Barbour Testimony: Salt Lake City, Utah

July 14, 2011

Senator Hatch and Members of the Committee, thank you for the privilege of being a part of this important hearing on Medicaid. Governors have unique and valuable perspectives on this complex entitlement program, and we appreciate your taking the time to discuss this effort during the Senate recess.

As debt reduction talks continue in Washington, it is fiscally irresponsible to add hundreds of billions in new costs to a Medicaid program that is already overburdened and unsustainable. We must address meaningful health care reform. The Patient Protection and Affordable Care Act (PPACA) has created widespread uncertainty.

Medicaid is strangling state budgets now and causing business owners to halt job creation and investment because they can't know their costs or obligations for PPACA employee health care. The job numbers last week emphasized it. The June unemployment rate stands at 9.2 percent, and the economy only created 18,000 jobs last month and 25,000 for the month before. Labor market recovery once again has not happened this summer, with job creation essentially flat for the second straight month.

States went into their budget seasons facing a combined shortfall of $86 billion, according to the National Conference of State Legislatures. The stimulus funding cliff and Medicaid mandates forced states to choose healthcare spending over other state priorities like education and public safety. On July 7, 2011, a chart in the Wall Street Journal indicated Medicaid comprises an average 22 percent of state budgets, followed by K-12 education (21 percent) and higher education (10 percent). A second chart demonstrated that K-12 and higher education each bore more than twice as many budget cuts as Medicaid during mid-year budget cuts in the last fiscal year, even though Medicaid comprises a larger share of the average state's budget.

Governors, in bipartisan fashion, have asked Congress for relief from onerous Maintenance of Effort requirements both in January and as recently this past Saturday. On July 9, Governors Gregoire and Heineman wrote on behalf of the nation's governors, "Budget challenges have driven many states to implement reductions in Medicaid programs and the severe limitations on further reductions posed by federal maintenance-of-effort requirements and the proposed access regulations, are causing state Medicaid spending to rise even faster without increased flexibility for governors to administer the program to best meet the needs of their individual states."

As Congress considers tightening its belt and reducing federal spending for Medicaid, remember to grant the flexibility states need to provide health care to the poor without overburdening taxpayers. Otherwise, states will be forced now to increase state taxes or reduce funding for education, transportation and public safety. If federal Medicaid spending is reduced — and flexibility from Washington's rules is not granted, the most likely, if not the only permissible, source of savings would be additional reductions in payments to doctors and hospitals. This

option would force states to run afoul of the proposed PPACA requirements regarding physician access. Washington is setting states up for failure.

Exacerbating the problem, CMS has failed to provide reliable guidance and direction on just about all of the PPACA changes. The most recent proposed regulations on exchanges is full of holes. The Administration needs to be honest with states and the American people about the federal government's own readiness to meet the requirements of PPACA.
In addition, recent information from CMS about setting Medicaid rates and access will burden states. What states need is freedom from Washington to focus on patients – not new mandates from Washington to fill out more paperwork. In addition, the delays in guidance about Health Information Technology initiatives hinder states' ability to begin the program. In fact, states are required to implement some mandates within weeks after CMS issues final regulations. This is unrealistic.

On May 23, 2011, Senator Hatch and Chairman Upton wrote the nation's governors and requested our input to modernize the Medicaid program. Senator Hatch, you wrote — and I quote, "We are concerned that the program is failing patients; is a target for waste, fraud, and abuse; and is bankrupting both state and federal governments." I agree. The program is broken and must be fixed.

Governors appreciate your reaching out to discuss needed health care reform. Such discussions never occurred during the debate of the PPACA despite multiple requests from governors to be included in discussions. In fact, as you might remember, governors from both parties were excluded from a White House-arranged meeting on February 25, 2010, at the Blair House to discuss health care reform. This meeting was pitched as a bipartisan, open and honest discussion about needed reform, yet governors, critical stakeholders in this infamous reform, were not present.

Unlike the bipartisan Personal Responsibility and Work Opportunity Reconciliation Act, or welfare reform of the 1990s, where governors and states were part of the solution, PPACA was an exclusive, partisan effort that expanded a broken system while placing billions of taxpayer dollars at risk every year. Americans are no closer to affordable health care with the passage of PPACA than they were before the debate began.

