STATEMENT BY
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Hearing on "Saving Seniors and Our Most Vulnerable Citizens from an Entitlement Crisis"
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Summary of Testimony on
"Saving Seniors and Our Most Vulnerable Citizens from an Entitlement Crisis"
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The testimony highlights some of the challenges being encountered at the state level on entitlements, especially in Medicaid.

Discusses how Medicaid:

1) Has put tremendous pressure on state budgets, crowding out billions of dollars of spending on other public priorities,
2) Has forced state leaders to cut access to benefits and hike taxes to fund the program, and is
3) Leaving patients increasingly unable to access providers, which can lead to worse health

All three of these outcomes hurt the most vulnerable citizens in our country. Medicaid beneficiaries are captive to the whims of bureaucrats. Instead of being able to vote with their feet and take their "business" elsewhere, they are stuck with the top down decisions that dictate their insurance coverage. This approach is blunt and not sophisticated enough to take into account the real health differences amongst the vulnerable. As long as the current program remains in place, these problems will persist and we will fail to protect the most vulnerable

States such as Massachusetts with historically generous Medicaid programs can serve to illustrate the challenges that are encountered under the current healthcare entitlement crisis, and may also foreshadow some of the underlying issues that will be exacerbated under the Patient Protection and Affordable Care Act's (ACA) Medicaid expansion.

If Medicaid outcomes were presented as a business model, it would be shut down because it was not serving its consumers well, and in some cases may be hurting their health, all the while spending hundreds of billions annually.

Chairman Pitts, Ranking Member Pallone, and Members of the Committee,

Thank you for this opportunity to bring a local perspective to the important issue of protecting our most vulnerable citizens from the entitlement crisis. My name is Josh Archambault, and I serve as the director of healthcare policy at a non-partisan state-based think tank, Pioneer Institute, located in Boston, Massachusetts.

This morning I would like to highlight some of the challenges being encountered at the state level on entitlements, focusing primarily on Medicaid. Medicaid serves to illustrate the challenges that are encountered under the current healthcare entitlement crisis, especially in states with historically generous programs, such as Massachusetts. The experience of our state may also foreshadow some of the underlying issues that are sure to be exacerbated under the Patient Protection and Affordable Care Act (ACA), as roughly 20+ million individuals will be joining Medicaid.

My testimony will focus primarily on three outcomes under the current Medicaid program that point to the crisis at hand. Medicaid as currently constituted:

1) Has put tremendous pressure on state budgets, crowding out billions of dollars of spending on other public priorities,
2) Has forced state leaders to cut access to benefits and hike taxes to fund the program, and is
3) Leaving patients increasingly unable to access providers, which can lead to worse health outcomes.

Sadly, Medicaid has been afflicted by concerns over its quality, access, and financing for decades. The current payment structure of the program has codified perverse incentives that reward states when they spend an additional dollar, but disincentivizes state efforts to encourage efficiencies in care delivery and fight waste, fraud, and abuse. As long as the current program remains in place, these problems will persist and we will fail to protect the most vulnerable.

1) Medicaid puts tremendous pressure on state budgets, crowding out other public priorities.

Under the ACA, Medicaid is projected to increase spending by an additional $638 billion by 2022.[1] While supporters of the law argue that the state portion of additional spending will be minimal, $21 billion in premium contributions plus $12 billion in administrative costs,[2] it cannot be denied that many states are struggling to pay for the current program.

Medicaid is now the single largest line-item in the budget in numerous states, and has been so for the last four fiscal years.[3] For example, in Massachusetts it accounts for roughly 36 percent of the entire budget.[4] Medicaid is clearly crowding out spending on other state priorities. This sentiment was expressed strongly in a Bipartisan Policy Center report, "Reforming Medicaid Waivers: The Governors' Council Perspective on Federalism Today," in which both Democratic and Republican Governors commented on the "significant burden" that Medicaid places on states.[5] A July 2012 bipartisan report from the State Budget Crisis Task Force also stated, "Medicaid spending growth is crowding out other needs."[6]

Lawmakers in all states, red or blue, are being prevented from investing in our kids and communities due to the ballooning cost of Medicaid. One only has to look to spending trends to see the tradeoffs being made. For example, in 2012, 35 states funded elementary and high

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[1] Congressional Budget Office, "ACA Insurance Coverage Effects," February 21, 2013, Available at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/43900_ACAInsuranceCoverageEffects.pdf

[2] It should be noted that any new enrollment among the previously eligible population prompted by awareness of the Medicaid expansion will not be financed by the federal government at the enhanced match rate. Howard, P. and Holtz-Eakin, D., "A Medicaid Rebellion?" City Journal, Winter 2011.

