Governor Gary R. Herbert's Testimony to the Senate Finance Committee's "Medicaid Field Hearing" - July 14, 2011

Talking Points: (10 minutes)

Good afternoon, I am Gary R. Herbert, Governor of this great State of Utah.

I would like to thank Senator Hatch for convening this hearing and for your invitation to testify. I would also like to welcome Governor Barbour to our state.

Let me begin by noting these governors are joining many others from around the country in our state this week for the summer meetings of the National Governor's Association. We are colleagues who represent diverse states and diverse populations – and we all have our own unique challenges.

What we share, however, is the rightful authority to advance unique solutions to our unique challenges. I am a firm believer in the principles of Federalism embodied in the 10th Amendment - states are not powerless agents of federal authority.

A balance of powers between the states and the federal government is not only right and proper, but essential if we are ever to find solutions to the complex problems we face as Americans.

To solve those problems, it is critical for the federal government to provide states with the flexibility to find better ways to conduct our business. Simply put, the citizens of this great state deserve, and expect, that Utah challenges will be met with Utah solutions that address our unique demographics and dynamics.

One of our most significant challenges – and a challenge I know we share with other states that are represented by their governors here today – is the untenable growth of our Medicaid program. Medicaid is poised to wreak havoc on the state's budget for years to come, threatening our ability to fund other critical services, such as education and transportation.

In trying economic times, such as those we've experienced over the past several years, families increasingly rely on programs like Medicaid to get them through the rough patches. In May 2007, enrollment stood at 161,368 individuals. By last month – June of 2011 – enrollment had ballooned to 244,470 individuals, an increase of 51% in just 4 years.

As you might imagine, this growth has created a tremendous strain on Utah's budget. Medicaid growth rates have exceeded the state's annual revenue growth rates for the past two decades. Last year, the program's share of the overall general fund was 18 percent – more than double its share from the 1990s. And by 2020, it is estimated to exceed 30%, and that's without the federally mandated expansion of the program.

And it's not just increased enrollment driving up costs. The cost of delivering medical care is also to blame – partly due to health care inflation that is rapidly outpacing overall inflation, and partly due to a reimbursement structure that provides financial rewards overusing medical care.

We have a plan that addresses our unique challenges and will fundamentally change the way Medicaid services are delivered to Utah citizens

Our plan is patient-focused and provides for healthier people; it promotes individual responsibility and consumer choice; and it saves money by providing financial incentives to keep people healthy, not just to perform more tests and procedures on them.

It balances the policy demands of a growing program, with looking out for those who desperately need its services.

The plan is truly homegrown. It was crafted over the past several months by my administration and the Legislature, along with input from Utah citizens, health care providers and advocacy groups.

In order to make this work, the federal government needs to provide Utah with the flexibility to institute the plan.

Our solution has a number of distinct advantages over the current Medicaid service delivery model. Perhaps most importantly, is that it realigns financial

incentives for providers to deliver care in a manner that moves away from "billable events or services" and towards a focus on patient outcomes.

In other words, when it comes to the delivery of health care for Medicaid clients, we are going to stop paying for quantity and start paying for quality.

Our proposal replaces the current Medicaid Managed Care and fee-for-service models with a Medicaid Accountable Care Organization, or ACO, model. The model works by paying doctors and hospitals a lump sum to manage the care of a patient.

This offers the provider an incentive to work towards the best possible health outcome for each individual patient, and to move away from performing, and in turn billing for, services that may be medically unnecessary.

A centerpiece of this reform effort is the "Medical Home" concept. Each Medicaid client will have access to a primary care provider, or a group of primary care providers, who will not only deliver care, but will also coordinate their patients' care throughout the entire network of providers.

This new model will incorporate something that has been missing from Medicaid for quite some time: Consumer choice and individual responsibility

Not only will Medicaid clients have the choice to select from at least two Accountable Care Organizations, they will have the choice to opt out of the program all together and instead receive a subsidy to purchase private insurance.

Currently, individuals who are eligible for Medicaid do not have the choice to participate in the state's premium subsidy program. Our proposal allows an individual who is eligible for Medicaid to make their own choice: Enroll in the program, or opt to receive a premium subsidy and purchase their own insurance through the Utah Health Insurance Exchange or through their employer.

