



**Written Statement of Consumers Union  
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submitted to the  
Energy and Commerce Committee  
U.S. House of Representatives  
September 8, 2005**

**“Medicaid: Empowering Beneficiaries on the Road to Reform”**

Mr. Chairman, Members of the Committee:

Consumers Union is the independent, non-profit publisher of *Consumer Reports*. We have done extensive work over the years on consumer health insurance issues and on helping consumers get the ‘best buy’ in safe, effective prescription drugs.

**We urge Congress to reconsider and reject the idea of Medicaid cuts at this time.** Instead of Medicaid cuts, Congress should increase funding of Medicaid as part of the Katrina emergency bills to meet the health care needs of the victims and the financial needs of the impacted States.

Because of Katrina, individuals, states, and local governments will be facing billions of dollars of additional Medicaid costs. This is not the time to be cutting or disrupting this key safety net program or in anyway hurting enrollees. Even without Katrina, Medicaid cuts are inadvisable: the latest Census Bureau data show increasing rates of poverty, a widening gap between the rich and poor, and an increase in the number of Americans without health insurance. If it had not been for Medicaid enrollment growth in 2004, the number of uninsured would have increased by about another two million Americans. We believe that making Medicaid cuts now, as part of a budget process that includes huge tax cuts, many of which go to the highest income families, is unwise. If Congress makes any changes in Medicaid which do not hurt enrollees (such as reforming the AWP system or enacting anti-fraud provisions), the savings should be reinvested in the program to help in this time of disaster.

We would like to make three other points at today’s hearing for consideration at such time as Congress does make changes in Medicaid:

1. We oppose increases in health premiums, co-pays, or deductibles for low income Medicaid enrollees. As the August Census Bureau data showed, the percentage of Americans living in poverty is increasing. If Congress shifts further health care costs onto

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these low income citizens, many will be forced to do without health care services, their health will suffer, and the long-term treatment costs to the nation will increase.

There is already a range of co-pays in Medicaid prescription drug and other services. We urge that Congress encourage the use of preferred drugs by requiring States to apply the lowest copay to those drugs and the higher (up to approximately \$3) copay to the use of non-preferred drugs. **The key to this recommendation is the definition of preferred drugs. States should include on their list of preferred drugs the medicines that have been proven, through a transparent, scientific, evidence-based process, to be the most effective drugs and the drugs that have the fewest adverse side effect.**

Currently 14 States are participating in the Drug Effectiveness Review Project (DERP) administered through Oregon's Health and Science University. The DERP project uses a rigorous, public (transparent) study of the best scientific evidence to determine what drugs are the safest and most effective.<sup>1</sup> Most of the DERP member States use the information provided by DERP to help develop their State preferred drug lists. The States can use the DERP information to make the best drugs available. And since the scientific evidence shows that (contrary to advertisements) many drugs are equally effective and safe, the States can then obtain major savings by negotiating with the manufacturers of the best, comparable drugs to obtain discounts as a condition for being placed on the preferred list. **Thus the patients get effective, safe drugs as determined by the most up-to-date science, and the States get enormous savings.** The States of Washington and Missouri have documented major savings from moving to a DERP-type preferred drug list.

Because of the importance of maintaining an open drug list for certain diseases and illnesses where patients may have been stabilized on a particular drug, we recommend that this preferred drug system not be applied to the six areas identified by CMS in the Part D program<sup>2</sup> and that instead, in these areas, States provide an open formulary.

Consumers Union urges you to spell out this type of evidence-based approach to the co-pay differential in prescription drugs. This is the only way that we can be sure low-income people get good medicines at the same time that the States get dollar savings. Let me be clear however: states that make price the primary factor in choosing a drug on its preferred list, minimizing or ignoring the importance of effectiveness and safety, will ultimately not see cost savings and may risk the health of Medicaid beneficiaries.

To repeat, we urge Congress not to raise drug co-pays for preferred drugs for Medicaid beneficiaries. We do urge you to employ the current differential co-pay system and use the best science to provide the best medicine at the lowest long-term cost.