You and your colleagues here today have taken a different approach. In May, you requested governors' feedback on our challenges and sought ideas to make Medicaid better. As you suggested, Republican governors representing 29 states and 55.4 percent of the population submitted written recommendations on June 13. I appreciate the opportunity to share with you the challenges states face in implementing this complex program. Each governor faces a unique set of problems regarding Medicaid, making a one-size-fits-all solution impossible.

To that end, I am here today to discuss the Republican governors' seven guiding principles included in our June 13 response to you and Chairman Upton. We continue to believe that Governors must have the flexibility to make program adjustments in a timely manner, given our ever-changing economy. Governors are ready to work with Congress and the Administration to develop a better path, one that gives states greater leeway in determining how to provide safety net health care while allowing states to be good stewards of taxpayer dollars.

First, states and territories are best able to make decisions about the design of their health care systems based on their respective needs, cultures and values.

PPACA will add $26 billion in new administrative costs alone to Medicaid over the next decade. The high price tag will be split almost evenly with $14 billion to be paid by the federal government and $12 billion to be paid by the states. By 2019, administration costs are expected to reach $30.5 billion and continue growing at an annual rate of 5.2 percent. Such expensive red tape is not only onerous but unnecessary. Through greater flexibility in the management of Medicaid, states might be able to reduce substantially the hidden tax increase that forced expansion of the program will impose.

More simply and directly put: what works in Vermont, may not work in Mississippi; and what works in Arizona, may not work in Florida. We are all very different, both culturally and demographically, and should have the flexibility to deal with the health of our people.

The federal government's efforts to tie our hands do not account for state-specific needs, nor does it improve care. It simply imposes extra expense on taxpayers.

Second, states and territories also should have the opportunity to innovate by using flexible, accountable financing mechanisms that are transparent and hold states accountable for efficiency and quality health care. Such mechanisms may include a block grant, a capped allotment outside of a waiver, or other accountable and transparent financing approaches.

The FY2012 House Budget proposal recommends a federal block grant. As a governor, I appreciate the House putting this concept on the table. As Congress works to get federal spending under control, I understand that cuts must be made. Governors would be willing to accept cuts to their Medicaid programs if Congress would give us the flexibility to run our programs efficiently. We believe that we can run a quality Medicaid program at a lesser cost-saving the federal and state government's money.

In 2009, Rhode Island entered into a historic agreement with the Bush Administration where the State agreed to cap Medicaid spending for a five-year period (thus giving the federal government budget certainty) in return for the federal government granting substantially greater flexibility than Medicaid rules traditionally allow.

Rhode Island collapsed 11 different waiver programs under a single Global Waiver. That empowered state policy makers to create a consumer-centered health care delivery system that assures beneficiaries have access to services and supports more appropriate and most needed care in the least restrictive and most cost-effective setting.

Contrary to what some in Washington think, state lawmakers and policy makers are capable of making informed decisions. Rhode Island used the flexibility to begin rebalancing its long-term care system by offering more home- and community-based options for seniors and the disabled, mandated care coordination management to achieve better health outcomes and integrate service, and institute value-based purchasing approaches program-wide to ensure quality and access at a price taxpayers can afford. And Rhode Island managed to accomplish all of this, save approximately $100 million in two fiscal years without changing eligibility guidelines.

In return for total flexibility in managing my Medicaid program, I would agree to a block grant-type funding mechanism of the FMAP to Mississippi capped at, say, two or three percent per annual increase, or at one half of the average national increase, saving the federal government more than $100 million a year compared to the average increase in federal Medicaid costs nationally. I emphasize "total flexibility" to run our program, but note, since my state is about one percent of the nation, that deal nationally would save about $10 billion a year in federal spending. Since every state is different, states will have different opinions regarding the implementation of block grants, but such flexibility is critical, and the conversation regarding block grants needs to occur between Congress and Governors. What worked in Rhode Island may not be the solution in Mississippi, but it should be left to state policy makers -- who balance budgets and actually manage the Medicaid program -- to decide.

