

Chairman Upton, Ranking Member Waxman, and members of the Committee, thank you for the privilege of being a part of this important hearing on implementation of the Patient Protection and Affordable Care Act (PPACA). Governors have unique perspectives as we stand on the front lines of entitlement reform, and we governors appreciate your taking the time to hear our concerns and ideas.

On January 26, 2011, the Congressional Budget Office updated its baseline budget outlook which included a projection that this year's budget deficit will total a record \$1.5 trillion. The President's Fiscal Year 2012 budget proposal released last month calls for a \$1.6 trillion deficit.

Proving the point that healthcare reform did nothing to rein in entitlement spending, the January 26 report highlighted that spending on Medicare, Medicaid, and other mandatory federal health programs will reach \$870 billion in 2011, or 5.8 percent of GDP. In CBO's baseline projections, spending for health programs more than doubles between 2011 and 2021, rising by an average of about 7 percent per year and reaching \$1.8 trillion in 2021. On top of that, we all know these projections are unrealistically low, as they do not include major budget gimmicks such as the "doc fix" and CLASS Act.

Clearly, Americans are no closer to affordable healthcare with the passage of the PPACA than they were before the debate began. This law will greatly expand state Medicaid programs, pulling tax dollars from other necessary areas like education and law enforcement. Governors will soon be forced with the choice to either cut state spending in other priority areas or to

increase taxes to pay for the federally required expansion of the Medicaid program. The states need the flexibility and authority to craft innovative programs to provide medical care to our neediest citizens. But to do so, we need Congress to cut the red tape states must wade through to implement new programs and save money on what we already do. Through greater flexibility in the management of Medicaid, states might be able to reduce substantially the hidden tax increases that forced expansion of the program will impose. Our citizens should not have to wait years for agencies in Washington to green light new healthcare solutions. We need relief now.

Medicaid was established in 1965 to provide healthcare to the neediest among us – our poor and our elderly. However, the cost of Medicaid to the states has spiraled out of control. Medicaid is in serious need of reform, not expansion. It needs to cost less, not more. In Mississippi, over the last 10 years, program costs have doubled. However, during the four years under my predecessor, Medicaid costs went up nearly 16 percent a year. In my six years in office for which we have data, our Medicaid costs rose only 4 percent per year. If we had more flexibility, we could do more constructive things to reduce costs and provide quality care.

The Medicaid Program is broken from both a budget and health outcomes perspective. The growth in federal Medicaid medical service spending is unsustainable, increasing almost 8 percent annually during the past 10 years.

From a bureaucratic standpoint, CMS' process moves at a snail's pace. For a state to get approval of a waiver to meet its immediate needs, it may wait a year - or even two - for the bureaucrats to approve or deny such actions.

Despite all of this, instead of reforming the flawed program, the PPACA expanded a broken system. Governors are on the front lines to deal with the aftermath of this shortsighted effort.

Since I have become Governor, and before the PPACA, Mississippi has taken a number of concrete steps to enhance services and curb costs despite a rigid federal Medicaid system.

For example, when I became Governor, Mississippi began requiring face-to-face redetermination of eligibility for most Medicaid beneficiaries. The face-to-face meeting allows Medicaid a one-on-one interview to educate and assist eligible beneficiaries with enrollment in programs. During the in-person interview, discussions take place with other household members and if they qualify for Medicaid services, they are enrolled. For example, a beneficiary may be offered information on our Mississippi Cool Kids Program or, as you might know it, the Early and Periodic Screening, Diagnosis and Treatment Program, which provides wrap-around services.

The state does allow exceptions to the face-to-face redetermination for nursing home residents, foster care children, disabled children living at home and anyone home bound, such as an elderly adult in a home-and-community-based waiver program. As a whole, this process has proven very successful. Mississippi has a 0.1 percent eligibility error rate, the third lowest in the country, compared to the national average at 6.74 percent. My view is taxpayers are paying an average of more than \$6,000 for each person on Medicaid in Mississippi, for a plan that is more comprehensive than most private plans. An annual review to ensure those receiving Medicaid benefits are truly eligible is in the best interest of both beneficiaries and taxpayers.

Since I have been Governor, the Division of Medicaid has instituted a policy of prevention and wellness to encourage beneficiaries to utilize a medical home. Under the program, an individual can get care on a regular basis allowing the healthcare provider and beneficiary the opportunity to develop a relationship that fosters quality care. The goal of the program is to redirect existing dollars from a pay-for-service strategy to a wellness strategy, creating a healthier Mississippi. Beneficiaries are given one free annual physical examination, which does not count against their total number of doctor visits. This is done to establish a baseline health assessment in which to build beneficiaries' care around. Although Medicaid has offered this service for six years, very few beneficiaries in Mississippi use this important preventive care service. Having the flexibility and the ability to require an annual physical would assist the state in providing not only better preventative care and but also would result in a reduction of healthcare costs.