2. There is discussion of encouraging more private purchase of long term care insurance policies as a way of reducing the public cost of Medicaid. **Before providing further**

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<sup>1</sup> For example, using DERP data, a number of the States participating in DERP managed to avoid listing Vioxx on their preferred drug lists, thus saving lives and money.

<sup>2</sup>Anti-convulsants, HIV, cancer, anti-depressants, anti-psychotics, and immunosuppressants.

**public funding (directly or indirectly through the tax code) of long term care insurance policies, we urge you to adopt additional consumer protections.** In particular, purchasers of long term care insurance need to be protected against premium increases at a time when their income is fixed or in many cases declining. Despite a number of important reforms in 1996, thousands of consumers have been devastated by soaring premiums in LTC insurance policies and many have been forced to drop their policies, thus seeing their investment wasted.

For example, the July 11, 2005 edition of *The Seattle Times* contains an article by consumer columnist Liz Taylor, entitled, “Why long-term-care insurance rates are rising; growing older.” The reporter described how she bought a Penn Treaty policy in 1997 that she still considers excellent.<sup>3</sup> Yet even that excellently rated policy in a tough regulation state had just increased its premiums 78% over three years! If this is the premium experience with good policies and companies in consumer-friendly states, imagine what is happening elsewhere in the country. The column cites ‘similar large rate increases by Bankers Life & Casualty, Travelers, Consec, Life Investors, and Transamerica. She also signaled out CNA,

“the old industry warhorse, didn’t raise rates for 30 years. Then, in 2003, it stopped selling to individuals and increased rates by 50 percent to all existing individual policyholders. For people late in life on fixed incomes, CNA’s behavior was unconscionable.”

Taxpayer dollars should not be used to promote these flawed consumer products. We hope the Committee will review the consumer experience with these policies and provide stronger consumer protections before it even begins to consider more incentives to this industry.

3. There is also a great deal of discussion about home equity conversion mortgages as a way to tap resources to pay for LTC. Frankly, reverse equity mortgages can be a terribly inefficient way to pay for long-term care. Studies by Consumers Union in California in 1999 and more recent work by the Georgetown University Long-Term Care Financing Project have shown that these mortgages can be an excellent way to take \$100 of home equity and turn it into about \$35 dollars or so of lump sum payment to buy health care. **Consumers Union’s work in California showed that any encouragement of reverse equity mortgages needs to be accompanied by strong and independent consumer counseling and protection services.** In terms of efficiency, the collection of Medicaid-paid LTC costs after the death of the beneficiary (and after any spouse and dependent child has moved on) should be much more efficient than giving away half or more of the value of the home asset to middlemen in the banking and real estate industries. As the March, 2005 Georgetown University report says,

“Home Equity Conversion Mortgages [HECM] are much more costly than direct estate recovery, because of the interest, closing, and service costs that inflate the HECM loan balance.”

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<sup>3</sup> She noted that in 1997 *Consumer Reports* had rated it the best policy out of 127 different policies.

### Saving Money Through Ensuring Safer Drugs

**Finally, we also urge the Committee to enact major safety improvements at the Food and Drug Administration.** The current drug approval and post-approval safety monitoring system is badly broken. The Vioxx and Paxil scandals have shown how data was hidden and distorted, resulting in billions of dollars in unnecessary and unwise prescribing, deaths, and adverse medical events (like heart attacks and strokes). **What is Medicaid's share of those costs?** Congress needs to enact legislation like S. 470 and S. 930 (bills by Senators Grassley and Dodd) and HR 3196 (by Reps. Waxman, Markey, et al.). These types of bills would require the public registration of most clinical trials and the disclosure of results, would give more authority to the FDA to require post approval safety studies and risk management, and limit advertising of drugs during the period in which their true safety is unknown. These bills would not slow down the approval of life-saving drugs, but they would give the FDA more authority to ensure the public safety. If these bills had been law a few years ago, the tragedies resulting from the use of drugs like Vioxx and Paxil might have been avoided, and it is likely there would have been substantial savings to Medicaid.