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4 ``STATE OF UNCERTAINTY: IMPLEMENTATION OF PPACA'S EXCHANGES
5 AND MEDICAID EXPANSION''
6 THURSDAY, DECEMBER 13, 2012
7 House of Representatives,
8 Subcommittee on Health
9 Committee on Energy and Commerce
10 Washington, D.C.

11 The subcommittee met, pursuant to call, at 10:06 a.m.,
12 in Room 2123 of the Rayburn House Office Building, Hon.
13 Michael Burgess [Vice Chairman of the Subcommittee]
14 presiding.

15 Members present: Representatives Burgess, Shimkus,
16 Murphy, Blackburn, Gingrey, Latta, Lance, Cassidy, Guthrie,
17 Griffith, Pallone, Dingell, Engel, Capps, Schakowsky,
18 Baldwin, Matheson, DeGette, Sarbanes, Christensen, and Waxman

19 (ex officio).

20 Staff present: Gary Andres, Staff Director; Matt Bravo,
21 Professional Staff Member; Howard Cohen, Chief Health
22 Counsel; Nancy Dunlap, Health Fellow; Paul Edattel,
23 Professional Staff Member, Health; Julie Goon, Health Policy
24 Advisor; Sean Hayes, Counsel, Oversight and Investigation;
25 Robert Horne, Professional Staff Member, Health; Ryan Long,
26 Chief Counsel, Health; Carly McWilliams, Legislative Clerk;
27 Monica Popp, Professional Staff Member, Health; Andrew
28 Powaleny, Deputy Press Secretary; Chris Savercool, Policy
29 Coordinator, Environment and Economy; Heidi Stirrup, Health
30 Policy Coordinator; Phil Barnett, Democratic Staff Director;
31 Alli Corr, Democratic Policy Analyst; Ruth Katz, Democratic
32 Chief Public Health Counsel; Purvee Kempf, Democratic Senior
33 Counsel; Elizabeth Letter, Democratic Assistant Press
34 Secretary; Karen Nelson, Democratic Deputy Committee Staff
35 Director for Health; Anne Morris Reid, Democratic
36 Professional Staff Member; and Matt Siegler, Democratic
37 Counsel.

|
38 Dr. {Burgess.} I call the hearing to order, ``The State
39 of Uncertainty: the Implementation of the Patient Protection
40 and Affordable Care Act's Exchanges and Medicaid Expansion.``
41 This hearing is under the jurisdiction of the Energy and
42 Commerce Committee.

43 I do want to observe as we start, the chairman of the
44 subcommittee, Mr. Pitts, is ill today and we all of course
45 wish and pray his speedy recovery, and I hope that is well
46 underway and we look forward to his return here to join us in
47 the Congress next week.

48 In the meantime, it has been 1,000 days since President
49 Obama signed the Affordable Care Act into law. The Obama
50 Administration has not provided critical information to
51 Members of Congress, to the States, or to the health plans
52 that they need to begin implementing the health care law's
53 exchanges. We know Medicaid expansion is going to happen but
54 we don't know what it is going to look like. We know
55 insurance market reforms are occurring but we are not sure
56 about what is going to be expected of the plans themselves.

57 The President's law intends that the exchanges will be
58 ready to begin enrollment by October 1st. of next year. In
59 less than 10 months the Administration asserts they will have
60 a fully functioning, technologically advanced system by which

61 Americans will be able to enroll in an exchange. The
62 Administration has yet to explain how it will share
63 information between the three different federal agencies that
64 are involved in determining eligibility for the exchange:
65 Treasury, DHS and Health and Human Services. And further,
66 the Administration has yet to explain how it will distribute
67 the income subsidies, the cash to the beneficiaries to allow
68 them purchase coverage in the exchange, or how a State will
69 be able to afford the administrative costs to deal with
70 eligibility changes.

71 While the Administration has the ability to push back
72 the dates of implementation for federal provisions, the
73 States and the plans that are required to meet statutory
74 standards do not have that flexibility. It was not until
75 last week that the Administration released the proposed rules
76 regarding the State health insurance exchanges and the
77 essential health benefits. However, the latest proposed
78 rules and the other 13,000 pages of rules that the
79 Administration has released on the Affordable Care Act fail
80 to address the questions that the States and the policymakers
81 have asked since the law was signed.

82 Medicaid accounts for a quarter of most State budgets.
83 Governors cannot be expected to plan for major changes and
84 have legislative authority to prepare unless the

85 Administration makes clear the basic ground rules. Many
86 State legislatures only meet for a limited time each year, or
87 in the case of my State, they only meet every other year, and
88 that time will be quickly evaporated while they are awaiting
89 instruction on these rules.

90 There is a lot to be sorted out between now and the end
91 of the year in Congress in general but in this issue in
92 particular. The uncertain regulatory environment and the
93 overall lack of response from the Department of Health and
94 Human Services is not encouraging to States or to health
95 plans to move forward in cooperation with the agency. And
96 let us be honest: time is running out and the future of our
97 health care system, indeed, the future of the health of
98 America's patients becomes more uncertain every day.

99 It is my hope that this hearing will bring light to the
100 questions that the States and Congress have been asking of
101 the Administration for the past 2-1/2 years and provide the
102 States with an opportunity to provide their perspective as
103 they attempt to plan for the unknown effects of the Patient
104 Protection and Affordable Care Act.

105 [The prepared statement of Dr. Burgess follows:]

106 ***** COMMITTEE INSERT *****

|
107 Dr. {Burgess.} At this point I would like to yield the
108 balance of the time to the Member from Louisiana, Dr.
109 Cassidy.

110 Dr. {Cassidy.} Thank you, Dr. Burgess.

111 First, I would like to thank Mr. Greenstein from my own
112 State for being here and all the other panelists, and I will
113 tell you, I have multiple concerns about how this is being
114 implemented but I will say it is principally today about how
115 this is going to affect the average American family. There
116 is a McKinsey quarterly report from February 2011 that
117 suggests about 30 percent of employers will definitely or
118 probably put their employees in the exchange. Now, when I
119 speak to brokers, they tell me most people opt for the bronze
120 level, which has a 60 percent actuarial value. Then I pull
121 up this from ASBE, which is a government agency which I can't
122 recall the acronym for, in which it shows that roughly 98
123 percent of these workers have actuarial values of 80 percent
124 or more. We have got a law inducing that we put people into
125 an exchange in which the actuarial value of their policy will
126 decrease from 80 percent to 60 percent. I am not quite sure
127 how this serves the average American family. And just to put
128 this in perspective, we know that actuarial value has a
129 \$2,000 to \$4,000 deductible and an out-of-pocket of \$6,350

130 before it is completely paid for. Now, if we are trading 80
131 percent for 60 percent, I don't see the value for the
132 American worker, and I would love to discuss today how all
133 this was determined.

134 I yield back. Thank you.

135 [The prepared statement of Dr. Cassidy follows:]

136 ***** COMMITTEE INSERT *****

|
137 Dr. {Burgess.} The gentleman yields back his time. The
138 Chair now recognizes the ranking member of the subcommittee,
139 Mr. Pallone of New Jersey, 5 minutes for your opening
140 statement, sir.

141 Mr. {Pallone.} Thank you, Doctor, or I guess I should
142 say Chairman Burgess. Thank you. You like doctor better?
143 Polls better? Okay.

144 Let me start out by saying that I am beginning to learn
145 the Republican playbook on the Affordable Care Act. First
146 they spent a year and a half holding repeal votes, and when
147 that didn't work, they advocated that the Supreme Court would
148 most certainly reverse the law, and of course, that didn't
149 happen, and finally they crossed their fingers and hoped that
150 the President would lose the election, and when all else
151 failed, their next move now is to delay implementation under
152 the guise of lack of information.

153 I want to stress that the President won the election.
154 Implementation is going to move forward and the landmark
155 health care law will continue to have a positive effect on
156 millions of people's lives, and I just hope that I will be
157 here one day when the Republicans finally realize that we did
158 the right thing, the world is not coming to an end, and in
159 fact, the Nation will be better because of the Affordable

160 Care Act.

161 Now, I wanted to clear some things up for the record.
162 One of the critical goals of the Affordable Care Act was to
163 improve access to health care for millions of uninsured and
164 underinsured Americans because a healthy nation is a
165 successful nation, and it simply is immoral to allow our
166 fellow Americans to suffer because they can't access health
167 insurance. A key feature to accomplish that was expanded
168 Medicaid to help cover millions of low-income Americans, and
169 when the Supreme Court allowed States to choose whether or
170 not to accept the Medicaid expansion provision, Republican
171 governors became nothing but openly hostile. But there is no
172 question that accepting the Medicaid expansion is a good deal
173 for States because it is a boon to the States' uninsured and
174 its taxpayers. Today we are going to hear from both Maryland
175 and Arkansas, two very different States, about their own
176 cost-benefit analysis that proved this point with dramatic
177 facts and figures.

178 Another critical piece of the ACA is the creation of
179 health insurance exchanges, which beginning in 2014 will
180 provide a stronger marketplace that provides coverage options
181 for millions of Americans, and plenty of States have forged
182 ahead with implementation of their State-based or partnership
183 exchanges. Now, those states that have not are simply using

184 HHS's regulation as an easy excuse. In fact, yesterday
185 experts consulting with States on exchange development
186 insisted that there is enough information and time to build
187 an exchange. Meanwhile, as we will hear today from the
188 director of CCIIO, the Administration has been steadily
189 working with States, providing flexibility, guidance and
190 resources.

191 Now, a lot more work needs to be done, and I recognize
192 that challenges do exist, but implementation of the
193 Affordable Care Act puts this Nation on a path to better
194 health, and we must not allow States to continue to play
195 politics, which is what some are doing. I expect a lively
196 discussion today, so I appreciate the witnesses'
197 participation.

198 I did want to yield initially to the gentleman from
199 Michigan, Chairman Dingell.

200 [The prepared statement of Mr. Pallone follows:]

201 ***** COMMITTEE INSERT *****

|
202 Mr. {Dingell.} I thank my good friend, and I commend
203 you, Mr. Chairman, for holding this hearing today.

204 In my entire career, I have fought to secure the
205 affordable, quality health care our citizens deserve and
206 need. The passage of the Affordable Care Act by the House
207 and Senate, ratification by the President and subsequent
208 upholding of the law by the Supreme Court brought to fruition
209 a dream that began with my father long before me.

210 The health insurance exchanges and Medicaid expansion
211 are two fundamental provisions of ACA that will achieve our
212 goal of providing affordable health care of high quality to
213 every American. Through the exchange, patients and small
214 businesses will be able to easily opt for a health plan that
215 best suits their needs, and the Medicaid expansion will
216 provide millions of uninsured Americans will access to our
217 Nation's world-class health care system which heretofore has
218 lacked the means of paying for it. Therefore, it is critical
219 that we get them right, and I hope that this hearing will
220 enable us to do so.

221 [The prepared statement of Mr. Dingell follows:]

222 ***** COMMITTEE INSERT *****

|
223 Dr. {Burgess.} The gentleman yields back. The Chair
224 now recognizes the gentleman from Georgia, Dr. Gingrey, for
225 the purpose of an opening statement.

226 Dr. {Gingrey.} Mr. Chairman, I thank you.

227 What the distinguished Member from Michigan didn't say
228 was that the Obamacare bill will cost \$1.7 trillion and
229 result in increased costs of health care, and it does not
230 bring it down. So I find it remarkable, frankly, that 33
231 months after the passage of this bill, PPACA, a hearing like
232 this is even necessary. We have States including my own of
233 Georgia still looking for direction from HHS on provisions
234 that come into effect within the next year. This type of
235 uncertainty makes it impossible for such States to
236 successfully budget for the future. What is more, State
237 officials are left with no good options as HHS imposes
238 arbitrary deadlines on them in regard to creation of the
239 exchanges. That is why our State of Georgia, our Governor
240 Deal, who served on this Committee and indeed was chairman of
241 this Health Subcommittee, has rejected the idea of the State
242 of Georgia setting up its own exchange because the
243 restrictions or handcuffs that are put on the States by HHS
244 just almost make it prohibitive. And the same thing in
245 regard to Medicaid expansion. Our State has taken the

246 option, and again, I think Governor Deal is correct in doing
247 this, in not expanding Medicaid because of the bottom-line
248 cost to the State over an extended period of time.

249 Unfortunately, this hearing today is very much needed.
250 I hope that we are able to find some real answers from CMS
251 which allow States to indeed plan for the future.

252 And with that, Mr. Chairman, if there is anyone on our
253 side that would like to have time yielded, I will be happy to
254 do that. Otherwise I will yield the balance back.

255 [The prepared statement of Dr. Gingrey follows:]

256 ***** COMMITTEE INSERT *****

|
257 Dr. {Burgess.} Seeing none, the gentleman yields back.
258 The Chair recognizes the ranking member of the full
259 committee, the Hon. Mr. Waxman of California, for purposes of
260 an opening statement.

261 Mr. {Waxman.} Thank you, Mr. Chairman.

262 In March of 2010, after decades of trying, Congress
263 finally passed landmark legislation that extends access to
264 affordable, quality health insurance to all Americans, and
265 since then, the law has already provided remarkable benefits
266 for American families. It has allowed over 6 million young
267 adults to stay on their parents' insurance. It has extended
268 a lifeline in the form of the preexisting coverage insurance
269 plan to over 90,000 people. It has lowered prescription drug
270 costs for 5.5 million seniors and people with disabilities.
271 It has given 86 million people in the private market and in
272 Medicare access to preventive health benefits at no cost.
273 And it has eliminated lifetime insurance company limits on
274 coverage for 105 million individuals. That is an outstanding
275 beginning. And now we stand on the threshold of full
276 implementation.

277 Despite the law's many benefits, it has faced united
278 opposition from the Republican Party since the day it was
279 passed. There have been over 30 votes to repeal this law.

280 There have been numerous court challenges to the law. There
281 are States that have steadfastly refused to move forward to
282 assure smooth and effective implementation.

283 Yet none of these efforts have been successful. The
284 House votes proved to be partisan political posturing. And
285 the Supreme Court declared the law constitutional. Let us be
286 clear: the Affordable Care Act is the law of the land. We
287 should all be united in seeing that its implementation works.

288 As we will hear today, HHS and CMS have done their job.
289 They have provided a constant stream of assistance and
290 information to those taking steps to make this law their own.

291 For Some states, no information will ever be enough.
292 And that is the tragedy of politicizing a law that will
293 benefit so many Americans.

294 But other States are acting responsibly. Two of those
295 States are here today. And there are many others. Just this
296 week, for example, Nevada's Republican Governor announced
297 that Nevada will move forward with the Medicaid expansion.
298 The Republican Governor of Idaho said the State will set up a
299 State-based exchange.

300 I welcome and look forward to hearing from all of our
301 witnesses. I am particularly interested in testimony from
302 Dr. Sharfstein from Maryland and Mr. Allison from Arkansas on
303 what they have been able to accomplish with regard to the ACA

304 expansions. And I would also like to thank Mr. Cohen and Ms.
305 Mann for their work, the work they have already done and the
306 work we expect from them in the future.

307 The Affordable Care Act is a solid law that will improve
308 our Nation's health and health system for decades to come.
309 Let us move forward and work together to implement it
310 efficiently and effectively. Why do we have to have this
311 political fight over and over again? We have a law that is
312 doing good already. It is going to do so much more if we
313 make it work effectively, and it is time to stop the fighting
314 about it and work together.

315 I would like to now yield the rest of my time to
316 Representative Baldwin from Wisconsin.

317 [The prepared statement of Mr. Waxman follows:]

318 ***** COMMITTEE INSERT *****

|
319 Ms. {Baldwin.} Thank you, Mr. Waxman, and thank you to
320 our chairman and Ranking Member Pallone as well as all of my
321 colleagues on this subcommittee. I want to appreciate your
322 dedication to health care issues, and it has been an honor
323 serving with you in the House of Representatives.

324 On the topic before us today, the Affordable Care Act is
325 the law of the land, and it is now time for all of us to come
326 together and put politics aside and make American's new
327 health law work for the American people. And that includes
328 expanding health care coverage through Medicaid to those who
329 need it most, and that includes creating health insurance
330 exchanges that will provide individuals and small businesses
331 with quality, affordable insurance options. If we all do our
332 part, access to affordable health care will be within reach
333 for all Americans and small businesses, strengthening their
334 economic security.

335 To that end, I am pleased to be in the same room today
336 with leaders who are integral to implementing the Affordable
337 Care Act. Our esteemed witnesses from HHS and State
338 officials are making decisions that impact the lives of
339 citizens, citizens who deserve to have us put progress ahead
340 of politics, and I ask that in our discussions today, we keep
341 those Americans in mind.

342 I look forward to your testimony, and thank you for
343 being here, and yield back.

344 [The prepared statement of Ms. Baldwin follows:]

345 ***** COMMITTEE INSERT *****

|
346 Dr. {Burgess.} An observation from a Member of this
347 side of the dais is, you are already starting to sound like a
348 Senator and you filibustered a little long, but notice the
349 Chair was very preferential and let you go. I hope the
350 courtesy will be reciprocated when you are in the august
351 higher house. The gentlelady's time is expired.

352 I do want to welcome our witnesses here today and make
353 the observation that there will be a vote on the Floor at
354 some point. We generally allow 5 minutes for an opening
355 statement, generally try to be pretty flexible with that.
356 This morning I am going to ask if you would try to stay
357 within the confines of that time so that when votes come, we
358 perhaps could have gotten through the entire panel. We have
359 a single panel today but it is a large one but it is a very
360 distinguished one.

361 Our first witness will be Mr. Gary Cohen, who is the
362 Director for the Center for Consumer Information and
363 Insurance Oversight at the Centers for Medicare and Medicaid
364 Services, United States Department of Health and Human
365 Services. We are also joined this morning by Ms. Cindy Mann,
366 who is the Deputy Administrator and Director for the Center
367 for Medicaid and CHIP Services within the Centers for
368 Medicare and Medicaid Services. I am very grateful to

369 acknowledge the presence of Mr. Dennis Smith, who is the
370 Secretary of Department of Health Services, State of
371 Wisconsin. We are also joined this morning by Mr.
372 Greenstein, Secretary, Department of Health and Hospitals for
373 the State of Louisiana. Mr. Gary Alexander, who is the
374 Secretary of the Department of Public Welfare, the
375 Commonwealth of Pennsylvania, Dr. Joshua Sharfstein, the
376 Office of Secretary, very familiar to this committee from his
377 time at the FDA, now works at the Department of Health and
378 Mental Hygiene in the State of Maryland. We are also very
379 fortunate to have Dr. Andrew Allison, the Director of the
380 Division of Medical Services in the Department of Human
381 Services for the State of Arkansas.

382 Mr. Cohen, sir, we will begin with you, 5 minutes for
383 your opening statement, sir.

|
384 ^STATEMENTS OF GARY COHEN, DIRECTOR, CENTER FOR CONSUMER
385 INFORMATION AND INSURANCE OVERSIGHT (CCIIO), CENTERS FOR
386 MEDICARE AND MEDICAID SERVICES (CMS), U.S. DEPARTMENT OF
387 HEALTH AND HUMAN SERVICES; CYNTHIA MANN, DEPUTY ADMINISTRATOR
388 AND DIRECTOR, CENTER FOR MEDICAID AND CHIP SERVICES, CENTERS
389 FOR MEDICARE AND MEDICAID SERVICE (CMS), U.S. DEPARTMENT OF
390 HEALTH AND HUMAN SERVICES; DENNIS G. SMITH, SECRETARY,
391 DEPARTMENT OF HEALTH SERVICES, STATE OF WISCONSIN; BRUCE D.
392 GREENSTEIN, SECRETARY, DEPARTMENT OF HEALTH AND HOSPITALS,
393 STATE OF LOUISIANA; GARY D. ALEXANDER, SECRETARY, DEPARTMENT
394 OF PUBLIC WELFARE, COMMONWEALTH OF PENNSYLVANIA; JOSHUA M.
395 SHARFSTEIN, M.D., OFFICE OF SECRETARY, DEPARTMENT OF HEALTH
396 AND MENTAL HYGIENE, STATE OF MARYLAND; AND ANDREW ALLISON,
397 PH.D., DIRECTOR, DIVISION OF MEDICAL SERVICES, DEPARTMENT OF
398 HUMAN SERVICES, STATE OF ARKANSAS

|
399 ^STATEMENT OF GARY COHEN

400 } Mr. {Cohen.} Thank you, Chairman Burgess, Ranking
401 Member Pallone and the members of the Health Subcommittee for
402 having me here today to speak about implementation of the
403 Affordable Insurance Exchanges.