The status quo must be changed. The current process, which states are required to follow in order to make changes to their programs (either via a state plan amendment or a waiver), is time consuming, costly and challenging to navigate. States should not have to kowtow to CMS to request permission to do what is right for their unique situations. From a bureaucratic standpoint, CMS's process moves at a snail's pace. A state may wait months or years for CMS to approve or deny program changes for immediate needs.

The renewal of the Healthier Mississippi Demonstration Waiver is a good example of CMS's lethargic response to states' seeking to tailor their programs to meet the needs of their people. The Healthier Mississippi Waiver provides coverage for a segment of the aged and disabled population with incomes at or below 135 percent of the Federal Poverty Level (FPL) who are not eligible for Medicare and do not otherwise qualify for Medicaid. Medicaid began submitting its renewal documents in July 2009 and did not receive final approval until October 2010, 15 months later. And this was for renewal of an already successful program providing care to the elderly and disabled that only required minor adjustments to the original waiver.

My colleagues in other states have experienced similar interaction with CMS.

Texas's 1115 concept paper was submitted in April 2008 and negotiations broke down more than a year ago because CMS wanted them to spend more money and expand eligibility. Texas wanted to provide care for more low-income individuals in the private market.

One of the most visible and humorous examples of this bureaucracy is from my friend, Governor Hebert. After working with CMS for 9 months on a waiver and hearing no response, Utah received an email denying their request. Governor Herbert did not receive resolution until he personally lobbied the President back in February when the governors visited the White House. Should states have to go through such hurdles to manage their programs?

The nation has lost the benefits of innovation in the past few years. Look back to the creation of the state Children's Health Insurance Program. No one knows its history better than you, Senator Hatch. And no one deserves more credit for its creation than you. But SCHIP at the federal level was preceded by innovation by states--Florida, New York, and Pennsylvania. SCHIP is an overwhelmingly bipartisan and popular endorsement of state flexibility and capped federal allotments. Some of us dare to call this model for what it is--a block grant.

After the creation of SCHIP, the creativity of states was unleashed during the Bush years. Call the roll across the country and you will find innovation in states as diverse as Massachusetts, Rhode Island, Vermont, West Virginia, Florida, Kentucky, Tennessee, Indiana, Iowa, and Idaho. These were states led by Democrats and Republicans alike. Ask former governor, now Secretary of Agriculture, Tom Vilsack about his ideas on basic health insurance coverage. Ask Phil Bredesen how important flexibility granted by the Bush Administration was to his Administration. Now try to name states that have been granted innovative, comprehensive waivers during the current Administration,

Look at the expansion of home and community-based services during the Bush years. States accelerated the shift from institutional care to community based care because they were allowed to do so in their own way at their own pace.

Third, Medicaid should be focused on quality, value-based and patient-centered programs that work in concert to improve the health of our states' citizens and drive value over volume, quality over quantity, and, at the same time contain costs.

The Medicaid Program is broken from both a budget and health outcomes perspective. The growth in federal Medicaid medical service spending is unsustainable, increasing almost 8 percent annually during the past 10 years. In Mississippi, the PPACA will result in a massive expansion of Medicaid, which is projected to cost Mississippi taxpayers up to an additional $1.7 billion over the next decade despite little spending during the first four of those years. This increase will add 390,000 to 400,000 new individuals to Mississippi's Medicaid rolls, a two-thirds increase, meaning one-in-three Mississippians will be on the state's Medicaid program. With full implementation by 2020, PPACA will cost Mississippi's taxpayers $443 million a year, increasing our state Medicaid cost by half and far outpacing the growth of our revenues. The cost will only rise in subsequent years and the collective impact to states will be $118 billion through 2023.

In Mississippi we offer every Medicaid beneficiary a free annual physical exam. Very few accept our offer, and federal law prohibits us from requiring them to do so. In my state, we have some of the highest incidences of obesity, heart disease, diabetes and cancer. If we could require Medicaid beneficiaries to have an annual exam, it would allow for early detection and proper treatment, improving the quality of life for thousands of Mississippians. We also believe it would save money within a year or two. Preventive care is obviously important, so we are currently partnering with the Mississippi Healthcare Alliance, a physician-led organization that is helping us promote screenings and physical exams through community outreach and meetings with physicians. However, Medicaid programs should have the flexibility to require beneficiaries to get an annual exam to ensure our goal of promoting the use of primary and preventive care. As it stands, we cannot provide incentives to Medicaid recipients to encourage healthier behaviors without going through the infamous waiver process. States want to focus on patients and improve their programs. The problem is that Washington gets in the way.

