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MEDICAID: EMPOWERING BENEFICIARIES ON THE ROAD TO REFORM

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BEFORE THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

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MEDICAID: EMPOWERING BENEFICIARIES ON THE ROAD TO REFORM

THURSDAY, SEPTEMBER 8, 2005

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

The committee met, pursuant to notice, at 10:05 a.m., in room 2123, Rayburn House Office Building, Hon. Joe Barton (chairman) presiding.

Members present: Representatives Barton, Bilirakis, Upton, Stearns, Gillmor, Deal, Whitfield, Norwood, Shimkus, Wilson, Shadegg, Bass, Pitts, Walden, Terry, Ferguson, Rogers, Otter, Sullivan, Murphy, Burgess, Blackburn, Dingell, Waxman, Markey, Pallone, Brown, Rush, Eshoo, Stupak, Engel, Wynn, Green, Strickland, DeGette, Capps, Doyle, Allen, Schakowsky, Solis, Baldwin, and Ross.

Staff present: Chuck Clapton, chief counsel, Health Subcommittee; David Rosenfeld, majority counsel; Jeanne Haggerty, majority counsel; Brandon Clark, policy coordinator; and Chad Grant, legislative clerk.

Chairman BARTON. Let me make an announcement about process this morning.

Yesterday's hearing on the energy situation in Katrina I thought showed our committee in a very positive light. We had a good discussion; 45 of the 57 members participated.

Our opening statements yesterday took 2½ hours, so that by the time we got to the second panel it was myself and I think Mr. Stupak was here for part of it and Mr. Rush came in. I am going to ask that the rank in file members try to eliminate your opening statement to 1 minute, but I am not going to enforce it. If somebody feels strongly enough that you want to talk 2 or 3 minutes, that is fine; but we have a distinguished panel here, a lot of witnesses that the minority wanted, and we want to hear from them and then have some questions, and so I would encourage members to be judicious in our opening statements and try to do it within 1 minute, but we are not going to insist that it be a 1-minute statement.

All right. The Chair recognizes himself for an opening statement.

I want to thank our witnesses for their testimonies.

Unlike the devastation recently caused by Hurricane Katrina, the crisis facing Medicaid is a man-made disaster, it is a result of a program that, established with the best of intentions, remains tied to the bureaucratic rules and requirements that were first established back in 1965, over 40 years ago. In those intervening

years, the health care industry has fundamentally changed, but Medicaid has not.

Medicaid was originally established to provide a safety net for the poorest of the poor and the most vulnerable members of our society. It is now one of the largest providers of health services in the Nation, covering a growing percentage of working Americans. These expansions are placing enormous financial pressure on the States and are causing the Medicaid safety net to begin to fray and unravel. This endangers the very people that Medicaid was originally intended to protect and highlights the primary need we need to reform Medicaid.

State Governors have recognized the need to create a 21st century Medicaid. That is why a bipartisan group of Governors led by Republican Governor Huckaby and Democratic Governor Warner have been working for months to develop a plan to strengthen and improve Medicaid. Their plan recommends several common sense reforms, including allowing States to charge basic copays to higher income beneficiaries, reducing Medicaid overpayment for drugs and making it more difficult for wealthy seniors to shift or hide assets in order to qualify for Medicaid coverage for nursing home services. These are thoughtful policies that will strengthen and improve the Medicaid program.

I hope that in the next few weeks the Energy and Commerce Committee will mark up legislation that is similar to many of the Governors' bipartisan reformed proposals. These proposals will begin to build a Medicaid program for the 21st century that empowers Medicaid beneficiaries, increases their access to health care, and improves the quality of care that they actually receive.

Some critics are going to challenge the premise that Medicaid can be improved, or that we can achieve some modest savings from reforming the modern program. They are going to argue that any change hurts the poor. They ignore, however, how the system is already hurting the poor. Between 2002 and 2005, 38 of the 50 States have reduced eligibility, 34 States have reduced benefits. This year hundreds of thousands of beneficiaries are losing Medicaid eligibility and facing reduced benefits; that is under the current system. Their safety net is rotting away as we stand by and watch.

Whether Medicaid changes is no longer in question, the question is, how will we begin to transfer this program so that we continue to help the neediest of the needy in our country, are we going to stand by and allow it to literally rot away?

Some critics are also going to attempt to use the devastation caused by Hurricane Katrina as a justification to block Medicaid reform. They are going to argue that we cannot impose new burdens on Medicaid beneficiaries at a time when many have lost everything. I have great sympathy for the victims of Hurricane Katrina, but the arguments about using that to block Medicaid are patently false. Evacuees from Hurricane Katrina will not be put in jeopardy because of these reform proposals. Let's say that again, evacuees from Hurricane Katrina are not going to be hurt. We are going to do everything we can to help the victims of Hurricane Katrina. If we need to be specific in any pending legislation or new legislation, we will do that, but the reforms we are talking about

are long term, they will help the very States that are trying to deal with Katrina. We are going to work with the Governors in the affected States and the Governors of the States surrounding the affected States that are taking care of the victims of Hurricane Katrina.

Creating a Medicaid program for the 21st century is not just about saving money, it is about preserving the basic safety net that protects our Nation's poor. If we cannot reform Medicaid, we are going to put those very beneficiaries at grave risk.

So I hope that we have a good hearing today. In fact I know we are going to have a good hearing, and I look forward to listening to the witnesses and, more importantly, listening to the questions and comments of the members of this committee.

[The prepared statement of Hon. Joe Barton follows:]

PREPARED STATEMENT OF HON. JOE BARTON, CHAIRMAN, COMMITTEE ON ENERGY AND COMMERCE

Good Morning. Let me first thank our witnesses for their testimony, which will provide valuable perspectives on the crisis facing Medicaid.

Unlike the devastation recently caused by Hurricane Katrina, the crisis facing Medicaid is a man made disaster. It is the result of a program that, while established with the best of intentions, remains tied to the bureaucratic rules and requirements that were first established in 1965. Over the intervening 40 years, health care in this country has fundamentally changed, but Medicaid has failed to keep up.

Medicaid was originally established to provide a safety net for the poorest and most vulnerable members of society. It has since grown into one of the largest providers of health care services in the nation, covering a growing percentage of working Americans. These expansions are placing enormous financial pressure on the states, and are causing the Medicaid safety net to begin to fray and unravel. This endangers the very persons that Medicaid was originally intended to protect, and highlights why we need to reform Medicaid.

State governors have recognized the need to create a 21st Century Medicaid program and respond to the threats to beneficiaries' access to care. That is why a bipartisan group of governors, led by Governors Hucakbee and Warner has been working for months to develop a plan to strengthen and improve Medicaid. Their plan recommends several common sense reforms, including allowing states to charge basic co-pays to higher income beneficiaries, reducing Medicaid overpayments for drugs and making it more difficult for wealthy seniors to shift or hide assets in order to qualify for Medicaid coverage of nursing home services.

These are thoughtful policies that will strengthen and improve the Medicaid program. I expect that, within the next few weeks, the Energy & Commerce Committee will mark up legislation that is very similar to many of the Governors' bipartisan proposals. These proposals will begin to build a Medicaid program for the 21st Century that will empower Medicaid beneficiaries, increase their access to healthcare and improve the quality of care they receive.

Nevertheless, some critics continue to challenge the premise that Medicaid can be improved or that we can achieve modest savings from reforming the program. They argue any change to the system will hurt the poor. They conveniently ignore, however, how the system is already hurting the poor. Between 2002 and 2005, 38 states reduced eligibility; and 34 states reduced benefits. This year, hundreds of thousands of beneficiaries are losing Medicaid eligibility or facing reduced benefits. Their safety net is rotting away, as we stand by and watch. Whether Medicaid changes is no longer in question—the only question now is whether we will begin to transform this program or stand-by and allow it to implode.

Some critics may also attempt to use the devastation caused by Hurricane Katrina as a justification to block Medicaid reform. They will argue that we cannot impose new burdens on Medicaid beneficiaries at a time when many have lost everything. These arguments are patently false. Evacuees from Hurricane Katrina will not be put in any jeopardy because of these reform proposals. Let me repeat, so that everybody hears me—evacuees from Hurricane Katrina would not be hurt! Also, these reforms will help the very States that are trying to deal with Katrina. We will also work directly with Governor Barbour and the other governors over the next few

weeks to provide them with immediate assistance so that they can continue to meet the health care needs of all of the victims of Hurricane Katrina.

Creating a Medicaid program for the 21st Century is about much more than savings—it is also about preserving the healthcare safety net that protects the nation's poor. If we cannot make reform Medicaid, we will put the beneficiaries who depend on the program at grave risk. Doing nothing is simply not an option.

Chairman BARTON. With that, I recognize my very distinguished ranking member, Mr. Dingell, for an opening statement.

Mr. DINGELL. Mr. Chairman, first of all, we on this side thank you for your cooperation to us in preparing this hearing. The issues before us today we think are of exquisite importance to this country, and especially to those in most desperate need, a matter of which is highlighted by the events which we see going on in the Gulf States following Katrina.

Today, Mr. Chairman, we are going to hear from people who are directly and negatively affected by the cuts proposed. We have heard from Governors Warner and Huckabee about the National Governors' proposal. We know that significant parts of this proposal would shift costs that are already shared by the Federal and State governments onto the backs of families struggling to make ends meet.

I hope that some of what we are hearing today from those representing infants and children, individuals living with disabilities, the elderly, will give Congress pause about cutting Medicaid at this time. This is a program that provides health insurance for more than 50 million Americans. Coverage under Medicaid and State Children's Health Insurance Program, CHIP, rose from 12 percent in 2003 to 12.9 percent in 2004. These increases helped offset the reduction of private employers sponsored insurance and kept the percentage of uninsured Americans, including children, from rising in 2004.

Some of the proposals brought forward by the Governors and by the Bush administration will have serious consequences for the health of seniors. One, it will evict poor and elderly from nursing homes or deny them admission when they need care. Two, new cost sharing burdens on the poorest of the poor will result. These will result in higher medical costs to everyone later on. Three, it will reduce benefits for children that will affect their ability to grow and develop properly. Four, uncompensated care for providers, many of whom are forced to absorb the unpaid cost of their care of term patients, will find themselves in a worst situation than they are today.

The proposed cuts to Medicaid are unwise to say the least. They are couched in terms of flexibility to allow States to more effectively manage their programs, but it is really flexibility to design State Medicaid programs in a way that would cause many needy families already struggling to meet ends to loose their only health care coverage.

We all know of the unprecedented disaster that struck our gulf coast, we know the magnitude of the damage, and we know how it is going to take us a long time to restore lives and property, those who are affected, to anything close to normal, but we do not know how the greatest health care needs will be met if we make the cuts suggested here.

Health care coverage is absolutely imperative to those families trying to get their lives back together. At this time, we should not be cutting Medicaid but shoring it up and getting States the Federal assistance they will need to care for a huge influx of hurricane survivors. Medicaid is one of our Nation's critical safety nets. It has been there to serve those in need in disasters in the past, and it must be there for those who will need it now, and that includes not only persons who are going to have health problems, but the health care system, the providers, and also the Governors and the States.

I want to welcome today's witnesses, who bring a human face to Medicaid, a program that protects tens of millions of our most vulnerable citizens, including those near the end of their lives, and those just beginning their lives, and those most helpless in confronting the hideous costs which they have.

I thank you again, Mr. Chairman, for recognizing me, and I thank you also for your cooperation in bringing this hearing about. Thank you, and I yield back the balance of my time.

Chairman BARTON. Pleasure to work with you, Congressman Dingell, on these issues.

We are going to recognize the subcommittee chairman, Mr. Nathan Deal of Georgia, for 3 minutes.

Mr. DEAL. Thank you, Mr. Chairman, and I thank you for your opening statement.

I want to express appreciation to the continued follow up that we have had from our first hearing in which we heard from the National Governors' Association and have continued to work with their staff on a bipartisan basis as we have tried to develop legislation that conforms to the request that the Governors have made on a unanimous basis across this country saying that Medicaid is a system that is broken and needs to be reformed, and that as partners with us in this Federal program that they are requesting that we make changes in order to keep the program alive and service the needs of the constituents of the various States.

Mr. Chairman, I will not use all of my time, but I did want to use a portion of it to welcome one of the members of the panel, my good friend Mr. Gardner from my hometown of Gainesville, Georgia. Jim is the President and CEO of the Northeast Georgia Health System, which is one of the largest health care providers in our State; in fact it is the largest Medicaid OB and ER provider in northeast Georgia.

Jim comes to his position from the home State of one of our colleagues, Ms. Cuban, in Wyoming, where he had been the CEO of the Wyoming Medical Center, which is the largest health care provider in that State, before coming to our State of Georgia.

Jim was educated at University of Virginia, and also has a Master's in health care administration from the Medical College of Virginia. He has been in this business for some 21 years. He has served in a variety of capacities across our country, both in the for profit, the not for profit and the not for profit faith-based hospital settings, so he comes to us with a wide breadth of knowledge and understanding.

In his current capacity as CEO of the hospital in my area, he has 3,200 full-time employees, a $400 million net operating revenue, and is one of the pioneers in a free-standing not for profit health

care system in our State. So I am pleased to have Jim Gardner as a member of this panel.

And I would also like to say to the other members of our panel, thank you all for coming. We recognize that you make sacrifices to appear before our committee. We thank you for your insights and your perspectives.

We will certainly hear differences of opinion today, but that is not unusual to any of you as you have served in your various capacities in the health care system of our country, and we thank you for your presence.

With that, Mr. Chairman, I yield back.

Chairman BARTON. We thank the gentleman and we welcome his constituent, Mr. Gardner. I know a Jim Gardner in Texas, he is from my hometown. He is a banker, a very successful banker.

Mr. DEAL. He served in many hospitals in your State, Mr. Chairman, as a CEO.

Chairman BARTON. We are now going to recognize the ranking member of the Health Subcommittee, the distinguished Mr. Sherrod Brown of Ohio, for 3 minutes.

Mr. BROWN. Thank you, Mr. Chairman.

Hurricane Katrina, as we know, is a wakeup call. If we heed today's hearing we will unite our committee behind a common goal, not divide it across party lines.

Katrina put a human face on hardship. It reminded us that there are Americans who work hard and play by the rules and pay their taxes, but are still hanging on by a thread. It reminded us how easily that thread can break, and in the clearest terms possible it communicated the value of both the tangible and intangible of government assistance.

Working together, members of the committee can engage our fellow public servants in a Medicaid reform initiative that this time will be an effort to reform policymakers, not policy. Our Nation's leaders must stop blaming the poor for needing the same health care we do; helping them secure it isn't an extravagance, it is an expression of American values. Health care is expensive. No one on this committee has figured out a good way to contain costs without medical progress. Our Nation's leaders must stop pretending that taking health care away from the poor solves that dilemma. They must stop pretending that the poor take advantage of Medicaid as if enrollees look for excuses to visit the doctor. The Nation's leaders must stop pretending that taking health care away from the poor won't hurt them. It is a convenient theory, it is also false.

Hurricane Katrina forced this Nation, at least for a while, to see the world through the eyes of Americans living in poverty. It is a grim reminder that Americans from all walks of life can be financially independent 1 day and in desperate straits the next day. A natural disaster, a catastrophic illness, a stock market crash, an aging parent, a sick child, that is all it takes. Katrina reminds us of when Americans witness human suffering they do everything in their power to alleviate it.

Medicaid is the Nation's insurer of last resort. Medicaid serves people who have no resources of their own. In Louisiana, Mississippi and Alabama we have seen what that kind of poverty looks like. Some policymakers propose saving money by increasing the

cost sharing burden on Medicaid enrollees, people who already ration every dollar they have to cover basic necessities. This committee should dismiss any proposal that robs from the poor to give to the poor. We should dismiss any proposal that cuts Medicaid when the need for it has never been greater. That doesn't mean we shouldn't do anything. We must ensure that Medicaid is available to hurricane victims, we should federally finance 100 percent of hurricane-related Medicaid spending. It can be effectively deployed to help the victims recover their health and rebuild their lives if the Federal Government invests in that priority. And we can and should reduce fraud, waste and abuse from Medicaid. Any dollar saved should be reinvested to protect existing coverage and reach more people in need.

Hurricane Katrina indeed was a wakeup call, we should heed it. Americans help those in need, we don't make scapegoats of them.

Thank you, Mr. Chairman.

Chairman BARTON. Thank you. We are now going to do the rest of the opening statements. You are going to have an option of no statement, which gives you 1 extra minute in the question period, 1 minute or 3 minutes. So you get your choice of deferring and getting an extra minute, taking a minute now or taking a 3-minute now. I am going on start with Mr. Bilirakis. What is your preference?

Mr. BILIRAKIS. I am going to waive my opening statement, but I want to welcome the panel, particularly my fellow Floridian, Dr. Thomas Thames. Welcome, sir. And I waive opening statement.

Chairman BARTON. Mr. Upton, did you wish to——

Mr. UPTON. Hopefully I will take less than a minute for an opening statement.

I appreciate your leadership and the work of Mr. Deal and others. We have had a lot of hearings on Medicaid and we have heard complaints both here and in our district about the way the system works. Frankly, I don't think there are a lot of us here who think that doing nothing is the right option. We have heard from beneficiaries, providers, our Governors. This is a partnership program that Governors have the lead on, and I for one am not focused on cutting Medicaid, I am instead putting policy over the budget process. We need a policy to work and we need to listen to our Governors. We know that this program is increasing by about three times over inflation, hundreds of billions of dollars over the next couple of years, but our focus should be on reform and working with the Governors to continue to let them have the lead, Republican and Democratic Governors, by the way, to make this program have some sense.

I yield back my 6 seconds.

Chairman BARTON. What is Mr. Waxman's pleasure? Three minutes, 1 minute or defer?

Mr. WAXMAN. I will take 1 minute with an option to 3, and I want to know if I can get a 3-minute addition if I waive my opening statement?

Chairman BARTON. No. It doesn't come with fries either.

Mr. WAXMAN. I will take 3 minutes.

Mr. Chairman and my colleagues, welcome all the witnesses that are here today. I fear that what you all have to say—and even the

fact of a hurricane displacing the health care needs of thousands of Americans will not make much difference if this committee is intent to making a $10 million cut in the Medicaid program. I think it is unthinkable. This is a partnership program between the States and the Federal Government, but it is not for their benefit, it is for the benefit of the very vulnerable poor in America. And they are going to be bearing the brunt of these proposals.

And what is the best example of that? The money that may be saved through so-called reform is not going to be reinvested in Medicaid, it is going to be deducted from the Federal share of the Medicaid program. While the health care needs of people whose lives were ravaged by Hurricane Katrina will be great, the demand of the health care system across the country will be high. These people are scattered throughout the Nation. States are going to be called upon to help pay for their Medicaid needs. We ought to be doing something to help those States and those people.

It brings into stark relief a point that we made over and over again in the Medicaid debate. The program is a critical one, not just to the victims of Katrina, but for very, very poor people, 54 million vulnerable Americans. And it is truly a matter of life or death for people who depend on it. It is a program that is there to respond to these unforeseen disasters. It needs more Federal support. Any savings that result in sensible reforms ought to be turned back to the program in the form of increased support, not just simply deducted from it.

Most of the so-called reforms that this committee is intending to enact are bad for the beneficiaries who depend on Medicaid. Let's be crystal clear about that. People who have nothing are going to be asked to pay more in copayments or lose their necessary services if they cannot. People who are disabled or frail or old, maybe even suffering from Alzheimer's or other chronic conditions, will have barriers put in their way if they need home and community-based services or nursing home care. If they inadvertently transferred assets, they may find someone to pay the bill, unlikely, they may not even be able to find a nursing home that will take them if they fall into this big chasm that we are creating for them.

These policies have one point in common, make the poor person pay, that is not what we should be doing here. Cutting Medicaid, and especially in the face of the tragedy caused by Hurricane Katrina, is simply not right. I look forward to the testimony, and I hope some of you will say something that might penetrate those who have a proposal that I think is already heading down the tracks.

Chairman BARTON. I thank the gentleman.

Mr. Norwood, 1 minute, 3-minute or defer?

Mr. NORWOOD. Mr. Chairman, I will also pass, but I do want to welcome Jim Gardner, who is from Georgia and has a great deal of health care facilities in my district. Welcome, Jim.

Chairman BARTON. Mrs. Wilson.

Mrs. WILSON. Thank you, Mr. Chairman, I will give an opening statement.

Chairman BARTON. One or three?

Mrs. WILSON. Three, sir.

Chairman BARTON. The gentlelady is recognized.

Mrs. WILSON. Thank you, Mr. Chairman.

I wanted to commend Chairman Deal for all the work that he has done on Medicaid and beginning to identify some of the changes that need to be made in order to improve Medicaid.

I believe that Medicaid is desperately in need of reform because it doesn't improve the health status of those who depend upon it. It doesn't work very well for people who really need it, but I am concerned that we are moving forward within artificial constraints, particularly driven by budget time lines. I believe that the context in which we operate here has changed profoundly over the last 10 days, and I believe that reconciliation should be postponed.

More broadly, I think we need policy to drive the budget, and I believe that this committee has the capacity to identify big ideas and move them forward.

We have seen three of the States most dependent on Medicaid who now have lost all of their State assets from match. We have seen a million people displaced to other States, and I would like to insert into the record a letter from my Governor describing a conference, teleconference with States affected by Medicaid where States are asked to either bill Louisiana and Mississippi or to apply for a waiver for people who pretty easily passed the asset test and should be covered under presumptive eligibility, and I would ask unanimous consent to enter that into the record.

This is a system that is not responsive to the people who need it most, and it needs to be reformed, but I am not sure we are on the track to effectively do that, and we need to focus on the health status of those who need it most.

I yield the balance of my time.

Chairman BARTON. The gentlelady yield backs.

Mr. Markey.

Mr. MARKEY. Three minutes, please.

Chairman BARTON. The gentleman is recognized.

Mr. MARKEY. Today, a white hot spotlight is shining on what could be a very black mark on this Congress, the enforcement of budget cuts against the poor while money continues to be shoveled out the door to the richest fat cats and the biggest corporations in the form of tax cuts, subsidies, royalty relief and other gems of tax avoidance and greed, and that was before the hurricane hit. Now the question is squarely on the table, is this Republican Congress going to stay the course on cuts to the least fortunate Americans, to those whom disaster, health emergencies and poverty have brought low?

Fundamentally this is a moral question, not a budget question. If the budget mattered to this Congress, the tax cuts would have been canceled after 9/11 but they weren't. They should have been canceled after the administration decided to start a war, but they were not. Now the safety net is down for all to see and billions more are needed to rebuild the gulf coast and yet here we are engaged in the process of deciding how many more poor or near poor families should be asked to pay more so that changes don't have to be made in tax cuts for the rich.

As we consider a cut of $10 billion in Medicaid, it is to go to ensure that 53 percent of the benefits of these capital gains and dividend tax breaks go to people who make more than $1 million a

year. That is just morally wrong at this time. Forty percent of all babies in our country are born on Medicaid, two-thirds of all people in nursing homes are on Medicaid, 90 percent of all HIV children are on Medicaid. Half of all mental health in our country are on Medicaid. If we have some savings that we might be able to get from reform, it should go back into those poor people, those people with health problems. All of the blind and the disabled in America are on Medicaid. And this Congress, this Republican Congress is talking about a tax cut for people who make over $1 million a year out of the savings from the money that can be taken from these people at this time in our country.

We just learned from the U.S. Census that 1 million more Americans fell into poverty in the year 2004. We now know that 37 million Americans are in poverty. We know that infant mortality rate rose last year for the first time since 1958, that in some cities in America the infant mortality rate is higher than some cities in India. This is no time to be cutting Medicaid, this is no time to give a tax break of $10 billion to the people who are making more than a million a year out of the money that should be used for these Americans who are most in need. This is a moral decision, not a budget decision.

Chairman BARTON. We thank the gentleman. I am sure he knows this, but we do have jurisdiction over health care policy in this committee, we don't over tax policy. I am sure he knows that.

Mr. Stearns.

Mr. STEARNS. Mr. Chairman, thank you very much, and thank you for——

Chairman BARTON. One or three?

Mr. STEARNS. I am going to take three—for holding this hearing, and I want to also compliment my colleague, Mr. Deal, for his thorough preparation and work on this.

Listening to my colleague from Massachusetts, you would think tax cuts caused Hurricane Katrina. In fact, tax cuts might have created every problem we have in this country because every time he starts out in any hearing it is always the tax cuts and helping the rich, and there is really a total separation and divorce from this.

I think my colleagues all of us realize that all we are doing here is slowing the growth. We are proposing a 1 percent slowing the rate of growth. We are not removing any safety net, contrary to what the gentleman from Massachusetts is talking about. In fact, in the State of Florida we are going to be able to provide under this kind of program services that children do not have, and in Florida right now the reimbursement is so low in my hometown of Ocala, Florida, if a child on Medicaid gets an ear infection there is no ear, nose and throat specialist who could treat this child because they don't want to be involved.

So we have a tremendous opportunity, my colleagues, at this time to take a fresh look at Medicaid. It doesn't hurt to have a fresh look at this program. This is about how we can make things better, a life enhancing program for beneficiaries. And I am especially excited that the Governors are asking for the waiver program.

Now these are the Governors of the United States. They see some merit in this.

There is one particular area that I have championed called a cash and counseling. For years, working with Florida's Governor Jeb Bush in one of the three pioneer States on this, it instills flexibility and choice to fragile seniors and disabled children. And the Robert Wood Johnson Foundation analysis of it reveals it is quite successful. So we have not only a proposal here but we have cases where the Robert Wood Johnson Foundation said it has been very successful.

So we must examine Medicare, Medicaid, including giving flexibility for each State, because of its unique need and better patient outcomes. This thinking results in the successful transformation of welfare from an entitlement—that everybody uses that word since the 1960's—to an assistance program, and it is something that we want to work to try to improve the effectiveness.

And finally, I am encouraged, as I mentioned earlier, that Governors like Jeb Bush in Florida have discussed beneficiary behavior, and this could change how this health care delivery system is delivered if we allow them to actually—their behavior is brought into play with choice.

So these are opportunities today with Medicaid coverage. This very small vast savings could be reaped just by a 1 percent cut, and I think the quality of life, which is the most important thing, can be vastly improved.

So I look forward to discussing this bill and hearing our witnesses, and I thank you, Mr. Chairman.

Chairman BARTON. The gentleman's time is expired.

Mr. Pallone, one, three or defer?

Mr. PALLONE. Mr. Chairman, I will take three, but I will try not to use it all.

Let me say I am just amazed by the Republican spin machine, it is still hard at work, as evidenced by the title of today's hearing, Medicaid: Empowering Beneficiaries on the Road to Reform. And I would like to know how Medicaid beneficiaries are going to be empowered by Republican plans to slash $10 billion from the program in which they rely on to access health insurance. And I don't think there should be any mistake about it, Republican efforts to reform Medicaid would only create new barriers to care and leave millions of Americans worse off, including many of our sickest and poorest citizens.

In my opinion, it is unconscionable at a time when survivors of Hurricane Katrina and millions of other Americans are most in need of government assistance, Republicans still remain steadfast from what I can see in their efforts to get rid of public safety net programs like Medicaid and at the same time providing $70 billion in additional tax cuts, mostly to the wealthy and to corporate interests.

I heard what the gentlelady from Mexico said about reconciliation, I know Mrs. Capps has a letter that she is circulating saying that we should just forget about this $10 billion cut. As far as I am concerned, if the Republicans were to tell us today that we are going to get rid of reconciliation, we are not going to make this $10 billion cut, I would feel better about what is going on here, but I

don't think that is what is going on here. I think they still want to proceed with it for the most part and slash Medicaid, and the bottom line is that Medicaid, if you—particularly if you gave it more money or if you had 100 percent Federal pay so that the States didn't have to put up any of their own dollars at this point would be a lot more successful and could be expanded to people of higher incomes or maybe cover everybody in the country, and we would be a lot better off. We don't need to make it more difficult for people to access Medicaid either because providers won't get an adequate reimbursement or because we are going to have some assets test or have higher copays.

Everything that I see that is being done in the name of reform is going to make it more difficult for people to get Medicaid, and that is what is really going on here, cuts in the Medicaid program, other ways of trying to cut back and make it more difficult for people to access Medicaid.

I urge my colleagues, what really needs to be done here today is to simply abandon their efforts to cut Medicaid, get rid of this $10 billion reconciliation and instead focus on how we can ensure that our most vulnerable citizens have continued access to Medicaid and other vital health insurance programs. And this is particularly important now in the advent of Hurricane Katrina, with all these people that—a lot of people who maybe even had health care before and are not going to have it now. We should be providing health care to anybody who is a survivor of the hurricane for the next year or 18 months totally free in my opinion. I mean, this is—what the Republicans are suggesting is not a reform, but just a way to try to kill Medicaid. That is what is going on here. Let's not kid ourselves.

Thank you, Mr. Chairman.

Chairman BARTON. Did the gentleman yield back?

Mr. PALLONE. Yes.

Chairman BARTON. Mr. Gillmor.

Mr. GILLMOR. I will waive, Mr. Chairman.

Chairman BARTON. Mr. Gillmor gets an additional minute.

Mr. Whitfield.

Mr. WHITFIELD. I will waive.

Chairman BARTON. He gets an additional minute.

Mr. Pitts.

Mr. PITTS. I will waive.

Chairman BARTON. He gets an additional minute.

Mr. Walden.

Mr. WALDEN. Thank you, Mr. Chairman. I will just try and take a minute here.

I have listened to a lot of this debate, I have been involved in this sort of debate when I was in the State legislature in the late 1980's, early 1990's, trying to expand the scope of Medicaid to cover those most in need by trying to get the most efficient use of the dollars. And I have heard a lot of rhetoric so far from my colleagues and friends from the other side, but let's face it, Medicaid today, as I understand it, requires that one of the drugs be available is for Ed, requires that one of the drugs be available for hair loss. Now do you really think that is the most sufficient use of Medicaid dollars?

The Oversight and Investigation Subcommittee of this very committee investigated what I believe is an enormous ripoff in the drug purchasing. We found examples that obviously my colleagues have ignored of upwards of 5000 percent inflated costs in what Medicaid sales versus the actual sales price of the drug, that is the kind of reform that needs to take place so that the taxpayers' dollars are properly spent to take care of those most in need.

Chairman BARTON. We thank the gentleman.

Ms. Eshoo.

Ms. ESHOO. Mr. Chairman, 1 minute. Thank you for cooperating with Mr. Dingell in terms of this hearing, and welcome to the witnesses.

I have spoken out at the beginning of every one of the hearings on these cuts to Medicaid, I don't support them.

I just want to say today two things. In terms of abuse of the system, I stand ready to work with any of my Republican colleagues where the system is abused. My colleague just described some of these things, and I don't support that, and the reason I don't and the reason I would join with others to do something about abuse is because I have so much respect for the program. This program takes care of the poorest of the poor, but it also has an additional layer to it, and that is that it now covers the working poor in our country.

We are, I think, on very, very tender ground these days. The American people are watching TV and saying what has happened to the soul of our Nation? What we do in this committee is not disconnected from that. We have to differentiate where there is abuse and where we are going to subject people to being abused by some of these massive cuts that are scheduled. It is not the time, it is not the case, we can do better. This is not Republican or Democrat, this is about standing up and being the kind of American that the American people are really looking for now. They are disappointed, they are let down, they are aghast at what has happened in our country.

So, Mr. Chairman, I hope that all together, all of us, the Republicans, will stand up to their leadership and say don't do this thing, this is not what we are about. We have to find the soul of the Nation in the Congress. It is out there with the American people. We have got to find it here and act on it. Thank you.

Chairman BARTON. We now know that a California 1 minute is about 2½ minutes.

Ms. ESHOO. Take it out of the rest of my time, Mr. Chairman.

Chairman BARTON. I am teasing.

Let's see, on our side, Mr. Sullivan.

Mr. SULLIVAN. I waive.

Chairman BARTON. Mr. Murphy.

Mr. MURPHY. I waive.

Chairman BARTON. We are out of Republicans. Mr. Stupak.

Mr. STUPAK. Thank you, Mr. Chairman, I will try to keep it under 3 minutes.

Mr. Chairman, I urge the committee to abandon the misguided, irresponsible cuts to Medicaid that we are supposed to make in the name of reform. This is not the time to be cutting services, dropping beneficiaries and raising costs for those most in need.