404 I have the privilege of serving as Director of the

405 Center for Consumer Information and Insurance Oversight in
406 the Centers for Medicare and Medicaid Services. I oversee
407 federal implementation of the exchanges as well as many of
408 the provisions of the Affordable Care Act that are working to
409 ensure more Americans have access to affordable, quality
410 health insurance.

411 I am confident that States and the federal government
412 will be ready in 10 months when consumers in all States can
413 begin to apply for quality, private health insurance through
414 the Affordable Insurance Exchanges. Whether a State chooses
415 to run its own exchange, partners with CMS or defers to the
416 federal government to operate an exchange, consumers and
417 small employers in every State and the District of Columbia
418 will be able to shop for, select and enroll in high-quality,
419 affordable health insurance beginning on October 1, 2013.

420 This is a groundbreaking time for health care in our
421 country. Many families will have health insurance for the
422 first time, and many people who lost their insurance when
423 they changed jobs or became sick will again have the security
424 of knowing that their health care needs will be met.

425 I know States are ready because they have the
426 information and resources they need to decide whether to
427 establish their own exchange or whether they need the federal
428 government, at least at first, to take on some of the

429 responsibilities of operating the exchange in their State.
430 States that want to move forward are moving forward. For
431 example, on Monday we announced that six States have already
432 made enough progress in setting up their own exchanges that
433 we have conditionally approved their plans.

434 While there is more work to do before open enrollment in
435 October, these six States, including Maryland, which one of
436 my fellow panelists is representing, have shown that they are
437 on track to meet all exchange deadlines.

438 We are pleased that many States are taking leadership
439 roles and implemented exchanges in their States. That is
440 what the Affordable Care Act envisioned: States taking the
441 lead. We will make more announcements about State progress
442 in the weeks and months to come. We hope every State will
443 take an active role in operating its exchange.

444 Since the enactment of the Affordable Care Act, we have
445 been working hard with States to prepare for the day when
446 exchanges will be open for business. We began issuing
447 guidance for the States about the exchanges over 2 years ago
448 in November of 2010. Since then, we have released
449 regulations, guidance and fact sheets including a final
450 establishment rule and the essential health benefits proposed
451 rule as well as detailed IT information about the specific
452 processes for implementing exchanges. My office has been in

453 contact with States every day in order to provide technical
454 assistance and answer questions. We have held hundreds of
455 hours of webinars, teleconferences and meetings at which
456 thousands of State workers have participated. And States are
457 helping each other as well, sharing many tools and documents
458 with other States to help each other get the job done.

459 In addition to guidance and hands-on assistance, we have
460 been working to ensure that States have the resources they
461 need starting with Exchange Planning Grants and progressing
462 on to Establishment Grants. States that were eager to move
463 forward to establish an exchange could qualify for an Early
464 Innovator Grant as early as October 2010 and the general
465 funding for exchange implementation has been available since
466 January of 2011.

467 To date, 34 States and the District of Columbia have
468 received about \$2.1 billion in grants to fund their process
469 and building their exchanges. These grants are available
470 through 2014 to help States build exchanges or fund first-
471 year start-up activities. In addition, States that choose to
472 partner with the federal government to build their exchange
473 may receive these grants to establish State functions that
474 are performed in support of the federally facilitated
475 exchange.

476 Many states including the six we conditionally approved

477 earlier this week are moving forward, and we are working to
478 support them. At the same time, we are working with States
479 that want to partner with us by taking on some of the key
480 responsibilities of operating an exchange, and we will be
481 ready to operate a federally facilitated exchange in States
482 that choose not to pursue a State-based or partnership
483 exchange at this time. If a State elects to have a federally
484 facilitated exchange at first, it is no a permanent choice.
485 States may choose to operate a partnership exchange or State-
486 based exchange in 2015 or beyond.

487 Now, in operating the federally facilitated exchange, it
488 is our goal to preserve the traditional State role as
489 insurance regulator and not to duplicate State regulatory
490 activity while also providing help for consumers based on
491 where they live who have questions while selecting or
492 enrolling in a health plan in their State's exchange.

493 We have made significant progress in developing the IT
494 systems needed for the federally facilitated exchange
495 including systems for determination of eligibility for tax
496 credits, enrollment in health plans and operation of the
497 reinsurance, risk adjustment and risk corridor programs,
498 which will help keep coverage affordable. We are now
499 beginning to test these services so we can sure they will be
500 up and running in 10 months.

501 Since the federally facilitated exchange will need to
502 interact with State Medicaid and CHIP agencies, we have been
503 working with States on the technical details of those
504 interactions and have held webinars with all States on these
505 issues. States that defer to a federally facilitated
506 exchange will not have to pay for federal operating costs,
507 and those States can apply for federal funding for any State
508 functions that they perform in support of the federally
509 facilitated exchange.

510 This hard work, both in CMS and in the States, is
511 beginning to pay off. As I said, six States have already
512 demonstrated their readiness to stand up and operate
513 exchanges. My office stands ready to aid any other States
514 who would also like to move forward in establishing exchanges
515 to offer affordable, accessible, quality private health
516 insurance for their citizens.

517 Thank you.

518 [The prepared statement of Mr. Cohen follows:]

519 ***** INSERT 1 *****

|
520 Dr. {Burgess.} Thank you. The gentleman's time is
521 expired.

522 Ms. Mann, you are recognized for 5 minutes for the
523 purposes of an opening statement.

|
524 ^STATEMENT OF CYNTHIA MANN

525 } Ms. {Mann.} Thank you, Chairman Burgess, Ranking Member
526 Pallone and members of the subcommittee, for the opportunity
527 to testify today.

528 For Medicaid, the implementation of the Affordable Care
529 Act is occurring in the context of an existing program that
530 is undergoing rapid change. Change is being driven by the
531 broader transformation in the private health care marketplace
532 by States that are focused on changing the way that care is
533 delivered and paid for and by federal action, both
534 legislative action and administrative action. We at CMS have
535 a clear focus on helping State Medicaid programs improve care
536 delivery and reduce cost through those improvements. There
537 is no one-size-fits-all model. Medicaid's flexibility and
538 the fact that it is run by 56 different jurisdictions assure
539 that innovation is unfolding in different ways across the
540 country.

541 With this backdrop, let me turn to the initiatives that
542 are underway to promote timely implementation of the
543 Affordable Care Act and the Medicaid provisions in that Act.
544 People are often surprised to learn that Medicaid does not
545 already cover all low-income people. Its coverage of

546 children and pregnant women is robust, and most of its
547 spending is devoted to care provided to the elderly and
548 people with disabilities but millions of low-income parents
549 are not eligible for Medicaid, and before the new law, other
550 adults weren't eligible at any income level except through a
551 waiver. The Affordable Care Act filled this gap and helps to
552 establish a simplified, coordinated system of coverage. It
553 does so by establishing one application, one set of
554 eligibility rules that will apply to the Medicaid program, to
555 the Children's Health Insurance Program and to subsidies
556 available on the exchange in the form of the premium tax
557 credit, and by having a coordinated system for determining
558 eligibility. Consumers will be able to apply, be found
559 eligible for the appropriate program and enroll in a health
560 plan without delay, but as we all know, much work is needed
561 to implement these changes, and for States to be successful,
562 they do need guidance and support from CMS. We have been
563 working aggressively to provide that guidance and support.

564 In April of 2011, we released a final rule that
565 increased the support we provide for the development and
566 operation of State Medicaid eligibility systems. Forty-eight
567 States and the District of Columbia have received approval
568 for that funding. In March 2012, we issued a final
569 regulation covering all of the major new income rules

570 effective in the Medicaid and CHIP program that will be
571 effective in 2014, and we did that regulation at the same
572 time that my colleagues in CCIIO issued their income rules so
573 that States would have the full array of rules available at
574 the same time as they moved forward to implement. This fall
575 we released comments for the elements of the new application
576 and we are continuing to consult with States and others as we
577 finalize that application. We have issued guidance on the
578 data services hub and ways in which State Medicaid and CHIP
579 programs will interface with the hub as well as with the
580 federally facilitated exchange as applicable in a given
581 State. And last month, we issued guidance on the flexibility
582 States have to construct their Medicaid benefit package that
583 will be available to newly eligible adults.

584 In addition to this guidance, we have been creating and
585 sharing tools that help States move forward. We have shared,
586 for example, a verification plan with States so that they can
587 help construct their verification rules in the way that they
588 design them to be consistent with our overall regulations.
589 We have sent to each State the net income standards and
590 disregards that will be applicable in their States and that
591 will need to be converted to the new rules.

592 Throughout the years, we have had a particular focus on
593 helping States accelerate their system builds to save time

594 and resources. Through various venues, we are making our
595 development products available to States and facilitated
596 States sharing their system artifacts with each other with
597 CMS making direct links depending upon a State's design
598 objective and the vendors that they are using. Complementing
599 these efforts, we have conducted more than 20 webinars with
600 States on 2014 implementation and established a State
601 operational technical assistance team for each State, which
602 consists of a multidisciplinary team of CMS experts on
603 systems, eligibility, benefits and outreach, so each State
604 has one-stop shopping in terms of answering the questions
605 that they individually and uniquely have. Since this summer,
606 we have conducted 200 calls with States.

607 It is important to say that the guidance and tools we
608 have made available and will continue to make available have
609 been created with substantial assistance from States
610 themselves. We have numerous State work groups and learning
611 collaboratives on a wide variety of topics. The vast
612 majority of States, though not every State, has participated
613 in one or more of these work groups. We think States have
614 gotten the value from these work groups. We know we have,
615 and we appreciate their assistance and contribution.

616 The Supreme Court's decision did not alter the
617 importance of any of this work. The decision left intact the

618 provisions of the law other than the penalty provision
619 relating to the new adult coverage. What the Court did was
620 to make the decision to take up the Medicaid coverage
621 expansion for low-income adults voluntary with each State.
622 States are considering this important question. Soon after
623 the Court's decision, Secretary Sebelius wrote to the
624 governors to say there was no deadline for when a State had
625 to make the decision and that the Court's ruling left fully
626 intact the very significant federal financial support
627 available for that expansion. In a second letter, we
628 confirmed to States that not only did they have the decision
629 to decide when to come in and if to come in, but if they did
630 decide to adopt the expansion, they could later drop it, and
631 we also noted that the enhanced federal funding for systems
632 modernization would remain available to States without regard
633 to whether a State decides to expand coverage.

634 In mid-November, we issued further questions and
635 answers, and on December 10th, we issued a comprehensive set
636 of Q's and A's on a range of exchange and Medicaid matters.
637 The releases continue as does the ongoing intensive technical
638 assistance and support. Many States have been able to take
639 the guidance, the tools, the technical support we are
640 providing and move forward. This is a big job, and we are
641 very much appreciative of all that needs to get done at the

642 State level.

643 Let me assure you that we are eager to work with every
644 single State no matter what their current stage of
645 development may be, and I join Gary Cohen in saying that we
646 are confiding that every State can be ready in time for open
647 enrollment on October 1st.

648 Thank you.

649 [The prepared statement of Ms. Mann follows:]

650 ***** COMMITTEE INSERT *****

|
651 Dr. {Burgess.} Time is expired. Let me just note that
652 the bells are signaling that the House is in recess subject
653 to the call of the Chair. It is not a vote.

654 So I will recognize Mr. Smith for 5 minutes, sir.

|
655 ^STATEMENT OF DENNIS G. SMITH

656 } Mr. {Smith.} Thank you, Mr. Chairman. It is a pleasure
657 to be with you and all the members of the subcommittee today.
658 I thank Senator-elect Baldwin for being here and congratulate
659 her. We look forward to your service in the Senate, ma'am.

660 I want to preface my remarks. I have a lengthy
661 statement for the record, and really did take my statement
662 from the perspective of implementation. I bring with that
663 perspective two things. First, Wisconsin already has done
664 much of the work that the Nation is going to be catching up
665 to. We have 90 percent insurance coverage in the State, over
666 90 percent if you add in the people who are today already
667 eligible for Medicaid. If they simply showed up and
668 enrolled, we would have 93 percent coverage for the State.
669 We also have, I think, been one of the leaders in integrated
670 eligibility systems in which people can apply on the Internet
671 as well as by mail, phone, and of course face to face. So we
672 have done a lot of the work of what to expect an exchange
673 would be faced with.

674 And I also bring experience from implementation at the
675 federal level. I was at the Centers for Medicare and
676 Medicaid Services shortly after the Medicaid Modernization

677 Act of 2003 was passed, so was charged with part of the
678 responsibility of preparing for implementation of the drug
679 benefit. I would say CMS has a much more daunting job today
680 than what we did in 2003 and yet in 2003 we were adjusting
681 through the very last minute and in fact, even months into
682 it, we still had State partners assisting the federal
683 government because we couldn't quite pull it off all at once.
684 But at that point in time, we had another eligible system
685 called the Social Security Administration as a major partner
686 that was trusted by our senior citizens. We had many things
687 that were already intact. We knew exactly who we were
688 enrolling. We were simply extending a new benefit to a set
689 group of people. We knew a lot about their health care. So
690 CMS has a far more daunting job than what we were charged
691 with at that point in time.

692 There are lots of good people doing their very best at
693 CMS. I do not envy for the job that they have. But from the
694 perspective that I have been looking at this throughout, that
695 we take deadlines seriously. The deadline that States faced
696 was the Secretary of HHS was going to start reviewing States
697 January 2013, as in next month, to see if we were going to be
698 ready. We took that deadline very seriously and decided a
699 year ago that that job was too big, and I would say today, we
700 still do not know who is eligible, who will get paid, how

701 will cost sharing be transferred between the federal
702 government to a health plan or to someone else. We do not--
703 again, all of the rules and everything else, we have still
704 some very fundamental things. At the end of the day, you are
705 trying to connect a buyer to a seller, and the fundamental
706 things that are required to do that are not yet in place. So
707 we would not have been ready to have that review. We took
708 that deadline very seriously.

709 The Wisconsin experience again, we submitted as part of
710 my statement real-life eligibility standards of what is going
711 to be faced out there in converting to Modified Adjusted
712 Gross Income, MAGI. MAGI inherently has marriage penalties
713 involved in it. You are going to have different outcomes for
714 similarly situated households making the very same income,
715 and you are very going to have different outcomes of whether
716 or not different members of the family are going to be
717 eligible for Medicaid, whether they are going to be eligible
718 for the tax credit or not eligible at all. I think when some
719 of those inequities start coming to light, there are going to
720 be a lot of unhappy people. I think in the federal exchange
721 again, and I gave some of our Wisconsin experience in terms
722 of volume of what needs to be anticipated, we don't know
723 again, call centers, who is that going to be for, what are
724 the standards to be able to answer the phone in what period

725 of time. The idea that you are going to train a whole set of
726 eligibility workers who are going to know Wisconsin's
727 Medicaid eligibility, it is a little hard to accept that,
728 given the short period of time. Again, we are 10 months
729 away.

730 Finally, affordability. Again, with the agreement of
731 our partners at the federal government, we have been since
732 last July modeling affordability. That is, we have been
733 applying the percentage of income towards premiums because,
734 again, Wisconsin has already expanded eligibility. We have
735 parents, caretakers, adults up to 200 percent of the federal
736 poverty level, people on transitional medical assistance who
737 have income well above 200 percent of the federal poverty
738 level. So we have been modeling those premiums, and again,
739 that experience, I think, needs to give everyone pause for
740 what we have found. People at the lower income level, they
741 aren't thinking in terms of percentage of income. They think
742 in dollar amounts: how much money is this going to cost me
743 on a monthly basis. The good news at the lower income
744 levels, we predicted pretty accurately what they were going
745 to be willing to pay on average amounts of around \$59 a month
746 for their care, for their premium, and again, this is just
747 the premium, this is not cost sharing. That is going to be
748 applied on top of that. But when you get above 200 percent

749 and that dollar amount has now gone above \$200 a month,
750 individuals have dropped by half. The law does not determine
751 what affordability is. People will determine what
752 affordability is, and I think it is going to be a vastly
753 different experience.

754 Thank you.

755 [The prepared statement of Mr. Smith follows:]

756 ***** INSERT 2 *****

|

757 Dr. {Burgess.} Thank you. Time is expired.

758 I recognize Mr. Greenstein for 5 minutes for purposes of

759 an opening statement, sir.

|
760 ^STATEMENT OF BRUCE D. GREENSTEIN

761 } Mr. {Greenstein.} Thank you, and good morning, Vice
762 Chairman Dr. Burgess and Ranking Member Pallone and the
763 distinguished members of the subcommittee. Thank you for the
764 invitation to testify on Louisiana's position regarding the
765 implementation of the Patient Protection and Affordable Care
766 Act, PPACA, particularly as it relates to exchanges and
767 Medicaid expansion.

768 My name is Bruce Greenstein. I am the Secretary of the
769 Louisiana Department of Health and Hospitals, and Senior
770 Health Policy Advisor to Bobby Jindal. Earlier in my career
771 at CMS during the Bush Administration, I oversaw Medicaid
772 programs in the Northeast and led the federal government's
773 efforts to reform the Medicaid programs in several states.
774 In fact, I have two of my previous bosses here on the panel.

775 In my current role, I have broad responsibility over an
776 array of health service areas including Medicaid, behavioral
777 health, public health and disability and aging services.
778 Before I begin, I would like to pause to recognize the
779 position that we are in. It feels somewhat awkward to be
780 here testifying on the implementation of one of the largest
781 expansions of entitlement programs in nearly 50 years at the

782 same time as ongoing discussions about federal spending
783 reductions to avert the fiscal cliff and raising the debt
784 ceiling takes place. It is a little bit of a parallel
785 universe.

786 Nevertheless, we are here. As you know, Louisiana has
787 continually shared its concerns regarding the practical and
788 policy ramifications of PPACA. Our decision not to assume
789 the risk of building a State-based exchange is not the
790 product of political positioning, rather it was made after
791 careful analysis of the laws and regulations.

792 Beyond the past and ongoing legal challenges of the law,
793 we have broad concerns about PPACA as policy. While the
794 concept of a health insurance exchange is a good one, the
795 PPACA-defined exchanges provide for rigid federal control
796 over coverage options available to consumers, raising costs
797 and limiting choice. In fact, a study recently released by
798 AHIP and the Louisiana Association estimates that PPACA
799 premium tax will force policyholders in my State to pay over
800 \$2,000 more for single coverage and \$4,500 more for family
801 coverage for individuals over the next 10 years. Similar
802 increases are noted for small and large group employers.
803 This is a significant burden on individuals and families in
804 Louisiana and across the country.

805 Beyond these concerns, there are major practical and

806 implementation hurdles. With guidance having been largely
807 delayed or altogether missing, the October 1, 2013, deadline
808 to begin open enrollment seems unrealistic, considering the
809 scope and complexity of building an exchange. The FAQs
810 released earlier this week is certainly helpful but it is
811 simply too little and too late.

812 The State's decision not to build an exchange should not
813 be taken as general unwillingness to tackle a complex reform
814 project. Rather, the number of remaining concerns and
815 unanswered questions simply do not give us the needed
816 confidence. Regardless of the type of exchange that will
817 operate within a State, there are five key issues fully
818 outlined in my written testimony that need attention from
819 Congress and action from HHS including administrative
820 simplifications and adjustments to make timelines more
821 realistic.