I will remind you that Medicaid cannot require beneficiaries to schedule an annual exam because the federal law prohibits us from doing so. In my state, we have some of the highest incidences of obesity, heart disease, diabetes and cancer. If we could require Medicaid beneficiaries to have an annual exam, it would allow for early detection and proper treatment, improving the quality of life for thousands of Mississippians. Preventive care is obviously important because the PPACA now requires coverage of certain preventative services. Medicaid programs should have the flexibility to require beneficiaries to get an annual exam to ensure our goal of promoting the use of primary and preventive care.

In 2005, the cost of prescriptions for the Mississippi Medicaid program was out of control. Pharmacy costs reached \$697 million that fiscal year. We took action to rein in these

excessive costs. I can tell you in one year our drug costs went down from \$697 million to \$422 million in FY 2006. The next year, we saw a full year of savings when costs dropped further to \$279 million, a nearly \$420 million or 60 percent annual reduction.

We promoted the use of generic drugs by limiting the number of expensive brand-name prescriptions to two per month. These changes applied to Medicaid beneficiaries ages 21 and older. We reduced the maximum number of prescriptions allowed from seven to five per month. There were also cost savings from the Medicare Part D pharmacy program.

Our efforts to encourage the use of generic prescriptions worked. In June 2010, the Mississippi Medicaid program was using generics at a rate of 78 percent – far more than the 46 percent utilization rate seen six years earlier.

Another area where states and the federal government could save tax dollars and improve health care is in long term care services. Mississippi's population between the ages of 55 and 64 increased by 10.2 percent from 2005 to 2009. Mississippi pays nearly five times more for each citizen placed in a nursing home, than it pays for the same individual to receive care at home near family and friends. In the current fiscal year, the estimated amount to add one nursing facility bed to the Medicaid program is \$55,731, and that cost is expected to be \$60,190 next year. In comparison, the cost to serve one person receiving home- and community based services, who meets the same criteria as those in a nursing facility, is \$10,949 this year. In a few years when this group is in need of long-term care, the cost of a nursing home to the Medicaid program will far surpass the cost of receiving care at home.

How should you encourage more home and community care? First, let's make sure that those who are admitted to long term care facilities in lieu of home and community based services require the highest level of long term care. As you know, nursing facility services are federally mandated. Therefore, if a person meets the financial and functional/medical criteria for Medicaid-funded institutional care, they have an "entitlement" to that care. There is no such entitlement to Medicaid-funded home and community based programs although the functional/medical criteria for admission to these home and community based programs is the same as the criteria for institutional care. The admission requirements for home and community based care should be less stringent than the requirements for institutional care and the institutional requirements should be such that only those requiring the highest level of long term care need should be eligible. Over the past several years, despite difficult budget circumstances, we've gradually increased the number of persons served in our home and community based programs. Due to effective management of the Medicaid program and the savings produced over the last year, this year I have been able to authorize the addition of 6,200 more individuals to our Medicaid home and community based program. These individuals will be able to receive quality care in the setting they are most comfortable at less cost to Medicaid than institutional care.

In a February 3 letter sent from Secretary Sebelius to Governors, she writes of flexibility at the states' disposal to control costs. Although there are avenues states can utilize to try to make changes to their programs, making these changes is often lengthy, time-consuming and burdensome to the states. CMS continuously tells states, such as Mississippi, to be creative and flexible in developing new programs and implementing changes to existing programs to provide smarter care choices. However, all these things require CMS approval. They shouldn't.

For example, there is a need in Mississippi for a specialty-skilled nursing facility for the care of medically complex and fragile children. The University of Mississippi Medical Center is working with the Division of Medicaid to utilize Civil Money Penalty Funds (CMP) as start-up monies for the development of this specialty-skilled nursing facility for children. Nursing homes pay CMPs when they violate Medicare and/or Medicaid quality-of-care requirements. The PPACA expanded the use of CMPs. CMS has even said it provides greater flexibility to use those funds to support the quality-of-care and quality-of-life initiatives for those persons who must reside in a nursing home even for a short period of time. We want to do just that in Mississippi by developing a nursing home program specifically for these medically fragile children; however, we are required to get CMS approval. This process can take months, as CMS will refer our request to a team who will provide technical assistance. We know what we need, and we have a plan to get these very special children out of a hospital into a more home-like setting. We work with the parents to eventually allow them to go to their home. The steps CMS is requiring us to take are delaying our efforts to do just what they say they want us to do.