[3] Harvard Kennedy School, Fels Institute of Government at University of Pennsylvania, and American Education Foundation, "The State of the States: Full Report 2012," The States Project, Available at: http://www.thestatesproject.org/wp-content/uploads/2012/Full_Report.pdf

[4] Patrick, D., "An Act making appropriations for fiscal year 2014," Supplemental material, Expanding Access to Affordable, Quality Health Care, Issues in Brief, Available at: http://www.mass.gov/bb/h1/fy14h1/exec_14/hbudbrief3.htm

[5] Bipartisan Policy Center, "Reforming Medicaid Waivers: The Governors' Council Perspective on Federalism Today," March 2012, Available at: http://bipartisanpolicy.org/sites/default/files/Federalismpercent20Paper.pdf

[6] State Budget Crisis Task Force, "Report of the State Budget Crisis Task Force," July 2012, Available at: http://www.statebudgetcrisis.org/wpcms/wp-content/images/Report-of-the-State-Budget-Crisis-Task-Force-Full.pdf.

schools at a lower level than in 2008.[7] Additionally, total infrastructure spending is down 20 percent since 2009.[8] This translated into fewer teachers in the classroom, less police officers on the street, and more structurally deficient bridges and roads. Moreover, the impact falls disproportionally on vulnerable communities.[9]

Even with the federal government offering to pay a significant portion of the ACA's Medicaid expansion costs, any additional spending does not come "free." The projected $638 billion in additional costs will have to come either from higher federal taxes drawn from our sluggish economy, or from cuts in the budget, which will likely leave less money for other worthy programs. A recent Harvard Kennedy School, University of Pennsylvania, and American Education Foundation study calculates that the state and local government unfunded liability to be $7.3 trillion, $1.2 trillion of which is for healthcare benefits.[10] Finding any new money for Medicaid highlights the challenges ahead and the deep entitlement crisis that our country faces.

2) State leaders have cut access to benefits and hiked taxes to fund the program,

In 2010, 15 states cut benefits in Medicaid.[11] In 2011, 18 states eliminated, reduced, or restricted benefits. For example in 2010, Massachusetts cut dental coverage including filings, root canals, crowns and dentures, and also moved legal immigrants out of the subsidized Commonwealth Care program to reduce costs. States such as Arkansas, California, Kansas,

[7] Oliff, P., Mai, C. and Leachman, M., "New School Year Brings More Cuts in State Funding for Schools," Center on Budget and Policy Priorities, Updated September 4, 2012.
[8] Easton, N., "The next entitlement crisis: Medicaid spending threatens education," CNN.com, December, 3, 2012.
[9] Harvard Kennedy School, Fels Institute of Government at University of Pennsylvania, and American Education Foundation, page 16. The report draws the line between increasing Medicaid spending which leads to crowding out of state level education funding, and a heavier reliance on local tax revenue for school funding. "…school funding based on local tax revenue may disadvantage low-income communities. The same tax rate in a low-income community will raise fewer funds than in a high-income community."
[10] The States Project, "The State of the States: Full Report 2012," Available at: http://www.thestatesproject.org/wp-content/uploads/2012/Full_Report.pdf
[11] "State Actions to Close Budget Gaps" Presentation to the NCSL Fiscal Leaders Seminar, 2010 Phoenix, Arizona.

Kentucky, Louisiana, Maine, Mississippi, North Carolina, Oklahoma, South Carolina, Tennessee, Texas, Utah and West Virginia have all put limits on drug coverage.[12] In a controversial move, Arizona opted to drop coverage for some organ transplants in December of 2010.[13]

Putting aside the debate over the generosity of Medicaid programs in each state for a moment, the real losses of these cost containment strategies are endured by the beneficiaries, as they are captive to the whims of state bureaucrats. Instead of being able to vote with their feet and take their "business" elsewhere, they are instead stuck with top-down decisions that dictate their insurance coverage. This approach is blunt and not sophisticated enough to take into account the real health differences amongst the vulnerable.

Increasing costs have also led to additional taxes. States have continued to increase questionable provider taxes, in order to maximize federal reimbursements, and others such as Massachusetts and Indiana have raised taxes to help offset the expenses of an expanding Medicaid program.[14] As long as the current program remains in place, these problems will persist and we will fail to protect the most vulnerable.