We cannot continue with plans to slash Medicaid by $10 billion, especially in the wake of Hurricane Katrina. Over 700,000 victims of Katrina have fanned out across the country, without jobs, without homes, and many without health insurance. These displaced Americans are more likely to be older, with lower incomes and in the most need of medical assistance. We need to give these victims and the States that are taking them in a helping hand.

In my State of Michigan, and many other States, Medicaid rolls are already at record levels, not because people are irresponsible or because they want a free ride, Medicaid rolls are at a record levels because the economy is stagnant, health care costs continue to skyrocket, and employers are dropping their health insurance.

This week the Congressional Budget Office estimates that the Nation will lose over 400,000 jobs because of Hurricane Katrina. We don't know how long these displaced Americans will need help or how long the States will need help. While supplemental efforts to address the Hurricane Katrina victims' health needs are important, Congress will undermine these efforts if we fail to properly compensate the health care system which Americans depend upon.

Katrina highlights what the so-called reforms over the last several years have accomplished, an American society segregated by class, by income, by health care, and segregated by race. We have a chance to reverse this trend in America by abandoning these Medicaid cuts and to make a real commitment to all Americans, to the States and the millions of our constituents who depend on Medicaid.

And with that, Mr. Chairman, I will yield back my 1 minute.

Chairman BARTON. Mr. Stupak, did you yield back?

Dr. Burgess, did you wish to make an opening statement?

Mr. BURGESS. Mr. Chairman, in the interest of time I will waive and insert my insightful statement for the record. I did want to welcome Dr. Matthews from Metroplex to our hearing, and am very glad to see him here today.

Chairman BARTON. We thank you.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. And I will be as brief as possible.

Chairman BARTON. Is that 1 minute or 3 minutes?

Mr. GREEN. I will do the 3 minutes.

Chairman BARTON. Okay, the brief 3 minutes.

Mr. GREEN. I want to thank you for holding this hearing on the impact of the Medicaid reform on beneficiaries. It is fitting that we are holding this hearing in the aftermath of Hurricane Katrina, which brought home the reality faced every day by low income Americans. Many Katrina survivors remained in their homes simply because they did not have the resources to purchase gas or the bus fare necessary to leave town.

The Katrina survivors, the low income, the disabled, the children, the seniors are the face of the Medicaid program and should give us tremendous pause as we work on this legislation to cut $10 billion from the very program that gives them their only source of health insurance. Many of us feared that we would have to go down this road without the benefit of hearing from Medicaid beneficiaries. While we all want to help our States with their fiscal

troubles, we cannot deny that beneficiaries are the most affected by the changes in the Medicaid program.

We must not lose sight of the fact that we are forced to craft a bill to fit within arbitrary budget figures, and what concerns me, Mr. Chairman, is knowing what is happening in our home State of Texas now. We have a lot of Medicaid beneficiaries from Louisiana who have come, and the States don't have the flexibility now. Maybe we need to have some flexibility, but I would hope that we can empower the Federal Government to help our local States, and I introduced legislation last night to do that for the immediate need.

I guess the worry we have is that States that are taking people from Louisiana, Mississippi or Alabama—I will give you an example. In Texas we have 150,000 people at least, and I am sure other States, Arkansas and our neighboring States have people too. If the States have to come up with that Medicaid match for these new, even maybe temporary residents, then that is going to cause even more problems if we are looking at cutting $10 billion elsewhere.

So, Mr. Chairman, that is why I am glad to have this hearing, and hopefully we will judiciously look at not only $10 billion but how we have to do that. That will make it easier for the folks who are the beneficiaries of this.

Thank you.

Chairman BARTON. We thank the gentleman.

Ms. DeGette.

Ms. DEGETTE. I will take 3 minutes, Mr. Chairman.

Chairman BARTON. The gentlelady is recognized.

Ms. DEGETTE. Mr. Chairman, we all know that Medicaid costs are increasing at an unsustainable rate. That is not to be denied. Medicaid is now the single largest health program in the country, and in the States Medicaid spending has surpassed education spending, previously the largest annual State expenditure. But that doesn't mean we should just have a meat axe approach into what we do about it at the Federal level, because at the same time Medicaid spending is going up our country faces numerous challenges to health care access. The number of uninsured is increasing, the current jobless economic recovery has meant more people without employer-based health insurance and employers are just shifting costs to employees or dropping health insurance benefits altogether. So as a result, people are turning to Medicaid as a last resort and, as we have heard from everybody here, the recent hurricane is going to cause even more of a burden on this system.

So now we shouldn't just be cutting Medicaid simply for the sake of cutting Medicaid. As we determine how to reduce or control overall Medicaid spending, we shouldn't be asking the beneficiaries to shoulder more of the cost because frankly doing so would be the equivalent of a tax on the poor. I think it would be a tragedy if the capital gains tax cuts for the rich would also be included in the same budget reconciliation instructions, and so therefore parents would be deferring necessary medical care for their children. That is just wrong, as some of my colleagues have said. And I think that we can look sensibly at this and say, instead of across the board cuts or caps on spending, we can be more creative.

Denver Health in my district, for example, could save as much as $5.6 million annually if they just allowed Medicaid recipients to get their prescription drugs from public health providers that purchase drugs at public health prices, which is the lowest price offered by pharmacies. There is no problem to the beneficiaries there, but yet we are saving money in the system.

In 1965, Mr. Chairman, Medicaid was created to ensure that those most in need have access to health care services. It is our duty to make sure that Medicaid's legacy of providing health care to the poor continues and that it is not turned into a cash cow for misguided tax cuts.

Now I have got 30 seconds left, so let me just say, it is not enough of an explanation to say this committee does not have jurisdiction over tax policy because we are the U.S. Congress, and it is our job to figure out how we spend our money and how we get our revenue in as Congress. And we shouldn't be putting tax cuts on the program for the very wealthiest in this country and at the same time cutting medical care benefits for the poor. It is not only immoral, it also will cost more money in the long run.

I yield back.

Chairman BARTON. I thank the gentlelady.

Mrs. Capps. One minute, 3 minutes or——

Mrs. CAPPS. Two minutes. Where does that put me?

Chairman BARTON. You might as well take three.

Mrs. CAPPS. I am teasing. I thank you, Mr. Chairman.

Sometime during this month this committee is scheduled to take up a budget reconciliation package that fundamentally changes Medicaid by implementing a savings of $10 billion. These are cuts. They were wrong before Hurricane Katrina, they are more so now. In fact, the aftermath of Katrina shines a bright light on why they are wrong.

One of the changes that would be proposed is to ask the poor to pay more out of their pockets for their Medicaid. It is clear this is a patently absurd thing to ask of Medicaid beneficiaries, especially when you think of those who lost everything in the recent events. Louisiana, Mississippi, Alabama, Texas and other States are going to see their Medicaid rolls expand to deal with victims. Their State budgets are going to be stretched even thinner by the recovery effort.

Mr. Chairman, you just promised that victims of Hurricane Katrina will not be harmed by these cuts, but I ask for how long. If Medicaid itself is restructured by our actions, many of these victims would eventually be denied coverage. Many were Medicaid beneficiaries before the hurricane, many have permanent disabilities. As Gene Green from Houston has stated over and over again, many will be permanently displaced. So how will they be identified as hurricane related?

And what about all the people in other parts of the country who are destitute but were not harmed by a natural disaster? Don't they deserve the same protection as well?

I am circulating right now a letter to Speaker Hastert urging him to abandon these cuts. This letter already, in just 2 days, has the support of nearly a hundred Members of Congress. Now is the time for the Federal Government to put more money, to change the

match into Medicaid, to assist these States at this time and the people they are caring for, not less.

I yield back the balance of my time.

Chairman BARTON. I thank the gentlelady.

Mr. Doyle.

Mr. DOYLE. I will choose door No. 1.

Chairman BARTON. One minute.

Mr. DOYLE. Mr. Chairman, the Medicaid program is already incapable of caring for the populations it was designed to serve. If modernizing Medicare can generate savings, then I think we ought to put those savings right back into the program.

I understand that on average Medicaid represents about 22 percent of the States' budget, and I know the States are struggling, but we can't forget that Medicaid serves as a safety net for our most vulnerable members of society and these people are struggling, too.

Now, some of the provisions in the NGA plan make sense and they are borne out of fiscal realities, but much of the NGA plan submitted to this committee will not lead to improved health care for Medicaid beneficiaries. That is because it is not designed to do that. It is just an effort to control spending. However, simply shifting additional costs on the beneficiaries and allowing States to cut back on benefits is nothing more than rationing care, and rationing care can lead to some very costly consequences.

The problems Medicaid has experienced are indicative of a broken health care system. The solution to a broken system is not to penalize the most vulnerable members of society. This committee should strive to do better than that.

Mr. Chairman, I yield back.

Chairman BARTON. We thank the gentleman.

Mr. Allen.

Mr. ALLEN. Three minutes, Mr. Chairman.

Chairman BARTON. The gentleman is recognized.

Mr. ALLEN. Mr. Chairman, I usually thank you for holding a hearing, but this time I do find it hard to believe that we are having this hearing today to consider $10 billion in cuts to Medicaid. Survivors of Hurricane Katrina are now scattered across the country and in need of significantly more Medicaid resources than they did before.

Any cut to Medicaid will have a significant impact on States. Maine will lose $76 million over 5 years, and for my State that is a lot of money. Fifteen States, including Maine, are scheduled to have more than a 1 percent decline in their Federal matching rate beginning October 29th.

Cutting Medicaid will unravel an already fraying health safety net, jeopardizing support for hospitals, clinics, doctors and health plans that serve low income people. Cutting Medicaid will increase the number of uninsured, which is already nearing 46 million people. Sick people cost more when they are uninsured and receiving care in emergency rooms than when they are covered by Medicaid. Cutting Medicaid will set back the quality of nursing homes. Cutting Medicaid will put children, who make up nearly half of all Medicaid beneficiaries, at risk.

This administration and this Congress have given enormous tax cuts to the wealthiest Americans over the past few years to the long-term detriment of the financial prospects of this country. Now, the 2005 reconciliation process includes $70 billion more in new tax cuts, including dividends and capital gains, $70 billion in new tax cuts that is to be offset by $35 billion in spending reductions, including spending reductions in Medicaid.

Republicans say, as some did earlier, the gentleman from Florida, that there is no connection between revenues coming in and the expenditures we make here. Well, there isn't a businessman or woman in America who believes that about their business. The fact is these are connected. It is not just the same Federal budget, it is the same reconciliation process.

So what we are doing is we are doing $70 billion in tax cuts without a prospect of filibuster in the Senate, and we are doing $35 billion, including this $10 billion of reduction in Medicaid. If that isn't robbing from the poor to give to the rich I don't know what is.

Medicaid, like every program, should be subject to oversight and reform, but this entire reconciliation process, including the $10 billion from proposed cuts from Medicaid, should be set aside and reconsidered in light of Hurricane Katrina and its aftermath.

And with that, Mr. Chairman, I yield back.

Chairman BARTON. I thank the gentleman. Before we recognize Ms. Schakowsky, I just want to make an announcement. I am a little bit puzzled if there are members on the minority side that did not want the hearing done today. We had this hearing set in August and we have negotiated extensively with Mr. Dingell and the minority staff to make sure we had a good panel, and we did it at a time that was timely, that was not at midnight or something like that. If I wanted to be political I would have canceled the hearing, you know. The fact is I think this committee needs to be an activist committee, and I think we need to get these issues before the public, and I think they need to be presented in a fair and open fashion. And the easiest thing in the world to do is say, oh, my gosh, we have got a hurricane, everybody is upset, let's don't move forward and at least get the issue debated.

Mr. ALLEN. Mr. Chairman, I hear what you are saying, and I understand the need for a hearing. What I would say is it is frustrating on our side that the context in which this is being held and the context of the debate is driven by decisions that were made weeks and months ago, and some of us believe it is time for a complete reevaluation.

Chairman BARTON. We are not saying that we can't reevaluate, but if you don't do a hearing you don't do anything, okay?

Ms. Schakowsky.

Ms. SCHAKOWSKY. Thank you, Mr. Chairman. First, I want to apologize to the witnesses, I am going to take 3 minutes, but you know, Democrats often are so thoroughly excluded from the process of a very important decisionmaking that very often all we really have is our voice and I want to take that opportunity.

And Mr. Chairman, if we were having a hearing, for example, on Mrs. Wilson's proposal that we postpone, at the very least, reconciliation or the letter that Representative Capps wrote that we

reconsider the total budget reconciliation package, not only in light of what has happened but in light of the poverty that it has exposed, that would be one thing, but clearly—so let me just also take issue, Mr. Chairman, with what you said, that Hurricane Katrina is very different from this Medicaid issue. You know, that was an act of nature, Hurricane Katrina, but human decisions, decisions by this administration to, for example, defund the building up of levees, often the contempt for the public sector that I think has been demonstrated leading up to this hurricane disaster made it into a man-made disaster. Americans watched with shock and shame, not shock and awe at the complete failure, the dysfunction of this government in responding to this situation, and the President said no one could anticipate a breach in the levees. Well, that wasn't true because it was predictable and predicted.

Just as a cut in Medicaid of $10 billion, let us be clear and let us get the word to the President that that will cause people to die just as surely as people have been dying in the aftermath of Hurricane Katrina. People will die if we cut $10 billion from Medicaid.

I want to associate myself with the remarks of my colleague, Mr. Markey, who said this isn't just a budget decision. This is a moral decision. This does get to the heart and soul of who we are as Americans and what our priorities are.

Are they moving ahead with the $70 billion in tax cuts and making permanent the repeal of the estate tax for the wealthiest, the wealthiest of Americans? Or are we going to consider what Hurricane Katrina revealed? Not just the poor in Louisiana and Mississippi and Alabama, but that there are poor people in every city around our country, in my city of Chicago, every rural area in this country, that are suffering because they can't now afford the health care that they need. We need to be expanding Medicaid, not cutting Medicaid when we look at those Census numbers and 1.1 million people fell out of the middle class into poverty and the number of uninsureds have increased.

So it is shameful if we are here today to talk about more cuts in Medicaid. Let us improve it, let us not cut it. Thank you, Mr. Chairman.

Chairman BARTON. We thank the gentlelady. I just want to point out that we have had six meetings with the Governors' representatives. The minority staff, from my understanding, have been involved in all six of those meetings. As we began to put the legislative proposal together, we have offered to include the minority staff in those discussions; they have deferred so far to participate. But we have tried to have an open process throughout the process.

The gentlelady from California, Ms. Solis.

Ms. SOLIS. Thank you. Three minutes, please.

Chairman BARTON. The gentlelady is recognized.

Ms. SOLIS. Thank you, Mr. Chairman. And I applaud you for having this hearing.

Unlike the $52 billion supplemental aid package that we are going to be approving today, no Democrats have had an opportunity to see that. And I feel very, very bad because we are talking about Medicaid cuts here. Why are we not talking about at this time what we need to do to help those States that are going to be recipients of these Medicaid patients and reducing the matching

aid that is going to be required that has not been dealt with yet? And I understand that it is not in the supplemental. Shame on us for not doing that right now when the public is awaiting action by this Congress that is not acting in a manner I think that is responsible.

Medicaid is a very important program in my district. A number of people there live and die by the fact that they get their medicines, that they are able to get their dialysis, that they are able to get their assistance that they need. Racial minorities are highly, highly impacted by the fact that Medicaid is available for them. It is their only safety net. Look at Katrina, look at the victims there. Most of the people that were affected have no form of health care. What are we sending a message to them right now, telling them that they are not going to be eligible for aid because it is not going to come? And we are making those decisions right now. And I think it is a bad time for us right now to talk about reform in a manner that is deceiving to the public. When we talk about reform, we are talking about increasing caps, we are increasing costs for low-income people, for working families who have no other measure of safety net. The gaping hole is increasing every single day. And it is true, poverty is increasing in my district alone. We have a high number of people who are chronically unemployed. We are not doing anything to address that, either.

Medicaid, as I said, is very important. But it is also important for our care providers, our health care facilities, our centers of health, our doctors. We have minority doctors who are refusing to now see these types of patients because the reimbursement rates are so low. Why are we not addressing that chronic form of immediacy that needs to be addressed and we have been talking about for many years?

I do want to thank the chairman for having this hearing, because unlike other Members of Congress, we don't have this kind of debate openly and often. And I hope that people will understand that we need to hear from them, the public, because I don't believe that we should be moving in a direction to somehow reduce services particularly to the most vulnerable, our children. A large number of Medicaid patients in my district happen to be young children, under the age of 6, who have no voice at this table today.

I yield back the balance of my time.

Chairman BARTON. We thank the gentlelady.

Mrs. Baldwin.

Ms. BALDWIN. Thank you, Mr. Chairman. Three minutes, please.

Chairman BARTON. Three minutes.

Ms. BALDWIN. Thank you, Mr. Chairman, for holding this hearing that highlights a very important perspective: The voice of Medicaid's 52 million beneficiaries. In light of our anticipated debate on reconciliation, I think it is important to keep in mind what Medicaid is. Medicaid is the program that keeps millions of Americans from joining the ranks of our Nation's 45.8 million uninsured. Medicaid provides millions of families with security from having to face bankruptcy due to health bills that exceed their capacity to repay. Medicaid ensures that one third of our Nation's newborns have pre- and postnatal care. Medicaid will ensure that victims of Hurricane Katrina have health care.

In short, Medicaid does what it was created to do: Medicaid is our country's health insurance safety net program that catches people when they fall out of our increasingly dysfunctional health care system.

Given the importance of Medicaid for so many millions of Americans, I look forward to our discussion about the beneficiary perspective on Medicaid. And I am particularly interested in discussing the effect of proposals that would increase cost sharing for beneficiaries. We know from numerous studies that even seemingly small cost sharing increases can have a profoundly negative effect on beneficiary health, and I look forward to hearing from our witnesses addressing this particular point. Again, thank you, Mr. Chairman. I yield back.

Chairman BARTON. The gentlelady yields back. I thank the gentlelady. Does Mr. Shadegg wish to make an opening statement?

Mr. SHADEGG. Mr. Chairman, I will make a brief opening statement.

Chairman BARTON. Do you want 1 minute?

Mr. SHADEGG. One minute is ample.

Chairman BARTON. One minute.

Mr. SHADEGG. Mr. Chairman, I just want to commend you for holding this hearing. I think it is very important. I think we are very much aware of the problems that confront the Medicaid system. The Governors' report and the bipartisan support for reforming the system I think call upon us to take action. My State, Arizona, I think, has done a great job in Medicaid. We sought an exemption early on. We have tried to provide better services in a different model than is used across the Nation, and I think it is important that we look at the successes that Arizona has had.

At the end of the day, the important issue here is providing the benefits that people need. And, quite frankly, I think the current system in most of the Nation is not doing that. It is certainly not doing that at a reasonable cost. And I think it is our duty to try to improve the system for those for whom it is intended to benefit and for whom it is indeed a lifeline. With that, Mr. Chairman, I yield back.

Chairman BARTON. I thank the gentleman.

Mr. Ross.

Mr. ROSS. Thank you, Mr. Chairman. One minute? Three minutes? If you are last, you get 4?

Chairman BARTON. No. You could defer and get an extra minute in questions.

Mr. ROSS. Yes.

Chairman BARTON. Just a thought. So, do you want 1 minute or 3 minutes?

Mr. ROSS. I think I will take the 3 minutes.

Chairman BARTON. All right.

Mr. ROSS. And the statement I was going to read, I am not going to read, and I just want to make some comments after sitting here and listening to a lot of things that have been said this morning. I mean, Mr. Chairman, we are talking about $10 billion worth of cuts to Medicaid. In the same budget, we are talking about $106 billion in tax cuts. And those tax cuts will not be debated in this committee, but they will be debated in this Congress; and the last

time I checked, we are all members of the 109th Congress. So it is about priorities.

A lot of talk these days about faith. Some people talk it, some try to do something about it. As we go through this debate affecting the poorest among us, I hope all of us will pause for a minute and think about Matthew 25:40: I tell you the truth. Whatever you did for one of the least of these brothers of mine, you did for me.

Let me tell you about my America. Half of the children in Arkansas are on Medicaid. Eight out of ten seniors in the nursing homes in Arkansas are on Medicaid. One in five people in my home State of Arkansas are on Medicaid. And now we have 60,000—the number could be larger, we are still trying to figure it out. But we have at least 60,000 of our neighbors from Louisiana and Mississippi and New Orleans now in Arkansas, and many are in desperate need of Medicaid.

Now, the gentleman from Oregon talked about the erectile dysfunctional drug and how it is covered by Medicaid. I don't know where the gentleman got his information from, but I can tell you, my wife and I own a small-town family pharmacy, and in Arkansas, Medicaid does not pay for erectile dysfunctional ads. Perhaps the gentleman from Oregon was confused, because the Medicare drug bill that he voted for does cover erectile dysfunctional ads but Medicaid in Arkansas does not.

In terms of the hair loss drug, I am still trying to get an answer to that. But I can tell you this. My wife and I own a pharmacy, and never once has Medicaid paid for a hair loss drug at our pharmacy. So let us get our facts straight as we debate these issues, because we are talking about people's lives. We are talking about $10 billion in cuts—in cuts, to Medicaid.

Medicaid is a health insurance plan for the poor, the disabled, and the elderly. In my business and from my home State, I see a lot of poor people, and never once has someone walked up to me and said, I like being poor. And, as I mentioned, my wife and I own a family pharmacy; we see a lot of sick people, a lot of sick people, but never once has someone walked through our doors and said, you know, I just love being sick. And when you talk about cutting Medicaid $10 billion, it is like we are going to wake up tomorrow and people are going to quit being sick or quit being poor. This is more about shifting more of the expense to the States. We saw it happen with the end of Federal revenue sharing in the early 1980's. And poor States like Arkansas simply cannot afford to take on any more of the burden. This is about shifting burden to the States. It is about turning our backs to these——

Chairman BARTON. The gentleman's time has expired.

Mr. ROSS. Mr. Chairman, I believe that is wrong. Thank you.

Chairman BARTON. Well, the gentleman's time has still expired. Mr. Rogers.

Mr. ROGERS. I am going to yield, Mr. Chairman. I just want to welcome somebody I have known for years who is a friend and just a great advocate for those who are in need of mental health services and certainly a compassionate health care professional, Bob Sheehan from Michigan. So welcome, sir, and thank you for coming.

Chairman BARTON. Mr. Engel.

Mr. ENGEL. Thank you, Mr. Chairman. I will take the 3 minutes. And I want to, at the outset, thank you for holding this hearing and thank you for the way you have conducted this committee as Chair, giving everybody a chance to speak. That is not true in many other committees. So we do appreciate it.

A lot of my colleagues have spoken about tax cuts, and I want to speak about it as well because I think it is important to keep hitting this issue time and time and time again.

Today's Congress Daily on the front page says: "in Katrina's wake, Republicans delay but won't abandon tax cut agenda." On the third page it says: Senate House Dems unhappy with GOP hurricane probe because, again, the Democrats are being excluded and left out.

When Democrats complain that we feel we have been marginalized, very often from the majority we get back: Well, when you guys controlled the House for 40 years, you marginalized Republicans. You know, my mother, who bless her soul, is 85 years old, always had a saying, and that is, two wrongs don't make a right. And I would say that. We need to come together in a bipartisan fashion when it comes to talking about Katrina and investigating why there was such a slow response.

And that is why in yesterday's hearing I called for a bipartisan commission very similar to the 9/11 Commission, because I think that is the kind of commitment we need to have. And today we are talking about Medicaid cuts. And I think it is especially callous to talk about it in light of Hurricane Katrina. And being a New Yorker, a lot of people talk about September 11th. You know, we in New York feel it. It is a hole in my heart every time I go by and don't see the Twin Towers in our skyscrape. It is a hole in my heart when I think of all my constituents who are buried because they were killed at the World Trade Center.

And I think one of the things we can learn from Hurricane Katrina is that it demonstrates how unwise our proposed $10 billion cuts to the Medicaid program are. So many people have lost their jobs. It is clear more than ever how much our citizens need Medicaid to be responsive in times of crisis. And I want to talk about September 11th, because Medicaid did just that for New York after September 11th through the united collaboration and efforts through our delegation.

And, again, in a bipartisan fashion, the mayor's office, Governor's office, and CMS, over 350,000 New Yorkers enrolled in the temporary disaster relief Medicaid program. And with widespread damage to New York City's Medicaid computer systems and hundreds of thousands New Yorkers in need, New York made the choice not to let technology and backlog affect offering desperately needed health care assistance. And we should do the same thing for Katrina. The success of the disaster relief Medicaid was due to health officials' use of a vastly simplified expedited application process. People simply had to attest to the truth of information on the one page form, and decisions for coverage were made by Medicaid caseworkers on the same day of application. Beneficiaries received coverage for 4 months, and were able to use this time to obtain the necessary documentation to be enrolled in the standard Medicaid program, if necessary.

So I think that we should do this again for Katrina. We have to remember the compassion that disaster relief Medicaid offered to the people of New York, and States that are hosting Katrina victims should receive 100 percent FMAP match Medicaid coverage for these individuals. I thank you, Mr. Chairman.

Chairman BARTON. We thank you, Mr. Engel.

We have two votes. We are going to hear from Mr. Murphy for 1 minute, and then we are going to recess until after the second vote, and when we come back, we will hear from our panel. So, for the last word, Mr. Murphy for 1 minute.

Mr. MURPHY. Thank you, Mr. Chairman. I was going to defer before and submit my comments for the record, which I will still do, but listening to the other comments here, I have some thoughts.

Only couple of us on this committee have served in hospitals and have treated patients on Medicaid, and I don't think there is anybody on this committee that does not have compassion for anybody who has been poor because many of us have come from families of low economic means as well. But what we have to keep in mind is the Federal Government is the largest purchaser of health care, some 45 percent of mandatory spending goes to health care in the Federal Government. This is an opportunity for us to change the discussion from who is paying to what we are paying for.

One quick example. In Pennsylvania, the data suggests that the average hospital charge for medical assistance patients without an infection is about $20,000 for an average length of stay for 4 days. The average hospital charge for patience with an infection is $125,000, average stay of 15 days.

There are things we can do to help hospitals and doctors do a better job, and I am looking forward to ways that we can review this to give States the authority to help make some of these improvements in health care happen. Thank you, Mr. Chairman.

Chairman BARTON. We thank you. That is all the opening statements. All members that are not present we can insert their written statement in the record. That closes the opening statements.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. PAUL E. GILLMOR, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OHIO

Thank you, Mr. Chairman for holding this important and timely hearing. I am glad to see reform plans put forth by the National Governors Association as well as savings recommendations produced by the bipartisan Medicaid Commission, and look forward to hearing from the well-balanced panel of witnesses regarding the potential impacts of these recent reform proposals from the perspective of our nation's Medicaid beneficiaries.

As I mentioned before, in my home state of Ohio, despite recognizing the reality of a broken system and enacting a number aggressive cost containment and budget strategies, Medicaid expenditures are increasing at twice the rate of growth of state revenues, amounting to a total $10.5 billion. This figure represents over 40% of the state's general revenue fund spending and is larger than Ohio's entire state budget in 1987.

With a generation of baby boomers growing older, life expectancy on the rise, a shrinking labor force, and smaller family units, the demand for long-term care is likely to increase, producing an even further strain on our nation's Medicaid program. Absent future demographic realities, there is no question that Medicaid is in dire need of transformation now.

With the evolution of Medicaid over the years, reform ideas have come and passed, or simply been swept under the rug. We must take hold of today's circumstances and remain committed with our governors and stakeholders alike to

transforming our system into one of personal responsibility, quality, and efficiency, for our citizens that need it the most.

Again, I thank the Chairman and yield back the remainder of my time.

PREPARED STATEMENT OF HON. EDOLPHUS TOWNS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW YORK

Thank you Mr. Chairman and members of the committee for holding this important hearing. I also want to thank the panel for coming to share their views on one of the most important issues facing our Nation today.

Medicaid is our Nation's largest insurance program and a critical safety net for more than 50 million individuals each year. Children and families make up the majority of the Medicaid program. However, medicaid also provides essential public health services for disabled individuals and low income seniors, including long-term care.

While program improvements are needed, it is imperative that congress base these improvements on sound health policies that will empower Medicaid beneficiaries. Of particular concern is the effect of the proposed increases in cost-sharing. For the poor, increasing cost-sharing is not a sound policy. Many, especially some in my district, depend on life sustaining medicines that are inaccessible without Federal support. And increasing cost-sharing is a barrier to those with chronic illnesses who tend to get sick frequently.

Likewise, enforcing cost-sharing and raising the total amount higher than what is allowed in State Children's Health Insurance (SCHIP) program is of concern.

Presently providers cannot turn away patients if they are unable to pay their copayment. Making cost-sharing enforceable is immoral because it forces providers to deny care to the poor. Also, overall health care costs will significantly escalate as a result of the poor seeking continuous health care for chronic conditions from emergency rooms instead.

Last but not least, SCHIP was designed to help families whose incomes are slightly above medicaid-income levels. Increasing total cost-sharing charges more than what is allowed by SCHIP will injustly burden these families. Likewise, requiring cost-sharing for millions of children, including disabled children, who are slightly above 100 percent of poverty will injustly burden families and penalize innocent children. Under current law, all children are exempt from cost-sharing because congress wanted to encourage and ensure that children got needed services.

As Members of Congress, let us make sure that children, the disabled and elderly have essential health services via Medicaid. Thank you.

Chairman BARTON. We are going to recess now; we have two pending votes, a 15 and a 5. My expectation is we will reconvene at noon. So we are in recess until noon after these two votes.

[Brief recess.]

Mr. DEAL [presiding]. We will call the hearing back to order. Thank you for your indulgence while we voted. We are operating under some time constraints for some of the witnesses, and Governor Keating is one of those. He is first on the panel; we are going to let him continue to be first on the panel, and he may have to leave—for members of the committee—may have to leave before the questioning is completed, but we understand that, and we thank you for being here. And we are pleased to introduce Governor Keating as the President and CEO of the American Council of Life Insurers, the former Governor of the State of Oklahoma. We are pleased to have him as our first witness. I will go down the list and introduce the witnesses at this point.

Mr. Parrella, who is the director of the Medical Care Administration Department of Social Services of Hartford, Connecticut.

Dr. Alexander, who is the president of DeVos Children's Hospital in Grand Rapids, Michigan.

And Mr. Jim Gardner, who I have already previously introduced who is the CEO of Northeast Georgia Medical Services.

We have Mr. Sheehan, who is the executive director of the Community Mental Health Authority of Clinton-Eaton-Ingham Counties in Lansing, Michigan.

And is it Dr. Thames, is that the correct pronunciation? Dr. Thomas Thames is a member of the board of directors and representing AARP.

And Mr. Merrill Matthews, who is executive director of The Council for Affordable Health Insurance in Alexandria, Virginia.

Gentlemen, we are pleased to have you on our panel. And, Governor Keating, we will start with you.

STATEMENTS OF FRANK KEATING, PRESIDENT AND CEO, AMERICAN COUNCIL OF LIFE INSURERS; DAVID PARRELLA, DIRECTOR, MEDICAL CARE ADMINISTRATION, DEPARTMENT OF SOCIAL SERVICES; DAVID ALEXANDER, PRESIDENT, DEVOS CHILDREN'S HOSPITAL; JIM GARDNER, CEO, NORTHEAST GEORGIA HEALTH SYSTEM; BOB SHEEHAN, EXECUTIVE DIRECTOR, COMMUNITY MENTAL HEALTH AUTHORITY OF CLINTON-EATON-INGHAM COUNTIES, LANSING, MICHIGAN; THOMAS THAMES, MEMBER, BOARD OF DIRECTORS, AARP; AND MERRILL MATTHEWS, EXECUTIVE DIRECTOR, COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Mr. KEATING. Thank you, Mr. Deal, ladies and gentlemen of the committee. I appreciate the opportunity to speak on behalf of the American Life Insurance Industry. ACLI member companies provide 81 percent——

Mr. DEAL. Your microphone.

Mr. KEATING. Thank you, Mr. Chairman. I have a formal statement for the record, if that would be acceptable. And my brief remarks will focus on private long-term care insurance and its contribution to the cost challenge and the service challenge in the debate over Medicaid.

