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FROM MEDICAID TO RETIREE BENEFITS: HOW SENIORS IMPACT AMERICA'S HEALTH CARE COSTS

HEARING

BEFORE THE

SPECIAL COMMITTEE ON AGING
UNITED STATES SENATE

ONE HUNDRED NINTH CONGRESS

SECOND SESSION

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FROM MEDICAID TO RETIREE BENEFITS: HOW SENIORS IMPACT AMERICA'S HEALTH CARE COSTS

THURSDAY, JULY 13, 2006

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Washington, DC.

The Committee met, pursuant to notice, at 10:06 a.m., in room SD–106, Dirksen Senate Office Building, Hon. Gordon H. Smith (chairman of the committee) presiding.

Present: Senators Smith, Talent, Kohl, Wyden, Carper and Clinton.

OPENING STATEMENT OF SENATOR GORDON H. SMITH, CHAIRMAN

The CHAIRMAN. Good morning, ladies and gentlemen. We welcome you all to this hearing of the U.S. Senate Special Committee on Aging. We have a very important topic to consider today, "From Medicaid to Retiree Benefits: How Seniors Impact America's Health Care Costs."

We are joined by two very distinguished witnesses. Richard Wagoner is the president of General Motors and Janet Napolitano is the Governor from my mother's home State, the great State of Arizona. We thank you so very much, Governor, for being here.

We will begin by having opening statements by my colleagues and then we will turn to our witnesses. Our colleague, Debbie Stabenow, will be introducing more formally Richard Wagoner. So we thank you, Senator, for being here at this important hearing.

Our nation is facing a crisis. Health care costs continue to escalate, while quality continues to lag behind other industrialized nations. Just this past April, a study was released in the Journal of the American Medical Association that compared the health status and spending of Americans to that of British citizens. The results were alarming. Not only did Americans have lower overall health status, we are spending almost twice as much.

We will hear from our witnesses how health care costs continue to impact employers, States and the Federal Government's ability to deliver health care. The two driving factors for growth in health care spending are continually high health care inflation and a growing senior population. While the size of the over-age–65 population can't be changed, steps can be taken to better their care and create efficiencies to ensure we are spending our health care dollars wisely.

Obviously, the question is asked why is this important. The National Center for Chronic Disease Prevention and Health Promotion estimates that 80 percent of people over age 65 have at least one chronic health condition, and 50 percent of those have at least two chronic conditions. Further, the size of this population is projected to explode to 71.5 million people, or 20 percent of our population, by the year 2030, when all the baby-boomers will have retired.

These alarming statistics clearly indicate that our nation is facing a financial train wreck. That is why it is important to act now to reform our system, and I believe the place to start is Medicaid. The Medicaid program, which was created in 1965, has failed to evolve over time. As innovations in the delivery and management of care have become mainstream in the private sector, Medicaid has remained firmly set in its original fee-for-service model.

However, Medicaid is not a failure. It is an integral and essential component of America's health care system, providing safety net coverage to over 60 million Americans. These Americans are the poor, the elderly and the disabled. However, as strongly as I support Medicaid, I am not an apologist for it. I do not believe Medicaid needs to be reformed. I do not believe it should be put on a pedestal, never to be changed, I believe that reform is essential.

In that respect, I continue to try to be a bridge from my party, the Republican Party, to the Democratic Party, fighting to protect the program, but at the same time urging sound, rational reform. That is the purpose of this hearing, to create a bipartisan forum where all stakeholders—members, beneficiaries, providers and advocates—can come together to chart the future of Medicaid.

I hope that by starting this dialog now, we can develop sound policies that are based on improving care and ensuring efficiency rather than simply cutting funding to meet a dollar figure. In the end, I fear the latter approach only ends up costing the country more both in actual dollars spent and in the negative impact to human life.

The Aging Committee has a long tradition of leading the Congress toward innovative and necessary changes to our social programs. In fact, the Social Security program and Medicare were created based on recommendations that came from this Committee. We also have continued to operate in an open and bipartisan manner, and I have to make special note of Senator Kohl and the privilege and pleasure it is to work with him on such a basis.

As Congress embarks on changes to Medicaid, and hopefully the entire health care system, we have an opportunity to once again lead the way. We need to put ideology aside and develop solutions that will ensure the long-term solvency of Medicaid. In doing so, I am hopeful the combined effect will drive efficiencies and modernizations throughout the entire health care system.

As we will hear from our witnesses, both of whom oversee large health care programs, utilizing the size and clout of Medicaid can force innovation in the delivery of care and provide lower-cost, higher-quality health care. It is time to act, and I hope my colleagues will join me as I begin a series of hearings and monthly roundtable discussions focused on reforming Medicaid the right way, not just the budget way.

I look forward to hearing from our witnesses, and before we do that, I will turn to my colleague, Senator Kohl.

OPENING STATEMENT OF SENATOR HERB KOHL

Senator KOHL. Well, thank you, Mr. Chairman, and, of course, we welcome all of our witnesses today. This hearing will kick off a series of Committee meetings to examine Medicaid, its challenges, and bipartisan proposals for reform. I congratulate you, Mr. Chairman, for undertaking this very ambitious agenda.