822 In addition to our concerns regarding the exchanges, we
823 have serious reservations about blanket expansion of the
824 existing Medicaid program without fundamental reforms to
825 improve health outcomes and lower costs. While States now
826 have a choice, it is not surprising that many remain
827 reluctant, even with enhanced federal funding. Some
828 organizations have heralded the expansion as ``a great
829 bargain'' for States. However, State leaders must be careful

830 before accepting the long-term liabilities of expanding a
831 1960s-era entitlement program.

832 A recent Kaiser Family Foundation and Urban Institute
833 report reveals that expansion creates winners and losers
834 among States. There are cost estimates which we believe
835 actually fail to capture the full administrative costs and
836 other impacts. They vary widely among States. For example,
837 the New England and Mid-Atlantic States combined will save
838 almost \$16 billion in State funds over 10 years. At the same
839 time, South Atlantic States will be paying about \$22 billion
840 more. Governors in States like Massachusetts, New York,
841 Maryland and Vermont combined will shift nearly \$23 billion
842 of State costs to federal taxpayers. At the same time, my
843 State alone is projected to pay nearly \$1.8 billion, and this
844 all comes from the same report.

845 Beyond the costs, we want to make sure we are providing
846 individuals with access to coverage that makes sense for
847 them, that it is cost-effective and gives them access to
848 high-quality services. While groups like those who publish
849 the report might declare victory through the simple act of
850 handing out a Medicaid card, we know that that is simply not
851 enough.

852 However, I believe this if Administration and Congress
853 begins to engage with States interested in pursuing market-

854 driven health care reform, we can create a more sustainable
855 and effective program. Specifically, these discussions
856 should be driven by several tenets of Medicaid reform that
857 include eligibility simplification and flexibility that would
858 allow us to keep families together on one coverage product.
859 These points are fully outlined in my testimony, and again in
860 even more detail in a 31-point report issued by Republican
861 Governors last summer.

862 President Obama himself said, ``We can't simply put more
863 people into a broken system that doesn't work.'' He is
864 right. Today's Medicaid model doesn't give States adequate
865 flexibility to improve health outcomes or lower overall
866 costs. Instead of rushing to expand, the Administration
867 should first engage in earnest discussion with States like
868 Louisiana that are eager to further reform their existing
869 programs now rather than spend more money on a rigid and
870 expensive program that will not work for all States.

871 Thank you. That concludes my testimony. I look forward
872 to questions at the appropriate time.

873 [The prepared statement of Mr. Greenstein follows:]

874 ***** INSERT 3 *****

|

875 Dr. {Burgess.} Thank you. Time is expired.

876 I recognize Mr. Alexander for 5 minutes for purposes of

877 an opening statement.

|
878 ^STATEMENT OF GARY D. ALEXANDER

879 } Mr. {Alexander.} Good morning, Vice Chairman Burgess,
880 Ranking Member Pallone and members of the committee. My name
881 is Gary Alexander and I am the Secretary of Public Welfare
882 for the Commonwealth of Pennsylvania. Thank you for asking
883 me to discuss the operational implementation impact of the
884 Affordable Care Act on the Commonwealth, and I encourage you
885 to review my entire printed testimony.

886 We in the Commonwealth have never witnessed a law so
887 vast with such demands on State resources and lack of federal
888 guidance. The ACA is not just about the expansion of
889 Medicaid or establishing an insurance exchange. It is about
890 the hundreds of federal mandates and procedural requirements
891 that have escaped public attention but which we must, by law,
892 obey. The fine print of this legislation is so complex, even
893 the federal government struggles to understand it.
894 Consequently, the States cannot fully understand the law's
895 impact on finances, staffing requirements, systems changes
896 and operations. In short, this law completely overwhelms
897 society's safety net for the needy.

898 Here are just a few of the problems in Pennsylvania
899 created by the ACA. The law mandates that we expand our

900 provider enrollment system to check with our Medicare data.
901 Medicare databases, however, cannot handle automated changes.
902 We will have to add staff resources to respond to 100,000
903 inquiries every month. We are mandated to create separate
904 databases to accommodate IRS exchanges and some databases
905 such as the Federal Death Master File we have not been given
906 access to.

907 The ACA mandates that we adopt passive Medicaid
908 renewals, radically changing Pennsylvania's tailor-made
909 renewal systems that took years to refine and perfect.
910 Unlike today, the ACA verification system will not be
911 coordinated with other welfare programs, creating eligibility
912 verification issues.

913 The ACA mandates that we use the National Correct Coding
914 Initiative. Pennsylvania already performs this task through
915 Claim Check, a federally approved system that cost
916 Pennsylvania \$12 million to develop. The difference now is
917 that the new system will be micromanaged by the federal
918 government.

919 The ACA mandates that we create new transaction methods
920 for claim status and eligibility verifications. Our
921 technology is more advanced than what is mandated, and no one
922 will use the outmoded ACA method, but CMS has told us that
923 the law requires us to develop it anyway.

924 The ACA mandates that States implement the Modified
925 Adjusted Gross Income methodology to determine Medicaid
926 eligibility by 2014. This mandate requires extensive
927 eligibility changes and enhancements. That timeline is much
928 too short for large IT system changes, which will prevent us
929 from developing a system that delivers the best value to the
930 taxpayers. This one change will cost the Commonwealth \$250
931 million.

932 The ACA mandates that States have an HHS-approved single
933 streamlined application. Pennsylvania already has one. We
934 are struggling to include the changes and enhancements
935 necessary to incorporate MAGI rules of federal data.

936 The ACA mandates that we use Medicaid to cover the
937 health care needs of children between the ages of 6 and 18
938 living in households with incomes between 100 and 133 percent
939 of the federal poverty level. Pennsylvania already provides
940 health coverage for these children through CHIP, a much less
941 costly program. The federal government is thus mandating
942 that we switch to a more costly and less efficient program.

943 The ACA mandates that we cannot use asset tests, a
944 welfare eligibility tool. When we removed the asset limit
945 test for food stamps, we ended up with lottery winners on the
946 program. We have since reinstated the asset limit test but
947 we are precluded from considering this tool for Medicaid.

948 The ACA allows hospitals to do presumptive eligibility
949 determinations for Medicaid. This change could create
950 conflicts of interest. As with many other aspects of the
951 law, CMS has not provided the guidance necessary to implement
952 this requirement. This may leave the States to pick up
953 additional costs.

954 The ACA mandates us to pay primary care physicians
955 Medicare rates. The feds will pay the difference through
956 2014. Thereafter, the States will be hit with increased
957 costs. Starting in 2015, this change will cost Pennsylvania
958 \$45 million a year.

959 To summarize, some of the timelines in the law are
960 unrealistic and many of the mandates impose unnecessary
961 duplications of effort that some of our States have already
962 achieved. These changes add to our costs, and as mandates
963 often do, impose a one-size-fits-all approach, making our
964 processes less efficient, not more.

965 We are told that the federal government will pay 90
966 percent of the costs of the ACA, making this a good deal.
967 That claim overlooks the magnitude of the costs to the
968 States. Ten percent of a huge number is still a very large
969 number. Beyond that, the magnitude of the federal deficits
970 shakes our confidence that the federal government will be
971 able to fulfill its end of the bargain. The ACA will likely

972 have broader economic impacts that will also directly impact
973 the Commonwealth. We do not have the time to go into these,
974 but we note that businesses are already changing their hiring
975 practices in order to transfer health care costs to the
976 State. Perhaps the largest cost of the ACA is the failure to
977 treat the States as true partners, which was the original
978 intent of the Medicaid program. The federal government now
979 dictates the States almost every detail of how to run this
980 program. How is that a partnership?

981 Finally, the ACA invites bureaucratic gridlock that
982 works against its desirable goal of securing greater
983 affordable health coverage for more Americans. To fix the
984 problem, States and localities must be engaged and viewed as
985 partners to create innovative solutions. There is a great
986 deal of work to be done to make this law more reasonable and
987 less burdensome for States, businesses and all Americans.
988 Thank you.

989 [The prepared statement of Mr. Alexander follows:]

990 ***** INSERT 4 *****

|
991 Dr. {Burgess.} The gentleman's time is expired.

992 I recognize Dr. Sharfstein for 5 minutes for the purpose
993 of an opening statement, sir.

|
994 ^STATEMENT OF JOSHUA M. SHARFSTEIN

995 } Dr. {Sharfstein.} Thank you. Good morning, Chairman
996 Burgess, Ranking Member Pallone, members of the Health
997 Subcommittee. I am Dr. Joshua Sharfstein, Secretary of the
998 Maryland Department of Health and Mental Hygiene. In this
999 position, I oversee our State's Medicaid program and I also
1000 serve as Chair of the Board of the Maryland Health Benefit
1001 Exchange. I am grateful for the opportunity this morning to
1002 speak with you about the implementation of the Affordable
1003 Care Act in Maryland. I am also a pediatrician, and with
1004 respect to the last three speakers, all my distinguished
1005 colleagues from other States, I think I am the answer to the
1006 Sesame Street question of ``Which one of these is not like
1007 the other?''

1008 My testimony today will include, one, background on the
1009 key elements of Maryland's health care system and the
1010 importance of improved access to care and cost control; two,
1011 a description of how broad public engagement has guided
1012 Maryland's process implementing the Affordable Care Act;
1013 three, specific details on how Maryland with the support of
1014 HHS is customizing the tools in the new law; and four, a
1015 summary of the economic value of health care reform

1016 implementation in our State.

1017 So first, a little background. Over the course of
1018 several decades, Maryland has pursued innovation in health
1019 care financing and insurance markets to expand access to
1020 care, control costs and promote health. Important aspects of
1021 Maryland's system include a unique all-payer approach to
1022 hospital payment; a small group market that has modified
1023 community rating and serves more than 400,000 Marylanders; a
1024 high-risk pool, a health information exchange that includes
1025 data from all hospitals and allows doctors to have access to
1026 help patients at the point of care; An all-payer pilot for
1027 medical homes to improve primary care; and a Medicaid and
1028 CHIP program that covers children up to 300 percent of the
1029 federal poverty line and expanded in 2008 to include parents
1030 of dependent children with incomes up to 116 percent of
1031 poverty.

1032 Now, I came onboard a couple years after that expansion,
1033 and I met some of the more than 97,000 Maryland parents who
1034 are covered, and I heard how the coverage allowed them to get
1035 back to work, to get over injuries that had happened, and I
1036 have met one like the mother on the Eastern Shore who said
1037 that because of coverage, ``Now if I have to pick up a
1038 prescription, it is not I am not going to have to have the
1039 money, I am going to have to take it away from groceries.''

1040 You know, hearing that from somebody where they don't have to
1041 take money from groceries in order to pay for health care is
1042 something that, you know, we deal with all the time at the
1043 State level, and I think it was the legacy of expanding
1044 Medicaid and having it be positive for the State that kind of
1045 overshadowed the implementation and kind of was what happened
1046 right before the Affordable Care Act passed.

1047 Now, despite this progress, major challenges face our
1048 health care system, challenges that are common to many States
1049 including significant numbers of citizens who are uninsured,
1050 substantial disparities in health care, rising health care
1051 costs.

1052 So the second thing I would like to talk about is public
1053 engagement in the State. From the day after the Affordable
1054 Care Act was signed, Maryland has been working with hundreds
1055 of interested people from doctors, hospitals, insurance
1056 brokers, businesses and others, carriers, to design and think
1057 through how this set of tools could work for the State. That
1058 is included in early consensus that it made sense for
1059 Maryland to operate its own health insurance exchange, expand
1060 Medicaid and take advantage of other options within the law.
1061 There was wide understanding that the various aspects of the
1062 law that included allowing kids to stay on their parents'
1063 coverage, improving seniors' access to prescription drugs

1064 also provided great benefits to the State. There was a major
1065 report in 2011 that led to the exchange getting established
1066 in the legislative session. There are nine members of the
1067 board including six public members, and we have had more than
1068 six advisory committees with all sorts of representation and
1069 engagement across the State. They have met dozens of times.
1070 We have had numerous public input sessions, and that led to a
1071 second law that passed in 2012 that adopted a series of
1072 recommendations, 27 recommendations on how to structure the
1073 exchange. All these things were up to Maryland under the way
1074 the law was structured.

1075 We have made multiple decisions to tailor the law.
1076 These include allowing insurance brokers to sell inside the
1077 exchange and continue to be paid directly by carriers like
1078 they are now, selling adult dental plans as an option for
1079 participants, designing the Maryland Health Connection as a
1080 consumer portal for access, and today Marylanders can send a
1081 text message of ``connected'' to be notified when coverage is
1082 available. We have been customizing Medicaid including women
1083 in private health plans to become newly eligible for Medicaid
1084 to stay in their private plans while having Medicaid dollars
1085 pay for their premiums, and in making all these individual
1086 decisions, and there are many more in my written testimony,
1087 we have had tremendous support from both CCIIO and Medicaid

1088 as part of the regular process that they use to engage with
1089 State officials, and that is extended across into development
1090 of an integrated IT system which we have been working on for
1091 the last 2 years and will really be a leap forward for the
1092 State in terms of access to care and coverage.

1093 The last thing I just wanted to mention is that there
1094 was an independent economic analysis by the University of
1095 Maryland, Baltimore County, on the impact of health care
1096 reform implementation in Maryland, and the study found that
1097 implementation would benefit the State economy by about \$3
1098 billion per year and create more than 26,000 jobs. It would
1099 benefit the State's budget by more than \$600 million through
1100 2020 through a series of mechanisms that are described in the
1101 testimony, and that it would generate more than \$800 million
1102 in additional tax revenue just because of the economic
1103 activity. This incoming revenue exceeds the State cost of
1104 the Medicaid expansion, both considering the direct expansion
1105 and the potential woodwork effect.

1106 So I go around the State talking about all this work
1107 that is being done in the State, and people don't ask me
1108 about the rules and the guidance and our decisions; they ask
1109 me about when help is coming, and we are really excited for
1110 this to really launch next year.

1111 Thank you.

1112 [The prepared statement of Dr. Sharfstein follows:]

1113 ***** INSERT 5 *****

|
1114 Dr. {Burgess.} The time is expired.
1115 We will note that there is a vote on the Floor. I
1116 believe, though, we have time for Dr. Allison to go ahead
1117 with your 5 minutes at which time we may take a brief recess
1118 for votes, so proceed, sir.

|
1119 ^STATEMENT OF ANDREW ALLISON

1120 } Mr. {Allison.} Thank you, Mr. Chairman. My name is
1121 Andy Allison. I am the Medicaid Director in Arkansas. I am
1122 also the President of the National Association of Medicaid
1123 Directors. I appreciate the committee's invitation to
1124 Arkansas and to other States represented on this panel to
1125 hear about these important issues.

1126 My written testimony, which I have submitted, addresses
1127 the two main challenges that Medicaid faces today. Foremost
1128 is the challenge of the fiscal duress brought on by long-term
1129 rates of growth in the Medicaid program and also by the loss
1130 to our tax base suffered as a result of the economic shift
1131 that occurred in this country beginning in 2008. The second
1132 challenge is really an opportunity, and that is, the option
1133 for States created in the Affordable Care Act to extend
1134 health insurance coverage to poverty-level adults through the
1135 Medicaid program. I want to focus my brief remarks this
1136 morning on the decision Arkansas faces about whether to take
1137 up this option.

1138 Governor Beebe expressed his support for the Medicaid
1139 expansion this summer. His decision came after CMS confirmed
1140 that the expansion remains optional and could be revoked in

1141 the future. His support for the expansion is driven by the
1142 benefits it would provide to State taxpayers, for the State's
1143 safety net, especially hospitals, and to the beneficiaries of
1144 the expansion themselves.

1145 Arkansas has a great many low-income uninsured adults,
1146 and we know that Medicaid saves lives, it improves health and
1147 it provides financial protection. The decision of whether to
1148 expand Medicaid in Arkansas now rests with its General
1149 Assembly, who meet beginning in January for three months. A
1150 supermajority, a 75 percent vote, is required to appropriate
1151 funds in Arkansas regardless of their source. This is the
1152 challenge. The legislature's decision may rest heavily on
1153 the financial implications of expansion for the State.
1154 Arkansas's estimates of the size of the Medicaid expansion
1155 use as a starting point the Urban Institute's March 2011
1156 state-level projections of the expansion. To those
1157 estimates, Arkansas added both costs and enrollees. The
1158 estimates include some crowd-out of private insurance,
1159 include the woodwork effect. Current eligibles represent
1160 about 14 percent of the expected new enrollment. It also
1161 includes the added administrative costs. Overall, the gross
1162 costs of the expansion total about \$900 million per year
1163 including both federal and State payments.

1164 But there are also expected savings for the State of

1165 Arkansas associated with the expansion. The first source of
1166 savings stems from our expectation that a number of
1167 populations currently served through traditional Medicaid
1168 will migrate or will otherwise transition into the new
1169 expansion group of eligibles, thereby qualifying for a much
1170 higher federal match rate. Key examples are individuals who
1171 currently enroll in Medicaid because of pregnancy or because
1172 they have suffered a catastrophic, high-cost medical event.
1173 In the future, these populations will already have health
1174 insurance when these changes in their health status occur,
1175 and there will be no reason for them to switch to the old
1176 eligibility categories, which carry with them a much lower
1177 federal match rate.

1178 The second source of savings to the State is a reduction
1179 in State spending on uncompensated care. If Medicaid
1180 expansion is approved, more than 200,000 additional Arkansans
1181 will have a payer for their health care. Consequently,
1182 uncompensated care provided by State programs outside of
1183 Medicaid should decline significantly. Program areas
1184 affected include health costs to the Department of
1185 Corrections as well as State subsidies to community health
1186 centers, community mental health centers and public
1187 hospitals.

1188 Finally, because of the unusual nature and size of the

1189 optional Medicaid expansion, Arkansas is making the unusual
1190 decision to consider its macroeconomic impact. If the State
1191 legislature approves the expansion, federal Medicaid payments
1192 to the State are expected to grow by around \$800 million per
1193 year. Given Arkansas's small size versus the federal tax
1194 base, Arkansas assumes in its estimates that federal Medicaid
1195 payments for the expansion will come from taxpayers in other
1196 States. Put simply, Arkansas's economy will be hundreds of
1197 millions of dollars larger if it chooses to expand Medicaid,
1198 and this difference in the State's tax base will have some
1199 impact on tax revenue. All told, we estimate that the fiscal
1200 benefits will outweigh the costs and the expansion on net is
1201 expected to save or increase State tax dollars by \$44 million
1202 in fiscal year 2014, \$115 million in State fiscal year 2015,
1203 and about \$700 million between now and 2025.

1204 Thank you, Mr. Chairman.

1205 [The prepared statement of Mr. Allison follows:]

1206 ***** INSERT 6 *****

|
1207 Dr. {Burgess.} The gentleman's time is expired.

1208 I would note that there is still over 7 minutes left on
1209 the vote on the House Floor, so if it is agreeable with
1210 everyone, we will start with questions. I would ask that
1211 members who feel it necessary to leave because they are so
1212 slow that it takes them 7 minutes or over 7 minutes to get to
1213 the Floor, that we do leave quietly, but the committee will
1214 remain in session and we will recess when there is literally
1215 no time left on the votes.

