that will help you, as State Governors, with your budgets because, if we model it on the lines that we did a couple of years ago—in New Mexico, for example—by adding a prescription drug benefit, $87 million worth of pressure comes off of the State Medicaid program that is trying to cover prescription drugs for low-income seniors.

We also need to address the disproportionate share hospital issue, and I hope that we will address that this year. There are pockets of poverty and areas of hopelessness that we need to address. We need to reform this system, and I look forward to working with you and with this committee to do so. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The Chair thanks the gentlelady. If he is still there—Mr. Dingell, are you there—you are recognized.

Mr. DINGELL. Good morning, Mr. Chairman. Thank you. I would like to welcome our three Governors. Governor Bush, welcome. Governor Rowland, welcome. And to our old friend, Governor Richardson, a former member of this committee, welcome. It is good to see you back in this room. We have missed you.

I am delighted, Mr. Chairman, to have this hearing. I think that this is only the beginning of the inquiry that must be made by this committee into the business that we discuss this morning. I note that as we are sitting here, the Budget Committee is preparing instructions to this committee to cut $110 billion out of Medicare and Medicaid. I think we ought to see this proposal before us with an appreciation of what it means not just to this committee, but to others.

I am delighted that we have the Governors here. I think it would be splendid if we were to be hearing from witnesses who are recipients of Medicare and Medicaid so that we can understand what

these proposals mean to us. It would be very useful if we could hear from witnesses on behalf of the administration. I would note that this committee is hearing this matter with a bag on our head. We haven't got the vaguest idea, nor do the three Governors sitting here before us have the least idea of what this legislation means because it has not been submitted to them or to the Congress. In a word, we don't know what is going on here.

I would note that I would normally counsel my friends, the Governors, to read the fine print because I think we have at hand here a situation which might best be described as a kind of legislative "bait-and-switch." I hope that that is not the case, but I think that we are looking at a situation where we are going to see block grants, and I would warn the Governors that block grants have a way of being cut over time, and that the money which would normally appear to be available may start out to appear to be available, but when we are done it "ain't" there.

Having said that, I think that the proposals that I have seen and the description I have seen of them coming from President Bush are not reform but, rather, a frontal assault on the health insurance safety net of this country. Under the guise of helping States with fiscal relief, the President has proposed capping Federal assistance to the States, ultimately shifting more, not less, of the burden to the State. And this is going to be sweated out of the hides of the recipients of Medicare and Medicaid.

Some say the proposal is optional, so what is the harm? Simple fact of the matter is it is not optional, and it is not optional to those who have needs. I believe we need a dialog on this matter.

I would note that the optional populations are an interesting group. Illness knows no such designation as optional nor should we. An elderly widow living on Social Security benefits, a mother of two diagnosed with breast cancer through a CDC screening program, or a 7-year-old with cerebral palsy living in a rural farm area, these people may be optional by the letter of the law, but by the great horn spoon they are not optional when we look at their health needs and the concerns which they feel and the sheer terror with which they confront their health problems.

I am particularly interested to hear today how our Governors think this will affect the long-term benefits and others to their residents in their respective States. How will this proposal benefit working families who rely on Medicaid to care for a disabled child or a frail elderly parent, for example?

And I would note to you that most of the people who lack health insurance in this country are working families and not parasites who do not seek to work or to carry their end of the log.

There are a lot of needs here. The States need help to address the problems of a growing—indeed, a burgeoning—low-income Medicare and Medicaid population. The Bush proposal provides no such relief.

States need assistance to deal with the cost of prescription drugs. There is little, if anything, of that sort to be discerned here. The Bush proposal provides, again, no such relief.

States need assistance with the cost of long-term health care. There is no sign of that being here. I would note that, indeed, we could probably expect that there will be cuts in these things, with

consequences not just to patients, but consequences to providers—to doctors, to nurses, to nursing homes, and the hospitals—all of which are in significant peril or, indeed, may kindly be described as being in desperate straits.

For more than 35 years, the Federal Government has been a partner in this program. It has been a great program and it has helped the people of this country.

I think I should close with a little advice to all concerned. I would tell our Governors "read the fine print," but there ain't no fine print here before us today, so we have no way of knowing exactly what the administration proposes except to know that shortly this committee will be receiving instructions to cut some $110 billion out of this program.

I thank you for your recognition, Mr. Chairman. I ask unanimous consent to revise and extend my remarks.

Mr. BILIRAKIS. Without objection, the opening statements of all members will be made a part of the record. The gentleman's time has expired.

I would remind all of the members of the subcommittee that I was very pleased to see $3.2 billion in new money in the President's budget. That does not connote a cut in Medicare services to me. It basically says to us, improve it. We have additional money here for those improvements.

And now the Chair would recognize Dr. Fletcher for an opening statement.

Mr. FLETCHER. I will defer to the question period.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Upton.

Mr. UPTON. Thank you, Mr. Chairman. I am going to put my full statement in the record and maybe take just a minute. I would like to welcome our guests, and note that Governor Richardson looks a little more wide awake than he did on the Today Show the other day, but I figure that was 3:30 in New Mexico and you got up for that show. Governor Rowland, it is good to have you back week after week. And, Governor Bush, welcome.

I would just say I just came from the Republican Conference where we talked a lot about the Republican budget, the Nussle budget, that is likely to be on the floor next week. We were reminded that Medicaid has gone up to the States—Medicaid payments to the States—reimbursements have gone up by 78 percent since Republicans took charge in 1995. However, the Nussle budget apparently cuts 1 percent from the baseline for Medicaid, which is a 2.5 percent reduction from the President's request. And since the Governors are on the front line of Medicaid and leading the States to see who is eligible and the services that are provided, I will be most anxious to hear from you three in terms of what will happen if you look at a 2.5 percent reduction from the President's request. I yield back my time.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Waxman.

Mr. WAXMAN. Mr. Chairman, I am going to make no opening statement, and reserve the time for my question period.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Stupak.

Mr. STUPAK. Mr. Chairman, I will reserve the time for my questioning.

Mr. BILIRAKIS. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman, and I won't take the full 3 minutes, but I would like to just make an opening statement because I know the timeframe that we have.

I was in the Legislature for many years in Texas and welcome Governor Richardson. We obviously miss you on our committee. And I know what my legislators in Texas are going through right now, just like in Florida and other States.

And the concern I have is our solution is to block grant it and provide flexibility. The problem is both on the Federal level and the local level, we are seeing so much—I am worried we are getting into the quality of the program in particularly States like Texas who would not have a rich Medicaid program. That is the concern I have, and so many people, particularly in urban areas and some of our rural areas, are dependent so much on it. I do think we are seeing maybe ultimately the demise of the Medicaid program, although I can tell you right now the proposal that is on the table, if States can borrow against 10 years from now under Medicaid, we would do it because, again, we have a balanced budget requirement in our State, like most States have, and we will do it now to pay it back later, but I think the program will be hurt, and that is the concern I have, Mr. Chairman.

Again, I am glad you are going to have a continuing series of hearings not just from our Chief Executive of our States, but also for providers, for recipients, for everyone else, because I think this is too important for us not to delve into. Thank you.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Barton.

Mr. BARTON. Mr. Chairman, I will defer. I do just want to welcome my classmate from 1984, Mr. Rowland, and my nemesis on the baseball field, Governor Richardson, and our good friend, Governor Bush, from Florida. We appreciate you Governors being here.

Mr. BILIRAKIS. The Chair thanks the gentleman. Mr. Burr for an opening statement.

Mr. BURR. Thank you, Mr. Chairman. Clearly, Mr. Barton has aged at a much faster pace than his classmates.

Let me also take this opportunity to welcome Governor Bush, Governor Rowland, and our good friend, Bill Richardson. And let me stand up for the three of you in your defense. There are some of us that believe that Governors do care about the people that live in their State; that when you are sworn into office it is not to serve as the leader of your State for some people and not for others; that when you are in charge of a budget—in many cases like North Carolina where ours is mandatory to balance—that getting control of a Medicaid problem is an important budgetary item, but it is also a great responsibility to make sure that those people at-risk are covered in some way, shape or form.

There are some in this town that believe that great ideas only come from here and, in many cases, whether you call something a block grant or a gift or a stipend, if we send along with that money the regulations as to how you have to spend it, it does you no good. The fact is that each one of the States that are represented here today—and I believe any other Governors that we could invite up—have different challenges in their States as to how to design their systems if they want them to rely on the strength of the health care delivery system in that given State.

My hope—and I believe the President is right—to allow more money up front, to allow you to make the structural changes that you need to make to fix the health care delivery in your State, that it not come with a set of mandates out of this institution or this town, that it come with suggestions if we believe we have some that are worthwhile, but ultimately we leave it up to you. I thank the Chair.

Mr. BARTON. The gentleman's time has expired. The gentleman, Congressman Davis, do you wish to make an opening statement?

Mr. DAVIS. I do, thank you, Mr. Chairman, very briefly. I want to welcome my Governor, Governor Bush, as well as the other Governors, and briefly state that I understand why Governor Bush is here today to promote the flexibility. Governor Bush has done some very positive things for the State of Florida using flexibility, particularly with the developmental disability program, that I think are a model for the rest of the country, and he is building upon a tradition that Laughton Childs seized in using flexibility in the Medicaid program.

But I think the key point to highlight here, that I am hopeful Governor Bush will address, as well as the other Governors, in States like Florida where the rate of aging in the population is beginning to skyrocket, it is not truly reflected yet in the Medicaid budget. By taking the flexibility and the additional funds, I am terribly concerned that Florida and other States are giving up the additional Federal funds it will need in the years ahead as the population grows and ages remarkably because, if you study the fine print that Mr. Dingell referred to, each of the States that accepts this program are being locked-in to a percentage rate of growth off your 2002 fiscal year baseline. It does not take into account population increase, does not take into account fully the rate of increase in aging and the additional mental cost that poses. And I am terribly concerned about the long-term implications of that to the residents of all of our States.

I want to close by saying that one of the documents that has been presented to this committee in support of the administration's recommendation are OMB numbers that show that ultimately the goal here behind the President's proposal is to reduce the cost of the program and save money to the Federal Government. The key question is how is that going to affect the folks at home, particularly in States that are growing rapidly and aging rapidly. Thank you, Mr. Chairman.

Mr. BARTON. Does the gentleman from New York wish to make an opening statement?

Mr. TOWNS. I won't use the entire 3 minutes, Mr. Chairman.

Mr. BARTON. The gentleman is recognized.

Mr. TOWNS. First of all, let me take the opportunity to welcome my former colleagues to the committee, and also to thank Governor Bush for coming.

My concern is Medicaid has been able to respond to the change in treatment therapies for AIDS patients because there was no cap or block grant of the program. When the cost of new innovative therapies increased, Federal Medicaid dollars were available to assist States with those rising costs. So I am concerned now as to how States will be able to provide new therapies to people with

chronic illnesses like HIV infection if this administration's proposal actually goes through.

So, I would hope that in your comments that you would address this because I think this is a very important issue. And on that note, Mr. Chairman, I yield back.

Mr. BARTON. The Chair thanks the gentleman. Does the gentlelady from Colorado with to make an opening statement?

Ms. DEGETTE. Thank you, Mr. Chairman. I would like to join my colleagues in welcoming our distinguished guests, and particularly my Governor, the friend to the South, whose seat I took on this committee when I was elected to Congress. This is a very important hearing. I am looking forward to all of your testimony.

I would like to talk about Medicaid in general, but in particular a couple of the programs. I have read the testimony, and there is one point on which Governor Bush and I agree, and that is that the Medicaid program which was adopted in 1965 was created at a different time for a different population. It was established for people who were not in general employed. But contrary to popular belief, today most of the people in this country who are uninsured are working. They are the working poor. Nearly 4 out of 5, or 78 percent, of those without health insurance in 2001 and 2002 were employed. And Medicaid, in 1965, never factored in this population or the challenges they face. And, similarly, Medicaid never factored in our elderly population who is in need of these services.

In Colorado, 1.2 million people, almost 1-in-3 in Colorado under the age of 65 do not have health insurance, and many States, because of their fiscal crises, are considering plans to cut funding for Medicaid coverage. For example, the Colorado General Assembly recently passed and my Governor, Bill Owens, signed a bill which eliminates Medicaid coverage to legal immigrants. This is going to affect, we estimate, maybe 17,000 people in Colorado. Now, this affects people like 85-year-old women who have immigrated from the former Soviet Union with promises that they would be taken care of in the Land of Freedom. It affects young Latino children in my district whose mothers are working several jobs, but whose employers do not offer health insurance. This is going to be devastating to these populations.

Our Nation's public hospitals are also suffering because of Medicaid and disproportionate share hospital or DSH cuts. Denver Health, for example, is having a huge number of increasing people coming in without insurance, but yet in the 1997 Balanced Budget Act, Congress froze the disproportionate share funds.

The President's proposal is silent on how the funding for these providers is going to be treated. It doesn't have a separate funding stream, as near as I can see, to deal with these folks or to deal with the many millions of children for whom SCHIP has been such a benefit in the last 2 years. I am interested to hear in the testimony how this will work.

And, finally, Mr. Chairman, I have a letter in my hand dated January 16, and it is from Governor Bush, my Governor, Governor Owens, and Governor Rowland, who is here, to President Bush and Secretary Thompson about Medicaid. I would ask unanimous consent that this be placed in the record.

Mr. BARTON. Without objection, so ordered.

Ms. DEGETTE. And the point I want to make about——

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

Ms. DEGETTE. If I may just finish my sentence.

Mr. BARTON. Finish your sentence.

Ms. DEGETTE. Thank you, Mr. Chairman. The point I would like to make is that all of the Colorado programs that I know of in this letter could continue without any fundamental changes to the Medicaid program. Thank you, Mr. Chairman.

Mr. BARTON. Thank you. And thank you for talking in complete sentences, that was excellent.

Ms. DEGETTE. Always glad to help, Mr. Chairman.

Mr. BARTON. Does the gentleman from Louisiana wish to make an opening statement?

Mr. JOHN. Yield.

Mr. BARTON. Does the gentleman from Michigan, Mr. Rogers, wish to make an opening statement?

Mr. ROGERS. Not at this time.

Mr. BARTON. The Chair would recognize Mr. Stearns of Florida to personally welcome his Governor, and ask Mr. Upton to take the Chair.

Mr. STEARNS. Thank you, Mr. Chairman. I just want to welcome the great Governor from Florida, Mr. Bush, and our colleagues from the House, Mr. Rowland and Mr. Richardson. These are great individuals who served with distinction here in the House, and so it is always a pleasure to welcome our colleagues back.

For Governor Bush, I have touted his consumer directed care on the House floor, and also talked about his preference for home and community based care over institutionalizing our disabled. So I think he is to be commended, Mr. Chairman, for his initiatives here, and I thank all of them for coming on the floor.

And thank you, Mr. Chairman. I just want to make my opening statement a part of the record.

Mr. UPTON [presiding]. Mr. Deal, would you like to make an opening statement?

Mr. DEAL. Pass.

[Additional statement submitted for the record follows:]

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

Today we will hear from several of the Nation's Governors on the current state of Medicaid, and their views on what can be done to make the program work better in serving the 47 million vulnerable Americans who depend on it.

This hearing occurs against a backdrop of extremely difficult fiscal times for our States, and an clear need for increased Federal assistance to help maintain Medicaid services during this economic downturn. And obviously, this hearing is held against the backdrop of a proposal from the Administration which would take the first steps toward block granting the Medicaid program, removing vital protections for beneficiaries, and capping the Federal commitment to bear its fair share of the cost of the program.

Let's be clear: the Bush Administration's proposal is very bad news for the vulnerable people who depend on help from the Medicaid program—

—most of the people in nursing homes—in fact nearly 5 of every 6 of this vulnerable population,

—the wives and husbands left alone in the community who need enough money to live on when their spouses have to go into a nursing home so that they can avoid impoverishment,

—at least one-quarter of the disabled people covered by Medicaid, including severely disabled people who need help in order to stay in the work force,

—many of the children now covered in the program, as well as many of the pregnant women,

—people with AIDS who depend on Medicaid help for their life-saving drug therapies,

the list goes on and on. In fact, there is hardly a current beneficiary who is not at risk under the Administration proposal because of the simple fact that this proposal caps the Federal financial commitment and severs the link between Federal support and the cost and eligible population growth in any given State.

Instead of giving States the fiscal relief they need to maintain their Medicaid programs, the Bush proposal is an outrageous attempt to use the current fiscal crisis to entice States to give up their open-ended access to Federal funds and to agree to block grant the program.

There had been a great deal of attention to the carrot the Bush Administration has put on the table to bribe States to give up the long-term Federal support that under current law is inherently part of Medicaid. The Administration promises a short-term loan of some $3.25 billion next year, and a total of some $12.7 billion over the next several years—all of which has to be paid back through reduced Federal funding in the following three years—to States which agree to the block grant. Not only is this increased funding clearly insufficient, not only does it have to be returned out of future budgets—but it masks the real long-term fiscal threat to any State that takes up the offer: a cap on future matching payments. It is unconscionable that the extra assistance has to be paid back. But even if it didn't, closing the end on the Federal share of the program—determining it by formula unrelated to a State's expenditures, is the real dagger pointed at the heart of Medicaid.

This Administration has made the calculation that Governors, understandably desperate for fiscal relief now, will ignore the long-term fiscal plight in which they will place their States if they agree to a cap on Federal support for Medicaid. I think this demeans the Governors, and is a cynical attempt to deny fiscal help now to States that stand up for their future rights and refuse to accept a future cap on Federal funds.

Over a long history of block grant programs, we know that once an artificial cap on Federal funds is in place, ultimately significantly less Federal funds will be available. The fact that the Administration has proposed an increase factor, based on a nationwide formula, does not change that fact one wit. Once an artificial limitation is in place, future increases in need, cost, and demand will no longer be the Federal government's problem.

This is particularly ironic and troublesome given the aging of the population and the critical role Medicaid plays in providing nursing home and community care services.

The very area States have identified as the one that should ultimately be a Federal responsibility is one for which the Federal government is capping its contribution.

All of us are willing to consider views of the Governors and of the beneficiaries Medicaid serves to see what legislative changes would improve the program. We know that immediate help in the form of an enhanced Federal match is critical. And adjustments to make the program work more efficiently and effectively should of course be considered.

But asking Governors to pick short-term fiscal relief over long-term Medicaid support is wrong. It is bad for the States' ability to provide coverage to their needy citizens. And the ultimate losers will be the people who depend on the program.

The Administration has tried to mask the effect of their proposal by claiming that "mandatory" populations will be protected. The implication is that the poorest will be protected. That is wrong. It implies that this population will be unaffected. That is wrong. Match for critical services like prescription drugs would face limited funding through the block grant. Further, there has been no assurance that growth in payments for the population that still gets the regular Federal match would not further reduce the block grant funds available.

This Administration has made no secret of its desire to get out of the open-ended financial obligation that they have with the current Medicaid program. They know that the population is aging, that services for baby boomers are on the horizon, that expenditures for prescription drugs are increasing at double digit rates, that as the technology to deal with severe disabilities increases costs do as well. They want to insulate themselves from these fiscal problems and leave them in the lap of the States.

This is the Administration that refused to support the bipartisan Senate bill that passed overwhelmingly that would give an immediate increase in Federal matching funds to all the States.

This is the Administration that let funds lapse under the SCHIP program to provide health care coverage for low-income children.

This is the Administration that puts tax breaks for high-income people way above any help for low and middle income people.

Make no mistake: if the Congress passes this proposal, it will mean more uninsured people, more vulnerable people who will not be able to get the services they need, more tragedies for America's families trying to care for aging parents, disabled children, and kids with special needs.

It would mean a tremendous shift of responsibility to the States without adequate Federal help.

It would mean the end of Medicaid, and a loss of its protections for the nearly 47 million Americans that depend on it.

Mr. UPTON. That concludes the opening statements. Governors, welcome to the full committee, particularly Governor Bush, we appreciated the welcome you gave to my Wolverines in the Orange Bowl on January 1. Governor Bush, we will start with you. Your statements are all part of the record, and if you would limit your remarks to about 5 minutes or so—I know they are expecting votes close to 11 o'clock for us. So, Governor Bush, welcome.

STATEMENTS OF HON. JEB BUSH, GOVERNOR, STATE OF FLORIDA; HON. JOHN G. ROWLAND, GOVERNOR, STATE OF CONNECTICUT; AND HON. BILL RICHARDSON, GOVERNOR, STATE OF NEW MEXICO

Governor BUSH. Thank you, Congressman Upton, and I want to thank Congressmen Stearns and Bilirakis and Davis for being great Floridians and representing us so well up here in Washington. I was going to say something nice about Congressman Dingell. My dad told me to do that. It doesn't help much, but it is a joy to be with him and I appreciate the fact that he came to this subcommittee meeting.

Rather than read what I was going to read, I want to respond to some of the concerns. First of all, I am not here and I don't believe that my fellow Governors are here to defend a concept that hopefully will be thoroughly discussed—Congressman Brown and others that have expressed—we don't know what the fine print is, but yet you all seem to have defined the fine print in your own terms. I don't know what the fine print is either, but I do know—I do know—any proposal that does not deal with reforming the system will create significant problems for all State governments. If we do nothing, we almost assure that there is going to be reduction in the number of people that are receiving care from Medicaid. I believe that 48 or 49 of the States have either proposed cuts in this year's upcoming budget in terms of the number of people eligible, or have already done so.

Reform is essential for many reasons, but one of them is to protect the people that are already receiving Medicaid because it is such an important insurance benefit for so many people.

I think by providing flexibility, that we can embark on a period of time where reform is the norm, where new ideas and innovations are the norm rather than the exception. I appreciate the fact that Washington has allowed us to take advantage of Medicaid waiver requests and they have come faster than before, and we are very appreciative of that. But managing the waivers is a complicated process, and a cumbersome one at best.

So, I would hope that the National Governors Association, in a bipartisan fashion, working with Congress and the administration, could come up with meaningful reform that gives us flexibility, that allows us to protect the growing Medicaid populations that we have—Congressman Davis, I concur with your assessment completely, that if we are locking into a budget allocation over a 10-year period without having any recognition of the fact that some States grow faster than others, then that would be a difficult—we couldn't participate in that both because of the aging of our population as well as just the ongoing growth. We have 250,000 children brought into the world each year in our State. Roughly 45 percent of them are financed by Medicaid. We have a growing population of the developmentally disabled. We have provided care over the last 4 years. We have added 25,000 new people on those rolls through a Medicaid waiver program, and those numbers are growing. So any reform has to recognize that there is a baseline growth that is different for every State.

Having said that, an 8 to 9 percent increase in the Medicaid budget, which is about where we are today—in the State of Florida, that is $1 billion a year—will mean that in 12 years our State budget will be completely—the budget we have today, the $52 billion budget, that is the size of our Medicaid budget in 12 years' time. That is not a sustainable amount. No matter how generous Washington wants to be to provide support for the States, we cannot sustain that type of growth. There needs to be significant reform so that we focus more on prevention to lessen the cost of health care, that we are creative in providing benefits that Medicaid beneficiaries want—and I will give you one example, and I will conclude.

The SCHIP program is a great example of how, in partnership together, Washington and States have provided health care insurance for moderate and lower-income Floridians and Americans. It is a great program. Medicaid beneficiaries would opt into that program if they were given that chance because it has higher a quality set of providers, a more expansive list of providers. It has the kinds of options that families need. It is not as demeaning in many cases as it is, sadly, for many of the Medicaid beneficiaries in terms of their access to health care. It requires a co-payment. It requires deductibles. But it is a wildly successful program. And because of that, now 94 percent of all the children that are eligible for Medicaid or KidCare are receiving it. It is the vehicle by which we have attracted many lower-income Floridians' families to be able to receive the Medicaid insurance policy that they are qualified to receive. Were it not for that KidCare or SCHIP program, we would have lagged behind. And so that, to me, is one of the models that we should emulate. I guess that's a block grant, I don't know, but it is incredibly successful, and our State is the third largest provider of SCHIP insurance in the country because people have embraced it. And that is, to me, the type of thing that working together we can achieve.

And I will conclude by urging the Congress to work with the Governors. We hope to have a group under the leadership of Governor Patton and Kemfor—we hope to have a group prepared to negotiate to take the best practices that we have used in a wide vari-

ety of different areas, in curbing costs and expanding benefits, to work with Congress and the administration to build a Medicaid system that won't be forced to cut people off over the long haul. Thank you very much, Mr. Chairman.

[The prepared statement of Hon. Jeb Bush follows:]

PREPARED STATEMENT OF HON. JEB BUSH, GOVERNOR, STATE OF FLORIDA

Chairman Tauzin, Chairman Bilirakis, Congressman Dingell, Congressman Brown, and Members of the Committee, good morning. Thank you for the opportunity to speak to you today about Medicaid—the nation's health program for lower income Americans.

The Medicaid program has now surpassed Medicare as the single largest health insurance program in the nation. As the nation's major health insurer of low-income families, the elderly and the disabled, Medicaid spending nationally exceeded $250 billion in fiscal year 2002. The program consumes more than 20 percent of state budgets and represents a growing and significant portion of the federal budget. Medicaid enrollment is growing at annual rates of more than 6 percent, and spending is increasing nationally at a rate in excess of 13 percent.

Two weeks ago, the Nation's governors met here in Washington and agreed that the reform of Medicaid was an urgent priority. Secretary Tommy Thompson requested that the National Governors' Association form a Medicaid Reform Task Force to work with the Administration and Congress NGA is formulating the Task Force and expects to soon have a formal announcement. I have already agreed to participate.

Prior to the NGA winter meeting, Connecticut Governor John Rowland, Colorado Governor Bill Owens and I wrote to President Bush and Secretary Thompson. In our January 16th letter, we provided a profile of today's Medicaid beneficiaries, shared our thoughts and concerns about the program, and offered suggestions and support for reforming Medicaid. We must resolve not merely to tweak an old system. We must seize the opportunity to create a new system that honors the original vision of Medicaid while also recognizing that our society and health care system have changed dramatically over the 38 years since its inception.

I believe Florida can serve as a model for discussing Medicaid reform. On the one hand, we are the very picture of the future of the United States, given our population growth, our cultural diversity and our large number of seniors. On the other hand, while we have implemented several programs designed to improve access to appropriate services, those programs have also helped us to highlight the barriers to a more flexible, responsive system. My hope is that this hearing will set in motion a national discussion on Medicaid reform.

FLORIDA'S MEDICAID PROGRAM

Let me begin by reviewing how Medicaid serves Floridians.

Medicaid currently provides health insurance for more than 2 million Floridians, or over one-eighth of our population—and finances more than $11 billion of our state's health care expenditures.

Medicaid provides health care coverage to our most vulnerable populations—children in lower income homes, the aged and the disabled. For these Floridians, Medicaid has enhanced their access to care, improved their health, and contributed to their quality of life.

The program currently serves more than 45 percent of the state's pregnant women, provides care for more than 1.2 million children, offers acute and chronic care for 330,000 disabled individuals, supplements Medicare coverage for 288,000 seniors, provides coverage for more than 20,000 of our AIDS victims, and pays for 60 percent of nursing home days for approximately 47,000 seniors.

THE CHALLENGES

Florida's experience also demonstrates that the Medicaid system has endemic problems—problems that cannot be fixed by a growing economy or by one-time adjustments in the federal matching formula. Many of these problems are due to the vast changes that have occurred in our society over the past several decades—changes that could not have been anticipated by the original designers.

I'd like to outline briefly five challenges we face in Florida—population changes, disease prevention, diminishing provider networks, red tape, and unpredictable program costs.

POPULATION CHANGES

Medicaid was adopted in 1965—at a different time, for a different population, to finance a different health care system. Nevertheless, Medicaid today is largely unchanged from what it was nearly four decades ago. It is tethered to an outmoded insurance model that does not fully accommodate the changes in the marketplace or reflect the new faces of our Medicaid populations.

The dramatic population shifts across the nation are especially visible in Florida. The table below illustrates just some of the demographic changes that have occurred in our state since Medicaid was created.

Florida—1965 Compared to 2000

Characteristic	1965	2000
Total Population	5,954,000	15,982,378
% Elderly	11.2% (1960)	17.5%
Ages 5-17	23.7%	16.9%
National Rank Population	10th (1960)	4th
Foreign Born	272,000	2,400,000
Percent of Total Population	4.6%	15%
Life Expectancy	69.7 (1960)	76.9
Per Capita Income	$2,498	$27,764
% Below Poverty	26.5%	12.5%
High School Degree	41.1% (1960)	84.0%

* Note: Data are from 1965 and 2000 unless indicated.

Medicaid was originally created to provide benefits to those receiving public assistance and having exceedingly low incomes. Today, many beneficiaries work and have incomes above the poverty level and a substantial percentage no longer receive publicly financed economic assistance. Typical health care needs have changed from acute care to chronic and long-term needs; and Medicaid increasingly serves as a supplement to Medicare. We see more beneficiaries entering our program who have worked and have had positive experiences with commercial insurance plans. They come into the Medicaid program with an expectation and desire to be treated as active participants in their own health care decisions.

The current Medicaid system, however, has not adapted to any of these changes. For example, 47,000 Floridians are potentially eligible for consumer-directed care, but only 1,500 participants are permitted under the federal cap on Florida's waiver. As a result, a 38-year old quadriplegic living in Key Largo without consumer-directed care must go to bed at 5:00 pm every night, because the assistance he needs is only available through agency health providers until that hour. Without the ability to direct his own care and choose his own providers, he has lost his independence and dignity in choosing his bedtime.

A mother with two children contacted us to say that her two children—ages 10 and 5—had been members of the S-CHIP, Florida Healthy Kids. She appreciated its affordability and the coverage it offered her family. In May 2002, she lost her job, and needed to apply for food stamps. While she was not informed, Medicaid rules required that her youngest daughter move out of the Healthy Kids program and into Medicaid. After finding work three months later, the mother requested that her daughter be re-enrolled in Healthy Kids, but was told that the child had to remain in Medicaid for another 9 months. At this time, her 10 year old was also removed from the S-CHIP program and enrolled in Medicaid

The current Medicaid system is increasingly isolating beneficiaries from personal choice and common sense answers to today's health care dilemmas.

LACK OF FOCUS ON PREVENTION

Despite the billions devoted to Medicaid in Florida there is substantial dissatisfaction with the program. Beneficiaries have trouble finding doctors who will accept Medicaid. Specialists and continuity of care are particular problems. Patients struggle with chronic diseases and their long-term effects. Medicaid focuses on treatment and allows very little for prevention.

In order to design a system that focuses on prevention, it would be necessary to provide incentives to those we contract to run our delivery systems (HMOs, EPOs), using prevention to improve the health of our beneficiaries and lower short-and long-term costs. It would also be important to reimburse health care providers using a fee schedule that places value on prevention. The system permits payments to treat and rehabilitate a stroke victim, but does little to encourage preventing the

stroke in the first place through blood pressure control, education and counseling. By focusing on treatment rather than prevention, the current Medicaid system has its priorities reversed.

HEALTH CARE PROVIDERS ARE LEAVING THE MEDICAID SYSTEM

Frustrations are spilling over from our patients to our providers. Federally mandated services and the burdensome costs of administering a disjointed system leave very little room in Florida's Medicaid budget to adequately compensate doctors, hospitals, and other health care providers. Many of our health care providers are no longer willing to participate in the Medicaid program due to the rules and regulations that have become more complex, and have compromised their ability to provide the best care.

Consider that a child with cerebral palsy living in Volusia County must travel to Hillsborough County—a five-hour round trip—to see a neurologist and orthopedic surgeon to treat chronic back pain. Lack of local providers willing to participate in Medicaid reduces access to health care, and worse, perpetuates an inferior tier of care. This is only one example of the failures of the Medicaid program, but similar failures occur daily.

Florida has sought to offer new opportunities for care, but we are limited when we cannot keep providers in the system. Medicaid patients should not have to rely on emergency room services, or have to delay receiving care because of limited providers available for coverage. Last year, non-critical Medicaid visits to Florida's hospital emergency rooms cost the system more than $40 million.

TOO MUCH RED TAPE

Bureaucracy is also isolating our patients from care. Providers constantly complain about the difficulty of navigating patients through the current system—with its paperwork and low fees. Patients also must maneuver the system, and are equally discouraged. There are costs associated with time delays, approvals, needless paperwork, and processes for monitoring each individual component of our state program. Current inefficiencies and bureaucracies also create an atmosphere for fraud and abuse. These additional costs are burdensome for all, and dilute health care resources.

To provide a more patient-focused system, Florida has implemented waivers to attain some flexibility in meeting the needs of our beneficiaries. We have welcomed the spirit of cooperation between the Administration, HHS, and the states in addressing Medicaid issues. We appreciate their effort to grant the states new flexibility and opportunities for innovation through measures like the Health Insurance Flexibility and Accountability waiver process.

However, managing multiple waiver programs on top of the federally mandated Medicaid program has become a challenge in and of itself. Florida has seized the opportunities afforded by federal Medicaid waivers, but a better system would eliminate the need for waivers by building flexibility in as a guiding principle.

EXPENDITURES

The bottom line is that Medicaid is not serving the needs of those it is meant to serve. If that isn't frustrating enough, the program costs are unpredictable and growing rapidly.

Virtually all states are facing unsustainable growth in Medicaid costs, and the nation's Medicaid price tag now surpasses that of Medicare. Florida ranks 4th nationally in beneficiaries and 6th in spending. Our state spending is now increasing by an average of $1 billion annually. Spending has nearly doubled in just six years. Florida Medicaid now represents more than 22 percent of the state's budget.

The number of Florida Medicaid patients is growing by more than 8 percent per year. One in eight Floridians are covered by Medicaid. One in three Floridians get their health insurance coverage through either Medicare or Medicaid. In just 12 years, at current growth rates, Florida's Medicaid costs will equal today's entire state budget.

These are only five of our daily challenges. Populations continue to change, needs are shifting, providers are dwindling, red tape is growing, and costs are spiraling. Medicaid beneficiaries deserve a better system of care. The size of our joint federal and state investment demands reform.

CONFRONTING THE CHALLENGES

While we believe that a new Medicaid system is a necessity, that belief has not stopped us from implementing reforms to make the old Medicaid system work better.

Let me highlight what we have done in Florida to enhance Medicaid services for beneficiaries.

- In the early 80s, Florida implemented home and community-based services for our citizens who are disabled and elders. We participated in a demonstration to test consumer directed care, allowing beneficiaries more discretion in planning for and buying their services. Expanding this effort of choice and control for other beneficiaries requires further permission through waiver approval—a timely process that delays and limits access.
- We have expanded drug coverage for our seniors, while implementing a comprehensive prescription drug cost management program—one that preserves benefits but uses aggressive utilization monitoring measures, oversees prescribing and benefit use, secures supplemental rebates from manufacturers, and promotes the use of preferred products. These efforts to serve this Medicare population have been important to maintaining the health of those seniors who qualify. Until a Medicare prescription drug benefit is enacted, there are still many who do not have coverage.
- Recognizing that 50 percent of our spending is devoted to 5 percent of the population, we implemented a large disease management program. We've developed partnerships with drug manufacturers to prevent disease, engage and educate our beneficiaries and encourage healthy lifestyles.
- This includes our groundbreaking public-private partnership with Pfizer, Inc. and 10 of the state's largest hospital-based health care systems to help more than 80,000 patients diagnosed with asthma, hypertension, heart failure or diabetes to manage these chronic diseases and their health. With Pfizer, we have also launched a large-scale Health Literacy program. Knowledge is power. Literacy and understanding are the keys to self-sufficiency, and the ability to participate fully in the care of one's health. As successful as these initiatives are in maintaining good health and avoiding costly treatment alternatives, expanding it into the mainstream can only be achieved through the flexibility of reform.
- Fraud and abuse are problems facing all payers and states. In Florida, we are working to minimize the problem. We have done this by quantifying the extent and nature of the issue, and where it is occurring. This effort has led to the utilization of new software in order to develop better profiles of potential fraud and abuse. We are limiting provider networks, using more sanctions, expanding investigations, and increasing background checks. We will continue this effort to safeguard our limited health care resources.
- We've greatly expanded the percentage of our population receiving managed care, not just through health maintenance organizations (HMOs), but through new provider owned and operated networks, minority physician networks, exclusive provider organizations (EPOs), and emergency department diversion programs. These are examples of meeting the distinct needs of the people in Florida. Taking ideas from the drawing board to reality requires a lengthy process of approval and limitations that hinder progress.
- In working with the state legislature, one of my highest priorities has been to provide a better system of care for Floridians with disabilities. Funding for the developmentally disabled population has increased by more than 100% during my administration. The state provides our disabled citizens a meaningful choice of home and community-based supports, rather than institutional care. Medicaid reform will offer more flexibility for consumers and their families, and done properly, will enable the state to manage the costs more effectively by targeting the appropriate services for the individuals' needs.
- Florida is also financing new residential programs for emotionally disturbed children, nursing home diversion programs, and has implemented breast and cervical cancer coverage statewide. Florida would like to do more in these emerging areas and others, but is constrained by the inflexibility of the Medicaid program. For example, we have been working for the past six months on federal waiver approval to implement a demonstration adult day health care program. However, the waiver is focused in a two-county area for only 100 daily placements. Despite sound reasons for seeking federal waivers, and successful demonstrations in other states, federal regulations do not guarantee waiver approval even after a lengthy process.
- We have the third largest State Children's Health Insurance Program (S-CHIP) in the nation that together with Medicaid is reaching 80 percent of those eligi-

ble. S-CHIP has been good for our children and stands out as a model federal/state partnership.