Medicaid is the largest health care program in the United States, covering more than 60 million people. While Medicaid is traditionally viewed as a program for low-income families and their children, 70 percent of spending is on the elderly and the disabled. There is no question that the current trends in Medicaid growth and spending are not sustainable for Federal or State governments. We all agree that we have to cut costs. The question is how, without endangering the most vulnerable in our society.

In my State of Wisconsin, Medicaid provides quality services to a broader population than is required by law. Our Governor has worked to avoid limiting enrollment and services, seeking instead to buy prescription drugs at better prices and rely on home and community-based care options as an alternative to costly long-term care institutions.

Arizona is engaged in a similar battle to cut Medicaid spending without cutting Medicaid care, and we look forward to hearing from Governor Napolitano about their success. We also hope to hear from Richard Wagoner about General Motors and the private sector's struggle with rising health care costs. These costs threaten GM's fiscal solvency just as certainly as they affect that of the entire Nation.

So again I thank you, Mr. Chairman, for holding this first hearing on the topic, and we all look forward to working with you on this issue.

The CHAIRMAN. Thank you, Senator Kohl.

Senator Wyden.

OPENING STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. Thank you, Mr. Chairman. Mr. Chairman, I think I mentioned to you back when I was director of the Oregon Gray Panthers, we used to say we dream of the idea of an Oregonian being Chairman of the Senate Committee on Aging. It is great to see that you have the gavel in your hands, and I appreciate all of our bipartisan work in this regard.

The CHAIRMAN. Thank you, Senator.

Senator WYDEN. I think it is well understood that escalating health care costs are hitting America like a wrecking ball. This was seen again yesterday when there was an announcement that Medicare premiums were going to go up at least 11 percent next year. What that means is that many older people are going to be looking to their companies and companies like General Motors in order to secure good health care. Because health care is like an ecosystem, if you can't secure your health care from Medicare and you can't secure it on the retiree benefit side in the private sector, then, of course, you slide on to Medicaid.

So I am very pleased that we are going to have our witnesses today, Mr. Wagoner and Governor Napolitano, because I am interested in looking with them particularly at how as entities—a big private employer and a major State—how they use their purchasing power in order to help drive down the costs of health care.

We have Senators here who have been of great help to Senator Snowe and I, for example, in trying to life the restriction on Medicare so that Medicare could bargain to hold down the costs of medicine. We are just a handful of votes away, and I am sure Mr. Wagoner and Governor Napolitano—one of the first things that they do is try to ensure that they can use their clout in the marketplace in order to drive down the cost of health care.

What I will be asking you, Mr. Wagoner, first, because I know you have thought a lot about health care and thought about it in an innovative way, is about your ideas on shared responsibility in terms of holding down health care costs and securing good services. It seems to me that there is a role for government, there is a role for the private sector, and I would also say as a Democrat there is a role for the individual, as well. So I am really glad you are here.

I note Senator Stabenow is here. You are running with the right crowd, Mr. Wagoner, because Senator Stabenow has been a great advocate for quality and affordable health care.

I thank my friend and colleague, Senator Smith, for bringing the Committee together to examine these issues.

The CHAIRMAN. Thank you, Senator Wyden.

Senator Talent.

OPENING STATEMENT OF SENATOR JAMES TALENT

Senator TALENT. Thank you, Mr. Chairman. I want to echo what the other Senators have said about the importance of this hearing. Medicaid is a vital program that makes a difference everyday to millions and millions of vulnerable people. It is the safety net in this area.

We do have fiscal challenges ahead. I am actually optimistic that if this Committee and others like it will canvas what is happening out there and the good people involved in health care in the States and the localities, we can find ways really to make this program sustainable and affordable without cutting access or quality directly or indirectly, without taking it out of the hide of providers. There is so much good going on in health care. I really believe we can find it.

I did want to make a comment. This is very timely, especially in view of the administration's proposal to reduce the provider tax assessment program from 6 percent to 3 percent, which I know you are leading a struggle against, and I appreciate that.

I do want to make a comment just to make certain you are aware of it that Missouri is a State that has entered into a special partnership agreement with CMS regarding its provider tax program. We opened up all our books and let them see everything, in return for which they agreed that they would not change the terms of the program during the life of the agreement.

So this proposal not only has broad national effects, but it effects Missouri, in particular, because we have this partnership agree-

ment negotiated in good faith and that Senator Bond and I are trying to make certain gets respected, whatever else is done. So I wanted to make certain the record had that in it.

Again, I am grateful to you and to Senator Kohl for holding this important hearing. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator.

Senator Stabenow.

STATEMENT OF SENATOR DEBBIE STABENOW

Senator STABENOW. Thank you, Mr. Chairman. I want to particularly thank you and Senator Kohl and all of my colleagues for beginning this series which is so critically important to all of us.

I am extremely pleased to have the opportunity to introduce the chairman and CEO of General Motors, Rick Wagoner, today. Over his 29-year career with General Motors, Rick has been involved, I am sure, in every facet of the company. He was elected to his current position on May 1, 2003, after serving as president and chief executive officer since June 2000, making him the youngest CEO in GM's history.