My Medicaid staff submitted a State Plan Amendment over a year ago to implement a Care Coordination Program. The Plan Amendment has been approved, but the comprehensive risk contract under the State Plan Amendment was submitted last spring and has yet to be approved. My staff has been in regular communication with CMS staff and was assured there were no problems with the contract. Yet in December, CMS made us aware of a possible problem, and then it took another month to get CMS to let us know what they consider the problem to be. It is impossible to make any meaningful changes to the Medicaid program when the process takes so long to approve a State Plan Amendment and has become increasingly burdensome on states.

Last but certainly not least, the federal PPACA, if it goes into effect, will have a dramatic negative impact on Mississippi's budget for years to come. It is important to examine the potential costs of the substantial expansion of Medicaid on our financial future. I requested Milliman Inc., a consultant currently on contract with the Mississippi Division of Medicaid, to analyze the potential cost of the PPACA on the State of Mississippi.

Their findings are staggering. The PPACA will result in a massive expansion of Medicaid, which is projected to cost Mississippi taxpayers up to an additional \$1.3 billion to \$1.7 billion over the next decade despite little spending during the first four of those years. Milliman's analysis focused solely on the expansion of the state's Medicaid program and did not take into account the number of additional unfunded mandates contained in the law. Those mandates coupled with the changes in Medicaid will surely make those numbers even higher.

Of course, expansion of the Medicaid program will require the State to commit additional tax dollars to both staffing and service needs. Although the federal government will cover some of the additional costs of the expansion, there are numerous associated costs that are the responsibility of the State. As you know, the legislation tries to accomplish this goal by massively expanding states' Medicaid programs.

We expect more people to enroll in Medicaid rather than face federal fines for lacking private health insurance coverage. In 2014, the PPACA will significantly expand Medicaid eligibility thresholds to individuals with incomes of 138 percent of the Federal Poverty Level (FPL). The 138 percent of FPL population reflects the 133 percent of FPL eligibility level

indicated in the Act with the additional 5-percent allowance. This increase will add 390,000 to 400,000 new individuals to Mississippi's Medicaid rolls, a two-thirds increase, meaning one-in-three Mississippians will be on the state's Medicaid program. With full implementation by 2020, this will cost Mississippi's taxpayers \$443 million a year, increasing our state Medicaid cost by half. That number will continue to rise in subsequent years.

This estimate considers all reform provisions related to the Medicaid expansion, including items such as increased administrative costs and shifting children from CHIP to Medicaid. Due to the PPACA's individual mandate to require an individual to have health insurance, the state expects a high participation rate by the newly eligible individuals in addition to people who are currently eligible for Medicaid but not enrolled. This high participation rate is reflected in the cost analysis by Milliman.

Further, within a few years, we will see more Americans on government health care and fewer businesses offering health care coverage. The new law will hurt small businesses – the backbone of the American economy. Employers who do not offer adequate insurance will be fined thousands of dollars. And who decides whether an insurance plan is adequate? The folks in Washington. To stay in business, we will see employers drop healthcare insurance coverage, cut wages or hire fewer workers, or all three. That's certainly not the answer to curing our economic troubles.

States need flexibility now, and we can't wait. State tax revenues from every source are still well below 2008 levels and will continue to lag behind the national economic recovery especially if skyrocketing gasoline prices hurt the economy as in 2008. Although nearly every

state is required to enact a balanced budget, according to the Fall Fiscal Survey of States report, 11 states are reporting nearly \$10 billion in budget gaps that must be closed by the end of fiscal 2011. In addition, fiscal 2012 and fiscal 2013 also represent significant challenges for states as the funding provided by the expiration of American Recovery and Reinvestment Act, or stimulus dollars, will no longer be available. Although not all state budget offices have completed forecasts, so far 23 states are reporting \$40.5 billion in budget gaps for fiscal 2012, and 17 states are reporting \$40.9 billion in budget gaps for fiscal 2013. Many states continue to cut their general fund spending. In Mississippi, I've had to cut spending \$700 million, including 9.4 percent in cuts of General Fund spending in Fiscal Year 2010. States must live within their means and balance their budgets. The infusion of federal stimulus funds for state budgets, which included a number of Maintenance of Effort provisions and ended with steep cliffs, has delayed the inevitable need for governors to plan for each state's fiscal reality. But the time is now.