1216 So I will start with myself, and Director Cohen, if I
1217 could, sir, I ask you, on November 26 of this year, Health
1218 and Human Services released the long-awaited rule detailing
1219 the essential health benefits that must be covered by any
1220 health plan offering a plan in the PPACA exchange. While I
1221 understand this rule has far-reaching consequences on health
1222 care premiums, benefits that must be provided to those newly
1223 eligible for Medicaid and federal and State budgets. Now,
1224 according to the notice in the Federal Register, the rule was
1225 approved at the Centers for Medicare and Medicaid Services by
1226 Administrator Tavenner on August 1, 2012. That is 3 months
1227 before. Yet the rule did not receive approval from Secretary
1228 Sebelius and the Office of Management and Budget until 2
1229 weeks ago. So what this committee would like to know is, why

1230 did it take nearly 3 months for the Administration staff to
1231 conduct technical work and review and yet the public will
1232 have only 4 weeks to review during this period of public
1233 comment on the rule that was issued on November 26? And I
1234 would also note that this is a time of year where people's
1235 focus is generally on things other than long-awaited rules.
1236 So can you speak to that, sir?

1237 Mr. {Cohen.} Thank you, Chairman Burgess. I would be
1238 happy to. You know, we put out a bulletin on the essential
1239 health benefits quite some time ago and got comment on that
1240 bulletin and so the public and interested parties had an
1241 opportunity to provide public comment on essential health
1242 benefits before the proposed rule was put out. There were
1243 some changes in the proposed rule from what had been in the
1244 bulletin but by and large what is in the bulletin is what is
1245 in the proposed rule, so actually I think there has been
1246 ample opportunity for the public to comment on the rule, and
1247 they will have the additional formal comment period as you
1248 mentioned.

1249 Dr. {Burgess.} So it is your opinion that Wisconsin,
1250 Pennsylvania and Louisiana had actually during that 3-month
1251 hiatus from the time the rule left HHS and circulated through
1252 OMB and came back, they actually knew what the rule was going
1253 to be and could be confident that they knew what the rule was

1254 going to be and could begin to make their plans accordingly?

1255 Mr. {Cohen.} They had the bulletin, which laid out our
1256 approach to essential health benefits using the benchmark
1257 approach, which basically said as the law does that essential
1258 health benefits are based on what is in a typical employer
1259 plan and they knew that the State had the option to choose
1260 from a range of available benchmark plans. Yes, they knew
1261 that.

1262 Dr. {Burgess.} All right. I didn't plan to ask this
1263 question, but Mr. Smith, can you tell us, was Wisconsin
1264 absolutely confident that what came out in August was
1265 circulated in a bulletin or a pamphlet was going to be what
1266 the rule eventually would be?

1267 Mr. {Smith.} Well, again, I think we still have
1268 questions about what the essential health benefit package is.

1269 Dr. {Burgess.} Thank you. I accept that as your
1270 answer. That is going to be a no.

1271 So let me just ask you, Mr. Cohen, on November 20th, a
1272 paper that I don't normally read that is called the New York
1273 Times--some people have heard of it--published an article by
1274 Robert Pair that the essential health benefits rule had been
1275 delayed--I am quoting here--`had been delayed as the
1276 Administration tried to avoid stirring up criticism from
1277 lobbyists and interest groups in the final weeks of the

1278 presidential campaign.' ' Now, that is accurate that there
1279 was a presidential election between August 1, 2012, and
1280 November 26, 2012. That is a fair statement, is it not?

1281 Mr. {Cohen.} Yes. I believe President Obama was
1282 reelected.

1283 Dr. {Burgess.} Well, that being the case, was the rule
1284 delayed so as not to interfere with that happy occasion that
1285 you just referenced?

1286 Mr. {Cohen.} I am not aware of what Mr. Pair's sources
1287 might be for that and I am not aware that that happened, no.

1288 Dr. {Burgess.} Well, certainly for, you know, those of
1289 us who were preparing to lay down in the Elysian Fields of
1290 the Affordable Care Act, it did strike us as strange that the
1291 rule was available for discussion in August but not published
1292 as a rule until after Election Day, and not just under the
1293 auspices of the Affordable Care Act, there does seem to be a
1294 regulatory push now out of several federal agencies to get
1295 things moving and up off the deck now that the election is
1296 settled. I know that--I am not cynical but, you know, there
1297 are people in Washington who are and would look at that and,
1298 again, I don't read that newspaper, but apparently they felt
1299 that there was some relationship.

1300 Thirty-three months delay on the fundamental rule
1301 necessary for the operation of these exchanges does cause

1302 some of the people who are cynical in this town to repeatedly
1303 ask the question: what is the holdup? And this an important
1304 deal what you all are doing and it does seem to be--it
1305 appears to me that it is possible that these cynical people
1306 could be correct, that it was held up for political reasons.

1307 So what I am saying to you is, we are going to have a
1308 series of questions, and it is too long to go into here but I
1309 would appreciate--it has been hard to get information out of
1310 your agency, in all honesty, sir. The Governors have had
1311 trouble. Members of Congress have had trouble. I would
1312 appreciate the expeditious handling of those questions when
1313 they come to your attention.

1314 Mr. {Cohen.} We will do the best we can.

1315 Dr. {Burgess.} My time is expired. All right. The
1316 vote on the Floor is a motion to instruct conferees on the
1317 National Defense Authorization Act. The committee will stand
1318 in recess and will convene immediately after the last vote.

1319 [Recess.]

1320 Dr. {Burgess.} The committee will reconvene. The
1321 committee is reconvened, and the Chair recognizes the ranking
1322 member of the subcommittee, Mr. Pallone of New Jersey, 5
1323 minutes for questions, sir.

1324 Mr. {Pallone.} Thank you, Mr. Chairman. The title of
1325 this hearing is: ``State of Uncertainty: Implementation of

1326 PPACA's Exchanges and Medicaid Expansion.' I want to say,
1327 Mr. Chairman, that I think the title is provocative and I
1328 think it does a disservice to the progress and the people of
1329 this country with regard to the ACA. The fact is, the ACA
1330 has prevailed and it is the law of the land. It means that
1331 people have already experienced positive changes from the
1332 Affordable Care Act, whether it is through the elimination of
1333 lifetime limits, the ability to stay on their parents' health
1334 insurance plan, coverage of preventative benefits with no
1335 cost sharing. Lower prescription drugs costs are another
1336 provision of this law. In any case, the Affordable Care Act
1337 is improving the lives of Americans already, and over the
1338 next decade, 30 million Americans who otherwise would be
1339 uninsured could have access to health care. Millions more
1340 will be put in charge of their health care as opposed to
1341 being at the mercy of insurance companies and the arbitrary
1342 limits and fine print denying coverage for critical services
1343 or overly burdensome cost sharing. And States have the
1344 options of flexibility to help make this a reality for their
1345 residents, and CMS has been working with those States that
1346 have been ready and wanting to move forward and make this
1347 work.

1348 My questions are to Mr. Cohen and Ms. Mann. Critics
1349 have cited a dearth of information, lack of answers, an

1350 inability to move forward. You have heard that from some of
1351 the other panelists. Can you talk about your outreach
1352 efforts to States, the engagement with them, the types of
1353 assistance you have provided over the past 2 years?

1354 Mr. {Cohen.} Thank you, Ranking Member Pallone. I am
1355 happy to do that.

1356 Just in 2012 alone, CCIIO has hosted 119 different
1357 events of different kinds for States that total approximately
1358 215 hours of technical assistance. We have done 69 webinars
1359 that over 3,000 State people have participated in. We have
1360 48 teleconferences. Over 2,500 State workers have
1361 participated in those. And we have held two in-person
1362 conferences where people have come in, over 1,000 attendees
1363 have come to those, so we have been--in addition to that, we
1364 are on the phone literally every day with people from the
1365 States helping them, answering their questions, and enabling
1366 them to move forward.

1367 Mr. {Pallone.} I appreciate that.

1368 Ms. Mann, and then I want to ask Dr. Sharfstein.

1369 Ms. {Mann.} Sure. Thank you, Mr. Pallone. You know, I
1370 think it has been a very different experience than past
1371 experiences in CMS where you usually put out guidance, put
1372 out regulations and hope for the best. We have been very
1373 aggressive with our partners at CCIIO to reach out to States

1374 and to bring them in partly our decision-making and certainly
1375 their decision-making as they are going forward by topic, by
1376 groups of States as well as very much individually. We do
1377 gate reviews on their systems developments individually with
1378 States. We do that together with CCIIO so that we are
1379 providing some coordinated technical assistance and support.
1380 We have pulled together work groups and learning
1381 collaboratives of groups of similar interest so that we can
1382 help them think about how to problem-solve with respect to
1383 the issues that are utmost in their minds, and we have
1384 provided and increasingly are providing different tools for
1385 them so that as they are moving forward looking at our
1386 regulations, looking at our guidance and thinking about how
1387 to implement, they have easier ways of doing it than if they
1388 just reinvented the wheel and did it on their own.

1389 Mr. {Pallone.} All right. Thank you.

1390 Dr. Sharfstein, can you talk about the interactions you
1391 have had with the Centers for Consumer Information and
1392 Insurance Oversight in preparing your State-based exchange
1393 for Maryland?

1394 Dr. {Sharfstein.} Sure. We have had a terrific
1395 interaction. There are regular opportunities for all States
1396 that we have taken advantage of, and we have regular
1397 consultation, and what we have been really impressed with is

1398 that both CCIIO and CMS have really met us where we are on a
1399 particular issue. Sometimes it is general help. Sometimes
1400 it is very, very specific. And they have been really willing
1401 to move at the speed that we are moving on a particular issue
1402 and work together across organizations. So from Maryland's
1403 perspective, the assistance we have gotten from HHS and the
1404 spirit of cooperation and support has allowed us to really
1405 customize implementation in a way we think works for our
1406 State.

1407 Mr. {Pallone.} Thank you.

1408 I am going to try to get a question in to Mr. Allison.
1409 Despite claims to the contrary, the ACA was fully paid for
1410 when passed, and if repealed would actually increase this
1411 country's budget deficit by more than \$100 billion, and the
1412 ACA contains strong cost-containment measures aimed at
1413 reducing health care costs the right way by improving care.
1414 I was interested in Arkansas's payment reform efforts. It
1415 seems aligned with the activities of the Center for Medicare
1416 and Medicaid Innovation. Could you tell us a little more
1417 about these payment reforms and how that would bring down
1418 costs, not just slash benefits or cost-shift?

1419 Mr. {Allison.} Yes, absolutely. We believe in Arkansas
1420 that the incentives that we face and the activities that we
1421 are engaged in and our payment improvement initiative are

1422 wholly aligned with the objectives of the Center for Medicare
1423 and Medicaid Innovation, CMMI. We are engaged in moving away
1424 from fee-for-service in order to pay for outcomes in health
1425 care instead of the process that we currently pay for. We
1426 are paying for team-based outcomes. We are engaged in
1427 population-based reforms. We are looking for patient-
1428 centered care, and if we look for that, that means we are
1429 going to have to pay for it. We haven't done that in the
1430 past, and we are engaged in dramatic and sweeping changes
1431 working also with our private health insurance partners in
1432 Arkansas. We have worked very closely with CMS to make the
1433 first of these changes implementing in October through our
1434 State plan, not through waiver, an incentive-based episodic
1435 treatment payment reform that incentivizes for ADHD, for
1436 perinatal care and for upper respiratory infection,
1437 concentrated accountability and incentives for team-based
1438 care, and that happened very quickly and we appreciate CMS's
1439 support in that.

1440 Mr. {Pallone.} Thank you.

1441 Dr. {Burgess.} The gentleman's time is expired. I
1442 recognize the gentleman from Illinois, Mr. Shimkus, for 5
1443 minutes for your questions, sir.

1444 Mr. {Shimkus.} Thank you, Mr. Chairman. Thanks for
1445 being here. When you hear both sides, it is kind of like a

1446 Jekyll and Hyde. Will this turn out to be the Jekyll or will
1447 this turn out to be the Hyde, and I don't think we really
1448 know yet, unfortunately.

1449 The Patient Protection and Affordable Care Act implies
1450 that health insurance will be affordable in the exchanges.
1451 The claim put forth was that if you like your insurance, you
1452 can keep it, and that health care costs would go down. That
1453 is how it was sold to us, most of us, some of us reading the
1454 bill but most of us passing the bill before we could read it.
1455 The CMS recently proposed a 3.5 percent fee on all plans
1456 offering plans in a federal exchange. Are you afraid this
1457 fee will get passed on directly to individuals and families
1458 purchasing coverage in your State? And this is a question
1459 for Mr. Smith and Mr. Greenstein and Mr. Alexander, and if
1460 you could be short, because there is a couple more questions
1461 I want to ask.

1462 Mr. {Smith.} Well, they will be passed not only on to
1463 the purchaser in the exchange but these also apply to
1464 Medicaid managed care plans as well, so there is a direct
1465 impact on the State budget for these new fees.

1466 Mr. {Shimkus.} So more costs?

1467 Mr. {Smith.} Yes, sir.

1468 Mr. {Greenstein.} Yes, it puts these plans at a
1469 competitive disadvantage as well, and we fully expect that

1470 those costs get passed on rather than absorbed with already
1471 small margins for the plans that participate, at least in
1472 Medicaid managed care.

1473 Mr. {Shimkus.} Great. Mr. Alexander?

1474 Mr. {Alexander.} The short answer is yes. I think I
1475 would concur with my colleagues.

1476 Mr. {Shimkus.} Great. I appreciate the shortness of
1477 those answers.

1478 Mr. Cohen and Ms. Mann, do you know what our national
1479 debt is right now? Just the national debt. It is on every
1480 debt website in the world. Sixteen trillion dollars. Do you
1481 know what our deficit spending of this country has been the
1482 last 4 years? In essence, how much we have spent more than
1483 we have taken in? You don't know. Do you know?

1484 Ms. {Mann.} I don't have that information right here.

1485 Mr. {Shimkus.} Okay. Mr. Cohen, do you know?

1486 Mr. {Cohen.} I don't know the exact number.

1487 Mr. {Shimkus.} Well, in 2009, it was \$1.4 trillion. In
1488 2010, it was \$1.2 trillion. In 2011, \$1.3 trillion. That is
1489 more spending than we have taken in. In 2012, I don't know,
1490 \$1 trillion. Already this year, first quarter, first two
1491 months, \$292 billion more in spending than we have taken in,
1492 which if you push that through to the full year, it is
1493 probably \$1.7 trillion additional deficit added to the \$16

1494 trillion debt. That is part of this debate because Medicare
1495 and Medicaid are entitlement programs, and that is part of
1496 the reason why we are going to be here until Christmas and
1497 New Year's and have all the battles.

1498 Let me go to just--again, for Mr. Smith, Mr. Alexander
1499 and Mr. Greenstein, and this is really about the State of
1500 Illinois now. Estimates from earlier this year have the
1501 State of Illinois unpaid bills growing to \$34 billion in 5
1502 years. That will be \$2 billion more than Illinois's total
1503 projected revenue that year. The biggest problem? Can you
1504 guess what the biggest problem is, Mr. Smith?

1505 Mr. {Smith.} Medicaid.

1506 Mr. {Shimkus.} Mr. Greenstein?

1507 Mr. {Greenstein.} Medicaid.

1508 Mr. {Shimkus.} Mr. Alexander?

1509 Mr. {Alexander.} Medicaid.

1510 Mr. {Shimkus.} Illinois's Medicaid has been on an
1511 unsustainable path for years and expected to increase more
1512 than 40 percent over the next 5 years to about \$12 billion by
1513 2017. Overall, this will create an estimated \$21 billion in
1514 Medicaid payment backlogs, and this figure doesn't even
1515 factor in the unknown additional costs from new Medicaid
1516 requirements from--what would you guess, Mr. Smith?

1517 Mr. {Smith.} Medicaid.

1518 Mr. {Shimkus.} From the new health care law and the
1519 Affordable Care Act. Mr. Alexander?

1520 Mr. {Alexander.} I concur.

1521 Mr. {Shimkus.} What do you believe will be the result
1522 for Medicaid providers and patients if these backlogs remain?
1523 What do you think, Mr. Smith?

1524 Mr. {Smith.} Well, again, I think we have been looking
1525 at what happens to the Medicaid rates themselves. We are
1526 expecting to have to--again, I know there is a lot of
1527 discussion about the FMAP for the newly eligibles, but this
1528 affects the entire program. Otherwise we will not have
1529 providers who will see Medicaid patients unless the rates go
1530 up.

1531 Mr. {Shimkus.} Mr. Greenstein?

1532 Mr. {Greenstein.} Yeah, I worry about the participation
1533 in Medicaid from the provider perspective, but I also worry
1534 about programs like education that get crowded out within the
1535 context of the State's budget because we continue to consume
1536 a greater proportion of the overall budget in our health care
1537 costs.

1538 Mr. {Shimkus.} Mr. Alexander?

1539 Mr. {Alexander.} I concurred with the last one, so I
1540 was going to say I concur, but I would like to just add to
1541 Mr. Greenstein's that the crowding out of other priorities is

1542 extremely important for Pennsylvania infrastructure. It's
1543 extremely important in transportation. So the growth of
1544 these programs growing to 10 percent while revenues are
1545 growing at 2 percent keep crowding out education,
1546 transportation and thus have a direct impact on jobs.

1547 Mr. {Shimkus.} Thank you very much. Yield back my
1548 time, Mr. Chairman.

1549 Dr. {Burgess.} I thank the gentleman for yielding. The
1550 Chair now recognizes the gentlelady from California, Ms.
1551 Capps, for 5 minutes for the purposes of questioning.

1552 Mr. {Waxman.} Mr. Chairman.

1553 Dr. {Burgess.} The Chair recognizes the ranking member
1554 of the full committee, Mr. Waxman. I am sorry. I didn't see
1555 you sitting there.

1556 Mr. {Waxman.} Thank you, Mr. Chairman. I thought I was
1557 next.

1558 Medicaid is an expensive program but we have a lot of
1559 people who are very poor in this country, and we can save a
1560 lot of money if we didn't give them health care. Now, I
1561 suppose, Mr. Smith, Mr. Greenstein and Mr. Alexander, you
1562 think the way to solve the Medicaid problem is to put it in a
1563 block grant. Is that correct? Mr. Smith, do you like a
1564 block grant? Yes or no.

1565 Mr. {Smith.} Yes.

1566 Mr. {Waxman.} Mr. Greenstein?

1567 Mr. {Greenstein.} If given the choice, I would take it,
1568 gladly.

1569 Mr. {Waxman.} Mr. Alexander?

1570 Mr. {Alexander.} Absolutely.

1571 Mr. {Waxman.} Okay. You three would like a block grant
1572 on Medicaid. That simply shifts the costs. So the States
1573 can cut back on services for these people and the disabled
1574 and poor will go without health care. Your idea is not going
1575 to succeed. That was one of the issues in the presidential
1576 campaign, and you lost.

1577 So we have Medicaid, and let us accept that fact. You
1578 are running the programs. You ought to be supporting the
1579 program you are running in your States. The Medicaid
1580 expansion in the Affordable Care Act is a tremendous step
1581 forward for our health care system, and it is going to
1582 improve the lives of tens of millions of Americans. The
1583 expansion will dramatically reduce uncompensated-care costs
1584 in States around the country. It will provide States with
1585 extremely generous enhanced match rate from the federal
1586 government. We crafted this piece of Affordable Care Act to
1587 ensure that Medicaid expansion would not only be good for
1588 Americans' health but for the health of State budgets.

1589 And a new report from the Kaiser Family Foundation shows

1590 just how beneficial this expansion will be to States around
1591 the country. The report found that over the next decade,
1592 with the federal government paying for well over 90 percent
1593 of the cost, Arkansas will reduce its uninsured population by
1594 nearly 150,000, Louisiana by 270,000, Maryland by 140,000,
1595 Pennsylvania by over 310,000, and Wisconsin by nearly
1596 125,000. I doubt that a block grant would accomplish those
1597 goals. The report also found that these States could
1598 dramatically reduce uncompensated-care costs through the
1599 Medicaid expansion, over \$25 million in savings in Arkansas,
1600 over \$260 million savings in Louisiana, nearly \$180 million
1601 in savings in Maryland, over \$875 million in Pennsylvania
1602 that would be saved, nearly \$250 million in Wisconsin. These
1603 are big, staggering, impressive numbers.