We have implemented these initiatives in Florida while reducing the growth in Medicaid spending by $1.3 billion from 1999-2002—without major changes in eligibility or benefit coverages.

I have no doubt that other states have implemented Medicaid reforms that also provide a glimpse of what a more flexible Medicaid program might look like. But please make no mistake. None of Florida's innovative programs represent comprehensive reform. While these "band-aids" make an outdated system work better, they do not create a new system.

REFORM PRINCIPLES

In our January 16 letter, Governors Rowland, Owens and I suggested that it is time to fundamentally rewrite the nation's Medicaid law. In order to modernize this program, we need to reaffirm its purpose, assure its long-term viability and establish a set of guiding principles.

We have the opportunity to restructure the program to increase access for the uninsured, improve treatment outcomes, promote private sector coverage, and lower future-year costs. Our goal should be to create a program that is grounded in patient access, preserves the dignity of the patient, and is predictable in terms of cost.

PATIENT FOCUS

I believe that the Medicaid program should be modified to encourage beneficiaries to be active participants, make informed choices, and direct their own care. The system should assist a family in identifying their specific needs and choosing the right plan for those health concerns. Emphasizing current screening components of the Medicaid program, we can determine patient needs and establish a medical relationship that addresses their personal requirements, and is seamless to Medicaid providers.

This focus is critical to families who participate in the current program—about 50 percent of Medicaid beneficiaries in a 2000 nationwide study by George Washington University reported at least one stigma-related problem with receipt of Medicaid. They suggested that the application process is humiliating, with unfair personal questions, and they felt that they were treated unequally by physicians. They felt badly about themselves, and believed that others had a misperception that the Medicaid program is only for those receiving welfare. These problems can often times lead to a delay in primary care until a beneficiary's health becomes critical.

This dissatisfaction has been shared with us through feedback from our Florida beneficiaries. Family after family has indicated that they would trade their Medicaid for S-CHIP like coverage and pay for it, but states are prevented from allowing these choices. Like S-CHIP, beneficiaries could contribute to the cost of their care through policies that use incentives for good preventive care, appropriate utilization, and sound decision-making regarding their family's needs.

When used properly, beneficiary cost sharing can improve health care. For example, if states were able to use meaningful but affordable co-payments for the non-emergency use of emergency rooms, patients would have an incentive to see their physician more regularly for care. The result would be better treatment and preventive care, with more emphasis on total well-being.

FLEXIBILITY

Medicaid is today largely what it was in 1965. Unlike other public programs, it has not been modernized. It still has many of the original eligibility and benefit mandates, discourages personal responsibility, encourages dependency, and limits cost sharing. The program emphasizes treatment rather than prevention, and does not reflect the new health care marketplace, the changing demographics of Medicaid beneficiaries, and new options tested by the states through waivers.

Extensive state plan and waiver standards and processing requirements are unwieldy and time-consuming. Although states have served as laboratories to test innovations in health care, we are constrained under the current outdated Medicaid model. State flexibility will create economies, lead to further innovation, and facilitate the spread of best practices between states. Flexibility will allow a state to tailor its program to fit its unique needs, even community by community. Truly, one size does not fit all. States should have the additional flexibility to partner in innovative ways with cities and counties in providing health care through locally designed networks.

CHOICE OF COMMERCIAL MODELS-PRIVATE OPTIONS

The nation's most recent work in designing a health insurance program was with S-CHIP in 1997. I commend Congress and the Governors for this outstanding effort, and for the legacy it is creating. It required states to use commercial coverage as the benefit standard, and providers and consumers alike have given high marks to the results. I believe the development of an S-CHIP-like model could be a roadmap for Medicaid reform.

Across the country, we applaud our private health insurance system, but that system is increasingly a public one. One of four Americans gets their health care through Medicare, Medicaid, and S-CHIP. As encouraged by the S-CHIP statute, through buy-ins and subsidies, we can promote private coverage.

SIMPLIFIED ADMINISTRATION

Many potential beneficiaries delay Medicaid participation to avoid the difficult, and often humiliating administrative process. New flexibility will encourage earlier access to health care, and healthier patients.

Medicaid beneficiaries have extensive application hurdles. Provider billing is complicated and medical record requirements are extensive. Simplification through HIPAA will help, but I think there are many other things we can do to simplify the administration of the program.

In Florida, we are trying to further limit administrative costs and reduce burdens on our beneficiaries by out-posting eligibility workers, shortening and streamlining eligibility applications, using passive eligibility re-determinations, using presumptive eligibility, coordinating eligibility between public programs, expanding provider electronic billing and remittance, and limiting attachments to claims. These efforts help maintain the dignity of those in the program, and control costs. Flexibility will allow us to eliminate many of these barriers.

AFFORDABILITY

If we reform Medicaid by emphasizing the first four principles, we will also realize our final principle, and that is affordability. We simply must get a handle on the exploding costs of this program.

The Medicaid program has now surpassed Medicare as the single largest health insurance program in the nation, covering 44 million Americans. The nation's governors and state legislatures are struggling to balance their budgets, some are facing billions in deficits, and many have been asking for immediate fiscal relief.

I urge you to recognize that spiraling Medicaid costs are not merely a budget issue. Any program in which costs spiral out of control—no matter how noble—severely limits our ability to fund other state priorities that also enhance our quality of life and which our people clearly want to fund.

These are basic principles—patient focus, flexibility, choice, simplification and affordability. With reforms that address these principles, Medicaid should ensure that we get both good care and good health.

A REFORM AGENDA

While Congress has updated the Medicare program several times since its enactment, there have been few attempts to reform the Medicaid program. No matter how successful states have been in stretching the muscles of the Medicaid program to compensate for the lack of meaningful reform—these efforts will only take us part of the way.

As a first step to reform, I would like to offer the following specific suggestions:

- Tailor a program to meet the needs of different populations. Medicaid could have many parts providing different coverages for different populations to meet different needs. It might include a core package of benefits, a long-term care package, and a supplemental package for lower income individuals with specific chronic health conditions.
- Recognizing S-CHIP as an example of how comprehensive, affordable packages can be crafted, we should consider state proposals to design benefit packages that look more like commercial models.
- Encourage Medicaid beneficiaries to be active participants in the program by making informed choices, directing their own care, sharing in the cost of their care, and helping to control program costs.
- States should be provided with greater flexibility in determining their Medicaid program designs and addressing the needs of their unique populations.
- Recognize state and federal funding limits. We want to provide care for those in need and seek their active participation in managing their health. We rec-

ommend moving away from entitlement without responsibility and encourage the recognition of the capabilities of beneficiaries.
- Reverse recent trends and encourage choice through private health insurance, and supplementing costs when necessary.
- Promote better integration and collaboration between Medicare and Medicaid programs for common populations and break down the distinct walls between acute and long-term care.
- Modernizing Medicare, including a prescription drug benefit, would provide an essential step in advancing Medicare reform and assist state Medicaid programs.
- Focus on healthy lifestyles and promote personal responsibility.
- Consider mental health reform as an important component of any Medicaid restructuring.

THE FUTURE OF MEDICAID

The current Medicaid system simply cannot be the best system possible. Across the nation, patients feel stigmatized and families have inferior access to care, providers are abandoning the system and costs are exploding. Florida does not have all the answers to these problems, but our experience does suggest that a better model for a new Medicaid program is not unrealistic.

I believe that this Congress has the courage and the vision to see what is working in the Sunshine State and in other states. I believe that this Congress can craft a new program for the nation that will serve our people better. I believe that this Congress has its work cut out for it, but we all must proceed as if lives depend on our very actions. They surely do.

Mr. UPTON. Thank you, Governor Bush.

Welcome, Governor Rowland.

STATEMENT OF HON. JOHN G. ROWLAND

Governor ROWLAND. Thank you, Mr. Chairman. First, we would like to thank you for the opportunity to present some of our ideas and some of the suggestions we have for what we think is a work-in-progress.

I certainly appreciate the comments made by the members, and what I would like to also do is respond to some of the comments. Congressman Dingell came to the NGA meeting a few weeks ago and made some of the similar comments, and talked about reading the fine print. And at that time, I responded by saying that the Governors of this Nation would like to help write the fine print. And we fully recognize that we have the most to lose or gain, that the Congress is very busy. You have numerous issues to direct your attention to, and when all is said and done, this is a plan that allows Governors, Republican and Democrat, to better manage their budgets but, more importantly, to better serve our constituents.

So I wanted to respond to some of the comments I have even read in the papers from Members of the Congress that have said, "Well, we can't possibly allow this reform to go back to the States because the Governors and the Legislatures, they don't really care as much about the constituencies as we do." And I would like to add that we do this for a living, all of us and, believe it or not, the days of Governors coming to Washington just asking for more money are over. Of course, we would all love to have more resources and increases in every budgetary line item, but the new day, the Governors that you see in the modern era, are here to say we are willing to try to reform the systems that we are managing back home each and every day of our lives.

And as I listen to some of the comments on both sides of the aisle, I can't help but look back in a sense of deja vous that I am sure that the welfare reform discussions of years ago were very

similar to these discussions, that if we reform the welfare system people will go hungry, and so forth and so on. Probably the best thing we have ever done in government was to reform that welfare system. In my State, 40,000 people now off of welfare and working and getting educated and having a much better quality of life.

The reality, as Governor Bush pointed out, there are probably 42, 43, 50 States, in some way, shape or form, that are making changes, negative changes to Medicaid. We have 45 States that are facing deficits. We have growing populations. You know all the issues and I know the issues as well. But I want to add that during the good economic times of the last six or 7 years, many of our States, the majority of our States, added to the Medicaid program, added options, increased the populations, increased the poverty levels. We are up to, in what we call our HUSKY plan, which is our uninsured program for children and parents, we increased that for children up to 300 percent of the poverty level. So we had working families making $54,000 a year that were eligible to put their children on the State-run HUSKY plan, which is a darn good plan.

And so Governors and legislatures, in the good times, have desperately tried to increase the poverty levels and increase the population served and increase the benefits across-the-board. So we do recognize the tougher economic times, and I want to just review a couple of the facts, and the facts are all going north. All of our populations are increasing. Health care costs, the percentages of our budgets, the Medicaid population costs certainly are 20 to 25 percent of our budgets. If you take in all health care costs, easily 40 percent of all of our State budgets. So this is something that Governors have laser-like focus on.

And during our National Governors meetings and discussions, we recognized and realized that we have an opportunity, and we recognize it is our opportunity, and it is a defining moment and a window of opportunity that we could lose if we do not engage with the Congress and tell you all how we think the program can work.

Now, some will say, "Well, it is not broken and it doesn't need fixing." I have heard those arguments and read those arguments over the last several weeks. We are not saying that it is totally broken. What we are saying is we need the flexibility. Most of us who have been Governors for a period of time have spent most of our time seeking waivers to expand Medicaid, and seeking waivers to do more resourceful things.

And in my testimony I have an example of three working families that can take part in a variety of different programs offered by the State of Connecticut. A family making $40,000, working, can of course use their insurance plan at work, and those costs are increasing by 15 or 20 percent per year, and their co-pays are increasing. We have another plan that allows working families to put just their children into the uninsured health care plan, and that is a great program, but those co-payments and those changes are taking place, as well. And then, of course, a third family with a lower income, both the father, mother and the children can go into the plan.

The reality, however, is that with our budget constraints we will be taking away that benefit to the parents. And so now the question becomes "How do we take care of that uninsured person?" And

Governor Richardson will talk about the huge percentage of uninsured people he has in his State. I will tell you that we do a great job insuring our people because we have great benefits and a fairly wealthy population. But because of the budget situation, I now have to think creatively of how to help that person who had the HUSKY plan for adults last year, who on April 1 will no longer have that plan. Give me the flexibility to help—and in my presentation I have a hypothetical presentation to help my friend Tony be able to pay for the plan at work.

The other key issue is long-term health care. We try to get most of our residents to move to Florida, to retire in Florida, and to be on the Medicaid rolls in Florida, and we are very, very successful. But for those that choose to stay, I need flexibility. Our health care costs and our nursing home costs are through the ceiling.

I did a comparison of the average nursing home cost versus assisted living, for example. You are talking $3,000-4,000 difference per month. And doesn't it make more sense to use at-home health care and assisted living programs and have a whole menu of possibilities ranging from a lot of medical attention to providing meals? If Governors have that flexibility, we can avoid paying $4,000 or $5,000 per month to take care of our aging population and allow our seniors to have some dignity to live at home or to live in assisted living accommodations, and right now we don't have that flexibility, and I think that would be a huge, huge savings.

Now, someone will say that we are going to run out of money in 7 years. The truth is that what you see from the proposal is a $12 billion up-front investment. And then I think the job becomes the States'. Can we, with that up-front investment of $12 billion over the next 7 years, can we creatively the options and the savings and the programs that serve our populations?

And I said this to some congressmen earlier today, I am a firm believer that if we fail miserably—if we fail miserably—seven years from now—and I don't think we will—I am sure the Congress is not going to walk away from that population. So this window of opportunity allows the Governors of this great country to provide the flexibility, the resources, the ingenuity, and the capabilities to change the status quo because the status quo is not working. The status quo is a budget-buster. We are not saying it is totally broken, we are just saying, my gosh, we need to do something about it because, if we don't do anything, I will guarantee you one thing, you will continue to see the Medicaid population decline in terms of who we serve.

Mr. Brown mentioned Connecticut and how many Medicaid recipients we have taken off, and in Florida, and I would also point out, in California, the Governor there wants to cut 543,000 people off the Medicaid rolls. And in Michigan they are cutting 52,000 patients. Missouri, it is 20,000. Nebraska, it is 22,000. Tennessee, 160,000. So what we do know is that will continue to decline in our services and our capability. And I have the optimism and I believe that with the work of the legislatures and the Governors, we can fix this problem before it gets any worse.

So I would end by saying that I know that many things in Washington end up being somewhat of a partisan nature, as welfare reform was a handful of years ago, the States can provide the safe-

guards, we can provide the flexibility, if you give us the opportunity. And I guarantee you that we will not let the citizens of this country down.

I know that there are many interest groups that will protect the status quo, and I am saying to you that, hey, we can work with everybody, and I believe with the Congress, in assuring that we put a proposal together that everyone can be happy with, with the appropriate safeguards to make sure that at the end of the day we can take care of those that we serve and those that we care so much about.

So, I thank you for the opportunity. I am looking forward to your questions. And as Governor Bush said, the National Governors Association is in the process of putting together a committee which now sounds like of 12—which is a frightening number—but we recognize the sense of urgency in working with all of you. And tomorrow morning when you are all talking about Iraq and tax policy and other issues, the Governors of this country will be home at work doing what we do best, and that is trying to take care of our citizenry, and we just need your help and your support and your trust. And it is not a leap of faith, we truly believe that this is a partnership that can work very effectively.

[The prepared statement of Hon. John G. Rowland follows:]

PREPARED STATEMENT OF HON. JOHN G. ROWLAND, GOVERNOR, STATE OF CONNECTICUT

Chairman Tauzin, Chairman Bilirakis, members of the subcommittee, and distinguished guests. Good morning. Thank you for the opportunity to appear before you today to testify in support of the President's proposal to reform the Medicaid program. If there is one message that you take away from speakers that you will hear today, it is that these reforms are necessary if the states are going to able to sustain a health care safety net for working families during the hard economic times that the states now confront. The status quo based on outdated concept of the same individual entitlement for all covered populations is not an option.

Let me begin by describing a theoretical conversation between three workers employed by a light manufacturing company in my hometown of Waterbury, Connecticut. The first worker, we'll call him "Joe", is the head of a household of four persons, including his wife and two children. "Joe" earns over $40,000 a year. He is the only wage earner in his family. He has provided health insurance to his family for the past ten years through the group health plan provided by his employer. During the last three years he has seen his contribution towards coverage for his dependents increase by 15% per year. He pays a $20 co-payment each time a member of his family sees the doctor. He pays a co-payment of $10, $15, or $35 for each prescription depending on whether the prescription is for a generic drug, a legend drug, or a drug, which is not covered by the formulary, offered by his health plan. All of his covered benefits are subject to defined limits on amount and duration. His employer plan is self-insured, and is therefore protected from state or federal regulation by ERISA. His appeal rights for any denials of service are limited to those defined by his employer. He has no coverage for dental care, vision care, or home care and only limited coverage for behavioral health and rehabilitation services.

The second worker is "Maria", a single mother of three. She earns just under $40,000 a year. She has declined coverage for her dependents and has enrolled her children in Connecticut's SCHIP program known as HUSKY B. For her three children she pays a maximum premium of $50 a month. Her children have no drug formulary. She pays a $3 co-payment for generic drugs and a $6 co-payment for legend drugs. Her co-pay for office visits for her children is only $5. Her children enjoy full coverage for dental, vision, and behavioral health services. If a service is denied, she can appeal that decision at no cost through the State Department of Insurance.

Finally, there is "Tony". As a new employee with less seniority than either "Joe" or "Maria", "Tony" earns $27,000 a year. With an household income under 150% of the federal poverty limit (FPL) for his family of four, "Tony" has enrolled himself, his wife and his two children in Medicaid managed care, known in Connecticut as HUSKY A. "Tony" pays no monthly premium for any member of his family. He pays

no co-pays for any service, including prescription drugs. His family is not subject to any absolute limits on services. The Managed Care Organization (MCO) in which he is enrolled does require prior authorization for certain prescription drugs, but he can obtain a 30 day temporary supply even if prior authorization is denied if his physician certifies that there is an urgent need for the medication. If any member of his family is denied a service, he must be informed in writing. If the denial is for a service that has been ongoing, he can continue to receive the service pending the outcome of an appeal to his MCO or a Fair Hearing with the Department of Social Services. His family enjoys full coverage for all the services covered under the Medicaid State Plan. His children may be eligible to receive services beyond those covered in the State Plan under the EPSDT (Early and Periodic, Screening, Diagnosis, and Treatment) benefit if the services are deemed to be either medically necessary or medically appropriate.

The topic of their conversation today is the reductions in benefits faced by these three workers on April 1. "Joe" is anticipating another increase of 10 to 15% in his contribution towards the cost of covering his dependents in the year ahead. He may have to consider a plan for his family with a higher deductible or increased co-payments. "Maria" will see her monthly premium for her children enrolled in HUSKY B increase more moderately from $50 to $75 a month. Some of their ancillary benefits will be eliminated, but she is looking forward to new in-home behavioral services for her son under the Behavioral Health Partnership involving the Departments of Social Services, Mental Health, and Children and Families.

For "Tony", the future is more uncertain. Due to the rising cost of health care and the sharp decline in state revenues, his wife will lose coverage under Medicaid on April 1. The family will no longer be able to receive coverage through the same health plan. Although his children will be able to retain their coverage, "Tony" may find himself uninsured if he is unable to pay the cost of his own rising employee contribution at work. He is hopeful that the State will be able to provide a subsidy towards the cost of family coverage at work, but he knows that it is dependent on federal approval for a waiver that may take many months to obtain.

It is a cruel irony in this situation that the working family that recently benefited from the expansions in Medicaid eligibility during the economic boom now find themselves in the most precarious position. The entitlement that was supposed to protect them has caused some members of the family to lose their coverage all together due the costly benefits and administrative requirements that are unique to the Medicaid program. In 22 states, including my own, Medicaid eligibility has been reduced. Medicaid benefits have been reduced in 22 states, and many others are seeking to implement premiums, co-payments, preferred drug lists, and other techniques routinely applied in the private sector to contain health care costs. Faced with the startling rich benefit package and cumbersome administrative requirements adopted in Medicaid to protect the most vulnerable, states find themselves forced to withdraw coverage from working families.

Now, you might ask, why don't the states move expeditiously to implement cost containment measures? The answer is, we have and we will. States have a great deal of experience in managing a health care delivery system that goes far beyond the mandates of the current Medicaid statute.

However, that capability is eroding. Prescription drug costs continue to rise at 15 to 20% per year. Legal challenges and regulatory requirements have made it increasingly difficult for the states to maintain a managed care network to control costs. Amendments to waivers and State Plans are slow and subject to challenge in the courts. We need the flexibility to adapt the coverage that we offer to all of the Joes, and Marias, and Tonys to fit the times we live in, coverage that makes sense, maintains equity and personal responsibility, and is sustainable.

The President's proposal offers the states a realistic chance to do just that. But there is another face to the Medicaid program. It is the face of thousands of individuals living with disabilities, of the elderly in long term care, of the families receiving benefits under the Temporary Assistance to Needy Families (TANF) program. We will never turn away from the obligation that we have to provide Medicaid benefits to these mandatory populations and federal funding should continue for these groups as it is today. The flexibility that we seek through the President's reform proposal will only enhance our existing efforts to provide services to these populations with dignity and in the least restrictive environment.

In Connecticut we have provided state funded assistance to these populations that pushes the boundaries of Medicaid coverage for prescription drugs, home care, and assisted living. Often times these programs have been state funded, simply because we cannot wait for Washington to do the right things to forestall the onset of the looming crisis in providing affordable long term care for the aging baby boom generation. Make no mistake about it, if the states cannot develop a comprehensive net-

work of care that includes alternatives to nursing home care for this population, our resources will be consumed by this issue, leaving little to provide for the uninsured. That is why we are pursuing a waiver of the current rules on the penalty period for illegal asset transfers; Long Term Care Insurance; Medicaid reimbursement for assisted living; a spend down option for persons who receive home care to address the institutional bias in Medicaid eligibility; and a host of other strategies to contain the costs of lifelong care. These strategies are every bit as dependent for their success on the kind of flexibility offered by the President's proposal as those directed at providing coverage for working families.

President Bush has taken an important step towards addressing this problem with his proposal for prescription drug coverage under Medicare. There are a host of other issues concerning the dual eligibles, those individuals who are covered by both Medicare and Medicaid, that that are of great concern to the states. States must be given the ability to manage the care of those Medicare beneficiaries whose premiums they pay for and whose benefits they supplement through the Medicaid program or that financial relationship must also be revisited.

This proposal provides a forum for that conversation, meaningful conversation, to take place. I ask that you support it, and that you help us provide sustainable coverage that can address the challenges of the new century. Thank you. I would be happy to answer any questions that you might have.

Mr. UPTON. Thank you very much, Governor Rowland.

Welcome back, Governor Richardson.

STATEMENT OF HON. BILL RICHARDSON

Governor RICHARDSON. Thank you very much, Mr. Chairman. First, let me say how great it is to be back in this room with my old colleagues. Fifteen years I spent on this what used to be the most exciting committee in the Congress. I take it it still is. And I want to just thank all of you for the nice comments, and it is great to be with my colleagues from the National Governors Association.

Mr. Chairman, I want to make four basic points and then perhaps suggest some ways we can work out some of these very serious problems that we are having with Medicaid in our country. I think we have to look in the larger context that this is a time of an economic downtown, a serious economic downturn in our country. People are hurting. We may be going to war soon. There is a lot of economic uncertainty. And the four basic points I want to make are obvious, but I think they need to be made.

First, Medicaid plays an essential role in the health care delivery system and economies of all the States. It is a key program. Forty-seven million Americans use this Medicaid program. In my State, two-thirds of Medicaid enrollees are children. I think what also needs to be noted is Medicaid also plays a key role in the economies, in the economic health of our communities, $3.4 million in business activity for every $1 million spent.

The second point I want to make is Medicaid costs are rising despite the best efforts of Governors trying to control those costs, and there are several reasons for those increases. First, prescription drug costs—I know you are going to try to deal with that—$7 billion per year growing at a rate of about 20 percent per year. The second is enrollment increases. In my State of New Mexico, 10 percent will increase next year just by normal activity—10 percent more enrollees—and it will increase by 3 million in this country since 2000.

Long-term care of our aging society, that is another reason for the increases. Medicaid cost growth is causing serious State budget problems. State revenues have plummeted with 16 States actually

experiencing negative growth in 2002. Medicaid's aggregate cost grew by 13 percent in the year 2002, the fastest growth in a decade just this last year.

Third, Medicaid's historic Federal/State partnership is critical and has to be preserved. We have to find ways to keep that partnership strong and alive. The Federal side has always participated proportionately in the Medicaid program.

Fourth, and my fourth point, Mr. Chairman, is in this year that you are going to deal with Medicare and Medicaid, it is critically important that the Congress act to strengthen Medicare and Medicaid and make some of these programs more responsive to States and more responsive to beneficiary needs.

What we need to do is also find ways that States get some kind of fiscal relief and we put in some kind of adequate cost-containment that already have broadbased national support. We also have to look at Medicare, and I know you are going to be doing that. Medicare reform is as key as Medicaid reform. We have got to do them together, and we have got to do them now because what is happening is the State share of Medicare enrollees' health care cost has increased from 30 to 40 percent and expected to reach 45 percent by the year 2012.

Now, Mr. Chairman, I think what is also important is that we be concerned about some of the reports that are coming out about plans that are going to be considered, perhaps the administration plan. Capping the Federal portion of Medicaid spending leaves the States with most of the risk. This new proposal, if it happens—and I admit that details are still sketchy, that it is going to be formulated, that we are discussing it—that increased flexibility is always great, but what does that mean for a Governor? Does that mean that I can now make easier decisions on who to take off the rolls? I think we have to be very careful that that is not the flexibility that we are talking about.

I think it is also important that we not have a choice between limited new resources—and I admit that the early funds that we get in the Medicaid proposal perhaps the first 3 years are good, but then in the outyears as you get into the seventh, eighth and ninth year, the resources dwindle dramatically and there is a cap, and that is going to be a problem for many States.

What do we do about this, Mr. Chairman? I think, first of all, let us do no harm. One of the concerns that we have is that at this point, as I have said, we have potentially millions of Americans whose coverage is at risk as a result of the State fiscal crises and the economic downturn. We should act quickly to provide some kind of State fiscal relief to preserve coverage for families, and I am talking about now, at this time, before your plan and your consideration is given in the next year to changes in Medicaid and Medicare.

Second, let us remember that Medicaid is the lifeline of our most vulnerable citizens. I don't think that capping Federal assistance is going to improve access, and I hope that you seriously consider that.

Third, I think we can provide States with fiscal relief and new flexibility without block granting the program. You did this, the Congress did this, in 1997. Congress provided States with many

new flexibilities without capping a Federal program. The health care needs of our people aren't going to go away. Capping is just going to shift the burden down to the States and down to families, but capping the program shifts the burden, and I don't think we should do that.

My last point, Mr. Chairman, we need to continue the State/Federal partnership, not weaken it. And my hope is that through the Governors Association and through working with this committee and the other body, we can come up with a plan that is truly bipartisan, that truly reflects the needs of our citizens. I want to echo what Governor Rowland said, we are not here to ask for handouts, we are not here to ask for just give us money and let us decide everything, I think we are ready to see a viable Medicaid program. The status quo is not working. Thank you.

[The prepared statement of Hon. Bill Richardson follows:]

PREPARED STATEMENT OF HON. BILL RICHARDSON, GOVERNOR, STATE OF NEW MEXICO

Mr. Chairman, former Chairman and Ranking Democrat Dingell, Subcommittee Chairman Bilirakis, Ranking Democrat Brown, Congressman Waxman and Members and friends of the House Energy and Commerce Committee, it is privilege and a pleasure to be before you in my new capacity as Governor of New Mexico. As a former Member of this distinguished Committee, it is also an honor to be asked to testify about the essential role Medicaid plays in our health care delivery system, the many challenges and opportunities that confront it, and the competing visions for this important program's future that are now before you.

As a Governor and a former Member of this Committee, I have had the opportunity to work on Medicaid policy from different perspectives. From my new vantage point, I can tell you that the costs of this program can and do produce great challenges for my State and all States. There is no question that we need some changes to ensure that this program will be able to continue to serve as the critical safety net it has for almost 40 years. Having said this, we must also make certain than any change that is contemplated does not do more harm than good. We can never forget what a vulnerable population Medicaid serves. Its 47 million enrollees include over 23 million children, 5 million seniors and 8 million adults with disabilities. As such, we should strive to improve—and not undermine—the program's Federal-State financing and delivery partnership.

OVERVIEW

Today, I would like to make four basic points.

First, Medicaid plays an essential role in our health care delivery system, assuring affordable, meaningful insurance coverage for seniors, children, and disabled individuals. As the second largest proportion of State governments' budgets and the fastest growing part of our budgets, it also plays a critical role in the economic health of our communities, representing $3.4 million in business activity for every $1 million spent.

Second, Medicaid costs are rising in spite of the best efforts of Governors to control them. The major cost challenges Medicaid faces—recession-driven enrollment increases, pharmaceutical cost increases, and the aging of America—are largely outside the Governors' control. Almost every state has had to consider and implement cuts in services, covered populations, and/or provider rates. Clearly, States need the Federal government to act now to assume its fair share of responsibility for financing and managing these growing costs.

Third, Medicaid's historical federal/state partnership is a critical element and must be preserved. The Federal government has always participated proportionately in the rising costs of the Medicaid program. Now, while States are in desperate need of Federal assistance with increasing healthcare costs, the policy offered by the current Administration is simply to cap Federal cost increases and shift to the States the tough decisions about whether to cut people or services. States would be given a choice to accept short-term fiscal relief that is insufficient and will end in a few years, in order to obtain additional flexibility to design the program to meet each State's needs. Federal responsibility must increase as uninsured populations increase.

And fourth, Congress should act to strengthen Medicaid and make the program more responsive to States' and beneficiaries' needs. Democratic Governors have and will continue to advocate for Federal policies that provide for increasing flexibility, immediate fiscal relief and long-term cost containment and that have already received broad-based support—amongst Governors and the Congress alike. We also welcome a serious, well thought-out discussion about even broader, more long-term Medicare and Medicaid reforms that seriously address flexibility issues and appropriate Federal and State divisions of coverage, delivery and financing responsibility. We call for a truly equitable prescription drug program for Medicare recipients, not one that forces seniors into managed care in order to obtain assistance with increasing drug costs. And we call on Congress to adopt legislation to cover the acute and long-term care costs of elderly and disabled beneficiaries so that States can focus on building a true safety net for children, seniors and disabled Americans not covered by Medicare.

I. MEDICAID ROLE IN THE HEALTH AND ECONOMIES OF THE STATES

Medicaid is a lifeline for millions of the most vulnerable Americans. Fully two-thirds of the nation's nursing home residents are covered by the program. Medicaid assures affordable, meaningful insurance coverage for over one in five of all American children. In my home state of New Mexico, 44 percent of our children are enrolled in the Medicaid program. The majority of our nation's people with severe disabilities, including most people with HIV/AIDS, get their insurance through Medicaid. Until the recent round of State cuts to populations and benefits, this program was also helping States begin to address the issue of individuals who are unable to purchase or become insured. Because it helps low-income families, Medicaid is the only health insurance program in the nation whose enrollment increases during economic downturns, when States face lowered revenues and deficits. New Mexico is anticipating a 10 percent growth in enrollment in the next fiscal year, even without increased outreach efforts. It is worth noting, Mr. Chairman, that without Medicaid's enrollment increases in recent years, it is virtually certain that the nation would have at least 2 million more uninsured Americans, causing individual financial hardship and increases in uncompensated care in the healthcare industry.

Medicaid represents a major source of reimbursement to our nation's health care providers and health plans, including 17 percent of hospital payments and nearly 50 percent of nursing home payments. Not surprisingly, the impact of Medicaid's contribution to the economy is significant. A recent report found that every million dollars spent on Medicaid creates another $3.4 million in business activity, supporting jobs and related businesses, especially in rural areas. In 2001, New Mexico saw the second highest rate of return of all the states with $5.76 in new state business activity per dollar of Medicaid spending. State Medicaid spending throughout the country generated almost 3 million jobs with wages in excess of $100 billion in FY 2001. New Mexico will have the second highest number of jobs generated per $1 million in State Medicaid spending. In fact, as bad as it is, the current recession would be much worse without the actual growth of jobs in the health care sector. In short, the positive role Medicaid has played for both our nation's health care and its economy cannot be overstated.

Unfortunately, the challenges the program faces are at least as great as its successes. Medicaid cost growth is causing serious State budget problems. State revenues have plummeted, with 16 States actually experiencing negative growth in 2002. Coupled with greater demands on services due to the economic slowdown, States' year-end balances in 2002 were 70 percent below where they were in 2000. Medicaid is the largest single growth area for State budgets and has clearly contributed to this imbalance. The program's aggregate costs grew by 13 percent in 2002, the fastest growth in a decade. In New Mexico, we are fortunate to have a modicum of new revenues and reserves upon which to draw. However, over 55 percent of the growth in our State expenditures for FY 2004 will be for Medicaid, leaving little for teacher pay increases or non-Medicaid social services.

To find a solution to this rapid cost growth in Medicaid, it is important to understand the problem. A recent survey of States found that the top three reasons for Medicaid cost growth were prescription drug costs, enrollment increases (largely driven by the downturn in the economy), and long-term care. What is remarkable about these cost drivers is their reflection of the challenges in the larger health system. These factors are not just driving Medicaid costs but are affecting Medicare, private insurance, and out-of-pocket spending on health care. They also are similar in that comprehensive responses to them require more than action by State Governors who by law cannot spend more than the revenues they can generate in any

given year, and who have little control over these factors most associated with Medicaid cost growth.

Prescription drug costs: States spend about $7 billion per year on Medicaid-covered prescription drugs, and that amount has grown in recent years at a rate of 20 percent per year. New Mexico's expenditures for prescription drugs in its fee-for-service Medicaid program have grown from $46 million in FY 2000 to $79 million in FY 2003, an increase of 73 percent. These expenditures represent about 8 percent of the entire Medicaid program costs in New Mexico.

I am working with New Mexico's legislature to develop a Medicaid prescription drug program for seniors, with the non-federal costs born in part by State funds and in part by out-of-pocket costs to seniors. A significant proportion of this spending is for Medicare beneficiaries who should have had a prescription drug benefit years ago. Since its inception, Medicaid has been forced to fill the major coverage gap in Medicare's benefits for seniors with very low income or high health care costs. The Congressional Budget Office estimated last year that, from 2005 to 2012, States will spend about $120 billion on prescription drugs for Medicare beneficiaries. Moreover, the payment system for prescription drugs is largely set in law at the Federal level. States that have tried to extend rebates or extract additional discounts have frequently encountered political and legal challenges. In New Mexico, I am working with our State Legislative Medicaid Reform Committee to develop voluntary rebate programs, a preferred drug list, and pooling of resources to increase our pharmaceutical buying power to help contain these rising costs.

Enrollment: Enrollment in Medicaid, the second cost factor named by States, has increased in large part due to the economic downturn—the worse fiscal crisis facing the States since World War II. The surge in unemployment has caused millions of families to lose their jobs and health insurance. For these families, Medicaid and SCHIP are the only affordable health insurance options. Since the year 2000, Medicaid enrollment has increased by 3 million, at a rate of 10 percent in most States. In New Mexico, enrollment has tripled since 1991, providing coverage for one of every five people in New Mexico and, as indicated above, 44 percent of my State's children. Without further changes to the program and without additional outreach efforts, we are anticipating a more-than-10 percent increase in enrollment in FY 2004. While some States have shouldered the cost of this enrollment increase, this cost increase has occurred at the same time that State revenues have plummeted and, for most States, the Federal contribution to Medicaid has declined. For many States, eliminating optional populations is the only solution to control this enrollment increase, leaving many children and adults uninsured.

Long-term care: Third, long-term care costs have been rising rapidly, and this rate will only accelerate as the baby boom generation ages and needs this service. Within the next 27 years, the population age 65 years and older will increase by 60 percent over 2000 levels and one in five adults will be 65 or over. Neither private health insurance nor Medicare insures against the catastrophic costs of nursing home and other long-term care needs. Additionally, few insurers provide supportive services to enable people with disabilities to live at home. States, through Medicaid, have filled this gap, providing innovative and high-quality long-term care to citizens who need it. Eighty-two percent of the projected growth in Medicaid expenditures between 2002 and 2004 is attributable to increased costs for elderly and disabled individuals. Yet, because many of these people are also covered by Medicare, not only are there care-coordination and coordination of benefits (COB) problems between these two disparate programs, but there is cost shifting from Medicare to Medicaid and States. This will only worsen as the elderly population doubles by 2030 with the retirement of the baby boomers. Today, while seniors represent about 5 percent of New Mexico's Medicaid enrollees, costs associated with the healthcare for seniors represent 19 percent of New Mexico's Medicaid budget. Almost all the seniors enrolled in Medicaid are also eligible for Medicare. This is yet another example of the importance of integrating Medicare into any serious Medicaid reform debate.

II. MEDICAID'S STATE/FEDERAL PARTNERSHIP

Medicaid was created as a partnership between the Federal and State governments. The Federal government requires certain mandated populations be served and identified mandated basic benefits be offered. States are provided considerable freedom to design a program that adds populations or benefits and defines services within certain parameters to meet the unique needs of each State. The Federal government provides oversight and assurance that basic access, quality and accountability requirements are achieved. When the costs of the program go up, these governmental partners share in the burden; when costs go down, they share in the savings. This sharing of financial risk creates a dynamic that allows States the flexi-

bility to expand and contract coverage while maintaining core support for the poorest and sickest people that they cover.

This federal/state partnership is particularly critical when there is an economic downturn. The Federal government's lack of a balanced budget requirement with which the States contend means that the Federal government is more able to absorb the increasing costs of healthcare for an increasing number of otherwise uninsured citizens. Any proposal that would put a limit on the growth in the Federal government's share of these costs while shifting the difficult decisions about coverage and benefits to the States would be an abdication of this historical partnership and the Federal government's role in assuring the health of our nation.

