Testimony on Graham Cassidy Healthcare Amendment

Before the Senate Finance Committee

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In July of 1996, after two vetoes by President Clinton, the Senate passed The Welfare Reform Act of 1996. That reform ended a New Deal Era federal entitlement know as Aid to Families with Dependent Children and replaced it with a block grant to the states called Transitional Assistance to Needy Families. I was the floor manager of that bill and worked closely with Rep. Clay Shaw in the House and numerous governors to craft this reform.

President Clinton, from his experience as Governor of Arkansas, realized the faults in this federally controlled open-ended entitlement that was both inefficient and ineffective in addressing poverty. To his great credit, he accepted that this broken program was in need of a major overhaul. He boldly campaigned on "ending welfare as we know it."

What passed the Congress was more than a major overhaul. It repealed the old system and replaced it with a federalist solution that gave power and a block grant to the each state. The objective then, as with the bill before this committee, was to entrust sufficient resources and decisions into hands closer to the people in need so they can devise innovative solutions better suited for the unique needs of the people in their community. This was to be funded by a clearly defined amount of money that would be limited over time so state and local authorities could set their priorities.

Many progressive voices in and outside of the administration claimed that cruel assault on the poor would lead to rampant poverty, the deaths of thousands if not millions over time. Cries that states couldn't be trusted with caring for their poor, lack of resources, even though there was no reduction in spending in the near term, mean spirited requirements like insisting that the able-bodied work as a condition to receiving cash assistance, were all used to paint supporters of this approach as cruel and uncaring.

Fifty one Republicans voted for passage along with 23 Democrats, including then senators Joe Biden and John Kerry, as well as, I should note, the ranking member of this committee, Ron Wyden. Most of the states took on the challenge and transformed welfare. Within a few years welfare rolls were cut in half nationwide and by more than 90% in some states. The much feared reduction in the rolls did not however result in the much predicted increase in poverty. In fact, poverty among the most chronically poor went down, in some cases to record lows, and employment, particularly among the hardest to employ went up. This novel idea worked for those on welfare and for the taxpayer who has not seen an increase in the block grant in 20 years!

It was this experience in bipartisanship and the frustration of seeing the process bog down in Washington that lead me to reach out to a small group of governors, senators and House members to discuss designing a similar approach to addressing both Medicaid and ACA. Contrary to reports that this is a hastily patched together last minute Hail Mary, Senator Graham, Congressman Meadow and their

staffs have been working with a group of governors lead by Scott Walker and Doug Ducey for several months.

Before I go into the details of the repeal and replacement of the ACA, let me briefly address a proposal that has been debated in the congress for several months that I had nothing to do with. This is a proposal that puts Medicaid on a sustainable funding path while giving states both the resources and predictability necessary to craft a program to care for those in most need. The most significant criticism we hear about GCHJ is the Medicaid per capita cap will strangle this program to the disadvantage of the poor. I understand the per capita cap is something that President Bill Clinton proposed and in 1995, forty six Democratic Senators including the current ranking member of the HELP committee signed a letter in support of it. The claim is the per capita annual growth rate which starts as CPI Medical plus one and which settles at CPI Medical for the blind, elderly and disabled and CPI U for the younger and healthier population is insufficient.

I find this criticism particularly perplexing coming from those who supported Medicaid expansion and are now proposing Medicare for all. One of the principle selling points advanced by their advocates is that these government programs are the most efficient provider of health services. If that is true then pegging that program to an inflation rate that includes these so-called inefficient and profitable private sector plans should be a bonanza for Medicaid. How can you argue on one hand that everyone should be in a government program because it will increase quality and lower cost and then turn around and say that this government program will fail unless it gets more money than the private sector plans?

In spite of the intellectual inconsistencies of the advocates of Medicaid, GCHJ attempts to mollify these concerns by permitting states to use up to 20% of the of the GCHJ block grant to support the state's Medicaid program. In most states that will eliminate or at a minimum greatly reduce any funding shortfall.

That provision of GCHJ was one of the reasons that I suggested a "second" block grant to Senator Graham earlier this spring. The key to designing an effective solution to a rapidly changing and innovative sector of our economy like healthcare is a combination of equally distributed, sufficient but limited resources, the flexibility to adapt to its dynamic nature and multiple competitors to allow for innovation. The ACA provides none of those keys, GCHJ does.

Let me address each one of those keys. Unlike the ACA which distributes funds based upon how states align with ACA requirements, GCHJ is designed to create funding parity among the states and let the states decide how to best spend that money. The allocation is made by distributing the resources on a per capita allocation based upon the number of people between 50% - 138% of poverty. That amount is multiplied by the number of people at that level of poverty in each state. In order to minimize the impact of the transition to parity for the expansion states, GCHJ establishes a base year in 2020 based upon current levels of total funds received by the states under the ACA. The formula is phased in over 10 years to achieve parity among the states. There are three other provisions to further limit the impact on expansion states, non-expansion states are limited to 25% growth per year for the first six years of the formula. The 10% state funding match required by the ACA in 2020 is eliminated. Finally, states whose year over year increases fall below the rate of medical inflation (CPI-M) can buy back the reductions in Disproportionate Share payments eliminated under the ACA. As a result, only a handful of high cost Medicaid states see a reduction in projected spending.

In addition to putting Medicaid under some spending restraint, GCHJ takes another open ended unsustainable entitlement, the ACA, and puts it on a budget. As was the case in 1996 with welfare, this bill restrains spending on an inefficient and failing program. Contrary to the explosive rhetoric the bill does not slash spending. In fact, there are voices on the right and left who oppose this proposal because of the amount of taxes and spending. That usually means you are somewhere at or near appropriate levels of spending. This bill allocates $1.2 billion, all the ACA revenues projected to be collected over the budget window minus a few unpopular taxes like the medical device tax and the individual and employer mandate. Those states that wish to continue an ACA insurance and funding regime could simply adopt the identical mandates in their state implementing legislation.

Unlike the federal government, states, like families and businesses, are used to living within a budget. They can't just borrow seemingly unlimited amounts of money. Medicaid, and particularly Medicaid Expansion, encourage spending and create no incentive to be efficient or effective. The program that welfare reform repealed had a similar track record. They took responsibility to craft a superior system to care for those falling through the cracks in our country, welfare reform demonstrated they will and can.

This leads me to the last reason to support this bill. Allowing the states the flexibility to innovate, compete and imitate were the keys to welfare reform's success. Just look at what Rhode Island, Arkansas and Indiana have done with waivers in Medicaid and Medicaid Expansion. Some have suggested that states prior to the ACA didn't create insurance markets that were affordable and accessible to the individual market. That is true, but they didn't have $1.2 trillion either.

The ACA is failing and it is clear that the Democrats have no interest in structural changes to make it work and Republicans have no interest in propping up a doomed plan. This allows those areas of the country that want to continue with the ACA to do so and those that believe there is a better way to give it a try all within a sustainable budget.