1604 But even more impressive is the fact that in two of the
1605 States here today, the report found that given the generous
1606 federal match rate expanding Medicaid and dramatically
1607 reducing the number of uninsured would actually decrease the
1608 State's overall Medicaid budget, saving an additional \$250
1609 million in Wisconsin and \$1.75 billion in Maryland.

1610 Mr. Allison, I assume you can talk about the importance
1611 of engaging in a detail that factual comprehensive analysis
1612 of the Medicaid expansion in Arkansas and the conclusions it
1613 led you to. You think it is going to be a good deal for your

1614 State, don't you?

1615 Mr. {Allison.} I believe it is going to be a very good
1616 financial deal for the State of Arkansas.

1617 Mr. {Waxman.} Well, these expansions are going to be a
1618 good deal but it seems to me that the three witnesses in the
1619 center of the table have an ideological view that they would
1620 like the world redone.

1621 Now, the Affordable Care Act is a pretty important piece
1622 of legislation, and Dr. Sharfstein, since your exchange
1623 planning is well underway, I understand that insurance
1624 companies are sending in a great number of letters saying
1625 they want to sell insurance in the exchange. And I am
1626 curious to know, are you concerned that insurers won't show
1627 up or do you think they are going to show up? What are you
1628 seeing so far?

1629 Dr. {Sharfstein.} We asked insurers in Maryland to send
1630 letters of intent to participate in the exchange, and we have
1631 gotten more insurers interested than actually serve the
1632 Maryland market now. So we think that under the Affordable
1633 Care Act in 2014, it is going to be drawing new insurers in
1634 Maryland including, you know, plans that are very focused on
1635 better health, improved value, and it is going to be a real
1636 positive for the market in the State.

1637 Mr. {Waxman.} Well, it just shows, if we have more

1638 insurance companies willing to offer insurance policies, the
1639 competitive model for the consumer choice is going to be more
1640 successful under those circumstances. I submit that the
1641 competitive model that Mr. Greenstein indicated he would like
1642 to see, which is called a consumer market-driven health care
1643 reform, is not going to work for Medicaid patients. Nobody
1644 is going to be vying for those Medicaid patients and all the
1645 range of services that Medicaid provides.

1646 The ACA has been law for nearly 3 years now. It has an
1647 impressive list of accomplishments, and the basic reforms are
1648 still ahead of us. After full implementation, over 30
1649 million American uninsured will get quality, affordable care,
1650 etc. But the point I want to make is that many of us fear
1651 that the purpose of this hearing is simply to say that we
1652 can't move forward, we can't implement the law, that somehow
1653 we don't have the information needed to do it. That is flat-
1654 out wrong. It seems to me this is just the latest approach
1655 to try to undo the Affordable Care Act. Republicans have
1656 failed to repeal the law. They didn't want to pass it in the
1657 first place. Then they wanted to repeal it. They didn't win
1658 the presidential election. They didn't find that the law was
1659 declared unconstitutional. Let us not buy into this next
1660 line of attack that the law must be delayed. Let us
1661 recognize that we have got a law. Whether you wanted it or

1662 not, it is the law of the land. Many of us think it is going
1663 to do a lot of good. We are seeing a great deal of success
1664 already, and I think this hearing is just fitting for this
1665 Congress. It is a Groundhog Day Congress over and over and
1666 over again--`It can't work. We can't do it. We can't
1667 afford to cover people. Our debt is too great.' Well, let
1668 us make this thing work.

1669 Dr. {Burgess.} The gentleman's time is expired.

1670 Mr. {Smith.} May I respond, Mr. Chairman?

1671 Dr. {Burgess.} Please.

1672 Mr. {Waxman.} Wait a second, Mr. Chairman. If we are
1673 going to have the witnesses start responding, then I am going
1674 to be able to respond to them, I presume. My time is
1675 expired. I had the opportunity to use my time as I saw fit,
1676 and I don't think this is an open-ended question to have
1677 witnesses respond, unless you guarantee that I can come back
1678 and respond to them. If you want to open the hearing up to a
1679 two-way exchange, I am willing to do that, but you do have
1680 other members waiting to be recognized.

1681 Dr. {Burgess.} I do think as a matter of courtesy that
1682 we ought to allow our witnesses to respond. That has long
1683 been the practice in this committee. But as the ranking
1684 member sees difficulty with that, we will recognize Mr.
1685 Murphy and perhaps Mr. Smith, if you will hold that thought,

1686 we will get a chance for you to visit with us.

1687 Mr. Murphy, you are recognized for 5 minutes for
1688 questions, sir.

1689 Mr. {Murphy.} Thank you, Mr. Chairman.

1690 Mr. Alexander, you are from Pennsylvania and so am I,
1691 and you recognize that this is the law of the land, the
1692 Affordable Care Act? Am I correct on that?

1693 Mr. {Alexander.} Yes.

1694 Mr. {Murphy.} Are you trying to stop or undo its
1695 implementation?

1696 Mr. {Alexander.} I don't think anyone is trying to stop
1697 anything. I think we are trying to make sense of it.

1698 Mr. {Murphy.} So let me ask you a number of things you
1699 said in your testimony, I want to ask you about that. You
1700 identified a number of problems that Pennsylvania is having,
1701 and certainly the other witnesses are welcome to respond to
1702 these too, but a number of those key ones, I wanted to ask
1703 about. You had mentioned that we have the CHIP program, the
1704 Children's Health Insurance Program, in Pennsylvania. I know
1705 when I was a State senator, I worked on that as well. And
1706 you feel that actually works in a less costly manner and has
1707 good quality in the program. Is this something that you are
1708 able to ask--according to the law, are you able to ask for a
1709 waiver to use that instead of the other program right now as

1710 the law stands? Do you know?

1711 Mr. {Alexander.} I don't know of any waiver to be able
1712 to make that change.

1713 Mr. {Murphy.} Is that something you would recommend
1714 that Congress address in terms of allowing for waivers?

1715 Mr. {Alexander.} I think so. I think if things are
1716 working in the State, they should be kept that way, and
1717 especially if recipients are happy.

1718 Mr. {Murphy.} Ms. Mann, are you aware, are States
1719 allowed any waivers for programs like that if they have a
1720 problem they think is working well?

1721 Ms. {Mann.} There is a wide range of waivers that are
1722 available for States. One of the things about the changes in
1723 the law that brings the CHIP kids over into the Medicaid
1724 program is right now their younger siblings are already
1725 eligible for Medicaid, so one of the reasons for the changes
1726 is to put families together. Right now we have children in
1727 the same family, same income--

1728 Mr. {Murphy.} I appreciate that. I am not opposed to
1729 bringing people together.

1730 Ms. {Mann.} --they are in different programs, depending
1731 upon their age.

1732 Mr. {Murphy.} I know when we did the prescription drugs
1733 bill for Medicare, Pennsylvania already had a program for

1734 that and we were able to work in legislation to make sure
1735 that they did work smoothly, so that might be something we
1736 might want to work on in the future, and I would certainly
1737 hope that you can get together with Mr. Alexander.

1738 Mr. Alexander, you also said you can't use an asset
1739 test. What do you think is the benefit of having an asset
1740 test and what do you see in the law that restricts that?

1741 Mr. {Alexander.} Well, an asset test is a program
1742 integrity tool to be able to ferret out if families or
1743 individuals have high incomes or assets that would--not
1744 incomes but assets that would--that they shouldn't be on the
1745 program. So for example--

1746 Mr. {Murphy.} Such as?

1747 Mr. {Alexander.} So for example, if somebody, you know,
1748 owned a large home and cars and they had these assets or
1749 specific accounts, we would be able to utilize them, the same
1750 way we do with the food stamp program.

1751 Mr. {Murphy.} So you would like those same rules to be
1752 able to be applied?

1753 Mr. {Alexander.} It should be an option. It was an
1754 option prior and it should be an option.

1755 Mr. {Murphy.} Would you see similar things with regard
1756 to presumptive eligibility as another way of making sure that
1757 people who need these programs are eligible?

1758 Mr. {Alexander.} It is another program integrity
1759 measure to be able to--presumptive eligibility would presume
1760 that people are eligible. We still don't have guidance from
1761 CMS as to who would be on the hook for that money if these
1762 individuals later on are found not eligible. Would the State
1763 be paying that bill? Would the federal government be paying
1764 that bill? I don't think anybody should be paying that bill.

1765 Mr. {Murphy.} And I'm assuming you would ask for the
1766 same sort of assistance with what you referred to as adoption
1767 of passive Medicaid renewals, duplication of efforts, one-
1768 size-fits-all? Are you asking, Congress, Mr. Secretary, that
1769 one of the things we should do is either find out if we are
1770 missing something in the law to clarify that and in absence
1771 of that to look to this committee to pass some laws or rules
1772 that would help you do that so you are not adding to your
1773 costs if you are able to do things better?

1774 Mr. {Alexander.} I think that would be very helpful.
1775 The more you engage the States, the better. We are on the
1776 ground. We know how to run these programs, and I think that
1777 the more information you have from all of the States be very
1778 important. The purpose in these programs is to provide
1779 quality care to low-income individuals, and we at the State
1780 level have to be vigilant in terms of being able to prevent
1781 people that have the ways and means to provide for

1782 themselves.

1783 Mr. {Murphy.} Thank you.

1784 Mr. Smith, do you have any comments on those questions?

1785 Mr. {Smith.} I would agree with Secretary Alexander. I
1786 think he summarized them very well.

1787 Mr. {Murphy.} Thank you.

1788 The other witness, Mr. Greenstein?

1789 Mr. {Greenstein.} Sure. I would echo that sentiment in
1790 that every day with a finite budget, at least in our State,
1791 we don't have the option to run large deficits so we have to
1792 balance our budget every year, and that if there are resource
1793 decisions to make on how we allocate those resources, we
1794 would like to see those resources focused on the people that
1795 need them the most rather than those that have the means to
1796 pay for part of the care themselves.

1797 Mr. {Murphy.} Thank you. I see I am out of time.

1798 Mr. Chairman, I would hope you would ask the witnesses
1799 who have some specific recommendations that we might do some
1800 legislative actions that they would submit to you in writing
1801 some of those recommendations. And with that, I yield back,
1802 sir.

1803 Dr. {Burgess.} The record will remain open for 5
1804 legislative days for witnesses to submit.

1805 The Chair recognizes the chairman emeritus of the full

1806 committee, Mr. Dingell.

1807 Mr. {Dingell.} Mr. Chairman, I thank you for your
1808 courtesy.

1809 Mr. Cohen, we appreciate you being here this morning,
1810 and I have the following questions to be answered yes or no.
1811 Recently we have heard a lot of talk about a \$63 ACA fee that
1812 will go into the Reinsurance Fund. In your opinion, is this
1813 a tax? Yes or no.

1814 Mr. {Cohen.} No.

1815 Mr. {Dingell.} It is not in the U.S. Internal Revenue
1816 Code. Is that right?

1817 Mr. {Cohen.} Correct.

1818 Mr. {Dingell.} So we can call this a fee as opposed to
1819 a tax. Is that right?

1820 Mr. {Cohen.} Yes.

1821 Mr. {Dingell.} Now, CMS had the authority to set this
1822 free through Section 1341 of ACA. Is that true?

1823 Mr. {Cohen.} Yes.

1824 Mr. {Dingell.} Now, Mr. Cohen, this section does not
1825 set the per-insured fee, instead, it sets out a total amount
1826 to be raised. Is that right?

1827 Mr. {Cohen.} Yes.

1828 Mr. {Dingell.} This fee will be \$63 in 2014, lower for
1829 2015 and 2016. Is it true that this fee is short term and

1830 will end after the total amount is realized in 3 years?

1831 Mr. {Cohen.} Yes.

1832 Mr. {Dingell.} Now, Mr. Cohen, I happen to be just a
1833 poor Polish lawyer from Detroit so I want to make sure I
1834 understand this correctly. The fee goes into a Reinsurance
1835 Fund that will stabilize premium costs in individual
1836 insurance markets. Is that correct?

1837 Mr. {Cohen.} Yes.

1838 Mr. {Dingell.} Now, Mr. Cohen, this will help ACA to
1839 provide funds to insurance companies who deal with a large
1840 amount and a large number of vulnerable populations, those
1841 with serious preexisting conditions and high health care
1842 costs. Is that right?

1843 Mr. {Cohen.} Yes.

1844 Mr. {Dingell.} So essentially it is a reinsurance fund.
1845 Is that right?

1846 Mr. {Cohen.} It is.

1847 Mr. {Dingell.} Now, Mr. Cohen, this fee will lower
1848 insurance premiums in the individual market because insurers
1849 will not have to factor in the costs of disproportionate high
1850 costs of enrollment of high-risk patients. Is that correct?

1851 Mr. {Cohen.} Yes.

1852 Mr. {Dingell.} And isn't it true that this in turn will
1853 benefit employer plans and employees with stable prices

1854 because they will no longer have to pay for the cost shift
1855 that occurs when there are people out there without the
1856 insurance or the means to pay for health care? Yes or no.

1857 Mr. {Cohen.} Yes, it will.

1858 Mr. {Dingell.} Now, at the end of the day, this fee
1859 guarantees those in dire need of insurance or constituents
1860 with preexisting conditions are covered and by so doing we
1861 actually lower and stabilize the cost of health care for all
1862 of our citizens. Is this correct?

1863 Mr. {Cohen.} Yes.

1864 Mr. {Dingell.} Thank you, Mr. Cohen.

1865 Now I want to say a few things, Mr. Chairman. We have
1866 the law of the land, the Affordable Care Act, and I am
1867 hearing no end of carping and complaining about it, but the
1868 hard and simple fact of the matter is that the health care
1869 costs in this country are running away from us and will
1870 destitute the Nation. We have to do something to get it
1871 dealt with. We have to get all the people covered and we
1872 have to see to it that we deal with the problems of
1873 inadequate health care for our people in the future. This is
1874 a very serious matter. It is going to attack almost every
1875 single program including Medicare and Medicaid, and the costs
1876 that the State are being compelled to meet with regard to
1877 Medicaid.

1878 I find myself very distressed because I feel that I am
1879 kind of in the company of a bunch of people who are looking
1880 at the donut and seeing only the hole. You know, we confront
1881 a situation where we have to address these problems by making
1882 intelligent investments, and one of the things that I find
1883 that terrifies me is, we have got a lot of people in this
1884 country who can look and who can see the cost of everything
1885 but they can't see the value of anything, and the value of
1886 what we are trying to do here is to see to it that everybody
1887 has health care, to see to it that the health care of this
1888 country is affordable and available to all of our people and
1889 to see to it that the people of this country have a system
1890 which makes available to the ordinary citizen the right of
1891 health care, and it is, in my view, a right. It is not a
1892 privilege. There are a lot of people around here who seem to
1893 look at it as a privilege and they will do everything they
1894 can to save money on seeing to it that some other poor
1895 bastard doesn't have health care. So I am hopeful that we
1896 will look at this as an investment in the future of the
1897 country and that we will try and do something to see to it
1898 that the health care in this country, which potentially is
1899 the greatest and the best in the world, is shared amongst the
1900 people and that they are not denied this and they are not
1901 dying because they don't have health care.

1902 So I hope that this hearing will lead us to an
1903 understanding of these points, and I yield back the balance
1904 of my time.

1905 Dr. {Burgess.} The gentleman yields back. At this time
1906 I recognize the gentleman from Louisiana, Dr. Cassidy, for 5
1907 minutes for questions.

1908 Dr. {Cassidy.} Just so folks now, we have had some
1909 effectively implied allegations that some of us don't care
1910 about access to affordable care. I actually am a doctor who
1911 Tuesday and Monday will be in a safety-net hospital for the
1912 uninsured or the poorly insured, which includes Medicaid.
1913 And so just let us get that on the record.

1914 I have got lots of questions so hopefully I can run
1915 over. Mr. Cohen, I am not clear. Will CMS propose something
1916 about allowing premiums to go into health savings accounts?
1917 Will that money of the premium which goes into the health
1918 saving account, will that be considered as regards the MLR?
1919 You follow what I am saying? So Medical Loss Ratio, will
1920 that--please.

1921 Mr. {Cohen.} Yes, it will be considered first dollar
1922 coverage for purposes of the MLR to the extent that it is
1923 spent.

1924 Dr. {Cassidy.} So if someone does not spend their money
1925 in their health savings account, the insurance company does

1926 not get credit for an expenditure as regards the MLR?

1927 Mr. {Cohen.} That is right.

1928 Dr. {Cassidy.} So if somebody is frugal and doesn't go
1929 and buy overpriced goods, does preventive medicine on their
1930 own, takes care of themselves, keeps their weight down, etc.,
1931 the insurance company will be penalized?

1932 Mr. {Cohen.} No, they are not penalized.

1933 Dr. {Cassidy.} But it won't count against the MLR, and
1934 you are going to come back and take a portion of that and you
1935 are going to come back and make them rebate that cost. Is
1936 that correct?

1937 Mr. {Cohen.} Well, the Medical Loss Ratio provision of
1938 the 80/20 rule requires that insurance companies spend 80
1939 cents of every premium dollar on actual health care. If the
1940 money isn't spent--

1941 Dr. {Cassidy.} --deposited in the HSA does not count as
1942 an expenditure, it is only if the patient spends the money.

1943 Mr. {Cohen.} Right.

1944 Dr. {Cassidy.} So we are trying to hold down cost but
1945 we are basically putting in incentives to spend the money.
1946 By the way, it is hard to keep a straight face when Mr.
1947 Waxman speaks about access to affordable care. The only
1948 thing I have heard about this bill is that premiums have gone
1949 by \$2,500 since it was passed. It is kind of curious, isn't

1950 it?

1951 Dr. Sharfstein, only 65 percent of doctors in Maryland
1952 accept Medicaid patients. That is a statistic I can give you
1953 the source from, Health Affairs. How many of those Medicaid
1954 patients unable to find a primary care doctor seek their care
1955 in an emergency room? Do we know those statistics? Some
1956 States do know that statistic.

1957 Dr. {Sharfstein.} I don't know if I have a specific
1958 answer to that.

1959 Dr. {Cassidy.} Then let me go on because I have limited
1960 time. I don't mean to be rude to any of you. I apologize.

1961 Now, the issue is, in Maryland Medicaid, I presume there
1962 is no deductible.

1963 Dr. {Sharfstein.} Correct.

1964 Dr. {Cassidy.} Now, you all guys make out like a
1965 bandit. If I was a big blue State, I would be all for this
1966 expansion, because according to Kaiser Family Foundation, you
1967 are going to save \$500 million over 10 years. Why wouldn't
1968 you be for it? But let me put myself in the role of someone
1969 that I might be seeing Tuesday morning in a hospital if I
1970 were in Maryland instead of Louisiana. You are making 140
1971 percent of federal poverty level. The State grabs the money.
1972 Man, we are glad. It helps our budget. But now I am on the
1973 exchange. I have a \$2,000 deductible. As Mr. Smith points

1974 out, I am paying \$600 a year in a premium. Do we really
1975 think that family at 140 percent of federal poverty can
1976 afford that \$2,000 deductible?

1977 Dr. {Sharfstein.} Well, from my perspective, this has a
1978 lot to do with compared to what. Someone at--

1979 Dr. {Cassidy.} Compared to your current Medicaid plan.

1980 Dr. {Sharfstein.} A hundred and forty percent, there is
1981 no access to Medicaid, so they have no--

1982 Dr. {Cassidy.} Well, I thought you said in your
1983 testimony that you have up to 200 percent of poverty level in
1984 your Medicaid plan.

1985 Dr. {Sharfstein.} No, we do not.

1986 Dr. {Cassidy.} Oh, then I misunderstood.

1987 Dr. {Sharfstein.} For an adult. So they had no access.
1988 So we are able to give them affordable access through a
1989 subsidy.