As the president of the American Council of Life Insurance, our organization represents 356 life companies. Our member companies provide 81 percent of the long-term care insurance in the United States. We appreciate Chairman Barton's drawing attention to this issue, and we are pleased to discuss with the committee the role that private long-term care insurance provides in helping to assure private retirement security for millions of middle income families.

One of the greatest risks, Mr. Deal, and Chairman Barton and others, to asset loss and retirement is unanticipated long-term care expenses. The risks of meeting nursing home care also are substantial. Over half of the women in our country, nearly one third of the men 65 years of age and older, will stay in a nursing home sometime during their lifetime. According to a 2005 study, the annual cost of a nursing home stay currently is almost $70,000 a year. This increased by 6 percent in the last year alone.

Long-term care products which are provided in the private marketplace are very different than they used to be. The market has evolved from one that offered primarily nursing home plans early on to one that offers flexible care options and numerous consumer protections. Most policies allow customers to choose between in-home care, assisted living facilities, and nursing homes, encour-

aging the individual and their families to customize the care needs of each individual.

Plans today are guaranteed renewable, and that is extremely significant. They have a 30-day free look period; they offer inflation protection; they cover the plague of Alzheimer's disease, have a waiver of premium provision, and offer unlimited benefit periods. Benefits are paid when a person needs helps with two or more activities of daily living or is cognitively impaired. Industry data shows that between 1994 and 1997, the average issue age for private long-term care policies was over 67, and today's average age is 58.

Increasingly, States are tackling the costs of long-term care and are exploring ways to partner with the private insurance industry to alleviate a continuously growing Medicaid burden. One such way is through partnerships for long-term care, a pilot program developed by the Robert Wood Johnson Foundation in connection with the State governments and the support of our private insurance industry. The partnerships allow consumers to purchase a long-term care policy whose benefits must be fully utilized prior to qualifying for Medicaid. When that is exhausted, individuals may apply for Medicaid as they would have without the private insurance. Because they utilize their insurance coverage under the partnership, they can protect the level of assets as defined in their State's program, which, of course, provides additional money for a child or a grandchild who has special care needs or some other relative in a nursing home.

Partnerships have taken two forms. The dollar-for-dollar model allows people to buy a policy that protects a specified amount of assets, that is, how much they have paid out of pocket, and the total asset model provides protection for 100 percent of assets once they exhaust their private insurance coverage. The partnership program is currently operational in four States: California, Connecticut, Indiana, and New York. More than 225,000 long-term care insurance partnership policies have been purchased in those States, and remarkably fewer than 100 of those policyholders have exhausted they policies and accessed Medicaid. The partnership benefits consumers, Medicaid, and private insurers.

Congressman Deal, as you know, in addition 18 States have passed legislation that would implement a partnership once the 1993 restrictions are withdrawn or waived.

Now, our organization, ACLI, believes that the simplified approach in House bill H.R. 3511, sponsored by Representatives Burgess and co-sponsored by Representatives Johnson, Peterson, Pomeroy and Jindal, is the most appropriate approach for expansion of a long-term care partnership program. H.R. 3511 provides partnership eligibility for any State approved tax qualified long-term care policy. The bill's provisions also include State reciprocity, dollar-for-dollar asset protection, uniform simplified and reporting to a single repository, and agent training, and consumer education, all of which are extremely important and encouraged in the purchase of those policies.

By the year 2030, and I know members of the committee know this. But by the year 2030, Medicaid's nursing home expenditures could reach $134 billion a year. That is up 360 percent over 2000

levels. ACLI's research previously reported in Can Aging Baby Boomers Avoid the Nursing Home in March 2000 indicates that by paying policyholders nursing home costs, and by keeping policy holders out of nursing homes by paying for home and community-based services, private long-term care insurance could reduce Medicaid's institutional care expenditures by $40 billion a year or about 30 percent.

In addition, the same ACLI study found that wider purchase of long-term care insurance could increase general tax revenues by $8 billion a year because of the number of family caregivers who would now be able to remain at work. Today, according to a recent study by the National Alliance of Caregiving, 6 percent of caregivers quit work to care for an older person; nearly 10 percent have to cut back their work schedules; 17 percent take leaves of absence; and 4 percent turn down promotions because of their caregiving responsibilities.

All of these, Mr. Chairman, members of the committee, are extremely important. We would be grateful for the open mind, the consideration of the committee and the Congress as they debate this and other issues. Thank you, Mr. Chairman.

[The prepared statement of Frank Keating follows:]

PREPARED STATEMENT OF FRANK KEATING, PRESIDENT AND CEO, AMERICAN COUNCIL OF LIFE INSURERS

My name is Frank Keating and I am President and CEO of the American Council of Life Insurers (ACLI), a Washington, D.C.-based trade association whose 356 member companies account for 80 percent of the life insurance industry's total assets in the United States. ACLI member companies offer life insurance; annuities; pensions, including 401(k)s; long-term care insurance; disability income insurance; reinsurance; and other retirement and financial protection products. ACLI member companies also provide 81 percent of the long-term care insurance coverage in the United States.

ACLI is delighted that the Committee is addressing an important issue facing this nation—long-term care. We applaud Chairman Barton for drawing attention to this matter, and we are pleased to discuss with the Committee the role that private long-term care insurance plays in helping to provide retirement security for millions of middle-income families.

One of the greatest risks to asset loss in retirement is unanticipated long-term care expenses. The risks of needing nursing home care also are substantial. Over half of women and nearly one-third of men 65 and older will stay in a nursing home sometime during their lifetime.[1] According to the 2005 Genworth Financial 2005 Cost of Care Study, the annual cost of a nursing home stay currently is almost $70,000. This increased by 6% in the past year alone. The cost of Long Term Care services can quickly erode a hard-earned retirement nest egg.

CURRENT FINANCING FOR LONG-TERM CARE SERVICES

Long-Term Care Insurance

The long-term care insurance market is growing in both the individual and group segments. Long-term care insurance products continue to adapt to give policyholders more choices and flexibility at the time of claim. For instance, the market has evolved from one that offered primarily nursing home-only plans early on, to one that offers flexible care options and numerous consumer protections today. Most policies allow customers to choose between in-home care, assisted living facilities and nursing homes, encouraging the individual and their families to customize his or her care needs. In addition, policies offer the services of a care coordinator at the time of claim to help craft a plan of care and identify local care providers.

Plans today are guaranteed renewable, have a 30-day "free look" period, offer inflation protection, cover Alzheimer's disease, have a waiver of premium provision,

[1] Murtaugh, C.M., P. Kemper, and B.C. Spillman (1990). The Risk of Nursing Home Use in Later Life. *Medical Care* 28(10): 952-62.

and offer unlimited benefit periods. Benefits are paid when a person needs help with two or more activities of daily living or is cognitively impaired.

Industry data shows that between 1994 and 1997 the average issue age for private long-term care policies was over 67 and today's average issue age currently stands at 58 years of age.

Long-Term Care Partnerships

Increasingly, states are tackling the costs of long-term care and are exploring ways to partner with the private insurance industry to alleviate a continuously growing Medicaid burden. One such way is through the *Partnerships for Long-Term Care,* a pilot program developed by the Robert Wood Johnson Foundation in conjunction with state governments and the support of the private insurance industry.

The Partnerships allow consumers to purchase a long-term care policy whose benefits must be fully utilized prior to qualifying for Medicaid. When that coverage is exhausted, individuals may apply for Medicaid, as they would have without the private insurance. Because they utilized their insurance coverage under the Partnership, they can protect the level of assets as defined in their state's program.

Partnerships have taken the form of two models. The dollar-for-dollar model allows people to buy a policy that protects a specified amount of assets. The total asset model provides protection for 100 percent of assets once they exhaust their private insurance coverage.

The Partnership program is currently operational in four states: California, Connecticut, Indiana and New York. More than 225,000 long-term care insurance Partnership policies have been purchased in those states, and fewer than 100 policyholders have exhausted their policies and accessed Medicaid. The Partnership benefits consumers, Medicaid, and private insurers.

In 1993, shortly after the Partnership pilots began, Congress suspended expansion of the Partnership to any additional states. The pilots were stopped due to concerns that a publicly funded program such as Medicaid would endorse private insurance programs. Others were concerned that the Partnership might increase Medicaid spending. However, as Medicaid costs increase, Congressional representatives from non-Partnership states have become interested in implementing Partnership programs. In addition, 18 states have passed legislation that would implement a Partnership once the 1993 restrictions are withdrawn or waived. The long-term care insurance industry is interested in expanding the Partnership beyond the four pilot states and is actively engaged in a public policy dialogue that is intended to utilize the lessons learned from those four Programs.

ACLI believes that the simplified uniform approach in House Bill HR 3511, sponsored by Representative Burgess and cosponsored by Representatives Johnson, Peterson, Pomeroy and Jindal is the most appropriate approach for expansion of the long-term care Partnership Program. HR 3511 provides Partnership eligibility for any state approved tax-qualified long-term care policy. The bill's provisions also include state reciprocity; dollar for dollar asset protection; uniform, simplified annual reporting to a single repository and agent training and consumer education, all of which can play an important role in encouraging the purchase of long-term care insurance and help provide important savings to Medicaid. We thank Mr. Burgess and the members of this Committee for their support.

Incentives to Encourage Individuals to Buy Long-Term Care Insurance

ACLI also supports legislation that provides individuals with a phased-in above-the-line federal income tax deduction for the eligible portion of the premiums they pay to purchase long-term care insurance. The long-term care policies eligible for the deduction are subject to broad consumer protections. In addition, ACLI supports measure to permit long-term care insurance policies to be offered under employer-sponsored cafeteria plans and flexible spending accounts.

Expansion of the Partnerships, along with these important tax incentives, will go a long way toward encouraging the purchase of long-term care insurance by middle-income Americans. Moreover, encouraging people to plan for their own long term care needs will reduce the burden on the Medicaid system. Individuals will have the ability to pay privately and have the choice of a variety of services and care settings.

While the financial benefits to individual policyholders are obvious, the benefits to government—and future taxpayers—of wider purchase of private long-term care insurance are substantial. By the year 2030, Medicaid's nursing home expenditures could reach $134 billion a year—up 360 percent over 2000 levels. ACLI's research, previously reported in "Can Aging Baby Boomers Avoid the Nursing Home," March 2000, indicates that by paying policyholders' nursing home costs—and by keeping policyholders out of nursing homes by paying for home- and community-based serv-

ices, private long-term care insurance could reduce Medicaid's institutional care expenditures by $40 billion a year, or about 30 percent.

In addition, the same ACLI study found that wider purchase of long-term care insurance could increase general tax revenues by $8 billion per year, because of the number of family caregivers who would remain at work. Today, according to a recent study by the National Alliance for Caregiving, 6 percent of caregivers quit work to care for an older person; nearly 10 percent have to cut back their work schedules; 17 percent take leaves of absence, and 4 percent turn down promotions because of their care giving responsibilities.

In conclusion, ACLI believes that protection and coverage for long-term care is critical to the economic security and peace of mind of all American families. Private long-term care insurance is an important part of the solution for tomorrow's uncertain future. As more than 77 million baby boomers approach retirement, the rapidly aging workforce, together with more employees caring for elderly parents, heighten the importance of long-term care planning as a workplace issue. As Americans enter the 21st century, living longer than ever before, their lives can be made more secure knowing that long-term care insurance can provide choices, help assure quality care, and protect their hard-earned savings when they need assistance in the future. We also believe that the costs to Medicaid—and therefore to tomorrow's taxpayers—will be extraordinary as the baby boom generation moves into retirement, unless middle-income workers are encouraged to purchase private insurance now to provide for their own eventual long-term care needs. Education, options, incentives and the efficient use of both public and private resources are critical to our nation's ability to finance long-term care in the decades ahead.

Again, the ACLI looks forward to working with this Committee to help Americans protect themselves against the risk of long-term care needs.

Mr. DEAL. Thank you, Governor. And I will say to the panel members, I think you have been told, we try to keep your comments to 5 minutes. We will be tolerant as much as possible, but thank you very much for your cooperation in that. Mr. Parrella.

STATEMENT OF DAVID PARRELLA

Mr. PARRELLA. Thank you, Congressman Deal, and members of the committee.

Here is my short list of what needs to be on the table in terms of future reform and Medicaid: Continue the expansion of managed care. Like it or not, this is where most of us now receive our care. Despite fondness of the golden age of fee for service, anyone who is objective about the improvements in access and quality of care purchased from accountable networks will have to conclude that managed care works for Medicaid populations.

No. 2. Remove the Federal barriers to innovative management of the dual eligibles. Forty-five percent of all Medicaid expenditures are for recipients enrolled in another comprehensive Federal health care program known as Medicare. The current system fails to reward the States for innovative strategies like disease management or managed care that ultimately benefit the Medicare budget. This makes no sense from either a State or Federal perspective, especially with the impending retirement of the baby boom generation. States should be able to count Medicare savings toward the cost effectiveness calculations of the waiver applications that would impact the cost of care for this very high cost population.

No. 3. Expand State flexibility on benefit design and cost sharing for populations above the poverty level. You cannot convince families to take an interest the cost of their care unless they share in it, however marginal that contribution might be. Clients like the rest of us should have an economic stake in maintaining their wellness. Penalty-free inappropriate use of the emergency room does no one any good. Pharmacy utilization should be based on

need, not advertising. And premiums for expansion populations are a small contribution when measured against the value of the benefit that is conferred. In Connecticut, our recent history of parents eligible for our HUSKY program with household incomes between 100 and 150 percent of the poverty level on the program, off the program, back on the program with a monthly premium demonstrates that it is better to offer working families coverage with higher cost sharing than no coverage at all.

No. 4. Restrict asset transfers. It is morally wrong to impose cost sharing and other cost containment measures on the poor when people of means can utilize trusts or broken policy on the penalty period for inappropriate asset transfers to qualify for Medicaid when they need long-term care. Connecticut submitted a waiver that would start the penalty period at the point of entry into a long-term care facility rather than when the inappropriate transfer actually occurred, in some cases, years prior to the fact.

In Connecticut and other waiver States, we are waiting to see what will transpire at the Federal level since this is such a significant change in how eligibility for States is calculated for long-term care. Connecticut is one of four States that are currently allowed to grant asset protection to people who insure themselves against the cost of long-term care under our long-term care insurance partnership. This authority should be granted to other States either under a waiver or estate plan amendment option to encourage individuals to ensure themselves against such an eventuality.

No. 5. Maximize third-party resources through premium assistance. It is incomprehensible why we choose to ignore the ability to share the cost of providing health care for our working families with employers. Failing to do so ignores the potential third-party resource and drives up the cost and caseloads in the public program. A State policy to assist families with payroll deduction for employer-sponsored insurance with a State option for a full Medicaid wrap-around would allow access to new provider networks and reduce costs.

No. 6. Pay pharmacists as service providers. Drug pricing is one of the most contentious areas in our budget. We have consistently tried to reduce the material cost of the drug and the dispensing fee paid to the pharmacist as a way of controlling costs.

I think that in the future we should consider paying higher handling charges to the pharmacists provided that the amount paid for the ingredients in a prescription reflects the actual average sales price for manufacturers and distributors for the drugs with full transparency on pricing provided to Federal auditors.

No. 7. Pay providers for performance. Physicians should be paid to provide treatments that follow evidence-based practice in a cost effective manner. Good quality care is usually less expensive.

Finally, I would say to those who oppose any Medicaid reform, we will never reach anything like full coverage in this country with the current Medicaid program as our only option. The benefit is too rich and the costs are too high.

Reserve traditional Medicaid for populations below the poverty level, but reform must include some or all of these measures if we are to achieve success. And that success benefits all of us. As the recent hurricane experience demonstrates, public health does not

distinguish amongst populations by payer. We all breathe the same air, we all drink the same water. Our bodies are subject to infection by the same microorganisms. The children who are on Medicaid are defending us today in Iraq, and their brothers and sisters will care for us as we age. The program is vital to our national interest and deserves our best efforts to sustain it in the years to come. Thank you.

[The prepared statement of David Parrella follows:]

PREPARED STATEMENT OF DAVID PARRELLA, DIRECTOR, MEDICAL CARE ADMINISTRATION, CONNECTICUT DEPARTMENT OF SOCIAL SERVICES

Before I turn to the issues surrounding Medicaid Reform, it would be useful to take a moment to consider the characteristics of the Medicaid program as it stands today. Started in 1965 as a program to provide health benefits to the welfare population, today less than 25% of the recipients on Medicaid receive cash assistance. By providing health coverage to 38 million children and parents in low income working families, Medicaid and its sister program, SCHIP, has played a vital role as the health insurance safety net in an economic environment where more and more Americans are being priced out of health insurance in the private market. Despite these recent expansions, a staggering 45 million Americans today have no health insurance.

These numbers are important in today's debate. Medicaid is asked to do many things. It is the insurer of last resort for poor and working families. It is the mainstay of persons with disabilities struggling to live in the least restrictive environment. It is, in effect, our national long term insurance program, not only for the poor but for the middle class and the affluent who divest themselves of assets when nursing home costs are looming in their near future. And yet all of these populations are held to the same standards for coverage, the same limits on cost sharing, and the same benefit packages in the absence of specific federal waiver authority. For a program this large and this diverse, greater flexibility to define eligibility, benefits and cost-sharing for those populations with household incomes above the poverty level is necessary in order for Medicaid to participate in broader health care reform.

We should take pride in what Medicaid has accomplished while incurring an administrative cost ratio that would be the envy of any private insurer. Indeed, the recent articles about Medicaid fraud are stark evidence that higher administrative costs would be well justified as a means of rooting out fraud and insuring that tax dollars go to the purposes for which they were intended.

It is the relationship of Medicaid to the uninsured that is the strongest rationale in my mind for reform. Between 2000 and 2005 the national Medicaid caseload increased by an astounding 40%. Medicaid now provides benefits to 53 million people at a cost of over $350 billion a year. It is the ultimate recipient of bad selection, the largest payer of long-term care, and the last alternative for families that lose private health insurance.

Reform strategies work. Between 2000 and 2003 states pushed ahead with at times unpopular measures such as mandatory enrollment in managed care, pharmacy prior authorization, and preferred drug lists. During that period of unprecedented enrollment growth, Medicaid acute care costs increased by only 6.9% annually. The rates for employer-sponsored insurance increased by 12.6% through the same period. You cannot look at those figures and fail to understand that Medicaid has absorbed the abandonment of family coverage for low-income workers from the private sector, and that Medicaid has needed all the tools in the cost containment toolbox to enable it to do so.

We are only a few years away from a demographic tsunami that will send millions of baby-boomers like me into the public programs for long-term care benefits. Many in my generation still believe that new pharmaceuticals will keep them young. They won't, but they will cost a fortune. Many of my peers believe that Medicare and retirement benefits will secure them against long-term care costs in their golden years of assisted living bliss. The more likely outcome is a semi-private room in a skilled nursing facility with Medicaid picking up the tab. In a program where 50% of all expenditures currently go for institutional long-term care, this demographic prospect is scary. Left unchanged it will set up a political tension between our children and ourselves that will test the bounds of their affection for us as they see their own retirements forestalled and their FICA deductions from their paychecks increased.

Most importantly to me, this competition for resources from an aging population will inhibit further efforts by the states to address the problem of the uninsured. We are lucky in Connecticut. We live in one of the richest states in the country. We have an abundance of medical providers compared to states in rural and frontier areas. Despite the vicissitudes of the budget battles over the past decade, we still offer broad coverage for the poor that goes beyond what Medicaid is willing or able to match with federal dollars. Our state-funded SAGA medical program provides comprehensive coverage to over 30,000 single adults who do not meet the categorical requirements for Medicaid, despite their very low income. Our ConnPACE program provides state funded assistance for the cost of prescription drugs to over 50,000 senior citizens. Our SCHIP program provides coverage to uninsured children up to 300% of the federal poverty level with a buy-in for parents with household incomes above that. Medicaid covers children and pregnant women with household incomes up to 185% of the federal poverty limit without an asset test and parents up to 150%. We have a Breast and Cervical Cancer program that serves all uninsured women who are unfortunate to have either of those diagnoses, regardless of their income level. We have a medically needy program that through the bewildering process of spend-down does provide coverage to thousands of disabled adults and nursing home patients. As we sit here today, these programs together serve nearly half-a-million of our neighbors. One out of every ten residents of our state receives assistance through the HUSKY program for families and children. One quarter of all the births in the state each year are funded by that same program. Seventeen thousand seniors receive home care as an alternative to institutional care under our federal waivers. Two-thirds of all the patients in nursing home beds right now are supported by Medicaid. We are currently working to expand coverage for children with special health care needs, to provide more alternatives in the community for persons with cognitive disabilities, to expand access to mental health services for children, and to provide family planning services to all uninsured women with incomes below 185% of poverty.

We can do these things in Connecticut because we have the resources, despite the fact that we receive the minimum federal match rate of 50% on our Medicaid expenditures. Just like every other state, we struggle with budget priorities every year, balancing the growth in the percentage of the General Fund that goes to the Medicaid program against other priorities like education and public safety. This year Connecticut, like a growing list of other states, will spend more on Medicaid than it does on education, a first for our state. We continue to do these things in the face of a Medicaid regulatory environment that makes it all but impossible to implement many of the cost containment strategies that are currently employed by the private sector in providing care to comparable populations.

But don't assume that same situation pertains in other states. Many states simply have no option to increase revenues and no further state expenditures to capture under a Medicaid claim, regardless of the federal match rate. As you watch the implementation of Medicare Part D, its is the poor states that will feel most acutely the impact of clawback payments to the federal government on their dual eligible population with no off-setting savings on the pharmacy costs of state retirees or on a State Pharmacy Assistance Program like ConnPACE, either of which would have been historically unaffordable. States in the hurricane devastated areas in the Gulf face nearly insurmountable difficulties in providing medical care to the survivors in the midst of an economic and environmental catastrophe. The Centers for Medicare and Medicaid Services should immediately set aside any thought of special waivers for presumptive eligibility for the host states that are receiving refugees from the storm ravaged areas and authorize 100% federal reimbursement for the cost of providing immediate temporary Medicaid assistance to our displaced fellow countrymen and women.

Medicaid reform is a moral imperative that demands that reasonable measures be taken now to allow the states the time and resources to respond to the challenges of an aging population, a growing number of uninsured, and unprecedented, unanticipated events like 911 and Hurricane Katrina and the attendant economic dislocation.

Here is my short list of what needs to be on the table in terms of future Reform:

1. **Continue the expansion of managed care**—Like it or not, this is where most of us now receive our care. Despite nostalgic fondness for the golden age of fee-for-service, anyone who is objective about the improvements in access and quality of care purchased from accountable networks will have to conclude that managed care works for Medicaid populations.

2. **Remove the federal barriers to the innovative management of the dual eligibles**—45% of all Medicaid expenditures are for recipients enrolled in another comprehensive federal health care program known as Medicare. The current system

fails to reward the states for innovative strategies like disease management or managed care that ultimately benefit the Medicare budget. This makes no sense from either a state or a federal perspective, especially with the impending retirement of the baby boom generation. States should be able to count Medicare savings towards their cost effectiveness calculations for their waiver applications that would impact the cost of care for this very high cost population.

3. **Expand state flexibility on benefit design and cost sharing for populations above the poverty level**—You cannot convince families to take an interest in the cost of their care unless they share in it, however marginal that contribution might be. Clients, like the rest of us, should have an economic stake in maintaining wellness. Penalty-free inappropriate use of the emergency room does no one any good. Pharmaceutical utilization should be based on need, not advertising. And premiums for expansion populations are a small contribution when measured against the value of the benefit that is conferred. In Connecticut, the recent history of parents eligible for our HUSKY program with household incomes between 100 and 150% of the poverty level—on the program, off the program, back on the program with a monthly premium—demonstrates that it is better to offer working families coverage with higher cost sharing, than no coverage at all. Preserve the existing limits on Medicaid cost sharing for populations with household incomes below the poverty level, but give states the option of making them enforceable. Give states the option of imposing greater cost-sharing, including things like tiered co-payments for prescription drugs, for populations above the poverty level. Make it affordable for states to assist the working poor with coverage that is comparable to the coverage that is available to their peers through their place of work.

4. **Restrict Asset Transfers**—It is morally wrong to impose cost sharing and other cost containment measures on the poor when people of means can utilize trusts or a broken policy on the penalty period for inappropriate asset transfers to qualify for Medicaid when they need long-term care. Connecticut submitted a waiver that would start the penalty period at the point of entry into a long-term care facility, rather then when the inappropriate transfer actually occurred, in some cases years prior to the fact. This measure alone has been scored by the Congressional Budget Office as having the potential to save $1.4 billion nationally over the next five years. In Connecticut and in the other waiver states we are waiting to see what will transpire at the federal level, since this is such a significant change in how eligibility for long-term care is calculated. Connecticut is one of four states that are currently allowed to grant asset protection to people who insure themselves against the cost of long-term care under our Long Term Care Insurance Partnership. This authority should be granted to other states either under a waiver authority or a State Plan Amendment option to encourage individuals to insure themselves against such an eventuality. Grant tax incentives or other inducements if necessary. But we must change the mindset that long-term care under Medicaid is a middle-class entitlement that people have no responsibility to insure against.

5. **Maximize Third Party Resources through Premium Assistance**—It is incomprehensible why we choose to ignore the ability to share the costs of providing health care for our working families with employers. Failing to do so ignores a potential third party resource and drives up the costs and caseloads in the public programs. A state policy to assist families with the payroll deduction for employer-sponsored insurance with the state option for a full Medicaid wraparound would allow access to new provider networks and reduce costs significantly. The federal government should make it a priority to simplify the steps necessary to partner with the private sector to provide coverage.

6. **Pay Pharmacists as Service Providers**—Drug pricing is one of the most contentious areas in the Medicaid budget. We have consistently tried to reduce the material cost of the drug and the dispensing fee paid to the pharmacist as a way of controlling costs. I think that in the future we should consider paying higher handling charges to the pharmacists provided that the amount paid for the ingredients in a prescription reflects the actual average sales price from manufacturers and distributors for the drugs with full transparency on pricing provided to federal auditors. We need the pharmacists as partners in the management of a complex benefit that now includes prior authorization, generic substitution, and consultation with a preferred drug list. The costs of the transaction for materials between the manufacturer and the pharmacist should not drive Medicaid costs.

7. **Pay providers for performance**—Physicians should be paid to provide treatments that follow evidence-based practice in a cost effective manner. Good quality care is usually less expensive.

Finally, I would say to those who oppose any Medicaid reform on principle, we will never reach anything like full coverage in this country with the current Medicaid model as the only option. The benefit is too rich and the costs are too high.

Reserve traditional Medicaid for a population below the poverty level. But Reform must include some or all of these measures if we are to achieve success in a viable, sustainable Medicaid program.

That success benefits us all. As the recent hurricane experience demonstrates, public health does not distinguish amongst populations by payer. We all breathe the same air. We all drink the same water. Our bodies are subject to infection by the same microorganisms. The children of Medicaid are defending us today in Iraq and Afghanistan. Their brothers and sisters will care for us as we age. The program is vital to our national interest and deserves our best efforts to sustain it in the years to come.

All of us who care about Medicaid must not be enemies, but friends. Our disagreements may divide us on methods, but they should never divide us on principle. Surely with a common commitment to improving the health of the least fortunate of our neighbors we can discover, as Lincoln said, the better angels of our nature.

Thank you, I would be happy to answer any questions that you may have.

Mr. DEAL. Thank you.

Dr. Alexander.

STATEMENT OF DAVID ALEXANDER

Mr. ALEXANDER. Thank you, Congressman Deal, and members of the committee for the opportunity to testify today. I am the president of DeVos Children's Hospital in Grand Rapids, Michigan. We are Michigan's second largest provider of Medicaid services to children and part of Spectrum Health which is the largest employer in West Michigan. I am also a pediatrician.

In my remarks today, I want to underscore three points. First, Medicaid affects all children, because it is the financial backbone of children's health care.

Second, I urge Congress to exercise caution in assessing proposals to achieve Medicaid savings through cost sharing and benefit flexibility for children who today are exempt from cost sharing, and guarantee coverage for medically necessary care.

Third, I recommend reforms in Medicaid that address the unique challenges children and their providers face including enrollment, quality improvement, and access.

I want to begin by explaining why changes in Federal Medicaid policy have the potential to affect all children, not only children from low income families. Medicaid is by far the Nation's largest payor of children's health care. It pays for the health care of 26 million children, more than half of all Medicaid recipients. One in four children is covered by Medicaid. Medicaid pays for on average half of the patient care provided at a Children's Hospital.

I also want to emphasize the fact that children offer little opportunity for Medicaid savings. Fortunately, most children are healthy. As a consequence, children account for only 22 percent of Medicaid spending. Medicaid per capita spending for children is comparable to costs under private insurance despite the fact that Medicaid serves many more children with disabilities and special health care needs.

Given these facts, children's hospitals urge Congress to exercise caution in considering proposals to achieve savings through cost sharing or benefit flexibility. Cost sharing has been demonstrated to reduce utilization of care, but that said, it doesn't only reduce frivolous care, it reduces needed care as well including the primary and preventive care that children need. A good example of this is in asthma, which is the most common reason children are seen for

emergency care and their most common hospital admitting diagnosis.

Preventive care for children with asthma includes regular office visits. Additionally, there is clear evidence that early intervention with acute asthma attacks is critical to preventing more costly care including hospitalization.

Cost sharing has the potential to create barriers for children's access to care, resulting in sicker children, more costly care, and increased cost shifting to providers. I respectfully ask you to continue the Federal exemption of children from cost sharing under Medicaid.

In addition, we ask Congress to retain Medicaid's promise of medically necessary care for children. Federal Medicaid law ensures children receive comprehensive benefits including medically necessary care. Fortunately, again, most children do not need to use the full benefits that Medicaid promises; but when a child is sick or disabled or injured, which can happen in the blink of an eye, Medicaid's benefits can make the difference between growing up to be a productive adult or not growing up at all.

Now I want to turn to three reforms that would benefit children. First, we need to enroll all Medicaid eligible children. Two thirds of uninsured children are already eligible but unenrolled in Medicaid or SCHIP. That is why President Bush and others have made improved enrollment one of their priorities. Congress should act on these proposals.

Second, there are no Federal Medicaid quality standards for children. Congress needs to make the same investment in quality and performance measures for children that is being made for adults and the elderly under Medicare.

Third, independent children's hospitals are excluded from an important source of savings for hospitals serving a disproportionate share of low income patients, the 340B drug discount program. Children's hospitals are excluded only because they are exempt from the Medicare Perspective Payment System even though they are among the most significant safety net hospitals in this country. Congress should remove this barrier.

I want to take a moment to speak to two points related to Hurricane Katrina and its impact on children. First, very sick children need care that is often available only on a regionalized basis in children's hospitals. Last week, Children's Hospital in Houston, Little Rock, Birmingham, Miami, and Kansas City sent evacuation teams to New Orleans. Dozens of the sickest children were evacuated using their own transport and medical teams. These hospitals were able to act quickly and effectively, even under extraordinary conditions, because they are experts in caring for children.

Returning to the specific subject of this hearing. Medicaid is extremely important to these and all children's hospitals. They were able to help last week because they are strong, experienced institutions. But they are also vulnerable. All of them devote 40 percent or more of their care to Medicaid patients. The future of Medicaid can profoundly affect our ability to meet the needs of the sickest children no matter what their circumstances.

In conclusion, as you pursue the development of Medicaid legislation, please keep in mind that your decisions will affect health care for every child, including yours and mine. Thank you.

[The prepared statement of David Alexander follows:]

PREPARED STATEMENT OF DAVID ALEXANDER, PRESIDENT, DEVOS CHILDREN'S HOSPITAL

Chairman Barton, Ranking Member Dingell and distinguished members of the Committee, my name is David Alexander and I am the president of DeVos Children's Hospital in Grand Rapids, MI, and a pediatrician. I appreciate the opportunity to testify before you today on behalf of my hospital and the National Association of Children's Hospitals on the critical role Medicaid plays for children and children's hospitals.