All the Governors want more flexibility to meet their changing needs and the changing face of healthcare service delivery. However, flexibility should not mean having to cut people from the rolls, reducing coverage, or watching children and seniors suffer, or even die, due to lack of healthcare. And, all the Governors need immediate fiscal relief. But receiving new federal monies now to address immediate issues should not be coupled with acceptance today of a future drop in these funds when we know that healthcare costs are going to continue to rise.

III. COMPETING REFORM PROPOSALS: WHAT SHOULD CONGRESS DO?

I applaud this Committee, the Congress and the President for taking up the issue of Medicaid reform. Indeed, my Democratic Governor colleagues and I agree with many of the sentiments expressed by Secretary Thompson in announcing the President's proposed Medicaid initiative. However, while we may agree on this program's importance and, to some degree, its challenges, we do not believe there are sufficient details of the Administration's proposal to determine the true impact at this time. The apparent solution: to provide State fiscal relief—however limited—only to those Governors willing to accept a capped, block grant for most Federal Medicaid and SCHIP funding causes us great concern. The Federal government needs to step up to the plate, not away from it; if it does not, States will either be overwhelmed by the new costs and need OR will have to shift an excessive amount of the burden to populations least able to afford it and to providers already burdened with extensive uncompensated care.

Later this week, the NGA will appoint a bipartisan Medicaid Task Force to review many different approaches to the financing and delivery challenges facing the Medicaid program and the other health systems it supplements. We look forward to working with all interested parties on this critically important issue and to receiving the Task Force's findings and recommendations. Some of our concerns are discussed below.

The President's Plan—Capping the federal portion of Medicaid spending leaves States with all the risk. President Bush's proposed Medicaid plan would replace the historical state/federal partnership with a forced choice between limited and capped new resources and increasing flexibility and the status quo in which costs are rising beyond States' ability to control them. The President's proposal is not well-defined at this point. As questions are asked by Governors, advocates and media, it is clear that the proposal's details are not determined and in fact are changing. Without those details, it is hard for anyone to determine the exact implications for any particular State. However you look at it, this plan protects the Federal government's budget while shifting difficult decisions and/or exploding costs onto States and their citizens. The Federal government—despite its lack of a balanced budget requirement and broader revenue base—would leave States at full risk for the two-thirds of Medicaid costs that represent "optional" populations and services. While Federal financing for "mandatory" populations and services would remain as a Federally-matched entitlement, Federal financing for the two-thirds of the Medicaid program that is "optional" populations and services would be set in law, and would grow at an arbitrary, capped rate. Since 80 percent of spending on the elderly is "optional," 86 percent of nursing home residents are "optional" and 90 percent of long term care spending is "optional," and since these costs are the ones rising the quickest, this cap on "optional services" would be especially devastating for States.

What would this mean if this proposal were applied to New Mexico? The Federal funding for prescription drug coverage in New Mexico—and all States for that matter—would be capped. Why? Because prescription drug coverage is an optional benefit. If my State is unable to constrain drug costs, we would be forced to reduce coverage, drop other benefits or limit enrollment. Moreover, because Federal funding for most of our so-called "optional" nursing home residents would be capped, New Mexico's influx of older residents would be made even more vulnerable to coverage or service cuts should costs exceed what appears to be an arbitrarily-imposed capped formula. Similarly, spending on mental health would be capped under this proposal.

Many of the rehabilitative services necessary for adults with serious mental illness and children with severe emotional disturbance are "optional." Inevitably, these caps for various populations and services would eventually force us to make unconscionable decisions between various populations in need, if we take this option in order to receive fiscal relief.

In addition to these difficult choices, it is important to note that projections of health care costs are often wrong. The inflexibility of block grants punishes the States and their citizens for this unpredictability. An unexpected surge in unemployment, a breakthrough in medicine that produces miracles—but at a high cost—or an epidemic or rise in chronic illness could all create an unexpected demand for health coverage. Governors would be under immense pressure to be responsive, but the Federal funding commitment would be limited by the cap on its portion of these costs. If a Governor did not respond to the demand through Medicaid, his or her State would likely be on the hook for the cost in any event as it would pay—directly or indirectly—the costs of uncompensated emergency room use, delays in care that result in unnecessary hospitalization, and public health problems resulting from unimmunized people or untreated diseases. In addition, local economies and providers would suffer from the loss of Federal Medicaid revenue. What is more, a poor decision by one Governor in one State, would tie his or her successor Governors and their citizenry to a permanent limitation on Federal support for the foreseeable future, or until Congress acts again.

What States Get In Return Is Not Likely to Be Worth the Gamble. In return for accepting the proposed Federally capped financing structure, States that opt for this approach would get a portion of the $3.25 billion allocated for 2004 and additional flexibility to design the Medicaid program as they want. The amount available for each State would depend in part on the number of States who choose this option. This amount of funds is actually less than the revenues the States are projected to lose if the President's economic stimulus bill is passed. It is one-fourth the amount of funds that would be made available with the enactment of the bipartisan and NGA-endorsed Collins, Hutchinson, Rockefeller, Nelson "State Budget Relief Act of 2003". It is less than one-tenth the amount of relief that Democratic Governors are advocating. And it is three times less than the King, Brown "State Budget Relief Act of 2003." Moreover, even if this funding were sufficient to meet today's needs, accepting the block grant on most Federal Medicaid funding means that this relief comes at the cost of coverage for State residents tomorrow. This creates an untenable position for future leaders saddled with choices made by their predecessors without the benefit of hindsight.

In addition, because the vast majority of the "optional" populations have incomes below poverty (about $9,000 a year), savings achieved by the proposed cost-sharing flexibility are low. Over half of the elderly covered by Medicaid are considered "optional". They are on Medicaid in the first place because they have been impoverished by health care costs. The income line between optional and mandatory coverage for parents is set at an average of 41 percent of the poverty line—about $3,600 of income for the year. How much cost-sharing can one obtain from these populations before either reducing access to needed care or shifting all the costs to health care providers? In New Mexico, a legislative Medicaid Reform Committee spent several months in 2002 looking at ways Medicaid costs could be controlled. That Committee found that while cost-sharing was an important component of cost control and should be implemented, it would only generate minimal savings for the program.

States do need additional flexibility with regard to delivery system innovations. Eligibility categories and processes could and should be streamlined. Services that can be covered should be flexible to keep up with evidence-based practices. And we should consider adding funding to SCHIP for parents and uninsured adults and ensuring that benefits and cost sharing for higher income populations make sense. However, reducing benefits and increasing cost sharing on populations with extremely limited means or high health care costs would work to shift costs to seniors, families, and health care providers. Moreover, appropriate and well thought out flexibility reforms should not only be provided to States that agree to block grant a major portion of their programs; they need to be considered in the context of broad and thoughtful Medicare and Medicaid reforms that should and would benefit all States.

Another vision for Medicaid reform. As my comments have made clear, Democratic Governors do not favor the status quo. I am unaware of any Democratic Governor who is anything but strongly supportive of Medicare and Medicaid reforms to be enacted this year. Frankly, we believe the sooner the better. We are reserving judgment on any final reform proposal until we understand the details, and until we

have engaged in a process to determine the best approach for our States and the individuals they serve.

If we learned anything from all the fights in Washington, D.C. over health reform in the last decade, we have learned that we must find a way to pursue changes that can attract bipartisan support. We should start this process by looking at the policies recommended by the majority of Governors. And, likewise, we should look at Medicare and Medicaid reforms that have broad, bipartisan support in the Congress.

Both the NGA and the DGA have endorsed the bipartisan State Budget Relief Act of 2003, which would provide short-term fiscal relief to the States through a temporary Federal Medicaid payment increase. Congress should go further and set the Federal Medical Assistance Percentage (FMAP) to an on-going formula that is flexible and that would be responsive to economic downturns to help States maintain healthcare services and still live within their balanced budget requirements. Congress should also consider increased FMAP for Federal mandates such as translation services, transportation, emergency services for undocumented immigrants and EPSDT services for children. Frankly, in my State, some legislators and public commentators think of Medicaid as offering "rich benefits" because it covers things employer and commercial insurance often does not. Most of these so-called "rich benefits" are actually federal requirements for a State's participation in the program. For some of these services that are access mandates, the Federal government should be higher than the States' regular FMAP. Finally, Congress should provide opportunities for increases in disproportionate share hospitals for low DSH states and utilization of unspent SCHIP funds by those States such as New Mexico that could use such funds now. Prompt enactment of legislation such as this would provide the States the ability to avoid senseless and harmful cuts to some of our most vulnerable seniors and children. Moreover, such an investment is one of the most effective economic stimulus tools we have.

One of the most important contributions you could make would be the passage of a meaningful, workable and bipartisan Medicare prescription drug benefit. If structured properly, such an initiative would rightly reduce States' prescription drug liability by finally providing Medicare beneficiaries who are also eligible for Medicaid (dual eligibles) the benefits they so desperately need. Governors from both parties want to be constructive players in this debate and have much to offer in terms of expertise in administering benefits and assisting low-income populations. The relationship between Medicare and Medicaid in funding acute, primary and long-term care needs of persons who are dually eligible also needs to be considered. When changes are made to Medicare, such as increased co-payments or premiums, the States have to pick up a portion of these costs through the Medicaid program. In fact, as new service mechanisms are developed, the federal government could actually save money in hospital costs while State costs in pharmaceutical and other costs could actually increase.

States' Medicaid programs are paying a larger share of health insurance costs for older and disabled persons. In 1984, Medicaid paid 30 percent of these costs and Medicare paid 70 percent. In 1998 this proportion had shifted to 40 percent for States and by 2012, the States' share of these costs is expected to be 45 percent. The Federal government's responsibility is decreasing for this population, and this latest proposal will decrease that responsibility further at a time when the population's needs are increasing.

Governors want to work with our Federal partners on ways to reduce costs at least as much as to encourage them to provide needed and appropriate financial assistance during severe economic downturns. Along these lines, many Governors and Members on both sides of the aisle have supported ways to constrain pharmaceutical costs by reducing barriers to generic competition and, in some cases, supporting ways to increase and expand access to the pharmaceutical rebates and discounts. In New Mexico, we are engaging in a "Working Smarter" initiative to explore these issues as well as the expansion of disease management approaches to improve care and decrease rising costs of care for those with chronic illness. We are also undertaking initiatives to examine ways to utilize existing State dollars as match and ways to increase our collection of third party benefits and our detection and prevention of Medicaid fraud.

States should be given more flexibility to cover pregnant women, parents, uninsurable adults and to expand coverage to children with disabilities. States should also be given flexibility to change or implement services and cost-sharing approaches that will encourage community-based cost-effective care, rehabilitation and supports. In New Mexico, we are exploring ways to create innovative approaches to addressing the needs of those who are uninsured. And, we are undertaking a Med-

icaid System Redesign effort this Spring and Summer to determine how best to structure and define services to meet the needs of New Mexico's residents.

Finally, while my fellow Governors and I are focused on how to make ends meet now, we have a responsibility to think about the future of Medicaid, the future of Medicare, the future of long-term care, and how our health and retirement security systems are going to respond to the aging of America. The time is now to begin the discussion and to develop bipartisan solutions. I more than most Governors know how hard it is to do this in Washington, D.C., but we must take on these challenges.

Medicaid, in particular, faces enormous challenges as both its long-term care costs increase with the changing demographics, and its basic health insurance role expands if only because the number of uninsured Americans grows unabated. I urge you all to rethink the Federal-State partnership. I, for one, believe that if Medicare were to assume all—or certainly a much greater portion—of the health and long-term care costs of the elderly, then States could provide a true, nationwide safety net for all Americans, regardless of family type, illness, immigration status or age. I think we could build on SCHIP to create a Medicaid safety net for elderly and disabled Americans, as we have done for children. And I think we could contribute to a dialogue about how we set the nation on a path to ensure that all Americans have basic health insurance.

CONCLUSION

In conclusion, I want to emphasize the importance of working across party lines at both the Federal and State levels to address challenges we all face. We faced a crossroads in the debate around Medicare and Medicaid in 1995 and 1996. After a face-off that literally closed down the Government, both parties eventually agreed to reject block grant approaches and provide more flexibility to the states in administering the Medicaid program and the establishment of the SCHIP program. Ironically, in 1997, three Governors who have since become members of President Bush's cabinet, signed a letter to then President Clinton along with 38 other Governors. These three Governors included current HHS Secretary Tommy Thompson as well as Tom Ridge and Christine Whitman. This letter stated as follows:

> We adamantly oppose a cap on federal Medicaid spending in any form. Unilateral caps in federal Medicaid spending will result in cost shifts to states, enabling the federal government to balance its budget at the expense of the states . . . Under a cap, once the federal spending obligation is fulfilled, states would become solely responsible for meeting uncontrollable program cost increases . . . Governors must be involved in any budget negotiations related to the future of Medicaid.

With a Congress and a nation so evenly divided politically, we must again find ways to govern across political lines. This cause is not served well by proposals that require states to agree to a block grant for much of the Medicaid population we serve in order to gain access desirable new flexibility and to short term fiscal relief—however insufficient. Democratic Governors stand ready to participate and contribute to this debate as I hope my comments have made clear. We strongly support reforms that would stop harsh cuts from occurring to the program and to the seniors and children it serves, to provide more flexibility to the States in administering the program, and to seriously engage in a substantive discussion to strengthen and modernize our retirement security programs, including Medicare and Medicaid.

Mr. Chairman, I hope my comments have been responsive to your request. Again, it is a pleasure to appear before you and I would be happy to answer any questions you may have.

Mr. BILIRAKIS. Thank you very much, Governor. Well, we have a vote on the floor, but I am going to start and see if we can get in as much as we can before we have to run over.

I apologize, Governors, for my having to run out, but we have a prescription drug meeting taking place in another room on the other side of the building, so it is that kind of a life up here.

Governor Bush, you did go into the cash and counseling Medicaid waiver in your statement. I wonder if I could ask you to maybe in a couple of minutes at least expand upon that, and then I would ask Governor Richardson to comment, if he has any comments regarding that Florida plan. I don't know whether Governor Richardson is familiar with it or not. If he is, possibly he may want to com-

ment on it without Governor Bush going into more expanding upon it. Do you know what that is, Governor Richardson?

Governor RICHARDSON. Mr. Chairman, vaguely. I think I could just probably——

Mr. BILIRAKIS. Why don't we do that then. Would you please proceed, Governor Bush?

Governor BUSH. Well, it is a waiver that we receive where we provide self-directed care possibilities for Medicaid beneficiaries, where they work with a third-party benefits administrator and they create their budget, and then we empower them and we give them—we trust them to be able to select their providers. They can move—they have the flexibility of moving to different providers if they are not satisfied, not treated respectfully, or if they are not comfortable with the quality of care. And it is designed rather than to give them these mandated benefits, they basically create their own health care policy for their own family. It works, I think, better, Congressman, for the motivated beneficiaries, the insured that are engaged in their making decisions for their families and for their health care needs.

We have hundreds of people, not thousands of people, on this Medicaid waiver program and, frankly, this is just an example of scores of examples across the country, I believe, where through waivers people are trying to move toward empowering people to make decisions for themselves and giving them greater health education and focus more on prevention and give them more choices, give them more ability to direct their own care.

Mr. BILIRAKIS. The Chair yields to Mr. Richardson, but when my time is up, I will yield to Mr. Tauzin. Will you have time, Mr. Chairman, to wait another 5 minutes?

Chairman TAUZIN. Yes.

Mr. BILIRAKIS. All right. Mr. Richardson.

Governor RICHARDSON. Mr. Chairman, I would just like to add to what Governor Bush said, and that is, when somebody talks about flexibility and a Governor talks about flexibility, what is it exactly we are talking about? And I think what we are talking about new delivery system innovations.

In New Mexico, we want to look at some of the initiatives that the Governor talked about. Cash and counseling for seniors as part of what is called the "Working Smarter Medicaid Plan." This is a plant that allows individuals and families to direct their own care and, in essence, helps prevent institutional care which I know, Mr. Chairman, you have done a lot on. At the same time, I think streamlining eligibility categories is also something that is important in flexibility.

Finding ways to keep up with evidence-base practices, adding parents, pregnant women—you know, it is not easy to get waivers. We keep talking about waivers. I know that GAO is doing a study on how many waivers are granted by Governors. I think that would be very interesting to see, but I think if we talk about some of these issues, Mr. Chairman, in terms of what is flexibility—pharmacy, disease management, cost-sharing, auditing fraud and abuse, benefit limitations or restrictions, service designs and structures. I just wanted to add to what Governor Bush had said about what exactly flexibility means.

Mr. BILIRAKIS. We are talking about waivers, and you indicated it is difficult to get waivers. Should it be easier to get waivers?

Governor RICHARDSON. Yes, Mr. Chairman. And I have known some Governors that have gotten waivers, but I think it would be very interesting to see statistics on how many States are actually succeeding in getting waivers. I was talking to some of the very able staff members earlier, and I don't know if it is 50-50 or 60-40 or maybe 10 percent, perhaps these Governors that have served longer than I have—I have been in office 60 days, so I hardly have enormous expertise.

Mr. BILIRAKIS. We expect an awful lot from you.

Governor ROWLAND. Mr. Chairman, if I may——

Mr. BILIRAKIS. Very, very quickly, if you would.

Governor ROWLAND. I would just simply add that if you actually give true Medicaid reform, we won't have to go through this "May I please" waiver process. And the other thing that none of us pointed out, that I would like to leave you with is, we have skin in this game. This is not just the Federal Government sending us a bunch of money that we willy nilly spend on a variety of programs. For the most part, we are 50 percent partners in all of these programs. So we have skin in this game all the time.

And so as we try to use creative, innovative ways to serve our constituencies, we are using our dollars as well, and I think we keep forgetting that. We keep thinking it is just a Federal program.

Mr. BILIRAKIS. Thank you. Chairman Tauzin is recognized.

Chairman TAUZIN. Thank you, Mr. Chairman. Mr. Brown, I want to thank you and the Minority for allowing me to go first. I simply want to take a moment to thank our three guests and witnesses today, Governors of three incredibly important States in our Union, and apologize. I know this is the second time we have tried to bring you together where we could discuss with you our mutual problems in keeping Medicaid programs afloat in our States. I particularly wanted to welcome my friend Bill Richardson back, a former U.S. Congressman who served on this Energy and Commerce Committee and a dear friend for many years—by the way, our mutual friend Ed Gabriel asked me to wish you well, Bill—and to congratulate him on his years of service for this country as U.N. Ambassador, Secretary of Energy, and now Governor of a great State. So, again, what a career, Bill. We are glad to see you back in our committee.

And to Governor Rowland and Governor Bush, let me also thank you for coming. We have gotten some good news today—at the same time we got bad news—as the Budget Committee is struggling with the Federal budget, as you are struggling with State budgets, we learn that there is a very strong likelihood the Budget Committee will recommend including the $12.7 billion over the next 7 years the President has recommended as additional funds to assist the States in return for working with us on reform programs that will create even more flexibilities for you in designing the State programs. The bad news, of course, is that we are in a terrible budget crunch. And if we are going to get the budget balanced again, all of us are going to be looking at ways in which to restrain the growth of Federal programs, all Federal programs, and that means "all" Federal programs. So we have got a lot of work

to do in terms of dealing with this crisis, just as you have on the State level.

I mainly wanted to come as Chairman of the full committee and thank the chairman and the ranking member for bringing you together so that we can learn with you what problems you are experiencing on the State level, that we might understand better how this administration recommendation might be of some help and assistance and how we might change it to make it better for you and for all the populations that you serve.

In short, I simply want to say thank you for spending this time with us and, Mr. Chairman, Mr. Brown, thank you for the courtesy of allowing me to do so. Thank you.

Mr. BILIRAKIS. I thank the chairman. We have three votes on the floor, so we are going to have to break and come back immediately after those three votes are up. So we are probably talking about 20 minutes, something of that nature. Thank you.

[Brief recess]

Mr. BILIRAKIS. The Chair thanks everybody for their cooperation, and now recognizes Mr. Brown for 5 minutes.

Mr. BROWN. Thank you, Mr. Chairman. We all know from the comments of Governors Bush and Rowland and Richardson that Governors want more flexibility, and I think all of us want them to have it.

We can look back, however, in 1997 Congress gave States flexibility to provide health care services through managed care organizations for the vast majority of beneficiaries without a waiver. We can look at what happened after September 11 in New York, when several hundred thousand people, my recollection is, were added to Medicaid under this sort of block grant loan—block loan more than block grant—proposal of the President's. I am not sure that because their budget would have been set, that they could have done that.

Governor Richardson, if you would for a moment sort of talk that through so we better understand it, it just doesn't seem to me that we need to block grant/block loan this program to give flexibility. We have been able to do that, it seems, in a program like that. If you would share that with us.

Governor RICHARDSON. The first element in flexibility is, as I said, do no harm. I think the greatest flexibility of all is the flexibility that the Medicaid program has to adjust in an economic downturn, which we are in right now. We have to preserve the flexibility in the program so that we are guaranteed to have the money that we need to provide for health care needs at a time of recession, at a time that the needs may be greater.

Let me just give you an example. After 9/11 in New York, the State enrolled an additional 350,000 people in their Medicaid program in just 4 months. The State hadn't budgeted for that increase. It wasn't built into any Federal projections of Medicaid spending. It came as a result of an unforeseeable tragedy. And under Medicaid today, the State had the flexibility to enroll those individuals and make sure that they had health coverage under very difficult circumstances.

If there is a block grant program in New York, Federal funding in this instance would have already been established for the year,

and the State would have been unable to cover the full cost of these people.

So, I think, in summary, what does flexibility mean? It means new delivery system innovations. In other words, new Federal/State/private sector partnerships. It means streamline eligibility categories in ways that you can improve the process. It means services to keep all evidence-based practices. It means adding parents. It means adding pregnant women, uninsurable adults, cost-sharing for higher income populations. And, finally, different services for different populations.

I have a huge number of Native Americans in my State, and nine times more than in any State, and the Indian Health Service System is not working as well as it should. So you need that flexibility to cover on the State basis all of your people.

Mr. BROWN. Thank you very much. Governor Bush, I understand the House Republican budget is including reconciliation instructions for this committee, charging this committee to cut $110 billion out of entitlement programs. I understand $101 billion of the $110 billion comes out of what is called Function 550, which is Medicaid. The Republican budget had to have room for the tax cuts. It was fully in the budget. There is, unfortunately, not in the budget any entertaining of the concept of what this war is going to cost. But putting the war aside to make room for the tax cut, there is $110 billion cuts in apparently Medicare/Medicaid, another $260 billion in Ways and Means, and I don't know if that is Social Security, Medicare, or what that is.

How do we cut $110 billion? Could you give us ideas of which services Medicaid now covers that it should not, or which people Medicaid now covers that it should not?

Governor BUSH. Well, you know, I have got my own budget problems, Congressman. Is this Washington cut where you cut the growth, or is this real cuts?

Mr. BROWN. This is real cuts. I would add——

Governor BUSH. That means the budget would be $110 billion less?

Mr. BROWN. No. And I would add that the $9 billion that the President has proposed, the $9 billion reserve fund which Mr. Tauzin and Mr. Bilirakis mentioned, we don't get access to that $9 billion. The States don't get that $9 billion until the cuts have come from the entitlements.

Governor BUSH. If there was a year-to-year decrease of $110 billion on Social Service spending, it would have a very dramatic impact on Florida and other places. If this is a cut of projected growth which is not family income kind of budget talk, but government budget talk, I don't know what the implications of that would be.

What we have tried to do is curb the cost so that we can maintain benefits. And we have increased benefits—we have cut benefits for some, we have dramatically increased benefits for others. We have done it in the traditional ways of focusing on ratcheting down reimbursement rates. We have been successful—after double-digit increases in our prescription drug budget costs, we have been successful in lowering the cost there. We have disease management programs that have lessened the increases. But our Medicaid budget will grow—we project it to grow by 8 percent or 9 percent this

year, even with some pretty dramatic efforts to reduce costs. And since we have begun this process, in 4 years we have reduced the growth, the projected growth, by about $1.4 billion which for a State our size is pretty significant.

Mr. BROWN. Governor Rowland, could you absorb those kinds of cuts that this Congress apparently is going to make to Medicaid?

Governor ROWLAND. Well, again, to echo what Governor Bush has said, we don't know what your numbers are, whether it is a cut from last year or this year. We have had probably 40 or 42 States that have had to make changes in Medicaid either ratcheting back some of the optional benefits that had been added.

One of the things that our growing population is in the nursing home side, and we probably don't give it—I would say the last 2 years I don't think we gave a 1 percent increase to the nursing home providers.

But, again, getting back to the reason we are here—and we all appreciate that you would like us to solve your budget problems, but 45 States have deficits. The reason we are here is that we can save you money, meaning the Federal Government. By the way, it is not your money or our money, it is everybody's money, the taxpayers' money. Give us the flexibility, we can run these programs and really have either budget savings or more options.

Mr. BILIRAKIS. The gentleman's time has long expired. Dr. Norwood for 8 minutes.

Mr. NORWOOD. Thank you very much, Mr. Chairman. Gentlemen, thank you for being here, we are honored to have you. And as you know and we know, this is a very serious discussion. I do want to make the record clear that the budget previously mentioned is in a discussion draft. And when you use the term $110 billion, that is over 10 years. Nothing is settled yet at all, and it makes a big difference when you talk about $110 billion, whether it is a year or 10 years. So the record should be correct.

Governor Bush's testimony indicated that one-eighth of Florida's population is on Medicaid, and 45 percent of pregnant women are on Medicaid. Governor Richardson indicated that 1 out of every 5 New Mexico residents are now covered by Medicaid, and 44 percent of the State's children are under Medicaid.

Given that Medicaid now covers large populations—we are covering a lot of people—doesn't it make sense to you—and I think you have implied that—that no longer this deal of one set of rules fits all, that Washington knows best about these number of patients, doesn't it make sense to you that we do offer our Governors flexibility?

Now, I am curious to know if any of you disagree—and this would be a good time to state that—if you disagree that you should be allowed the flexibility to work the Medicaid problem in your State. Does anybody disagree with that?

Governor ROWLAND. I don't think so.

Mr. NORWOOD. Do any of you disagree with the thought that block grants would give you a lot more flexibility to deal with your problems at home? Yes, sir?

Governor RICHARDSON. Dr. Norwood, I would categorically state it. If a block grant means capped funds—then I believe that we are talking about that—that would limit, seriously limit my flexibility

in a State with a high number of uninsured—you have cited the statistics of children and pregnant women—to account for the increases in Medicaid population. And so a diminishing fiscal commitment from the block grant capping these services at a time that the States have serious fiscal problems would be a problem for me in my State.

Mr. NORWOOD. Well, you are rather capped now in a sense. The budget caps you every year. There is a known amount that you are going to get, and if you knew precisely what that amount was, I have got great confidence in my Governor, and the three of you, too, for that matter, to be able to operate your State on a given number.

You said earlier that the problem with flexibility—or it means to you do no harm. My view of that is flexibility is given to you and it means you do no harm, not us, but the flexibility would be your responsibility to deal with.

Let me ask a question that is different from anything maybe we have discussed here. I have, for a long while, tried to understand the policy of putting long-term care into Medicaid. Long-term care, by its very name, implies mostly people who are eligible for Medicare.

Now, I understand the political policy of putting long-term care under Medicaid, but it really actually makes no sense to me. It would be better, in my view, if long-term care were put under Medicare. We dealt with that problem, as we should, not make you deal with that problem, and I am curious if any of you have any thoughts about that.

Governor BUSH. I think there are ways to provide support for the States in this discussion of reform, without—I know that there seems to be an interest here to just give the States more money without reform—I would prefer to consider embarking on a discussion about that or, for example, Medicare reform with a prescription drug benefit where the Federal Government would take as its responsibility the duly eligible that we now—it is one of the fastest growing parts of our budget—is for duly eligible Medicare and Medicaid beneficiaries, that we pay the prescription drug costs, and that to me is a good tradeoff. Give us more flexibility and responsibility over our program; in return, assume responsibility for senior citizens in that particular area.

I would have to look at the long-term care element, but it is a very different part of—it is an incredibly important part of Medicaid today. Increasingly in our State each year the number of people that are Medicaid-eligible in our nursing homes is growing. We want to make sure that we provide care for them. But I would hope that this would be the kind of discussion we would have about how Medicaid was set up 38 years ago. There have been interesting and important additions to Medicaid, but there hasn't been a systemic review in 38 years. The world has changed. Health care delivery has changed. Modern medicine is a miracle—I mean, if people 38 years ago thought that medicine and the technologies and the drugs that exist today, they would probably have thought you were from another planet.

And so I think having this kind of discussion in a systemic way, hopefully with the inclusion of the Governors, would be very meaningful right now.

Mr. NORWOOD. Governor Rowland, you indicated that in your State the cutoff for Medicaid was at $54,000?

Governor ROWLAND. That was for a program for uninsured children. We have a 300 percent of poverty level number. So you can be a family of three or four, making $54,000, and be eligible for the HUSKY children's program.

Mr. NORWOOD. Right. But in a sense, meaning they are eligible for Medicaid benefits.

Governor ROWLAND. That is correct, under our optional plan.

Mr. NORWOOD. Governor Richardson, what is the cutoff in your State?

Governor RICHARDSON. Dr. Norwood, I will answer that. I also want to make the point that I do agree with you that it is important that Medicare stay at the Federal level. I just think we should recognize, though, that prescription drug costs, nursing home care just statistically has increased from 30 to 40 percent—in other words, the State share—and it is expected to reach about 45 percent by the year 2012.

So, I think Medicare reform, we have to approach it at the same time. Now, my cutoff, I think, is 235.

Mr. NORWOOD. Two thirty five of poverty?

Governor RICHARDSON. Yes.

Mr. NORWOOD. What is that in dollars? Ask that smart staffer back there.

Governor RICHARDSON. It is about $41,000.

Mr. NORWOOD. And, Governor Bush, what would be the dollar amount cutoff in Florida?

Governor BUSH. Over which you are no longer eligible for a family?

Mr. NORWOOD. Or for SCHIP.

Governor BUSH. It varies, 185—with children, it is 185 percent down to 100 percent by the time someone turns 18. The largest are newborns at 185 percent, I believe.

Mr. NORWOOD. Well, time is going to run out, but basically hadn't we ought to give some serious thought to that, the fact that we are covering higher income families much more than we used to in the future. And we all face a budget problem, your States as well as us up here. It appears to me that the higher that income level goes, the less amount of treatment and dollars can go to the actual people that this program started out to help. And I would presume that number is yours to choose, at what point the cutoff is. And I would suggest that that ought to deserve at least some very good discussion about how high that number should be. Mr. Chairman, I see it is up.

Mr. DEAL [presiding]. Mr. Waxman is recognized for 8 minutes.

Mr. WAXMAN. Thank you very much, Mr. Chairman, and I appreciate the testimony of the Governors. Governor Richardson, it seems to me that there is no reason to say that giving more flexibility to the States means that we have to cap the Federal contribution, that one implies the other. In fact, to me, if they are tied together, it really reflects a philosophy—which, by the way, I think

is the philosophy of this administration—that we can't trust the States with more flexibility in an open-ended Federal matching program because they will just abuse it. Do you agree with that?

Governor RICHARDSON. Well, Mr.——

Mr. WAXMAN. I mean, in other words, do you think we can trust the States with an open-ended program as we have seen it now, and give them more flexibility?

Governor RICHARDSON. Well, now that I am a Governor, the answer is yes.

Mr. WAXMAN. It seems to me, Governor Richardson—because I only have 5 minutes and I want to make a number of points—you have made that point so clearly. You can have flexibility without a cap of the Federal dollars. Nothing will make it easier than if we put a cap on the Federal dollars, for Washington to make cuts after that because once the States lose their entitlement to matching funds, they are going to be left holding the bag and with a lot bigger problem than they face today. It was interesting that Governor Bush said if you look at the amount of money that they are spending for Medicaid in Florida, that budget is unsustainable down the road, obviously, because of seniors going into nursing homes.

So, if you don't think your budget is sustainable and you are going to get less Federal dollars, then the States are going to have to come up with even more money in the future, and that strikes me as really an untenable situation for the States, unless they just cut large numbers of people out of the program.

Now, all of the Governors here testified how important their Medicaid program is—how many women are getting prenatal care because of Medicaid, having healthier babies, how many severely disabled people who can get appropriate care nowhere else get it because of Medicaid, how many seniors depend on the program for drugs and long-term care. I think that is exactly the same point I would make about how critical it is for some very vulnerable people, and what an important program it has been in keeping millions of people from joining the rolls of the uninsured.

Governor Richardson, do you think we would have seen the expansions in Medicaid we have, if your State and other States didn't have the assurance that Federal matching dollars would increase if you expand your program or served more people?

Governor RICHARDSON. I share that view, Chairman Waxman. And my concern is this. If you look at the proposal that has been outlined, the block grant program—there is an initial increase in Federal funding of $3.25 billion in fiscal year 2004, and then $12.7 billion over 7 years, but then you have to pay it all back in the last 3 years.

Mr. WAXMAN. Well, it is a bribe for a Governor faced with a tough budget decision right now to say, "I will take care of my situation and I will leave my successor Governors with a problem that is going to be untenable if I, in fact, make the choice." But we have had ideas of these fixed or preset amount of Federal funding on the table before. We had this in 1981. The administration proposed we fix the Federal funding for Medicaid and freeze it. At that time we had never heard of AIDS, and suddenly we had this epidemic. Before 10 years, there were over hundreds of thousands of Americans who never expected to need Medicaid enrollment to cover AIDS pa-

tients, and then we had to pay for the AIDS epidemic. We found that there were new drugs that had to be paid for. No one could have predicted this sudden surge in the cost of care.

I want to put in the record, Mr. Chairman, a statement about how Medicaid matters to people with AIDS because it illustrates that if we had just predetermined the Federal dollars and that is it, without knowing what the future would bring and not recognizing the changes in epidemiology, demographics, retirement patterns, migration, recession, natural disasters, cost of drugs, cost of diagnostics, cost of care, and on and on and on—and the AIDS epidemic is the single best example we could point to—that if we didn't have the Federal Medicaid program increasing the Federal dollars to take care of the AIDS epidemic, the States would have been overwhelmed by that epidemic.

It seems to me that what we have is a tradeoff. It is not a good tradeoff for the people in the States. Governor Rowland, you said that you think there ought to be flexibility to deal with the long-term care issue in a more realistic way, not just force people into nursing homes. But the States have the ability to do that now under waiver programs, and perhaps we should allow even more flexibility to pay for some of the noninstitutional care for those who are required to get some help, but every time there is a waiver, it has to be cost-neutral. Do you think we ought to have waivers that allow greater expenditure of Federal dollars and State dollars?

Governor ROWLAND. Yes. As Governors, we have been chasing waivers for the last 5 years and, frankly, it is our money, it is the taxpayers' money, it is your money, it is the State's money. And I think Mr. Norwood asked a key question when he talked about some of the dual-eligibles as well. I mean, for us, especially in Florida and Connecticut, the dual-eligible issue is huge. So between the drug benefit and our ability, whether it is redefining what homebound is or being able to manage that homebound person, that will save us significant dollars in the future.

Mr. WAXMAN. Well, I think we ought to take those ideas to heart and figure out some way to add flexibility to deal with people in a less costly and more humane setting than forcing them into nursing homes, but we don't need to cap the program to do that. We need to assure that flexibility.

Governor Bush, your State of Florida, as we have already heard, is the "retirement capital of the United States," and we all know people—seniors in my family have moved there. Shouldn't you be concerned that the vast majority of Federal Medicaid funding for seniors would be capped in the administration's proposal. It would place a cap on funding for so-called "optional" people or benefits. We have heard that these people are not optional, but very vulnerable low-income people, including the seniors. More than 80 percent of spending on seniors would be under the cap. More than 85 percent of nursing home residents are considered optional. Ninety percent of long-term care spending would be under the cap. Isn't the State concerned that if the Federal cap does not meet a State's actual needs, Florida would have no choice but to institute devastating cuts to our seniors, especially those in nursing homes?

Governor BUSH. Congressman, first of all, I would agree that, as I mentioned to my friend Congressman Davis, that there needs to

be underwriting of natural population growths in any reform. And, again, I am not sure—if anybody was watching this, they would, when they hear caps and fixed amounts—as I understand it, the administration's proposal is a 9 percent per annum increase, and then the extra money on top of that to provide the necessary investments in reforms that might yield the savings that then would allow for that money to decline in the outyears.

Mr. WAXMAN. But it is still limited in terms of cost of care going up, and the population numbers increasing for care, and unforseen epidemics. It is still limited. Even though it sounds generous to say 9 percent, you don't know what the future will hold, except in your State we know there are going to be more and more seniors who are going to need long-term care, and no block grant is going to provide for that.

Governor BUSH. Absolutely, and that is why in the last 4 years we have expanded State dollars and matched them with Federal dollars for community care for the elderly programs. Significant numbers of people are receiving services where they can age in place and age with dignity. And all States—I mean, we are just ahead of the game. I mean, I appreciate the fact that your relatives are in Florida, and if I ever can help them, please let me know, but——

Mr. WAXMAN. Let me write that down.

Governor BUSH. California is faced with the same issue, and so is Ohio, and so is Georgia. Thankfully, we are aging demographically because we are living longer and living healthier. So these issues are going to have to be dealt with in the most comprehensive ways, not just related to Medicaid. But a 9 percent compounded rate of growth over 10 years is explosive. It is not sustainable. And if it is Medicare or private health care or Medicaid, we have to figure out how do we curb these costs and provide better health care benefits together.