1990 Dr. {Cassidy.} Now, okay, let us just take that person
1991 at 140 percent. Do we really think they are going to be able
1992 to afford that \$2,000 deductible? By the way, if I was an
1993 insurance plan, I would be moving to your State too. Now we
1994 have the federal government telling you you have to buy
1995 insurance. It isn't competition; it is a forced market. Do
1996 we really think that family at 140 percent of federal poverty
1997 can afford that \$2,000 deductible?

1998 Dr. {Sharfstein.} Well, we certainly think that there
1999 is a lot of value for them, and part of what we are going to
2000 be doing and what we are working with, so many people in
2001 Maryland, is to figure out how to develop an outreach plan
2002 that engages--

2003 Dr. {Cassidy.} Even though it is going to cost them
2004 \$2,000? I tell you, I like Mr. Smith's line. It is not a
2005 percentage, it is the dollar amount, and when you are at 140
2006 percent of federal poverty, \$2,000 might as well be \$50,000.

2007 Dr. {Sharfstein.} It is not every family that has to
2008 pay \$2,000.

2009 Dr. {Cassidy.} Only if they access the insurance
2010 portion.

2011 Let me go to Mr. Allison--Dr. Allison. I am sorry. Dr.
2012 Allison, in your testimony, you mentioned that the State of
2013 Arkansas will have to come up with \$500 million between
2014 January and June 14 to implement this plan. Is that correct?

2015 Mr. {Allison.} That is not correct, sir. What will--

2016 Dr. {Cassidy.} That is your testimony.

2017 Mr. {Allison.} That is not what the testimony says.
2018 The testimony says that the legislature will have to
2019 appropriate \$500 million for the second half of State fiscal
2020 year 2014. That would include, in this case, almost all
2021 federal funding.

2022 Dr. {Cassidy.} So that is going to be all federal
2023 dollars? It won't be State dollars?

2024 Mr. {Allison.} Almost all federal funding.

2025 Dr. {Cassidy.} Okay. So they have to appropriate
2026 federal dollars?

2027 Mr. {Allison.} Correct.

2028 Dr. {Cassidy.} Okay. That is interesting. And the
2029 economic aspect of this--by the way, let me just point out,
2030 the Kaiser Family Foundation study that Mr. Waxman had
2031 proposed is going to cost Louisiana \$1.8 billion over 10
2032 years, Arkansas \$1.2 billion, and that is assuming that we
2033 don't have to raise taxes on the federal or State taxpayer to
2034 pay for this extra money, which is an assumption which seems
2035 a little silly.

2036 I am over time. I yield back. Thank you.

2037 Dr. {Burgess.} I thank the gentleman for yielding back.
2038 The Chair now recognizes the gentlelady from California, Ms.
2039 Capps, 5 minutes for the purposes of questions.

2040 Mrs. {Capps.} Thank you, Mr. Chairman, and to all of
2041 our witnesses, thank you for your testimony today and for
2042 your availability.

2043 I want to give you, Mr. Cohen, just a minute to respond
2044 to the previous question Mr. Cassidy asked about the Medical
2045 Loss Ratio and the HSA contributions, but if you could be

2046 very brief?

2047 Mr. {Cohen.} So what we have said is that the 80/20
2048 rule says insurance companies have to spend 80 cents of every
2049 premium dollar on care, so to the extent that the HSA dollars
2050 are actually expanded, they will be counted towards that 80
2051 cents that the insurance company has to spend.

2052 Mrs. {Capps.} Thank you very much.

2053 I want to address some questions to you, Ms. Mann. The
2054 Affordable Care Act includes a provision that will bump up
2055 the payment for primary care providers in Medicaid to the
2056 rates we currently pay through Medicare. On average, this
2057 will improve primary care reimbursement by 67 percent on
2058 average nationally. My State of California, the increase
2059 will be even more important, 113 percent increase for current
2060 reimbursement. Could you explain why raising primary care
2061 reimbursement for Medicaid providers is so important and how
2062 this will benefit patients but also the health care system as
2063 a whole, the role it plays?

2064 Ms. {Mann.} Of course. In the Medicaid program and in
2065 changes going on in the health care marketplace more
2066 generally, there is real appreciation of the value of primary
2067 care, and to avoid unnecessary high utilization of specialty
2068 care, to avoid catastrophic care, people need regular primary
2069 care preventive care, and what this primary care boost does

2070 is encourage more primary care practitioners to enroll in the
2071 Medicaid program, participate in the Medicaid program and to
2072 provide a greater share potentially of their hours of service
2073 to Medicaid beneficiaries. So we are very excited about the
2074 opportunity to expand and deepen access, particular around
2075 primary care, and to reduce costs overall as a result.

2076 Mrs. {Capps.} Absolutely. I share your belief in that.
2077 As I understand it, the research on provider rates shows that
2078 States with higher rates have greater numbers of providers
2079 accepting new patients and States that have increased their
2080 rates have seen more providers willing to increase their
2081 participation. Given that, do you think that increasing
2082 rates to Medicare levels for primary care physicians with
2083 both increase the number of physicians participating in the
2084 program and allow some who are already participating to
2085 increase the number of Medicaid patients they see? That's a
2086 big problem right now.

2087 Ms. {Mann.} I do think it will boost participation. I
2088 think there is a general agreement that it will boost
2089 participation. I do want to say that I think that rates are
2090 one of many factors that help us make sure we have good
2091 provider participation in the program but this will go a long
2092 way to assure greater participation, particularly in the
2093 needed area of primary care.

2094 Mrs. {Capps.} Thank you. And as you may know, there is
2095 a lot of talk from some in Congress that the Medicaid primary
2096 care payment bump should be used to pay for SGR. I have
2097 consistently voted to get rid of the SGR, and we even did so
2098 in the House version of health care reform. But this pay-for
2099 idea is frankly, in my opinion, foolish. This would
2100 literally incentivize providers to take care of our seniors
2101 at the expense of the poor and the health care community,
2102 providers and patients alike, agree. You may have a comment
2103 on this, or I can move on and ask another question.

2104 Ms. {Mann.} I appreciate your support for assuring good
2105 primary care in the Medicaid program. Thank you.

2106 Mrs. {Capps.} Now, when States expand Medicaid under
2107 the Affordable Care Act, they pull in federal dollars to
2108 provide health insurance to millions of people who don't have
2109 it now. Right now these uninsured people are relying on
2110 health care safety-net providers and programs that are paid
2111 for by State dollars. Many of our States can't afford to do
2112 this. Won't States be able to actually save some significant
2113 dollars in their State health budgets on programs that pay
2114 for uncompensated care, on mental health savings, etc.? In
2115 fact, the net cost to State budgets of expanding Medicaid
2116 could be quite negligible, or even a net gain. Is that
2117 correct?

2118 Ms. {Mann.} I think that is absolutely correct.
2119 Different States have done their studies and different
2120 organizations have done studies, and it obviously varies by
2121 State but the amount of the increase overall under the Kaiser
2122 study that people have been citing today of the Medicaid
2123 expansion just looking at the expansion is less than one-half
2124 of 1 percent in terms of the impact on States budget
2125 notwithstanding the big change in the number of people who
2126 would gain coverage, but then as you say, there's offsetting
2127 savings. Uncompensated care will be reduced. And Governor
2128 Sandoval came out this week and supported the Medicaid
2129 expansion. One of the things he cited in Nevada is the
2130 reduction in State funding for mental health services that
2131 will no longer be necessary. Those were funded by the State
2132 to fill in the gap, and that gap will be filled through the
2133 Medicaid expansion.

2134 Mrs. {Capps.} Thank you very much for answering.

2135 And Mr. Chairman, as I close, I ask unanimous consent to
2136 enter the following letters into the record opposing this
2137 pay-for idea: a letter from the Family and Children's Health
2138 Groups and Providers, a letter from the majority of our
2139 Nation's physicians and a letter from the California
2140 Children's Hospital. I request that these be submitted.

2141 Dr. {Burgess.} Without objection, so ordered.

2142 [The information follows:]

2143 ***** COMMITTEE INSERT *****

|
2144 Dr. {Burgess.} I would also likewise like to insert
2145 into the record a letter from the Governor of my State. We
2146 have had several good States testify here today. Governor
2147 Perry also wrote a letter on this subject, and I would like
2148 to have that made part of the record as well, so without
2149 objection, so ordered.

2150 [The information follows:]

2151 ***** COMMITTEE INSERT *****

|
2152 Dr. {Burgess.} And the Chair now recognizes the
2153 gentleman from Georgia, Dr. Gingrey, 5 minutes for questions,
2154 sir.

2155 Dr. {Gingrey.} Mr. Chairman, thank you very much, and I
2156 want to thank all seven witnesses for bearing with us through
2157 the break and the vote series.

2158 My question is over a concern that I have in regard to
2159 the exchanges and the authority of the Secretary in regard to
2160 rulemaking, and I am going to direct my questioning to the
2161 Secretary of the Department of Health Services in Wisconsin,
2162 Mr. Dennis Smith, and hopefully we will be able to get all
2163 this done within 5 minutes.

2164 The recently released request for information regarding
2165 health care quality for exchanges on November 27th
2166 specifically mentions a Section 1311 of PPACA which directs
2167 quality health plan issuers to, among other things, implement
2168 quality improvement strategies as directed by the Secretary.
2169 Specifically, subsection H of 1311 would allow the Secretary
2170 to prevent physicians from treating patients in the exchange
2171 unless they implement such mechanisms to improve health care
2172 quality the Secretary may by regulation require.

2173 Let me restate that. Physicians must follow quality
2174 directives as defined by the Secretary or lose their

2175 business. Mr. Smith, are you aware of this provision in the
2176 law?

2177 Mr. {Smith.} I am not familiar with that section, no,
2178 sir.

2179 Dr. {Gingrey.} Okay. Well, let me ask you this then.
2180 In this provision, you may not know this either, but the word
2181 ``quality'' is not defined in the statute. So it is safe to
2182 assume that the Secretary, not just Secretary Sebelius but
2183 every Secretary to follow, Republican or Democratic
2184 Administration, will be able to define through regulation
2185 what that word ``quality'' means. Yes or no?

2186 Mr. {Smith.} I believe that is the correct
2187 interpretation. I think quality--again, we have tried to
2188 introduce quality performances into a variety of parts of our
2189 programs, both in managed care and the fee-for-service world.
2190 Again, this is another one of our concerns that we are going
2191 to have state standards, then we are going to have federal
2192 standards.

2193 Dr. {Gingrey.} Well, it is a huge concern of mine as a
2194 physician member, and I know very well what ``quality'' means
2195 in regard to the specialty of obstetrics and gynecology as
2196 defined by the American College, the same thing for the
2197 American College of Surgeons, you know, the specialty
2198 societies define quality. If the Secretary decided to use

2199 this provision in the law under 1311(h) and it is there very
2200 clearly, and she or any Secretary uses this provision to
2201 determine, let us say, for example, mammographies for women
2202 under 50, did not improve their health care because of false
2203 positives, like her, U.S. Preventive Services Task Force did
2204 back in 2009. You all remember that. Would a physician be
2205 able to treat patients in the exchange if they prescribed a
2206 mammogram for a 49-year-old woman? Can you answer that for
2207 me?

2208 Mr. {Smith.} I don't think I can.

2209 Dr. {Gingrey.} Well, I can answer it for you. The
2210 answer is no. If the Secretary decided that physicians who
2211 performed abortions were not practicing quality medicine
2212 because they endangered the life of a child, could the
2213 Secretary run providers who performed abortions out of
2214 business? And I will answer that one for you too. The
2215 answer is yes.

2216 Mr. Chairman, I believe that this language in 1311 would
2217 allow the Secretary to control what physicians prescribe,
2218 what health care patients can access. Is there a single
2219 person in this room who thinks that the Secretary should have
2220 that kind of authority whether it is a Republican or a
2221 Democrat?

2222 Mr. Chairman, I have a bill, 6320, which repeals this

2223 clearly dangerous provision, and I plan to reintroduce this
2224 bill in the 113th Congress, and I hope that this committee in
2225 a bipartisan fashion can work together in this effort because
2226 look, I don't know whether this Section 1311 or subsection H
2227 was an intentional provision or unintended consequences. I
2228 would rather like to think unintended consequences. But this
2229 is a thing you get in a 2,700-page bill that you have to pass
2230 and then finally find out what is in it, and maybe you will
2231 like it and maybe you won't, but this clearly is a provision
2232 where any Secretary of Health and Human Services can pretty
2233 much determine what the quality of care is for physician
2234 providers in one of these exchanges in the 50 States and the
2235 territories and the District of Columbia and any specialty
2236 when each specialty society has clearly defined what is
2237 quality care but yet the Secretary now can just say well, you
2238 know, you are not providing quality care as determined by me
2239 under Section 1311 and therefore you are basically out of
2240 business, you can't be part of a provider panel in the
2241 exchanges. This is clearly wrong and has to be repealed, and
2242 Mr. Chairman, I have probably gone a little beyond, but I
2243 will yield back now and just remind my colleagues H.R. 6320
2244 just repeals that section and hopefully in a bipartisan way
2245 we can get that done in the 113th, and I yield back.

2246 Dr. {Burgess.} The gentleman yields back. The Chair

2247 now recognizes the gentlelady from Wisconsin, Ms. Baldwin,
2248 for 5 minutes for your questions, please.

2249 Ms. {Baldwin.} Thank you, Mr. Chairman.

2250 I am very proud of the work we did in this committee to
2251 pass the Affordable Care Act because access to affordable
2252 health care is an essential pillar of middle-class economic
2253 security. Many States are making very impressive progress in
2254 moving health care reform forward. We have heard Maryland
2255 and Arkansas as two great examples of two States that have,
2256 it seems, put politics aside and are doing the very hard work
2257 involved in implementation because they know it is the right
2258 thing to do for families and small businesses and others in
2259 their States.

2260 While these States have moved forward and certainly
2261 others have across the Nation, I have really been concerned
2262 about my home State of Wisconsin and the way it has been
2263 holding back. Earlier, Wisconsin returned an Early Innovator
2264 federal grant that would have enabled our State to build a
2265 Wisconsin-run health insurance exchange. Building a State-
2266 based exchange, in my opinion, would have provided families
2267 and businesses with more choices for the quality coverage
2268 that our State has been known for providing to our citizens
2269 for years. I am committed to bringing people together and
2270 working collaborative to make our Nation's new health law

2271 work for my home State of Wisconsin and other States. Our
2272 State has a strong tradition and history. Secretary Smith,
2273 you talked about that history and tradition of being a
2274 national leader in advancing health care reforms, and it is
2275 my hope that we can continue in that proud tradition by
2276 extending our Medicaid eligibility so that those who need
2277 health coverage the most have access to it.

2278 Secretary Smith, you mentioned in your testimony, and I
2279 read Governor Walker's comments, I believe, yesterday that he
2280 has not made a decision as of this moment of whether our
2281 State will participate in the Medicaid expansion. Is that
2282 correct?

2283 Mr. {Smith.} That is correct.

2284 Ms. {Baldwin.} I want to delve a little bit deeper in
2285 terms of a timeline in mind for making that final decision.
2286 I know you held some press availability yesterday in the
2287 State of Wisconsin in anticipation of this visit to
2288 Washington, D.C. You made some comments that concern me
2289 about this impending decision. You said the math is just not
2290 going to work out, and yet the State has not yet completed
2291 its financial projections. There were comments you made
2292 about still continuing to build modeling, and yet you say it
2293 is a straightforward calculation. Based on those quotes,
2294 what is the timeline that you contemplate for doing that math

2295 and having the decision move forward with the Administration?

2296 Mr. {Smith.} Thank you so much, and again, if I can
2297 clarity, my comments about the math were a very specific part
2298 of that in terms of whether or not the federal government
2299 would buy out our existing childless adults population so,
2300 again, my comment was, we have about 21,700 childless adults.
2301 Even if we get 100 percent FMAP for them, that is not going
2302 to entirely offset the cost of all the new people who would
2303 come in to the program. That is what my comments were in
2304 reference to.

2305 Ms. {Baldwin.} So in terms of just a timeline for the
2306 overall calculations that you need to do, how soon can we
2307 expect to hear?

2308 Mr. {Smith.} The Governor's budget, he will include in
2309 the Governor's budget that decision whether or nor to expand.

2310 Ms. {Baldwin.} Okay. So when the Governor's budget is
2311 released, we will know about--that is when he will announce
2312 his decision?

2313 Mr. {Smith.} Yes.

2314 Ms. {Baldwin.} Okay. Thank you.

2315 Well, I just want to repeat that I believe it is
2316 crucially important that our State expand the coverage.
2317 According to the Kaiser Commission on Medicaid and the
2318 Uninsured, over 200,000 Wisconsinites could gain Medicaid

2319 coverage through the Affordable Care Act Medicaid expansion,
2320 and if it is uncertainty that we are concerned about, surely
2321 those 200,000 people in Wisconsin deserve the certainty of
2322 knowing that quality and affordable care will be there for
2323 them.

2324 You know, we know the impacts for those 200,000 people.
2325 Accessing preventive care can forestall more expensive and
2326 costly and sometimes deadly illnesses, and 200,000 people who
2327 we hope would be living healthier and more productive lives,
2328 are better able to manage chronic illnesses that they might
2329 experience. With 100 percent federal funding for the new
2330 Medicaid population through 2016, then phasing down to 90
2331 percent funding after that point, our State could actually
2332 save a quarter of a billion dollars in Medicaid costs and
2333 another quarter of a billion, \$250 million in uncompensated-
2334 care costs, factors that we heard testimony from the
2335 Secretaries of Health in other States, and on that topic,
2336 although I see I am running out of my time, I was going to
2337 ask Director Allison to talk a little bit more about some of
2338 the other savings that you have realized that your State,
2339 Arkansas, can recognize. Given that I have run out of time,
2340 we will follow up in writing afterwards. Thank you.

2341 Dr. {Burgess.} The Chair thanks the gentlelady. We
2342 would recognize the gentlelady from Illinois, Ms. Schakowsky,

2343 5 minutes for your questions, please.

2344 Ms. {Schakowsky.} Thank you, Mr. Chairman.

2345 First, I want to thank Director Mann for working with
2346 Cook County, Illinois, my county, on the waiver that will
2347 allow Cook County to early enroll more than 115,000
2348 individuals who will be eligible for Medicaid in 2014. You
2349 have given us the opportunity to get a head start on
2350 providing the many people who need the health care who are
2351 eligible for the care to be enrolled, so thank you very much.

2352 I wanted to set the record straight on a couple of
2353 things too. There was some talk about the expenses for
2354 Illinois that were made earlier. The federal government is
2355 going to provide almost \$157 million to Illinois to support
2356 insurance coverage for 898,000 Illinoisans with Medicaid,
2357 reducing our uninsured population by about half. How
2358 fantastic is that. And Illinois will save \$953 million in
2359 uncompensated expenditures, and actually there will be
2360 increase in the cost for Illinois, about 1 percent, and look
2361 at what we are getting. I mean, it is just a miracle to me.

2362 I also wanted to point out that in terms of the overall
2363 increase in insurance cost that actually yes, costs for
2364 insurance have increased less than before the Affordable Care
2365 Act was passed, and the ACA saved an estimated \$2.1 billion
2366 on health insurance premiums through the Medical Loss Ratio

2367 and Rate Review. Almost 13 million consumers received a
2368 check because their insurance company spent too much money,
2369 over a billion dollars, and Rate Review saved consumers about
2370 a billion dollars. That is individual and small group
2371 markets. So these are victories, I think.