DeVos Children's Hospital is a tertiary referral center for 37 counties in Western Michigan and an established leader dedicated to improving the health and lives of children and families. We receive nearly 7,000 inpatient admissions and provide more than 100,000 outpatient visits and nearly 30,000 emergency department visits annually. We are a vital resource for our communities and our region, providing care to every child who comes to us, regardless of ability to pay. We are part of Spectrum Health, the largest employer in West Michigan. We are also affiliated with 17 other hospital providers across western and northern Michigan from St. Josephs to Cheboygan in a "Partners in Childrens' Health Network."

Founded in 1995, N.A.C.H. is the public policy affiliate of the National Association of Children's Hospitals and Related Institutions (NACHRI). N.A.C.H. represents more than 130 children's hospitals nationwide, including independent acute care children's hospitals, children's hospitals within larger hospitals, and children's specialty and rehabilitation hospitals. N.A.C.H. assists them in fulfilling their missions of clinical care, education, research, and advocacy devoted to children's unique health needs.

In my testimony, I would like to underscore three points.

1. Medicaid affects health care for all children. Children are more than half of Medicaid recipients, yet account for only 22% of Medicaid spending, including children with disabilities. Medicaid reforms that seek to find savings in the area of children's coverage, whether by reducing benefits or imposing cost sharing, can put children and their providers at risk. When Medicaid support for children tightens, it can have such a large financial impact on children's providers that it can affect their ability to deliver a wide range of services needed by all their patients, not only those covered by Medicaid. Children's hospitals urge Congress to retain children's guarantee of medically necessary care and children's exemption from cost sharing under Medicaid.

2. Medicaid is the financial backbone of children's hospitals and children's health care. The nation's children's hospitals welcome Congress' interest in taking a serious look at how to sustain, strengthen, and modernize Medicaid. Children's hospitals, and the children and families we serve, rely upon a strong, stable Medicaid program because it is a vital partner in health care for all children, rich and poor alike. One in four children relies on Medicaid for health coverage. Medicaid on average represents more than 30% of a pediatrician's payments and 50% of a children's hospital's revenues. In many states, the proportions are much higher.

3. Children's hospitals support reforms that address the unique and very real challenges children face in Medicaid today. The most significant challenge facing Medicaid coverage for children is not out-of-control spending or too rich benefit packages that are inappropriate to their needs. Instead, the real challenges are barriers to enrollment for eligible children, a dearth of pediatric quality and performance measures, and the absence of adequate payment, much less any reward or incentives for efficiency, for children's health care providers. A Medicaid program that can recognize and reward quality and efficiency can mean better care and lower costs.

Medicaid Is a Vital Partner in Health Care For All Children

Both directly and indirectly, Medicaid has become a vital partner in the provision of health care for all children. Medicaid not only covers 26 million children, along with the State Children's Health Insurance Program (SCHIP) it also protects children from the loss of health insurance plaguing a growing number of adults. According to the U.S. Census Bureau, it is because of Medicaid and SCHIP that the number and proportion of children who are uninsured has not increased at a time when employer-sponsored health insurance has been declining and the number of all unin-

sured people has continued to grow. Children's hospitals support federal incentives to deter loss of private coverage, but we believe Medicaid and SCHIP's safety net coverage for children should be maintained and strengthened.

More than half of Medicaid's enrollees, 50.5 percent, are children. Children under one year of age are 3.8 percent of Medicaid enrollees, children ages 1-5 are 16.5 percent of enrollees, and children ages 6-18 are 30.2 percent of enrollees. Fifty percent of children receiving Medicaid or SCHIP live at or below the federal poverty level.

At any point in time, Medicaid pays for the health care of one in four children, nearly one in three children with special health care needs, and one in three infants in the U.S. In some of the nation's poorer states, Medicaid pays for the health care of nearly one in three children and one in two infants.

With Medicaid financing health care for such a large number of the nation's children, it is surprising to many that expenditures on children's health services are not driving the growth in Medicaid spending. Children, including children with disabilities, account for only 22% of all Medicaid spending. On average, Medicaid spends $1,388 per non-disabled child, compared to $1,790 per non-elderly, non-disabled adult, $11,408 per disabled individual, and $10,694 per elderly adult per year, as of FY 2002. Annual per capita spending for all children, including children with disabilities, is $1,773, compared to $4,891 for all non-elderly adults, including those with disabilities.

The low Medicaid cost per child reflects the fact that children are generally healthier than adults. It also reflects the fact that in the last decade, the major strategy used by states to control Medicaid spending has been capitated managed care plans. Children have led the managed care revolution in both public and private insurance, with the majority of all children assisted by Medicaid now enrolled in managed care but only the minority of adults and the elderly.

Taken together, these facts mean two things. First, because it finances such a large proportion of children's health care, over time Medicaid literally can affect access to health care for all children. Second, because children account for such a small proportion of Medicaid spending, there is little opportunity to achieve substantial Medicaid savings from children's health care.

Medicaid Is the Financial Backbone of Children's Hospital Services

In the U.S., children's hospitals are indispensable to children's health care, because pediatric health care services, particularly specialty care, are concentrated in relatively few institutions.

- Children's hospitals are the major providers of both pediatric inpatient and outpatient services. Less than 5% of all hospitals, children's hospitals provide more than 40% of all hospital care for children, and more than 80% of hospital care required by children with serious illnesses, such as cancer or heart disease. Children's hospitals perform 98% of pediatric organ replacements.
- Despite representing such a small proportion of all hospitals, children's hospitals train the majority of the nation's pediatricians, virtually all of its pediatric subspecialists and the large majority of pediatric research scientists.
- Children's hospitals house the nation's leading pediatric biomedical and health services research centers. More than a third of all of the National Institutes of Health's pediatric research funding supports research in children's hospitals or their affiliated medical school pediatric departments.
- Children's hospitals are the major safety net providers for children. They are often doctor, clinic, dentist and hospital for low-income children. Children's hospitals work hand in glove with community health centers in providing staff and taking referrals for children needing specialty care. They are the frontlines of support for child abuse prevention and treatment, as well as public health and injury prevention advocacy for children.

Although almost all are private institutions, children's hospitals depend on Medicaid financing to serve all children, as well as children from low-income families, because Medicaid plays an extraordinarily large role in their financing. On average, children's hospitals devote about 50% of their patient care to children assisted by Medicaid. It is not unusual for a children's hospital to devote 60%, 70%, or more of their care to children assisted by Medicaid. At DeVos Children's, 41% of our patients are covered by Medicaid. We are the second largest provider of Medicaid services to children in Michigan.

Medicaid is characterized as a state/federal partnership, but a key partner is missing from that characterization: safety net providers, such as children's hospitals, that provide the majority of care to Medicaid beneficiaries.

Medicaid depends on safety net hospitals such as children's hospitals to remain true to our missions: to provide the highest quality care to all children who come through our doors, regardless of ability to pay. The nation's children's hospitals will

always strive to hold steadfast to our missions, but low Medicaid reimbursements have increasingly made it more difficult.

Since 2001, children's hospitals, along with pediatricians, have struggled annually to avoid state Medicaid provider reimbursement cuts, as almost every state has adopted repeated, annual reductions in its Medicaid budget. In Michigan, where the state economy continues to struggle, the state Medicaid program has been cut more than $540 million since 1998, and is now underfunded by $1 billion.

Medicaid also falls short of paying the cost of the care required for the children it covers. On average, Medicaid reimburses 73% of the cost of patient care provided by a children's hospital. Even with disproportionate share hospital (DSH) payments, a children's hospital is reimbursed for, on average, only about 80% of costs. For outpatient primary and specialty care, as well as physician care, the picture is even worse.

Taken together, these facts mean that Medicaid plays such a large role in the financing of children's hospitals that any changes in Medicaid potentially could affect the financial ability of the hospitals to serve all children, because we cannot reduce services for only poor children in order to absorb Medicaid losses. Our hospitals must absorb Medicaid losses in their clinical, training, research and community programs by increasing waiting times for services, closing the financially weakest services, delaying expansion of new services, curtailing training programs at a time of growing pediatric subspecialist shortages, or curbing the development of research enterprises. Such actions affect access to health care for *all* children in our communities.

Children's Hospitals Recommend Retaining Medicaid's Unique Benefits for Children and Federal Exemption From Cost Sharing Benefits

Calls for increased state flexibility to provide different benefit packages across populations promise little in real savings from children's health care and do not reflect the reality of children's health care needs. By and large, children are very small consumers of health care. Nationwide, 95% of children account for only about 6% of personal health care spending. In Medicaid, children represent more than 50 percent of enrollees but account for only 22 percent of spending.

Although most children are healthy, a child can become seriously ill in the blink of an eye. That is why all children need the full scope of Medicaid's Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit, including its federal guarantee of medically necessary care for children. EPSDT was designed to meet children's unique health care needs, particularly children with disabilities who are disproportionately represented in Medicaid.

Congress should retain the EPSDT benefit package for Medicaid eligible children and should not permit it to be waived. At a minimum, EPSDT should be retained for all mandatory eligible children, all children with family incomes below 150% of poverty, and all eligible children with disabilities, including optionally eligible children with disabilities, such as "Katie Beckett" children and children in foster care.

Cost Sharing

Congress should retain Medicaid's exemption of children from cost sharing. Research has demonstrated that cost-sharing can discourage health care utilization, with adverse impact on health status. Imposing cost sharing on children is unlikely to prevent what is often deemed "inappropriate" or excessive use of medical services. It could, however, prevent parents from seeking care at the right time and in the right setting, resulting in a sicker child and more expensive care.

At a minimum, new cost sharing obligations should not be imposed on children with family incomes below 150% of poverty. All eligible children with disabilities, including optionally eligible children with disabilities such as "Katie Beckett" children, and children in foster care, should also be exempt from cost sharing obligations.

For children with incomes above 150% of poverty, cost sharing obligations should be no greater than what is permitted by SCHIP. Such cost sharing should be limited to co-payments and deductibles; it should not include insurance premiums, which, if unpaid, would leave a child uninsured.

Additionally, parents' failure to pay cost-sharing obligations should not prevent children from receiving the care they need, nor should it prevent providers from being reimbursed for the services. As President Bush said in his first inaugural address, "Children at risk are not at fault."

Children's Hospitals' Recommendations for Modernizing Medicaid for Children

The real challenges facing children in Medicaid are unfulfilled enrollment, the dearth of pediatric quality and performance measures and a lack of federal Medicaid

investment in their development, and the absence of any reward for quality and performance in pediatric care.

To address these challenges, children's hospitals recommend reforms that would:

1. Dramatically improve enrollment of millions of eligible but unenrolled children in public insurance programs.
2. Make a meaningful investment in the development and evaluation of pediatric quality and performance measures.
3. Give Medicare Prospective Payment System (PPS)-exempt children's hospitals the ability to participate in the 340(B) drug discount program if they meet the same eligibility criteria as other disproportionate share hospitals (DSH).

Enroll All Eligible Children

Two-thirds of the nation's uninsured children are eligible but not enrolled in Medicaid or SCHIP. If all eligible children were enrolled, the nation would have virtually eliminated the problem of uninsured children—and the health risks that accompany it.

President Bush, as well as leaders in both parties in Congress, supports proposals that would help states to enroll all eligible children in Medicaid and SCHIP. Last September President Bush said, "America's children must also have a healthy start in life—we will lead an aggressive effort to enroll millions of poor children who are eligible but not signed up for the government's health insurance programs. We will not allow a lack of attention or information to stand between these children and the health care they need."

Children's hospitals recommend both financial and administrative reforms to promote effective enrollment and retention. For example, "express lane" enrollment using a single, simplified application form for multiple public assistance programs, such as the school lunch program, and procedures that allow for enrollment of children by mail or through the Internet, would reduce barriers to children' enrollment. Such proposals are included in S. 1563, the "ABCs for Children's Health Act of 2005."

Make a Federal Investment in High Quality, Safe and Efficient Care for Children

Although it is the nation's single largest payer of children's health care, the federal Medicaid program has done little to invest in pediatric quality and performance measures. There is a serious dearth of pediatric quality and performance measures for children's health care, because private payers are investing primarily in the development of measures for adult care and the federal government is investing primarily in the development of measures for the health care of Medicare recipients. Most states do not have the resources, much less a sufficiently large population of children, for the development and testing of effective pediatric measures.

Advance Pediatric Quality Measures. Children's hospitals recommend a top to bottom federal commitment to improving the safety, efficiency and effectiveness of health care services to children just as it is already doing for adults in Medicare. Such a commitment should result in better outcomes and reduce costs in hospitals.

This was the premise of a Robert Wood Johnson Foundation grant program called Pursuing Perfection. One of its grantees, Cincinnati Children's Hospital Medical Center, made a significant investment in capital and commitment to a number of initiatives from more efficient use of facilities to electronic medical records and outcomes reviews. The hospital won a national award for its progress in quality and cost effective change. But when the hospital turned to the federal government to seek a broader application of its findings, it found there was no where to go to focus on children's unique needs.

Development, testing and application of pediatric quality and performance measures cannot be accomplished on a state by state basis. Federally funded demonstration projects, with shared risk-adjusted measures appropriate to children, can advance current efforts and transfer the results across children's hospitals nationwide.

Improve Access. Emergency room (ER) use continues to rise. For non-emergent care, this is inefficient and costly for hospitals and payers and it doesn't provide children with the best care. Texas Children's Hospital, through its subsidiary, Texas Children's Pediatric Associates, has a program to provide primary care pediatric practices in medically underserved communities where families often turned to ERs for primary care. This program, Project Medical Home, currently serves children in three communities, regardless of their ability to pay. Other children's hospitals have similar projects. Giving children and their families a consistent pediatrician or "medical home", with extended hours and 24-hour phone availability, can reduce non-emergent ER use, deliver more efficient care and reduce hospital admissions.

These models of care are not organizationally complex or bureaucratic. A federal investment is needed to replicate such innovations.

Promote Disease Management. More than half of the children served by children's hospitals have chronic conditions. Many children's hospitals have programs to provide disease management for at least some of these children. These programs are often difficult to sustain or to expand to meet the number of children who could be served, because disease management itself is often not covered by Medicaid and because outpatient and physician payments are, in general, very low. While studies at individual institutions have shown the cost effectiveness of disease management as well as the improved health of the children served, studies of a larger scope, across institutions, with more evidence-based measurement are needed. Effective disease management can help stabilize medical conditions, improve functional outcomes, prevent or minimize acute exacerbations of chronic conditions, and reduce adverse health outcomes and avoidable hospitalizations.

In sum, the children's hospitals recommend:

- A 4-year program to develop, report and evaluate national quality and performance measures for children's hospital services. The federal government is making an investment in quality and performance measures for seniors and adults in Medicare, working with hospital groups. It is time to do the same for children and Medicaid, working with children's hospitals and others with expertise in pediatric hospital measures. It will enable states and providers to have the national measures and process they need to move forward.
- A CMS Medicaid Demonstration Program: Transforming the Delivery of Children's Health Care. There are currently no avenues to fund multi-state demos or promising approaches in providing better, safer, more efficient and effective care for children. Demonstration project areas should include: Project Medical Home—children's hospitals' community based clinics for medically underserved populations, models integrating health IT and quality for children's hospital care, transforming the delivery of children's hospital care—more efficient and effective care means better care at less cost, and care management for children with chronic conditions.

Permit Children's Hospitals to Participate in the Medicaid Drug Discount Program.

Children's hospitals also recommend that Congress amend Section 340(B) of the Public Health Service Act to permit independent children's hospitals to qualify for drug purchasing discounts if they meet the criteria for the other participating DSH hospitals, with the exception that they be Medicare PPS hospitals. Independent children's hospitals are exempt from Medicare PPS.

Conclusion: Work on Medicaid as If It Matters to All Children

Medicaid faces many challenges today in large part because of its success in helping the nation address so many different challenges that our health care system otherwise is not designed to handle: the long-term care needs of millions of middle and low-income Americans, the chronic health care needs of adults and children with serious disabilities, basic and catastrophic health care needs of low-income senior citizens, and the basic and catastrophic health care needs of millions of low and middle-income children.

As Congress focuses on the fiscal future of Medicaid, we urge you to act as if your decisions will have the potential to affect, directly or indirectly, every child in this country, including our own children and grandchildren.

Mr. DEAL. Thank you.

Mr. Gardner.

STATEMENT OF JIM GARDNER

Mr. GARDNER. Thank you. Mr. Chairman, members of the committee, I am honored to be with you today. My name is Jim Gardner, and I am the chief executive officer at Northeast Georgia Medical Center and Health System in Gainesville, Georgia, about an hour north of Atlanta. Our hospital is a 557 bed regional not-for-profit community hospital serving well over a half million individuals in northeast Georgia. Our emergency room treats close to 100,000 patients a year and is the third busiest in the State of Georgia. I was asked to share with this committee the perspectives

of a real-life community hospital working hard to survive in this country.

We are facing considerable challenges, dealing with increases in the number of uninsured parents and potential reductions in government funding for Medicaid. I am not sure I can do that assignment justice in our short time together, but I would like to offer a few thoughts for your consideration.

Let me begin with Medicaid. I deeply respect the pressure you and your counterparts at the State level are under to reduce the unsustainable rate of growth in the Medicaid program. In Georgia, Medicaid enrollment has risen more than 50 percent in 5 years, and Georgia hospitals are paid 13 percent less than the actual cost of care for each and every Medicaid patient that we treat. In combination with rising private insurance premiums and illegal immigration rates, Georgia is already living health care's perfect storm. This same is being played out all over the country and respectfully demands a bipartisan action plan to redesign what has evolved into a flawed Medicaid program that threatens not only hospitals and other providers, but also the communities and the people you represent. Without fundamental reform of the Medicaid program that includes measures to protect providers, especially nonprofit safety net community hospitals like Northeast Georgia Medical Center from bearing the burden of such reforms, I am confident the rapidly escalating costs of the inefficient program will force States to cut more people from the Medicaid rolls. This will increase the number of the uninsured and further weaken the health status of communities across the Nation which will drive costs even higher and force hospitals to implement severe cost reduction to stay solvent.

In the current system, patients all too frequently access health care in the emergency room, which I am sure all of you know is the single most expensive setting to provide medical care. In our community, a typical visit to the doctor's office costs about $74, but the cost in the ER is more than three and a half times that amount. Due to Federal EMTALA regulations, however, my hospital has no choice but to service the community safety net. In 2004, our health system treated over 20,000 uninsured emergency room patients at a cost of $6.9 million. In the last 5 years, our combined bad debt, indigent care, and charity care has more than doubled hospital-wide from $16.6 million in 2000 to more that $35 million this year. To reinforce this point, I stress, these are my costs, not charges.

A full 29 percent of the patients to the ER in 2004 were nonemergent and seeking basic health care for common maladies like ear infections and the flu. Just extrapolating our numbers, that is roughly 29,000 patients and $5.6 million needlessly wasted in just one ER. That is $5.6 million would have purchased an additional 75,000 physician office visits at their price. With proper incentives, 104,000 patients could have been provided care in Gainesville instead of just the 29,000 with no cost increase to the system or our State. Right now there just aren't incentives for patients to seek care in the proper setting. Just show up in any hospital ER, and, by law, you have the right to be seen even if you never pay. That is simply not a sustainable model.

Current EMTALA regulations also compound inadequate Medicaid reimbursement rates even as providers seek to create greater local ownership of issues and cost effective treatment options. In our local community, public and private interests have formed an innovative health access initiative project. The objective of this initiative is to redirect unfunded patients to settings other than hospital emergency rooms. This is no magic bullet, but it has improved the situation in our region. Although I have seen some limited success, its true potential will not be realized until EMTALA is reconsidered and enhanced legal protection is afforded providers in the ER setting, who are prudently redirecting patients to the proper level of care.

At present, hospitals are precluded from redirecting patients to other more appropriate sources of care, assuming they exist, prior to a screening exam. This exam must include any and all diagnostic tests to complete the screening, so by the time we are done with the evaluation phase, all that is left are the medications.

Prescription drug costs are another huge irritant to Medicaid cost escalation and ER utilization rates. I can't give this committee an exact number, but can say with confidence many Medicaid and the uninsured patients become ER frequent fliers because they can't afford to fill their prescriptions. It is simply easier and more practical in the current environment to return to the hospital. Again, fundamental change is required.

Immigration trends in our region and country are also significantly impacting the growth of Medicaid and the cost of caring for the uninsured. In 2000, a local health study known as Healthy Hall, found 11 percent of our population to be uninsured, which in 2005 equates to 18,000 individuals. In that same survey, 33 percent of Latinos self-reported being uninsured.

Latinos in our local community are predicted to double from 19 percent of the population in 2000 to 38 percent by 2009. Reform of both Medicaid and immigration must be entwined, from my perspective, if large community hospital providers like Northeast Georgia Medical Center are to survive, especially when financial viability is largely a function of geography, not management talent or innovative community.

Let me explain the implications of our broken system. In relative terms, Northeast Georgia is one of the more financially stable hospitals in Georgia, and yet this year we are losing money on operations. Year to date, we have a negative operating margin. These past several years have seen a continued deterioration of that margin. Our hospital also frequently operates at or beyond capacity, especially in critical high-volume Medicaid dependent services like obstetrics where we expect to deliver close to 3,800 babies in 2005, most than 56 percent of whom are Medicaid. Absent dramatic changes, including significant staff reductions, our health system will not be able to generate the projected $340 million in capital required over the next 5 years to maintain and expand an aging infrastructure.

This past week my hospital was forced to eliminate 231 full-time jobs, and I am worried that that number will only increase over time in the current environment.

In closing, we all share a common interest in affordable health care serving those in our community. I know that Medicaid reform is complex and calls for systemic change that doesn't make an already tenuous situation any worse. I live and breathe the reality of your decisions every day and have been forced to make some very difficult management choices in the wake of a system that today just does not incentivize rational patient care. At the same time, I appreciate the work of the committee and its members, and know how seriously you approach the challenge before us. Thank you.

[The prepared statement of Jim Gardner follows:]

PREPARED STATEMENT OF JIM GARDNER, CHIEF EXECUTIVE OFFICER, NORTHEAST GEORGIA HEALTH SYSTEM, INC.

Mr. Chairman, Members of the Committee, I'm honored to be with you today. My name is Jim Gardner and I am chief executive officer at Northeast Georgia Medical Center and Health System in Gainesville, Georgia, about an hour north of Atlanta. Our hospital is a 557-bed regional, not-for-profit community hospital serving well over a half-million people in northeast Georgia. Our emergency room treats close to 100,000 patients a year and is the third busiest in the state of Georgia.

My congressman, Chairman Nathan Deal, asked me to share with this committee the perspectives of a real-life community hospital working hard to survive in this country. We are facing considerable challenges—dealing with increases in the number of uninsured patients and potential reductions in government funding for Medicaid. I'm not sure I can do that assignment justice in our short time together, but I would like to offer a few thoughts for your consideration.

Let me begin with Medicaid. I deeply respect the pressure you and your counterparts at the state level are under to reduce the unsustainable rate of growth in the Medicaid program. In Georgia, Medicaid enrollment has risen more than 50% in five years and Georgia hospitals are paid 13% less than the actual cost of care for each and every Medicaid patient we treat. In combination with rising private insurance premiums (partly due to "cost shifting") and illegal immigration rates, Georgia's already living healthcare's "Perfect Storm". This same scenario is being played out all over the country and respectfully demands a bipartisan action plan to redesign what has evolved into a flawed Medicaid program that threatens not only hospitals and other providers, but also the communities and the people you represent.

Without fundamental reform of the Medicaid Program, that includes measures to protect providers, especially non-profit "safety net" community hospitals like Northeast Georgia Medical Center, from bearing the burden of such reform, I am confident that rapidly escalating costs of this inefficient program will force states to cut more people from Medicaid rolls. This will increase the number of uninsured and further weaken the health status of communities across the nation which will drive costs even higher, and force hospitals to implement severe cost reductions to stay solvent.

In the current system, patients all too frequently access healthcare in the emergency room, which I'm sure all of you know is the single most expensive setting to provide medical care. In our community, a typical visit to the doctor's office costs about $74—but the cost in the ER is more than three and one-half (3.5x) times that amount. Due to federal EMTALA regulations, however, my hospital has no choice but to serve as the community "safety net". In 2004 our health system treated over 20,000 uninsured emergency room patients at a cost of $6.9 million. In the last five years our combined bad debt, indigent care and charity care cost has more than doubled hospital-wide, from $16.6 million in 2000 to more than $35 million this year. To reinforce this point—I stress these are my costs—not charges.

A full 29% of the patients presenting to the ER in 2004 were non-emergent, and seeking basic healthcare for common maladies like ear infections and the flu. Just extrapolating our numbers, that's roughly 29,000 patients and $5.6m dollars needlessly wasted in one ER. That $5.6m would buy an additional 75,000 physician office visits. With proper incentives 104,000 patient visits could have been provided in Gainesville instead of just 29,000 with no cost increase to our state. Right now, there just aren't incentives for patients to seek care in the proper setting. Just show up in any hospital ER, and by law they have to see you every time—even if you never pay. That's not a sustainable model.

Current EMTALA regulations also compound inadequate Medicaid reimbursement rates even as providers seek to create greater local ownership of issues and cost effective treatment options. In our local county, public and private interests have formed an innovative Health Access Initiative project. The objective of the initiative is to redirect unfunded patients to settings other than the hospital emergency room. This is no magic bullet but it has improved the situation in our region. Although we've seen some limited success, its true potential will not be realized until EMTALA is reconsidered, and enhanced legal protection is afforded providers in the ER setting who are prudently redirecting patients to the proper level of care. At present, Hospitals are precluded from redirecting patients to other more appropriate sources of care, assuming they exist, prior to a screening exam. This exam must include any and all diagnostic tests to complete the screening—so by the time we're done with the evaluation phase, all that remains is the writing of any prescriptions which might be indicated.

Prescription drug costs are another huge irritant to Medicaid cost escalation and ER utilization rates. I can't give this committee an exact number, but can say with confidence many Medicaid and uninsured patients become hospital ER "frequent flyers" because they can't afford to fill their prescriptions. It's simply easier and more practical in the current environment to return to the hospital. Again, fundamental change is required.

Immigration trends in our region and county are also significantly impacting the growth of Medicaid and the cost of caring for the uninsured. In 2003 a local health study, known as "Healthy Hall", found 11% of our popoulation to be uninsured, which in 2005 equates to 18,000 individuals. In the same survey, 33% of Latinos self reported being uninsured. Latinos in our local county are predicted to double from 19% of the population in 2000 to 38% by 2009. Reform of both Medicaid and immigration must be inextricably entwined from my perspective if large hospital providers like Northeast Georgia Medical Center are to survive, especially when financial viability is largely a function of geography, not management talent, or innovative community program development.

Let me explain the implications of our broken system. In relative terms, Northeast Georgia Medical Center is one of the more financially stable hospitals in Georgia, and yet this year we are losing money on operations. Year-to-date, we are running a (negative) "0.2 percent operating margin, and even with investment income our total margin will be less than 3 percent. In the last few years we have seen our total margin steadily deteriorate from 5.1% percent in 2002 to 2.9% percent so far in 2005.

Our hospital also frequently operates at, or beyond, capacity especially in critical high volume Medicaid dependent services like Obstetrics (Where we expect to deliver close to 3,800 babies in 2005—more than 56% Medicaid). Absent dramatic changes, including significant staff reductions, our health system will not be able to generate the projected $340 million in capital required over the next five years to maintain and expand an aging infrasturcture. This past week my hospital was forced to eliminate 231 full-time jobs and I'm worried that number will only increase over time in the current environment.

In closing, we all share a common interest in affordable healthcare for those in our communities. Medicaid reform is complex, and calls for systemic change that doesn't make an already tenuous situation any worse. I live and breathe the reality of your decisions every day, and have been forced to make some very difficult management choices in the wake of a system that today just does not incentivize rational patient care. At the same time I appreciate the work of the Committee and its Members, and know how seriously you approach the challenge before us. Thank you.

Mr. DEAL. Thank you.

Mr. Sheehan.

STATEMENT OF BOB SHEEHAN

Mr. SHEEHAN. Good afternoon, Congressman Deal, and members of the committee. I am the chief executive officer of Community Mental Health Authority of Clinton-Eaton-Ingham Counties in Lansing, Michigan. Each year, the CMH provides a comprehensive range of services to over 6,000 adults and children with mental illness throughout our three-county area. Central to our mission in providing services is the precept that anyone experiencing mental

illness should have access to those services right in their home community.

The National Council for Community Behavioral Care is the national voice of organizations that share that philosophy. National Council members provide safety net mental health care to over 5.9 million people across the U.S. My comments today reflect the concerns of the National Council and the providers it represents. We applaud your efforts to examine the Medicaid program, things that can be done to modify and to empower beneficiaries to fully participate in the process of obtaining health and wellness.

However, as you consider the ways in which the Medicaid program can be empowered, I also urge you to take a considered approach to Medicaid reform. It is important that first we do know harm when we change the program.

Unfortunately, I must report that a number of recent reform proposals would bring disastrous consequences to people with mental illnesses and others who depend on the Medicaid program. Specifically, these proposals include increasing cost-sharing requirements for beneficiaries, reducing access to medications, and sharp restrictions on services such as rehabilitation and targeted case management all are crucial in meeting the health care needs of vulnerable populations.

Much of the negative impact of these proposals would fall on populations for whom Medicaid plays a special role and as people who need mental health care. According to the Substance Abuse and Mental Health Services Administration, Medicaid is the top payer for mental health services in the United States.

The first reform proposal I would like to address increases the cost-sharing requirements for Medicaid beneficiaries as a means of saving the program money. The organizations advancing these proposals suggest the effects on access to health care would be minimal. However, a recent study of the Oregon health plan, a prominent State Medicaid reform initiative, found that 44 percent of plan enrollees lost Medicaid coverage within 6 months after premiums and co-pays were increased.

An earlier study conducted by the Kaiser Commission on Medicaid and the Uninsured found that nearly half of the beneficiaries reported not filling prescriptions due to cost, and over a third reported unmet mental health care needs. Cost sharing policies simply appear to fail because of extremely low income of Medicaid beneficiaries.

On many occasions, when mental health consumers in Michigan have lost access to regular psychiatric treatment or medications, they have lost their jobs, lost their housing, lost custody of children, and sometimes their lives. In addition, this loss of regular care drives up overall costs in the health care system as these consumers seek more expensive emergency and hospital-based care.

A second set of proposals would limit access to medications. Serious brain disorders are complex and costly conditions affecting a substantial portion of Medicaid beneficiaries. For many with serious mental illnesses, access to the right pharmacological treatment in a timely manner is key to clinical stability. Beneficiaries experience significant risk when care is limited or significantly delayed through mechanisms such as prior authorization, step therapy, and

restricted formularies. For example, most psychiatric medications are not clinically interchangeable, even if they are classified in the same therapeutic category. These medications work differently on each patient based on a multitude of factors, including age, gender, and race. Only the patient's physician in close interaction with the patient is qualified to determine which medications are effective for a patient's mental health treatment.

We have seen in our work in Michigan that patients who were not provided appropriate access to medications or were treated with the wrong therapeutic agent end up using much more costly health care treatments, including hospitalization, and, again, emergency room visits.

I would like to close by alerting you a proposal that would decimate the U.S. Public mental health system.

On August 5, the Secretary of the Department of Health and Human Services sent a model of legislation language to the Speaker of the House that would severely restrict Medicaid funding for case management and rehabilitation services. Ironically, these threatened services lie at the center of our Nation's community-based approach to treating mental illnesses.

It is these very services that are focused on empowering Medicaid beneficiaries by supporting them in self-care activities that significantly improve their lives and reduce the cost—the use of costly hospital-based care. In fact, the President's new freedom commission, in its final report, actually calls for expanded use of case management in rehabilitation service under Medicaid that would enable more Americans with psychiatric disabilities to reach the goal of living full lives in their community.

I urge you to preserve case management and rehabilitation services and preserve the full range of services and medication needed by all Medicaid beneficiaries. To achieve true Medicaid reform, Congress should look to the increased use of service that empower consumers to pursue wellness. For example, we have only begun to use disease management programs in mental health, but the data arising from States such as Missouri, Idaho, and Utah shows that patient care can be improved while reducing overall health care costs.

Mr. Chairman and Congressman Deal and distinguished committee members, it is this kind of systemic change that should be the focus of your Medicaid reform efforts, not policies that would limit access to life-saving services and medications. Thank you.