Fourth, states and territories must be allowed to streamline and simplify the eligibility process to ensure coverage for those most in need, and states must be able to enforce reasonable cost sharing for those able to pay.

States should invest in technology and improved capabilities to determine eligibility; however, states should set their own eligibility thresholds. The dramatic expansion of states' Medicaid populations in 2014 will greatly worsen an already costly challenge: Tracking individuals and families.

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

The state allows exceptions to the face-to-face redetermination for nursing home residents, foster care children, disabled children living at home and anyone home bound, such as an elderly adult in a home- and-community based waiver program. As a whole, this process has proven very successful. Mississippi has a 0.1 percent eligibility error rate, the third lowest in the country, compared to the national average at 6.74 percent. Taxpayers are paying an average of more than $6,000 for each person on Medicaid in Mississippi for a plan that is more generous than most private plans. I believe an annual review to ensure those receiving Medicaid benefits are truly eligible is in the best interest of both beneficiaries and taxpayers. We think it is important to provide the right services to the people, but note that the Maintenance of Effort provisions get in the way of other states implementing this policy at this time. Allowing states to implement what Mississippi has done ensures that care gets to those who truly need it. If the eligibility error rate fell from 6.74 percent to 1.74 percent, far above Mississippi's .1 percent, federal and state governments would save a combined $20 billion a year.

Secretary Sebelius noted in a February 23, 2011, letter that Congress gave states additional flexibility to impose cost sharing in Medicaid in the form of co-payments, deductibles, coinsurance and other similar charges without requiring states to seek federal approval or a waiver. However, this option is available only for the population above 133 percent FPL, or the optional population, not the mandatory population. Further, these federal regulations do not allow a provider to deny services to an individual on the basis of the individual's ability to pay. No cost-sharing measures can be imposed on the bulk of Medicaid enrollees.

The federal government should give states the flexibility to increase enrollee cost sharing and permit cost sharing for all enrollees. For example, more than half of Mississippi Medicaid recipients are children. When the federal government ties states' hands by not allowing cost sharing for children's care and guarantees service regardless of payment, cost-sharing measures become pointless.

Enforceable co-pays and steeper tiers of co-pays for all enrollees are examples of how Medicaid could incentivize beneficiaries to choose an equivalent service at a lower cost. It is important for consumers to have some personal responsibility for their own health care. For example, if a Medicaid enrollee wants a certain drug advertised on television that costs 10 times as much as a generic brand, which is its molecular twin, a state should be able to charge a $20 or $50 co-pay for the brand name drug and $1 co-pay for the generic drug, unless a doctor gives a medically necessary reason why the generic is unacceptable. A patient or a parent will choose the $1 route almost every time, resulting in the same quality of health care but at much lower costs for the taxpayer. This is done for Americans with private insurance every day.

Other states are working to shift their programs to more a preventative care mode. Utah has submitted a waiver which would allow them to increase copays for beneficiaries and move providers away from fee-for-service payment model. Louisiana is working on one waiver to create a coordinated care system (Coordinated Care Networks) and another waiver to combine care for at-risk children that includes Medicaid, Juvenile Justice and Education. My other neighbor, Alabama, has a state-of-the-art Maternity Care program that coordinates care for pregnant women. This program has saved Alabama taxpayers money and improved care. Governors could do much more with improved flexibility and better tools in our toolbox.

Senator Hatch, please remind your colleagues that the majority of Medicaid spending occurs because states have expanded eligibility and services beyond the federal entitlement. In response to state pleas for flexibility as states were confronted with their funding crises, CMS basically told states they can cut certain optional eligibility groups and optional benefits. That is true from a legal perspective but far from helpful. Prescription drugs are an optional benefit under federal law. Home and community based services are optional. To tell states that we can entirely remove optional eligibility groups but we cannot re-determine eligibility more frequently or be trusted with figuring out how much of a co-payment to charge to encourage use of generics rather than brand name drugs is misguided and short-sighted. We applaud your efforts to secure relief from the MOE. The statutory provision is difficult enough but the CMS interpretation which is even more restrictive than the law undermines the Administration's credibility when federal officials talk about flexibility.