2372 A number of people on the panel have talked about the
2373 problem that somehow the Affordable Care Act messes up your
2374 opportunity to get rid of fraud and eligibility requirements,
2375 etc., and I wanted to talk for a minute about Pennsylvania.
2376 My understanding is that in the late summer, the Pennsylvania
2377 Department of Welfare began notifying hundreds of thousands
2378 of families by mail that they had 10 days to provide
2379 necessary documentation in order to keep their children
2380 enrolled in Medicaid, and if the family missed the deadline
2381 or even if they met the deadline, if the Department of Public
2382 Welfare failed to process the paperwork within 10 days, they
2383 were dropped from Medicaid, and in fact, 89,000 children were
2384 dropped from Medicaid. Here is my point. Are some of these
2385 so-called problems an excuse and the opportunity to set up
2386 barriers to actually bump people from the rolls? I think it
2387 is completely unfair, and Mr. Alexander, you certainly do
2388 have an opportunity to answer. To say that not only do you
2389 only have 10 days to keep your children in Medicaid, but if
2390 we can't process your papers, then we are going to bump you

2391 off of Medicaid and that happened to 89,000 children. That
2392 is included in your fraud prevention numbers, and I think
2393 that it is a fraud to do that to children. So what do you
2394 think?

2395 Mr. {Alexander.} Well, thank you very much for your
2396 comments. When we arrived, Governor Corbett arrived and I
2397 arrived at the department, we had hundreds of thousands of
2398 cases that had not been processed in years and left piling up
2399 in county assistance offices, and it is our duty as a State
2400 where mandated by federal law to follow the laws that you
2401 pass.

2402 Ms. {Schakowsky.} Ten days?

2403 Mr. {Alexander.} And indeed we do that. We went
2404 through meticulously to make sure that whichever family was
2405 eligible was eligible and whichever family was not eligible
2406 was not eligible. Now, this was not about children because
2407 we determined this as a family, so we are talking about
2408 families and individuals, not just children.

2409 Ms. {Schakowsky.} My understanding is that the records
2410 show that the 89,000 figure represents only children.

2411 Mr. {Alexander.} There were much more than 89,000. Now
2412 let us get to what we did do. We meticulously went through
2413 after we sent them notices per federal law. We followed the
2414 law and followed the regulations.

2415 Ms. {Schakowsky.} Is 10 days the regulation?

2416 Mr. {Alexander.} It was more than 10 days. We followed
2417 the regulation. We followed the law. We sent them notices.
2418 If they did not reply, then they were terminated. So if they
2419 did not reply within the accounted time, then they were--so
2420 we gave them every chance possible to--

2421 Ms. {Schakowsky.} And what if you couldn't--

2422 Mr. {Alexander.} And even after that, we had done
2423 outreach.

2424 Ms. {Schakowsky.} And what if you couldn't process? My
2425 understanding is if the Department of Public Welfare failed
2426 to process the paperwork within 10 days, they were dropped.

2427 Mr. {Alexander.} That is incorrect. By law, it is a
2428 30-day time period, so we gave them ample time, and in fact,
2429 it was extended past the 30 days for them to be able to
2430 contact us, and we told all of the families that if you come
2431 in and contact us and come in and have your paperwork, we
2432 will get you right back on the program. The point of the
2433 matter is, Congresswoman, is that when you come into a
2434 department like this and you have hundreds of thousands of
2435 cases that are piled up and hadn't been gone through in
2436 years, there is a problem. We have a process that is given
2437 to us by Congress. We follow those laws. We have State
2438 rules and regulations that we need to follow. Now, if

2439 somebody tells us not to follow rules and regulations and
2440 they pass laws to that effect, then we will do that
2441 accordingly but we followed all of the rules and regulations.
2442 We have reached out to the families. We want everyone that
2443 is eligible for Medicaid to be on Medicaid, but if you are
2444 not eligible, then we don't want you on the program. There
2445 is a difference. We are here to serve the truly needy
2446 eligible families and children.

2447 Dr. {Burgess.} The gentlelady's time is expired. The
2448 Chair recognizes the gentleman from New York.

2449 Ms. {Schakowsky.} Can I just say, with due respect, I
2450 have different numbers and I would like to submit them for
2451 the record.

2452 Dr. {Burgess.} The Chair would entertain a glance at
2453 those records. I recognize Mr. Engel for 5 minutes for
2454 questions, please.

2455 Mr. {Engel.} Thank you. Thank you very much, Mr.
2456 Chairman.

2457 I want to talk about two issues and try to do it fast
2458 because I want to get it all in involving DSH payments and
2459 the ``do gooder'' States. I made sure when we were crafting
2460 the Affordable Care Act that my State, New York, which is a
2461 so-called do-gooder State was not penalized for it, and also
2462 DSH, because we have a lot of indigent people in the New York

2463 City metropolitan area, I wanted to make sure that we were
2464 not penalized.

2465 So the New York Medicaid program already covers most
2466 categories of individuals beyond the Affordable Care Act
2467 expansion threshold and plans to extend additional coverage
2468 to non-pregnant childless adults, thereby fully meeting the
2469 ACA parameters by 2014. However, it is projected that after
2470 the ACA is fully implemented in New York, 10 percent of our
2471 residents will still remain uninsured, which means DSH
2472 funding will still be important.

2473 Ms. Mann, I know you and I spoke about the importance of
2474 DSH funding to New York a few months ago. I just want to
2475 reiterate how important this funding is to those States which
2476 already have broad eligibility for their Medicaid programs or
2477 do plan to expand their Medicaid programs. I hope the
2478 upcoming regulations will not punish these States, these
2479 States who did the right thing by expanding Medicaid
2480 eligibility with disproportionately deep DSH cuts. I don't
2481 know that you have to answer, but as you know, that is a very
2482 big concern of mine.

2483 Let me ask Dr. Allison and Dr. Sharfstein, can you
2484 briefly talk about how declining funding for uncompensated
2485 care and DSH influenced your decision to push for Medicaid
2486 expansion in your States?

2487 Dr. {Sharfstein.} Sure. Maryland, just to give one
2488 very specific example from Maryland because we have a unique
2489 way of funding uncompensated care, about a billion dollars a
2490 year in uncompensated care goes into a pool on the hospital
2491 side and there is about a 7 percent assessment that goes on
2492 every single person's hospital in the State for every service
2493 to pay for that uncompensated care. So when that goes down
2494 because more people get covered, everybody benefits--small
2495 businesses, individuals, the State through the Medicaid
2496 program and so it is one of the factors that we use to see,
2497 and in Maryland it is very explicit because of this system,
2498 you can really see the specific savings that will accrue
2499 across the State. It is sort of eliminating a hidden tax.

2500 Mr. {Engel.} Dr. Allison?

2501 Mr. {Allison.} Congressman, we estimate so far we have
2502 found about \$90 million per year that the State spends on
2503 non-Medicaid programs for uncompensated care. The
2504 legislature, the Governor will have to make decisions about
2505 how to use that funding going forward. We have assumed in
2506 our estimates that at least half of that would be diverted to
2507 the State general fund, really as an offset to the Medicaid
2508 expansion, which is not very different, by the way, from the
2509 Urban Institute's assumptions.

2510 Mr. {Engel.} Thank you. Let me talk about the do-

2511 gooder State issue. As I mentioned before, New York has
2512 worked hard to ensure that low-income and vulnerable New
2513 Yorkers have access to health care services by expanding
2514 eligibility for Medicaid beyond the federal requirements even
2515 prior to the expansion included in the Affordable Care Act.
2516 Though the federal support for newly eligible populations is
2517 incredibly generous, and the law includes provisions to
2518 benefit these do-gooder States, the reality is that New York
2519 will not see the same federal support as States which have
2520 historically been less generous with their eligibility
2521 thresholds.

2522 So regardless of that, I am proud of the fact that New
2523 York intends to further expand its Medicaid program to meet
2524 the ACA threshold of 138 percent of the federal poverty
2525 level. It is estimated that the State of New York will save
2526 \$2.3 billion a year as a result of this enhanced federal
2527 Medicaid support. With the federal government providing 100
2528 percent of the funding for newly eligible populations for the
2529 first 3 years and providing at least 90 percent of the
2530 funding beyond, I simply cannot understand why a State would
2531 choose not to provide health care coverage to its neediest
2532 citizens.

2533 So let me quickly ask both Dr. Sharfstein and Dr.
2534 Allison. Dr. Sharfstein, in your written testimony, you

2535 stated, and I quote, ``Expanding Medicaid is the best
2536 decision for Maryland's providers, the State economy and the
2537 uninsured.'' Can you elaborate on the input you received
2538 from health care stakeholders regarding the Medicaid
2539 expansion?

2540 Dr. {Sharfstein.} Sure. After the Affordable Care Act
2541 was passed, there was a process that involved hundreds of
2542 Marylanders, many of whom have submitted comments, the
2543 business community, the provider community, advocates,
2544 uninsured individuals, and there was a real consensus across
2545 the State that it made sense to expand coverage, that it not
2546 only has been proven to reduce mortality and improve health
2547 outcomes but it would have great benefits to Maryland's
2548 health care system and economy, and so Maryland has moved
2549 forward from that point based on, you know, input that we
2550 received from across the State.

2551 Mr. {Engel.} Dr. Allison, same question to you. What
2552 input did you receive from health care stakeholders regarding
2553 a possible Medicaid expansion in Arkansas?

2554 Mr. {Allison.} Virtually all of the health care
2555 stakeholder associations in Arkansas have come you in favor
2556 of the Medicaid expansion. They understand the good that it
2557 would do for their patients. They understand the harm that
2558 it would do to them as the safety net if Medicaid were not

2559 expanded.

2560 Mr. {Engel.} Thank you. And Ms. Mann, did you want to
2561 make a comment on what I mentioned before about States do not
2562 get punished if they expanded their Medicaid eligibility? Am
2563 I done, Mr. Chairman?

2564 Dr. {Burgess.} Yes, we have got other members who have
2565 been waiting a long time, Mr. Engel.

2566 Mr. {Engel.} Okay.

2567 Dr. {Burgess.} The gentleman's time has expired. At
2568 this point the Chair would like to recognize the gentleman
2569 from Utah, Mr. Matheson, 5 minutes for your questions,
2570 please.

2571 Mr. {Matheson.} Thank you, Mr. Chairman. I appreciate
2572 you holding this hearing. With tomorrow being the deadline
2573 for States to declare their intentions with regard to the
2574 Affordable Care Act exchanges, I would like to focus my time
2575 on some outstanding questions that remain with regard to the
2576 function of the exchanges. There are other issues about the
2577 law I would like to address such as how the health insurance
2578 tax would be assessed and what effect it will ultimately have
2579 on consumers, but my time is limited as if the jurisdiction
2580 of our committee.

2581 Now, the Affordable Care Act envisions a seamless
2582 process for consumers to access health insurance coverage

2583 through the exchanges or expanded Medicaid or CHIP coverage,
2584 depending on eligibility. One of the potential unknowns in
2585 this process is the issue of how to provide for uninterrupted
2586 coverage for those whose eligibility changes during the
2587 course of the year due to fluctuations in income. The
2588 statute is not clear as to whether these consumers would be
2589 able to maintain their existing coverage or if they will be
2590 required to move between private coverage and Medicaid as
2591 their income shifts through the year. This potential for
2592 churning could not only place significant administrative
2593 burdens on consumers and on plans but could also threaten
2594 continuity of care as consumers move between plans with
2595 different provider networks. In the end, it is going to lead
2596 to adverse health outcomes for the beneficiary.

2597 So I guess I will direct the question, maybe Ms. Mann
2598 would be the one to answer this. Can you provide some
2599 clarity on this issue about how these individuals will be
2600 assessed and how best the system can maintain continuity of
2601 coverage for people who may fall into this situation?

2602 Ms. {Mann.} Absolutely. It is a very important
2603 question. The Affordable Care Act and the regulations ensure
2604 that there will be continuity of eligibility if income
2605 changes so the rules and the law are pretty explicit about
2606 ways in which there should be no gap in coverage if

2607 somebody's eligibility changes from Medicaid to the exchange
2608 or from the exchange to Medicaid, but there is the issue of
2609 continuity of plan and provider, and in our recent questions
2610 and answers that we released on December 10th, we gave three
2611 options for States to consider to try and minimize this
2612 disruption of care. One of the first things States can do if
2613 they are running a State-based exchange is, they are
2614 encouraged to have the same plans doing business on the
2615 exchange as they are doing business in the Medicaid and the
2616 CHIP program and then families have an ability, even if their
2617 eligibility changes, to stay in the same plan.

2618 Beyond that, we have noted some premium assistance
2619 options that States can use inside their State, options in
2620 the Medicaid program. It is a way of assuring continuity of
2621 coverage. They can purchase the coverage for a Medicaid- or
2622 CHIP-eligible person by contracting with a qualified health
2623 provider that happens to be doing business on the exchange.
2624 That way, if that individual's eligibility changes from
2625 Medicaid and CHIP to eligibility on the exchange for premium
2626 tax credit, they would switch to a tax credit for Medicaid
2627 but they wouldn't have to switch plans.

2628 Mr. {Matheson.} Thank you. My home State of Utah is
2629 one of several States deciding on which health exchange
2630 approach is most appropriate for our residents, and our

2631 Governor has raised some very relevant questions recently
2632 with regard to how the different approaches may operate, some
2633 of which I would like to explore with you, if I could. If
2634 several States band together to form a multi-State exchange,
2635 what role would State regulators play in enforcing State law?
2636 Have we thought about that?

2637 Mr. {Cohen.} State regulators will have the same role
2638 that they do today in terms of reviewing policy forms, making
2639 sure they are consistent with any State law, State mandates,
2640 for example, as well as with the federal law so there
2641 shouldn't be a change in the role of State regulators in a
2642 multi-State exchange.

2643 Mr. {Matheson.} Is that also the same if they are under
2644 the federal exchange?

2645 Mr. {Cohen.} Yes.

2646 Mr. {Matheson.} Do State policymakers relinquish any
2647 ability to provide counsel, advice or influence on the
2648 operation of a federal exchange should the State opt out of
2649 operating their own State-based exchange?

2650 Mr. {Cohen.} I think that we are always interested and
2651 will continue to be interested in working with States to make
2652 the exchanges work best for their State, whether it is a
2653 federally facilitated exchange or not. I think that there
2654 are some important decisions that States get to make

2655 themselves if they are in a State exchange or a State
2656 partnership exchange. For example, one example is just how
2657 the thing will be funded. We have proposed one funding
2658 mechanism which will work in the federal exchange a but
2659 States could use a different funding mechanism if it is State
2660 exchange.

2661 Mr. {Matheson.} Thank you, Mr. Chairman. I will yield
2662 back.

2663 Dr. {Burgess.} The gentleman yields back. The Chair
2664 recognizes the gentleman from Virginia, Mr. Griffith, for 5
2665 minutes for your questions, sir.

2666 Mr. {Griffith.} Thank you, Mr. Chairman, and I
2667 appreciate all of you all being here. I know it has been a
2668 long day, and I look forward to working with each of you and
2669 the members of this committee as we move forward.

2670 Mr. Chairman, I will yield my time to you for questions
2671 that I believe you may have.

2672 Dr. {Burgess.} I thank the gentleman for yielding.

2673 Mr. Smith, and again, to everyone on the panel, thank
2674 you for your indulgence today. I believe it is the policy of
2675 this committee, we invite smart people to come and tell us
2676 what they think about things. If there is an opinion that
2677 needs to be offered, I think it should be offered.

2678 So Mr. Smith, a long time ago, Mr. Waxman offered some

2679 comments to which you wanted to respond. I know we have kind
2680 of removed the immediacy of your response to those questions,
2681 but if you had comments you would like to make, we would love
2682 to hear them now.

2683 Mr. {Smith.} Thank you, Mr. Chairman. I appreciate
2684 that greatly, and it is nice to be with a bunch of smart
2685 people.

2686 The question about block grants, and I wanted to respond
2687 in a couple of different ways. First, the State Children's
2688 Health Insurance Program is a block grant. That was one of
2689 the most successful programs that everyone has claimed great
2690 credit for. There are different forms of block grants.
2691 There was a per capita cap approach that during the Clinton
2692 Administration, Clinton Administration officials supported
2693 that type of approach. The block grants themselves, again
2694 for States, we do believe we can run these programs more
2695 efficiently and more effectively than under federal rules.
2696 First of all, more than half of Medicaid dollars are spent
2697 because States have expanded beyond federal requirements. We
2698 have added eligibility, we have added benefits well beyond
2699 what the federal law expands. So again, sort of the
2700 perspective that if the federal government doesn't require
2701 it, the States aren't going to do it, the history is actually
2702 the opposite. States have expanded beyond what the federal

2703 requirements are, so we believe very strongly States can
2704 indeed be trusted.

2705 Most of the money is in people who are either senior
2706 citizens needing long-term care or individuals with
2707 disabilities. In Wisconsin, we have in fact lowered the cost
2708 of care because we have been able through waivers put people
2709 into private sector managed care situations. Again, regular
2710 Medicaid fee-for-service is the most expensive type of care,
2711 and in many respects least appropriate because the care is
2712 not being provided for.

2713 So from my perspective, when I look at all of these
2714 Medicaid dollars that are being spent under the different
2715 formulas that have been offered, which guarantee federal
2716 dollars growing by population at least medical CPI or CPI
2717 plus one, I say absolutely, I can make that deal work. If my
2718 federal dollars are guaranteed, I become more efficient. The
2719 State therefore actually increases the federal match rate
2720 because the State match goes down because the federal dollars
2721 are guaranteed to be there. So absolutely, we can make that
2722 situation work. Again, I go back to the very beginning
2723 before legislation was even put out. In December of 2008,
2724 Chairman Baucus at the Finance Committee put out a paper
2725 saying there is \$700 billion in excess spending in the health
2726 care system. Through Medicare and Medicaid, the government

2727 spends almost half of those dollars. Medicaid and Medicare
2728 therefore do indeed have to be brought to the table, and
2729 there is a great deal of overutilization in the system. From
2730 our perspective, again, it is not the cost of health care, it
2731 is the excess cost of health care. The excess cost of health
2732 care is what we are going after. We have done it
2733 successfully in Wisconsin. We think we can go even further.

2734 Dr. {Burgess.} Well, along that line, I am terribly
2735 disappointed to hear Mr. Cohen's response to the Medical Loss
2736 Ratio question and health savings accounts. You know, Mr.
2737 Pallone, I sat on this committee with you down at the kids'
2738 table while we heard all the comments about how to bring down
2739 cost of health care. That is what the Affordable Care Act
2740 was supposed to do. Remember the word ``affordable'' is in
2741 the title. If we wanted to bring the cost of health care
2742 down, we would have invited Governor Mitch Daniels to this
2743 committee and asked him how he did that in his State, 11
2744 reduction over 2 years. He did it with a health savings
2745 account for his State employees. It was voluntary, but he
2746 found out something important: people when they spend their
2747 own money for health care, something magic happens, even if
2748 it wasn't their own money in the first place. It sounds like
2749 from your interpretation of the Medical Loss Ratio, that
2750 effect is going to be lost. That is yet more one failing of

2751 this very large law that came into being under very difficult
2752 circumstances.

2753 I will yield back my time and recognize Dr. Christensen
2754 5 minutes for questions.

2755 Dr. {Christensen.} Thank you, Mr. Chairman, and thank
2756 you to all the witnesses for your patience and being here
2757 with us today. I too am very proud of the work that we in
2758 this committee did on the Affordable Care Act and I don't
2759 want to see any of the gains lost. I want to see every one
2760 of the over 30 million people who are going to receive
2761 coverage receive coverage including the 20 or so million who
2762 will receive coverage through Medicaid expansion, and a large
2763 percentage of those are people of color for whom the Tri-
2764 Caucus worked very hard as we put together this law to ensure
2765 that African Americans, Hispanics, Native American and Asian
2766 Americans had access to health care. I wanted to go to our
2767 one of our poorer States that is not about to accept the
2768 Medicaid expansion, I don't think. No Medicaid expansion, no
2769 State exchange.