Mr. WAXMAN. If we put you in a block grant, we are not going to do it together. You are going to do it and you are going to have to cut people because you are not going to be able to come up with the funds to sustain it.

Mr. UPTON. We are doing it now.

Mr. WAXMAN. My time is up.

Mr. BILIRAKIS [presiding]. Dr. Fletcher for 8 minutes.

Mr. FLETCHER. Thank you, Mr. Chairman, and I appreciate you holding this hearing. I want to welcome the Governors and thank you all for your testimony, Governor Bush, Governor Rowland and Governor Richardson. I am glad to see that members of this committee have a history of becoming Governors.

When we look at Medicaid, one of the things that we need to realize is it is estimated that Medicaid's long-term care cost will quadruple by the year 2030. Now, some people use a different date, but around 2030 we will have a quadrupling at least of the long-term care cost.

The other thing when you look at quality of health care, the thing that is disturbing to me is that the National Cancer Institute reports that women on Medicaid are three times more likely to die from cancer than women who aren't on Medicaid. The Institute also found that women on Medicaid were 41 percent more likely to be

diagnosed with breast cancer at a late stage, and 44 percent less likely to receive radiation treatment.

So, I think we have a problem, and most of us, if we had a choice between going on Medicaid or keeping the insurance that we have through our employer or through the Federal Employee Health Plan would choose to stay where we are rather than choosing Medicaid.

There are plenty of examples—and, Governor Bush, from your State, examples of individuals who have to drive extra distance because of the problem of having providers who will participate with the current Medicaid program.

So, when I look at what is happening in Medicaid, I am reminded of why I got in politics. I was practicing medicine. I was seeing a number of single moms on Medicaid and Welfare. And I was talking to one specifically, and I was talking about their future. I said, "What are you going to do in the future as your child now is entering school?" She said, "You know, if I go out and get a job and go out and do some other things to improve my life, I start losing benefits, and actually I can't take care of my child as well as I can staying where I am."

And at that point we had a social welfare system that was capturing people in a cycle of dependency. We had Welfare Reform. And I think it has made a tremendous and improved the lives of numbers. We had the lowest poverty rate of minority children in the history of this Nation, we have been keeping records of it, because of that reform, I believe.

I believe Medicaid is the next Welfare Reform. And I think we hear, and we heard a lot of demagoguery when we reformed Welfare, about endless soup lines and those sorts of things, and I think we are going to hear the same demagoguery about taking people out of mandated regimens and those sorts of things.

But I am here to say that I think as we look at the future of Medicaid, that we must do some reform so that we can improve the quality of health care and, not only that, but be able to expand who we cover and make sure it is more appropriate.

Let me make a few corrections, too, that have been said here. This 1 percent cut they are talking about, the $110 billion, it was over 10 years, it is not a cut. It is just controlling the rate of growth. CBO estimates it is going to control 8.5 percent or 9 percent. It is not a real cut at all. So let us make that accurate. Only in Washington where we use this fuzzy math would that be a cut. It is actually controlling the rate of growth.

The President's plan additionally increases the rate above what is projected out those years, and then there is not really a payback system, it just again begins to control and reduce the rate of growth of Medicaid in those outlying years. So, let us get our facts straight and make sure we are using the words that really mean something.

Let me ask a few questions now because I think—Governor Bush, I know in Florida, in your cash and counseling program, you have found that at least thus far it seems to be budget-neutral, and in the future there are hopes of actually reducing the cost, but it incorporates some things of education which is a counseling, and

flexibility allowing the money to follow the patient. I wonder if you would address that and what you have seen in that program.

Governor BUSH. Well, that program and others that we have implemented are focused on empowering people to make decisions for themselves. Frankly, I think—again, this is broader than just Medicaid—the concern that I have looking over the horizon is if we maintain our reactive health care system where we focus on intervening when people are sick—and in the case of the Medicaid population, there are five illnesses that create a significant percentage of the cost—rather than focus on health care education and prevention and disease management, it is not a sustainable situation, and that is not related to Medicaid, that is related to the private sector health care insurance system as well.

So anytime that you can provide, using the medical model but also a social model where you intervene in people's lives, give them the information that they need to make decisions, empower them to be part of that process, you are going to, I believe, save a lot of money but, more importantly, have a better health care result.

Ultimately, what we should be focused on is healthier people. Healthier people will create significant decreases in expenditures in any of the insurance programs that exist. This is one example of that. We have others related to ventures with drug companies where, in the case of one drug company, 80,000 people are receiving their prescription drugs, but they are also receiving through nurse-practitioners and through paraprofessionals, information about lifestyle choices that they make that the combination of which will save money. In fact, the drug company is guaranteeing us the savings by participating in this program.

And back to the subject at hand, waivers can help us with some of this, but to move to the prevention model all together in a more dramatic way I think will require significant reforms in Medicaid.

Mr. FLETCHER. Thank you, Governor. Governor Richardson, let me ask you a question—and I don't know, this may be too specific—I hope you can answer. Do you know how much per patient per month that you are spending on the Medicaid patient? I know there is a disparity in whether it is long-term care, institutional, but if you could kind of give me a figure of that so we could get an idea.

Governor RICHARDSON. Average cost per enrollee per year has grown from $4,133 in Fiscal Year 2000 to $4985 in State Fiscal Year 2003, an increase of 21 percent. That is for us in our State.

Mr. FLETCHER. Let me ask you a question. I know we agree, and I agree with you clearly on the flexibility, and I want to see incorporated education flexibility personal responsibility in a way that will work, and that is the reason I think it is important, particularly in the optional individuals. In the mandated individuals, there is one thing, but the President has talked about giving flexibility in this optional population, which is a population which you all could quit covering immediately if you wanted to because it is not mandated, and so we are just giving you option on what kind of benefit. If you could use that $4985, say, instead of using it for one optional benefit, say you could use $2400 or $2500 for two individuals that you optionally cover, wouldn't that be a better option for the States to do so that you could help some people—maybe not

help them with a fully mandated benefit, but you could help them where they needed help, especially in that 300 percent poverty rate that you talked about?

Governor RICHARDSON. Well, that would strike me as being a flexibility that would be welcome. I don't necessarily think that flexibility is just a definition of who you could take on or off the rolls. I think that this is the kind of flexibility that a Governor would want to have.

But I think, Congressman, you have to have the resources, and my worry is that in the outyears, that when you cap—you are telling me it is going to be $12.5 billion over 7 years and in the outyears I have to pay it back——

Mr. FLETCHER. Well, I have said that there is really not a payback on that, Governor, it is a reduction. I think my time is up, but thank you. We really appreciate your being here.

Mr. BILIRAKIS. Thank the gentleman. Mr. Pallone for 5 minutes.

Mr. PALLONE. Thank you, Mr. Chairman. Governors, I have to say that I can't help but think that the real issue here is resources. I think that was what Governor Richardson just ended talking about the need for resources.

When I was doing my opening statement earlier, I was trying to get the point across that, from my perspective—and I think it is true for most of us, at least on the Democratic, but hopefully everyone—the real goal is to try to cover as many people as possible, and provide them with as much care as possible that they need.

So, for us, the issue of how much money is available, what the flexibility is, all of that has to be in the context of what is going to accomplish the goal of covering the most people. And the concern that I have is that—I know it sounds political in saying it—but in the last few years of the Clinton Administration we were, through the efforts of this committee, on a bipartisan basis expanding the number, the money and the programs that were available to the States, and the number of uninsured, for the first time in anybody's memory, was actually going down—the SCHIP program, the parents of the kids in the SCHIP, expansion of Medicaid.

Now we see the opposite happening, and I don't really understand why the issue is flexibility at all. It seems to me that we have had Secretary Thompson here. He has tried to give States, like my own, flexibility with waivers where they have been able to waive in the parents of the SCHIP children, or even maybe single adults in some cases, I understand. So I just think that the President's proposal has nothing to do with flexibility. He has provided flexibility by giving waivers through Health and Human Services when it is needed. The problem is money. The problem is lack of resources. And there is nothing that anybody has said that convinces me that that is not the case.

You may have some limits on your flexibility by what the Health and Human Services does, but the bottom line is that there has been a lot of flexibility there as well.

Just let me give you an example. I know there is a young woman here in the audience today, Jeannette Morrisette Johnson. She is over here in the orange dress and sweater. In 2001, after 12 years of being on a waiting list, she was admitted to the Minnesota Cash and Counseling Program. But she just received a letter this Feb-

ruary telling her that her allocated money has been reduced 51 percent due to the State budget crisis and, worse yet, the allocated amount was to be cut retroactively.

So this is the problem with caps and waiting lists. Jeannette's care under this demonstration will be cut. Now, because Medicaid is an entitlement under current law, she still is able to get services, but she has to enter a nursing facility to get them. But under the Bush block grant, she would no longer have that entitlement. She would be left with nothing after March 29.

So, my point with this is—Governor Bush talked about this Cash and Counseling program, and maybe there is some flexibility there. But if you don't have the money because of the cap, then what good is the flexibility? I mean, that is what this is all about.

I wanted to ask Governor Richardson, if I could quickly, one question, and I wanted to ask about American Indians because you brought it up. In your home State—because I know it is true in New Jersey—our Governor has had to cut back on SCHIP. No single adults anymore. No parents. Now even some of the kids are going to be cut. What is happening in your State? Is that because of flexibility, or is it because of lack of resources?

Governor RICHARDSON. Well, I think it only has been because of congressional intervention that we have been able to maintain the unspent SCHIP funds that you talked about. And I think this is an example why I am concerned about the Medicaid proposal on the table right now, that this program for kids, the SCHIP program, basically has to be preserved by the Congress every year because, otherwise, it allows States to maintain their allotments permanently.

So, I think what is important is that a poor State, unless we have the flexibility to spend that money, we lose some of these funds to more affluent States that are able to juggle their resources more effectively, or they are reverted to the Federal Treasury. This is why I think it is very important that you are not just talking about increased flexibility, but you are talking about resources.

Mr. PALLONE. And I appreciate that. I understand it is an issue of flexibility, but I just think without the resources it is meaningless. I wanted to ask you, though, because you brought up American Indians. Many American Indians rely on a mix of Indian Health Service and Medicaid funding. Can you provide some insight into how you think this administration's proposal would impact the American Indian people of your State, and how it might be improved or better address their needs, because you have expressed concern in that regard.

Governor RICHARDSON. Well, in my State——

Mr. BILIRAKIS. The gentleman's time has expired. Please proceed, Governor Richardson, but if we can be brief, I would appreciate it.

Governor RICHARDSON. Yes. And I think many of you have Native American populations. In my State, we have nine times the national average, we have 173,000. Of those 173,000, 68,000 are on Medicaid. So when you have rural areas, when you have increased access, it is more difficult. You have Native Americans with highest incidence of diabetes, alcoholism, health care needs from drug abuse. You have a very vulnerable population. And twice as many Native Americans live below the poverty level.

So at the same time that the Indian Health Service costs and budgets are being reduced, you have got the States trying to plug in some of those gaps, and it is a problem. And the worry that I have is that the capping of the block grant is going to just make some of the American Indian populations more vulnerable, especially in rural areas.

Mr. BILIRAKIS. The gentleman's time has expired. Governor Richardson, very quickly, talking about the waivers, what does it cost the State to go in and request these waivers, and what is the process there? We talk about waivers we have gotten all the time, and flexibility, and that sort of thing, but what does it cost you?

Governor RICHARDSON. Well, I don't think it costs that much. I think there is a lot of I think necessary bureaucratic effort. I have my Secretary of Health and Human Service—we have only been in office 60 days, but——

Mr. BILIRAKIS. You keep repeating that.

Governor RICHARDSON. [continuing] I am really hoping to get some waivers. I hope this testimony doesn't hurt me.

Governor ROWLAND. I think it is going to help.

Governor RICHARDSON. But, again, I don't think there is much of a cost. Just dealing with the Federal Government, as you know, is difficult, but I don't think there is much of a cost.

Mr. BILIRAKIS. Governor Bush, I know you have to leave. Anything you want to add to that as far as cost is concerned?

Governor BUSH. Well, the cost really relates to the administering of the waivers. We have 13 of them, I believe, and there is administrative cost. And as it relates to flexibility, just to make the point, the SCHIP program is a great example of flexibility that we can't now implement. If a Medicaid beneficiary, a family, wanted to go to a KidCare SCHIP like program today, they would not be allowed. No waiver will change that, they would not be allowed. And there are people in our State that are receiving Medicaid that would be happy to do a co-pay, would be happy to get the better quality health care professionals, would be happy to be in that program, but they can't.

Wouldn't it be better to provide that option in a new system? And as it relates to people that are in consumer directed care, as you stated, Congressman, if a pilot program runs out and they have to go back to an institutionalized setting, a new system wouldn't necessarily require that.

We can find lower cost ways of providing better dignity, better care for people, and waivers are part of it. We are thankful for the waivers we have, particularly for the developmentally disabled. Were it not for the MED waiver program that frankly was granted in the Clinton Administration, in the last days, we would not have been able to dramatically increase the number of people receiving care at a lower cost than putting them in institutions.

I just think we can go beyond where we are and, Mr. Chairman, I appreciate the opportunity to start this dialog. I hope that you will invite others that are, as people have said, patients and providers and others, to be part of this debate, but we should not let this opportunity go to waste.

Mr. BILIRAKIS. We plan to do that. Thank you very much for taking your time to be here, Governor. Governor Rowland, very briefly, did you want——

Governor ROWLAND. Mr. Chairman, I just wanted to add, the experience I have had is a little bit different than my two colleagues. I served under two administrations and went through a waiver process with both administrations and, frankly, the previous administration, with all due respect, was very difficult to get a waiver. It was almost impossible. But, more importantly, the waiver system should not be at the discretion of who happens to be the HHS Secretary. There should be some uniformity. On any given day at any given moment, it shouldn't be, "Well, on Tuesday we will do a waiver, but not on Thursday. In New Mexico we will do one, but not California," and so forth. So there has to be some consistency, something that we can work off of. And it just flies in the face of what we are trying to do—and that speaks to Congressman Pallone's point—we are trying to cover as many people as possible. And the more flexibility we have, the more people we can cover.

So I think your argument leads to—and I would like to try to convince you—leads to us having more flexibility. We can cover more people. I look at California. California has a $30 billion budget deficit. You can pour more Federal dollars into that program, but they are going to have great difficulty matching it dollar-for-dollar for some of those optional benefits.

Mr. BILIRAKIS. Thank you. Mr. Deal is recognized for 8 minutes.

Mr. DEAL. I, too, want to express my appreciation to the Governors for their appearance here today and for your insight into what is a difficult issue for you as well as for those of us here at the Federal level.

I want to mention one topic that for my State is a problem, and I think probably at least for Governor Richardson is a problem. That is the issue of undocumented aliens and their impact on the cost of providing care.

There is a study that has been commissioned through GAO to try to study that impact and submit a report by the end of this fiscal year for the top ten States in estimated illegal populations, and New Mexico, as I understand it, is in that list.

There has also been legislation introduced on both the House and Senate side that would propose to make additional allocations to those States that are the sixth highest in estimated undocumented populations. Since my State of Georgia is seventh and is not included, I have some problems with that cutoff. And since New Mexico is not in that top seven, I would assume the Governor of New Mexico would also have similar problems.

Would you care to comment on that aspect of the cost to your system, and suggestions as to how we might better deal with that problem?

Governor RICHARDSON. Well, Congressman, first, I would say that both of our States deserve to be on that list. And then, second, I do think we have to, with this population, revert to our role as a Nation that is compassionate. Many of these undocumented workers are participating in civic society, and they are going to school, they are law-abiding citizens. And in New Mexico, even though we are on the border, we don't experience the dramatic

growth that exists in other border States like California, like Texas, but it is a strain on resources, but one that we are trying to find ways that we have sensible policies.

Now, again, it is—I just keep saying it—it is a matter of resources. It is a matter of finding ways to have eligible populations that you can take care of not just with resources, but with partnerships with the State, the Federal Government, clinics, private sector, but this is something that I know your Hispanic population in Georgia is one of the highest growing in the country. In fact, I think you elected a Hispanic State Senator for the first time, so I know this is a problem for you.

Mr. DEAL. Let me move to the topic and the one word I think we have heard the most of, and that is flexibility. Having just met with a health care provider group just a few minutes ago during the midst of this hearing, one of the concerns for some that are maybe not considered mainstream in the health care providers is that flexibility will mean that they cut out of the system, whether it be dental services, therapeutic services, et cetera.

We have gone through that same argument, as you know, when we dealt with the education bill during the last Congress, about doing away with categorical areas and giving broader discretion to the States.

Can you all give some assurance to these groups that if you are given some flexibility, that they will have their just say and hearing at the State level so that you don't have certain provider groups being excluded? I think that is a concern that is always there when you remove people from mandatory categories and put them into discretionary categories.

Governor ROWLAND. I would be glad to take a stab at that, and my first comment would be that, first and foremost—and this hasn't come up in our discussions just yet—but this whole talk of the reform plan is voluntary to the States, and that needs to be highlighted. So if 20 States that, for example, don't even have optional benefits, or do not have a SCHIP program, or don't have a drug prescription plan, if they think, well, things are going fine under the way we are doing this, then they can continue to do what they are doing, and the other 30 States that have been creative with optional plans and extensions of programs, they may presumably go running after the $12 billion over the next 7 years.

With regard to various groups that provide benefits, what I have seen at the State level is that you have got that balancing act. And what we are facing today, if you look at the Medicaid pie, you are looking at the dollars and then make a determination to, in Congressman Pallone's comment, you want to serve as many people as possible. And over the last 6 years, I would argue that because of the better economic times and for the State economic times, all of us have surpluses. We are chasing optional programs like crazy—dental plans, this plan, that plan. But certainly under the Medicaid plan, you know, the dental care, braces, everything is no co-pays, no contribution, it is the best plan in America.

But my point is that you will see at the State level that debate over extending the optional care or trying to take care of more. I would caution, however, under these tighter fiscal times, you are going to see more focus on taking care of the lower-income and

making sure that—well, arguably, that the bells and whistles won't be there. Having said that, if we don't do anything, if we don't adopt this type of a plan and we maintain the status quo, we are only going in one direction, and that is less benefits and less people covered. That we know for sure.

Governor RICHARDSON. Congressman, I would give you that assurance, too. In fact, in New Mexico, I think, because of this dramatic increase in Medicaid services and enrollees, that we are looking at peer practitioners. I think this is where you can experiment a little bit—alternative practitioners, traditional healers and services. I should be careful because I know there are a lot of doctors on this committee. But I think a State like mine has to do that with very rural Native American and Hispanic populations that have access problems, that have delivery problems, that have limited resources, few rural health clinics.

Mr. DEAL. Thank you both. Another topic that I know we all have concerns about, and that is the disproportionate share payments. And for States like—I am sure probably New Mexico is like Georgia in the regard that we have many areas where disproportionate share makes a big difference in terms of rural hospitals that have those large Medicaid populations.

Certainly, it is one of those topics that is on the table for discussion as to how we deal with it in the future, and I would just simply lay that subject matter out for your consideration as to any comments later down the road that you would like to share with us. And, also, as I understood it, the Governors Conference is going to provide us with some list of waivers that have been effective, and I think that would be very, very beneficial for us to hear from you as to the kinds of waivers you think have worked and the kind that maybe should be incorporated and not have to be asked for, but maybe incorporated into the basic system.

Governor ROWLAND. I think, Congressman, that is a great starting point for discussion, and I would take it a step further, and I would say to the chairman and to interested members that what you ought to do is put the gauntlet down and say to the Governors of this country, "If you want this reform plan, you sit down and work with the administration and interested parties on this committee, and put something together that we can all agree upon." Absent that, it becomes—if we have five different plans floating around out there and the DSH payments aren't satisfactory to New Mexico and Connecticut, and this plan is not satisfactory, and we don't engage and make sure that there is a sense that the mandatory populations are going to be protected—and I think that has to happen—then shame on us.

And so I would encourage you to challenge the Governors to make it happen.

Mr. DEAL. Thank you, Mr. Chairman.

Mr. BILIRAKIS. The gentleman's time has expired. Mr. Stupak for 8 minutes.

Mr. STUPAK. Thank you, Mr. Chairman, and welcome to the Governors. I have sat through most of this hearing, and we met Jeannette Johnson over here with her parents, and Donna Lucero is right over here, and she recently lost her job and, when she lost her job, she lost her health insurance. She was told she could go

buy her health insurance under COBRA once you lose your job. But we all know when you try to do that and get a single-payer plan, it is too expensive, especially when you don't have a job, and there was no way she could afford any health care plan. So she went in and applied for Medicaid and, of course, Medicaid denied her, but at least her daughter got some coverage under Medicaid. And Donna says that Medicaid does matter to her, it is a relief that at least her daughter is covered by any illness that she might encounter. She is a star student at her high school, and being able to stay healthy is critical for her to be able to continue learning at an optimum level.

And as I have listened to all this today—and Governor Rowland indicated that even with the proposal of the President, there may be a decline in service and, therefore, with a decline in service we may not be capable of providing services like we have in the past to people like the Johnsons or Lucero. And both the Governors, Governor Richardson and Governor Rowland, also mentioned the war.

So I ask this question with all due respect because when I am back in my district, this is what I am hearing. And this weekend, Saturday, I will be at UP legislative dinner, with all of our American Legion Post and don't have enough money for health care for veterans. Sunday I will be down in Patosci with the nurses, never enough money there in health care. I'm doing a town hall meeting Monday night. But my constituents have been asking me lately—and now they are hearing about proposals to cap Medicare and Medicaid because States can't afford it, and I think you mentioned that my State of Michigan lost 50,000 people on Medicaid—but then, yet, last week they saw the President on TV saying that after we defeat Iraq, the U.S. will go on to provide food and medicine for Iraq. And, yet, here in the United States we don't either have enough resources and we don't have enough money for Medicaid to take care of people, whether it is the 50,000 in Michigan or the Johnsons or Luceros, and we don't have a prescription drug program. Medicaid pays for some prescription drugs for beneficiaries.

So how do we cut Medicaid recipients' benefits here at home, but we promise medicine to Iraq, or how do we pass a plan that caps Medicaid benefits, but I don't hear any caps on aid we are going to give to countries we may be at war with. And my constituents are saying, "How do you do that? What is going on up there? Where are your priorities?" How do we answer that?

Governor ROWLAND. I think it is a great question, and the answer, I think, comes back to what your colleague said earlier, and the challenge should be for all of us. Let us cover as many people as we can. The dilemma we continue to face is as we expand the coverages and the optional categories and as we begin to get into the SCHIP programs, are we taking away from the mandatory population? So there is this constant give-and-take, and I am not sure that at the State level we see funds being diverted, if you will, to the war, or funds diverted to health care for other countries, but all I know is that we spend probably 40 percent of our entire budget on health care for the people of our State, some of it matched by the Federal Government and much of it not.

What I do also know is that economically, except for New Mexico, most of our States are in a real jam, your State in particular. I mean, you have got layoffs of State employees, reduction of benefits across-the-board, and I don't see it going away anytime soon.

So, leaving aside foreign policy discussions, all the more reason to engage with your Governor, who I think is enterprising enough and flexible enough in working with the Federal Government, and courageous and creative enough to figure out what population to serve and how to utilize the Federal and State dollars that are available.

Mr. STUPAK. But if you start capping it—and this plan I think Mr. Pallone said lack of resources—there is no doubt in outyears you do have a cap on it, and hopefully the economy is better—we can always hope against hope—but, still, 40 percent of your budget right now is going for health care and you don't have enough. How do you help these other people?

Governor ROWLAND. That is why this plan is a home run, it increases by $12.5 billion over the next 7 years. So you are going to look at $3.2 billion next year and $12 billion over the next 7 years.

Mr. STUPAK. So $3.2 billion will take care of all your health care needs?

Governor ROWLAND. Better than the alternative which is the status quo? Absolutely.

Mr. STUPAK. Well, shouldn't we really put more resources into Medicaid? After all, the Federal Government picks up about 57 percent of every Medicaid dollar.

Governor ROWLAND. There is no question, we would all love to see more money. Believe me, all of us, every Governor, would love to see more dollars, but let me emphasize that the State still has to match those dollars.

Mr. STUPAK. On, I don't disagree.

Governor ROWLAND. And whether it is Michigan or California, the ability to match it is going to be difficult.

Mr. STUPAK. And I agree with the SCHIP program, Governor Bush was saying they would rather be in the SCHIP program as opposed to the Medicaid program because they get more benefits, and I think that is what people are saying, and health care is so critically important. But you talk about the $3.2 billion, Governor, how much would your State give of the $3.2 billion? You have 50 States out there, plus Puerto Rico and the other——

Governor ROWLAND. No. 1, all 50 States wouldn't utilize it. It is a volunteer program. The estimate is that probably half would. So, if that is the case, it would be about a 2 percent increase. With that 2 percent increase I can do an enormous amount.

Mr. STUPAK. But unless the economy really picks up tomorrow, you are going to have more than a 2 percent increase or demand in your State of Connecticut.

Governor ROWLAND. It would be a 9 percent increase, but what I am saying is that a 2 percent increase with flexibility is a much better plan than the status quo. And I would also add that if you would do a drug prescription plan at the Federal level, that would be great relief to many States, as long as that is flexible as well.

Mr. STUPAK. Sure, but if you are going to get a 2 percent increase and a 9 percent increase in demand in your State, there is a 7 percent gap there. How do you cover that?

Governor ROWLAND. By not having to spend $5,000 a month for a nursing home recipient. I can spend $1,000 or $2,000.

Mr. STUPAK. What would that nursing home recipient do then, if the State wasn't there to help out, and they are qualified for Medicaid so you know they don't have a lot of resources, so what does that recipient, that nursing home recipient?

Governor ROWLAND. Oh, I would offer a menu of services, anything from assisted living to at-home health care. We only have one option right now. The option is to go into the nursing home. With dual-eligibles, we have a disaster at the management level at home health care and homebound. So, right now, if you look at, for example, my $3.5 billion spent on Medicaid, both Federal and State, half of that is going to optional services, well over half of that. And of that half, of that $2 billion, $1 billion of it is going directly into the nursing homes. They haven't had an increase in the last 2 years.

Mr. STUPAK. Governor Richardson, anything you want to add to that?

Governor RICHARDSON. When you have a Democratic Governor or a Republican Governor, one of the things that we have tried to do is approach these problems on a bipartisan basis. Where I would differ a little bit with John is I do worry about the capping at this time of uncertainty, at this time when we are telling Turkey we are going to give them $26 billion, and then we have got this shortfall in the States and so many other problems.

I guess my position, Congressman, is that at this time of economic downturn and uncertainty, it is important that we not do the status quo—I am with John on that—but that we not experiment so dramatically that by capping—and I have looked at those numbers, it is $12.7 billion over 7 years—but then in the outyears it is a drop off, and I do think we have to pay it back. And I worry about what you are going to do in States like mine where this program just continues to grow, and where you have—I would hope that you consider having Medicare be more active in dealing with health and long-term care costs of all people so that the States, regardless of immigration, regardless of illnesses, family type, status of age, so that we at the Medicaid level can really concentrate on doing that, and have the SCHIP program expanded so that we can deal with disabled, with kids, with seniors. I think that would be a constructive step that we could take to deal with the long-term issue that you talked about.

Mr. STUPAK. Thank you.

Mr. BUYER [presiding]. Thank you, Mr. Stupak. Mr. Brown.

Mr. BROWN. Mr. Chairman, I would like to ask unanimous consent to enter these letters and statements on Medicaid from groups like the Alabama Hospital Association, ACT-UP Atlanta, American Academy of Pediatrics, American College of Ob/Gyn, American Diabetes Association, AFL/CIO, American Hospital Association, AARP, Catholic Health Association, Center on Budget Priorities, Children's Defense Fund, Consortium for Citizens with Disabilities, Florida Alliance for Retired Americans, Health Care for All Coalition, Leadership Council of Aging Organization, March of Dimes,

Association of Children's Hospitals, National Association of Public Hospitals, National Citizen's Coalition for Nursing Home Reform, National Committee to Preserve Social Security and Medicare, National Health Law Program, National Mental Health Association, National Women's Law Center Premier, and AARP. If I could submit these letters for the record.

Mr. BUYER. Hearing no objection, so ordered.

Mr. Strickland, you are recognized for 5 minutes.

Mr. STRICKLAND. Thank you, Mr. Chairman. I am sitting here thinking that we make decisions that affect real people, and we have one of those real people in the audience today. I would like to recognize Rose Spears, from Portland, Oregon. Rose has two children, four grandchildren. She has heart problems and diabetes. Thank you, Rose, for being here today.

She gets her health coverage through Medicaid. She is one of the optional beneficiaries. She is on disability, not on SSI. She has been getting her drugs through Medicaid. What does that mean? It means in February she was told that she would no longer be able to get her prescription drugs paid for. She pays $912 a month for her medications and her insulin. She receives $728 a month in disability payments, and $61 a month in food stamps, and her rent is $373 a month. Her medications cost more money than she has each month to live on. She is an optional beneficiary.

Governor Richardson, I have a question, but before I have a question I want to thank you because when you were Secretary of Energy, you did something courageous, you admitted that this government injured people without their knowledge. And today in my district and across this country, people are being compensated because of your courage, and I want to thank you for that.

Your two colleagues with you sent a letter to the President not long ago opposing the State Fiscal Relief legislation that has been introduced or authored by Congressman King and Congressman Brown. They wrote, "Rather than seeking one-time relief from the Federal Government through the Federal medical assistance percentage increases or other measures, we would suggest it is time to review and fundamentally rewrite the Medicaid program."

In the State of Ohio, the Governor has recently terminated Medicaid coverage for adults with vision problems, psychological problems, sight problems. Anything above the neck is pretty much excluded from Medicaid coverage.

I have met with pediatric dentists who have been treating disabled children who are now disabled adults, and they are stunned by the fact that they will no longer be able to treat these disabled adults that have serious dental problems.

I note that—I think I am correct here—Connecticut is now trying to close a budget deficit of at least $700 million. The State already dealt with a $650 million hole in their budget this current year. Florida has a deficit of $2 billion expected for the upcoming year, and is unlikely to be able to cap the classroom sizes as required by the Florida Constitution. Those States would gain $71.5 million and $217 million under this Federal medical assistance percentage proposal.

In your State, Governor, you would gain $87.7 million. It would seem to me that it would be important to have these additional

monies to at least preserve coverage for the States that are faced with these awful choices.

Don't you think, Governor, that our first choice should be to protect coverage which is currently being provided to vulnerable families and to maintain this as much as possible? In other words, doesn't the Federal Government have responsibility to step in and help out these States now because people like Rose Spears are being hurt now, and not wait for some reform that may be desirable in the system?

Governor RICHARDSON. Congressman, I agree, and I said in my opening statement that I felt that passing the legislation, the King, Brown, and in the Senate I think Collins and Hutchinson of Texas, which is bipartisan immediate fiscal relief for the States. This process is going to take about a year of drafting legislation on Medicaid and Medicare. And my hope is that some of these funds are available now, and hopefully as part of a compromise there can be—I don't know if we can expect all the $10 billion that you talked about.

I do want to say something that is very healthy, and Congressman Rowland alluded to it, and that is when I used to sit on this committee, even more junior than some, and Governors would come up, I didn't recall the committee really listening to them. And I would say, "God, they are just whining." And now that I have seen first hand how we are the ones that are managing this Medicaid, but we are the ones that see the people that are hurting.

I have Donna Lucero, from New Mexico, who is here, who lost her job. And they look in your face and they say, "What am I going to do? I pay my taxes. I want to work. I want some hope for my family," and you can say, "Well, you know, I can't deal with Medicare reimbursement, that is a Federal issue. I can't deal with giving you this new program because I have to get a waiver, and I don't know if I can do it," and you sometimes feel powerless.

My point is that I would hope that this committee—I know it has policymaking authority in the health care area—works with the Governors—and we are forming a task force of 12 Governors that will work with the administration and with the Congress in fashioning legislation that at least limits the pain, the short-term pain that we have in this time of economic uncertainty.

And I want to return the compliment to you for your work on behalf of your people. I have never seen a Member of Congress that fought more for his people especially in need than you do.

Mr. STRICKLAND. Thank you, Governor. Thank you, Mr. Chairman.

Governor ROWLAND. Mr. Chairman, if I may, I just wanted to correct the Congressman, apparently he has got some misinformation alluding to a letter that was sent from myself and Governor Bush and Governor Owens in opposition. I believe he referred to H.R. 816. We did not send a letter in opposition to H.R. 816, we sent a letter to the President and to the Secretary of Health and Human Services, talking about flexibility and the process that we are following. That letter that we sent was on January 16. H.R. 816 was not even introduced until February 13. So our letter was not in opposition, and I know that some of that misinformation is being spread around, but it is not the case.

Mr. BUYER. Do you support the legislation, sir?

Governor ROWLAND. I don't even have an idea what the legislation is.

Mr. BUYER. Thank you. I just have a couple quick questions. First of all, gentlemen, thank you for coming. One of the challenges we face in drafting this Medicare prescription drug piece is trying to prevent dumping. I hate to use that word, but corporations that have legacy costs want to put retirees on the Federal Government. States have an interest on dual-eligibles.

When I looked at—just to go by last year's bill, Connecticut alone, over 10 years, would stand to reap about $729 million. That is a tremendous benefit over 10 years if the Federal Government picks up the cost of dual-eligibles. New Mexico is $87 million. So, I just want you to know those are things that add to our cost——

Governor ROWLAND. We can negotiate that.

Mr. BUYER. Sir?

Governor ROWLAND. We can negotiate that.

Mr. BUYER. I do have a question follow-on from Mr. Deal's about the unauthorized aliens and emergency medical expenses. When he asked you the questions about DSH payments, I would like to know if you have any data on the amount of DSH payments that are used for unauthorized aliens? Do you have anything on that?

Governor RICHARDSON. We will provide that for the record, Congressman. We are what is called a low DSH State. This would be added to the administrative part of the allotments under the administration's proposal. These are service dollars, but not administrative.

Mr. BUYER. Governor Rowland, would you have any data?

Governor ROWLAND. We do. Our DSH payments are about $230 million. I didn't catch the whole question but, if, indeed——

Mr. BUYER. It was whether or not you have any data on the amount of DSH payments used for unauthorized aliens.

Governor ROWLAND. For unauthorized aliens, I could probably get that information for you.

Mr. BUYER. If you could get this for the record——

Governor ROWLAND. I don't think it is significant in the State of Connecticut.

Mr. BUYER. It would be, though, in New Mexico.

Governor RICHARDSON. Probably higher, yes, than Connecticut.

Mr. BUYER. The last question I have, I was surprised when I reviewed the testimony, and Governor Bush talks about 45 percent of the State of Florida's pregnant women served by Medicaid, 44 percent in New Mexico—I don't know what yours is, Governor Rowland—but that is very high. I immediately began to think about the fathers out there, and we have a system to go after deadbeat dads and the collections on welfare. Is this included in what is happening in your courts, your AGs are going after the deadbeat dads to make collections back to your State relative to the cost of Medicaid for providing for these children?

Governor RICHARDSON. Yes. In my State, it is.

Mr. BUYER. Do you know what that number is, and how well it is being done?

Governor RICHARDSON. Well, it is not being done as well as it should. The number on the program—I am informed that we get

$1.56 for every $1.00 that we spend on the program, from the Federal Government. So we do well proportionately.

Mr. BUYER. I just want to make sure that you are comfortable. That AGs are actually making those demands and collecting on judgments on deadbeat dads.

Governor RICHARDSON. I am comfortable with the efforts of our officials. The results, I would like us to do a lot better like obviously we should.

Mr. BUYER. Governor Rowland?

Governor ROWLAND. We have had a very successful rate, I can't give you exact percentage. I will tell you that the challenge for us is out-of-state dads. And I know that the Attorney Generals Association has been diligently working and we are using all kinds of technology, and there have been many cases we have actually sent people out of the State to other States to pick up the dads and to force them to pay the price.

Mr. BUYER. Could both of you provide that for us for the record? What we will attempt to do is—there is a myth—well, it is the difference between myth and reality. If you come to the Federal Government and you just ask us for more money, our question to you is how well have you been collecting with regard to those costs. If you are doing it well, that is great. If you are not doing it well, then we know how we need to sort it out. That would be very helpful.

I have no further questions. Mr. Davis is recognized for 5 minutes.

Mr. DAVIS. Thank you, Mr. Chairman. I want to thank the Governors for sticking around, given your busy schedules, and my Governor, Governor Bush, for spending so much time here.

There are three ingredients to what we discussed today that I would like to briefly go back and highlight and give you the chance to comment on and respond to a question. The first is the level of the proposed increase, the second is the proposed flexibility, and the third is what I will essentially refer to as a cut in the per capita amount of Federal dollars you receive for each of the people you represent who are Medicaid beneficiaries.

As Governor Bush said so eloquently early, this is not about government numbers, this is about family incomes and people. And I want to refer to simply one Floridian who is in the audience today—I hope there are others—Carolyn Chavan is here. Carolyn, would you raise your hand so folks can see you.

Carolyn—I expect she doesn't mind me mentioning this—was diagnosed with cancer in April of 2000. She is fighting the good fight and hopefully doing well. She had to quit working. She had to fall back on the medically needy program in Florida to pay her prescriptions, in addition to some disability she receives.