Fifth, states and territories can provide Medicaid recipients a choice in their health care coverage plans, just as many have in the private market, if they are able to leverage the existing insurance marketplace through innovative support mechanisms.

States should have the ability to reward individuals for participating in health promotion or disease prevention activities without having to go through a third-party contractor, and we should look for ways to provide easier access to private insurance for Medicaid clients who would prefer to access the commercial market in lieu of Medicaid. Policy makers could consider allowing vouchers for Medicaid recipients.

The federal government doesn't need to tell states how to leverage the existing marketplace; they need to give us the tools and allow us the flexibility to design systems to enhance the private market through innovative support mechanisms - which may look different in all 50 states.

In Mississippi, I have supported a conservative, market-based health insurance exchange that does not include subsides or an individual mandate, much like that of Utah. We have more than 135,000 small businesses employees who could be served through such a mechanism, covering more people and providing a means for private coverage to follow the person, not the job.

Mississippi also has one of the most successful risk pools in the country, covering 3,600 individuals. Before PPACA passed, thirty-five states, including Mississippi, already operated high-risk pools covering more than 200,000 Americans. The federal government decided state risk pools weren't enough and through PPACA, allocated $5 billion and required new duplicated risk pools to be established. That subsidized program in theory would allow more people to switch to a less-expensive option. CBO predicted 200,000 people, who had been denied coverage because of pre-existing conditions, would be covered by the new federal risk pool between 2011 and 2013. They were wrong. As of April 30, 2011, there are a total of 21,454 individuals utilizing the federal high-risk pool and 75 of them are Mississippians.

Sixth, territories must be ensured full integration into the federal health care system so they can provide health care coverage to those in need with the flexibility afforded to the states.

Currently, Puerto Rico's federal share is only thirty five percent, putting a strain on the local budget that limits Puerto Rico's ability to offer the range of services States offer. Governor Fortuno tells me that Puerto Rico is also the only jurisdiction in the United States in which seniors are not automatically enrolled in Part B of Medicare, causing many seniors to opt into the program after the enrollment period ends, at which point they must also pay substantial late enrollment penalties. Puerto Ricans have a distinguished history of serving in the Armed Forces, but they are denied coverage in Tricare Premium, the best health policy for our men and women in uniform.

There is no justification for these disparities. The 3.8 million natural born US citizens in Puerto Rico deserve the right to have the same benefits of our national health care program, including having the flexibility to adequately implement a state health care program.

Seventh, states must have greater flexibility in eligibility, financing and service delivery in order to provide long-term services and support that keep pace with the people Medicaid serves. New federal requirements threaten to stifle state innovation and investment. In addition, since dual eligibles now constitute 39 percent of Medicaid spending, Medicare policies that shift costs to the states must be reversed and the innovative power of states should be rewarded by a shared-savings program that allows full flexibility to target and deliver services, which are cost effective for both state and federal taxpayers.

One way Mississippi wants to improve long-term care is a specialty-skilled nursing facility for children. There is a need in Mississippi for a specialty-skilled nursing facility for the care of medically complex and fragile children. The state wanted to use Civil Money Penalty Funds (CMP) as start-up money for the development of this specialty-skilled nursing facility for children. Prior to PPACA, states were not required to seek CMS approval to use CMP funds. With the passage of PPACA, the use of CMPs were expanded, but utilizing the funds now

requires CMS approval. Mississippi petitioned CMS to use the CMP funds for the specialty-skilled facility and the request was denied.

We know what we need, and we have a plan to get children who require ventilation services out of a hospital into a more home-like setting, but CMS is preventing us from getting there even though the money is in the CMP account to pay for it . This is just another example of CMS not allowing states to be innovative or granting the necessary flexibility to make each Medicaid program meet individual states' needs.

Another example of how the cost of the Medicare program is being shifted to states is in the Medicare Part D 'clawback'. States must pay a share of this Medicare benefit in addition to being required to pay for some drugs not covered in this program for those dual eligibles. In addition, Medicare only covers nursing home services if skilled care, such as active therapy, is needed and only for 100 days, not if the person just simply needs 24/7 care. The burden of nursing home care after the 100 days is borne by the state's Medicaid program.