3) Poor Access to Providers and Worse Health Outcomes

Largely due to the program management structure of Medicaid, the federal government has placed restrictions on how states can manage costs in the program. As a result, the prime tool to "save" money is to adjust payment rates for providers. States that have already expanded Medicaid eligibility tend to pay for it by cutting provider reimbursement rates. Over time, this

[12] Galewitz, P. "States Cut Medicaid Drug Benefits to Save Money," Kaiser Health News, July 24, 2012.
[13] Bialik, C., "Health Studies Citied for Transplant Cuts Put Under the Knife," *Wall Street Journal.* December 18, 2010.
[14] Massachusetts raised the cigarette tax to help pay for the federally subsidized Commonwealth Care program, but the end result also freed up additional money for Medicaid.

has resulted in underpayment of doctors and hospitals,[15] and subsequently more and more providers refusing to treat those on Medicaid.[16] This trend prevents many recipients from gaining access to basic and specialist care. As a result, when Medicaid patients are admitted into a hospital, they often suffer from a higher level of co-morbidity than privately insured patients, and with more serious illnesses.

Low reimbursement rates may also account for the elevated number of emergency department (ED) visits by Medicaid patients. They are roughly twice as likely to visit an ED compared to both the uninsured and Medicare patients, and four times more likely than the privately insured.[17] To make matters worse, in Massachusetts, 55.1 percent of visits to the ED in FY 2010 were deemed "avoidable/preventable" for Medicaid beneficiaries.[18] This form of care is providing uncoordinated, expensive care to patients and costing our country billions.

In 2010, at least 2/3 of the states reduced provider rates.[19] In 2011, 39 states lowered provider payments, and 46 states expected to do so again in 2012.[20] Just recently the Administration encouraged states to further cut reimbursement levels.[21] As a result, access issues are likely to get even worse in the near future. In addition, with tens of millions joining the program under the ACA, the sickest of those on Medicaid today will find it even harder to find a physician to see them.

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[15]Medicaid typically pays physicians 56 percent of the amount that private insurers pay

[16]Decker, S., "In 2011, Nearly One-Third of Physicians Said They Would Not Accept New Medicaid Patients, But Rising Fees May Help," Health Affairs, Vol. 31, No. 8 (August 2012), pp. 1673–1679

[17] Haislmaier, E., "Should States Opt Out of the Health Law's Medicaid Expansion?" *The Wall Street Journal*, February 18, 2013.

[18] Compared to 43 percent for the privately insured . Division of Health Care Finance and Policy, "Efficiency of Emergency Department Utilization in Massachusetts," August 2012.

[19] National Conference for State Legislators, "State Strategies to Manage Budget Shortfalls," Budgets & Revenue Committee, 2011 Legislative Summit, August 9, 2011.

[20]Smith, V., Gifford, K., Ellis, E., Rudowitz, R., and Snyder, L. "Moving Ahead Amid Fiscal Challenges: A Look at Medicaid Spending, Coverage and Policy Trends Results from a 50-State Medicaid Budget Survey for State Fiscal Years 2011 and 2012." Kaiser Commission on Medicaid and the Uninsured, October 2011." Available at: http://www.kff.org/medicaid/upload/8248.pdf

[21] Pear, R., "States Can Cut Back on Medicaid Payments, Administration Says," *The New York Times*, February 25, 2013.

With the ACA's Medicaid expansion, the experiences in states like Massachusetts, Illinois, and California support this growing concern over access.

Concerning Access Issues in Massachusetts

For many years, the Commonwealth has provided coverage to a much higher income level than most other states, some of which are reflected in the expansion under the ACA. [22] (See Appendix 1) Even though Massachusetts has the highest per capita doctor ratio of any state in the country, access is still a problem for those on Medicaid.[23] According to an annual survey conducted by the Massachusetts Medical Society, only 54 percent of internal medicine and 64 percent of family medicine offices accept Medicaid patients. To provide some context, Medicare acceptance rates in the state hover closer to 85-90 percent. The problem of access for Medicaid patients looks even worse when one digs deeper to observe geographical differences and admittance to specialists. For example, in Barnstable County on Cape Cod, only 14 percent of offices accept Medicaid.[24]

Anecdotal evidence can illustrate this problem as well. A Boston-area Medicaid recipient was provided a list of eligible providers by the Medicaid office, and yet failed to find one accepting new patients after calling 20+ doctors.[25] However, access issues are not isolated to Massachusetts. Other states with robust Medicaid programs have experienced some of the same issues and have also found detrimental effects on children.