I am a firm believer that Medicaid recipients need to take more responsibility for the delivery of their health care – both in terms of outcomes and payments.

We know that better health outcomes lead to reduced health care costs. And we know that better health outcomes are often achieved by patients cooperating and complying with a recommended course of treatment.

Our plan allows Accountable Care Organizations to offer incentives to patients with chronic diseases who follow their recommended treatments. Such incentives could come in the form of limiting or waiving co-payments, or granting limited cash rewards or gift cards.

The state has nearly 20 percent of its budget, almost $1.8 billion, invested in this program. It's time to move away from the entitlement mentality that has gotten us into this situation by requiring recipients to shoulder a <u>little</u> more of the financial load.

Federal Medicaid co-payment limits were established at $3 back in the early1980's during an initial wave of Medicaid reform. Since that time, co-payment limits have increased by only 60 cents. You would be hard pressed to find a family in our state whose private insurance copayments haven't increased by 60 cents in the past year, much less the past 30 years.

Had that co-payment adjusted with inflation throughout the years, it would be the equivalent of about $11 today.

These onerous and archaic restrictions established by the federal government have put states on a path to financial ruin.

We're ready to change paths.

We're suggesting a modest increase from $3 to $5 for primary care co-payments. And to help ensure patients seek care in appropriate settings, clients visiting an emergency room for non-emergent care will be responsible for a $25 co-payment, rather than the current $6 amount.

We believe this will help reduce much of the unnecessary spending created by patients seeking primary care in the costly emergency-room setting.

I've heard the criticisms that we are placing an undue burden on a population that can little afford to shoulder it. And I'm not unsympathetic to the plight of those who truly would be unable to bear such a burden. Those with no income would still be exempt from the cost sharing. Additionally, our proposal grants

the Accountable Care Organizations the flexibility to waive co-payments, if they find it to be in the best interest of their patients' health outcomes.

Our intent is to implement these reforms in the state's four most populated counties on July 1, 2012.

This should give the Centers for Medicare and Medicaid Services (CMS) ample time to review our waiver and to work through any concerns.

The highest levels of leadership at CMS have been receptive and supportive of our efforts thus far. I would encourage those leaders to provide their staff with the flexibility they will need to make sure we are successful.

The ramifications of this reform effort extend well beyond the borders of our state. Not only could this model be the tipping point for Utah's public insurance program, but I believe private insurance companies will soon follow suit – in Utah, and across the nation.

This is where true health reform will rise from, from the "laboratories of democracy" that we call states.

In Utah, we know we're on the right track. Our health system reform efforts began five years ago, and the lessons we've learned are already serving as a guide to other states as they begin their own reform efforts.

Utah is unique in that a majority of our uninsured population is employed. Most work for small businesses which do not offer health insurance benefits. In order to reduce our uninsured population, we needed to make insurance coverage accessible to our state's small employers.

Utah also has the youngest population in the country. Many of our uninsured are so-called "young immortals", persons between the ages of 18-34 who are generally healthy and employed but who have deemed traditional health insurance coverage to be either unnecessary or too expensive.

In Utah, we have chosen a path of business- and consumer-oriented health system reform which responds to Utah's needs.

One of the tools we're using to help reduce our uninsured population is the Utah Health Insurance Exchange – one of just two exchanges operating in the nation.

The Exchange gives Utah small business employees more than 100 plan choices, all of which retain the pre-tax and guaranteed-issue advantages of traditional small group insurance.

The Utah Health Insurance Exchange is now fully operational. In its first month alone, the exchange helped more than 1,000 employees get health insurance they have chosen. Each month, enrollment continues to climb. Our figures show that 20% of businesses participating in our defined contribution market through the Utah Health Exchange are offering health benefits for the first time.

This is another example where we have used market principles to create a Utah solution for Utah's challenges.

These are the types of innovations Washington should be celebrating – not stifling.

If there is one thing the committee takes away from my testimony here today, and from the testimony you'll hear (have heard) from the other Governors, it's that states are poised to act – but we need flexibility from Washington in order to do so.