What Governor Bush would have acknowledged if he were still here is that under the budget that he has had to submit in Florida, the medically needy program is eliminated. And, Carolyn, I don't know what is going to happen. I guess I hope that isn't going to happen and the Federal Government can help Governor Bush avoid doing that so you and others can fight the good fight and get well and get back to work and be with your families.

But the point is, I believe you need this increase. And a lot of people laughingly refer to Florida as the place where, as Senator Gramm likes to say, if you live long enough you will be a resident one of these days. But the truth of the matter is, one of the reasons the Federal Government needs to provide some support is because of the issue of mobility. And certainly in New Mexico, perhaps less so in Connecticut, Governor Rowland, more and more people are moving to your State because of the good things it holds and what you are trying to do for it, and that is one of the reasons why the Federal Government needs to support Medicaid and needs to provide increase because of your budget situation.

On the flexibility, Governor Bush—and I am sure you as well—have done some very nice things with the developmental disability area in terms of getting the dollars where they need to go, to people that need it. One of the projects he has pursued is something we talked about today and I think is terribly important, which is getting out of the institutionalization business for developmentally disabled people and the seniors, and allowing people to age at home in place.

One of the projects that Governor Bush referred to in his testimony is only in two counties, serving about 100 people. That is simply a beginning. To me, it is another example of why we need to give you the increase, and we need to give you the flexibility as well.

Finally, I think it is very important that we try to reach agreement, Democrats and Republicans, Federal and State, on exactly what this proposal means because I think what it means, based on the numbers we have gotten from OMB and the CBO, is that once this program really kicks in, the amount of Federal dollars you perceive on a per capita basis, which is ultimately what affects Carolyn, is going to be dramatically reduced at a time the Baby Boomers are starting to retire. And once we can agree on those facts, if that is where people want to head, then we will go ahead and take the votes and move accordingly, but I don't think that is where we want to head. I think those of you all who are encumbered by tremendous amount of knowledge of the details as Governors, need to help us make an informed judgment on this, and hopefully there will be bipartisan agreement on this, and I expect you will be leaders in that, on whether that is the direction the Federal Government needs to take.

The last thing I want to say is that I do support giving you the flexibility on the co-payment. I supported it as a State legislator in Florida. But you know that is a very, very powerful tool to be used, and it can be abused, and I want to cite you one example and give you the chance to comment on this or any other points I raised.

The Department of Veterans Affairs budget this year suggests a $15 co-payment on drugs and a $250 deductible for low-income veterans. They further estimate this will result in a 34 percent drop in Priority 7 and 8 veterans—these are low-income veterans using health care. I don't think that is what we intend to do when we talk about personal responsibility in cost-sharing. That sounds to me as something that is going entirely too far. Ultimately, we have to resolve the level of trust and flexibility we will give you to make the right decisions for the people we all represent.

So, I just want to give you in my remaining time any chance to comment on any of the matters I have said, or anything else you haven't had a chance to raise.

Governor ROWLAND. Congressman Davis, let me first thank you for what I think are very constructive remarks. I think you had to duck out for a moment when we talked about at the NGA level we will have a task force, if you will, of about 12 Governors, Republican and Democrat, that are willing and able to meet with your committee and any other interested individuals, to try to craft something. And I also said to the chairman at the time, I think it is imperative that the challenge and the burden is placed on us. I think the burden has to be placed on the Governors bipartisanly to come up with a plan that you feel comfortable with, that the administration feels comfortable with and, frankly, that is the only way it is going to work. Absent that, this falls apart under its own weight.

When we talk about flexibility, we are talking about the ability to better serve our constituents and not a one-size-fits-all program. I would say that one of the things I have learned after 9 years as Governor is that what works in New Mexico may not work in the State of Connecticut. What works in Idaho may not work in New York State. We are a very diverse population, but the rural challenges and health care delivery systems and benefit levels are all very different. The mere fact that only half of the States have adopted what I call the CONPACE program, which is State drug prescription plan, the mere fact that only about half the States have adopted any of the optional programs under Medicaid. So you have a very diverse population, and the flexibility that you would give us will help us better do our jobs.

Mr. DAVIS. And, Governor, I want to strongly urge you to include Medicaid beneficiaries on this commission you are describing.

Mr. BUYER. Thank you. The gentleman's time has expired. I ask unanimous consent to enter into the record questions by Mr. Brown which will be submitted to you gentleman.

At this point, I want to thank Governor Bush, Governor Rowland, and Governor Richardson for coming, your testimony, and adding your contributions. Thank you very much. This hearing is concluded.

[Whereupon, at 1:10 p.m., the subcommittee was adjourned.]

[Additional material submitted for the record follows:]

RESPONSES TO FOLLOW-UP QUESTIONS OF GOVERNOR JOHN G. ROWLAND

QUESTIONS OF THE HONORABLE STEVE BUYER

Question 1). What portion of the DSH dollars you receive are used to pay for the care of unauthorized aliens?

Response: In Federal Fiscal year 2002, Connecticut made hospital disproportionate share (DSH) payments to private acute care hospitals totaling $151,729,042. In addition, the state made $89,921,52 in DSH payments public psychiatric hospitals for a total of $241,650,894.

DSH payments are made in accordance with the payment methodologies described in the Medicaid State plan, which identify how costs for uncompensated care and costs attributable to the Medicaid shortfall can be claimed. In both categories, costs are an aggregate amount reported by the facilities.

We do not determine the eligibility or the status of individual recipients in this process, including any determination their citizenship status. We do not have any

way of estimating what costs, if any, were attributable to the cost of uncompensated care provided to unauthorized aliens.

Question 2). What sums have been collected from dead-beat dads to support their Medicaid eligible children/spouses expenses?

Response: In State Fiscal Year 2002 (July 1, 2001 through June 30, 2002), the state colleted $13,971,821 in child support collections specifically for Medicaid expenditures. In addition, the state collected $19,374,977 in additional Child Support, some undetermined portion of which was attributable to Medicaid.

QUESTIONS OF THE HONORABLE CLIFF STEARNS

Question 3). Are Medicaid rates a contributing factor in "physician flight" from Medicaid? What about the administrative requirements?

Response: Medicaid rates for physician's services average about 60% of the allowable rates under Medicare. Following the passage of the Balanced Budget Act of 1997, Connecticut no longer automatically pays the Part B crossover payments for recipients who are dually eligible for both Medicare and Medicaid. We now pay crossover payments for Medicare coinsurance and deductibles only up to the Medicaid allowed amount.

Despite the lower fees and the reductions in so-called Medicare crossover payments, physician participation in Medicaid has declined only slightly in recent years. This may be, part, attributable to the fact that nearly 70% of all Connecticut Medicaid recipients are enrolled in Managed Care Organizations (MCOs). The two largest MCOs (Anthem Blue Cross Family Plan and HealthNet Northeast) are commercial plans and pay physicians fees, which are approximately 20% higher than the Medicaid, fee schedule. The majority of the remaining recipients in fee for service are dual eligible so the Medicare fee schedule ultimately determines their reimbursement.

In recent months we have seen some ominous signs in recent months of significant practices either limiting their Medicaid caseload or withdrawing from the program. If this tend continues we could face an issue with access to care.

We don't know how much of this trend is attributable to rates, versus malpractice, versus administrative requirements. We can tell you that over 90% of the claims for physicians services are submitted and paid electronically. We are implementing the new HIPAA requirements this weekend to bring our system into compliance with the national standard. We do not believe that administrative requirements pose a significant barrier.

The most helpful thing that Congress could do would be to help the states with the cost of care provided to dual eligible recipients. This fiscal relief would allow the states greater flexibility to adjust or own reimbursement rates in a more timely fashion to continue to attract physicians to provide high quality care.

Question 4). Please clarify your statement about recipients receiving medical assistance in your state with household incomes up to $54,000 a year?

Response: In that context Governor Rowland was referring to coverage of children under our SCHIP (Title XXI) program, known in Connecticut as HUSKY Part B. In our HUSKY managed care program, different categories of individuals are eligible at different income levels.

In HUSKY Part, A which is Medicaid managed care; children up to the age of 19 are eligible with household incomes up to 185% of the federal poverty level (FPL) ($34,000 a year for a family of four). Adults are currently eligible up to 150% of FPL ($27,600 a year for a family of four), although we were recently enjoined under a temporary restraining order in attempting to reduce that coverage ultimately back to 100% FPL ($18,400 a year for a family of four).

In HUSKY B, uninsured children up to age 19 are eligible for subsidized coverage with monthly premiums and co-payments with household incomes up to 300% FPL ($55,200 a year for a family of four). Families with incomes above 300% FPL can buy into HUSKY B coverage for uninsured children at the group rate negotiated by the state with no subsidy.

Eligibility for HUSKY B is limited to children under the age of 19. Eligibility is determined solely based on insurance status (i.e. uninsured), residency in Connecticut, and household income. There is no asset test in HUSKY A or HUSKY B.

As of March, 2003, there were 14, 352 children enrolled in HUSKY B. During the same month, there were 206,584 children and 88,836 adults enrolled in HUSKY A.

QUESTIONS OF THE HONORABLE CLIFF STEARNS

Question 5). How can we justify covering optional services such as optometry dental, non-emergency medical transportation, and others to Medicaid clients with in-

comes up to 300% of poverty when we don't provide such services in Medicare or to our veterans?

Response: As noted above, in Connecticut coverage at 300% of poverty is provided only children in SCHIP. In Medicaid, income eligibility varies widely by coverage group but does not approach 300% of poverty (see response to Congressman Norwood's question).

That having been said, Connecticut does recognize the cost of providing such optional services and the need to re-evaluate that coverage in difficult financial times. In January, 2003 Connecticut eliminated coverage of the following optional state plan services for adults 21 years of age and older: podiatry, chiropractic, naturopaths, psychologists, physical therapy, occupational therapy, and speech therapy. We have proposed the elimination of adult dental coverage to our legislature beginning July 1, 2003.

States cannot eliminate coverage of any optional services for children due to the federal mandate for coverage of EPSDT services (Early and Periodic Screening, Diagnosis, and Treatment). What that means is that the Medicaid program must cover any medically necessary service that is diagnosed and ordered by licensed practitioner of the healing arts within his or her scope of practice. This mandate applies whether or not the service ordered is included in the State Plan.

Question 6). Do you think that a $5 co-payment is sufficient to get beneficiaries aware and involved in their health care and to perform a utilization and cost-sensitizing function?

Response: Under federal regulations, which have not been updated since 1983, all Medicaid co-payments must be nominal and cannot exceed $3 per service. Broad classes of individuals and services are completely excluded from co-payments, including children, pregnant women, family planning and preventive services, and individuals residing in institutions. The $5 co-payment which I believe you were referring to was referring to the co-payment imposed on services in our HUSKY B program which operates under Title XXI (SCHIP) where the rules are somewhat more flexible.

Our actuaries tell us that there is a quantifiable effect on utilization in low-income populations even from the application of co-payments at the $5 level. Higher co-payments in tiered structures for pharmacy where the lowest amount would be applied to generic drugs, a higher amount to legend drugs, and the highest amount to drugs which are off-formulary are a common practice in the private sector and have been shown to be effective in changing market behavior.

A first step would be to allow states to use even limited co-payments that exceed the current $3 limit. Co-payments should also be enforceable, at least for some services for certain populations. Today, a Medicaid provider must provide the service even if the recipient fails to pay the co-payment.

QUESTIONS OF THE HONORABLE CHARLIE NORWOOD

Question 8). Please identify the income levels in your state at which a person qualifies for Medicaid.

Response: The Medicaid program is actually a composite of different coverage groups based on various categories of individuals. The major groupings are Family Medicaid, which includes pregnant women as well as children and their adult caretakers, and Medicaid for the Aged, Blind, and Disabled, which includes aged, blind, and disabled individuals as well as residents of nursing facilities.

Each Medicaid coverage group has its own income requirements. Additionally, each group has different rules on how much income is counted toward the income limit. For example, we do not count $90 per month of gross wages under the Family Medicaid groups. Aged, blind, and disabled individuals are allowed a $183 per month disregard of their Social Security benefits.

With respect to income limits, pregnant women and children under age 19 may qualify for Medicaid if their household income, after certain deductions, does not exceed 185% of the Federal Poverty Level (FPL). Adult caretakers may qualify if their household income, after certain deductions, does not exceed 100% of the FPL. Non-disabled individuals aged 19 and 20 may qualify if their household income, after certain deductions, does not exceed our Medically Needy Income Limit (MNIL). For most of Connecticut, the MNIL is $476.19 for a household of one, $633.49 for a household of two, $776.49 for a household of three and $913.77 for a household of four. Our MNIL's are somewhat higher in our state's Fairfield county area.

Aged, blind, and disabled individuals generally qualify for Medicaid if their counted household income is less than the MNIL. The limits are, however, different for certain aged, blind, and disabled individuals. For example, residents of nursing facilities generally qualify if they do not have enough income to pay for their nursing

home care independently. Individuals receiving home and community-based services as well as State Supplement recipients may qualify if their gross monthly income is less than $1,656, which is 300% of the Supplemental Security incomes program's payment standard. (State Supplement recipients are also required to pass a net income test in which their income, after certain deductions, is compared to a payment standard based on their living arrangement.) Disabled individuals who are working may also qualify for Medicaid if their annual income is less than $75,000.

All of the Family Medicaid and Medicaid for the Aged, Blind, and Disabled groups cited above that use the MNIL as their income limit allow income spenddowns. With an income spenddown, individuals with too much income can deduct medical expenses from their income until their income reaches the MNIL. Medicaid would then pay for any additional medical expenses through the end of the budget period, which is typically six months in Connecticut.

RESPONSE FOR THE RECORD OF HON. JEB BUSH, GOVERNOR, STATE OF FLORIDA

Question 1. Governor Bush: What are some of the challenges facing Medicaid unique to Florida? For instance, does being a low cost of living state, and a border state, contribute to your Medicaid woes? (Congressman Cliff Stearns)

Response: Florida has many challenges that are unique or only faced by a few states in the same way as Florida: a small business economy with higher uninsurance rates, high immigrant/illegal alien/undocumented population, large population growth/increases, and the highest percentage elderly in the nation.

Question 2. Governor Bush: I have spoken here in the Committee and also on the floor on your consumer-directed care program. And I want to reiterate its high satisfaction rate: according to Mathematica, the independent evaluation firm, 96% of CDC participants describe themselves as satisfied with their relationship with their provider, and of those 96%, 99% of those are very satisfied. Do we know how that compares with the rates of satisfaction in traditional Medicaid? (Congressman Cliff Stearns)

Response: Although we have some studies indicating that satisfaction of Medicaid participating families with children is high, no study demonstrates a level of satisfaction that participants in the Florida Consumer Directed Care project indicate.

Question 3. Governor Bush: Because I have heard that CDC is very popular, I am concerned that everyone who would like to participate should be allowed to. Is this the case? (Congressman Cliff Stearns)

Response: Florida Medicaid was recently granted a federal waiver to increase the number of participants in the program by 150 individuals. We have also filed another waiver application with the federal Centers for Medicare and Medicaid Services seeking federal approval to eliminate the research and control segments of the demonstration project in order to increase participating to more than 3,200 individuals.

Question 4. All Governors: We have been hearing about providers fleeing the medical profession because of both low Medicare rates and high malpractice insurance rates. Are Medicaid reimbursement rates also a contributor to "physician flight" from Medicaid? And what about administrative requirements—I suspect we are burying providers in paperwork so that they can't treat patients. What solutions could we help with? (Congressman Cliff Stearns)

Response: Like many states, Florida has been unable to pay Medicaid participating physicians reasonable fees for their services. Physicians are increasingly complaining about the level of Medicare fees. On average, Florida Medicaid reimburses physicians at even lower levels—57% of Medicare. Florida Medicaid is having increasing difficulty ensuring beneficiaries access to care. In many counties there are insufficient participating physicians, particularly specialists. To help with this problem, I have proposed to the Legislature an across the board fee increase of 9% for FY 2003-04. This is only a start. Although there may be additional claims processing improvements, we receive 92% of our claims electronically and we pay clean claims in just 8 days, the fastest of all payers in Florida. We are making other adjustments to our processing so that more claims can be processed without attachments to avoid manual review and accelerate payment.

Question 6. All Governors: What concerns me is that what I would consider to be rather generous of the "optional" populations, for optional services. On February 4, 2003 the GAO presented to Committee Staff these findings. It was noted that States' Medicaid programs might include over thirty optional services, including optometry, dental, transportation services among others. We're providing these services sometimes to persons 300% of the poverty level (roughly $27,000) that we don't

provide in Medicare, or for veterans. How can the States justify these expansions to less than needy populations? (Congressman Cliff Stearns)

Response: As I testified on March 12, 2003, we estimate that in just 12 years Florida Medicaid spending will equal today's total state budget. Spending is growing at a rate of 13 percent annually. Unlike SCHIP or commercial coverages, Florida Medicaid covers virtually every conceivable benefit. Much of this coverage is mandated or, if optional, subject to many federal rules. As Governors Owens, Rowland and I wrote to President Bush and Secretary Thompson, Medicaid costs are no longer sustainable. We need substantive reform, and benefit requirements are a key area that must be addressed.

Question 7. All Governors: Related to #6, on February 4, 2003, the GAO says that for prescription drugs there is no cost sharing for children, and for adults it must be "nominal," which usually ends up being $5. A very accepted tenet of health insurance is that "cost-sharing," whether it is co-payments or deductibles, helps instill proper utilization and cost-consciousness amongst beneficiaries. Do you think $5 is sufficient to get beneficiaries aware and involved in their health care, to perform this utilization and cost-sensitizing function? (Congressman Cliff Stearns)

Response: I firmly support affordable but meaningful beneficiary cost sharing. Current Medicaid laws and regulations preclude anything but nominal cost sharing, exempt many populations from any cost sharing, and prohibit making cost sharing mandatory on the beneficiary (not passed on to the provider). Under current limits, states cannot promote beneficiary cost-consciousness. I have secured federal approval for a tiered co-payment for drugs for seniors under state's Medicaid Silver Saver program ($2 for generics, $5 for Medicaid Preferred Drug List (PDL) products, and $15 for non-PDL drugs). I have proposed the same tiered co-payments for other eligibles and a $15 co-payment for non-emergency use of hospital emergency departments.

Question 8. All Governors: Please identify the income levels in your states at which a person qualifies for Medicaid. (Congressman Charlie Norwood)

See attachment

Question 1. What portion of the DSH dollars you receive is used to pay for the care of unauthorized aliens? (Congressman Steve Buyer)

Response: Unqualified aliens, individuals who are illegal or in the first five years of legal residence, are eligible for Medicaid funded emergency services. In FY 2001-02, Florida Medicaid spent approximately $67.6 million for emergency services for this population, of which about $57.6 million was for hospital inpatient care.

Question 2. What sums have been collected from dead-beat dads to support their Medicaid eligible children/spouses expenses? (Congressman Steve Buyer)

Response: The following are child support collections related to Medicaid beneficiaries from FY 1994-95 to FY 2001-02. The amount for support of insurance or medical expenses is not separately identifiable.

Fiscal Year	Collections (in $millions)
FY 1994-95	$425.6
FY 1995-96	$498.3
FY 1996-97	$540.4
FY 1997-98	$585.2
FY 1998-99	$656.6
FY 1999-00	$735.0
FY 2000-01	$779.9
FY 2001-02	$870.5

Prepared Statement of American Hospital Association

On behalf of our nearly 5,000 hospital, health care system, network and other health care provider members, the American Hospital Association (AHA) appreciates the opportunity to submit this statement for the record regarding Medicaid reform. The AHA shares the committee's concern that the Medicaid program must be strong in order to continue meeting the health care needs of our most vulnerable people. Nearly 45 million poor, disabled and elderly individuals rely on Medicaid for their care. Over its nearly 40-year history, Medicaid truly has become the nation's health care safety net.

The importance of this role has never been more critical than today. The current economy has forced many Americans out of work, pushing them and their families into the ranks of the uninsured. Medicaid has historically served as a buffer to the

perils of an uncertain economy by providing access to health services for those who cannot afford it. Yet, today's recession has thrust upon states the most serious fiscal crisis in over 50 years. Last year nearly all states imposed Medicaid cutbacks in some form to fill budget gaps, or used up all of their specials funds to prevent direct cuts in Medicaid eligibility or key services. State governments currently face budget shortfalls of $40 to $50 billion, and projections are pushing that figure to over $70 billion next year. The vast majority of states expect to consider proposals to cut Medicaid eligibility, health services and payments to health care providers. It is imperative that any federal action to address the current crisis, and any federal efforts to change the current structure of the Medicaid program, must not put further financial pressure on the states nor diminish the guarantee of coverage for our most vulnerable Americans.

The Administration proposal seeks fundamental change to the Medicaid program and ties any fiscal relief for states to the acceptance of such proposed changes. It weakens the guarantee of coverage for vulnerable populations and dismantles the Disproportionate Share Hospital Payment (DSH) program. DSH is our nation's primary source of support for safety net hospitals that serve the most vulnerable Americans—Medicaid beneficiaries and the uninsured and underinsured. The proposal loosens federal oversight and state accountability. And it is the poor, disabled and elderly that would be affected.

Provide Fiscal Relief—The AHA believes that the current fiscal crisis faced by states demands immediate and meaningful federal support. That support could be in the form of an increase in the federal Medicaid matching percentage or other relief that would allow states to use such funds to help support their Medicaid programs. States should not be forced to radically transform their programs to receive such fiscal relief, nor should they be compelled to reduce future spending to repay the federal support given now.

Protect the Vulnerable—The AHA believes that this nation has an obligation to care for the neediest of our society. A federally enforced entitlement to a set of meaningful benefits for this population must be maintained. An approach that requires coverage of the mandatory Medicaid population, but allows states absolute flexibility in deciding which non-mandatory populations and health care services will be covered in the future, begins to erode the guarantee to coverage that has long been a fundamental feature of the Medicaid program. Optional services such as prescription drugs for the poor, elderly, and disabled, could be eliminated. Health services to more than 12 million non-mandatory children, parents, disabled and elderly people could stop if these populations are dropped from the Medicaid rolls, thereby swelling the ranks of the uninsured.

Maintain Financial Integrity—The AHA believes that the federal and state governments have an obligation and responsibility to maintain their financial commitment to the program. The Administration proposes to sever the federal and state financial partnership and replace it with a fixed federal commitment and a state maintenance of effort, which begins to unravel the financial foundation of the Medicaid program. At the heart of the proposal is the absorption of the Medicaid DSH funds into the acute care allotment. The current Medicaid DSH program is the reason that many hospitals have been able to continue serving our most vulnerable people. The elimination of this discrete payment program would be a devastating blow to these hospitals, and to the poor and uninsured patients they serve. Many of these hospitals are in financial jeopardy; many are the sole source of care in their communities. Their failure would put communities at risk, because without them, medical services, social services and important jobs would disappear.

The committee should enact the Access to Hospitals Act of 2003 (H.R. 328) introduced by Reps. Ed Whitfield (R-KY) and Diana DeGette (D-CO), respectively. This bipartisan bill would eliminate a scheduled falloff in federal Medicaid DSH funding, so that in 2003 and beyond each state DSH program can grow with inflation. And the committee should support legislation to be introduced by Reps. Heather Wilson (R-NM) and Gerald Kleczka (D-WI) to increase the federal Medicaid allotment for states with small Medicaid DSH programs so that those states can better help their safety net hospitals. Both legislative approaches would provide more meaningful help to states and support to financially vulnerable hospitals serving the neediest patients.

In addition, the Administration's approach would cap federal spending using FY 2002 spending as the base year, updated yearly by a non-specified trend factor. The required state maintenance of effort would also be tied to the FY 2002 base year amounts, with annual updates. What this translates into is a capped program that over time will struggle to meet the needs of the mandatory population by putting pressure on states to reduce coverage to the non-mandatory populations and to reduce payments to providers.

Protect Access to Care—The AHA believes that adequate provider payment is critical to ensuring that Medicaid beneficiaries have access to needed services by making certain there are providers available. Current Medicaid law has minimal protections that are mostly geared to making the payment rate-setting process more public. The AHA advocates that these current protections should be expanded and strengthened.

The AHA also believes that federal oversight of state Medicaid programs serves as an important tool in protecting access to health care services for vulnerable people. The federal government oversight role ranges from overseeing Medicaid managed care plans to make certain enrollees have access to quality health care providers, to assuring the financial integrity of the program by making certain states spend their Medicaid funds on health care. The Administration's approach would significantly weaken this oversight role for the federal government and erase state accountability for the management of their programs.

The Medicaid program has played a vital role in providing access to health care services to millions of Americans over its 40-year history. If the Medicaid program did not provide this coverage, tens of millions would be added to the ranks of the uninsured. The current fiscal crisis faced by states should not be the impetus for dismantling the program and abandoning its mission of serving those who need help the most—poor children and their families, the elderly and disabled. States need immediate and meaningful fiscal relief and any flexibility granted state governments should not put at risk the mission of the Medicaid program. The AHA stands ready to assist the committee in any way as it tries to meet its many challenges.

PREPARED STATEMENT OF THE FLORIDA HOSPITAL ASSOCIATION

The Florida Hospital Association and its more than 200 members appreciates the opportunity to comment on Medicaid reform and, specifically, the Administration's proposal for fundamental change. Common sense suggests the need to revisit and examine carefully a more than 35-year-old program, one that must be strong to meet the health care needs of our most vulnerable populations. At the same time, we understand the urgency in addressing needed changes given the serious budget problems faced by Florida and many other states.

In Florida, FHA supports Gov. Bush's call for assuring that program benefits meet individual needs and believes that the SCHIP model (Florida's Kidcare) offers important lessons for any reconsideration of the design of the Medicaid program. One of the critical lessons from the SCHIP model is highlighted by Health and Human Services Secretary Tommy Thompson's call to encourage coverage for whole families.

Two concerns are fundamental for FHA and all our members. First, the role of the Medicaid program in supporting a safety net for the uninsured is critically important. Florida has 2.8 million people who lack health insurance and risk needing medical services they can't afford, and nationwide there are 44 million uninsured. Hospitals are mandated to provide emergency care and treatment and Medicaid supports these essential services through critically important Medicaid enhancements such as disproportionate share and the upper payment limit. Protecting these vital funding sources is essential as we pursue comprehensive reform of the Medicaid program.

The very significant proportion of hospital patients covered by government programs drives the second critical issue for Florida's hospitals. Medicare and Medicaid combined account for two-thirds of all payments to Florida hospitals. Currently, Medicaid payments average 77% of costs and Medicare payments, while better, still come in at less than costs. Therefore, further erosion of the financing of hospital services threatens the sustainability of services for all Floridians.

We believe that establishment of a process for ongoing evaluation of the Medicaid program, as FHA recommended in Florida, will improve the current program as well as prepare for the future. Similarly, the federal government should pursue a careful and thorough examination of the Medicaid program in order to address specific problems and changing conditions. Federal efforts to change the current structure of the Medicaid program must not put further financial pressure on the states nor diminish coverage for our most vulnerable Americans.

We urge the Committee not to weaken coverage for vulnerable populations and dismantle the Disproportionate Share Hospital Payment (DSH) program—a primary source of support for safety net hospitals that serve the poor, disabled and elderly. The FHA believes that this nation has an obligation to care for the neediest of our society and maintain a set of meaningful benefits for this population. More than 12 million non-mandatory children, parents, disabled, and elderly people are covered by

Medicaid. Any approach that begins to erode this coverage could eliminate health services to these needy populations and increase the ranks of the uninsured.

We support enactment of Medicaid safety net legislation (H.R. 328) re-introduced by Reps. Ed Whitfield (R-KY) and Diana DeGette (D-CO), respectively, to protect the integrity of America's public health safety net. This bipartisan bill—which garnered 190 House cosponsors in the 107th Congress—would extend modifications to DSH allotments provided under the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, thereby eliminating a schedule falloff in federal Medicaid funding.

The FHA and our member hospitals and health systems urge the Committee to proceed cautiously and carefully in reforming Medicaid. We must not dismantle the program that serves those who are most in need. We urge you to consider the many successful features of the Florida's Kidcare in considering changes to the Medicaid program. We stand ready to work with you in this regard.

PREPARED STATEMENT OF LAWRENCE A. MCANDREWS, PRESIDENT AND CEO, NATIONAL ASSOCIATION OF CHILDREN'S HOSPITALS

The National Association of Children's Hospitals (N.A.C.H.) is a not-for-profit trade association, representing more than 120 children's hospitals across the country. Its members include independent acute care children's hospitals, acute care children's hospitals organized within larger medical centers, and independent children's specialty and rehabilitation hospitals. We appreciate the opportunity to submit this statement for the record outlining the critical role Medicaid plays in the lives of the nation's children and the hospitals that care for them.

N.A.C.H member hospitals strive daily to fulfill their four-fold missions of clinical care, education, research, and advocacy devoted to the health and well being of all of the children in their communities. Children's hospitals are regional and national centers of excellence for children with serious and complex conditions. They are centers of biomedical and health services research for children, and they serve as the major training centers for future pediatric researchers, as well as a significant number of our children's doctors. In addition, these institutions are integral to the pediatric health care safety net, providing both inpatient and outpatient care to a disproportionate share of children enrolled in Medicaid.

In effect, children's hospitals are an indispensable national resource for the health care of all children. Although they represent only 3% of all hospitals in the country, they provide nearly 40% of the hospital care required by children assisted by Medicaid, and most of the hospital care for children with serious medical conditions, regardless of their source of health coverage. In addition, they train most of the nation's pediatricians and pediatric subspecialists, and they house the nation's leading centers of pediatric research. And they are leaders in addressing the public health needs of children, such as injury prevention.

MEDICAID: ESSENTIAL TO LOW-INCOME CHILDREN AND WORKING FAMILIES

The future of Medicaid is a topic of special concern to the nation's children's hospitals because of the 44.3 million Medicaid beneficiaries in FY 2000, more than half—22.7 million—were children under age 19. In fact, Medicaid is the nation's single largest health care program for children, financing health care for one in four children. One in three children depends on Medicaid or SCHIP for health coverage.

In addition, Medicaid's health benefits are designed specifically to meet children's unique health care needs, including children with disabilities and other special needs. Preservation of Medicaid's federal guarantee of health coverage appropriate for children, including its Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) benefits, is an essential part of sustaining the pediatric health care safety net.

EPSDT assures that low-income children will have medically necessary benefits that incorporate their unique needs. These can include preventative services, developmental/habilitation services for very young children, eyeglasses and hearing aids to ensure that children may learn, as well as prostheses, orthotics and wheelchairs that can be provided and changed as children grow.

Medicaid coverage of children is also vital to working families. Of the children covered by Medicaid or SCHIP in 2001, 75% had at least one parent in the workforce.

MEDICAID: ESSENTIAL LOW COST COVERAGE FOR CHILDREN

It is important to recognize that Medicaid coverage for children is low cost. Although children represent more than half of all Medicaid beneficiaries, in FY 2000 children under 19 (including SSI disabled children) accounted for only 21% of Medicaid spending. Not only are children a relatively inexpensive population to cover, but children's coverage in Medicaid is not fueling Medicaid's spending growth. In fact, Medicaid spending for children accounts for only 10% of the annual growth in total Medicaid spending. In addition, more than 50% of children in Medicaid are already enrolled in managed care plans, and Medicaid per capita spending for children is comparable to private coverage.

MEDICAID AND DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS: ESSENTIAL TO CHILDREN'S HOSPITALS

Medicaid is the single largest program of public assistance for children's health care and the single largest payer of care delivered by children's hospitals. Although only 3% of all hospitals, children's hospitals on average devote more than 40% of their inpatient care to children assisted by Medicaid. Children's hospitals also provide the majority of inpatient care required by children with serious illnesses and conditions. For example, children's hospitals perform 99% of organ transplants and 88% of cardiac surgeries, and provide 88% of the inpatient care for children with cystic fibrosis. In some regions, they are the *only* source of pediatric specialty care, which makes children's hospitals essential not only to the children in their own communities, but to all children across the country.

Medicaid generally falls far short of reimbursing children's hospitals for the cost of providing these essential services, so Medicaid Disproportionate Share Hospital (DSH) payments, which average more than $6 million per children's hospital, are extremely important to the financial health of these institutions. In hospital FY 2001, Medicaid, including DSH payments, on average reimbursed only 84% of the costs of care in children's hospitals, a percentage that fell to 76% without DSH payments. This crucial source of funding for children's hospitals aids in their ability to serve all children. Cutting these funds, or even worse, eliminating the program altogether, will severely damage the nation's health care safety net for children.

MEDICAID: ESSENTIAL TO CHILDREN WITH SPECIAL HEALTH CARE NEEDS

The health care needs of all children are special and distinct from those of adults, but the term "children with special health care needs" (CSHCN) refers to a group of children who require specialized health care, habilitation, and rehabilitation services. Frequently children with special health care needs are limited—or have potential limitations—in their ability to function because of a chronic or congenital illness, a major trauma, a developmental disability, or exposure to a serious or life-threatening condition.

Because they are devoted to serving all children, children's hospitals dedicate a disproportionately large amount of their care to children with special health care needs. Although children with congenital or chronic conditions represent only small fraction of all children, children's hospitals devote extensive resources to this population. For example, they devote 60% of inpatient admissions, 70% of inpatient days, and 80% of inpatient dollars to children with one or more chronic or congenital conditions.

For CSHCN, simply having access to health insurance may not be adequate for their healthcare needs because health insurance policies, like children, come in all sizes and shapes. Private insurance often lacks the comprehensive benefits needed by this population, such as physical and speech therapy, durable medical equipment, behavioral health services, home health care and some medications. Benefits may require that an individual be improving, a definition that doesn't fit for a child with cerebral palsy who may need a service to maintain function or a child with a congenital condition who may need a service to maximize his or her developmental potential.

But Medicaid benefits were designed to reflect the unique needs of children, including CSHCN. Preservation of the Medicaid program's federal guarantee of accountability for children's health insurance needs under the Early and Periodic, Screening, Diagnosis and Treatment (EPSDT) benefit package is an essential part of sustaining the health care safety net for children. EPSDT requires that, only for children, states cover all Medicaid services that are determined to be medically necessary by their physician during a regularly scheduled EPSDT screening visit. States are not, however, required to provide this range of services to populations other than children.

MEDICAID: ESSENTIAL TO ALL CHILDREN

All children benefit from the work carried out at children's hospitals—regardless of whether they ever step foot inside their doors. The nation's children's hospitals serve all children by fulfilling a variety of critical public needs—training most of our nation's doctors devoted to children, providing continuing advancements in children's care, performing some of the most important, cutting-edge pediatric research and serving as centers of excellence for the sickest children in the country.

The specialty and critical care services the children's hospitals maintain carry costs that are not completely covered. But this "stand by" capacity assures that these services will be there when any child needs them. Because Medicaid is a vital revenue stream for children's hospitals, any single reduction in funding presents financial difficulties, which in turn can lead to curtailing or elimination of programs—programs relied upon not only by Medicaid-dependent children, but all children.

As the committee discusses different proposals to restructure the Medicaid program, it is important that particular attention be given to the unique ramifications these proposals will have on children and children's hospitals' ability to serve them. Although tremendous progress has been made in insuring children, Medicaid, along with the State Children's Health Insurance Program (SCHIP), holds the as yet unfulfilled promise of removing most children from the ranks of the uninsured. In 2000, of the 8.9 million uninsured children under age 18, 77% or 6.8 million were eligible for, but unenrolled, in Medicaid or SCHIP.

At a time when the number of uninsured is again rising, no reform should threaten the progress Congress has made in insuring children. Rather, reforms should seek to cover those children who are eligible, but remain unenrolled.

Please make sure that any reform protects Medicaid's low-cost coverage for children, and that it fulfills the program's potential to cover most of the nation's uninsured children.

PREPARED STATEMENT OF LARRY S. GAGE, PRESIDENT, THE NATIONAL ASSOCIATION OF PUBLIC HOSPITALS AND HEALTH SYSTEMS

The National Association of Public Hospitals and Health Systems (NAPH) is grateful for this opportunity to submit a statement for the record to the House Energy and Commerce Committee Subcommittee on Health on the subject of Medicaid reform.

NAPH represents more than 100 of America's metropolitan area safety net hospitals and health systems. The mission of NAPH members is to provide healthcare services to all individuals, regardless of insurance status or ability to pay. More than 61 percent of the patients served by NAPH members are either Medicaid recipients or patients without insurance. Medicare covers another 20 percent of the patients of NAPH members, who rely on governmental sources of financing for over 80% of their services.

Medicaid is as important to our nation's safety net hospitals as it is to the 44 million individuals it covers. Arguably, given the well-known gaps in Medicare benefits, Medicaid is our nation's most important and successful health care program. Medicaid covers 55% of all poor children (20% of all children in the nation) and pays for one third of all births. It is far and away the nation's largest purchaser of long term care services. It is also an essential lifeline for low-income elderly individuals and those who are blind and disabled. Indeed, any effort to reform Medicaid must start with the recognition that over two thirds of Medicaid spending today is devoted to the elderly, blind and disabled.

Medicaid is also a major source of essential financing for America's institutional health safety net. Forty percent of the net revenues of NAPH member hospitals are Medicaid revenues. In particular, the Medicaid Disproportionate Share Hospital (DSH) program is the cornerstone of financial support for hospital services to all low-income Americans, including the rising numbers of uninsured. In 2000, while constituting less than 9 percent of total Medicaid spending, Medicaid DSH payments covered 28 percent of the otherwise unreimbursed costs incurred by NAPH members in treating the uninsured and underinsured. In this regard, Medicaid must be considered a true partner of state and local governments, whose payments and subsidies account for another 39 percent of such unreimbursed costs. Medicaid reimbursement is also important to Federally Qualified Health Centers (FQHCs), which provide a significant amount of services to Medicaid patients and patients without insurance.