[The prepared statement of Bob Sheehan follows:]

PREPARED STATEMENT OF ROBERT SHEEHAN, EXECUTIVE DIRECTOR, COMMUNITY MENTAL HEALTH AUTHORITY OF CLINTON-EATON-INGHAM COUNTIES ON BEHALF OF THE NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE

INTRODUCTION

Good morning, Chairman Barton and members of the committee. My name is Robert Sheehan, and I am the Chief Executive Officer of the Community Mental Health Authority of Clinton-Eaton-Ingham Counties. Each year, the CMH Authority provides a comprehensive range of services to adults and children with mental illnesses and substance abuse problems throughout a three-county area in Michigan. Central to our mission in providing services is the community mental health precept that anyone experiencing mental illness should have access to all the services they need, right in their own community, regardless of their ability to pay.

The National Council for Community Behavioral Healthcare is the national voice of organizations that share this philosophy. National Council members provide safety net mental health and substance abuse services to 5.9 million people in 1,200 communities across the United States. My comments today reflect the concerns of the National Council and the providers it represents.

On behalf of the CMH Authority of Clinton-Eaton-Ingham and the National Council, I applaud your efforts to examine how the Medicaid program can be modified to empower beneficiaries to fully participate in the process of attaining health and wellness.

THREATS TO ESSENTIAL MEDICAID COVERAGE

However, as you consider today the ways in which the Medicaid program can be improved, I also urge you to take a considered approach to Medicaid reform. It is important that first we do no harm as we change this program.

Unfortunately, I must report that a number of reform proposals that have arisen recently would bring disastrous consequences to people with mental illnesses and others who depend on the Medicaid program. Most of these proposals have been issued by national organizations as Congress has engaged in a fast track process of defining Medicaid cuts for budget reconciliation legislation.

Specifically, these harmful proposals include increasing co-payment and cost-sharing requirements for beneficiaries, reducing access to medications, and sharp restrictions on services such as rehabilitation and targeted case management that are crucial in meeting the healthcare needs of vulnerable populations such as people with severe mental illness.

Much of the negative impact of these proposals would fall on vulnerable populations for whom Medicaid plays a special role. As you are aware, Medicaid plays a particularly important role in providing mental health care, an area much of my testimony will focus on. According to the Substance Abuse and Mental Health Services Administration, Medicaid is the top payer for mental health services in the United States, and it also provides more than half of the funding for public mental health services.

INCREASING BENEFICIARY COST-SHARING AND CO-PAYS

As you consider ways of reforming Medicaid to reduce program costs, it is important to consider the impact of these changes on the health of beneficiaries as well as additional costs the program may bear if beneficiaries are unable to access the services and medications they need.

Studies of one of the most prominent Medicaid reform initiatives, the Oregon Health Plan Standard (OHP), have unfortunately found that beneficiary cost sharing has resulted in reduced access to services. One study, published last month in *Health Affairs,* found that 44 percent of Oregon Health Plan enrollees lost Medicaid coverage within six months after premiums and co-payments were increased. Earlier research, conducted by the Kaiser Commission on Medicaid and the Uninsured, found that beneficiaries reported a number of unmet health needs. For example, "nearly half reported not filling prescriptions due to cost, and over a third reported unmet mental healthcare needs."

Many of the healthcare access difficulties that arise from increased premiums and co-pays can be understood by examining the difficulties Medicaid beneficiaries face in making decisions about how they spend their limited incomes.

For example, consider the situation of people with psychiatric disabilities that depend on Medicaid. Many of these people are unable to work, and depend on SSI for their income. Nationally, monthly SSI cash benefits in most states averages less than $600. For individuals with severe mental illnesses residing in supportive housing, board and care homes or other congregate living arrangements, most of their cash benefits are spent on their housing expenditures, and their disposable income consists of a minimal personal allowance that can be as low as $20 per week. Considering that people with severe mental illness often depend on 10 or more psychotropic medications, even a co-pay as low as $3 would become a substantial impediment to medications that are crucial to their health.

I can speak from personal experience about the tragic results of disrupting access to mental health care. On many occasions, when mental health consumers treated by the CMH Authority of Clinton-Eaton-Ingham have lost access to regular psychiatric treatment or medications, they have lost their jobs, housing, and sometimes their lives. In addition, this loss of regular care drives up overall costs in the healthcare system, as these consumer use more emergency and hospital-based services.

Many of these proposals to increase beneficiary cost-sharing will significantly reduce access to care, resulting in poor health outcomes and driving up healthcare costs.

REDUCING ACCESS TO MEDICATIONS FOR VULNERABLE POPULATIONS

Other proposals that would limit access in order to achieve savings are also likely to have the unintended consequences of creating negative health outcomes and increasing costs. Again, I will focus on how these consequences are likely to be seen in the delivery of mental health services to people with severe mental illnesses.

Serious brain disorders are complex and costly conditions affecting a substantial portion of Medicaid beneficiaries. For any individual suffering from a serious mental illness, access to the right treatment in a timely manner is the key to clinical stability and the reduced overall cost of their health care. There are significant risks, both physically and financially, when care is limited or significantly delayed through mechanisms such as prior authorization, step therapy, and generic substitution.

There are numerous reasons why it is inadvisable to limit access to medications for patients with mental illness. For example, most psychotropic medications are not clinically interchangeable, even if they are classified in the same therapeutic category. These medications each work differently in each patient based on a multitude of factors, including age, sex and race. Only the patient's physician, in close interaction with the patient, is qualified to determine which medications are appropriate and tolerable for a patient's mental health treatment.

We have seen in our work in Michigan that patients who are not provided appropriate access to medications or who are treated with the wrong therapeutic agent end up using more costly health care intervention treatments including inpatient hospitalization, emergency room visits and intensive case management services. These patients will also be less adherent to prescribed medications in the future which again exacerbates the situation personally and financially.

THREATS TO CASE MANAGEMENT AND REHABILITATION SERVICES IN MENTAL HEALTH

I turn now to a proposal that would affect two Medicaid services that play important roles in mental health. On August 5th, the Secretary of the Department of Health and Human Services sent model legislation to the Speaker of the House that would severely restrict Medicaid funding for case management and rehabilitation services. This proposal reflects a policy trend at the Centers for Medicare and Medicaid Services, a trend of increasing restrictions for these types of services. Unfortunately, this full implementation of this policy would decimate the US public mental health system.

Ironically, these threatened services—case management and rehabilitation—lie at the center of our nation's community-based approach to treating mental illnesses. It is these very services that are focused on engaging Medicaid beneficiaries in self-care activities that effectively improve clinical outcomes and reduce the use of costly hospital-based care.

This proposal to sharply restrict Medicaid funding for case management and rehabilitation services is surprising in light of HHS's leadership in promoting community-based, empowering health services for people with disabilities. This leadership was prominently displayed in the President's New Freedom Commission on Mental Health, which focused the nation's attention on promising approaches to address the nation's unmet mental health needs.

In its final report, the President's Commission established recovery from the disabling aspects of mental illness as the goal of the U.S. mental health system, and it specifically calls for the *expanded* use of case management and rehabilitation services under Medicaid to enable more Americans with serious mental illnesses to reach this goal.

The Commission's call to expand the use of these programs in mental health reflects the healthcare industry's growing recognition of the importance of consumer empowerment in improving outcomes and saving money. Recognition of the value of teaching consumers how to manage their illnesses is reflected in the industry's widespread use of disease management programs, and the recent enactment of the Patient Navigator Act underscores the importance of providing consumers help in navigating the healthcare system.

I'd like to focus now on how case management and rehabilitation services empower mental health consumers.

Looking first at case management, at the Community Mental Health Authority of Clinton-Eaton-Ingham Counties, we provide one of the most prevalent models of this program, a type of case management called Assertive Community Treatment or ACT. While the effectiveness of ACT in improving clinical outcomes and quality

of life is well supported by rigorous medical studies, I can speak most directly about the difference it makes in the lives of people with severe mental illness who live in the communities of central Michigan.

We provides ACT case management services to over 1,800 people with serious illnesses such as schizophrenia and bipolar disorder. Like all forms of case management, our ACT teams teach illness management skills and link people with psychiatric disabilities to a full range of needed healthcare, rehabilitative, and social services. Furthermore, these teams teach consumers about their illnesses and how to best use medications and a range of supports to regain an optimal level of functioning. Should CMS's proposed restrictions apply to the CMH Authority of Clinton-Eaton-Ingham today, we anticipate that we would lose funding for this program altogether.

Looking briefly at rehabilitation services, there is consensus throughout the mental health field that these services are important in achieving good clinical outcomes and restoring functioning. The Substance Abuse and Mental Health Services Administration is actively promoting these services as part of its evidence-based practices program—reflecting the strong evidence base for these programs in the literature.

Given the recognized value of these programs, it is simply ironic that HHS's proposal would result in a catastrophic loss of funding for these programs.

THE ALTERNATIVE: EXPANDING SERVICES THAT EMPOWER MENTAL HEALTH CONSUMERS

In closing, I urge you to preserve and support services such as case management and rehabilitation that focus squarely on developing the skills of mental health consumers so they can participate in their treatment, experience recovery from psychiatric disability, and live full lives in their communities.

In addition to expanding access to these programs, Congress should look to the increased use of other services that empower consumers to pursue wellness. We have only begun to use disease management programs in mental health—but the data arising from states such as Missouri show that patient care can be improved while reducing healthcare costs. Mr. Chairman and distinguished committee members, it is this kind of systemic change that should be the focus of your Medicaid reform efforts.

Mr. DEAL. Thank you.

Dr. Thames.

STATEMENT OF THOMAS THAMES

Mr. THAMES. Mr. Chairman, members of the committee, I am Byron Thames. I am a member of the board of directors of AARP. And I want to thank you for inviting AARP to testify on the need to strengthen Medicaid, a critical safety net for millions of our members and their families. One in six Americans now relies on Medicaid. Enrollment growth due to declining employer-based coverage, along with inflation throughout the health care system, is straining Medicaid as never before. For AARP, strengthening our Nation's health care safety net is a priority. There are steps that Congress can take to relieve some of the strain within the Medicaid itself. For example, significant savings can be achieved in drug spending, and a broader range of long-term care options can be developed. However, efforts to produce savings simply by shifting cost or denying necessary care will harm vulnerable people and not hold down overall health care spending. AARP is opposed to reforms that would do that. For example, we believe that efforts to prevent improper asset transfers should be properly focused on fraud, not the natural actions of typical middle class families.

Changing the penalty date for Medicaid eligibility and extending the current look-back period would deny needed coverage to individuals who simply helped family members or contributed to charities with no intention of gaming the system. Indeed, instead, State-based loopholes that allow abuses to occur should be closed. Options for long-term care financing should not include changing

the protected status of the American home. Increases in cost sharing could create serious financial burdens for beneficiaries. Strong protections are necessary to help the most vulnerable.

Increased flexibility and management should not include funding caps as they inevitably lead to denials of necessary care. Increased flexibility requires an open, thorough, and fair process at both the State and Federal level for public input to ensure that changes do not cause harmful cost shifts or care denials. More importantly, it isn't enough to focus on Medicaid alone. Medicaid's problems are rooted in the lack of affordable coverage for both acute and especially long-term care, and they are compounded by the spiraling inflation as we pay higher prices for new treatments without any evidence that they are better than less costly alternatives.

The problem isn't Medicaid. The problem is health care. AARP stands ready to work with Members of the Congress to strengthen this critical health care program and to address the larger health care system's shortcomings that are putting so much strain on this critical safety net.

I will be happy to answer questions at the appropriate time, Mr. Chairman.

[The prepared statement of Thomas Thames follows:]

PREPARED STATEMENT OF THOMAS "BYRON" THAMES, AARP BOARD MEMBER

Mr. Chairman and members of the Committee, my name is Byron Thames. I am a physician and a member of AARP's Board of Directors. Thank you for inviting AARP to testify on the need to strengthen Medicaid—a critical safety net for millions of our members and their families.

One in six Americans now relies on Medicaid—as declining income, reductions in the number of persons covered by employer health insurance and severely limited long term care options leave few alternative coverage sources. Enrollment growth, along with inflation throughout the health care system, is straining Medicaid as never before.

Clearly, some change is needed to alleviate the pressure on Medicaid and to make the program as effective as possible. But changes should be based on sound policies rather than an arbitrary budget target. We believe that $10 billion in Medicaid spending cuts could create serious barriers to care for beneficiaries.

For AARP, strengthening our nation's health care safety net is a priority, and we believe there are steps that Congress can take to relieve some of the strain within Medicaid itself.

- Significant savings can be achieved in drug spending through more accurate payments to pharmacies, greater rebates from manufacturers, the use of evidence-base formularies, and state purchasing pools.
- A broader range of long-term care options can be developed. Expanded home and community-based services—preferred by many older Americans "can be more efficient in many cases than nursing homes. Stronger consumer protections, such as ensuring premium stability, can make long-term care insurance policies more attractive to consumers. And outside of the reconciliation process, innovative financing methods—like enabling people to voluntarily use home equity for long-term care services—can be tested.

However, efforts to produce savings within Medicaid simply by shifting costs or denying necessary care will not hold down overall healthcare spending and will harm vulnerable populations.

- Efforts to prevent improper asset transfers should be properly focused on fraud, not the natural actions of typical middle class families. Changing the penalty date for Medicaid eligibility and extending the current look-back period to five years would deny needed coverage to individuals who simply helped family members or contributed to charities with no intention of gaming the system. These changes may result in severe hardship. Instead, state-based loopholes that allow abuses to occur should be closed.
- Options for long term care financing should not include changing the protected status of the American home.

- Increases in cost-sharing could create serious financial burdens for beneficiaries. Strong protections are necessary to help the most vulnerable.
- Increased "flexibility" in management should not include funding caps as they inevitably lead to denials of necessary care. Increased flexibility requires an open, thorough, and fair process for public input and ongoing assessment to ensure that changes do not cause harmful cost shifts or care denials.

Most importantly—it isn't enough to focus on Medicaid alone. Many of the problems facing the program are rooted in the lack of affordable coverage options outside Medicaid for both acute and especially long term care. The Census Bureau last week reported that fewer people received health care coverage from their employer in 2004—down to 59.8 percent from 60.4 percent in 2003—while the percentage covered by government health insurance programs rose from 26.6 percent to 27.2 percent. The number of Americans enrolled in Medicaid increased from 12.4 percent in 2003 to 12.9—percent in 2004.

Compounding the problem is spiraling inflation as we pay higher prices for new treatments without any direct comparative evidence that these treatments are better than less costly alternatives. According to many analysts, these rising costs are why more employers are dropping health coverage for workers, who in turn are seeking health coverage from Medicaid and other public programs.

Medicaid, despite its rising cost, still covers only three out of every five Americans under age 65 below the poverty line. An AARP survey this spring found that four out of five Americans oppose cutting Medicaid to reduce the federal debt, and a majority of respondents say their state does not have enough money for this vital program.

AVOIDING HARMFUL CHANGES

AARP objects to some of the proposed Medicaid changes now being considered by Congress because they could result in cost shifts or denial of necessary care, rather than true increases in efficiency.

Preventing Improper Asset Transfers

There are legitimate concerns that some people who can afford long term care transfer assets to appear poor so Medicaid will pay for nursing home care. It clearly was not the intent of Congress that Medicaid be used this way, but with so few viable long term care options, estate planning attorneys have found many ways to do so legally. Loopholes in state laws—which vary from state to state—allow such abuses to occur. These state loopholes, including certain annuities and self-canceling installment notes, should be identified and closed.

However, some proposed changes now under consideration would hurt innocent people by denying them necessary coverage because of transfers that were in no way intended to game the system. These include:

- *Changing the penalty date* to deny coverage when people really need it. The current penalty date starts at the point a person makes an asset transfer. The penalty period lasts for as long as care could have been paid for by the amount transferred. For example, an individual who transfers assets equal to the cost of one year of care is ineligible for Medicaid coverage for one year from the date of the transfer. However, if the transfer occurred more than one year before applying for Medicaid, the penalty period is over and the individual is not denied coverage. The proposed change would start the penalty at the time of application for Medicaid, so if a person transfers enough to pay for one year of care at any time in the look-back period, the person would still be denied coverage for one year from the date of application, regardless of the need for coverage and lack of other financing options.
- *Extending the "look-back" period* for asset transfers beyond the current 3-year window to 5 years or more. Any asset transfer for less than fair market value, such as tithing to a church, donating to a charity and helping a grandchild pay college tuition, would be considered improper and result in denial of coverage, again regardless of the need for coverage and lack of other financing options.

Consider how these penalty date and look-back changes might affect a 66 year-old grandmother in good health who helps with her grandchild's tuition. Four years later, she has an unexpected stroke and requires nursing home care. Mounting health care bills force her to liquidate all her remaining assets. When those assets are exhausted, she applies for Medicaid but is denied because she helped her grandchild with college costs. She cannot go home, and has no way to pay for the care she needs.

Despite that kind of harm that would result, changing the look-back and penalty periods would do nothing to close real loopholes.

These changes would, instead, punish middle-income people for being caring parents and generous to their community. We should not deny needed coverage because someone tried to do the right thing in giving to a family member or charity long before an unexpected health care crisis consumed their resources and required nursing home care.

These changes are also unpopular with the American people. The survey we conducted earlier this year found that 75 percent of those surveyed oppose extending the look-back period. That is because the public knows that many people end up relying on Medicaid, not because they try to game the system, but because there are so few other affordable options for funding long term care. AARP believes it would be wrong to deny coverage to innocent people who need it when so little has been done to provide other affordable options for financing long term care.

Required Use of Home Equity/Reverse Mortgages

Some recent proposals have suggested that the protected status of the home be removed for Medicaid eligibility. These proposals would require older homeowners to use their home equity, such as by taking out reverse mortgages, before becoming eligible for Medicaid benefits. While using home equity to finance long term care may be a good option for some people, AARP strongly opposes proposals to require older homeowners to use their home equity to pay for long-term care or medical expenses in order to be eligible for Medicaid.

Home ownership is part of the American dream, a source of pride and economic security for most older people. Americans should not be forced to forfeit their homes to secure the care they need. Further, exhausting home equity could jeopardize the spousal impoverishment protections in current law and leave the community spouse—who may also need care one day—more vulnerable.

Reverse mortgages are costly, and mandating reverse mortgages would do nothing to reduce the high costs of these loans. These costs can amount to a very high percentage of the equity potentially available, especially for older homeowners with modest home values who are most likely to need Medicaid.

AARP believes that any use of home equity or reverse mortgages should be voluntary, should focus on reducing reverse mortgage costs, and be done on a demonstration basis to measure the effects before launching major changes.

Increased Cost-Sharing

We have serious concerns about proposals to make very poor people pay premiums and higher copays for the health care they need. Several studies demonstrate that imposing even moderately higher cost sharing on people with very low incomes results in them not getting needed care. They end up needing more expensive health care services, such as preventable emergency room visits and hospitalizations. There are no real savings in the long run but there exists potential for harm in the process. Because many beneficiaries require multiple health care services, even small increases in cost sharing requirements can very quickly add up to create significant barriers to necessary care. Any change that allowed states to increase cost sharing would need to limit the total amount beneficiaries would be expected to pay. Most importantly, the current Medicaid policy of not denying care to someone who cannot pay should be maintained for those who can demonstrate genuine hardship.

Increased Flexibility

A number of reform proposals have been described as mechanisms to increase program "flexibility"—a word that is very appealing and even more ambiguous. Some proposals labeled as "flexibility" are clearly harmful because they would inevitably lead to cost shifting and denial of necessary care.

These include any proposals that would place caps on federal funding to states through block grants, per capita caps, or some other type of allotment. AARP is unequivocally opposed to such proposals.

Other "flexibility" proposals may—if done right—improve program efficiency, for example by tailoring benefits to the needs of specific patient populations without denying coverage for medically necessary services. AARP therefore believes any proposals for increased flexibility need to be carefully, individually, and openly evaluated to determine whether they are likely to lead to true increased efficiency, or merely result in cost shifts and denial of care. Thus, any proposals for increased flexibility need to include meaningful opportunity for public review and input at both the federal and state level. It is essential that all stakeholders be allowed to review and comment on proposed policy changes, and that there be thorough and objective analysis of whether the changes could compromise beneficiaries' access to appropriate care. This is a serious concern, as current avenues for flexibility within the program lack adequate openness, or "sunshine."

Large-scale program changes are now allowed through a waiver process that is a cumbersome black box, with details negotiated behind closed doors between only state and federal officials. Some states have recently enacted laws, with strong support from AARP, requiring public hearings and other legislative review of waiver proposals before they can be enacted. However, in many states, only the most cursory attempt is made to adhere to requirements for public input.

There are even fewer opportunities for meaningful public input on smaller scale changes made through the state plan amendment process. Federal regulations merely require that a state publish notice of such changes before they are enacted along with an address to which comments may be sent. However, a state can enact such changes in as little as one day after publishing them and there is no requirement that submitted comments be acknowledged or addressed, often rendering the comment process virtually meaningless.

AARP urges Congress to require meaningful opportunities for public input—including hearings and written responses to stakeholder comments—before permitting policy changes that might be allowed under the rubric of "flexibility."

RELIEVING PRESSURES WITHIN MEDICAID

AARP supports steps that can be taken now to relieve some of the financial pressures on Medicaid in ways that make the program more effective. That is a critical distinction because, as discussed above, many proposals for reducing Medicaid expenditures would merely result in cost shifting and denial of care—not true efficiencies—and not really save money in the long run.

Overpayments for Drugs

The greatest potential area of increased efficiency is in payments for prescription drugs. AARP believes the following steps should be taken:

- *Accurate Reimbursement to Pharmacies*—Most state Medicaid programs now reimburse pharmacies based on the average wholesale price (AWP), a highly inaccurate and inflated measure of what pharmacists actually pay to obtain drugs. AARP believes Congress should require states to use a more accurate measure that is based on actual audited information on the cost to acquire drugs, such as average sales price (ASP) or average manufacturer price (AMP). In order to ensure fair margins for pharmacists, payments based on such a measure should include an adequate dispensing fee that fully covers legitimate overhead costs involved in filling each prescription.
- *Increased Rebates from Manufacturers*—Drug manufacturers are required to give rebates to states for Medicaid drug purchases, but studies by the HHS Inspector General indicate that the rebates paid by manufacturers are often much less than what is required. AARP believes the minimum rebate amount should be increased and steps taken to ensure full compliance with rebate requirements.
- *Evidence-based Formularies*—Some states are providing preferred coverage for certain drugs in each therapeutic class based on scientific evidence of effectiveness. If a drug is more expensive but not more effective than other drugs in its class, then it is covered only when a treating physician demonstrates that it is medically necessary for an individual patient. This yields significant savings by increasing use of the most appropriate drug—often a generic or other low-cost drug—while maintaining a safety valve for the small number of patients who truly need more expensive alternatives. States should be given strong incentives to use evidence-based formularies.

  Perhaps the most important step Congress can take to help states increase use of evidence-based formularies is to *increase funding for "comparative effectiveness" research.* This is needed to fill significant gaps in scientific evidence on which drugs are the most effective. Comparative effectiveness research can show whether a more expensive drug produces better outcomes and therefore is worth the cost, and when a less costly drug is as or more effective. The Medicare Modernization Act included authorization for comparative effectiveness research coordinated by the Agency for Healthcare Research and Quality (AHRQ) but to date the appropriations have fallen well below the authorized level.
- *Purchasing Pools*—Some states have joined together to negotiate collectively on behalf of all their Medicaid beneficiaries for increased manufacturer rebates, which can yield savings because the states are collectively negotiating for a larger number of consumers. States should be encouraged to participate in these pools and to add additional groups for whom they buy drugs, such as state employees and prison inmates, to further increase negotiating leverage.

Ending the "Institutional Bias"

Another potential area for increased efficiency is in providing more access to home and community based care as an alternative to nursing homes for long term care. AARP members strongly prefer to remain in their own homes. In many cases care provided in the home or community-based settings can help delay the need for more costly institutional services.

Medicaid, however, has an "institutional bias," that requires states to cover unlimited nursing home services when people qualify for them but makes home and community-based services optional. When home and community-based services are provided through federal "waivers," there are sometimes long waiting lists of people with legitimate needs who are denied coverage because the waivers cap funding. AARP supports efforts, such as the administration's New Freedom Initiative, to address this bias, and we urge Congress to make such changes a priority in any Medicaid reform package.

AFFORDABLE LONG-TERM CARE OPTIONS

AARP believes that another way to alleviate some of the current pressure on Medicaid is to provide more options for financing long-term care needs. We hear from our members every day who are trying to do the right thing—balancing the demands of work and family and balancing their personal finances—while worrying about their future retirement income and how to pay for long-term care.

Unfortunately, there is no comprehensive public system of long-term care available to most Americans. Long-term care insurance is limited and generally expensive. Medicare covers very little long-term care, and Medicaid requires impoverishment before it will help—an all-too-often reality as paying out of pocket for long-term care quickly outstrips most people's personal savings. As outlined in AARP testimony before this Committee last April, we believe that options for expanded long-term care coverage could include:

- *Reverse Mortgages:* These allow people to voluntarily tap into the equity in their homes to fund a variety of options, including those that can keep people out of institutions and in their homes where they prefer to stay.
- *Long term care Insurance:* Currently long-term care insurance pays for only about 11 percent of all long-term care costs. Standards and protections for long-term care policies could encourage more consumers to buy such policies. For example, automatic compound inflation protection is needed to ensure that the value of the insurance benefits does not erode over time. And premium rate stabilization is needed to protect consumers from unreasonable rate increases that could make their policies unaffordable.
- *Long Term Care Partnerships:* These programs, which now operate in four states, are intended to promote long term care insurance by allowing purchasers to protect a certain amount of their assets and become eligible for Medicaid when the insurance benefit expires. While it is difficult to determine yet whether these programs have helped reduce reliance on Medicaid, they might offer another option for financing long-term care if several improvements could be made. These include:
  - Protecting Medicaid for low-income people if Partnerships increase Medicaid expenditures for those with significant assets.
  - Mandating consumer protections and clear disclosure of current Medicaid income criteria and the state's right to change them.
  - Guaranteeing the types of care (particularly home- and community-based services) that the state would provide under Medicaid.
  - Requiring that states monitor nursing home admissions to ensure that equal access is available to everyone, regardless of source of payments.

CONCLUSION

Millions of Americans rely on Medicaid's safety net. While some change is needed to make the program as effective as possible, we should reject those changes that simply shift costs or deny needed care to vulnerable populations.

AARP stands ready to work with Members of Congress on both sides of the aisle to enact policy changes that will strengthen this critical health care program for our most vulnerable citizens and to address the larger health care system shortcomings that are putting so much strain on this critical safety net.

Mr. DEAL. Thank you.

Mr. Matthews.

STATEMENT OF MERRILL MATTHEWS

Mr. MATTHEWS. Thank you, Mr. Chairman. I am Merrill Matthews, director of the Council for Affordable Health Insurance. It has been around since 1992; it is located in Alexandria, Virginia.

I want to commend you on your leadership and the committee for beginning this dialog. My comments are going to focus primarily on State leadership for creating an environment of flexibility that will allow States to take on a leadership role in Medicaid reform.

What the U.S. needs today is a Tommy Thompson for Medicaid. And there are surely several Governors who could fill that role if the Federal Government gives them the opportunity. Welfare reform—Tommy Thompson for a decade worked on welfare reform in the State. He found some formulas that worked. Other Governors were watching what he was doing, they began to do what he was doing and build on his experience. Welfare reform became one of the more successful policies at the State level, and in 1996 Congress passed legislation implementing it at the Federal level. It has been very successful from both the State and Federal Government. It is important to note that Governors, both Republicans and Democrats, were involved in welfare reform. Ideology was not driving their efforts, pragmatism was. They were looking for a way to get an effective welfare system that worked but also saved money. Now the Governors are calling for more flexibility and restructuring Medicaid. Some may want to tweak the program, others may be looking at a grander overhaul. But we won't know what works best until Congress gives them the flexibility they need.

I think we can learn some lessons from the welfare reform, and I would like to point out three of them.

No. 1. Provide enough flexibility to match the program to the population. States have different populations. They vary significantly, their job base varies significantly. In addition, Medicaid has a wide ranging population. Medicaid is three separate programs basically rolled into one. You have got your low income families that use it for health insurance, you have got people on long-term care, and then you have got your disabled populations. Reforms that work well for one set of population may not work well for the other. Increased flexibilities allow the States to assess these populations and their health care providers and devise a plan that maximizes their resources.

No. 2. Benefits should mirror the private sector as much as possible to ease the transition. The goal of welfare reform was to move people from welfare to work. And, as a result, they tried to create a work environment there for people so that when they moved off of welfare they had already started that work process. We need to—we should not forget that Medicaid is also a welfare program, and the goal should not be to enroll more people in Medicaid but to help those who need help get the care they need, but also transition those who can into private sector coverage. Medicaid does not look like private insurance. And if somebody is moving to work and going to be moving into the job-based environment perhaps with employer-provided health insurance, they are going to get a sticker shock when they move into that situation because Medicaid is different.

Smoothing that transition by allowing Medicaid to offer higher co-pays for those who have higher incomes, those who are moving into work simply makes sense. Most of our—virtually all of our means-tested programs have some type of sliding scale in there, and what I think we should allow is some type of sliding scale in co-payments, maybe in premiums, not for the most vulnerable populations, but for those who are at least in the higher incomes of Medicaid.

No. 3. Reward good behavior. Economic incentives matter, and we are talking about economic behavior here. Medicaid creates a policy problem in that it insulates people from their decisions. The private sector tends not to do that. Auto insurance, for instance, if you are a bad driver and you have tickets or wrecks, you pay higher premiums.

Medicaid doesn't send that kind of economic message. Take what happens with long-term care. States are reeling under the cost of long-term care. Several of them would like some kind of freedom or flexibility to do something different.

There is the partnership program I think Mr. Burgess is the sponsor of. Mr. Terry has sponsored legislation at the Federal level to give people the ability to use IRAs or tax credits to pay for long-term insurance. States would also like to have some flexibility to move people into long-term care and to get them off of gaming the system. It is not everybody who does that, but some do.

Which one of these proposals work best? I don't know, but that is what the laboratory of the States is for.

Can the States do a good job of reforming Medicaid? They did a good job of reforming welfare. I expect there is concern that some people are going to be hurt by this, but I believe that the States, led by the Governors, can be successful with welfare reform again, this time with Medicaid.

To conclude, the Medicaid program is 40 years old. It has helped millions of Americans get the health care they need but couldn't afford, but it is too monolithic and rigid to adapt to the changes of a consumer-driven health care system and increased plan flexibility that is transforming the employer coverage in the insurance industry.

Medicaid is an anachronism today. Congress has the power to change that, and it should. Mr. Chairman, we need a Tommy Thompson from Medicaid. I hope the committee will provide the States with enough flexibility so that one can emerge.

Thank you.

[The prepared statement of Merrill Matthews follows:]

PREPARED STATEMENT OF MERRILL MATTHEWS, DIRECTOR, COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Good morning Mr. Chairman and members of the Committee. I am pleased to be here, and I want to thank the Chairman and the Committee for calling this very important hearing today on "Medicaid: Empowering Beneficiaries on the Road to Reform."

I am Merrill Matthews, Ph.D., director of the Council for Affordable Health Insurance (CAHI), which is located in Alexandria, Virginia. CAHI is a research and advocacy association of insurance carriers active in the individual, small group, Health Savings Account and senior markets. CAHI's membership includes health insurance companies, small businesses, physicians, actuaries and insurance brokers. Since

1992, CAHI has been an advocate for market-oriented solutions to the problems in America's health care system.

Mr. Chairman, the Medicaid program is growing at unsustainable rates, and has been for more than a decade. The country needs leadership both at the state and federal levels to find a way to transform the program so that it can continue to be the safety net the country wants and needs, provide quality care in a timely fashion and yet remain affordable. I commend you for your leadership in beginning this dialogue at the federal level. However, comments today focus on the need for state leadership, and for creating an environment of flexibility that will allow the states to take on that leadership role.

Welfare Reform as a Model for Medicaid Reform. What the U.S. needs today is a Tommy Thompson for Medicaid. There are surely several governors who could fill that role, if the federal government gives them the opportunity.