2770 Mr. Greenstein, you mentioned in your testimony that
2771 Louisiana has some of the worst health statistics and your
2772 State has some of the most persistent health disparities in
2773 the Nation. Numerous studies have shown that expanding
2774 access to health care through programs like Medicaid help to

2775 reduce health disparities. The National Urban League
2776 released a report last week about the economic cost of health
2777 disparities and found that the health disparities cost this
2778 Nation more than \$82 billion in direct health care spending
2779 in just one year, and the highest burden, of course, is in
2780 the South where health disparities cost about \$35 billion in
2781 just one year. So aren't you concerned that not expanding
2782 Medicaid would exacerbate the disparities in your State,
2783 leaving more people as the sickest in our Nation and also
2784 increase the financial costs in the end because they are
2785 going to come to you at some point without having preventive
2786 care, without having health care maintenance, when they are
2787 very sick and cost the State more?

2788 Mr. {Greenstein.} Thank you very, very much to focus
2789 the attention on what all the coverage is supposed to
2790 address, which is people's health status and the health
2791 outcomes. Indeed, in my State and many other States nearby,
2792 we see great disparities in diabetes, in obesity, and they
2793 are dramatic. We have looked at the outcomes for people on
2794 Medicaid and those without insurance, and we don't see a
2795 great deal of difference. This is distressing. We have a
2796 system that is not turning out the kind of health outcomes
2797 that we would expect for the amount of money that we put in.
2798 We have looked very deeply at expanding Medicaid, and

2799 let me share with you some of the numbers around it. I
2800 believe Chairman Waxman went through the numbers in Louisiana
2801 that we would expand Medicaid, how many people that don't
2802 have insurance would get it, and he cited about 265,000.
2803 When we looked at our numbers in the first year alone,
2804 467,000 people would join the Medicaid rolls. Of that,
2805 187,000 people already have private health insurance today.
2806 We would see a cannibalization of the private health
2807 insurance market taking generally healthy risk from a system
2808 where people pay some portion of their care and move that
2809 into Medicaid. Hospitals, doctors would see reimbursement
2810 levels reduced. So this it not an easy way to think through
2811 that expansion equals better health outcomes for everyone.
2812 It doesn't.

2813 Dr. {Christensen.} Nothing, as I understand it,
2814 precludes you from making changes within the Medicaid system
2815 to address some of the areas that, you know, may not be
2816 working so that where you now see that Medicaid-covered
2817 patients don't do any better than patients how are insured.

2818 Ms. Mann, is there anything that--I have heard several
2819 of the panelists say that, you know, the law dictates to the
2820 States, does not allow them the flexibility? Is that the
2821 case, or can't they also fix whatever is wrong with their
2822 Medicaid system?

2823 Ms. {Mann.} They can, and we would hope that they do
2824 and we will be prepared to work closely with Louisiana to do
2825 just that. There is a study in Oregon that recently came out
2826 that looked at people on Medicaid and people not on Medicaid
2827 had a control group. It was considered a gold standard
2828 study. It showed definitively that the care and the well-
2829 being and the health outcomes for the people receiving the
2830 Medicaid coverage were far superior to those who weren't
2831 having health care coverage and who were uninsured. There
2832 are lots of issues in Louisiana that are difficult, are
2833 challenging for anyone to tackle, but the evidence around the
2834 country is that you can make Medicaid work well for
2835 beneficiaries and improve health outcomes. The discretion
2836 around designing the program, determining the delivery
2837 system, contracting with the providers, those are all
2838 decisions that are fundamentally State decisions in the
2839 Medicaid program.

2840 Mr. {Smith.} May I offer an idea on eligibility? You
2841 mentioned Native Americans as a specific population. When we
2842 are switched to Modified Adjusted Gross Income, in Medicaid
2843 currently where Native Americans are exempt from cost-sharing
2844 entirely in the program, in Wisconsin, we disregard certain
2845 income that is available to them as members of the tribe.
2846 That gets changed under MAGI. Those people will become tax-

2847 credit eligible where they will be paying cost-sharing rather
2848 than Medicaid eligible.

2849 Dr. {Christensen.} I don't think that is the case, but
2850 my time is up and, you know, I hope that Ms. Mann and Mr.
2851 Cohen will have a chance to respond to that because I don't
2852 think that is the case.

2853 Dr. {Burgess.} The gentlelady's time is expired. I
2854 recognize a member of the full committee, Mr. Sarbanes, 5
2855 minutes for your questions, please.

2856 Mr. {Sarbanes.} Thank you, Mr. Chairman, and thank you
2857 for letting me participate today in the hearing. I
2858 appreciate it very much.

2859 I just want to say to Mr. Cohen and Ms. Mann, thank you
2860 for your tremendous work on this. It is incredibly exciting
2861 actually what you are doing because you are helping to build
2862 an expanded infrastructure that is going to provide more
2863 access to millions of Americans and over time I think also
2864 begin to reign in health care costs in a very effective way
2865 for individuals and for the system as a whole.

2866 I wanted to ask you, Ms. Mann, real quickly, what do you
2867 anticipate when we get to the end of this process in terms of
2868 the number of States that will actually have done a State-
2869 based exchanged versus those that will have done a
2870 partnership exchange versus those who will be federally

2871 facilitated? Any kind of sense of where--

2872 Mr. {Cohen.} I think that is actually for me. We don't
2873 know yet. There is a deadline on the State-based exchange
2874 that is coming up this Friday. So far we have heard from 14
2875 States and the District of Columbia have said they want to be
2876 State-based exchanges. There may be more by Friday but we
2877 don't know that. The second deadline that comes along is
2878 February 15th of next year, which is when we have asked
2879 States to tell us that they want to be in a partnership
2880 exchange, so we will know more in February as far as how many
2881 are going to work with us.

2882 Mr. {Sarbanes.} All right. Well, let me ask you, Dr.
2883 Sharfstein. First of all, thanks for being here.
2884 Congratulations on the work in Maryland. I know you and
2885 Governor O'Malley and others that are a part of this effort
2886 have really been part of the vanguard in demonstrating that
2887 these State-based exchanges can work and can get in place,
2888 and we are very proud of that in Maryland.

2889 I wanted to ask you, in view of the fact that States
2890 soon will be making a judgment about whether they think they
2891 can stand up a State-based exchange and in other instances
2892 will be look at the partnership model, you talked to your
2893 colleagues around the country who are making these decisions.
2894 What are the kinds of anxieties they express to you that you

2895 are able based on Maryland's experience to say look, there is
2896 a way to do this and, you know, whether it is certain
2897 technical things that you would comment on or just the
2898 process of sort of how you get consensus behind it and get
2899 people comfortable moving forward, what are you saying to
2900 your colleagues who maybe want to get there but are worried a
2901 little bit about it based on the Maryland experience that can
2902 give them some comfort and confidence that they can do this?

2903 Dr. {Sharfstein.} Sure. Thanks for your question, and
2904 thanks for your leadership in Maryland. We really appreciate
2905 it.

2906 There is a lot of engagement with the States that are
2907 moving forward on the State-based exchanges. There are a
2908 number of calls that happened. There is exchange of
2909 documents. Sometimes it is very explicit like a document or
2910 analysis that we will do other States will use directly or we
2911 will use something that they have done, and sometimes it is
2912 more just talking over, you know, different situations. A
2913 couple days ago up in west Baltimore, we had a meeting of the
2914 exchange board, probably 75 people in the public watching.
2915 We worked our way through a bunch of issues that we have been
2916 talking to our peers around the country, how billing would be
2917 done. We resolved that the exchange would take the first
2918 payment but the carriers would do the payments after that,

2919 and that is an issue where there is, you know, different ways
2920 to go. We have figured out a way to partner effectively with
2921 insurance brokers and we adopted some policies related to
2922 that. We decided to offer adult dental and vision plans if
2923 possible in the exchange.

2924 So for each of these things, there is a discussion, and
2925 I understand there are a lot of details involved but, you
2926 know, we have gotten energy from talking to people about
2927 those details both within our State and with other States,
2928 and systematically step by step, you know, moving forward
2929 with each part.

2930 Mr. {Sarbanes.} I just want to emphasize that from the
2931 beginning of this process, obviously a State looking at it
2932 without any peers having undertaken the process, without CMS
2933 and others having, you know, fully gotten into it yet, you
2934 could look at it and it would appear very daunting, and
2935 States like Maryland decided, you know, we want to get out in
2936 front of this thing and other States did as well. But we are
2937 now at a point as a result of this where the expertise that
2938 results in CMS, practical expertise about how implementation
2939 of this can happen, plus the expertise that resides in a peer
2940 group of States that have started to build these exchanges,
2941 have created the models, have looked at the computer systems
2942 and how all that is going to work. It means that States

2943 that, you know, maybe didn't get started as fast as they
2944 could are now if they make the judgment to go forward are
2945 going to come to the table with a, let us call it a support
2946 group or a network of people that hammer through a lot of
2947 these issues and they will be able to get where they need to
2948 go maybe faster than you had to do it starting from scratch,
2949 but that is important, I think, in making people understand
2950 that this is very feasible, and if people get into this and
2951 start working on it, we are going to get this framework in
2952 place. Thank you very much.

2953 Dr. {Burgess.} The gentleman's time is expired. That
2954 concludes the questions from the members of the subcommittee
2955 and members of the full committee who wished to ask
2956 questions. We have time, I think, for two follow-up
2957 questions, one from each side.

2958 The Chair will recognize Dr. Cassidy for our side.

2959 Dr. {Cassidy.} First, let us just give some reality to
2960 some of the quotes regarding Medicaid expansion improving
2961 health care. That Oregon study you quote, Ms. Mann, was a
2962 study limited to Oregon on an outpatient basis, and there is
2963 some evidence that people felt better just because they won
2964 the lottery. Secondly, as regards the New England Journal of
2965 Medicine article you quote, Dr. Sharfstein, it was by driven
2966 by New York solely, and in fact, in Maine, although it was

2967 not statistically significant, the Medicaid expansion
2968 resulted in poorer outcomes among those who were on Medicaid.
2969 Now, it was not statistically significant but that was
2970 entirely driven by the State of New York.

2971 And as regards Mr. Engel speaking of the do-gooder
2972 States, I will point out that New York pays physicians less
2973 well than does Louisiana and Texas, and only 60 percent of
2974 physicians in New York accept Medicaid. That is not access.

2975 Now, that said, just to clear up the record a little
2976 bit, now that we know, Mr. Smith, that the one thing that has
2977 been shown to lower costs, which is health savings accounts,
2978 will not be allowed in the MLR unless it is actually spent,
2979 i.e., we are no longer lowering costs, we are now encouraging
2980 insurance companies either not to sell them or perhaps
2981 insurance company to encourage a person to sell it, what data
2982 do you have in your State on the effect of the increased
2983 premium cost on someone who is, say, 200 percent of federal
2984 poverty level who is currently employed with employer-
2985 sponsored insurance, dumped into the expansion as McKinsey
2986 Quarterly says about 30 percent of these employers will do,
2987 now has an actuarial value of 60 percent, what do you project
2988 is going to happen to that person?

2989 Mr. {Smith.} Thank you, Mr. Cassidy. Again, we have
2990 been modeling the PPACA premiums in Wisconsin Medicaid since

2991 the first of July.

2992 Dr. {Cassidy.} So you actually are seeing--this is not
2993 a computer model, you have actually got real-life data?

2994 Mr. {Smith.} Yes, sir. This is the actual experience.
2995 Wisconsin has already expanded Medicaid coverage. We have
2996 parents, caretakers, relatives up to 200 percent of poverty.
2997 Some of our eligibility groups have transitioned to medical
2998 assistance, individuals with income above 300 percent of
2999 poverty. We have started applying only the premiums, not any
3000 of the additional cost-sharing.

3001 Dr. {Cassidy.} Not the \$2,000 deductible?

3002 Mr. {Smith.} No, sir, this is only premiums, not any
3003 additional cost-sharing that would be in effect. So in the
3004 results to date, people at the lower income level, again,
3005 because they are looking at a dollar amount, they are not
3006 thinking of a percentage--

3007 Dr. {Cassidy.} Yes, in Washington, we speak about
3008 percentages but we are actually talking about a dollar
3009 amount.

3010 Mr. {Smith.} Yes, sir, so at 133 to 150 percent of
3011 poverty, again, because the poverty level includes not only
3012 someone's income but also the size of the family, and so a
3013 percentage of your gross income. So--

3014 Dr. {Cassidy.} Please hurry.

3015 Mr. {Smith.} I apologize. For people making over 200
3016 percent of poverty, the average now of \$200 premium,
3017 participation was cut in half. So people are saying we are
3018 not paying \$200.

3019 Dr. {Cassidy.} So 50 percent more people are without
3020 insurance?

3021 Mr. {Smith.} Fifty percent of people who had been
3022 enrolled dropped their Medicaid coverage when premiums--

3023 Dr. {Cassidy.} So when that working family's employer
3024 puts them on the exchange and they have an actual value of 80
3025 percent with the employer but it may be 60 percent on the
3026 bronze level, they are facing premiums and deductibles they
3027 never faced before, they are dropping their coverage
3028 potentially?

3029 Mr. {Smith.} Exactly, because you have, again, the
3030 employer--

3031 Dr. {Cassidy.} This is good for the American worker?

3032 Mr. {Smith.} I think the results are going to be quite
3033 different.

3034 Dr. {Cassidy.} And this is not theoretical, this your
3035 actual experience, correct?

3036 Mr. {Smith.} Yes.

3037 Dr. {Cassidy.} Now, Mr. Greenstein, we speak of
3038 percentages in D.C., isn't it interesting, and that Kaiser

3039 Family Foundation based on the Urban League speaks about how
3040 much Louisiana is going to get, but actually it is going to
3041 cost our State, according to that study, \$1.8 billion over 10
3042 years.

3043 Mr. {Greenstein.} We suspect that those figures
3044 actually are understated and don't capture the full
3045 administrative costs.

3046 Dr. {Cassidy.} And they also, I might say, probably
3047 understate the amount of taxes that will have to be raised
3048 for those costs, a macro effect that it has ignored.
3049 Continue.

3050 Mr. {Greenstein.} Likely. When we looked at the study,
3051 we recognized that there were very large shifts in winners
3052 and losers. Some States end up reducing their overall
3053 burden, some States increase. But when we talk--and a good
3054 part of the discussion today has been about how States are
3055 going to save so much money by Medicaid expansion. It is
3056 just shifting cost from one place to another. At the same
3057 time, this is all net new spending.

3058 Dr. {Cassidy.} I agree with that. So one more question
3059 for Ms. Mann or Mr. Cohen.

3060 Dr. {Burgess.} We better cut it off.

3061 Dr. {Cassidy.} Oh, my gosh.

3062 Dr. {Burgess.} You can submit it in writing. You have

3063 until December 27, sir.

3064 Dr. {Cassidy.} Thank you all.

3065 Dr. {Burgess.} I recognize the ranking member of the
3066 subcommittee 5 minutes for your questions, please.

3067 Mr. {Pallone.} Thank you, Mr. Chairman.

3068 Ms. Mann, I just wanted to give you an opportunity to
3069 respond to the comments made by Mr. Smith, if you would.

3070 Ms. {Mann.} On the issue of the block grant, I think,
3071 is where I was trying to jump in.

3072 Mr. {Pallone.} Whatever you like.

3073 Ms. {Mann.} Yes. A couple things to say. Thank you
3074 for the opportunity. One, Mr. Smith harkened back to noting
3075 that the Children's Health Insurance Program is essentially a
3076 capped allotment, it functions as a block grant. That is
3077 true, and what we need to recall, I know it is hard to
3078 remember back that far, is that in the early years of the
3079 CHIP program, States ran out of money. States were desperate
3080 because the dollars allotted was what Congress thought they
3081 needed and of course it was a set amount of dollars, and it
3082 turned out that the enrollment was higher and the needs were
3083 higher, and States were on the verge of shutting down their
3084 programs or putting their State dollars on the table to cover
3085 children. That is the nature of a block grant. It is a
3086 capped amount of money and it shifts risks onto States and

3087 ultimately onto vulnerable Americans who are covered by those
3088 programs. Mr. Smith talks about who can do a better job, can
3089 the States do a better job, can the feds to a better job. It
3090 is really not about trust. It is really about having a
3091 financial partnership that works. I would submit that
3092 without that financial partnership, we would be moving into
3093 2014 with States operating 20-year-old legacy systems if we
3094 didn't provide some additional federal funding to help States
3095 finance their eligibility. I would submit probably without
3096 that flexible financing, we would not have had the situation
3097 where over the years people with HIV and AIDS were able to
3098 get the care that they needed, expensive care, and then were
3099 able to live healthy and productive lives, or poor children
3100 with leukemia or with autism were able to get effective care
3101 to help them. When you have a capped amount of money where
3102 the federal government says that it is all I am going to do
3103 and I am going to do no more, we risk those kinds of results.

3104 What we need and what is good about that partnership,
3105 while it is fraught with some tensions, is that it keeps us
3106 all at the table to make sure the program is as strong as
3107 possible. We all have incentives to get better care and to
3108 do that at lower cost, and that partnership helps us get
3109 there.

3110 Mr. {Pallone.} Thanks. And I just wanted to give Dr.

3111 Sharfstein and Mr. Allison an opportunity to talk briefly in
3112 closing. Why is Medicaid expansion the right answer for your
3113 States, and if you had to convince the three other States
3114 here, what would you say to them about it?

3115 Dr. {Sharfstein.} I would ask them to spend some time
3116 with individuals who would get coverage and who need coverage
3117 or who benefit from Medicaid coverage. I think we all agree
3118 that there needs to be more value in health care. I think we
3119 all agree that we need to get excess cost out, but I think
3120 basic services and basic health care for people shouldn't be
3121 consider excess.

3122 A couple nights ago, I was at a church in Howard County
3123 with about 300 people in the developmentally disabled
3124 community, and a mom got up and talked about what Medicaid
3125 meant for her daughter born with a heart defect, and it was
3126 just a harrowing story, and then the little girl ran across
3127 and basically gave me a hug, and it was a moment where we
3128 could just stop and say this is what Medicaid stands for.

3129 We want to get Medicaid to work. We need health care to
3130 work, but it shouldn't be don't expand, keep people out
3131 first. It should be, let us get people in and move forward
3132 with the health care system.

3133 Mr. {Pallone.} Okay. Thanks.

3134 Mr. Allison?

3135 Mr. {Allison.} Congressman, thank you for the
3136 opportunity. I would just say that Congress passed and the
3137 Supreme Court upheld a law that provides significant
3138 incentives to States to save the lives of its own citizens,
3139 to improve their health, to provide to them financial
3140 protection. I represent a poor State with many who are
3141 uninsured and who without this support never be able to
3142 afford care. We know that care makes a difference. It may
3143 be that we face challenges in the future to assure that this
3144 remains financially sustainable, the new commitment that we
3145 are making, but I would just encourage my fellow States to
3146 consider the opportunity which has presented itself now.

3147 Mr. {Pallone.} Okay. Thank you very much. Thank you,
3148 Mr. Chairman.

3149 Dr. {Burgess.} The gentleman yields back his time, all
3150 time having expired on the committee.

3151 Mr. Pallone, there was a unanimous-consent request from
3152 your side about providing some data about Pennsylvania, and
3153 without objection, I am going to make that part of the
3154 record.

3155 [The information follows:]

3156 ***** COMMITTEE INSERT *****

|
3157 Dr. {Burgess.} But Mr. Alexander, I think in fairness
3158 to you, I am going to submit a question to you about this
3159 data and I would be very grateful for your reply to that.
3160 The same courtesy will be afforded to Ms. Schakowsky as well,
3161 and I want to remind all members, I said earlier 5 business
3162 days, it is actually 10 business days to submit questions for
3163 the record, and we will ask the witnesses to respond to those
3164 questions promptly. Members should submit their questions by
3165 the close of business on Thursday, December 27th, and by
3166 happy occurrence, we will be here on Thursday, the 27th.

3167 So without objection, the subcommittee is adjourned.

3168 [Whereupon, at 1:30 p.m., the Subcommittee was
3169 adjourned.]