Concerning Access Issues for Children in Illinois

[22] For example, while the national average for providing coverage to non-working parents is 37 percent and 63 percent of the federal poverty Level (FPL) for working parents, Massachusetts sits at 133 percent FPL for both (which is largely mirrored under the ACA). In additional, Massachusetts unlike most other states, has no income eligibility limit for people with disabilities. The state also spends 46percent more overall per enrollee per year. ($8,066 compared to a national average of $5,535).

[23] United States Census Bureau, "The 2012 Statistical Abstract: State Rankings: Doctors Per 100,000 Population, 2007" U.S. Department of Commerce, available at: http://www.census.gov/compendia/statab/rankings.html

[24]Massachusetts Medical Society, "2012 MMS Patient Access to Care Studies," August 2012.

[25] Goodman, J., "Parallel Universes," National Center for Policy Analysis's Health Policy Blog, February 16, 2011.

A New England Journal of Medicine article highlighted the divergence in access for children on Medicaid and Children's Health Insurance Program (CHIP) when compared to those on private insurance in Cook County. In a random sample of specialists, children described as having a "serious medical condition" were denied an appointment 66 percent of the time if they said they had Medicaid, compared with 11 percent for those on private insurance. For those that did accept Medicaid, the wait times for an appointment were twice as long, 42 days for Medicaid patients compared to 20 days.

Concerning Access Issues for Children in California

A 2005 study published in *Urology* found that for boys on Medi-Cal (Medicaid in California) 96 percent of offices would accept privately insured patients, while only 41 percent would accept Medi-Cal.[26] Tellingly, 75 percent of the offices that did not accept Medicaid patients were unable to suggest another office that would.[27] While these states have had some serious problems with access, a 2011 Government Accountability Office (GAO) study captured the problem nationally for kids.

Is Being Uninsured Better for Access Than Medicaid?

The GAO study documented that children on Medicaid often have worse access to physicians than those with no insurance coverage at all. Of the roughly 1,000 doctors surveyed, 53 percent were not accepting new Medicaid patients, 45 percent were not accepting new uninsured patients, and 21 percent were not accepting new privately insured patients. However, the situation was even worse for those looking for a primary care doctor, as only 23 percent

[26]Hwang, A., Hwang, M. Xie, H., Hardy, B. and Skaggs, D., "Access to Urologic Care for Children in California: Medicaid Versus Private Insurance," *Urology*, Vol. 65, No. 1 (2005), pp. 170–173.
[27]Bisgaier, J. and Rhodes, K., "Auditing Access to Specialty Care for Children with Public Insurance," *New England Journal of Medicine*, June 16, 2011, pp. 2324–2333,http://www.nejm.org/doi/full/10.1056/NEJMsa1013285 (accessed November 7, 2012).

would accept Medicaid patients, and only 17 percent of specialists were open for business. [28]

Interestingly, the GAO survey also asked for doctors' motivations for not participating in the Medicaid program. Low reimbursement rates lead the way with 94 percent saying it greatly or somewhat limited their willingness to take Medicaid patients. Billing requirements and paperwork burdens also topped the list (87 percent), delays in payments and difficulty in provider enrollment and program stipulations also garnered significant support (85percent), and difficulty referring patients to other providers registered as a major concern (78percent).

It should be noted that factors such as the complexity of a patient's health or non-compliance were not primary drivers for non-participation. As some scholars have suggested, this reflects the worse possible outcome for Medicaid as doctors find it to have not only low payments, but also "burdensome requirements, excessive paperwork, and unresponsive bureaucrats."[29] As long as the program remains in its current form, these problems will persist.

Conclusion

It is impossible to infer a causal relationship between Medicaid participation and poor health outcomes without conducting a randomized controlled experiment, yet policymakers should be concerned about the strong correlation of troubling outcomes that are appearing more often in the academic literature.[30]

These studies raise legitimate questions about the quality of care being provided to some of our most vulnerable residents. If Medicaid outcomes were presented as a business model, it would be shut down because it was not serving its consumers well, and in some cases may be

[28]GAO, "Most Physicians Serve Covered Children but Have Difficulty Referring Them for Specialty Care" GAO-11-624, Jun 30, 2011

[29] Roy, A., "GAO: Children on Medicaid Have Worse Physician Access Than Uninsured Children," *Forbes.com,* July 5, 2011.

[30]Dayaratna, K., "Studies Show: Medicaid Pateients Have Worse Access and Outcomes than the Privately Insured," Heritage Foundation, Backgrounder #2740, November 9, 2012.

hurting their health.