When Tommy Thompson was governor of Wisconsin, he experimented with welfare reform for a decade. While his actions were initially criticized by people concerned that he would hurt the poor, his efforts to move the welfare population into productive jobs proved to be so successful that states around the country followed and built on his lead. And in 1996, Congress passed and President Clinton signed a federal version of welfare reform that incorporated Gov. Thompson's principles and experience.

Welfare reform has been one of the more successful legislative efforts undertaken by Congress and state governments; and it is important to note that governors, both Democrats and Republicans, were leading the reform efforts. They were the ones experimenting with welfare to find out what worked. Ideology wasn't driving their efforts; pragmatism was. They wanted a well-functioning welfare system that provided help to those who needed it most, but also helped the able-bodied find a job. *Welfare needed to be a safety net, not a hammock.*

Now the governors are calling for more flexibility in restructuring Medicaid. Some may only want to tweak the program; others may want more significant reforms. But we won't know what works best until Congress gives them the flexibility they need.

What We Can Learn from Welfare Reform. Welfare reform did not emerge in a vacuum. Like Medicaid today, states were seeing their welfare rolls and budgets grow. And there was a widespread perception that while some people needed and depended on their welfare benefits, others had the ability to hold down a job and move off the rolls.

As states moved forward with welfare reform, several principles emerged. Some of these principles can and should be applied to Medicaid reform.

(1) Provide enough flexibility to match the program to the population. Populations can differ significantly from state to state. Some have higher education levels than others. Some have a good manufacturing base while others have a stronger agricultural or service-sector presence. Some have significant immigrant populations while others don't. States are more able than the federal government to know their populations and assess their needs.

In addition, the Medicaid population differs significantly. Medicaid is really three distinct programs rolled into one.

- There are seniors who rely on Medicaid for long term care coverage;
- Millions of low-income, working-age families use Medicaid as their basic insurance coverage; and,
- There are the disabled, often with chronic illnesses, who can't work.

One of the benefits of federal programs is that they tend to provide uniformity and continuity. However, federal programs can also hamper efforts to take into consideration unique needs. Reforms that work well for one of these populations may not work for the others. Increased flexibility allows the states to assess their populations and their health care providers and devise a plan that maximizes their resources.

(2) Benefits should mirror the private sector as much as possible to ease the transition. The goal of welfare reform was to move people from welfare to work. In order to facilitate that transformation, it became very important to get welfare recipients into the work environment.

We should not forget that Medicaid is a welfare program. The goal should not be to enroll more people in Medicaid, but to help those who need health care coverage now while smoothing the transition from Medicaid to private sector coverage for those who can take that step.

However, one of the problems we face in Medicaid reform is sticker shock. Once a person moves from Medicaid to employer-provided coverage, they may find their co-pays are significantly more than they were under Medicaid (e.g., increasing from

$3 to $10 or $15). And they may be required to pay part of their premium, either for themselves or their families.

No one wants to impose significant cost sharing on the poorest and most vulnerable Medicaid populations. But different states have different eligibility requirements for Medicaid. Some states are more generous than others. And some Medicaid beneficiaries have more means than others. To address these variations, states should have the ability to adjust co-pays and other out-of-pocket expenses by requiring more from some than they do others.

Such a policy would have two benefits.

- It would help prepare some of the Medicaid population for the day they move to an employer who offers health insurance coverage.
- Second, it would make more money available for the poorest recipients.

States might also want to consider creating new options for working families using Medicaid as an insurance policy. State welfare departments try to help beneficiaries transition to work. One way to do that is to let Medicaid coverage look more like private coverage or an employer's policy. States may want to use Medicaid funds to help employers hiring people on or coming off welfare. Or they may want to provide subsidies so that Medicaid beneficiaries can buy their own policies. Or they may want to allow them into the state employees' plan. There are several possibilities, but we simply don't know which—if any—of these options work.

Make no mistake, this policy recommendation isn't about "cutting" benefits; it's about maximizing benefits with the limited funds that are available. This recommendation simply recognizes that there should be a sliding scale in Medicaid as there is in most means-tested programs. And states should have the flexibility to set that scale.

(3) Reward good behavior. My third and final principle has to do with rewarding good behavior. Economic incentives matter. The policy problem created by Medicaid—and, indeed, any type of third-party coverage—is that it mitigates bad decisions. If Medicaid recipients live unhealthy lifestyles—being obese, for example—the Medicaid program insulates them from some of the adverse economic impact. They may see the doctor more, but they don't necessarily bear a greater financial burden.

Notice that this is not how other insurance, such as auto insurance, works. If you have a bad driving record, you pay higher premiums. Those higher premiums encourage better driving habits.

Medicaid, by contrast, often sends the wrong economic message. Take long term care, for example. We know that there is a cottage industry of elder care attorneys who help middle- and upper-middle-income families find ways to hide their assets in order to qualify for Medicaid long term care coverage in nursing homes. Medicaid should be for the poor, but many non-poor families are able to access the program for nursing home care, imposing a huge financial strain on the states.

Several states want to try to change these incentives by providing tax breaks for the purchase of long term care insurance, being more aggressive in their estate recovery efforts or by creating long term care partnership programs that create a safe harbor for those who have bought private long term care insurance but exhaust their benefits.

Which one of these approaches would work best? I don't know. That is where the laboratory of the states comes in. They should have the freedom to experiment and find the best incentives that balance long term care coverage for those who need it while encouraging those with means to take responsibility for their future health care needs.

Of course, not all health care problems are self-inflicted, but some are. One of the newest private-sector trends is that insurers and employers are looking for ways to adjust their health insurance plans to encourage good behavior by rewarding it. They can do that because they have the flexibility to do so. States might try to do the same thing, but their hands are often tied.

Can the States Do a Good Job Reforming Medicaid? I expect there is concern about whether the states have the ability to find new and innovative solutions that get more and better care from their limited Medicaid budgets. There were similar questions raised about welfare reform.

But governors knew then that there was a lot at stake—including their jobs. They shared information, they looked at what worked and what didn't, they crafted welfare reform plans that took into consideration their populations and what could pass their legislatures. And the vast majority of them made significant progress.

I believe the states, led by the governors, can be successful with welfare reform again—this time with Medicaid. They have indicated that they want to do it, and they will be held accountable both at the state and national levels if they fail.

Conclusion. The Medicaid program is 40 years old. It has helped millions of Americans get the health care they needed but couldn't afford. But it is too mono-

lithic and rigid to adapt to changes such as consumer-driven care and increased plan flexibility that are transforming employer coverage and the insurance industry. Congress has the power to change that, and it should.

Mr. Chairman, we need a Tommy Thompson for Medicaid. I hope this Committee will provide the states with enough flexibility so that one can emerge.

Mr. DEAL. Mr. Chairman, would you like to resume the chair?

Chairman BARTON. I will ask 5 minutes of questions, but you are doing a great job.

Mr. DEAL. Well, I will recognize you for your questions then.

Chairman BARTON. Thank you, Mr. Chairman.

I want to ask Mr. Thames, I know AARP has got great credibility and I know you all are opposed to current proposals that the Governors have put forward with us that we are working on, but does AARP at least agree that, under the current system, tens of thousands if not hundreds of thousands of Medicaid recipients are going to be discarded from the program if we do nothing?

Mr. THAMES. Yes, sir. We understand that a lot of people are going to have problems. We are not suggesting that this Congress do nothing with Medicaid. I hope in my remarks I indicated to you that I believe there are things that can be done, and we don't disagree with all of the proposals in the National Governors Association. What we are concerned is that the safety net that is in place for Medicaid is not eroded from the people who sincerely need it and who qualify for it.

Chairman BARTON. Well, I hope—I had to step out of the room, and I missed some of the testimony of this panel. I have skimmed it and looked at the highlights of all of it, though—that everybody understands that if we decide as a Congress to not do anything on Medicaid this year for the hurricane or the difficulty of making some of these decisions, if the Governors are being truthful with us, next year tens of thousands to hundreds of thousands of people that currently get health care coverage under Medicaid are not going to get it. That is a fact. It is not an opinion; it is a fact.

So I believe that this Congress can take care of the Katrina victims and do long-term Medicaid reform. I may be wrong about that, but I believe we can do it.

I think the Governors' outline that we have put forward—we haven't fleshed it out in exact legislative language, and I have had discussions today with some of my friends on the minority side that we may yet do something on a bipartisan basis, but the general outlines of the proposal, that, No. 1, we need to reform the way we do prescription drug benefits—you may disagree with the specifics of the Governors' proposal, but since more and more health care is prescription drug based I would think that that should be a part of the component.

Since two-thirds of all Medicaid spending is for long-term health care, some sort of reform in the way we look at assets should be a part of the reform. And since there are many, many more people in the Medicaid system than the very old and the very poor, some sort of a copayment option that the Governors can implement, if they wish, should be a part of the reform package.

Now we can disagree over specifics, and that is what honest debate is all about, but when I hear from my Lieutenant Governor and my Speaker of the House from Texas and my Governor, and they tell me that Medicaid is the largest component of their State

budget, the largest component—and if you add the Federal share for Medicaid and the State share for Medicaid in Texas, it is approaching $80 billion a year, and that is almost—in fact, it may be more than the State of Texas spends at the State level on every other thing. I don't think we can sit here and say we are just not going to do anything.

So, again—I want to direct this to my AARP representative—what would you do if you were me to try to get our senior citizens that have assets to use some of those assets to take care of their long-term health care? What would you do? If you don't like the proposal that is on the table, what would your proposal be?

Mr. THAMES. Mr. Chairman, let me make a few points that we believe would be very helpful.

First of all, sooner or later Congress has to look at affordable coverage for everybody. I indicated—and you probably missed in my remarks—that this is putting a stress on Medicaid. Now we are not going to solve that here this morning, I understand that.

But, second, we need to put some more money into what was authorized for comparative effectiveness studies so that we know that the treatments we are paying for in Medicaid and everywhere else in medical care, that we are picking the most cost-effective treatments that actually are effective and not just paying for the newest thing that is up on the TV.

And, third, we need to make some changes in Medicaid to increase its efficiency. We can lower the cost and get better drug prices. You know, we can get a better rebate. We can do other things in allowing the——

Chairman BARTON. We have got that. You may disagree with the way we are doing it on the prescription drug program, but we have that. But you didn't answer my question.

Mr. THAMES. I am sorry.

Chairman BARTON. I am told that two-thirds of the Medicaid expenses go for long-term health care while two-thirds of the population are under the age of 20 that are Medicaid eligible. So we are putting two-thirds of the spending into our senior citizens for long-term health care while two-thirds of the Medicaid eligible are women and children under 20. And when the Governors go to start making these—State legislatures make these difficult choices, you know, in most States they are choosing to uncover the younger people.

If it is true—and I think it is true that two-thirds of what we are spending on Medicare is for long-term health care—why can't we do something to reform and enforce a real asset test so that seniors that have assets use some of those assets to pay for their long-term health care costs? If AARP doesn't like what is in the Governors' proposal, do you at least agree that that is some area that we should look at to reform?

Mr. THAMES. Yes, sir. I believe that is an area to look at to reform. I believe that my colleagues that are working in this field every day would agree with you that there are things that we can look at there and the assets and that we actually feel that most Americans want to pay for their health care, but we also believe—at some portion of their health care—and we also believe they want to stay in their homes.

Chairman BARTON. I want them to stay in their homes. I would rather them be in their home than in a nursing home or an assisted living facility. And I understand sometimes they have to be. Sometimes you have to. I am not opposed to that. But the segment of our society that now has the most assets is our senior citizen population, and while AARP doesn't condone it and doesn't—there are seminars where you go to learn how to hide assets so that you become Medicaid eligible for long-term health care. That is wrong. That is wrong.

Mr. THAMES. We don't disagree that people with high assets should pay for their health care and to pay for it as long as they possibly can, but we don't disagree either—we can't agree that whatever legal loopholes that are there for people to use are going to be used. And we don't—if they are not the right things to be done, then you have to close those loopholes, just as we believe the fraud that is being committed ought to be—those loopholes ought to be closed, and just as we feel that preventive medicine will keep people living longer and healthier and out of nursing homes.

Chairman BARTON. Which is a good thing, not a bad thing.

Mr. THAMES. Exactly. And better medications and being able to take their medicines correctly keep them from having the complications that also lead to them being in the nursing home. So all of those things have to be done.

I can't give you a simple answer of saying we are going to say everybody who makes $500,000 a year is going to be paying for all their medical care, but I would be very surprised if the people who make a lot of money are the people who are ending up on Medicaid. The people who have a lot of assets, I don't believe most of those folks are the Medicaid folks.

Chairman BARTON. Well, my time has expired. I appreciate AARP for being here; and I thank you, chairman, for your discretion in letting me go over.

Mr. DEAL. Mr. Waxman is recognized for 5 minutes.

Mr. WAXMAN. Thank you, Mr. Chairman.

I want to follow up on the discussion that was brought up by Mr. Barton. No one can condone the idea of somebody transferring assets, hundreds and thousands of dollars, and then having the public pay through a welfare poor people's program for their Medicaid. So the Congress dealt with that issue, and we set up a 3-year look-back period. If you transfer your assets in 3 years before you go to a nursing home, you count the amount of the assets and you say, well, we are going to keep you from having the Medicaid program pay for the nursing home cost based on the amount of assets you transferred and the period of time in which you transferred it. Now there is a proposal before us that would go to a 5-year look-back period. I just want to talk about that in a practical manner.

You can have an elderly woman with a modest sum of money—let's understand they have to have less than $2,000 in assets before they would be eligible for Medicaid, but let's assume they have a little bit more than that. And this 80-year-old woman has saved her whole live life and has $25,000.

Her daughter, who has no health insurance, gets sick and loses her job, not unusual. Maybe she was living in New Orleans. She gets sick, and she needs costly medical care. She can't pay her bills,

and the mother comes and helps her, also not unusual in this country. We want people to help each other.

Now, 4 years later, the mother has a stroke—unpredictable event. She didn't think she was going to go to a nursing home, didn't think she was going to go on Medicaid—and she has to go to a nursing home. She has technically transferred her assets, and now if we go back and look 5 years back and then start saying, as of that time, she is not eligible, but she needs to go to a nursing home, do you think a nursing home will take her? She can't pay for the nursing home. Her daughter doesn't have the ability nor the obligation to pay her back. She is not eligible for Medicaid. Who is going to pay for her nursing home costs, and what nursing home would take her in under those circumstances?

Mr. THAMES. Mr. Waxman, you are entirely correct. We are concerned about extending the period from 3 years to 5 years since you are going to see more and more of those events happen in people's lives. Where they make legitimate gifts or help their family or put a kid through college to help pay for it and then suddenly have a catastrophic event in their own health care and they lose their assets, our feeling is they shouldn't be penalized for not gaming the system and not attempting to illegally transfer assets.

Mr. WAXMAN. Now there is no real way to measure whether it was an innocent-enough transfer or intentional, because we don't look at intent. We simply look at the fact that there is a transfer.

Let's say a nursing home lets her in. What kind of quality of care is going to be available in that nursing home if they have a lot of people for whom they are not going to be paid? She is in the nursing home. They can't dump her. That is why they won't take her, probably. But let's say she can afford to pay for a month or 2. What will happen to the quality of care in that nursing home if they have uncompensated patients they have to care for?

Mr. THAMES. Obviously, the quality of care is going to suffer. Ultimately, the nursing home is not going to survive if it has enough of those people that don't pay; and it goes out of business.

Mr. WAXMAN. Two-thirds of Medicaid expenditures go for nursing homes, but I think most of the people in nursing homes who are on Medicaid didn't go to the nursing home and get on Medicaid. They went to the nursing home and paid for themselves, and when they spent away their money to less than $2,000, that is when they got on Medicaid, am I right?

Mr. THAMES. That is right.

Mr. WAXMAN. So I think the theory sounds right when you say why should we let people transfer huge amounts of money, a seminar for wealthy people. It is troubling. And if they want to anticipate in 5 years they are going to possibly need Medicare, well, then maybe we have to go back 6 years or 10 years. But once you do these things to try to plug up the loophole you are going to sweep up a lot of innocent Americans who worked hard all their lives, put away a little bit of money for themselves, and when they get hit by a stroke or some other catastrophic kind of problem, they are going to need full-time custodial care, we either leave them destitute, we will make the nursing home absorb the cost, or I don't think what we do with people, and I don't think it is sensible or fair.

Another question I have for Dr. Alexander. The Governor's Association is asking for flexibility in two areas of Medicaid that would essentially allow States to discriminate against people from one part of the State to another. Can you medically think of any reason why a person with diabetes in one part of the State should get care and someone with diabetes who is otherwise eligible, they are poor enough and all that, they are on Medicaid, what sense would that flexibility have from a medical point of view that you can see?

Mr. ALEXANDER. I guess the simple answer is I can't think of a medical reason why people in one part of the State would need or deserve a different standard of care than people in a different part of the State.

Mr. WAXMAN. I don't want to abuse the extra time I am getting, but I want to say one thing, when Medicaid was adopted it was to say no American anywhere who is poor enough will be denied health care; all Americans would have access to health care. We would have the program run with the State, but it is a Federal/State partnership, and we want all Americans to be treated fairly. Well, the program has become more and more States have flexibility through options, but if we are going to even give a State the option to be so flexible they can deny care to somebody in one part of a State for a disease and not in another part, that just seems to me backing away from the original premise that this program is going to be there for the very poor and vulnerable who need the protections.

Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. DEAL. I recognize Mr. Bilirakis for 6 minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman.

Dr. Thames, do you know to what degree AARP was invited in the process here in terms of your staff meeting with congressional staff on the crafting of these ideas? I mean, we don't have a piece of legislation yet, as I understand it, but the concept is one—do you know to what degree?

Mr. THAMES. That our staff was involved with your folks?

Mr. BILIRAKIS. Yes. In other words, they are invited for input.

Mr. THAMES. Yes, sir. I believe they have been meeting and giving input from AARP on all of the material that the committee is reviewing and looking at. I know that there was no bill to be given because, having testified on other health care issues in the past, if there is a bill, I get a complete copy of the bill so that I can study it before I am here, sir.

Mr. BILIRAKIS. Well, we, too, but we don't have a bill.

Doctor, you are a medical doctor. You have basically experienced it all, I think, at very level and with every person. Do you feel that the States care—and this is all about caring. It is all about caring, I think, of the creation, as Mr. Waxman has said, back in the mid-1960's of the safety net for the poor of our people. So we are talking about caring, caring for the poor of our people and caring for retention of a safety net and keeping it from losing it, keeping from losing it, if you will. Do you feel that the State authorities have just as much heart as we have up here in Washington, DC, as far as caring for their people?

Mr. THAMES. Yes, sir. I believe that it is supposed to have been and has been a Federal/State partnership, and I believe the States

and the Governors in the States and the other State legislatures have a heart and feel that it is of concern to them that poor people should be covered for health care.

Mr. BILIRAKIS. Okay. So you don't find any fault—I mean, there may be specifics, but you don't find any fault in general with the concept of flexibility, giving the States flexibility in view of the fact that they know their people and are closer to their people than we up here are.

Mr. THAMES. We agree that flexibility has some advantages, and as long as flexibility is looked at and does not include caps, funding caps which lead to denial of necessary services in our opinion for the people who can least afford them, then we think flexible options ought to be looked at, and some flexibility ought to be available for them. And I don't disagree with the testimony given earlier that States in some ways are going to be demonstration projects, although we also mentioned in the material given to you folks some demonstration projects, particularly for long-term care.

Mr. BILIRAKIS. All right. Doctor, getting to the discussion on assets transfers—it has taken up an awful lot of the time, obviously—when I was in law school back in the early 1960's there wasn't a particular course for elder law, if you will, or things of that nature. There certainly weren't any seminars taking place. There weren't any continuing legal education seminars taking place giving lawyers credit, certain hours credit for teaching people or showing people how they should get rid of their assets. There weren't, as far as I know, any seminars for non-lawyers basically asking wealthy people, if you will, or certainly if not wealthy, close to it, coming in and teaching them how to get rid of their assets.

Now you mentioned health care for those who sincerely need it—your exact words, and those were good words. So a person who goes in to see an attorney, who attends—and I think Mr. Waxman basically alluded to this, too. He finds that troubling, and I am very happy to hear him say that. I think we are all troubled, are we not? Should we not be troubled with the fact that people actually go to these seminars specifically to find a way to transfer their assets to their children and to others?

The situation that Mr. Waxman brought up, anybody with a heart would certainly agree with him there that this type of thing should not apply as far as that particular lady is concerned. And maybe if he is concerned that the legislation as it might be crafted would apply that particular situation, I think we ought to take another look at it. Because I don't think that is the intent here, but the intent is the assets transfer. There are statutes in the Social Security Act—I can read them here—would—basically, there wouldn't be any penalty if the advocate can show the assets were transferred for a nonMedicaid purpose, et cetera, et cetera.

So you would agree that there should be some legislation regarding asset transfer. Because is it not fraud? Is it really not fraud? I mean, is that too harsh of a word, that a person who actually might have a net worth of a half a million dollars or something of that nature would find a way to transfer it in order to go to the taxpayers for their care in the future?

Mr. THAMES. We certainly would agree that willful hiding of assets and moving those, which is fraud, is illegal. It is illegal under

the present Medicaid Act for them to do that, or at least it is a penalty phase if they do that.

What we are concerned about is the example I think that Mr. Waxman gave, so that people who are making an honest contribution not be penalized when that is done. I understand the difficulty in determining it, but I don't think it is too difficult if you look at the total amount of money, and it is a very large amount of money, and it got moved suddenly to something else to determine that is hiding your assets.

Mr. BILIRAKIS. With that kind of an attitude then on the part of AARP, they would be willing to be helpful to shore up, if you will, or tighten definitions or whatever it might take to really get to what we are trying to get to.

Mr. THAMES. Yes, sir, I believe we would be very willing to work with the committee on that.

Mr. BILIRAKIS. Thank you.

Thank you, Mr. Chairman.

Mr. DEAL. Thank you.

Mr. Dingell, you are recognized.

Mr. DINGELL. Mr. Chairman, thank you. I appreciate your courtesy.

Mr. Parrella, welcome to the committee. I appreciate your assistance here. I have a couple of questions for you.

As I understand it, the State of Connecticut authorized a waiver to CMS requesting permission to charge premiums with incomes as low as 50 percent of the poverty line, and that is an income of $636 a month for a family of three. But I found that the State legislature subsequently repealed the authorization because they found that, amongst other things, 86,000 children and parents would have lost coverage, is that correct?

Mr. PARRELLA. The State of Connecticut never submitted that waiver to CMS. There was never a waiver submission to CMS.

Mr. DINGELL. Why was that? They found it was bad policy, hurt people or what?

Mr. PARRELLA. It was as you said. Any waiver that would have had premiums assessed for clients at that income was found to be undesirable by our legislature.

Mr. DINGELL. The legislature authorized it and then repealed it, right?

Mr. PARRELLA. They never authorized it. We never applied—we never got to the point of our seeking waiver authority from our legislature.

Mr. DINGELL. Now, the State of Connecticut also submitted and withdrew a Medicare waiver request that CMS implement a policy that would make it more difficult for low-income seniors to qualify for nursing home care, such as increasing the look-back period when doing the Medicaid eligibility determination and changing the date a penalty applies when the transferred asset was made, but the State also withdrew this waiver, isn't that so?

Mr. PARRELLA. The State did withdraw the waiver application from CMS.

Mr. DINGELL. I just would observe here, Mr. Chairman, that it rather appears to me that we have before us a situation where we are finding that some of these flexibilities have been tried and

found wanting; and I am sure there would be many others that we could find where States have considered these and then found that they imposed hardships on the people that we are trying to help with Medicaid, which are the folk who have the least in the way of resources and means and the greatest needs to be addressed in terms of health care.

Mr. Parrella, thank you.

Thank you, Mr. Chairman. I yield back the balance of my time.

Mr. DEAL. Thank you, Mr. Dingell.

Mr. Parrella, let me follow up on with that. It is my understanding that the reason that the asset transfer waiver request was withdrawn was because your State, like all 49 State Governors, thought that the proposal to deal with asset transfers proposed by the National Governors Association was a better and more appropriate proposal, is that correct?

Mr. PARRELLA. That is correct, sir.

Mr. DEAL. And that is the proposal, by the way, that we are operating off of.

Let me go back to the illustration Mr. Waxman used about the lady who made legitimate transfers and then later on found that she needed Medicaid for nursing home care. Isn't it true that the current law already provides for hardship exemptions for individuals in that category and that States can grant waivers for those kinds of situations?

Mr. PARRELLA. That is true.

Mr. DEAL. And did your State look at that situation with regard to a proposal for those kind of waivers to even expand them?

Mr. PARRELLA. Yes, we did. We actually did pass legislation in our State legislature that would have codified hardship exemptions that would have applied even in the application of the asset transfer rules.

Mr. DEAL. Okay. With regard to the concern that Dr. Alexander expressed—and I think all of us have concern that we not do anything to hurt children, the most vulnerable population, isn't it true? Well, if we had a proposal that would exclude all mandated covered children from any co-pays, do you think that that would go to a large way to addressing those concerns?

Mr. PARRELLA. I believe that it would. As I understood it, in our conversations with our colleagues and the Medicaid directors and the National Governors' Association, we are really focused on changing the cost-sharing rules as they apply to optional populations to expansion populations that are above the Federal poverty level and Federal minimums.

Mr. DEAL. And Dr. Alexander, if we did exclude those mandated children populations from any co-pay, wouldn't that be a large portion of the concerns that you expressed?

Mr. ALEXANDER. It would be a large portion. I would probably differ in that 100 percent of the Federal poverty level was probably not enough.

Mr. DEAL. What about 133 percent?

Mr. ALEXANDER. I think 150 percent might be a more appropriate level to look.

Mr. DEAL. Dr. Thames, let me go back to another aspect of the AARP proposal that concerns me. We have talked about asset

transfers, and I think all of us recognize that if somebody is deliberately trying to game the system, we ought to try to do something to prevent that. That is what the Governors have said; and that is what we, hopefully, will try to do.

Let me talk about another portion of what you object to, and that is the equity in a home. Let's suppose that someone has a home that is worth $5 million in equity in that home, but otherwise qualifies to be Medicaid eligible and to have the taxpayers pay for their nursing home care. That $5 million home is probably going to have considerable accessories by way of pictures on the wall, furnishings, et cetera which would also be excluded. Do you think that is a fair situation or do you think we ought to try to do something to encourage those kind of population groups to use reverse mortgages to draw down some of that equity and keep the taxpayer from having to pay for their care?

Mr. THAMES. Well, the example you give is difficult to refute, except to say if a person has a $5 million home, his assets are down to $2,000, how is he going to pay the taxes and keep the home?

Mr. DEAL. Because another member of his family is volunteering to pay it for him.

Mr. THAMES. I guess that is one way that it could be done.

Mr. DEAL. What would be a fair asset in a home that should be allowed to be retained without putting a situation to encourage people to do reverse mortgages?

Mr. THAMES. I don't think we have set that level in discussions that I am aware of from the board, from AARP, but I will tell you that, in looking at this, we have looked at what we do in American values, and we tell people to try to save money, to buy a home, to send their children to college and try to have enough money to take care of themselves when they retire.

Mr. DEAL. We all agree with that. And those people struggling to pay their taxes also are trying to do that very thing, and they should not be taken advantage of someone who is trying to game the system.

My time is running, let me get to my hometown witness that I feel obligated that I need to get him involved in this discussion.

Jim, you are the director of our local hospital. You alluded to the fact that we have a private, through the medical association, over a hundred doctors volunteering their services free of charge to those who want to access it. Do you think that if we had some provision that would say that if you have got an offsite facility that is free of charge or a very low charge that that would help alleviate some of the problems that you are seeing for nonemergency presentations in the ER?

Mr. GARDNER. Again, Mr. Chairman, 29 percent of the folks that come through our emergency room are not emergency. We are very fortunate to have a public/private relationship that is working very hard to create alternative treatment sites.

If there were changes in legislation, both in terms of professional liability as well as some of the transfer rules that would give hospitals a little bit of flexibility, we do believe—and as part of that, how that came to be, you know the hospital is also investing in that. We are a not-for-profit health care system. But, at the same time, in trying to create these partnerships we are actually helping

to provide seed money that, in combination with other funds from our community, have helped to create this health access initiative.

It has been very, very successful, but I dare say that if there were a system where additional funds could be available for demonstration projects, we certainly would like to have the opportunity to do that with you and others that would be interested in that. I think it could have a profound impact on the numbers of patients that are seen in the emergency room. The lack of continuity of care and helping to hook this vulnerable population up with a physician that would see them on a regular basis and taking care of chronic illnesses and managing their drugs with them would be a huge benefit versus the episodic care that is hit or miss right now that comes through even the very best emergency rooms like ours.

Mr. DEAL. Thank you.

Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman.

Now, Mr. Matthews, in the interest of time I am going to pose yes-or-no questions, and I would appreciate if you would try to limit your response accordingly.

Since Medicaid beneficiaries are poor, your goal in supporting higher cost sharing cannot be to increase the financial burden on them, I assume. They are barely making it paying for food, for heating, for cooling, if they are in hot weather, and transportation costs. I am guessing you can afford, as we can up here, to pay 5 percent of your income on health care. Medicaid beneficiaries surely can't.

That leaves the only reason for this over utilization of health care. I am assuming that your premise is that Medicaid beneficiaries overutilize health care, and cost sharing will defer that. Since seeking medically necessary care does not qualify as over utilization, the goal must be then to reduce medically unnecessary care.

Here is my first question, if you would answer yes or no. Are you accusing States of illegally providing medically unnecessary care?

Mr. MATTHEWS. No.

Mr. BROWN. Then what—okay. Then give me something more than yes or no. If you say no, I don't know—I call back my yes-or-no request. Why do you think they could afford to pay this? I will ask that.

Mr. MATTHEWS. What I tried to say is that the Medicaid populations vary from State to State. Some have higher incomes, and States have expanded income eligibilities for some populations. Is it reasonable to allow the States to consider expanding co-pays for some of those populations, not the poorest? And my answer to that is yes. What is the right co-pay? I am not taking a position on that. I believe it is $3 right now. Is that $5? Is it $10 on prescription drugs?

Mr. BROWN. You are contending it should be something. Should it be some co-pay at 150 percent of poverty, 200 percent of poverty? Where do you want to begin the co-pays?

Mr. MATTHEWS. They are already spending $3 now. My comment is that it is reasonable to give the States the flexibility to expand that if some of the States choose to see what works for them.

And I also added in that that if the goal is to move people into private sector coverage ultimately, the private sector has higher co-pays, so someone who has a higher eligibility threshold in Medicaid, if that person is required to pay a higher co-pay or something of that nature, that actually gives them a little bit more of a look forward to what they would be experiencing——

Mr. BROWN. Why do you want to co-pay? Do you want the co-pay because you think there is overutilization? Do you want the co-pay because it means a little revenue to the system? Do you want the co-pay as punitive toward the poor? Why do you want co-pay?

Mr. MATTHEWS. Given the limited budget that States, by increasing the co-pays to higher income—and I realize that we are talking about poor people generally, but higher-income Medicaid recipients, you can make more money available to the lower-income people and perhaps expand the——

Mr. BROWN. So you would want that money put back into the Medicare system?

Mr. MATTHEWS. Yes.

Mr. BROWN. Not used to balance the budget that my friends on the other side of the aisle only seem to want to balance when it is time to cut programs like Medicaid.

Mr. MATTHEWS. I am not addressing the budget issue. I am just simply saying, from the State perspective, a State might say, if we raise a co-pay here, we can take some of that money and expand coverage here or reduce a co-pay for some lower-income people.

Mr. BROWN. Rand Health Experiment indicated that higher cost sharing will harm Medicaid beneficiaries. Can you provide evidence to the committee otherwise?

Mr. MATTHEWS. I did not provide evidence. The original Rand experiment looked back from the 1970's and 1980's, looked at higher co-pays and did not find from that an adverse result on health. That was working in private health insurance. That was not dealing with Medicaid.

Mr. BROWN. My understanding is they did, but we can talk about that. Should patients or doctors determine whether health care is medically necessary?

Mr. MATTHEWS. I think the answer is doctors.

Mr. BROWN. Dr. Thames, real quick—I have just 50 seconds left—I want to clarify some of the answers you gave to my friend, Chairman Bilirakis. Does AARP support moving the look-back period from 3 years to 5 years?

Mr. THAMES. Absolutely not.