Yet Medicaid is not without problems. Medicaid's funding and benefits (including DSH payments) are spread unevenly across the states. Eligibility and covered serv-

ices vary widely as well. At the same time, Medicaid has become the fastest growing part of many state budgets. This latter fact has been especially problematic for many states that are confronted with reduced revenues and fiscal crisis as a result of the current economic downturn. First and foremost, Medicaid reforms should not result in further pressure on states that are already facing such crises.

These and other concerns about Medicaid can and should be addressed by the Congress, and NAPH is willing to work with this Committee, the Administration and all other stakeholders to address needed reforms. At the same time, it is essential that any effort to reform Medicaid acknowledge and build on (not seek to dismantle) the program's considerable strengths. In that regard, NAPH strongly urges the Congress to be guided by several important principles in addressing future Medicaid reforms. Please note that NAPH is aware of, and has reviewed the limited information available thus far about, the Administration's new proposal for Medicaid reform. We do not believe the Administration's proposal meets the principles described below, based on the proposal as we understand it. We intend these principles to apply to any major Medicaid reforms that may be considered or introduced in the future, not just to the Administration proposal.

Protect the Guarantee of Coverage to Medicaid Recipients. Medicaid reform efforts should not result in reducing or eliminating the entitlement of our most vulnerable populations to coverage. A federally enforceable entitlement to coverage is the foundation of Medicaid's success. Eroding that entitlement for current recipients would be a major step backwards for a country that must already confront the dilemma of over 41 million uninsured residents.

Expand Coverage Beyond Current Levels. Health care coverage is recognized as the primary way to provide access to needed health services for low-income populations. Medicaid reform should not be enacted in a vacuum. Rather, Medicaid reforms must be carefully tied to renewed efforts to expand coverage, as one important tool in an anticipated combination of public program improvements and private sector initiatives. Moreover, it is important that the impact of Medicaid reforms on all populations among the uninsured (including, e.g., legal and illegal immigrants, persons with AIDS, etc.) be taken into account in crafting effective reforms.

Ensure the Availability of Comprehensive Benefits to Covered Individuals. As we understand it, the Administration's proposal would require coverage of the mandatory Medicaid population, but allow states absolute flexibility to decide which non-mandatory populations and health care services will be covered in the future. Of particular concern to NAPH is the erosion of coverage of optional services such as prescription drugs for the poor, elderly, and disabled. To the extent Medicaid reform permits states to limit essential services to enrollees, it will merely shift even more of the burden for providing those services to safety net providers, at a time when the health care safety net is already in crisis. Rising numbers of uninsured, worker shortages, increased drug costs, and expanded community-wide responsibilities (including an expanded role as first responder in the event of chemical and biological terrorism) are increasing costs. At the same time, current sources of federal, state and local funding are being eroded. Nearly half of NAPH members had negative margins in 2000 (the latest year for which data are available), up from one-third with negative operating margins five years earlier.

Strengthen Safety Net Providers. Particularly at a time when the number of Medicaid enrollees and uninsured are increasing, further reducing or eliminating direct payments to safety net hospitals, like Medicaid DSH, could rapidly destroy our nation's fragile system for providing care to the uninsured. Medicaid DSH is one of the most important funding sources for many hospitals—often the major (if not only) reason they can continue serving the uninsured and providing essential community-wide services like trauma care. The Institute of Medicine (IOM) in its March 2000 report recommended that "Federal and state policy makers should explicitly take into account and address the full impact (both intended and unintended) of changes in Medicaid policies on the viability of safety net providers and the populations they serve."

Future Medicaid Spending Must Be Based on Need, Not an Arbitrary Base Year. The Administration's proposal caps future federal Medicaid spending at FY 2002 levels, updated yearly by a non-specified trend factor. The required state maintenance of effort would also be tied to the FY 2002 base year amounts, with annual updates. Such a cap in effect constitutes little more than "price controls" at the state level. It is completely arbitrary and does not reflect one of the great strengths of Medicaid, which has been its ability to respond to changing needs. While it is true that health costs have been rising rapidly in recent years, those costs are largely beyond the control of states or providers, who would instead be forced to respond to arbitrary caps through reduced eligibility or coverage.

Whatever the direction this Committee chooses to take on Medicaid reform in the long run, there are several essential steps that need to be taken in the very near future, to preserve and protect both vulnerable patients and the providers that serve them. Those steps include:

Provide Urgent Fiscal Relief to the States. States are facing severe budget problems caused by the current economic crisis. Many states clearly need help to maintain their Medicaid programs while the economy recovers. Congress and this Committee should pass some sort of fiscal relief to states to help alleviate pressure on state Medicaid budgets.

Fix the Medicaid "DSH Cliff" Problem Created by the Balanced Budget Act of 1997. Congress and the Committee should move immediately to enact the Access to Hospitals Act of 2003 (H.R. 328) introduced by Representatives Ed Whitfield (R-KY) and Diana DeGette (D-CO). This bipartisan legislation would eliminate a drastic and untenable reduction in federal Medicaid DSH funding in the current fiscal year. This "cliff" has a potentially devastating impact on safety net hospitals and patients in many states, at a time when the number of uninsured is increasing and other funding sources are eroding. Last year, this Committee recognized the desperate need for Medicaid DSH relief in this fiscal year, including it in legislation passed by this Committee. We encourage the Committee to act swiftly and support efforts this year to fix this outstanding problem.

Provide a Modest Increase in DSH Funding for "Low-DSH" States. A significant inequity in the allocation of DSH funding among states must also be corrected to permit states with extremely low DSH allotments to increase DSH payments to the minimal level of 3 percent of state Medicaid spending. While this does not bring such states near the national average of nearly 6 percent, such an increase is both essential and equitable for affected states. Congress and this Committee should support legislation like H.R. 1604 introduced last Congress by Representative Heather Wilson (R-NM) to increase the federal Medicaid allotment for such states. We understand Representative Wilson and Representative Jerry Kleczka (D-WI) will introduce similar legislation shortly in this Congress.

Allow Section 340B Hospitals to Negotiate Better Prices for Inpatient Drugs. Drug prices are one of the major issues that face all providers, including public hospitals. Extending the best price exemptions to inpatient prices charged to 340B hospitals would allow safety net hospitals to negotiate better discounts on inpatient pharmaceuticals. The Congressional Budget Office has determined that this change would have no cost to the government. We encourage the Committee to clarify the law as quickly as possible.

Increase the Medicaid Rebate and 340B Drug Discount. Congress and this Committee should increase the Medicaid rebate and ensure that 340B providers have access to the same discounts as the Medicaid program to save money for federal, state, and local governments struggling to ensure pharmaceutical coverage to vulnerable populations.

Extend the Availability of SCHIP Allotments. Congress and this Committee should extend the availability of SCHIP allotments in order to allow states additional opportunities to use these funds to expand coverage.

NAPH appreciates the opportunity to share our observations and concerns. We urge the Committee to take action on these important issues. We look forward to working with you further to develop legislative solutions to the problems confronting our nation's poor and uninsured and the safety net providers that serve them.

PREPARED STATEMENT OF THE NATIONAL ASSOCIATION OF URBAN HOSPITALS

The National Association of Urban Hospitals appreciates this opportunity to submit testimony to the House Energy and Commerce Committee on the President's proposal to implement significant change in the federal/state Medicaid partnership. We invite questions about this testimony and would be pleased to offer additional perspectives once the entire scope of the administration's Medicaid proposal is unveiled.

ABOUT THE NATIONAL ASSOCIATION OF URBAN HOSPITALS

The National Association of Urban Hospitals (NAUH) advocates adequate recognition and financing for private, non-profit, urban safety-net hospitals that serve America's needy urban communities. These non-profit urban safety-net hospitals differ from other hospitals in a number of key ways: they serve communities where the residents are much older and poorer; they are far more reliant on Medicare and Medicaid for their revenue; they provide far more uncompensated care; and unlike public safety-net hospitals, they have no statutory entitlement to local or state funds

to underwrite their costs. NAUH's role is to ensure that when the federal government makes health care reimbursement policy decisions, policy-makers understand the implications of those decisions for these distinctive private, non-profit, urban safety-net hospitals. NAUH pursues its mission through a combination of vigorous, informed advocacy, data-driven positions, and an energetic membership with a clear stake in the outcome of public policy debates.

Non-profit urban hospitals across America have made a deep, unwavering commitment to their low-income communities. These mission-driven hospitals recognize that they almost never will enjoy what most organizations would call "good" economic times because above all else, their mission is to serve people suffering bad economic times. They work in partnership with government, with local businesses, with charitable organizations, and with their communities to provide care to those who need care, regardless of their ability to pay for it. They make business decisions based on their commitment to their mission and to their commitment to serve, not to a commitment to maximize profits at the expense of their mission. They do not flee their troubled communities in search of more lucrative markets; instead, they stand by their commitments and stand by their communities because they believe that as caregivers, they can do the most good where the need for care is greatest.

THE IMPORTANCE OF MEDICAID TO URBAN SAFETY-NET HOSPITALS

Medicaid is a major payer for most non-profit urban safety-net hospitals. Unlike in the typical American hospital, where Medicaid recipients constitute a modest proportion of the overall annual patient population, Medicaid patients are a major payer group for most urban safety-net hospitals. Because these hospitals generally are located in low-income communities, urban safety-net hospitals also care for higher proportions of uninsured patients—patients for whom they receive no compensation at all—than other private hospitals.

Urban safety-net hospitals are always interested in and concerned about Medicaid for two primary reasons. First, Medicaid is a much more important part of their overall patient revenue structure than it is for other hospitals. Second, Medicaid has historically been a poor payer, compensating them for less—often, far less—than historically allowable costs associated with caring for Medicaid recipients.

Poorer compensation applied to significantly more Medicaid patients has, over a period of years, taken its toll on the financial health of many urban safety-net hospitals. The operating margins of urban hospitals are three times lower than those of non-urban hospitals; among urban hospitals for which Medicaid is the payer for more than fifteen percent of their patients, operating margins are thirteen times lower than those of comparable non-urban hospitals. That latter margin is "7.84 percent, which means that for every dollar of patient revenue that these hospitals receive, they lose nearly eight cents.

As a result of these factors, urban safety-net hospitals have a much greater stake in the outcome of the Medicaid policy deliberations that have now begun in the wake of the President's Medicaid reform proposal. Consequently, NAUH offers its testimony to the House Energy and Commerce Committee in this context: the future of many non-profit urban safety-net hospitals hangs in the balance in these deliberations—as does access to care in low-income urban communities throughout America.

MEDICAID REFORM: AN IDEA WHOSE TIME HAS COME

While the testimony below generally focuses on aspects of the President's Medicaid reform proposal that NAUH finds potentially troublesome, this should not be interpreted as opposition to the concept of Medicaid reform. We agree with the President, and with many others, that the long-time federal/state Medicaid partnership would benefit from a number of well-chosen reforms. We also recognize the enormous financial pressure that rising health care costs and faltering tax revenues are causing in virtually every state in the nation and how this produces a heightened impetus for reform. Consequently, in addition to expressing our views on the President's Medicaid reform proposal as we understand it, we also will describe, just briefly, an additional component of Medicaid reform that we would like to see included in this public discourse.

We welcome efforts to reform Medicaid and look forward to the prospect of working with Congress and the administration to craft a better Medicaid program.

A NOTE ABOUT THE VIEWS TO FOLLOW

It should be noted that the following views are based on an as-yet incomplete understanding of the President's Medicaid reform proposals. As the administration shares more details about the reform proposal with Congress and the public, some

of our concerns may be addressed or allayed and other issues may arise. We hope we will have an opportunity to comment again as these important policy deliberations continue in the coming weeks and months.

FOUR MAJOR CONCERNS WITH THE MEDICAID REFORM PROPOSAL

NAUH would like to address four specific aspects of the Medicaid reform proposal that concern us:

1. the proposed use of hard spending limits to determine future Medicaid appropriations
2. the potential demise of the Medicaid disproportionate share program
3. the reduction of federal oversight of Medicaid
4. the redistribution of financial risk

The following are NAUH's perspectives in these four areas.

The Proposed Use of Hard Spending Limits

NAUH is very concerned about the proposal to use hard spending limits to determine future funding for Medicaid. Aside from the very real possibility that such a change potentially signifies a first step in moving Medicaid away from its status as an entitlement program—a major public policy decision that deserves much more extensive consideration and debate—we envision a number of potential problems involving how these spending caps are calculated and updated and the effect of this approach on eligibility, benefits, and access to care.

Implicit in using hard spending limits based on states' 2002 Medicaid expenditures, as has been proposed, is agreement that in 2002, the individual states covered the "right" people—that is, individuals whom, it is generally agreed, should receive Medicaid benefits; this acceptance extends beyond the mandatory population to those to whom individual states have voluntarily chosen to provide Medicaid benefits. Under the proposed approach, today's Medicaid program is to be used to create a baseline for tomorrow's Medicaid program.

But today's program is based on today's needs; tomorrow's needs could be different. A variety of factors could increase the need for Medicaid services either nation-wide or in individual states—factors ranging from a continuation of the current economic downturn to the residual effects of the U.S.'s continued fight against terrorism to the continuing aging of the American population to the unforeseen and unforeseeable collapse of major employers or individual industries that are concentrated in just one or a few states. Consequently, there could be, at some time in the future, an absolutely compelling and widely accepted need to extend Medicaid benefits to more people than receive those benefits today—and no way to increase federal funding to allow the states to do so. This, in turn, could lead states to reduce eligibility and curtail benefits at precisely the times when the need for Medicaid services is greatest.

The proposed Medicaid reform plan does not appear to provide a mechanism to facilitate such a necessary extension of benefits because it does not offer an opportunity to increase the federal share of the federal/state partnership at the very times that such increased needs may arise. Instead, it imposes arbitrary limits on future federal participation in this historic partnership. After ten years, according to the current proposal, the federal government's financial participation could be at a comparable level to what it is today. This could mean that the Medicaid partnership, as we know it today, would be no more: at times when the states most need help, the federal government will no longer be there to help them. This could leave states with very little choice: it could practically force them either to reduce Medicaid benefits among non-mandatory populations or to preserve benefits but reduce payments to providers. Neither solution is adequate: reducing benefits leaves poor people on their own, encouraging them either to forego seeking treatment for their medical needs or to seek services from already-overburdened safety-net providers; reducing payments to providers, on the other hand, risks chasing providers out of the system—as we have witnessed in recent months in the Medicare program—or forcing safety-net providers, already struggling under enormous financial pressure, to provide still-more free care, with no compensation at all. We know from experience that when provider payments fail to keep pace with costs, access to care will inevitably suffer. In addition, there seems to be an implicit assumption that when government cuts payments to providers, those providers will continue to provide care. Based on the economic data already presented above, it is clear to us that this is an erroneous assumption: there is no way that safety-net providers will be able to continue serving their communities if present funding levels are not maintained.

A fixed federal commitment to Medicaid and maintenance of effort only by the states are not enough to ensure adequate access to care for Medicaid recipients.

Consequently, if the proposed changes are adopted, NAUH recommends that three important provisions be added to the Medicaid program.

First, new Medicaid legislation should require states to maintain eligibility and benefits at their 2002 levels, at a minimum. Current eligibility and benefit levels, after all, constitute the foundation upon which future annual appropriations would be calculated; states should have discretion to increase eligibility or benefits but not to reduce them. Without such protection, the federal government could, in effect, be giving money to the states with no assurance that this money is actually spent on health care for the poor.

Second, new Medicaid legislation should restore Medicaid disproportionate share funds cut from the federal budget by the Balanced Budget Act of 1997. Non-profit urban safety-net hospitals depend on these payments to help finance the cost of caring for their low-income (Medicaid and uninsured) patients, and the cuts introduced through the Balanced Budget Act of 1997 have been devastating to them. In addition, these restored Medicaid disproportionate share funds should be added to the base year's calculations for future Medicaid allocations to states to help restore at least a modicum of stability for some of these hospitals and help them withstand the effects of the major financial blow they may suffer over time under the proposed Medicaid reform program.

Third, NAUH recommends a statutory assurance that federal financial participation would increase annually by 100 percent of an appropriate market basket index that reflects the true and full extent of health care input prices (as opposed to a use of a consumer price index or less than 100 percent of a true measure of the annual growth of input prices). Without such protection, the federal government's annual Medicaid appropriations would become less adequate with every passing year and necessitate shifting still more of the financial responsibility for caring for the poor to the states and to health care providers—many of which, like urban safety-net hospitals, are ill-equipped to take on new financial responsibilities.

The Potential Demise of the Medicaid Disproportionate Share Program

The administration's Medicaid reform proposal calls for folding all federal Medicaid funds into two annual allotments: one for acute care and one for long-term and community care. Funds currently allocated for the Medicaid disproportionate share program would be folded in the acute-care allocation. Like many others, NAUH fears that this would encourage states to end their Medicaid disproportionate share programs and use that money instead to cover their Medicaid budget shortfalls or to pay for benefits for additional people.

Ending Medicaid disproportionate share payments would be an unqualified disaster for private, non-profit, urban safety-net hospitals.

The purpose of the Medicaid disproportionate share program is to provide supplemental funds to hospitals that care for significant proportions of Medicaid recipients because historically, Medicaid does not adequately reimburse hospitals for allowable costs associated with serving Medicaid recipients; in addition, those same hospitals also care for large numbers of uninsured people. The Medicaid disproportionate share program was developed to help compensate safety-net hospitals for inadequate state Medicaid reimbursement—California, for example, pays hospitals only about fifty percent of their allowable costs for serving Medicaid recipients—and to help them defray the costs they incur caring for the uninsured. Without such payments, these hospitals, already reeling financially, would suffer a truly devastating blow. Many would lose hundreds of thousands or even millions of dollars and would be expected to absorb these costs themselves; they would, in effect, be expected to continue providing services to lowincome patients without the revenue that would allow them to do so. Non-profit urban safety-net hospitals cannot do this—they simply cannot. Without supplemental Medicaid disproportionate share payments, many of these hospitals will be forced to close their doors.

The Reduction of Federal Oversight of Medicaid

NAUH is greatly troubled by the apparent reduction of federal oversight that would result from enactment of the proposed Medicaid reform program. Historically, Medicaid has been a federal/state partnership. Under the administration's proposal, as we understand it, the sole role of the federal partner would be to provide funds to the states.

NAUH believes that the federal government has played too important a part in the development and protection of Medicaid, and has far too much expertise to abandon this absolutely vital role. In the name of flexibility and reducing federal expenditures, an important measure of oversight would be lost—and, we believe, the people for whom Medicaid was created to serve would suffer as a result.

NAUH believes that the value of reducing federal oversight of Medicaid in the name of enhancing program flexibility is greatly overstated. While some maintain that Medicaid today is the same as Medicaid in the 1970s and 1980s, we do not think this is the case at all. To the contrary, a quick glimpse across the nation reveals that mandatory recipients are served in a variety of ways; that different states provide different levels of coverage to non-mandatory recipients in a similar variety of ways; and that different states have worked effectively within the parameters of the Medicaid program and under careful, thoughtful federal oversight to develop and implement new, innovative approaches to meeting their Medicaid obligations under federal law.

Proof of the value and importance of federal oversight can be found in the performance of the states since Congress overturned the Boren amendment in 1997. That change in federal law, like the current Medicaid proposal, was intended to give states greater flexibility in how they spend their Medicaid funds. The Boren amendment required states to cover reasonable, allowable costs associated with providing care to Medicaid recipients; today, no such protection exists.

Since the Boren amendment's repeal, most states have systematically and dramatically reduced the adequacy of their Medicaid payments to providers. This is a critical consideration to weigh when evaluating the need for federal oversight: without the Boren amendment, states have been left to their own devices to determine the adequacy of their Medicaid payments, and they have made a clear choice not to make adequate payments. With so many states suffering from budget problems today, this problem will only get worse in the coming years.

Proponents of the Medicaid reform proposal maintain that the new flexibility it offers would encourage states to offer Medicaid benefits to more people. History has shown, however, that this will be a zero-sum game. States will do this only at the expense of providers, paying them less so they can extend benefits to more people—a politically popular idea. In NAUH's view, that does not constitute good public policy; to the contrary, it only shifts a vital government responsibility to a group that clearly lacks the means to carry it out on its own.

The Redistribution of Financial Risk

At the heart of any attempt to address health care reform is a very basic question: Who is responsible for financing care for the poor?

Since the advent of Medicaid, the answer to at least part of this question has been clear: it has been the federal government in partnership with state governments. The very enactment of Medicaid confirmed this, as did the later development of the Medicare and Medicaid disproportionate share programs, the SCHIP program, and other government health care initiatives.

Today, however, the answer to this question appears to be a moving target. In January of 2003, the chairman of MedPAC expressed that body's lack of interest in having the federal government shoulder this responsibility when he declared that "We should not use Medicare dollars to offset Medicaid losses." In so doing, he tacitly warned of reductions in Medicare reimbursement in areas such as disproportionate share. More important, he suggested a fundamental change in Medicare's role—and with it, the federal government's role—in financing care for the poor in the U.S. today.

The new Medicaid proposal appears, at first glance, to constitute yet another signal that the federal government may pull back from this responsibility. Under this proposal, it appears as if no provision has been made for the federal government to step up to help states, and their poorer residents, during hard times. It would base its contribution to care for the poor on states' 2002 Medicaid spending and make no further adjustments, other than for inflation in response to changes in the economy or our national condition.

The states, based on how they have responded to the freedom afforded to them through the repeal of the Boren amendment, have already signaled their intention to do less for the poor, not more. During hard economic times today, almost every state in the nation is in the midst of planning to do even less, not more. The states are proving, beyond question, that when times get hard, they will not be able to support their citizens.

The federal government seems only to be concerned with paying for the cost of care for the people it ensures. State governments do not even do that. If there is no "extra" money included in payments to safety-net providers—money that recognizes that those providers' costs are not covered for most of the patients they treat—then those hospitals will become, in effect, the insurers of last resort for low-income patients who lack insurance coverage of any kind or who are covered by a Medicaid insurance program that pays providers inadequately.

That leaves health care providers to shoulder an ever-increasing share of responsibility for financing care for the poor. Does anyone truly believe that where the federal government lacks the resources, and where the states lack the resources, that non-profit urban safety-net hospitals, already caring for more Medicaid recipients and more uninsured patients and experiencing margins well below other hospitals, can somehow find those resources themselves and become the provider and de facto insurer of last resort for the poor?

Health insurance—whether Medicaid, Medicare, or private insurance—always involves the careful calculation and prudent assumption of risk. Historically, the federal government and state governments have assumed most of the risk associated with financing health care for the poor. Providers, too, have assumed some of this financial risk, but there always was an implicit understanding that they were the least equipped to do so.

The proposed Medicaid reform program, as we understand it today, calls for a fundamental shift in the assignment of risk for financing health care for the poor in the U.S. today. The proposed predetermined federal commitment to Medicaid appears to leave the federal government with essentially no remaining future financial risk at all. The proposed maintenance of effort required of the states leaves them, too, with no financial risk—only political risk. Strangely, only hospitals, such as non-profit urban safety-net hospitals, are being asked to do more—and at a time when they clearly lack the financial resources to do so.

NAUH does not believe this is reasonable and is concerned about how the Medicaid reform proposal would redistribute financial risk for caring for the poor. We urge this committee to weigh what would amount to a striking change in public policy, to consider very carefully where this responsibility truly belongs, and to ensure that whatever legislation is ultimately adopted realistically places that responsibility where it is most appropriate. From a purely financial perspective, it is not possible for urban safetynet hospitals to assume the risk of financing care for the poor.

A PROPOSAL: DISTINGUISH AMONG PROVIDERS AS PART OF MEDICAID REFORM

One of the flaws of the current Medicaid program is that outside of the disproportionate share program, it does little to distinguish among health care providers. It treats hospitals that care for a few Medicaid patients a year more or less the same as it treats hospitals that care for many Medicaid patients in every corridor of their facility every single day. It treats safety-net providers the same as it does hospitals located in high-income communities that are part of extremely profitable hospital corporations.

The federal government and the state governments clearly expect hospitals to absorb some of the costs of caring for poor patients; this much is clear, and to this virtually every hospital, including urban safety-net hospitals, readily agrees. But the absence of a poor population that is equally distributed throughout the country results in an uneven distribution of this financial burden among hospitals. Hospitals that care for relatively few Medicaid recipients and uninsured patients can bear these costs because despite significant ratcheting back in private health insurance payments over the past two decades, those payments still typically exceed the cost of the services provided, even if only slightly. This gives such hospitals ample opportunity to counterbalance their modest Medicaid losses.

Hospitals that care for large proportions of Medicaid recipients and large proportions of uninsured patients, however, have no such opportunities. This is why the adequacy of Medicaid reimbursement is so much more important to some hospitals than it is to others. In a Medicaid system like we have today, where reimbursement is always less than cost, the more poor patients a hospital serves, the further behind it falls financially. Throughout the country, urban safety-net hospitals are teetering on the brink of insolvency as their margins plummet and their debts grow. Some move in and out of bankruptcy, constantly reorganizing; some have closed, and others are in danger of doing so.

Today, the federal government does not formally acknowledge that the continued inadequacy of Medicaid payments to hospitals is much more important to some hospitals—such as urban safety-net hospitals—than it is to others. NAUH believes that federal Medicaid policy should formally recognize this distinction, that it should not view all hospitals as equal or the same, and that it should make special provisions to treat different, selected hospitals—including non-profit, urban safety-net hospitals—differently and to assist those that help the government carry out its share of responsibility for financing care for the poor. It should do so, moreover, by providing explicit direction to the states as part of any Medicaid reform law—just as

it did when it created the Medicaid disproportionate share program and when it enacted the Boren amendment.

NAUH recognizes that such a move would not be easy; it would require significant political will. Nevertheless, because of how Medicaid has been structured and how Medicare is evolving, the federal government has, in essence, enlisted urban safety-net hospitals—along with selected others—to serve as its partners in ensuring access to care for the poor. Now, it has an obligation to function as a true partner in carrying out this mission. Private, non-profit, urban safety-net hospitals are doing everything we can, but we must have a Medicaid system that pays rates to hospitals that treat significant numbers of Medicaid patients that are closer to the true cost of providing that care.

CONCLUSION

Medicaid is one of the most important programs offered by government in the U.S. today. It signifies our intention—our insistence—on doing whatever we can for fellow Americans in need. The history of Medicaid since its inception in the mid-1960s is a true success story, and one of which we should be proud.

But Medicaid is not a perfect program; any government program approaching forty years of age will begin to show signs of wear, and it is important to step back periodically and reconsider how the program works and whether it is structured to achieve its goals in the most effective, most efficient, and most compassionate manner.

The National Association of Urban Hospitals supports efforts to refresh Medicaid and bring it into the twenty-first century. Some of the changes that have been proposed, however, would not refresh Medicaid, would not improve it, would not make it more effective, more efficient, and more compassionate. Specifically, we are concerned about the following aspects of the reform proposal.

1. The proposed reform program would limit Medicaid's future growth in a manner that does not correlate changes in spending with changes in need.
2. The proposed program would allow states to eliminate their Medicaid disproportionate share programs without providing for another way to achieve the essential objectives of that critical program.
3. The proposed program would reduce federal oversight of Medicaid, which history has shown to be absolutely vital to ensuring the program's integrity and effectiveness.
4. The proposed program redistributes financial risk for financing care for the poor, moving it from the federal government and state governments to individual hospitals, which is not economically feasible.

For these reasons, the National Association of Urban Hospitals has serious concerns about the Medicaid reform proposal as it is currently structured. We urge the House Energy and Commerce Committee to give careful consideration to these issues as you discuss and debate the proposal's future. As you do, we also urge you to consider requiring the federal government to distinguish among providers when it reshapes Medicaid and to provide special assistance to providers that constitute the health care safety net in the U.S. today—providers such as private, non-profit, urban safety-net hospitals. These hospitals have demonstrated their commitment to caring for the poor, they have proven their willingness to do so despite the financial jeopardy in which such efforts place them, and they have indicated their desire to serve as true partners of government in caring for the poor. These partners need special financial consideration to enable them to fulfill their role in this health care partnership, and in the health care safety net, and any effort to reform Medicaid should include a meaningful financial commitment to these vital institutions.

We appreciate the opportunity to submit this testimony and welcome any questions or comments you may have.

BROWN

MEDICAID MATTERS TO PEOPLE WITH AIDS

March 7, 2003

Dear Members of Congress,

The undersigned organizations are writing to express our opposition to the President's proposal to restructure Medicaid. Medicaid is the largest source of funding for health care for people with HIV/AIDS. Any action to limit the ongoing commitment of the federal government to Medicaid will seriously affect people living with the disease, as well as those health care providers who care for them. We urge you to oppose the inclusion of any of these proposals in any legislation and, instead, to support temporary additional federal assistance for states for their Medicaid programs.

Background:

People with HIV/AIDS rely on Medicaid for a vast array of services. It is the major source of the prescription drugs that can forestall their illness and disability. It is also the major source of diagnostic and preventive care, as well as treatment for those who become sick. Overall, state and federal governments provided roughly $7.7 billion for HIV/AIDS care in FY 2002 through the Medicaid program, serving well over 200,000 people with HIV/AIDS. While many people with HIV/AIDS benefit from other federal programs—most notably Medicare and Ryan White—these other programs cannot take the place of Medicaid. The need for services is too large for these other programs to compensate for lost Medicaid coverage—and these other programs do not provide all of the Medicaid covered services that are critical to people living with HIV/AIDS. Therefore, weakening Medicaid would seriously harm the HIV/AIDS care infrastructure.

The President's Proposal:

The President's Budget proposes to restructure Medicaid by inviting states to create a block grant. The essence of the proposal is to replace the open-ended federal commitment of funds with a pre-set formula of federal spending that is hard and fast over ten years. Under the existing Medicaid system, if the costs of the state's program go up, so does the federal commitment. However, under this proposal, if the costs of the state's program were to go up unexpectedly (because of a recession, an epidemic, medical inflation, or changing technology), the federal contribution would stay the same.

HIV/AIDS History and Medicaid:

Having dealt with HIV/AIDS over the years, we know why Medicaid matters for the more than 200,000 HIV positive beneficiaries. The arrival of the epidemic in the 1980s was obviously unpredicted and could not have been built into a pre-set formula. Because of the epidemic, there was a dramatic increase in the number of Medicaid beneficiaries. Many people became sick and disabled; many lost their jobs and their health insurance. Under the existing Medicaid system, the federal government shared the expense of increased enrollment with states automatically. If the block grant had been in place, states would have been left on their own to cope with the costs of this epidemic-related growth in enrollment.

Generally, states must treat all Medicaid beneficiaries equally. While they have freedom to cover or not cover a wide range of "optional" services, they are not permitted to pick winners and losers, by covering services for one group and not for another. In the 1980s, this core principle was tested when a few states tried to deny coverage for the first HIV medication—even though they had elected to cover prescription

drugs for other beneficiaries. Eventually, the requirement that states must treat all beneficiaries in a comparable way was upheld.

Likewise, when protease inhibitors—the drugs that fight HIV and postpone illness and death—were discovered and approved in the mid-90s, the cost of HIV/AIDS pharmaceuticals rocketed from $1,500 per person per year to more than $10,000 per person per year. This, too, could not have been planned and budgeted for in a ten-year formula. Under the existing Medicaid system, the federal government shared that expense with states automatically. If the block grant proposal had been in place, states would have been left with huge shortfalls with no federal assistance. These medications have made a huge difference. Before these effective therapies were available, HIV had become the leading cause of death of Americans aged 25-44. Because of the availability of these drugs—to which Medicaid contributes mightily—there has been a dramatic reduction in HIV-related deaths.

Conclusion:

In short, because of the open-ended, uncapped nature of the federal program, Medicaid was there when people with HIV/AIDS and their home states needed it. Under a block grant, that would not be true.

We hope that health care for people with HIV/AIDS and all people with chronic illnesses and disabilities will continue to improve. But we fear that a proposal like the President's block grant will make it impossible for low-income and uninsured people to benefit from improvements in care and treatment. Without a continued federal commitment, states will not be willing or able to provide new therapies and innovations to sick, poor people.

Many Members of Congress and Governors have supported increased federal matching payments; such increased payments would help states and the people who depend on Medicaid. We urge you to oppose the President's proposal and, instead, to work to enact these other efforts.

Thank you for considering our comments. If you have any questions, or need additional information, please contact Lei Chou, Director of the Access Project of the AIDS Treatment Data Network at (212) 260-8868, Michael Kink, Legislative Counsel of Housing Works at (518) 449-4207, or Laura Caruso, Policy Associate at Gay Men's Health Crisis at (212) 367-1228.

Sincerely,

ACT UP Atlanta, Atlanta, GA
ACT UP Philadelphia, Philadelphia, PA
AIDS Action, Washington, DC
AIDS Action Baltimore, Baltimore, MD
AIDS Action Project Northwest, Portland, OR
AIDS Alliance for Children, Youth, and Families, Washington, DC
AIDS Foundation of Chicago, Chicago, IL
AIDS Legal Council of Chicago, Chicago, IL
AIDS Project Los Angeles, Los Angeles, CA
AIDS Rochester, Rochester, NY
AIDS Services of Dallas, Dallas, TX
AIDS Survival Project, Atlanta, GA
AIDS Treatment Activists Coalition (ATAC)
AIDS Treatment Data Network, New York, NY
AIDSmeds.com, Brooklyn, NY

American Academy of HIV Medicine, Los Angeles, CA
Asian and Pacific Islander Wellness Center, San Francisco, CA
Baltimore Commission on HIV/AIDS, Baltimore, MD
Boulder County AIDS Project, Boulder, CO
Care for the Homeless, New York, NY
Cascade AIDS Project, Portland, OR
Catholic Charities AIDS Services, Albany, NY
Center for AIDS, Houston, TX
Community HIV/AIDS Mobilization for Power (CHAMP), New York, NY
Critical Path AIDS Project, Philadelphia, PA
Doorways, an Interfaith AIDS Residence Program, St. Louis, MO
Elizabeth Glaser Pediatric AIDS Foundation, Washington, DC
Fenway Community Health Center, Boston, MA
Florida AIDS Action, Tampa, FL
Florida Keys HIV Community Planning Partnership
Foundation for Integrative AIDS Research (FIAR), Brooklyn, NY
Gay, Lesbian, Bisexual, and Transgender Community Center of Baltimore and Central Maryland
Gay and Lesbian Medical Association, San Francisco, CA
Gay Men's Health Crisis, New York, NY
Harm Reduction Coalition, New York, NY
Health Education Resource Organization, Inc. (HERO), Baltimore, MD
Hemophilia Association of New York
Hep-C Alert, North Miami, FL
Hepatitis C Action & Advocacy Coalition (HAAC-SF), San Francisco, CA
Hepatitis C Caring Ambassadors Program, Oregon City, OR
Hepatitis C Outreach Project, Vancouver, WA
HIV/AIDS Alliance for Region Two, Inc., Baton Rouge, LA
HIV Medicine Association, Alexandria, VA
Housing Works, New York, NY
HUG-ME Program, Orlando Regional Healthcare, Orlando, FL
International Foundation for Alternative Research in AIDS (IFARA), Portland, OR
Iris House, Inc. New York, NY
Latino Commission on AIDS, New York, NY
Latino Organization for Liver Awareness (LOLA), New York, NY
Lifelong AIDS Alliance, Seattle, WA
Long Island Association for AIDS Care (LIAAC), Huntington Station, NY
Metro St. Louis HIV Health Services Planning Council, St. Louis, MO
McAuley Health Center, Grand Rapids, MI
Minnesota AIDS Project, Minneapolis, MN
Montrose Clinic, Houston, TX
Movable Feast, Inc., Baltimore, MD
NAMES Project Foundation, Upper Ohio Chapter, Wheeling, WV
Nashville CARES, Nashville, TN
National Association of People With AIDS (NAPWA), Washington, DC
National Health Law Program
National Healthcare for the Homeless Council, Baltimore, MD
National Minority AIDS Council (NMAC), Washington, DC
New York City AIDS Housing Network, New York, NY
Persons Living with HIV Action Network of Colorado, Denver, CO

Philadelphia FIGHT, Philadelphia, PA
Positive Employment Options, San Diego, CA
Project Inform, San Francisco, CA
Project Open Hand, Atlanta, GA
Providence Rhode Island Miriam Hospital Community Advisory Board, Providence, RI
Provincetown AIDS Support Group, Provincetown, MA
Rochester Area Task Force on AIDS, Rochester, NY
San Francisco AIDS Foundation, San Francisco, CA
San Mateo County AIDS Program, San Mateo, CA
SAVE ADAP Committee of the AIDS Treatment Activists Coalition
Seattle Treatment Education Project (STEP), Seattle, WA
Siouxland and Local Area AIDS Project, Sioux City, IA
St. Louis Effort for AIDS, St. Louis, MO
T.H.E. Clinic, Los Angeles, CA
Tennessee AIDS Support Services, Inc., Knoxville, TN
The Health Association, Rochester, NY
Title II Community AIDS National Network, Washington, DC
Treatment Action Group, New York, NY
Treatment Access Expansion Project (TAEP)
Vermont People With AIDS Coalition, Montpelier, VT
Visionary Health Concepts, New York, NY
West Virginia HIV Care Consortium
Williamsburg/Greenpoint/Bushwick HIV CARE Network, Brooklyn, NY
Wilson Resource Center, Arnolds Park, IA

Mr. Chairman, ~~[illegible]~~ ~~[illegible]~~ ~~[illegible]~~
We have received a number of letters from various groups expressing concerns with this Medicaid proposal The President has

Letters and Statements on Medicaid from Groups

ACT UP Atlanta, Atlanta, GA and other HIV/AIDS groups
Alabama Hospital Association
* American Academy of Pediatrics
American College of Obstetricians and Gynecologists
American Diabetes Association
AFL-CIO, Alliance for Children and Families, Alliance for Retired Americans and other groups
* American Hospital Association
AARP
Catholic Health Association
Center on Budget and Policy Priorities
* Children's Defense Fund
Consortium for Citizens with Disabilities
Florida Alliance for Retired Americans, Institute for Economic Justice and other Florida groups
Health Care for All Coalition – coalition of Connecticut groups
* Leadership Council of Aging Organizations
March of Dimes
National Association of Children's Hospitals
* National Association of Public Hospitals and Health Systems
National Citizens' Coalition for Nursing Home Reform
National Committee to Preserve Social Security and Medicare
National Health Law Program
National Mental Health Association
National Women's Law Center
Premier

I would like to ask that these letters get submitted for the record.