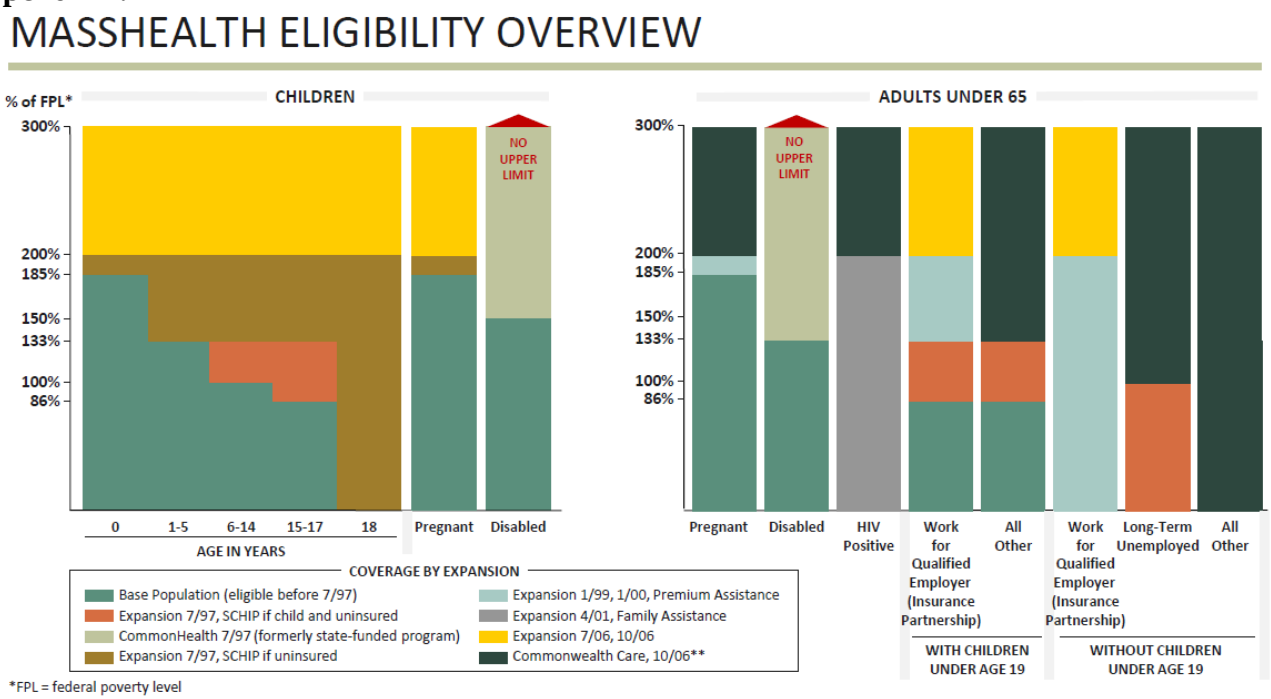
Furthermore, the problems of Medicaid leak out into the general marketplace driving up the cost of middle-class workers' insurance. A 2008 Milliman study found that the average family pays an additional $1,800 in premiums because of cost-shifting due to low Medicaid reimbursement rates.[31]

I trust that you will take these concerns seriously as you consider the best way forward to both protect the most vulnerable among us, and address the entitlement crisis. This is not a false choice between cutting benefits or simply raising taxes to fix the problem. It requires creative thinking and a true partnership with states to eradicate the billions of dollars of waste, fraud, and abuse that is preventing the level of care to be targeted at those that need it the most. It requires a departure from the current mindset that having access to a Medicaid card is the same as having access to a doctor. It requires us all to ask the tough question—are the billions we are spending as a country serving the best interest of the beneficiaries and of the taxpayers?

I appreciate the opportunity to share some of my thoughts with you all today, and look forward to answering any questions you may have.

[31] Fox, W. and Pickering, J., "Hospital and Physician Cost Shift: Payment Level Comparison of Medicare, Medicaid, and Commercial Payers," Milliman Client Report, December 2008.

Appendix 1.



*FPL = federal poverty level

**Commonwealth Care excludes employed people whose employers offer coverage. Undocumented immigrants are not eligible either for MassHealth (except for limited emergency coverage) or for Commonwealth Care.

NOTE: In general, the eligibility level for seniors age 65 and older is 100% of FPL and assets of up to $2,000 for an individual or $4,000 for a couple. More generous eligibility rules apply for seniors residing in nursing facilities or enrolled in special waiver programs. There is no income limit for seniors who need long-term services, but an individual contribution may be required.

Source: Massachusetts Medicaid Policy Institute, "MassHealth: The Basics: Facts, Trends and National Context," Updated June 2012.