Mr. BROWN. Does AARP support the change in the penalty period? Would that harm poor individuals who need long-term care?

Mr. THAMES. We do not support the change in the penalty period, and that would definitely harm poor people.

Mr. BROWN. And the last question, briefly, is the real problem State-based loopholes that people are using now?

Mr. THAMES. There are some State-based loopholes, and we believe they should be tightened up. I am not sure that we would say in any means that that is a real major factor in Medicaid.

Mr. BROWN. Thank you; and thank you, Mr. Matthews. Thank you, Mr. Chairman.

Mr. DEAL. Thank you.

Dr. Norwood is recognized for 6 minutes.

Mr. NORWOOD. Thank you very much, Mr. Chairman.

Mr. Parrella , just real quick, what percent of Connecticut's budget is Medicaid?

Mr. PARRELLA. The budget in the State right now, it is running about 25 to 26 percent of the overall budget.

Mr. NORWOOD. No wonder you were looking for ways to try to cut back. Well, we have the same problem in the State of Georgia, and the chairman mentioned the same thing in Texas, is this thing is getting to the point where it is unsustainable. We just cannot continue doing this. I hope AARP is hearing that, Dr. Thames; and I hope that, rather than being against everything we are talking about in long-term care, you better come up with some solutions or you are going to have fewer patients receiving Medicaid across the country. It isn't any harder than that. Two-thirds of this cost here is in long-term care, and if we don't come up with a solution a lot of people are going to suffer, and being against things doesn't get it done.

Mr. Gardner, we appreciate you being here. I was astounded at one of your remarks that Northeast Georgia Medical is the third largest ER in the State of Georgia.

Mr. GARDNER. Yes, sir.

Mr. NORWOOD. Who is two?

Mr. GARDNER. It is Grady in Atlanta, and then there is another system in Marietta. I am blanking.

Mr. NORWOOD. In and around Atlanta and you are three. Well, I am from Augusta. We have a pretty good hospital center down there, too. And Augusta is bigger than the Gainesville area. Why are you No. 3?

Mr. GARDNER. Well, Northeast Georgia serves as a feeder system really for all of north Georgia. Just looking at the confluence of the mountains and roads and houses, Gainesville is kind of the trap or the stop in terms of how all the roads work. So we see a large number of patients from all over the north part of Georgia.

By the way, the No. 2 is the Kennestone health care system in Marietta.

Mr. NORWOOD. Well, we see a lot of patients all over the middle and the southern part of Georgia in Augusta. I mean, something else has got to be going on up there for you to be No. 3, it seems to me.

Mr. GARDNER. Well, I think a lot of it has to do with the lack of other options. The hospital—again, in our situation, we are the safety net. We have a shortage of physicians—we have a significant shortage of physicians that accept Medicaid increasingly in our communities. You know, physicians would rather give their services away for free than put up with——

Mr. NORWOOD. It is a lot easier. I have been there and done that.

Mr. GARDNER [continuing]. Than actually having to submit a bill. That is certainly an issue. So those, in combination, create the high volume in the emergency——

Mr. NORWOOD. I am glad you mentioned that factor about so many of your caregivers simply aren't involved in Medicaid because it is much cheaper to just treat the patient and not be paying all the time and effort it takes to do it administratively.

I have been saying for 11 years up here that Medicaid, Medicare pays our providers, physicians and dentists and hospitals somewhere around cost, but you are telling me today now that I am out of line, that now it is 13 percent less than cost. And I believe you, but I am just amazed.

Mr. GARDNER. There are numbers to back that up. It is 13 percent across the State of Georgia. At our particular facility, Northeast Georgia, it is actually 17 percent is what the loss is per patient. So the math is pretty staggering.

Mr. NORWOOD. I hope Members of Congress will listen to that, because this will be an access problem except that you have so many great physicians up there trying to donate their free time to get this done.

In your testimony you said that 29 percent of the patients presenting to your ER in your hospital were seeking non-emergency care for common maladies like ear infections and flu. First of all, tell me what that 29 percent means. Who is that?

Mr. GARDNER. That 29 percent, if you look at—again, our clinicians, looking at the kind of patients that we see in the emergency room, they can very carefully—again, based on data—separate out what is traditionally considered by physicians to be emergency care versus routine or non-emergency care.

Mr. NORWOOD. But is it Medicare patients or the general population?

Mr. GARDNER. If you look at the general population in total, it is 29 percent. That is actually a very conservative number. If you look at hospitals across the State of Georgia—and Augusta may be one—those numbers can be as high as 60 percent.

Mr. NORWOOD. Yes, I am aware; and I know that you are correct.

Real quickly, because I have got one other important question, give me a conservative estimate—I presume this is that 29 percent conservative—how much money your hospital loses because of this improper utilization. Real quick.

Mr. GARDNER. If you look in total, it was about $6.6 million last year, but the greater opportunity is it cost $266 to see them in an emergency room, it cost $74 dollars or less to see them in a physician's office. If you look at that $192 difference, you can imagine how much care could be added to the system without increasing any costs if we can get these patients into the right setting.

Mr. NORWOOD. My district is all around Gainesville, so I have a good clue about what is going on up there. But in your testimony you made a statement that I admit it definitely caught my eye. You stated that reform of both Medicaid and immigration must be intertwined if your hospital is to survive. Now I cannot agree with that more. That said, how have the immigration policies of our country impacted our area and the care that you provide from your hospitals all around my district?

Mr. GARDNER. Well, the last thing I would do is to sit here and claim to be an immigration expert. Kind of like the budget, that is for folks that are above my pay grade. As I live and work in Gainesville, what we are watching is a fundamental change in the demographics of our community, and a lot of it has to do with our economy. It is based on agriculture. We are a large poultry producer.

Mr. NORWOOD. So you see a lot of illegal immigrants in your hospital? I know you do.

Mr. GARDNER. Absolutely. Every day we have situations where we literally have watched one person leave the emergency room, hand their insurance card with their name to the next person that is outside.

Mr. NORWOOD. Some of us in Georgia believe that the cost of the Medicaid program alone, because of illegal immigrants, is around a billion dollars a year. Now my complaint is that billion dollars ought to be used for U.S. Citizens, not having to cut back their programs that they are on in Medicaid, but quit wasting money on Medicaid, and I hope this will be part of our reform, too.

Thank you, Mr. Chairman. I appreciate going over a second.

Mr. DEAL. Thank you.

Mr. Stupak is recognized for 5 minutes.

Mr. STUPAK. Thank you.

First, let me thank Mr. Sheehan and Mr. Alexander for coming here today. They are both from Michigan, and I appreciate the work that you do day in and day out trying to provide quality health care to people in the State of Michigan.

Let me just go back to Mr. Gardner for a minute. You just said that you saw people hand their Medicaid card to the next person in line.

Mr. GARDNER. We have instances where we know that the same Medicaid card has been used by multiple family members.

Mr. STUPAK. Okay. I thought you said in your answer you witnessed it. Because I was going to ask you what did you do about it.

Mr. GARDNER. I am talking just anecdotally. I don't live in the emergency room.

Mr. STUPAK. I hoped you didn't. But I just found it surprising that these so-called stories, but then when you press people they don't know anything about it.

Mr. GARDNER. I am not trying to impress anyone. There are definitely cards being used by multiple family members, and we have repeated instances of it.

Mr. STUPAK. Well, I hope we crack down on that.

Let me ask Mr. Sheehan and Mr. Alexander a question or two. Because recently in the State of Michigan in the budget process—and I didn't think much about this until what happened in the budget process, the Upper Peninsula of Michigan got severely cut in their universities and some other institutions we had up there in the budget rules. We are a small part of Michigan, a vast geographic area, small voter population; and in the Governors' proposal, National Governors' Association proposal it says that the States should be allowed to pick and choose who they serve and which parts of the State they may offer benefits.

So I am a little concerned with this geographic waiver, since I live in a very rural area and we see where the Michigan legislature has made cuts which impacted the Upper Peninsula, I could actually now envision a scenario where Medicaid services would not be offered in the Upper Peninsula of Michigan because it is too expensive because of a large geographic area for a small amount of people.

Would you care to comment on that, Mr. Sheehan or Dr. Alexander?

Mr. SHEEHAN. You are talking about the waiver of State-wideness Medicare? That concerns us. Currently, State wideness is a good protection to say we will base our Medicare plan on clinical necessity, which is pretty ubiquitous across the State, and a strong entitlement program. The lack of State wideness then allows it to become a political process. And it is not only the UP in Michigan, who might not have the political power, but consumers I serve, adults who are mentally ill. When you look at the political spectrum, we are down toward the bottom in terms of power.

The concern that I would have is much more politically attractive Medicaid groups would receive services either geographically or because of their other needs. So it is a real concern. States currently have waivers, 1950(b) and (c) waivers States can apply for. The advantage of those waivers is Federal protections remain on Statewideness in comparability, and I think those are probably better ways to go.

Mr. STUPAK. Dr. Alexander.

Mr. ALEXANDER. Congressman Stupak, we are privileged to serve many of the children from your district, especially those with special needs at our hospital; and, as I referenced before, I can't imagine a clinical scenario where we can justify regional allocation of benefits. It just doesn't make any sense.

Mr. STUPAK. Okay. Mr. Sheehan, you mentioned about the mental health aspect of the people you represent. Being a former law enforcement officer, I am also concerned about the impact that Medicaid cuts would have on our correction system. It seems like the folks who need some help in the area of mental health, they don't get it, we find them in our county jails and State prisons. So we are just shifting the problem somewhere else and clogging up the criminal justice system. And I say that respectfully because they have no place else to go and they do things to get the help they need. Have you experienced that?

Mr. SHEEHAN. We have. The mental health system is a unique system, that if you don't treat it early part of the costs end up in the mental health system in terms of—in patient care. But most of those costs get externalized someplace else: correction system, homeless shelters, physical health, the ERs. That is a unique factor—schools, for example. That is a unique factor if you don't treat the mental health conditions of the kids or adults early.

I think what happens in mental health is maybe, unlike some physical health conditions, the deterioration of a patient is pretty rapid. If they lose access to case management or therapies or psychiatry or the drugs they need, decompensation happens pretty quick. It doesn't take months. So they end up in a jail or in a homeless shelter or they lose their home or they drop out of school very quickly, and that is a concern that we have.

Mr. STUPAK. In your testimony, Mr. Sheehan, you talk about the harm done by increasing co-payment and cost-sharing requirements for beneficiaries, reducing access to medications and implementing sharp reductions on services. Can you please share with the committee a story or two from your own experience just now devastating the so-called small changes to co-payments and medi-

cation availability can be on a clientele that you represent? And, Dr. Alexander, if you to want add to it, please do.

With that, my time would be up, but if you would both answer that for me I would appreciate it.

Mr. SHEEHAN. I think I can. If you don't mind, let me talk about the principles behind it. I think that is critical, and they were alluded to a second ago.

Cost sharing makes senses from two premises. One is the behavior you are trying to change is a health care behavior that is not appropriate. Somebody is seeking mental health care that is not appropriate. In the mental health world, with folks who are seriously mentally ill, the opposite is true. You can't get folks to come into treatment and stay with it. The treatment for mental health, to stay healthy and to keep taking your medications aren't easy, so you don't see over utilization of mental health. We don't run a boutique in mental health care where Prozac is used to make us feel better. Where that may happen in America, it doesn't happen in the Medicaid population that we serve. That is the premise No. 1, which is false. I don't think there is misuse of psychiatry and case management therapies, or in-patient use, for that matter.

The second premise is that the patient has assets or dollars they should be using to help pay for their health care. Most of the Medicare recipients we serve are severely disabled, they are on SSI, their average SSI payment is $600 a month. Virtually their entire check goes for shelter, and so the amount of money that they have to contribute to their health care is virtually minimal.

What we see in Michigan then is when people then are forced to pay for their health care, in Michigan, for example, the co-pay for psychiatry and psychiatric medications just went up. People stop taking their medications. The side effect on medications—it can be up to six or seven medications a month. The side effects of those medications are substantial. Trying to get people to stay on medications so their clinical stability is strong is hard enough. That $30 or $40 a month in co-pay is putting people off the edge, and they stop taking it. And I have got to tell you, when they stop taking it, they don't start showing up more, they show up less. We spend all our time with our case managers trying to find them. These are people that are marginalized already. They have behaviors that most people find bizarre and stigmatize. So then we find them in jail, as you mentioned, or we find them in a homeless shelter.

Mr. DEAL. The gentleman's time is expired.

Mr. Shimkus is recognized for 5 minutes.

Mr. SHIMKUS. Thank you, Mr. Chairman. Thanks for calling this hearing.

My district is southern Illinois. It is mostly 30 rural counties. And what we see, based on the current Medicaid system, is doctors and providers opting out of taking Medicare patients. The system is not working. We are seeing less care under the current system. So reform should be providing more care, and I would just encourage people to come to my district, and I can put them into contact with all of the providers and the doctors.

I would like to, at this time—we do have an expert in the dental field, and that is—because there is one community that is going to have a clinic, and they are very excited because they are going to

have a dental clinic, a community health care. It will be the first time in southeastern Illinois that Medicaid recipients are going to get dental care, and there is already a 3-month waiting list.

The system is not providing dental care. Dr. Norwood, can you talk to us about some of the problems in providing dental care to Medicaid recipients?

Mr. NORWOOD. Well, just for the panel's benefit, I practiced dentistry for 30 years; and years ago we did a lot of Medicaid, not because necessarily it was very profitable to do but because we sort of felt like that was what we needed to do in order to help people out. But over the years it got to the point that they paid so little—I mean, it wasn't even close to what your cost was—and then it was so difficult and expensive to even file for that little bit that we stopped seeing Medicaid patients in terms of filing with the State. We did continue to see them and alleviate pain and suffering and infection and that was all and didn't charge anybody because it was just too costly to mess with the State with their regulations and everything.

But it is important—and I thank you for asking me this. But it is important that Medicaid have basic dental plans in it to take care of pain and infection and suffering.

Mr. SHIMKUS. I want to thank my colleague, because a lot of us are not experts in a lot of these fields. We learn over the years. Some actually practice in the field, and they have had the firsthand experience.

In Missouri—I represent the metro St. Louis area, and I have been watching the Governor of Missouri trying to handle the excessive costs of an exploding Medicaid system. What are States doing now to address their cost? Can someone answer? Do we know what States are doing right now to address Medicaid reform? Mr. Parrella?

Mr. PARRELLA. Well, I think, Congressman, there is a wide range of things that States are doing. States are doing a lot of issues related to prescription drugs, for example, where a lot of States, including my own, have moved to a preferred drug list where we are seeking supplemental rebates from pharmaceutical manufactures to have a system that includes prior authorization for certain prescription drugs. We exclude psych meds, and we exclude HIV medications. That is protected classes. But we have a preferred list so that we can get a reduced price for——

Mr. SHIMKUS. Your testimony says Medicaid reform is a moral imperative. How so?

Mr. PARRELLA. Medicaid covers—whatever the number is these days—53 million people. There is 47 million people in this country with no insurance at all. A lot of them are just as poor as Medicaid clients, but they don't meet the same categorical eligibility requirements. Some of them are single adults, for example, who are just as poor as the adults that are taking care of children who are eligible for Medicaid. If we don't have reform in terms of how Medicaid provides benefits to its current population, how will we ever have the resources—speaking of those other folks who are currently without care, that, to me, is the moral imperative.

Mr. SHIMKUS. Well, as I have been watching the State of Missouri unfold on some of their issues, they have had to take off the

roll a hundred thousand beneficiaries, and those are based upon the optional benefits that they initially extended. So it is just like any other debate on entitlements. If we don't reform the system, the system itself will then ration the delivery to the lowest denominator. And what reform is trying to say is how do we make the system work for everything? How do we give the flexibility and how do we bring coverage?

I had a question for Mr. Matthews—my time is getting close to out—what will happen if Congress fails to address Medicaid's challenges soon?

Mr. MATTHEWS. I think what you will see is more States will begin to reduce benefits in eligible populations and you will see fewer people getting Medicaid. And the better approach is to find a way to get those people covered by giving the States the flexibility to adjust those benefits.

Mr. SHIMKUS. Thank you, Mr. Chairman.

Mr. DEAL. Mr. Rush is recognized for 5 minutes.

Mr. RUSH. I waived my opening statement.

Mr. DEAL. We are in the questioning phase. Did you waive your opening statement?

Mr. RUSH. I sure did.

Mr. DEAL. All right, we will give you 6 minutes.

Mr. RUSH. Thank you, Mr. Chairman.

In all these hearings that we have conducted on Medicaid, I have made my position quite clear. I do not believe that beneficiaries should bear any burden whatsoever when reforming—so-called reforming Medicaid. The program serves the most vulnerable and needy populations in our society: the poor, the disabled, children and the elderly. This program is already underfunded, and as the poverty rates in this country continue to grow really at an appalling rate, the need for Medicaid continues to grow also. In my mind, we ought to be discussing how we are going to substantially increase funding for this vital safety net program, not how we want to cut the funding.

Having said that, I want to address the whole notion of cost sharing and the need to promote personal responsibility; and I would like this panel to take a stab at defining what personal responsibility really means. This has often been a co-phrase for a very pejorative characterization of the conduct of poor people. Back in the 1960's it was used to depict images of so-called "welfare queens", and since some of that is going on right here, can the panelists, at least three of you all, give me an idea of what you mean by a personal responsibility? Start with Mr. Parrella.

Mr. PARRELLA. I can take a stab at that, Congressman.

One of the things that has been talked about today is use of health care services through the emergency room. Now as I think my colleague from north Georgia has testified to, folks go to the emergency room because they don't have access to providers in the community.

It is hard to be in a situation where you are blaming a victim in that case for saying, Well, you are using the system inappropriately. They have nowhere else to go. Congress and the government has provided funds to federally qualified health centers around the country as an alternative to emergency room use. Those are a valu-

able asset. I think where in that context comes an issue of personal responsibility is that if a client has access to a primary care physician, that access has been required but they do not use the system appropriately, they continue to use the emergency room despite the fact that they have available to them a community doctor. And in some cases they don't, but let us say that do, then that is an issue I believe of personal responsibility in terms of using a service which could be purchased by a State government for $75 as opposed to a service that is going to cost the government $225.

Again, I want to be very careful that I don't want to characterize clients as being always in a situation where they are the cause of the abuse. There are certainly situations where access for Medicaid clients, no matter where you are in this country, can be difficult simply because, as we have heard in the context of dental care, there are just a lot of providers who are not making themselves available. But if there is access available to secure networks of primary care providers, clients need to understand that they too have some responsibility to use those services appropriately.

Mr. MATTHEWS. Congressman, I will take a stab at that. I did not use the term personal responsibility in my testimony, but let me give you an—because I think for most Medicaid recipients personal responsibility does not become involved. But for some populations in Medicaid, it does, and I think that is true for some of the long-term care recipients.

I will give you an example. My director of research and policy who lives in Minnesota recently wrote an op-ed that was published in the Minneapolis Star Tribune on what her family is doing. Her family is from New England. She was getting ready to make a journey from Minnesota back to New England for the family because her grandmother, who has assets, they want her to go on Medicaid long-term care, go in the nursing home under Medicaid. So they had set an appointment with an eldercare attorney. She would be traveling back to New England. The family was going to meet with the eldercare attorney and find out how to hide grandma's assets so that she could go qualify for Medicaid. She wrote the op-ed. Lots of response there in Minnesota because—she called it The Medicaid Game. She was the dissenter in the family in doing this.

But the point was that the grandmother has assets and at one time did not take personal responsibility to buy a long-term care insurance policy or set enough money aside to make sure she was going to cover herself in the nursing home and was going on Medicaid.

Mr. RUSH. Okay. Thank you.

Mr. Parrella, let me just ask you, before we move on to the next. What specifically in this bill addresses the concerns that you had about getting, utilizing available medical services and then using the emergency room? Is there anything in the bill that addresses this specifically?

Mr. PARRELLA. There is nothing specifically in the bill, Congressman. I mean, the closest analogy that I would draw would be, in my plan as a State employee in my State, if I do that, if I use the emergency room inappropriately as opposed to using my primary care physician—my normal copay for an office visit is $10. It is a very generous policy. We have very good coverage.

Mr. RUSH. But isn't it a fact, though, that this bill actually discourages screenings that might prevent going into the emergency rooms, such as the early and periodic screening, diagnosis and treatment for children?

Mr. PARRELLA. I haven't seen the text of the bill. But certainly in the context of discussion with the National Governors Association, we would support continuing protections for EPSDT services and for children and mandatory coverage groups as being exempt from that kind of cost sharing.

Mr. RUSH. Thank you.

Mr. DEAL. Thank you.

Mr. Terry is recognized for 6 minutes.

Mr. TERRY. Thank you, Mr. Chairman.

This question, I have one general question that I wanted to ask Governor Keating and Dr. Thames and Mr. Matthews. So the rest of you can just hang back here. But I really believe that, when we look at modernizing Medicare, we have to look at it holistically. And one of the areas that, as the chairman, full committee chairman, brought up, Chairman Barton, is that two-thirds of the dollars are spent on long-term health care, with providing services to our seniors.

Now, if we are going to tackle the problem of reforming, I think we need to look at ways that we can encourage more middle class to purchase long-term health care policies so they don't have to engage in this shell game of moving assets around, dispensing of assets early in order to make themselves eligible for Medicaid when it comes time to move into a skilled nursing facility. So I think we need to focus on that. There are three bills. Governor Keating mentioned only one. There are actually three bills out there that I think all of them can work well as parts of a greater whole here to give people greater flexibility and encouraging—you have the bill that H.R. 3511, the Governor mentioned, but you also have the above the line tax deduction proposed by Congresswoman Nancy Johnson. You have, as Mr. Matthews kindly mentioned, the Terry-Peterson bill that allows tax-free and penalty-free withdrawals from your retirement accounts, be it a 401K, an IRA. And I just call that asset protection.

The hope here is that by tying the long-term health care in to some benefit like your pension or your retirement accounts funded partially between the employer and the employee, that a long-term health care benefit or policy becomes intertwined within that. If we can do that, I really believe that we can save the Medicare system a great deal of dollars. And, frankly, the long-term health care policies provide a great deal of flexibility. It was either Mr. Matthews or Governor Keating that mentioned a lot of—no. It was Dr. Thames that mentioned that a lot of seniors want to stay home. Under Medicaid, you don't have a choice. They won't pay for the home nursing care that is a heck of a lot cheaper. And I have had several seniors tell me they didn't want to, after a hospital stay, do 30 days in a skilled nursing facility; they wanted to do what their private payer paid for earlier in life, and that is a visiting nurse. A long-term health care policy pays for that visiting nurse to come in a couple times a day and maybe change some tubes or some feeding bags or something. Do you, Dr. Thames, have an

opinion on whether we should be more aggressive in this Congress and encouraging and providing incentives? And Mr. Matthews and Dr. Thames, do you have any statistical evidence of how much this could cost Medicare by moving more people, especially the middle-income, lower-middle-income, into long-term health care policies?

Mr. THAMES. I am going to answer, if I could, your second question first. I will have my colleagues and the people that at AARP see if we have some figures for you on cost savings and what the costs are. We may have that material, possibly John Rother in our policy institute. I am not at the moment able to give you those off the top of my head. Within 24 hours, we can tell you whether we have those figures.

Mr. TERRY. I think that would be very helpful to this committee.

Mr. THAMES. But, second, I appreciate the opportunity that you give me to talk for a minute about long-term care, because AARP does support some things about long-term care, and one of those is something you brought up. We do believe that improvements that make long-term care insurance more affordable, you know, that there is a bill that has been supported by AARP that would give some tax credits for people who buy long-term care insurance. So that is one thing that we are positive for in doing that.

But in addition to that, we have looked at the long-term care partnerships and whether or not there are ways to expand those out of the four States that presently do those and look and still keep the consumer protections detailed in the written statements so that they are going to be protected and continue to be protected. We don't want to lose the consumer protections in doing that.

And, third, we think we ought to look at options for ways that people can use their equity in their home without losing their homes. That is, use some of the equity in their homes, for the people who have homes of whatever value that may be great, but where the remaining partner, if they are married and one person is there, does not lose the ability to stay in that home as long as they live so that they are not denied the home if the other person that is in the nursing home uses up those assets. And there are ways in looking at doing that, and there are ways in looking at reducing the costs of those home equity conversion policies. And particularly for low-income people, perhaps the insurance premium at the beginning could be reduced or decreased for those that are truly in poverty levels.

Mr. TERRY. Just before Mr. Matthews answers, would you go back to AARP and ask them to take a look at H.R. 976, too?

Mr. THAMES. Absolutely, sir. You can be sure we will.

Mr. Terry. I would appreciate that.

Mr. MATTHEWS. Mr. Terry, we have not done an assessment of the economic impact on Medicaid that, if you were to expand that, that is something that we may want to take a look at. I can say, though, the problem—if the problem is bad now, it will be significantly worse in the near future because of the aging population. We have to address the issue now because we are facing an explosion in seniors going on Medicaid.

Mr. TERRY. Thank you.

Mr. DEAL. Thank you.

Ms. DeGette is recognized for 5 minutes.

Ms. DEGETTE. Thank you, Mr. Chairman.

I was doing some calculations about the NGA proposal, and it looks to me like cost sharing could be required under the NGA proposal from those above 150 percent of the poverty level to an amount as high as 7.5 percent of total household income. So if you do a calculation for a family of four at 165 percent of the Federal poverty level that made $32,000 a year, my statistics show that they could be required to pay up to $2,400 in cost sharing under this proposal. And I have got a couple questions about that. First of all, I was going to ask you, Mr. Sheehan, is that for people who have mental health issues in their family? $2,400 seems to me an amount that you could actually get up to pretty quickly with some of the drugs and some of the medical care that you need. Would that be accurate?

Mr. SHEEHAN. Yeah. It depends how big the cost-sharing proportions were, how the copays were structured.

Ms. DEGETTE. I mean, if they had to pay $2,400 in copays, and they had an income of $32,000, do you think that would make some people with mental health issues, as you were discussing earlier, forego medical treatment?

Mr. SHEEHAN. It would. I mean, again, it is important to parallel that against the behavior you are trying to stop. If they had to pay that because they were inappropriately using an ER——

Ms. DEGETTE. Right. I understand. But—such as copays. I am not talking about——

Mr. SHEEHAN. I think it is important to know what the contrast is. No, if people are behaving themselves and they are seeking appropriate care, if they end up with a bill like that, they won't be seeking appropriate—I can tell you that now.

Ms. DEGETTE. I was thinking about—I am the co-chair of the Diabetes Caucus in Congress, and I was thinking about costs for diabetics. And I worry about the same thing. Dr. Thames, I see you shaking your head. A lot of seniors who are diabetic may not seek the right medication or the level of treatment that they need. Would you agree with that?

Mr. THAMES. Absolutely. And the kind of preventive care that they need and the frequency of visits to look for poor circulation in the extremities and the eye changes that occur early and the other things that make diabetes and kidney failure and finding it early.

Ms. DEGETTE. Which could not only help them healthwise, but could save a lot of money in the long run. Correct?

Mr. THAMES. Absolutely.

Ms. DEGETTE. Now, Mr. Parrella, what do the States have to say about those kind of caps? I mean, that seems like a lot of money for a family of four making $32,000 a year to have to pay in copays, especially people with chronic health problems.

Mr. PARRELLA. Well, again, I think that the perspective from our State and from a lot of States is not necessarily to push cost sharing to the max. It is not intended to hurt people.

Ms. DEGETTE. Well, I know it is not. But that is part of the proposal. Isn't it?

Mr. PARRELLA. No. Well——

Ms. DEGETTE. It is part of the proposal. Isn't it?

Mr. PARRELLA. I think that the concept behind cost sharing from a State perspective is that, if we are faced with a situation where we can choose to continue to cover a population above 150 percent poverty with a monthly premium—it is not always copays.

Ms. DEGETTE. Well, answer my question. It is part of the proposal. Right?

Mr. PARRELLA. It is part of cost-sharing part of the proposal.

Ms. DEGETTE. And the other thing is, what you are saying is, you are basically saying we don't have enough resources so we are going to have to impose this on the beneficiaries. You are trying to be able to cover as many people as you can—right?—with limited resources.

Mr. PARRELLA. True.

Ms. DEGETTE. I want to ask a couple of other questions. Dr. Alexander, I just wanted to ask you, I know that the children's hospitals have been working across the country with the victims of Hurricane Katrina. And I think you would agree with me, the survivors are going to be scattered around the country and create demands on all different States. Correct?

Mr. ALEXANDER. Yes, absolutely.

Ms. DEGETTE. What is NACHRI's position on extending Medicaid with 100 percent Federal assistance to people who have survived Hurricane Katrina?

Mr. ALEXANDER. The children's hospitals think that that is essential as one of the steps that needs to be taken to get through this crisis.

Ms. DEGETTE. My second question, my follow-up question is, with respect to this entire hearing, here we are against the backdrop of this devastating hurricane talking about how we are going to cut $10 billion. Do you think that what we should be doing right now is trying to figure out how to cut $10 billion mainly in beneficiary copays and other ways? Or should we be trying to figure out a way to shore up and improve Medicaid so we can use it more efficiently and it can cover more people?

Mr. ALEXANDER. I think what the current situation points out is how fragile the safety net is. And as I referenced in my statement, we were able to respond, the children's hospital community was able to respond because we have institutions that are strong despite the fact that they care for a huge number of Medicaid patients as part of what they do every day. But that strength is always on the edge. And that safety net is clearly vulnerable to these sorts of cuts.

Ms. DEGETTE. And just one last question.

Mr. Parrella, given your druthers, you really wouldn't want to favor cutting $10 billion right now, either, given what is going on; would you?

Mr. PARRELLA. Given my druthers, I would never want to see the Medicaid program damaged in any way. I mean, I worked at Medicaid for 20 years; it's been my career. So if there can be reforms that can allow the Medicaid program to invest its dollars more effectively to purchase care for its clientele in a more favorable way, we are in favor of that.

Ms. DEGETTE. Thank you very much.

Mr. DEAL. Dr. Burgess is recognized for 6 minutes.

Mr. BURGESS. Thank you, Mr. Chairman.

And I thank the panel for having such patience to stay with us today. Mr. Rush, who has already left, talked about increasing funding rather than any type of reform for the program. Now, we are here having this hearing today because of the recommendations of the National Governors Association. And my recollection was, we were told that these were the unanimous recommendations of 35 Governors of this country, Democrat and Republican alike. Every Governor who has come in and testified before this committee has started off with the word unsustainable. And that has certainly gotten my attention.

I guess, Mr. Parrella, if I could ask this question of you. We are talking not about any particular number, but we are talking about transformation of a system that is not always working at peak performance. Could we agree on that?

Mr. PARRELLA. I would agree.

Mr. BURGESS. If it were to be a question of increasing funding, you alluded a minute ago to, that Connecticut is spending, what did you say, what percentage of your budget?

Mr. PARRELLA. 26 percent.

Mr. BURGESS. 26 percent. What percentage would you be willing to go to of your State budget to increase the funding for Medicaid?

Mr. PARRELLA. Well, those decisions are definitely made above my pay grade, Congressman.

Mr. BURGESS. The point is that we are already spending an incredible amount of money. And every Governor, whether they have a D or an R by their name, came in this committee and said unsustainable, the first word out of their mouth. Or, I guess in Texas that would be the first three words out of their mouth. But the first word out of their mouths was: Unsustainable.

Dr. Thames, I am a member of AARP, and I pay my dues and I am happy to do it. You have been advertising rather heavily, or your organization, my organization has been advertising rather heavily in my market about lobbying against any reduction in funding for Medicaid. The question came out of a study I guess or a poll that you said four to five Americans opposed cutting Medicaid to reduce the Federal debt. Do we know what question was asked? And do we think we would get a different response if we asked: Do you oppose strengthening and improving Medicaid so that the program does not collapse?