BY U.S. MAIL & FACSIMILE (202)225-5288

The Honorable John Dingell, Ranking Member
The Committee on Energy and Commerce
2322 Rayburn House Office Building
Washington, D.C. 20515

The Honorable Sherrod Brown, Ranking Member
House Committee on Energy and Commerce
2322 Rayburn House Office Building
Washington, D.C. 20515

February 4, 2003

Dear Representative Dingell and Representative Brown:

We are writing to express deep concerns about the Medicaid proposals included in the January 16, 2003 letter from Governors Bush, Rowland and Owens to President Bush and Secretary Thompson. The letter states that "...it is time to review and fundamentally re-write the nation's Medicaid law...," to give "...greater flexibility to states in determining Medicaid program designs..." and to "...move away from entitlement without responsibility." These proposals, in essence, call for the conversion of Medicaid to a block grant program with caps on enrollment and spending and no guarantee that essential health care services will be available to those in need.

Nearly two million Floridians, mainly the elderly, disabled and children depend on the Florida Medicaid program for vital health care services. *Most of these beneficiaries have income well below the federal poverty level.* (*See A Snapshot of Florida Medicaid*, 11/4/02, copy enclosed). Recent cuts in the Florida Medicaid program give a painful preview of the human suffering which will ensue if the program is restructured to give states even more flexibility to reduce income eligibility standards and cap enrollment. Effective July 1, 2002, over 5,400 elderly and severely disabled Floridians with monthly incomes of just $672 to $685 lost their Medicaid benefits. Enclosed are some of their stories.

Any claim that the new Silver Saver program, Florida's Pharmacy Plus Waiver, provides comparable benefits to these individuals is utterly misleading. It does not cover disabled individuals under age 65 and coverage is limited to $160 per month, an amount far less than the monthly medication needs of many elderly and disabled individuals with serious illnesses. *In exchange for this minimal benefit the state agreed to an aggregate spending cap for all services applied to all senior Medicaid beneficiaries at the unrealistically low growth rate of 8% per year.*

In essence, the Silver Saver program created a Medicaid "block grant" for elderly Medicaid beneficiaries which forfeits the state's ability and commitment to provide full Medicaid

coverage for elderly Floridians who may be eligible for Medicaid in the future. Notably, this was done with great stealth and no opportunity for public input prior to state officials obtaining a rapid approval of their waiver request.

Given increasing medical costs, the ongoing growth of the low income elderly population and their increasing need for services, it is highly unlikely that Florida will remain within the Silver Saver global cap. When that cap is inevitably met, federal funds that now pay over 58% of the cost of services will no longer be available for all eligible seniors. The Silver Saver program has put Florida's growing elder population on a collision course with a capped Medicaid budget.

Now Governor Bush is proposing to do the same for persons with disabilities. His 2003-04 budget eliminates the Medically Needy program for the aged and disabled population. This would impact over twenty-three thousand Floridians with catastrophic illnesses who rely on this program for life-saving hospital, physician and pharmacy services. The Governor's budget proposes to move current Medically Needy beneficiaries into a pharmacy assistance program established under a Medicaid waiver. While advocates have been unable to obtain details about the specific parameters of this proposed new program, *these facts are clear: program spending and enrollment in the new program will be capped.* This will undoubtedly mean long waiting lists for future needy individuals who cannot afford medically necessary medications. Placing severely ill individuals on a waiting list to get life sustaining prescriptions is not only inhumane, it is fiscally irresponsible. Individuals who cannot get their medications will be hospitalized or institutionalized, at far greater costs to themselves and their fellow tax payers.

Moreover, the Governor's plan ignores the fact that 56% of Medically Needy expenditures are for services other than prescriptions including physician and hospital services, as well as Medicare deductibles. Although many Medically Needy beneficiaries have Medicare coverage, without payment for Medicare co-insurance and deductibles, they are unable to access the Medicare benefit package.

The circumstances of Florida organ transplant candidates vividly demonstrate the gaps in the Governor's proposal. For years, the state Medicaid program has covered organ transplant procedures and post-transplant medications for Medically Needy enrollees. These medications are very costly, but transplant survivors will die without them. Without the Medically Needy program, individuals will not even be considered for a transplant unless they can demonstrate the financial capacity to pay for these medications. Consider the circumstances of B.W.:

> She has end-stage renal disease and was approved for a kidney transplant in November 2002. However the hospital will not place her on a waiting list until she can demonstrate the ability to pay $24,000-$48,000 per year for post-transplant medications. Her only income is a small monthly disability check. Without a transplant her life will be miserable and much shorter. For B.W., the Governor's proposal is a matter of life and death.

The Governor's budget is also proposing to increase cost-sharing for aged and disabled Medicaid beneficiaries. While pharmacy co-payments of $3, $5 and $15 seem reasonable for middle income individuals, they will be cost-prohibitive for a person living on $552 per month, particularly if they need multiple prescriptions monthly. Studies consistently show that increased cost sharing for low income populations reduce the use of drugs that are essential for disease

management and prevention and therefore result in an increase in the rate of physician visits, hospitalizations and emergency room visits. The tiered co-payments, similar to those already in effect in the Silver Saver program, do not lead to greater uses of generic drugs. Instead, they lead to an across-the-board reduction in the total number of prescriptions filled. In the end, requiring co-payments from people already living at or below poverty will result in worse health outcomes and greater costs to the community, and will heighten the pressure on low income Floridians to decide whether to cut health care, rent, child care or food.

Florida's current Medicaid budget crisis is the result of poor political choices, rather than the structure of the Medicaid program. The Governor's proposal to eliminate the Medically Needy program which leaves thousands of disabled and elderly Floridians without medical coverage comes at the same time he is proposing a $59 million sales tax holiday(nine days of sales tax exemptions for clothing and one month for books). The slight savings to any individual from the sales tax break are hardly worth the hardship that will be caused by the elimination of the Medically Needy program

As illustrated by the January 16, 2003 letter, states currently have much flexibility in the administration of the Medicaid program and plenty of opportunities to test new models for health care delivery through the waiver process. There is no need to dismantle a safety net program which has saved millions of lives in order to give states more opportunity to "experiment" on low income children, the elderly and people with disabilities. We urge Congress to protect current and future Medicaid beneficiaries by preserving the current structure of the Medicaid program.

Sincerely,

Anne Swerlick
Florida Legal Services, Inc.
2121 Delta Blvd.
Tallahassee, Fl. 32303
(850) 385-7900
Fax: (850) -385-9998

Karen Woodall
People's Advocacy Center for Training, Inc.
579 E. Call St.
Tallahassee, Fl. 32301
(850) 222-7607
Fax (850) 224-8093

Florida Alliance for Retired Americans

Institute for Economic Justice

Florida Conference United Methodist Church, Board of Church & Society

Florida Legal Services, Inc.

Florida Women's Consortium

Florida Transplant Survivors Coalition

Clearinghouse on Human Services

Farmworker's Self-Help

P3 Ventures, Inc.

Human Services Coalition of Miami-Dade

Daytona Communication Health Action Information Network

Joy with Love

North Florida Education Development Corporation

V.O.I.C.E.S.

People's Advocacy Center for Training, Inc.

LEADERSHIP COUNCIL
of
AGING ORGANIZATIONS
James P. Firman, Ed.D., *Chair*

PRESIDENT BUSH'S FY 2004 BUDGET PROPOSAL LCAO COMMENTS AND CONCERNS MEDICAID REFORM AND STATE FISCAL RELIEF

LCAO Position: The LCAO believes that Medicaid is a critical program for America's seniors, providing essential long-term care, prescription drug coverage and Medicare low-income protections. We oppose any attempt to cap or block grant the program. LCAO supports greater flexibility for states in providing home and community services under Medicaid.

We are very concerned that state budget shortfalls could result in cuts in these programs this year. We support a significant increase in the federal funds provided to states for the Medicaid program. Medicaid-financed long-term care services are already chronically underfunded, and the current recession has exacerbated the long-term care-financing crisis. An increase in the federal Medicaid match is critically needed to ensure the health and well being of millions of vulnerable low-income Americans, particularly our senior citizens.

Another form of state Medicaid fiscal relief we support would be to federalize the Qualified Medicare Beneficiary (QMB) and Specified Low-Income Medicare Beneficiary (SLMB) programs, which provide low-income protections to seniors with incomes below 120 percent of poverty.

President's Budget: The President has proposed a dramatic change in the Medicaid program. States could choose to receive a short-term infusion of federal funds—up to $3.25 billion in FY 2004 and $12.7 billion for the first seven years. After year seven, the states would have to repay the entire $12.7 billion, as their federal payments would be capped and reduced. States would accept two annual block grants– one for acute care and one for long term care. A state would be foreclosed from getting federal matching funds for any expenditure that exceeded its capped allotment. States would have a maintenance of effort (MOE) requirement based on their 2002 Medicaid spending, The MOE requirement would increase annually by the Medicaid Consumer Price Index (which has traditionally increased at a slower rate than actual Medicaid spending). Administration officials have said that states would have "carte blanche" flexibility to determine eligibility, services, cost sharing, and consumer protections for optional populations and services. The Administration's proposal does not include an increase in the federal Medicaid match to states or federalization of the QMB or SLMB programs.

(over)

300 D Street, SW, Washington DC 20024
202-479-1200 ✦ 202-479-0735 (Fax) ✦ www.lcao.org

LCAO Response: LCAO has very serious questions and concerns about the Administration's Medicaid proposal. A Medicaid cap threatens our nation's long-term care safety net and jeopardizes program guarantees. The proposal would create incentives for states to underserve high cost enrollees, such as older Americans in need of long-term care. Persons needing the most expensive care, who are most likely to cause states to exceed their spending cap, would be at greatest risk of being targeted for potentially harmful cost containment strategies, such as limiting access or services. In addition, efforts to improve quality or benefits under Medicaid would be thwarted, particularly since Federal payments would be cut between 2011-2013.

An estimated 83 percent of Medicaid spending on seniors is for optional services or populations. Giving states "carte blanche" to ignore or significantly weaken federal Medicaid consumer protection standards for optional services or populations could be devastating for America's low-income seniors and their families. Would essential nursing home quality standards for optional groups be eliminated? Could a state choose to charge a 50% copayment for home and community services to a frail senior with income at the poverty line? For an optional beneficiary, could a state choose to eliminate current spousal impoverishment protections? Could a state require families of optional Medicaid nursing home residents to supplement the payment to the nursing home? Could a state choose to make recoveries against the estates of the family members of a deceased optional Medicaid nursing home resident? LCAO would strongly oppose eliminating critical federal Medicaid protections in these areas for frail seniors and their families.

We urge the Administration and Congress to support a temporary increase in the federal Medicaid match and to federalize the QMB and SLMB programs.

March 5, 2003

Advocacy Center for Persons With Disabilities, Inc.
Florida's Protection and Advocacy Programs

■ Two million Floridians -- mainly elderly, disabled and children -- depend on the Florida Medicaid program for vital health care services.

■ Effective July 1, 2002, more than 5,400 elderly and disabled Floridians with monthly incomes of just $672 to $685 lost their Medicaid benefits.

■ Although Florida's Aged and Disabled Waiver has been approved by the federal government for 35,000 slots, to date the state has only funded 17,000 – despite tens of thousands waiting for services.

■ In addition, the state admits that even for those 17,000 people on the waiver, services providers are not available for all needed services or in all parts of the state.

■ The waiting list for the Developmental Services Home and Community Based Waiver still has approximately 10,000 people on it. Many currently on the waiver encounter delays, erroneous denials and difficulty accessing service providers for all the services they need.

■ Unlike many other states, Florida has not implemented the rehabilitation model for people with psychiatric disabilities under its state Medicaid plan. This approach has resulted in both increased federal dollars for the states using it and successful lives for those served by it. In Florida, however, the system is so neglected and under-funded that jails and prisons are the primary providers of services. Fully one-fifth of the inmates in Florida corrections facilities have mental illnesses that require treatment.

■ Despite Gov. Jeb Bush's claims for his Silver Saver program, Florida's Pharmacy Plus Waiver, it does not cover disabled individuals under age 65, and coverage is limited to $160 a month – an amount far less than the monthly medication needs of many elderly and disabled people who have serious illnesses.

■ In exchange for this minimal benefit, state officials agreed to an aggregate spending cap for all services applied to all senior Medicaid beneficiaries at the unrealistically low growth rate of 8 percent per year.

■ In essence, the Silver Saver program created a Medicaid "block grant" for elderly Medicaid beneficiaries which forfeits the state ability and commitment to provide full Medicaid coverage for elderly Floridians who may be eligible for Medicaid in the future.

■ Florida is ranked first of all states in proportion of residents aged 65 and older: 18 percent, according to a 2002 study by Florida State University's Pepper Institute on Aging and Public Policy. Florida's elderly population is expected to grow 66 percent by 2020, to 4.6 million.

■ The study also showed that 11.3 percent of Florida's elders are living in poverty with an income of less than $8,259 for an individual and $10,409 for a couple. More than 25 percent of Florida's older households live on less than $15,000 per year.

■ Given increasing medical costs, the ongoing growth of the low income elderly population and their increasing need for services, it is highly unlikely that Florida will remain within the Senior Saver global cap. When that cap is inevitably met, federal funds that now pay over 58% of the cost of services will no longer be available for all eligible seniors.

■ The Silver Saver program has put Florida's growing elderly population on a collision course with a capped Medicaid budget.

■ Now Gov. Bush proposes to do the same for people with disabilities. His 2003-04 budget eliminates the Medically Needy program for elderly and disabled Floridians. More than 23,000 Floridians with catastrophic illnesses rely on this program for live-saving hospital, physician and pharmacy services.

■ Those who cannot get their medications will be hospitalized or institutionalized at far greater costs to themselves and their fellow taxpayers.

■ Gov. Bush's proposal would move Medically Needy beneficiaries into a pharmacy assistance program established under a Medicaid waiver. Program spending and enrollment in the new program will be capped.

■ The plan ignores the fact that 56% of Medically Needy expenditures are for services other than prescriptions -- including physician and hospital care -- as well as Medicaid deductibles.

■ In a letter to Pres. Bush, Gov. Bush writes that "Medicaid increasingly serves as a supplement to Medicare." In Florida, however, advocates are finding that Medicaid delays or denies those supplemental payments to people with severe disabilities who are entitled to them.

March 11, 2003

Florida Medicaid Eligibility Coverages
FY 2002 - 03

Program	Income Limit % of Poverty	Estimated FY 20002-03 Eligibles
TANF[1]	24.4%	634,650
I[2]	73.75%	470,725
Unemployed Parent[1]	24.2%	98,290
Medically Needy*[1 9]	24.2%	26,786
OBRA Aged and Disabled (MED-AD)*	88.0%	96,552
Medicare Beneficiaries		
*Qualified Medicare Beneficiaries/QMB	100%	22,426
*Specified Low Income Medicare Beneficiaries/LMB	120%	35,607
*Qualified Individuals[3]	QI 1 135%	15,016
	QI 2 175%	
Pregnant Women*[4]	185%	52,598
Family Planning Waiver*[5]	TANF/ I Limits	109,979
Children		
Birth to Age One-Above 185% to 200% of Poverty[6]	200%	1,366
Ages One[7]	185%	50,001
*Ages One to ix	133%	195,155
*Born after 9/30/83 Age 6 but not Age 19	100%	279,599
Born before 10/1/83 but not Age 19[8]	100%	598
Refugee Assistance Program[3]	TANF/ I Limits	7,954
TOTAL		2,097,302

*Optional Eligibility Categories Social Services Estimating Conference, October 16, 2002
[1] Family of 3; [2] 82.11% (Family of 2); [3] 100% Federally Funded; [4]Mandatory Coverage to 133%, Maintenance of Effort to 150% FPL; [5] FFP is primarily at 90%; [6] FFP is at the Title XXI Rate; [7] Mandatory Coverage to 133%; Maintenance of effort to 185% due to Title XXI coverage of children; [8] Enrollment will decline until 10/1/02; FFP at the Title XXI rate; [9] Effective May 1, 2003, the income standard is increased by $270 for all beneficiaries except caretakers. The effective income limit will be about 46%.

Estimated Medicaid Spending FY 2002 - 03

Service	Estimated Annual Spending
Nursing Home Care	$2,167,696,927
Prescribed Drugs	1,979,379,821
Hospital Inpatient Services	1,541,939,437
Prepared Health Plans	1,247,856,619
Home & Community Based Services	852,141,216
Physician	523,709,946
Supplemental Medical Insurance	456,853,132
Hospital Outpatient Services	428,207,255
Special Payments to Hospitals	400,650,266
Disproportionate Share Hospital Payments	242,493,344
Therapeutic Services for Children	174,823,639
Private Duty Nursing Services	147,188,309
ICFDD	140,541,224
Other	1,083,216,979
TOTAL	$11,386,698,114

Preliminary Estimates for Temporary State Fiscal Relief, Based on Update of King-Brown Bill (H.R. 3414): Combination of Hold Harmless, 2.0 Percent Across-the-Board FMAP Increase and 2.5 Percent Additional FMAP Increase for States with High Unemployment, April 2003 to March 2004

(all amounts, federal funds in millions of dollars)

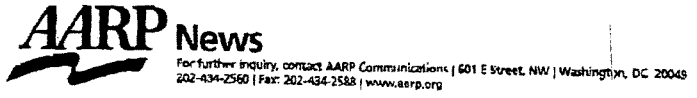
	TEMPORARY INCREASE IN FEDERAL MEDICAID MATCHING RATE (FMAP)								
	FY 2003 (Apr. 2003-Sept. 2003)				FY 2004 (Oct. 2002-Mar. 2004)				
	Hold Harmless*	Across-the-Board 2.0% Increase	Additional 2.5% for States with High Unemployment**	Total, FY 2003	Hold Harmless*	Across-the-Board 2.0% Increase	Additional 2.5% for States with High Unemployment**	Total, FY 2004	Total, FY 2003-4
Alabama	$0.0	$27.8	$34.8	$62.6	$0.0	$30.9	$38.7	$69.6	$132.2
Alaska	$0.0	$7.1	$8.8	$15.9	$0.0	$7.5	$9.4	$16.9	$32.8
Arizona	$0.0	$41.9	$52.3	$94.2	$0.0	$47.6	$59.5	$107.1	$201.3
Arkansas	$0.0	$22.6	$0.0	$22.6	$0.0	$23.7	$0.0	$23.7	$46.3
California	$189.2	$270.3	$337.9	$797.4	$196.2	$280.3	$350.4	$826.9	$1,624.3
Colorado	$0.0	$24.4	$0.0	$24.4	$0.0	$25.3	$0.0	$25.3	$49.7
Connecticut	$0.0	$34.3	$0.0	$34.3	$0.0	$37.2	$0.0	$37.2	$71.5
Delaware	$0.0	$6.7	$0.0	$6.7	$0.0	$6.8	$0.0	$6.8	$13.4
District of Columbia	$0.0	$11.1	$13.9	$25.0	$0.0	$11.5	$14.4	$25.9	$50.9
Florida	$0.0	$106.0	$0.0	$106.0	$0.0	$110.8	$0.0	$110.8	$216.9
Georgia	$0.0	$59.5	$0.0	$59.5	$0.7	$66.9	$0.0	$67.6	$127.1
Hawaii	$0.0	$7.8	$0.0	$7.8	$0.0	$8.2	$0.0	$8.2	$16.1
Idaho	$0.2	$8.1	$10.2	$18.5	$2.4	$8.7	$10.9	$22.0	$40.5
Illinois	$0.0	$85.3	$106.6	$191.8	$0.0	$100.0	$125.0	$224.9	$416.8
Indiana	$1.5	$43.9	$0.0	$45.4	$0.0	$49.3	$0.0	$49.3	$94.7
Iowa	$0.0	$21.9	$0.0	$21.9	$0.0	$23.2	$0.0	$23.2	$45.1
Kansas	$0.4	$16.8	$0.0	$17.2	$0.0	$16.4	$0.0	$16.4	$33.6
Kentucky	$0.9	$36.9	$0.0	$37.8	$0.0	$37.2	$0.0	$37.2	$75.0
Louisiana	$0.0	$40.4	$50.5	$90.8	$0.0	$42.7	$53.4	$96.1	$187.0
Maine	$2.7	$15.0	$0.0	$17.7	$4.8	$16.8	$0.0	$21.6	$39.3
Maryland	$0.0	$38.7	$0.0	$38.7	$0.0	$42.5	$0.0	$42.5	$81.3
Massachusetts	$0.0	$80.2	$0.0	$80.2	$0.0	$83.9	$0.0	$83.9	$164.1
Michigan	$35.7	$76.0	$95.0	$206.7	$17.9	$76.2	$95.3	$189.4	$396.1
Minnesota	$0.0	$49.6	$0.0	$49.6	$0.0	$54.5	$0.0	$54.5	$104.1
Mississippi	$0.0	$29.5	$36.8	$66.3	$0.0	$31.7	$39.6	$71.3	$137.6
Missouri	$0.0	$49.0	$0.0	$49.0	$0.0	$54.8	$0.0	$54.8	$103.9
Montana	$0.0	$6.1	$0.0	$6.1	$0.4	$6.5	$0.0	$6.9	$13.0
Nebraska	$0.2	$13.3	$0.0	$13.5	$0.0	$14.2	$0.0	$14.2	$27.7
Nevada	$0.0	$8.8	$0.0	$8.8	$0.0	$9.3	$0.0	$9.3	$18.1
New Hampshire	$0.0	$9.2	$0.0	$9.2	$0.0	$9.6	$0.0	$9.6	$18.8
New Jersey	$0.0	$69.2	$86.5	$155.7	$0.0	$73.5	$91.8	$165.3	$321.0
New Mexico	$0.0	$18.8	$23.5	$42.2	$0.0	$20.2	$25.3	$45.5	$87.7

	FY 2003 (Apr. 2003-Sept. 2003)				FY 2004 (Oct. 2002-Mar. 2004)				
	Hold Harmless*	Across-the-Board 2.0% Increase	Additional 2.5% for States with High Unemployment**	Total, FY 2003	Hold Harmless*	Across-the-Board 2.0% Increase	Additional 2.5% for States with High Unemployment**	Total, FY 2004	Total, FY 2003-4
New York	$0.0	$387.8	$484.7	$872.5	$0.0	$431.3	$539.1	$970.4	$1,842.9
North Carolina	$0.0	$71.0	$88.8	$159.9	$0.0	$79.8	$99.8	$179.6	$339.5
North Dakota	$3.5	$4.6	$0.0	$8.1	$3.8	$4.8	$0.0	$8.6	$16.7
Ohio	$0.0	$100.6	$125.7	$226.3	$0.0	$111.4	$139.3	$250.7	$477.0
Oklahoma	$0.0	$25.6	$0.0	$25.6	$4.1	$25.6	$0.0	$29.7	$55.2
Oregon	$0.0	$28.5	$35.6	$64.1	$0.0	$29.6	$37.0	$66.5	$130.6
Pennsylvania	$0.0	$125.2	$0.0	$125.2	$0.0	$133.1	$0.0	$133.1	$258.2
Rhode Island	$0.0	$13.5	$0.0	$13.5	$0.0	$14.3	$0.0	$14.3	$27.8
South Carolina	$0.0	$31.9	$39.8	$71.7	$0.0	$32.4	$40.5	$72.9	$144.6
South Dakota	$1.7	$5.3	$0.0	$6.9	$0.7	$5.3	$0.0	$6.0	$13.0
Tennessee	$0.0	$59.6	$0.0	$59.6	$5.9	$62.1	$0.0	$68.0	$127.6
Texas	$12.4	$137.9	$172.3	$322.6	$0.0	$144.8	$181.0	$325.7	$648.4
Utah	$0.0	$10.2	$0.0	$10.2	$0.0	$11.6	$0.0	$11.6	$21.7
Vermont	$2.2	$6.8	$0.0	$8.9	$6.2	$7.3	$0.0	$13.5	$22.5
Virginia	$16.4	$35.6	$0.0	$51.9	$28.0	$38.6	$0.0	$66.7	$118.6
Washington	$9.1	$49.1	$61.4	$119.6	$10.0	$53.8	$67.2	$131.0	$250.6
West Virginia	$1.9	$16.3	$20.4	$38.6	$0.7	$17.0	$21.2	$38.8	$77.5
Wisconsin	$3.2	$45.3	$0.0	$48.5	$3.9	$48.4	$0.0	$52.3	$100.8
Wyoming	$1.0	$2.9	$0.0	$3.9	$3.4	$3.1	$0.0	$6.6	$10.4
Puerto Rico	$0.0	$3.3	$0.0	$3.3	$0.0	$3.3	$0.0	$3.3	$6.6
American Samoa	$0.0	$0.1	$0.0	$0.1	$0.0	$0.1	$0.0	$0.1	$0.1
Guam	$0.0	$0.1	$0.0	$0.1	$0.0	$0.1	$0.0	$0.1	$0.2
Northern Marianas	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.0	$0.1
Virgin Islands	$0.0	$0.1	$0.0	$0.1	$0.0	$0.1	$0.0	$0.1	$0.2
U.S. Total	**$282.2**	**$2,497.3**	**$1,885.5**	**$4,665.0**	**$289.1**	**$2,686.1**	**$2,038.6**	**$5,013.7**	**$9,678.7**

* In FY 2003, hold harmless means the higher of 2002 or 2003 FMAPs. In FY 2004, hold harmless means the highest of 2002 or 2004 FMAPs.
** Additional states may qualify in subsequent quarters.

Preliminary estimates by the Center on Budget and Policy Priorities. Do not necessarily correspond to CBO estimates. CBPP estimates have been somewhat lower than CBO scores. We estimate CBO would score this about $300-500 million higher. Based on state projections of Medicaid spending for FY 2003, as reported by states November 2002.

Feb. 12, 2003



For further inquiry, contact AARP Communications | 601 E Street, NW | Washington, DC 20049
202-434-2560 | Fax: 202-434-2588 | www.aarp.org

FOR IMMEDIATE RELEASE
February 13, 2003

CONTACT:
Steve Hahn
(202) 434-2560

AARP CALLS FOR TEMPORARY RELIEF FOR THE STATES
- Financial Crises Make Medicaid Programs Vulnerable -

WASHINGTON – With 49 of the 50 states facing serious budget crises this year, AARP today called on Congress and the President to provide temporary assistance to the states to help them stave off cuts to programs for children, the elderly and the disabled.

Many states are feeling pressure to cut Medicaid budgets this year to address serious deficits. The AARP Board of Directors, which is meeting with key lawmakers and issue experts here this week, is concerned about the potential harm these cuts will cause to some of America's most vulnerable.

AARP President Jim Parkel explained, "Frail and disabled people will lose home and community-based health services. Nursing homes won't be able to hire enough staff. Children and older Americans will lose coverage from state assistance programs."

"With no help from Congress, states may be forced to cut off coverage for many in need and not just the poor," Parkel said. "Health providers, businesses, insurers and local governments will suffer as costs for services covered by Medicaid are shifted onto them," he added.

The Administration has proposed some short-term relief. However, AARP is concerned that the Administration proposal for "lump-sum allotments" to the states is insufficient and could lead to more Medicaid cuts. "This proposal handcuffs states because it leaves people more vulnerable in future years as states struggle to meet increased needs with decreased dollars," said AARP Executive Director and CEO Bill Novelli.

Novelli concluded, "states need temporary assistance to help maintain health coverage in the current economic climate, not permanent changes that will reduce or eliminate future care. Congress should provide a temporary increase in federal assistance to states for Medicaid programs."

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FOR IMMEDIATE RELEASE:
February 13, 2003

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Steve Hahn
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"States need temporary assistance to help maintain health coverage in the current economic climate, not permanent changes that will reduce or eliminate future care. Congress should provide a temporary increase in the rate at which federal government matches state Medicaid spending."

NATIONAL GOVERNORS' ASSOCIATION

Bob Miller
Governor of Nevada
Chairman

George V. Voinovich
Governor of Ohio
Vice Chairman

Raymond C. Scheppach
Executive Director

Hall of the States
444 North Capitol Street
Washington, D.C. 20001
Telephone (202) 624-5300

April 14, 1997

The Honorable William J. Clinton
The White House
Washington, DC 20500

Dear Mr. President:

As budget discussions continue to move forward, we wanted to reiterate our concerns regarding the role of Medicaid in a deficit reduction package. No single decision made in the context of balancing the budget will be of greater importance to states than the treatment of the Medicaid program. For that reason, we believe that it is critical that the concerns we raise on behalf of the National Governors' Association be addressed successfully as negotiations continue. Our most vital concerns relate to the level of Medicaid savings targeted in a deficit reduction package, the per capita cap, and the disproportionate share hospital (DSH) program.

As set forth in NGA testimony before the Senate Finance Committee and the House Commerce Committee on March 11, the Governors strongly believe that the overall level of Medicaid savings included in any deficit reduction package should reflect the contribution the program already has made to deficit reduction. Despite limited flexibility in the program, Governors have been able to significantly restrain Medicaid spending in recent years. In recognition of this success, the Congressional Budget Office lowered its baseline projections of future growth in Medicaid spending by almost $86 billion in February.

This $86 billion makes a significant contribution to deficit reduction. Accordingly, any additional Medicaid savings included in a balanced budget package should be kept to a minimum. Governors believe that with the additional program flexibility we outlined in our testimony, another $8 billion in Medicaid savings can be produced between now and 2002. Attached you will find a detailed description of our savings recommendations. Actual state experiences in implementation could well yield levels of savings beyond our conservative estimate.

In order to ensure that recipients retain access to high quality health care, Governors believe overall levels of additional Medicaid savings should be kept at $8 billion. Furthermore, the method adopted for achieving Medicaid savings is of primary importance to Governors. We adamantly oppose a cap on federal Medicaid spending in any form. Unilateral caps in federal Medicaid spending will result in cost shifts to states, enabling the federal government to balance its budget at the expense of the states.

Under a cap, once the federal spending obligation is fulfilled, states would become solely responsible for meeting uncontrollable program cost increases, stemming from things such as new drug treatments, lawsuits, and disasters. In confronting this cost shift, states would be presented with several bad alternatives. States would have to choose between cutting back on payment rates to providers, eliminating optional benefits provided to recipients, ending coverage for optional beneficiaries, or coming up with additional state funds to absorb 100 percent of the cost of services.

Rather than make the tough choices on budget priorities, the federal government is putting states in the position of having to make an impossible decision. No option would be painless. If states chose to address shortfalls by significantly cutting provider reimbursement rates, those who needed health care the most could find it difficult to access care. Medicaid options could not be easily eliminated because they make up an important core of the program. More than two-thirds of Medicaid spending goes toward the elderly and people with disabilities. So-called optional eligibility categories include the frail elderly in nursing homes and pregnant women and children. The largest optional benefit in many states is coverage for critical prescription drug services. In the end, states could find that they have no choice but to raise taxes or cut other important spending priorities, such as education.

The federal government will spend almost $7 billion on the Medicaid prescription drug benefit in 1998. Shifting costs to states through a per capita cap in order to achieve $7 billion in savings essentially forces states to confront choices such as discontinuing a vitally important benefit that is currently provided to 24 million Americans.

The Medicaid proposals that have been set forth so far have included significant cuts in the DSH program in addition to the federal savings that would be realized through a per capita cap. Governors believe that $8 billion in additional savings on top of the $86 billion already produced is a reasonable savings target for Medicaid. Accordingly, we would oppose the high levels of DSH savings included in the budget proposals on the table. It is also important that DSH not be considered a potential source of savings isolated from the rest of Medicaid; DSH funds are an important part of statewide systems of health care access for the uninsured. All Medicaid savings proposals will be evaluated on the basis of their impact on the program as a whole.

Furthermore, DSH funds must continue to be distributed through states and not directly to providers. This will ensure that DSH dollars are used in ways that complement other federal and state sources of health care funding. Maintaining the state role in the distribution of DSH will ensure effective coordination with the state's overall health infrastructure.

Governors place the highest priority on the successful resolution of the concerns we have raised. We would welcome the opportunity to work with you as Medicaid issues are addressed in the context of developing a balanced budget package, and we would be happy to provide you with any additional information you may require. Because states administer the program and provide on average 43 percent of its funding, Governors must be involved in any budget negotiations related to the future of Medicaid.

Sincerely,

Bob Miller

Governor Bob Miller

George V. Voinovich

Governor George V. Voinovich

Governor Lawton Chiles

Michael O.

Governor Tommy G. Thompson

Governor Zell Miller

Governor John Engler

Governor Edward T. Schafer

Governor Jim Edgar

Governor John G. Rowland

Governor Benjamin J. Cayetano

Governor Philip E. Batt

Governor Fife Symington

Governor Terry E. Branstad

Governor Paul E. Patton

Governor Arne H. Carlson

Governor Mel Carnahan

Governor Jeanne Shaheen

Governor George E. Pataki

Governor John A. Kitzhaber

Governor Tom Ridge

Governor Pedro Rossello

Governor Lincoln A. Almond

Governor David M. Beasley

Governor Frank O'Bannon

Governor George Allen

Governor Gary Locke

Governor Cecil Underwood

Governor Jim Geringer

Governor Fob James Jr

Governor Jim Hunt

Governor Tony Knowles

Governor Christine T. Whitman

Governor E. Benjamin Nelson

Governor Frank Keating

Governor Carl Gutierrez

Governor Pete Wilson

Governor Mike Huckabee

Governor Gary E. Johnson

Governor Marc Racicot

Governor Roy Romer

February 19, 2003

Dear Members of the Energy and Commerce Committee,

The undersigned organizations would like to respond to the letter from Governors Bush, Rowland, and Owens of January 16, 2003 urging major changes to the Medicaid program. These reform principles, if enacted, would permanently undermine the integrity of the Medicaid program—a public health program that provides coverage for 47 million low -income Americans.

Of great concern is the notion that the Medicaid program should become "predictable in terms of cost," thereby turning it into a capped block grant that will be incapable of helping our most vulnerable citizens, such as children, seniors and people with disabilities in current and in future economic crises. To impose "predictable costs" on Medicaid would destroy its ability to help in the times when it is most needed.

Instead of working to ensure that states have the tools to maintain their public health programs during this economic down turn, these reform principles may place states in a fiscal straightjacket that will cause states to cut off people and thereby increase the number of uninsured.

We look forward to working with you to protect and strengthen the Medicaid program. Thank you for your consideration of these views.

Sincerely,

AFL-CIO
Alliance for Children and Families
Alliance for Retired Americans
Alliance to End Childhood Lead Poisoning
American Academy of Pediatrics
American Association on Mental Retardation
American College of Nurse-Midwives
American Counseling Association
American Dental Hygienists' Association
American Federation of State, County and Municipal Employees
American Federation of Teachers
American Network of Community Options and Resources
American Psychiatric Association
American Public Health Association
Ascension Health
Association of Academic Health Centers

Association of Clinicians for the Underserved
Association of Maternal and Child Health Programs
Association of University Centers on Disabilities
Bazelon Center for Mental Health Law
Center for Independence of the Disabled, NY
Center for Medicare Advocacy, Inc.
Child Welfare League of America
Children's Defense Fund
Council of Women's and Infants' Specialty Hospitals
Families USA
Family Voices
Florida AIDS Action
Gay Men's Health Crisis
HIV Medicine Association
International Union, UAW
Jewish Federation of Metropolitan Chicago
National Association for Children's Behavioral Health
National Association of County Behavioral Health Directors
National Association of Protection and Advocacy Systems
National Association of Social Workers
National Coalition for the Homeless
National Council for Community Behavioral Healthcare
National Council of La Raza
National Council on the Aging
National Education Association
National Family Planning and Reproductive Health Association
National Health Care for the Homeless Council
National Health Law Program
National Mental Health Association
National Minority AIDS Council
National Partnership for Women and Families
National Renal Administrators Association
National Senior Citizens Law Center
National Women's Law Center
New York City Task Force on Medicaid Managed Care
New Yorkers for Accessible Health Coverage
Northern Regional Center for Independent Living, Inc.
Paralyzed Veterans of America
Parents Reaching Out
Planned Parenthood Federation of America
Project Inform
Renal Leadership Council
Service Employees International Union
The Alan Guttmacher Institute
The Arc of the United States
United Cerebral Palsy
United Church of Christ Justice and Witness Ministries
United Jewish Communities
Voice of the Retarded

March 12, 2003

Bush Administration's Medicaid Proposal Decimates Services for People with Disabilities

The Consortium for Citizens with Disabilities is a Washington-based coalition of over 100 national disability organizations. The CCD is strongly opposed to President Bush's recently proposed Medicaid reforms because they would eliminate the longstanding guarantee that all Medicaid beneficiaries in a state have access to a comprehensive array of services. The services and supports that beneficiaries currently receive — including children and adults with disabilities — are based on what they need. For their health and well being, these services are not optional. These supports and services enable children and adults with disabilities to live and work in their own homes and communities.