Secretary Sebelius has opined that flexibility is at the states' disposal to control costs. Although there are avenues states currently can utilize to try to make changes to their programs, making these changes is often lengthy, time consuming and burdensome to states. CMS continuously tells states to be creative and flexible in developing new programs and implementing changes to existing programs to provide smarter care choices. However, all of these things require CMS approval. They shouldn't.

On Friday, July 8, Secretary Sebelius announced a demonstration project with states to address the challenge of serving our citizens who are eligible for both Medicare and Medicaid, the so-called "dual eligibles." At the state level, we know a great deal about the dual eligibles, we know they are among the most medically complex and poorest among us. The costs to provide them with the health care they need are no doubt expensive because it is not unusual to find they have 5, 10, even 15 different medical conditions. But they are also costly because no one is managing their care. They are typically on their own and face difficulties in navigating through the health care complex by themselves. "FFS" typically means fee-for-service. But it also means "fend for self." These are the least capable to fend for self. In addition to complex medical needs, when you look at the characteristics of the dual eligibles, 54 percent have no high school diploma compared to 22 percent of non-duals.

Changes to Medicare policies impact Medicaid as well because Medicaid fills the gaps in Medicare coverage by paying for premiums, cost-sharing, and additional benefits, most especially long-term care that Medicare does not cover. When Medicare acts, there is a reaction within Medicaid. The so-called "doc fix" that seems to perpetually vex the Congress has a spill over effect onto Medicaid. The proposal to raise the age of Medicare eligibility will keep millions on full Medicaid for a longer period of time. Washington needs to stop masking the full costs of its decisions by passing costs onto states.

The demagoguery of proposals to reform Medicare must stop as well. We know that Medicare meets only about 60 percent of a beneficiary's health care expenses which is why more than 90 percent of Medicare beneficiaries have some type of supplemental coverage, either through retiree benefits, private medi-gap insurance, or, all too often, Medicaid.

States and the federal government need to start a serious discussion about how best to serve the dual eligibles at the best value to the taxpayers.

Although the new Medi-Medi project is intended to address fraud and abuse by sharing data between Medicare and Medicaid, having the duals lends itself to abuse for providers to bill both Medicare and Medicaid for services. The Government Accountability Office (GAO) just recently highlighted the missed opportunities to combat waste, fraud, and abuse because no one is looking at Medicare and Medicaid data simultaneously. Once payment is made and out the door, you will never fully recover the taxpayers' money. If Congress is at all serious about significantly lowering the loss of funds due to improper payments, give us the Medicare data for the dual eligibles on a real time basis.

As a condition of eligibility, individuals should be required to apply for all Medicare benefits. This is commonsense. Medicaid is supposed to be the payer of last resort so individuals should be expected to make use of all other resources before turning to Medicaid. Mississippi does this now; it is in our state plan. However, it would be easier if this did not require federal approval.

CONCLUSION:

There are three primary factors that drive Medicaid costs for states – eligibility, provider rates and utilization of services. Recent federal actions, the MOE restrictions in PPACA and the proposed access regulations regarding provider rates, prohibit states from exercising any real ability to control two of the three factors. States have limited control over utilization through the prior authorization process, but I know every Governor here does not want to sacrifice an individual's health to ensure the solvency of the program. In addition, the Obama Administration is proposing a blended rate to fund the federal share and, in effect, the state share, of the Medicaid program. States will suffer under this plan because it simply shifts more costs to the states without giving states any flexibility to design their own programs. It is unrealistic and unfair to think that states can manage their Medicaid programs when the federal government permits the states no flexibility in designing and no flexibility in administering their programs while continuing to push the ever-growing costs for the program down to the states. At the end of the day, states will be saddled with a Medicaid program that is significantly different than the one states signed up for 40 years ago. States will be forced to pay higher rates to providers, states will be forced to enroll individuals who are significantly above the poverty thresholds, states will have less federal financial support and states will have no flexibility to control their own costs. In short, Mr. Chairman, the Administration's constraints regarding eligibility and provider rates at the expense of economy, efficiency and flexibility will lock states into an unaffordable and unsustainable health care system that is destined to fail.