Given these dire budget situations across the country, and even in normal fiscal times, our systems can't support the broad PPACA Medicaid expansion now or in the future. States need the ability to be incubators of reform. People who say there is only one way to do conservative healthcare reform are missing the point of state-based health reform.

There has been much discussion lately among both Republican and Democratic governors regarding the Maintenance of Effort requirements set forth both in ARRA and PPACA. A letter was sent to Congressional leadership which outlined how MOE requirements freeze state governments' ability to adapt the state-administered Medicaid programs to changing populations or economic conditions. The MOE should be stricken both for income and eligibility

standards and methodologies and procedures. While this is not as bad for my state as many others, states should be allowed to manage their programs for their unique populations.

Eliminating the MOE requirements should be coupled with the ability to develop new financing structures and to tailor benefit packages. For example, in Mississippi approximately 65 percent of beneficiaries are pregnant women and children. Although states are allowed to constitute their benefit packages, CMS dictates each covered service must be sufficient in amount, duration and scope to reasonably achieve its purpose. When states try to tailor a benefit package, CMS uses this definition as a crutch and will not allow any changes. An alternative would be to give children, their mothers and pregnant women a voucher to purchase private insurance. This would benefit the recipient by providing increased choice and improved access to providers, and states would see a reduction in costs due to coverage and administration efficiencies.

Secretary Sebelius also noted in her letter that Congress gave states additional flexibility to impose cost sharing in Medicaid in the form of co-payments, deductibles, coinsurance and other similar charges without requiring states to seek federal approval or a waiver. The problem is federal regulations do not allow a provider to deny services to an individual on the basis of the individual's ability to pay. In addition, no cost-sharing measures can be imposed on many Medicaid enrollees, including children.

The federal government should give states the flexibility to increase enrollee cost sharing and permit cost sharing for all enrollees. For example, more than half of Mississippi Medicaid recipients are children. When the federal government ties states' hands by not allowing cost

sharing for children and guarantees service regardless of payment, cost-sharing measures become pointless.

Enforceable co-pays and steeper tiers of co-pays for all Medicaid enrollees are examples of how Medicaid could incentivize enrollees to choose an equivalent service at a lower cost. For example, when a Medicaid enrollee may want to get a certain drug that they saw advertised on television that costs 10 times as much as a generic brand that is its molecular twin, a State should be able to charge a \$50 co-pay for the brand name drug and a \$1 co-pay for the generic drug, unless a doctor gives a medically necessary reason why the generic is unacceptable. A patient or a parent will choose the \$1 route almost every time, resulting in the same quality of health care but much lower costs for the taxpayer.

Without such common-sense solutions, States are often forced to arbitrarily limit services or cut provider reimbursement rates to control costs. These approaches are not ideal, but they are often the only path the federal government allows.

In return for total flexibility in managing my Medicaid program, I would agree to a block grant-type funding of the FMAP to Mississippi capped at, say, two or three percent per annual increase, saving the federal government more than \$100 million a year compared to the average increase in federal Medicaid costs nationally. I emphasize “total flexibility” to run our program, but note, since my state is about one percent of the nation, that deal nationally would save at least \$10 billion a year in federal spending.

As to a state health insurance exchange, we oppose the mandate of a one-size-fits-all exchange. In my state, we are pushing forward with a conservative, market-based exchange that

does not include subsidies or an individual mandate, much like that of Utah. The federal government doesn't need to tell us how to do it.

In the PPACA, the federal government mandates creation of a temporary high-risk pool to subsidize individuals with pre-existing conditions. Thirty-five states, including Mississippi, already operate high-risk pools covering roughly 200,000 Americans. The federal government decided the state risk pools weren't good enough so the PPACA allocated \$5 billion and required new duplicative risk pools be established. This subsidized federal program, in theory, would allow people to switch to a less expensive option.

The federal government was wrong. As of February 1, there are a total of 12,437 individuals utilizing the mandated federal high-risk pool, 58 of these are Mississippians. Remember the states are already operating successful risk pools covering 200,000 individuals. The Mississippi risk pool, which is touted as a national model, covers 3,600 individuals.

Americans are not any closer to quality, affordable health care coverage than they were two years ago. Obamacare not only will increase already rising health care costs, but also will require major tax increases to pay the states' portion of the costs.

And the fundamental problem remains that States are tasked with running insurance programs but are prevented from using the basic principles of insurance and the free market to provide quality care at the lowest possible cost. With flexibility from the federal government's straight jacket of rules and regulations, States can design Medicaid programs that show compassion for both the enrollee and the taxpayer.