Mr. THAMES. I will answer your question by saying the polls that are done for AARP are done by experts in polling and supposed to take that kind of—so that we get—I mean, like Gallup polls and Roper and others that are supposed to take the prejudice out of the question. We don't make up our own questions in our polling in order to get an answer that we would like to get back. We want to know—because we represent over 35 million people, we want to be sure that the information that we are getting is based on the consensus, at least the largest percentage of our members, so that——

Mr. BURGESS. Good enough. Because my time is short. Let us move to long-term care. And Mr. Terry alluded to three bills that are before the Congress now. In so many ways—and we can argue about the parameters and the dollar amounts, but in so many

ways, people my age have been anesthetized to the need to provide long-term care coverage for their family. People who can afford. I am not talking about the poorest of the poor; I am talking about the people in the middle class who could perhaps afford a policy. We don't even think about it; I didn't think about it when I was 50 years of age and joined AARP. And my mother said you ought to also think about long-term care insurance because you won't be able to get it when you are my age. And I appreciate that advice, I took that advice. I would have bought that policy without a tax deduction. There was no tax deduction; there still is none. I would have bought that policy without any asset protection. But I guess my question to you is this, and we have heard a lot of stuff today about tax cuts for the wealthy: Would it be okay to give a tax deduction or a tax credit for the purchase of long-term care insurance or allow someone to protect assets under one of the partnership programs, like that great bill, 3511, that Dr. Matthews referenced? Would it be okay to do that simply to remove that veil of anesthesia from the population to let people know that this is a good idea to purchase long-term-care insurance at age 50, at the same age that you sign up for AARP, to prevent some of the problems that we are talking about today? Because I think Dr. Matthews is exactly right; the problem may be bad today, but it is going to be awful tomorrow.

Mr. THAMES. No question that any incentives that we can give to get the middle class and people who can afford to buy long-term care—providing they are insurable. Remember that underwriting may take some of those people out of the market for long-term care, and they can't be insured. But for those that can, any of those kind of incentives would not only be worthwhile to get them to do it, it would be cost effective.

Mr. BURGESS. I agree. So AARP would not be opposed to that type of tax cut?

Mr. THAMES. That is correct, sir.

Mr. BURGESS. Finally, Dr. Matthews, I will just ask you the question: Why do you think some people, some Members of Congress don't trust their own State Governors to ensure to do what is necessary to salvage the Medicaid system?

Mr. MATTHEWS. It is a very good question, because I suspect there will be some Members of Congress who may run for Governor at some time in the future.

Mr. BURGESS. About half of them are right now, I think.

Mr. MATTHEWS. And may want that flexibility when they get there. You know, it is true that if you give the States the freedom to do this, some States are going to do a very good job, some States may not do as good a job. That is what the laboratory of democracy is about and how you find out what actually works, and why I alluded to Tommy Thompson is finding a plan that worked amidst many of the Governors. And, once we found out, everybody wanted to move in that direction.

Mr. BURGESS. Thank you, Mr. Chairman.

Mr. DEAL. Mrs. Capps is recognized for 5 minutes.

Mrs. CAPPS. Thank you, Mr. Chairman.

And I am going to shift to a different, to the other end of the age spectrum and give away the fact I suppose that I came to Congress

following a tenure of being a school nurse in my school district and working with young children became a very big believer in early periodic screening, detection, and treatment, and see it as one of the hallmarks of Medicaid that now has been in my State emulated for the general population of young people as a—and a very worthwhile thing.

And I wanted to—when you were speaking, Dr. Alexander, I thought to myself, well, I wish he had 10 minutes or 15 to go into some of these issues. And I will probably sound like I am handing you that. But I want to focus some of your thoughts, if you would, to extrapolate on one of the things that I believe in but I want to hear you explain a little more fully is how Medicaid serves all children, not just the beneficiaries. I gave away one little piece of it that it is a program that can be modeled. But also, I think one of the challenges you and I will have is convincing my colleagues that the benefits' flexibility has some downsides when it comes to this, to the age group that you are an expert on. If you would do that. And then if you could do it in the light—well, maybe I will wait until a follow-up. But I want to focus on the effects of Katrina, and I want to ask Mr. Sheehan a little bit about the impact of that disaster on children.

Mr. ALEXANDER. Well, let me first talk to the issue of why Medicaid is something that affects all children. Medicaid is the single largest funder of children's health care in the United States today. Once again, if you are an average pediatrician in the United States today, a third of your patient care comes from children covered by Medicaid. If you are a children's hospital like the one that I work at, half of our care on average is provided to children under Medicaid. So if you—you know, we can't develop programs and services exclusively for the non-Medicaid population.

Another reality of children's health care is that, to maintain these programs and services, we need to be able to serve all children because we need the volume to maintain these critically important programs. So we can't develop a bone marrow transplant program for non-Medicaid patients. You know, the average children's hospital in the United States today that does kidney transplants does 10 a year. You can't do those for one population of children and not for the other.

So, very clearly, the single largest source of funding for children's health care can't be touched without it touching our ability to impact care to everybody.

One of the things that people have asked about is, what happens if funding for Medicaid is cut, as a Children's Hospital administrator? And, you know, I think there are some realities. I think, to the extent that we can, some of those cuts are going to get passed on to the private sector in terms of higher charges to people who have commercial insurance. And that is not something that we do lightly. But there are limits to the degree that we can do that, and at that point, we have to start to look at, can we afford to either continue to provide the services that we are providing today or buy the next piece of technology that comes along. And, you know, particularly services like dentistry and mental health and behavioral medicine are a huge risk under those sorts of circumstances.

In terms of your question about benefit flexibility, you know, I think that there is potential for a very slippery slope here. And the EPSDT benefit package, the reality is, is that, as I mentioned, fortunately most children are healthy and do not need to take advantage of that full benefit package, just like you and I don't hopefully need to take the full advantage of the benefits that are afforded to us through our insurance plan. That said, when those benefits are needed, we need to have them there.

Mrs. CAPPS. I appreciate that. Just in the half minute that is left, Mr. Sheehan, maybe I will ask you to briefly tell us some of the impacts that you see on children, many of whom, those impacted by the hurricane, are Medicaid beneficiaries, on the trauma that they have been a part of and how it will impact their lives.

Mr. SHEEHAN. It will impact it immediately, but then it will be sort of a slow-timing effect. You will see it 6 months out and a couple years out. Some of the stories we are hearing, even in Michigan, kids have come to Michigan from Louisiana. They are pretty tragic stories. I mean, loss of parents, loss of friends, to be blunt, dead bodies next to you as a kid. We are going to see that happen over the next several months. A lot of the folks, as you know, who were hurt most severely by Katrina were poor folks, Medicare recipients, I mean, either soon to be or currently Medicare recipients. So I think we are going to see that. I think we have to get ready for that sort of catastrophic almost secondary packet of money, to be blunt, that will take care of those kids' housing and clothing but as well as their mental health care.

Mr. DEAL. Ms. Blackburn is recognized for 5 minutes.

Mrs. BLACKBURN. Thank you, Mr. Chairman.

And thank you to each of you for your time and for being here. I think that I am like a lot of members of this committee: What we want to be certain we do is look at preserving access to health care for our citizens, and being certain that we do that as good stewards and in a way that our emphasis is on the quality of care.

And having served in a State legislature, having been in the State Senate in Tennessee, I appreciate the problems that the States have. I appreciate the Governors and am very grateful for their willingness to work with us and say, how do we go about looking at health care in the 21st century and being certain that we approach this wisely?

Dr. Alexander, I want to start with you to follow up on something Ms. Capps was saying about the children's programs. You referenced the Texas children's hospital effort in your testimony. I want to go back to that, where you talk about the project medical home and the 24-hour hotline and the extended hours with the pediatricians. Your hospital in Michigan, are you implementing this program?

Mr. ALEXANDER. Certainly not to the same degree as has been done in Texas Children's Hospital. We are one of—our hospital employees, one of the few groups of primary care pediatricians in west Michigan who have committed their practice to providing primary care to children covered by Medicaid.

Mrs. BLACKBURN. And you said that this program was neither organizationally complex nor bureaucratic.

Mr. ALEXANDER. No, it should not be.

Mrs. BLACKBURN. Okay. So do you know of other hospitals, other children's hospitals or trauma centers that have implemented a program similar to this?

Mr. ALEXANDER. I think there are many children's hospitals, although it has not been organized under a branded program. I think many children's hospitals have identified the need to create medical home for people out in the community.

Mrs. BLACKBURN. And are moving to that model?

Mr. ALEXANDER. And are moving to that. You know, there has been a lot of conversation about frivolous use of care. I don't think any parent thinks that taking their child to the doctor is a fun time and something that they would do frivolously. And I think that when parents bring their child to an emergency department, it is not because they have nothing else to do, it is because they don't have any other way to get the care. So if we can provide medical homes for children, they clearly will be utilized.

Mrs. BLACKBURN. And you are talking about specifically increasing the education component. And I have great appreciation for that.

I want to move to Mr. Matthews and Dr. Thames, if we can. I was going to direct this question to Mr. Keating and to you also, Mr. Matthews. And since he is not here, I will put it to you. We keep hearing and several of you have mentioned that there were limited options for long-term care when it comes to policies, when it comes to types of policies, when it comes to options, for people to access as they look for long-term care. And so that leaves Medicaid as the only option, the best option. And I would like to hear from you why you think that is the case. And Dr. Thames, as you answer that, Dr. Burgess was talking about being a member of AARP, I am not nor is my husband. It is something I have chosen not to do when I turned 50 and got your invitation to join. But I do have a long-term care policy. So if you talk about these severely limited options, what are you all doing to offer, to work with companies to offer programs to maybe incentivize? And what should be done there in addition to tax, looking at the governmental—and you talk about some of the tax consequences, some of the legislation that has been referenced here today. But what do you look at on the private industry side and say, this is a way to incentivize this? This is a way to get the costs down? You know, homeowners get a discount if your auto insurance is also with you. So I would like each of you to answer that and talk a little bit about that availability of a product and an increase of options, and then what you all would do to support that. Mr. Matthews first.

Mr. MATTHEWS. It is a good question. I think that there is a general perception out there, Dr. Burgess alluded to it, that the government is going to step in and take care of you if you need nursing home care. And that perception is not unfounded, because there are ways for people, even middle- and upper-middle-income people, to qualify for long-term care under Medicaid. Because there is that perception there, people do not plan for nursing home care like they do life insurance, setting assets aside for retirement so that they have income and so forth. And what we are encouraging is our policies that would make that thinking part of the person, of the working-age person. So that, for instance, under Congressman Ter-

ry's bill, being able to use your 401K or IRA, it is a qualified distribution, to pay your long-term care premiums with your 401K or IRA; you are using tax deferred—previously tax-deferred money for that. That puts it into the working-age person's thinking of, here is an option for me to cover for myself so that I can take—going back to another term—personal responsibility and set these assets, make these assets available if I need nursing home care when I hit retirement. We simply don't make that part of the financial planning process for many Americans now, and we need to.

Mr. THAMES. Let me just briefly.

Mrs. BLACKBURN. Very briefly. I am over time.

Mr. THAMES. Tell you what we are doing in AARP. First, we do have a commercial insurance carrier that underwrites and sells to our members at a reasonable rate with some things that are not in the regular policies for long-term care. That is the oversight that AARP offers to its members. And we are in the process of developing a financial center. And one of the things we do now is counsel people about the need for long-term care as long as they meet the underwriting, if they don't have underwriting things that throw them out. Because many people do not plan for it, they don't think they can afford it. And, unless there is some way like Mr. Terry's bill or tax credits, we are still going to have problems. And many people just don't want to accept the fact that they might ever have to go into a nursing home. But with good planning and good advice and financial centers and the other products that we offer—and when we offer life insurance, we try to talk to people about their need for long-term care insurance.

Mrs. BLACKBURN. Thank you very much. Yield back.

Mr. DEAL. Thank you. Mr. Doyle, you are recognized for 5 minutes.

Mr. DOYLE. Mr. Chairman, I didn't speak 3 minutes, I only spoke 1 minute. Does that give me like a 30-second bonus or something?

Mr. DEAL. We do not distinguish.

Mr. Doyle. Thank you, Mr. Chairman.

This is a tough problem. And you hear a lot of our members say this is a program that is not sustainable. The reason it is not sustainable is we are creating a bunch more poor people in this country. When you look at the National Governors Association report, they say the primary driver of their increased spending is that the program enrollment has gone up 33 percent in the last 4 years. So we understand that the program is costing a lot more money, but we need to understand why it is costing a lot more money, too. When you look at what Medicaid has been spending per person, between 2000 and 2003, Medicaid has only increased at 6.9 percent per year compared to private insurance which has gone up 12.6 percent per year. So I think we all need to understand that we are seeing the middle class eroded in this country. And many people that used to be part of the vibrant middle class—and you know, I was listening to that, $5 million home and spend it on your assets. Boy, my wife would like to figure out how to do that, Nathan. But where I come from, you could count on one hand the number of houses in the community—I am born and raised and lived all my life—that sell for over $100,000 a year. I mean, I have got four children; three of my boys are now homeowners. They are 29, 25 and

23. They paid $61,000, $53,000, and my youngest son just bought a house for $35,8 which he closes on this September.

The vast majority of the people that I represent, they live paycheck to paycheck. The idea that they could buy a long-term care policy, that is a joke. That is just not reality for the vast amount of people growing up in parts—you know, I represent Pittsburgh and the steel mill towns around Pittsburgh where there used to be a vibrant middle class where there is no longer one. And just many Americans just don't have the disposable income after they pay their rent and buy their food to even consider some of these things that we are talking about.

You know, this comes during the same week before Katrina hit that this Congress was about to consider repealing the estate tax on the richest 20,000 people in America at a cost of $1.5 billion a week. So when we talk about priorities here in the Federal budget, and when we talk about reform, you know, reform is a very interesting word. When we talk about tax reform, it is tax reform if your taxes go down. If your taxes go up, people don't think that is reform. We look at reform in the health care system. If you are one of these people who are having their benefits cut or if you are increasing their copay, they probably don't consider that reform of the Medicaid system, either. I understand what is going on in the States. In Pennsylvania, this is a big part of our budget, too. I mean, Governors are trying to get more money from the Feds, and they are looking for ways to reduce their costs. I mean, that is what is going on. But we also have to understand that there is a very vulnerable population of people that are being affected by this, some of the most vulnerable in our society. And when I think about the mentally ill, you know, you talk about personal responsibility, that isn't a concept some of our people that are mentally ill even have a grasp of in terms of their health care.

So I guess, you know, you wonder, should the goal of Medicaid be to keep people healthy, or is the goal of the program just to give them as much health care as we can afford to do? I mean, that is the fundamental question, and we have to answer as Americans. And when we look at our Federal budget, you know, for me, it is an easy ask. You know, do I want to exempt the last 20,000 richest families in America from estate taxes at a cost of $2.5 billion a week? Or would I rather shift that money down to some of the most vulnerable Americans, many of which I have the privilege of representing in the United States Congress? For me, it is a no-brainer.

Now, I have a couple questions, and I am getting down to a minute. I didn't mean to talk that long. But the cost-sharing requirements. Many are arguing that what this is going to do is lead to reduced payments for providers, because a lot of States may deduct the copay amount from the physician payment even if the physicians aren't getting paid. And so has anybody here estimated? Maybe, Jim, you could tell us what the impact of co-payments would have on providers that serve a large portion of low-income families where they are actually not getting paid but they are cutting that away from the payment. It seems to me that we should at least hold harmless providers that aren't receiving these payments. Does anybody have any comment on the impact of that?

Mr. GARDNER. Relative to what I do in terms of hospital work, it would be difficult for me to try to estimate that for you.

Mr. DOYLE. It just seems that, in many of the areas that I serve and many of the lowest-income areas, where these doctors—I mean, they are not paying, but yet that is being deducted from their payments. I think we need to look at that.

I guess, in closing, and I see my time is up already: You just wonder, is it really fair to put cost-sharing requirements on children regardless of what their income level? I mean, the thing that they are guilty of is they are growing up in a poor family. I just think in America it is unconscionable that we would ever put cost sharing on children. Maybe, Dr. Alexander, you can comment, and I will yield back my time.

Mr. ALEXANDER. Just one quick comment in the interest of time. I think the concept, just like the mentally ill, personal responsibility for a 2-year-old is an interesting concept. I think it is important to remember that the working poor who make up the majority of Medicaid are already cost sharing, because to take their child to the doctor, they are taking time off from what is usually an hourly wage place of employment. So there already is some cost sharing. And, you know, I think—there is a quote that comes from President Bush's first inaugural address that said: Children at risk are not at fault. And I think that is something that we have to remember as we have this conversation.

Mr. DEAL. Ms. Baldwin, I am afraid you got bumped again.

Mr. Strickland, you are recognized for 5 minutes.

Mr. STRICKLAND. Mr. Chairman, would you please recognize my colleague next?

Mr. DEAL. Ms. Baldwin, you are recognized.

Mr. STRICKLAND. Thank you.

Ms. BALDWIN. Thank you, Mr. Chairman.

And thank you, Mr. Strickland, for that courtesy.

I am actually interested in continuing this exploration of cost sharing, and I have a couple of specific questions that I will get to shortly, including the proposal in the NGA document that takes cost sharing and makes it enforceable. And presumably, enforceability would mean denying care to those who are unable to share in the cost.

I am also very interested in the debate we have had back and forth about what the consequences are of cost sharing. Cost sharing is intended to influence behavior. I was reading an article that was published in the New Yorker that touches on this in various spots. And it tackles this presumption that, if health care is paid for, that people will just seek it out. Do people really like to go to the doctor? If they have an option between checking in the hospital and playing a round of golf, if they are healthy, they are probably going to play the round of golf.

There have been extensive studies, and I would be interested to know whether you refute those studies or not, but that while there has been some debate earlier about cost sharing leading to lower utilization of emergency rooms and fewer hospital in-patient admissions, because people who have to cost share, they may not only cut out frivolous treatment, which is something I am sure we would all desire, but cut out very needed health care which would lead to

higher emergency room utilization and higher hospital input admissions. And I think The Commonwealth Fund study that was cited in this recent article said basically something that I agree with, that cost sharing is a blunt instrument. And it is not going to be something that will modify the behavior with precisely the same effects that Members of Congress want.

But before I use up all my time I just want to put us back in the frame of mind of thinking about who the people are that we are talking about. I appreciated Mr. Sheehan's example of a person struggling with mental illness on SSI receiving an average of $600 a month. Let us look at an example of somebody, a family much more affluent than that, a family at the Federal poverty level in my hometown of Madison, Wisconsin. Let us even put them a little bit above that. A family of four, poverty level is $19,350 a year. So let us put them at $20,000 just to round off the numbers. That is a monthly income of $1,666. Rent in Madison for a modest two-bedroom apartment is $600. Food for a family of four, roughly $500. Transportation—and given the gas prices, I can tell you this is a conservative estimate—$150 a month. Child care, $500 a month, another conservative estimate. And with these expenses, the family's entire monthly budget has just been depleted. The family has no money left over for necessities like telephone or other utilities. And heat, by the way, in Wisconsin is mandatory, you have to have it. School supplies, household items, clothing. And, trust me, again, in Wisconsin, you need a coat, a hat and boots and mittens in the winter. This family who would most likely be enrolled in Wisconsin's Medicaid program would have no money left to afford the cost of the health care. So when we talk about increasing cost sharing, even if it is a few dollars to the rest of us, it is something very significant to this family.

And so while it is rather a rhetorical question, perhaps, the first question I ask is, where are these families going to get the money? But then the second and third specifically, if we make the cost-sharing provisions enforceable, and a family truly cannot pay, are doctors going to refuse care? Are doctors going to cover that care? What is going to happen if we make these provisions enforceable? And last, given as recent as a 2004 study of our neighboring State of Minnesota's Medicaid recipients that resulted in higher ER utilization and more hospital admissions for higher copays and a number of other studies with similar results, why do you think this is going to work and alter the behavior in the way that you would like? I will open it to—Dr. Alexander, I don't know if you want to take a first kick at this.

Mr. ALEXANDER. I would certainly hope, based on your definition of enforceability, that that would not be something that this committee would consider. Our Children's Hospital and the Nation's children's hospitals are not going to turn away children who need care because mom or dad does not have a $3 copay. And if that means that we are not going to get paid anything for that care, we will have to make accommodations of the sort that I referenced before. And, once again, those accommodations are going to affect every child that we serve, not just the low-income children that are impacted by Medicaid.

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

Mr. Strickland for 5 minutes.

Mr. STRICKLAND. Thank you, Mr. Chairman.

I am sitting here, and I was listening in the back room. You know, the answer seems so simple: We ought to put adequate resources into Medicaid to meet the need. And given what is happening in our country with the increasing need within our States, for this Congress to consider the kind of significant cuts in Medicaid, I think it is immoral. You know, some people think morality involves what you do with your genitalia. I think morality involves what you do with your resources and how you choose to utilize those resources. I think we are engaged in an immoral practice. But that is where we are.

Mr. Sheehan, Dr. Matthews advocates for increasing cost sharing because, and I am quoting, "it would help prepare some of the Medicaid population for the day they move to an employer who offers health insurance coverage," close quote. Now, it seems to me that we should not base cost sharing off of potential future ability to pay. It is like saying to people that they should pay taxes based upon their future potential for earnings. I may be a billionaire 1 day, but I don't think today I should pay the same amount in taxes as Bill Gates.

Now, in 2002, higher-income adults with private insurance spent on average, and I have a chart here, .7 percent of their income on out-of-pocket medical expenses: .7 percent. That was up from .6 percent in 1997. So from 1997 to 2002, it went from.6 percent to .7 percent for those in the higher-income range with private insurance. Poor and nondisabled adults on Medicaid spent 2.4 percent. That was up from 1.9 percent in 1997. And disabled adults on Medicaid spent on average 5.6 percent of their income on health care costs, up from 4.4 percent. Those on Medicaid already are paying more out of pocket for their health care than their counterparts in private insurance. So, Mr. Sheehan, this is my question to you. It already seems that individuals with disabilities on Medicaid are paying more than their fair share out of pocket. Won't the cost-sharing changes proposed by the Governors and others fall disproportionately on the disabled, the chronically ill, and others who, because of their medical conditions, are high users of care?

Mr. SHEEHAN. Two parts of the answer. The answer is, first, yes, it will. The disabled use a lot more care per person because their disabilities are so high, and their incomes are no higher. So you are right; the proportion of their income spent on health care will be much higher.

The second point is an important one. We don't prepare people for private insurance by increasing what I would call the worst parts of private insurance; we get them private insurance. And you get private insurance in America by getting a job, to be blunt. So the way you move into private insurance is you have something called economic development. And when you don't, you don't make Medicaid look as onerous as private insurance without the income that goes with private insurance. Private insurance comes when I have a job. I have a job, so I have private insurance. Those two are inseparable, and they have to be. So my ability to pay that copay or the premium sharing is because I am employed. And I may even debate with my employer either individually or collectively if I am

in a union about how much that is. But to get somebody ready for private insurance in the Medicaid way isn't the way to go, I don't think. And I hate running counter to a panelist whom I respect, so let me just say that.

Mr. STRICKLAND. Thank you. And I have a second question for you, sir, quickly. Cost-saving methodologies like fail first, mandatory therapeutic substitution and closed formularies, these are proposals that I think could in the long run have very harmful effects. Would you just—I have got about a minute left. Would you speak to the effects of those practices?

Mr. SHEEHAN. David pointed out in Connecticut and Michigan, too, some drug classes have been exempt from it because some drug classes, in our case psychotropics, mental health drugs, there aren't therapeutic equivalents, or they are only determined by the physician and the patient. I think it can be done, but you have got to be very, very careful in building formularies or fail first. In the mental health world, fail first has been dropped in most States because the fail isn't, I felt bad today. The fail is, you end up in the hospital or losing my——

Mr. STRICKLAND. Having a psychotic breakdown.

Mr. SHEEHAN. Exactly. Right. And so I think most States have said fail first doesn't work there. I really can't speak to the other drug classes. Psychotropics are really a problem.

Mr. STRICKLAND. I want to thank you.

Thank you, Mr. Chairman. I yield back.

Mr. DEAL. Thank you.

Mr. Engel, you are recognized for 5 minutes.

Mr. ENGEL. Thank you, Mr. Chairman.

I want to talk about people who have multiple illnesses. The effort behind many of these initiatives is supposedly to save money. But, from my vantage point, the increasing cost sharing of prescription drugs and care could have devastating consequences to people who have many different illnesses and to health care in general and cost the States and local governments for delayed care. It is not uncommon to expect a Medicaid beneficiary to have more than one illness and need multiple drugs for each. For instance, a low-income person with AIDS who also has Hepatitis C and needs treatment for mental illness as well. Most AIDS patients have a minimum of three to five medications. There are lots of other things: Hepatitis C, people who take multiple drugs. All of these illnesses require stable regular care, and failure to take drugs for mental illness may mean that the individual is unable to manage their HIV and Hepatitis C treatment.

And so I would like to—you know, the problem is with a minimum of 10 drugs to take, not to mention the cost of health care treatment and the cost of living; increased cost sharing for prescription drugs for Medicaid beneficiaries would be in many instances financially prohibitive. So I would like to ask Mr. Sheehan to comment on whether this seems like good policy. And the same with Mr. Parrella who stated that—I am quoting you, sir—that you cannot convince families to take an interest in the cost of their care unless they share in it. Because, in my mind, this patient on a personal level is very aware of both the time and the expense of their care. So I wonder if Mr. Sheehan first and then Mr. Parrella.

Mr. SHEEHAN. The patients who are mentally ill, the term we used before a minute ago is personal responsibility. It is a great one. Personal responsibility for the mentally ill actually means seeking health care. It is an interesting thing, I mean, because you want them to use more of it, actually. We want them to see a psychiatrist or a case manager and therapist. If there is a cost sharing there, it actually makes me less personally responsible because the burden I have to do to pursue that. It is a really different world if we perceive folks as being health care wasters; personal responsibility is to stop doing that. In the mental health world, that is not what we perceive our folks to be, and that is not what we see.

Mr. ENGEL. Mr. Parrella.

Mr. PARRELLA. We believe that there is a place for cost sharing for higher-income populations to cover the Medicaid, not the SSI, mandatory coverage groups. But as you go up the income scale in terms of who you are choosing to cover in your Medicaid population, there is a role for cost sharing and allowing the States to have the sustainability to expand their programs.

We have a prescription drug benefit in Medicaid right now for people that are called dual eligibles. Those people do not have enforceable copays right now. That program is going to come to an end in January with the implementation of Medicare Part D. When they go into the Medicare Part D program, they will have copays, and those copays will be enforceable. That is not a State decision. State decision to look at copays was to use those copays as a way of financing care for some of our higher-income Medicaid covered individuals. With what is going to happen in Part D, those copays will be made enforceable for your dual eligible clients, who are among your sickest and among your poorest individuals. So—and I understand why that is done, because that was done as part of a cost equation in terms of being able to provide that benefit. States are looking at the same cost equation in terms of their Medicaid programs.

Mr. ENGEL. Let me just say, and in fact, one of the questions I wanted to get to is that I really believe very strongly that increased cost sharing for prescription drugs for some of these Medicaid beneficiaries would just be financially prohibitive. And I think it is one of the big flaws of this cost cutting that we are trying to do, squeezing more out of Medicaid.

Let me ask Dr. Alexander this question. The National Governors Association is asking for so-called flexibility in two areas of Medicaid that I think would essentially allow States to discriminate against individuals in their States. They would like to provide coverage in only certain parts of the State and also be allowed to give more benefits to some than others. I can see how this could become a political football at the State level. But, medically, can you tell me if there is any reason that a person with a certain disease in one part of a State wouldn't need the same benefits for their health condition as someone else in the State? For example, is there any medical reason someone with diabetes in a rural area wouldn't need the same medical treatment as someone with diabetes in an urban area? Or is there any medical reason why one type of person with a disability or debilitating disease who needs prescription medicines should get coverage for prescription drugs and another

person with the same disability or disease who needed medication should not? Say, for example, a child with AIDS?

Mr. PARRELLA. There would be no clinical reason why there should be a different set of benefits based on geography.

Mr. ENGEL. I couldn't agree with you more. Thank you.

Thank you, Mr. Chairman.

Mr. DEAL. Mr. Markey is recognized for 5 minutes.

Mr. MARKEY. Thank you, Mr. Chairman.

First of all, let us just define this whole program for what it is. We are talking about wealthier poor people. We are not talking about wealthier people; we are talking about wealthier poor people will pay more. So it is the Governors that put together a poor-people-pay-more program. So it is the Governors looking at the poor people saying it is the poor people pay more program, so that we can have tax breaks for the wealthiest. So that is what the Governors have decided that they are going to co-partner with Congress and the President on achieving.

Now, I think it was a shock to people to know that 100,000 people in New Orleans did not have automobiles to escape that flood. It was kind of a shock to people. Shock to Americans. Well, those people are living in cities all across America. I think it was a shock to people to know that 50 percent of all children in Louisiana live in poverty. But that is why this last week has been in a way such a revelation, because we all are forced to drive up and down those streets night after night, day after day and see this other America, see these other people.

Now, we come here with an underlying false premise as well. That is that a lot of people I think are under the impression that poor people don't pay for their medical benefits, that they are exempt. And now we are just going to make them pay a little bit because they don't have any skin in the game the way wealthy people do. Of course, it would be a shock to people to know that poor people are not exempt, that poor people already have to pay, and that they pay a higher percentage of their income than we pay of our income for medical benefits. But we are going to increase how much we ask them to pay under the Governors' poor-people-pay-more program.

In fact, right now, under existing law poor adults on Medicaid pay out-of-pocket medical expenses of 2.4 percent of their income. Under current law, disabled Medicaid beneficiaries pay out-of-pocket for their medical expenses 5.6 percent of their family income already. Under this bill, a family living at $13,000 a year—that is not even $300 a week—will have to pay $650 for their medical benefits. A family of $16,000 a year, a family of two, will have to pay $800 of that money that they have just for their medical care.

Now, in order to justify a tax cut for the wealthiest does it really make any sense that we are going to put the burden on those faces that are looking at us on the screen for the last 9 days and will continue to look at us for at least the next month? Can we not have the capacity to respond to human suffering when we see it? Can we not finally realize that there are people who live in our country who need this money more than the wealthiest need it at this time? Must we cobble together in this committee a tax break that—this committee says it is not in charge of tax policy. All we are

going to do is package $10 billion worth of Medicaid cuts and send it over the Ways and Means Committee, and then they will determine who gets the breaks. Are we not better than that as a society? Do we not have more compassion? You know, if you kick this Congress in the heart, you break your toe. Especially at this time. We have learned something in the last 8 or 10 days. Haven't we, America? Haven't we learned that we have this group of people who need this help? And even the liberals and conservatives on this panel agree that, if people are forced to pay more, then they will have less medical care because they won't go as often. But we also know that socioeconomic status is the greatest predictor of health and well-being throughout your life. So all we are really saying is they are going to get less medical care, and, as a result, later on in their life, greater medical problems will show up. Prevention is what this is all about. Giving them the care when they are young when they need it, those faces that we have all seen. You help them now, they will be healthier, they will live longer. You take the care away because you are making them decide, am I going to give the $800 over to more medical care, or am I going to buy more food? Am I going to try to live in a little bit better place for my family? How obscene is it that these are the people who the Governors poor people pay more program are going to be forced to suffer? And even if you can find savings in some part of this program, shouldn't the money go into the 1.1 million more Americans who have fallen into poverty in the last year? Shouldn't it go into a program that will be set aside for all the additional elderly who are heading toward nursing homes? Health is the first wealth, not tax breaks. Health is the first wealth. And we have an obligation on this committee to ensure that the money is going to be there. By packaging this $10 billion out of this committee and giving it to the wealthiest, the committee is ensuring the money will never be there for the other needs of people even if the reforms are justified. The savings should go to the poorest in our society, not to the wealthiest. I thank the chairman for his indulgence.

Mr. DEAL. I thank the gentleman.

Gentlemen, this will conclude the hearing. I thank you all of you for your patience and sticking with us. I would like to recognize someone who has been in the audience, and that is Matt Salo, who is the director of Health and Human Services Committee of the National Governors Association, who has been working as liaison. We appreciate your efforts.

Our previous hearing in which the National Governors Association presented this to us was led by the then chairman, the Democratic Governor of Virginia, Governor Warner. His comment at one point was that he believed the National Governors Association was the only bipartisan act in town. Unfortunately, gentlemen, you may have been forced to come to that same conclusion as a result of today's hearing. But your patience, your participation, and your input is greatly appreciated by all the members of this committee. Thank you very much. This hearing is adjourned.

[Whereupon, at 3:04 p.m., the committee was adjourned.]

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