The Bush Administration's Medicaid proposal states an interest in modernizing and streamlining the Medicaid program. However, disability advocates believe that the Administration's proposal would deconstruct and eviscerate a program that has been the lifeblood of millions of children and adults with disabilities and their families.

Services and supports currently provided by Medicaid that enable individuals to lead full and meaningful lives would be eliminated when no other alternatives exist. Medicaid is generally the only choice for most people to receive comprehensive services and supports

Medicaid Works

For children with all types of disabilities, access to the Early and Periodic Screening, Diagnosis and Treatment (EPSDT) benefit, with its variety of screenings, services and therapies, can often make a major difference in their lives. Access to these important services is what enables them to lead healthy and more active lives; avoid additional disabilities; continue to live at home with their families: make it through school; get a job; participate in recreation; and participate actively in the community in which they live.

Medicaid is the primary public source of funding for long-term services and supports for people with disabilities of all ages. It is the largest funder of state and local spending on mental health, mental retardation, and developmental disabilities services in the country.

For people with epilepsy, mental illness, HIV, and a variety of other conditions, Medicaid is very often the only source of access to essential prescription drug coverage.

For people with a variety of physical disabilities, such as spinal cord injuries, traumatic brain injuries, cerebral palsy, or amputations, Medicaid usually is the only way they can get access to durable medical equipment like wheelchairs or prosthetic devices, as well as assistive technology.

For many people with cognitive and other types of disabilities, Medicaid generally is the only source of funds for

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them to live and work in the community with friends and families and avoid more costly and segregated nursing homes or institutions.

Wrong Solution for the Wrong Problem

The Administration has proposed reforms that give only one stakeholder in the Medicaid program — the states — virtually unchecked flexibility at the expense of beneficiaries and providers. Removing the entitlement to Medicaid for children and adults with disabilities and their families– and capping funding -- will give states unlimited discretion to limit access to health and long-term services and supports that these individuals need. These are the people for whom "safety net" programs like Medicaid have life-altering implications.

The Administration's proposal undermines well-reasoned and time-tested beneficiary protections as though they were responsible for current challenges in financing Medicaid. They are not. Federal oversight of state programs is often the only way to ensure fairness and non-discrimination. It is often the only way to protect the most vulnerable individuals from abuse, as well as demand accountability for this taxpayer-supported program.

Medicaid can be a solution to lack of insurance. It is not the reason that so many children and adults in our nation are uninsured. Medicaid plays a critical role in mitigating the problem of lack of insurance by providing health care coverage to children and families, the elderly, and people with disabilities — often the most vulnerable and poorest individuals in the country. The Administration's plan would sacrifice what makes Medicaid work in the name of providing meager health coverage to new populations.

The President's proposal would hold the long-term health of Medicaid hostage to short-term state fiscal relief. This ignores the reality that short-term and long-term challenges require attention. Positive modernization proposals would include:

- Maintaining the existing entitlement to Medicaid's full range of benefits and to the federal protections that make access to these necessary services and supports dependable and real.
- Temporarily increasing financing to states that helps to preserve the national investment in Medicaid. When the economy struggles, the federal government has a vital role in preventing a worsening crisis.
- Ensuring that states effectively implement the EPSDT program. EPSDT is a critical tool to prevent and minimize disability and to ensure that children get the best possible start in this world so they can grow up to be contributing members of society.
- Establishing mandatory coverage for home- and community-based services that provide a viable alternative to institutional living for people with disabilities and the elderly.
- Increasing the federal responsibility for the cost of providing services to Medicare beneficiaries. This includes increased federal support for prescription drug coverage, durable medical equipment, and long-term care services for low-income persons eligible for both Medicaid and Medicare.

The Bush Administration proposal fails people with disabilities and dishonors the nation's commitment to its residents — it is not in the national interest. While the President has offered several proposals under the New Freedom Initiative that portray his understanding of some of the concerns of people with disabilities, his Administration's Medicaid modernization proposals expose a disconnect between rhetoric and reality.

Any changes to Medicaid must recognize the unique populations enrolled in Medicaid, including seven million people with severe disabilities – both children and adults. State Children's Health Insurance Program and private

market benefits packages are not only inadequate for these individuals, but they are also often completely unavailable. What the Medicaid program calls "optional" services are, in reality, mandatory disability services for the children and adults who need them. These services often are not only life-saving, but also the key to a positive quality of life – something everyone in our nation deserves.

We pledge to work with the Congress to ensure that any modifications to the program are in the best interests of children and adults served by Medicaid -- which in the long run would be in the best interests of our nation.

ON BEHALF OF:

Adapted Physical Activity Council
Advancing Independence: Modernizing Medicare and Medicaid
American Academy of Child and Adolescent Psychiatry
American Association on Mental Retardation
American Association of People with Disabilities
American Congress of Community Supports and Employment Services
American Council of the Blind
American Foundation for the Blind
American Medical Rehabilitation Providers Association
American Music Therapy Association
American Network of Community Options and Resources
American Occupational Therapy Association
American Therapeutic Recreation Association
Association for Educators of Community-Based Rehabilitation Programs
Association of Maternal & Child Health Programs
Association of Tech Act Projects
Association of University Centers on Disabilities
Bazelon Center for Mental Health Law
Brain Injury Association of America
Center on Disability and Health
Center on Disability Issues & the Health Professions
Council of Parent Attorneys and Advocates
Council for Learning Disabilities
Disability Service Providers of America
Easter Seals
Epilepsy Foundation
Federation of Families for Children's Mental Health
Family Voices
Inclusion Research Institute
Inter/National Association of Business, Industry and Rehabilitation
National Association for the Advancement of Orthotics and Prosthetics
National Association of Developmental Disabilities Councils
National Association of Orthopaedic Nurses
National Association of Protection and Advocacy Systems
National Association of Rehabilitation Research and Training Centers
National Association of School Nurses
National Association of School Psychologists

National Association of Social Workers
National Association of State Directors of Special Education
National Coalition on Deaf-Blindness
National Council for Community Behavioral Healthcare
National Down Syndrome Congress
National Mental Health Association
National Organization of Social Security Claimants' Representatives
National Respite Coalition
NISH
Rehabilitation Engineering and Assistive Technology Society of North America
Research Institute for Independent Living
School Social Work Association of America
Spina Bifida Association of America
TASH
The Arc of the United States
United Cerebral Palsy

For more information, contact:

Kathy McGinley, National Association of Protection and Advocacy Systems, (202) 408-9514, kathy@napas.org

Marty Ford, The Arc and UCP Public Policy Collaboration, (202) 783-2229, ford@thearc.org

February 6, 2003

The Honorable W.J. Tauzin
Chairman
Committee on Energy and Commerce
U.S. House of Representatives
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Tauzin:

On behalf of the American College of Obstetricians and Gynecologists (ACOG), and its 45,000 physician partners in women's health care, I appreciate the opportunity to share our concerns with the current Medicaid system, and proposals to reform Medicaid. Medicaid is a vital health care safety net that ensures essential services for low-income women, including prenatal care and preventive screening tests such as mammograms and pap tests. ACOG is committed to ensuring the program's viability as a source of these important services.

We recognize that many challenges lie ahead for states and the federal government as severe budget shortfalls impact Medicaid expenditures. As Congress examines ways to reform Medicaid, however, we urge caution regarding any proposal that may reduce access to necessary services. Medicaid serves our most needy populations. We urge your Committee to look for ways to enhance, not reduce, access to care.

Increased Pressure on Physicians

ACOG Fellows have a long history of volunteerism and service in underserved areas. Intense practice pressures continue to mount, however, for physicians who face not only decreased reimbursements, but also skyrocketing liability premiums. The ability to care for the Medicaid population is growing increasingly difficult.

In many states, the cost of providing care to Medicaid patients is much greater than Medicaid reimbursements. Low payments, which in some states amount to only one-third of the cost to treat the patient, have resulted in a crisis. In the past, physicians could count on privately insured patients to cover the costs associated with uninsured or Medicaid patients. However, many ob-gyns practicing today find it cost-prohibitive to absorb extremely low reimbursement rates and to provide charity care in general.

THE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS • WOMEN'S HEALTH CARE PHYSICIANS
409 12TH STREET SW WASHINGTON DC 20024-2188
MAILING ADDRESS: PO BOX 96920 WASHINGTON DC 20090-6920
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Medicaid provider payments are often the first item cut to address state budget crises. In 2002, the Des Moines Register reported "a panel within the state Department of Human Services voted to cut Medicaid care provider reimbursements by 13.2 percent." In Mississippi, legislators considered reducing Medicaid providers' reimbursements by 3-5 percent. Ohio's governor recently announced new cuts to the state Medicaid program as well. These Medicaid cuts come on the heels of recent Medicare physician payment reductions which, when taken together, have had disastrous effects on ob-gyn practices.

ACOG believes an increase in federal resources, including the Federal Medical Assistance Percentage (FMAP), will help states meet the needs of the Medicaid program. Without a federal commitment to assist states, which are experiencing increased unemployment and a growing demand for more Medicaid services, services may be cut. In addition, without fair and adequate reimbursement levels for provider services, more physicians may be forced to stop serving Medicaid patients. We urge Congress to reject reforms that would result in further reductions to provider reimbursements.

I also want to highlight an access problem that has particularly negative impacts on the Medicaid and uninsured population. In addition to continued payment cuts, ob-gyns are faced with skyrocketing medical liability premiums and increased regulatory burdens. Ob-gyns are particularly hard hit by these factors, forcing many to stop delivering babies and reduce the number of surgeries they perform. Low-income women, women in rural areas, and women with high-risk pregnancies are most at risk when care becomes difficult to find.

A recent survey conducted by the Clark County (Las Vegas, Nevada) Ob/Gyn Society noted that "80 percent of area obstetricians have stopped accepting Medicaid patients, plan to stop taking Medicaid patients or are considering doing so." A December 2002 report by The Center for Studying Health System Change found that, "physicians also limit the number of new Medicaid and uninsured patients in their practice to a much greater extent than they do other patients." Unfortunately, these examples are repeating across the country.

In the past, under your leadership, this Committee has taken steps to address these concerns. We appreciate the Chairman's support of liability reform and regulatory relief legislation and urge Congress to immediately act on these important issues. Without passage of legislation to stop out-of-control medical liability premiums and reduce physicians' regulatory burden, access to women's health care will further deteriorate.

Continue Comprehensive Coverage

Finally, ACOG was pleased to note that the Administration continues to support coverage of Medicaid services, including prenatal, labor and delivery, and postpartum care, for mandatory populations. ACOG has long recognized that a full spectrum of health services is necessary to ensure healthy pregnancies, healthy deliveries, and a postpartum period free of complications. A healthy start in life helps prevent future difficulties. It is important that Medicaid continue to provide these important services.

We have concerns about the Administration's proposal to permit states greater flexibility to design health programs. Congress must not allow states to reduce care to optional, or non-mandatory populations, or not provide recommended pregnancy-related services to pregnant women. The Administration's recently adopted State Children's Health Insurance Plan (SCHIP) policy, for example, provides coverage to the fetus, rather than the mother, and does not clearly guarantee whether postpartum services and other care for the mother are permitted. We instead support the Medicaid requirements and urge continued adherence to care that includes a full complement of services that ensure a healthy mother and child.

Chairman Tauzin, I appreciate the opportunity to share with you my concerns. I look forward to working with you and your staff as you review and identify solutions for Medicaid reform.

Sincerely,

Ralph W. Hale, MD, FACOG
Executive Vice President

American Academy of Pediatrics

STATEMENT FOR THE RECORD

FOR THE

U.S. HOUSE OF REPRESENTATIVES

COMMITTEE ON ENERGY AND COMMERCE

SUBCOMMITTEE ON HEALTH

HEARING ON

"MEDICAID TODAY: THE STATES' PERSPECTIVE"

March 12, 2003

OF THE

AMERICAN ACADEMY OF PEDIATRICS

Department of Federal Affairs
The Homer Building
601 Thirteenth Street, N.W.
Suite 400 North
Washington, D.C. 20005
202-347-8600 / 800-336-5475 / FAX: 202-393-6137

The American Academy of Pediatrics, an organization of 57,000 primary care pediatricians, pediatric medical subspecialists and pediatric surgical specialists, is deeply committed to protecting the 22 million children (22M through age 18, 24M through age 20) who receive health care through the Medicaid program.

Medicaid provides health insurance for one in every four American children, making it the largest children's health program in the country. Through the Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) program, the Medicaid program guarantees low-income children access to critical health care services, including preventive care. The Medicaid program also provides health care coverage to one-third of American children with special health care needs. Without Medicaid, many of these children and their families would have nowhere to turn.

The Academy is deeply concerned with the recent announcement of the Administration's plan to reform the Medicaid and SCHIP programs. For those states that agree to receive a limited loan of federal funds, the Administration's proposal would cap Medicaid and SCHIP funding, effectively eliminate the SCHIP program, and open both programs up to unlimited "flexibility" to cut benefits and undermine these critical child health care programs. Through these proposed reforms, millions of children will find they are no longer eligible for these programs or the critical services they need are no longer available.

The plan proposes to continue to provide services to "mandatory" populations, but does not state it would ensure these beneficiaries continue to receive the full scope of guaranteed Medicaid benefits. Similarly, the Administration's proposal would jeopardize the care "optional" populations receive through the Medicaid program by capping funds and giving states greater "flexibility" in order to stay within these funding limits. To control costs, the only "flexibility" states could exercise would be cutting benefits, limiting eligible participants, and lowering payments to providers.

Medicaid now covers over eight million children as "optional" beneficiaries. It is important to recognize that very little would be gained by limiting these "optional" beneficiaries, but much would be lost. Restricting access to comprehensive care for children would increase costs by forcing children into more costly sites of care. Without Medicaid, most--if not all--of these children would have no health insurance.

The Academy asks that Congress recognize the effect the Administration's proposal has on the SCHIP program. This proposal would effectively eliminate the SCHIP program in those states that opt-in to the capped-funding agreement and would have a detrimental effect on the SCHIP program nationwide. In recent years states have made great strides in expanding coverage to children and families through the SCHIP program. Combining the SCHIP allotments into an annual capped allotment to fund both Medicaid and SCHIP threatens the current protections for children provided by this extremely successful program that served 5.3 million children in FY 2002.

As states are facing the worst fiscal conditions they have experienced since World War II, the federal government should be stepping up, not capping, support to states for these critical programs for working families. The Academy supports legislative efforts to provide immediate fiscal relief to the states for their Medicaid program and those that address SCHIP funding problems, without undermining the safety net. Rather than provide real and much needed support to states, the Administration's proposal asks states to trade limited short-term budgetary relief for an uncertain future for the millions of children who depend on these programs for their health care. To provide the states with necessary funds to maintain their Medicaid programs, the Academy urges prompt passage of legislation that would provide a temporary increase in the Federal Medical Assistance Percentage (FMAP) such as that found in the State Budget Relief Act (S.138), bipartisan legislation introduced in the Senate by Sens. John Rockefeller and Susan Collins and introduced in the House by Reps. Peter King and Sherrod Brown (H.R. 816). To ensure the continued success of the SCHIP program and to prevent further state enrollment freezes and cuts, the Academy supports the passage of legislation to prevent the $2.7 billion in unspent SCHIP funds from reverting back to the federal treasury, as well as legislation to fix the SCHIP funding "dip".

The American Academy of Pediatrics is dedicated to ensuring that all children have access to quality health care. Currently, there are over 9 million children who are uninsured. Additionally, Academy research has revealed that millions more children are uninsured for part of the year. In 1998, while close to 11 million children and young adults did not have any health insurance coverage, another 12 million had gaps in their coverage that typically exceeded 3 months. This latter group represents one-third of missing coverage and presents a sizable, and not commonly considered, challenge to providing health care for the needy. The high number of children who are uninsured part of the year also signals significant rates of insurance turnover and churning that disrupt continuity of care and produce inefficiency in the health care system. Counting only the full-year uninsured also masks the number of families losing or going without insurance for their children and substantially underestimates the potential demand for and cost of public programs to insure children. The problem of uninsurance and underinsurance demonstrates the need to strengthen, not weaken, the Medicaid and SCHIP programs—a vital safety net for America's children.

As pediatricians, we urge Congress to protect the Medicaid and SCHIP programs, which are so critical for children.

HEALTH CARE FOR ALL COALITION

March 12, 2003

Members

American Federation of State, County and Municipal Employees
American Association of University Women
Capitol Region Conference of Churches
Caucus of Connecticut Democrats
Coalition for People
Congress of Connecticut Community Colleges
CT Association for Human Services
CT Association of Nonprofits
CT Citizen Action Group
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CT Primary Care Association
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CT State Council of Machinists
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Greater Hartford Central Labor Council
Hotel and Restaurant Employees Union, L.217
Legal Assistance Resource Center of CT
National Association of Social Workers
New England Health Care Workers Union, 1199
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Older Women's League/Northwest CT
Service Employees International Union
Staywell Health Center
Unitarian Society
United Auto Workers
University Health Professionals/ CFEPE

The Honorable W.J. "Billy Tauzin
Chairman
Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, D.C. 20515

The Honorable John D. Dingell
Ranking Member
Committee on Energy and Commerce
3233 Rayburn House Office Building
Washington, D.C. 20515

Dear Chairman Tauzin and Ranking Member Dingell:

The undersigned Connecticut organizations are extremely concerned that the state fiscal crisis is forcing many states to cut Medicaid coverage and provider payments. We are especically disturbed that Governor Rowland has written to President Bush and Secretary Thompson saying that we don't need an increased Federal Medical Assistance Percentage (FMAP) in our state as is contained in the bipartisan proposal. He is turning down federal money at the same time that he is cutting off tens of thousands of people from their health care and laying off nearly 3000 state workers.

Governor Rowland states in his letter that, "Connecticut also has a proud history of meeting the health needs of our citizens ..." He talks about how we have expanded Medicaid coverage for adults with children to 150 percent of poverty, but he has just cut 23,000 of those same working parents from this program. He talks about how we have expanded our State-run pharmacy program for seniors, but he has just effectively cut access to prescription drugs for Connecticut's seniors by increasing the membership fee for this program by 20% and the co-pays by over 33% His letter suggests that we need more flexibility in the Medicaid programs, but he is already cutting many of the "optional" Medicaid benefits that help thousands of Connecticut residents

We urge you to oppose the Bush Administration's Medicaid proposal as supported by Governor Rowland. It induces states to block grant their Medicaid programs. It also offers states the flexibility to make cuts and curtail coverage, but doesn't offer enough resources to assist states that want to meet the growing needs of their unique populations and circumstances or to try innovative approaches to expanding health coverage. With fewer federal rules, budget pressures may lead states to limit beneficiary access through waiting lists and high cost-sharing requirements. Provider payments are likely to be further squeezed. States will be tempted to use new Medicaid spending flexibility to deal with other pressing priorities, such as bioterrorism and disaster preparedness.

CCAG 139 Vanderbilt Avenue, West Hartford Connecticut 06110
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HEALTH CARE FOR ALL COALITION

Medicaid cuts are a drag on our economy. Medicaid and other Connecticut programs provide health care, nursing home care and prescription drug coverage to more than 350,000 people, about 1 in 10 residents. Connecticut's Medicaid program creates over 30,000 jobs and brings in $3.5 billion in business activity. Overall in this country, for every $1 million that states cut from their Medicaid programs, $3.4 million is lost from the economy.

Rather than jeopardize the Medicaid program that is the cornerstone for providing health care to our most vulnerable population, we urge you to provide immediate financial relief to your states by supporting a temporary increase in the Federal Medical Assistance Percentage (FMAP). The best way to help your state is to co-sponsor and support H.R. 816, the King-Brown State Fiscal Relief Act. Connecticut's share of this bipartisan proposal bill will bring in approximately $71 million so that we can provide urgently needed health care services for low-income children, seniors, and people with disabilities.

Sincerely,

Gretchen Vivier,Director
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On behalf of:

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CT Citizens Coalition for Nursing Home Reform
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Middletown, CT

National Council of Jewish Women
Judy Singer, CT Public Affairs Chairwoman
Representing 1000 members in Connecticut

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Coalition to End Child Poverty in Connecticut
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CT Alliance for Basic Human Needs
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Connecticut Council of Child and Adolescent Psychiatry
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Marilyn Tyszka

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CT Council on Developmental Disabilities
Margaret Cohan, Chair,

The Social Justice Committee of the Unitarian Universalist Society: East
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PRESERVING & STRENGTHENING MEDICAID

TESTIMONY FOR THE RECORD SUBMITTED BY
REV. MICHAEL D. PLACE, STD
PRESIDENT AND CHIEF EXECUTIVE OFFICER
CATHOLIC HEALTH ASSOCIATION
OF THE UNITED STATES

SUBMITTED TO THE
HOUSE COMMITTEE ON ENERGY AND COMMERCE

MARCH 12, 2003

For more information, please contact Michael Rodgers, Vice President, Public Policy and Advocacy (mrodgers@chausa.org) at 202-296-3993. If you are a member of the press and would like further comment, please contact Fred

As the House Committee on Energy and Commerce convenes to explore proposed changes to the Medicaid program, the Catholic Health Association of the United States (CHA) is pleased to provide this statement for the record. CHA is the national leadership organization representing the Catholic health care ministry. With over 2,000 members, CHA is the nation's largest group of not-for-profit health care sponsors, systems, facilities, health plans, and related organizations. CHA's members provide care to one in every six Americans, either in an acute care or long-term care setting, in communities across the country. We have been caring for the nation's poor and disenfranchised for over 275 years and remain committed to accessible and affordable health care for all. Medicaid is the premiere safety net program in the country, and we must take great care in making sure that as we strive to make improvements in the program, we do not unravel our nation's already fragile safety net.

Medicaid currently provides health coverage for some 47 million Americans—24 million children, 11 million adults in low-income families, and over 13 million elderly and disabled. The annual cost to federal and state governments is now estimated at $250 billion. This program is particularly important in providing care for low-income families and individuals, who have no where else to turn when looking for access to health coverage. In the past decade Medicaid has provided health care to millions of low-income Americans, particularly children, who otherwise would have been uninsured. While children and their parents make up 73 percent of Medicaid beneficiaries, *they constitute only one quarter of its spending*, with the rest going towards care of the elderly and disabled. Medicaid is also a primary source of funding for America's safety net institutions, including many Catholic hospitals, which serve a disproportionate share of the low-income uninsured and underinsured individuals in their communities every day. These individuals come to our nation's emergency rooms with nowhere else to turn for care and rely on us to make sure that their health care needs are addressed.

Medicaid has proven to be a stable and adaptable framework for providing health care. After nearly 40 years in existence, Medicaid has changed and grown, offering an

infrastructure flexible enough to face the new challenges in health care today. Medicaid works with diverse clients and providers and has adapted to changes in the health care market such as the advent of managed care. For example, according to the Kaiser Family Foundation, more than half of all beneficiaries and the bulk of children covered receive care under managed care arrangements. Medicaid's administrative costs account for less than five percent of total costs. Medicaid has demonstrated its ability to be a highly effective and efficient joint federal-state program that has been able to adapt to a changing constituency group. Medicaid programs across the country have been and continue to be "laboratories for innovation." However, we still have much to learn.

With millions of Americans depending on Medicaid and the State Children's Health Insurance Program (SCHIP) for health insurance, states are feeling the fiscal burden of providing care for our nation's most vulnerable. Medicaid expenditures comprise as much as 20 percent of many state budgets. As a result, it is a frequent target for cuts during trying economic times. Strong economic growth during the 1990s allowed states to bolster and strengthen their programs. Now many are considering limiting, or in fact, already have limited eligibility, reduced benefits and provider reimbursements, or increased cost sharing in order to balance their budgets. Yet cutting Medicaid spending is not really a means of containing health care costs – it simply shifts the costs to other parts of the health care system and to individuals who are least able to afford it.

In recent years federal and state policy makers have attempted to contain Medicaid's spending growth and provide greater flexibility to states in coordinating health programs. In 2001, Health and Human Services Secretary Tommy Thompson proposed the Health Insurance Flexibility and Accountability Initiative (HIFA Waivers) to give states more flexibility to coordinate their Medicaid programs. This initiative is intended to expand access to health care coverage by giving states more flexibility in designing their benefit packages, coordinating Medicaid and SCHIP with private-sector insurance programs, and creating incentives for streamlining administration and application

procedures. The Catholic health ministry remains concerned that under the waiver initiative a state could scale back Medicaid benefits and/or increase cost sharing without any appreciable benefit to the uninsured. For example, a recently approved HIFA waiver in the state of Utah provides primary care coverage to adults who do not qualify for Medicaid (incomes range between 0 - 150% of poverty; some are currently covered under a state-funded medical assistance program). This expansion population would receive limited basic health services, with an emphasis on preventive care. Benefits are limited to routine physician services and pharmacy coverage. This waiver provides no coverage for hospital (other than emergency) care, specialty care, mental health or substance abuse services to this population.

CHA acknowledges the tremendous fiscal challenge this program presents for federal and state government in light of the current economic downturn. However, as a society, we must remain committed to providing accessible and affordable health care for all, particularly the most vulnerable among us. The fundamental structure of the Medicaid program – as an entitlement for low-income families, the elderly, and the disabled in our country must be preserved and strengthened. Today Medicaid provides the safety net not only for its beneficiaries but for the states as well through the program's commitment to matching federal funds. That commitment must continue and the federal partnership with the states must be strengthened.

While the Catholic health ministry continues to advocate the retention of the Medicaid program as an entitlement with a strong federal presence and the overall expansion of the program to include more low-income persons and their families, CHA also would support a dialogue around innovative approaches that seek to achieve more effective and efficient mechanisms of providing care within the overall entitlement structure. In addition, CHA calls on Congress to move immediately to temporarily increase the Federal Medicaid Assistance Percentage (FMAP) to prevent any further erosion of the current program. Our societal commitment to provide access to health care must be preserved. The issues of benefit structure, cost sharing, eligibility, and access must be

safeguarded. CHA will work to build on the bipartisan spirit that was fostered during our discussions regarding the inception of the very successful SCHIP program in 1997 and seek federal protections for coverage for low-income children, pregnant woman, legal immigrants and parents of SCHIP eligible children under these programs.

We encourage discussions of a more rational approach to long-term care financing and, in particular, to more efficient and effective ways to deliver services to persons dually eligible for benefits under Medicare and Medicaid. CHA also will seek opportunities to strengthen Medicaid by ensuring adequate funding to stabilize access to quality health care for these very worthy populations.

In order to assure continued access to services - however the program is structured - attention must be paid to Medicaid payment rates for all providers. When Medicaid payment rates fail to keep pace with the cost of providing care, access to care for Medicaid beneficiaries is impacted. Provider reimbursement under Medicaid must be sufficient to foster access to care and avoid the creation of a two-tiered system of care for the poor and vulnerable in our society. Medicaid must continue to offer adequate protections for those who would otherwise be left with nowhere else to turn.

Medicaid represents a measure of how we, as a just society and the wealthiest nation in the world, treat the poorest and most vulnerable among us. In the absence of accessible and affordable health care for all, Medicaid is the critical and important link in our nation's safety net. CHA urges Congress at this critical juncture to make decisions that will preserve and strengthen this joint federal-state program.

March of Dimes
Birth Defects Foundation

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Washington, DC 20036
Telephone (202) 659-1500
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Press Statement

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March of Dimes Says Medicaid and SCHIP Are Critical To the Health and Well Being of Women and Children

Washington, D.C., March 12, 2003— The following is a statement by Dr. Jennifer L. Howse (pronounced HOUSE), president of the March of Dimes, on the U.S. House of Representatives' Committee on Energy and Commerce, Subcommittee on Health hearing entitled, "Medicaid Today: The States' Perspective."

"On behalf of the March of Dimes, I commend Subcommittee Chairman, Michael Bilirakis (R-Fla.) and Ranking Member Sherrod Brown (D-Ohio), for holding today's hearing to consider changes in the Medicaid and State Children's Health Insurance Programs (SCHIP) proposed by the Administration.

"We at the Foundation believe that Congress must weigh in to help States facing serious fiscal challenges. But because of the critical role Medicaid and SCHIP play in providing coverage to women of childbearing age—particularly those who are pregnant—as well as to their infants and children, it is important to follow the spirit of the Hippocratic Oath, 'first do no harm.'

"As major sources of health care financing for women and children, Medicaid and SCHIP are critical to the health and well being of some of the most vulnerable members of society. In 2000, almost 22 million children and more than one-third of births that occurred in hospitals (1.4 million) were insured by Medicaid. And in 2001, almost 5 million children relied on SCHIP as their source of health insurance.

"These programs are particularly important when families face major medical expenses. In fact, data from the Agency for Healthcare Research and Quality show that about 50% of hospital stays for preterm and low birthweight infants and 40% of infant and child hospital stays due to birth defects—the leading cause of infant mortality—were covered by Medicaid in 2000.

"Because Medicaid and SCHIP are vital sources of coverage for women, infants and children, changing the structure or financing of these programs should be done only if careful deliberations demonstrate that improvements are needed. Moreover, any program modifications should be designed to ensure that services for these highly vulnerable populations are not put at risk.

"The 3 million volunteers and 1500 staff of the March of Dimes located in every state, the District of Columbia and Puerto Rico look forward to working with Members of Congress and the Administration as well as with Governors and State legislators to improve the effectiveness of both of these important health programs."

The March of Dimes is a national voluntary health agency whose mission is to improve the health of children by preventing birth defects and infant mortality. Founded in 1938, the March of Dimes funds programs of research, community services, education, and advocacy. For more information, visit the March of Dimes Web site at www.marchofdimes.com, its Spanish Web site at www.nacersano.org, or call 1-888-MODIMES.

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National Citizens' Coalition for
NURSING HOME REFORM

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March 12, 2003

The Honorable Billy Tauzin, Chairman
The Honorable John Dingell, Ranking Member
Committee on Energy and Commerce
United States House of Representatives
Washington, DC 20515

Dear Representative Tauzin and Representative Dingell:

Over the past several decades, the Congress of the United States has made tremendous strides in legislation to preserve the dignity, health and safety of Americans when they need long term care. These laws were enacted, often, after years of government studies and congressional testimony had demonstrated tragic consequences of the federal government's failure to use its protective authority. As you consider Medicaid reform, we urge you not to weaken or eliminate these hard-won protections.

Any proposal to grant states flexibility in the care of optional beneficiaries must recognize that eighty-five to 90 percent of Medicaid recipients in nursing homes are optional beneficiaries. Many of these are "medically needy," people whose incomes are too high for public assistance but who qualify for Medicaid because their life savings are depleted and their nursing home costs exceed their income.

Why Current Medicaid Law Is Important to Nursing Home Residents and Their Families

- Medicaid supports the care of about 70 percent of nursing home residents. About half of these Medicaid beneficiaries spent their life savings on nursing home care before they became eligible for Medicaid.
- Medicaid provides the foundation for the regulation of nursing homes through the Nursing Home Reform Amendments of 1987. This foundation includes health and safety standards, resident assessment and data collection, residents' rights, annual inspections, and enforcement. All residents of Medicaid facilities benefit from these protections.
- "Spousal impoverishment" provisions enacted by Congress in 1988 ensure that spouses of nursing home residents can retain enough of the couple's resources to meet their own needs. Before Congress changed the law, elderly women, especially, were forced into dire poverty so their spouses could qualify for Medicaid nursing home benefits.
- Current law protects the adult children of nursing home residents – who may be paying for their children's education, even be retired themselves – from being forced to contribute to their parents' nursing home care.

- Under current law, states cannot discriminate in the amount or adequacy of services they provide. All beneficiaries must receive the same benefits, and benefits must be sufficient in "amount, duration and scope."

NCCNHR believes that Medicaid should provide greater options for the elderly and disabled to receive long term care in non-nursing home settings. However, expanding coverage of home and community-based care will not work if the only purpose is to move people into less expensive services and not to provide viable, safe alternatives to nursing homes. People who qualify for Medicaid long term care coverage have multiple health care problems, frequently including dementia. Nursing homes are regulated and inspected at least annually to ensure that health and safety standards are met. Assisted living and personal care homes, on the other hand, are poorly regulated in most states and often admit or retain residents whose needs they cannot safely meet.

Congress should not encourage redirection of Medicaid funds to home and community-based care until it enacts minimum federal standards to ensure that beneficiaries do not have to forfeit access to services and protections they need.

Finally, NCCNHR urges the Committee not to approve any Medicaid plan that would diminish federal funds over time or force children and the elderly and disabled to compete with each other for services that both need.

It has been NCCNHR's privilege over the years to work with the Energy and Commerce Committee on efforts to improve the care of long term care residents. There is still much to be done – a year ago the Department of Health and Human Services sent you a report showing that 90 percent of nursing homes are understaffed, more than half of them critically so. With the population rapidly aging, we must find real solutions to funding long term care and ensuring the quality of services for all who receive them. We look forward to continuing to work with you on these issues.

Sincerely,

Donna R. Lenhoff, Esq.
Executive Director

Janet C. Wells
Director of Public Policy

March 11, 2003

The Honorable Billy Tauzin
Chairman, Committee on Energy and Commerce
2125 Rayburn House Office Building
Washington, DC 20515

Dear Chairman Tauzin:

It is with concern for the millions of Americans living with and affected by diabetes that I write on behalf of the American Diabetes Association to formally express reservations about the Medicaid reform proposals put forward by President George W. Bush. The Association believes that legislation mirroring the Administration's proposal would reduce coverage for vital prescription drugs, equipment, supplies and services for poor Americans living with diabetes enrolled in the Medicaid program.

While states currently have some ability to eliminate Medicaid coverage for diabetes items, the Association believes that the Medicaid reform proposals under consideration will create vast gaps in diabetes care. These gaps will occur because the minimal coverage requirements being proposed will result in program standards for diabetes care that rest solely at the state level. Under such a program design, states would have the power to spend certain federal resources and their own Medicaid dollars as they see fit - potentially leading many states to ignore chronic diseases like diabetes.

Providing states with flexibility to design "optional" Medicaid benefits for "optional populations" will place hundreds of thousands of people with diabetes at risk of losing life sustaining therapies like insulin, syringes, blood glucose monitoring supplies and oral medications. Actions taken to date in California, Oregon, Ohio and Massachusetts suggest that states will use the flexibility offered by this proposal to design benefit programs for Medicaid that do not cover basic diabetes self-management tools needed to prevent life-threatening diabetes related complications.

Services like eye exams to prevent diabetes retinopathy, foot exams to prevent amputations and diabetes self-management training could also be cut from Medicaid programs as a result of increased flexibility. It is important to note that each of these services is a guaranteed benefit for our nation's seniors in the Medicare program. No such benefit guarantees for our nation's poor appear to exist under the proposals put forward to date.

States are under tremendous financial stress from the Medicaid program. Countless people living with diabetes have already lost Medicaid benefits this year. If people living with diabetes are removed from the Medicaid program or, conversely, if diabetes benefits and related benefit guarantees are removed from the program, it is certain that many Americans will develop diabetes complications like heart disease and stroke, blindness, kidney failure and amputations. The result of a rise in these complications will be a growing dependence on welfare programs like Supplemental Security Income by people living with diabetes and an increased enrollment in Medicare's end stage renal disease program.

The ADA recently released a study demonstrating that diabetes costs the United States approximately $132 billion dollars annually. If low-income people are denied access to necessary care and supplies under Medicaid, this number will surely rise due to the lack of vital treatment so many people depend upon.

States are also likely to see a rise in emergency room visits and inpatient hospital stays for unmanaged diabetes. Given the duress that states are under, the Association believes that providing immediate financial relief to state Medicaid programs is appropriate. Legislation is pending in the U.S. House of Representatives and the U.S. Senate to provide states with some funding to meet Medicaid obligations.

The Association also believes that a constructive approach to battle the epidemic of diabetes is to create a diabetes specific waiver for the Medicaid program. Based loosely on the breast and cervical cancer waiver program, this effort would allow states to enroll uninsured poor Americans with diabetes in their Medicaid program to receive comprehensive diabetes benefits. Placing poor uninsured Americans with diabetes in the Medicaid program will reduce the number of people with diabetes living with the complications of diabetes, allow people to remain productive members of the workforce for a longer period of time and reduce the financial burden of diabetes on state and federal welfare and safety net programs.

In conclusion, the loss of Medicaid protections that guarantee access to diabetes benefits will result in our nation paying the price for the provision of inadequate diabetes care. This price will consist of greater health costs, lost productivity and a worsening quality of life for Americans due to a dramatic increase in diabetes related complications.

At a time when the diabetes epidemic is worsening, and costs are rising; relaxing laws governing the Medicaid benefits that states provide to people living with the disease is unwise. The loss of Medicaid protections for people with diabetes will turn the clock of diabetes care back at least a decade.

The American Diabetes Association stands ready to work with you to improve the Medicaid program and to protect Medicaid benefits that are vital to people living with diabetes.

Sincerely,

R. Stewart Perry, Chair
Advocacy Committee

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