Given his wealth of experience, it is no wonder that when Rick Wagoner talks about health care, it makes national headlines and people listen. I think his words are very important, and his experiences, and those that he represents in terms of an industry are very, very important.

Health care costs are a huge challenge facing American businesses, as we know, who are trying to compete in a global economy. The reason for that is that we fund health care differently than any other country does, and this difference eats into the bottom line for companies.

Let me just mention, if I might, in making the introduction that there are many ways that we can work together. I have appreciated the work with General Motors on generic drugs, and Senator Lott and I have legislation to close loopholes currently in the generic drug laws to be able to speed generics to the marketplace. We have worked together on health IT, and I am sure Rick is going to talk about e-prescribing. I would say again Senator Snowe and I have legislation to move that forward, which I would look forward to working with you on. There are so many areas where we can work together.

Senator Wyden talked about shared responsibility, and I am sure that Rick is going to be talking about the fact that 1 percent of their employees have catastrophic costs, but that is somewhere between 20 to 25 percent of the entire cost of the company. There are ways for us to come together and I hope that the Committee will be recommending opportunities for us to partner on those issues, as well as on Medicaid and Medicare.

As I indicated, Rick Wagoner speaks for an entire industry which has created the middle class of this country, has given people good-paying jobs, health care, pensions and security in retirement. As our companies compete in a global economy, I hope that we will be listening closely and listening to what Rick is saying today because we have a stake in their success. We have a stake in their ability to succeed in a global economy because that means our people suc-

ceed, and I believe that means we keep the middle class of this country.

So I am very pleased that Rick Wagoner is here. He is someone that we hold in high esteem in Michigan for his work and for the leadership of General Motors on a host of issues. Certainly, health care is at the top of that list.

So welcome, Rick.

The CHAIRMAN. Thank you, Senator Stabenow.

Let me also now introduce, as well, our other witness who is the Governor of the great State of Arizona, Janet Napolitano. When I invited the Governor to participate in this hearing, it was because I am aware of and following the great things she is doing for the Medicaid population in Arizona and wanted very much to include Arizona's experience in this important hearing.

As I invited her to be with us today, it was very clear to me in our conversation that she had a much more important responsibility than being in Washington, DC today, not just running the State of Arizona, but being with her niece for this week, and on this Committee family comes first.

Governor, thank you so much for taking the time. I don't know whether you have a time constraint where you would like to go first in your testimony. We want to be respectful of that.

Governor Napolitano. Senator, thank you for that. I would like to hear from Mr. Wagoner first and then I will dive in, and then we will get to questions from the Committee.

The CHAIRMAN. Thank you so much, Governor.

Mr. CEO of General Motors, thank you so much for being here, and we invite your testimony now.

STATEMENT OF G. RICHARD WAGONER, JR., CHAIRMAN AND CHIEF EXECUTIVE OFFICER, GENERAL MOTORS CORPORATION, DETROIT, MI

Mr. WAGONER. Thank you very much. I very much appreciate it. Chairman Smith, Senator Kohl, members of the Committee, it is an honor to have a chance to testify.

Governor, thanks for joining us today and I will look forward to your comments momentarily. I wanted to thank Senator Stabenow for her kind introduction as well.

I would like to highlight a few of General Motors' efforts to improve the delivery and efficiency of health care services for our employees, retirees and dependents. In addition, I have provided a detailed description of GM's key initiatives in my written testimony. Let me start by giving a little background.

General Motors is the largest private purchaser of health care in the United States, paying the health care costs for 1.1 million employees, retirees and dependents. Of those 1.1 million people, approximately 530,000 are age 60 or over. In 2005, General Motors spent $5.3 billion for health care. That is more than we spent on steel. In fact, a staggering $1.9 billion of that cost was for prescription drugs.

As you know, the U.S. spends more on health care as a percentage of GDP than any other industrialized country, and costs continue to rise, as has been pointed out earlier. Despite all that spending, basic quality indicators would suggest the U.S. does not

have the best health care. In short, we need to get greater value for our health care dollar, and to do this requires the collaboration of stakeholders on many levels.

In our own analysis, we found that GM employees and retirees need three important things: first, better information on effective treatments; second, better tools to identify effective and efficient health care providers; third, education and outreach to prevent disease and better manage chronic illnesses.

To address these needs and to find innovative ways to create better health care delivery systems for all, GM is leading over 30 initiatives across the country. This morning, I would like to touch on just a few of them.

For example, we have in place a number of programs and educational tools to help our employees, retirees and their families stay healthier and better manage disease. Way back in 1996, GM, along with the UAW, our largest union, launched Lifesteps, our comprehensive health and wellness program designed to help individuals identify controllable health risks, develop plans to reduce those risks and modify their lifestyles.

Today, more than 75 percent of GM employees and a very substantial number of retirees have participated in this Lifesteps program which has led to more than 1 million health risk appraisals and the reduction of more than 185,000 specific health risks.

What is more, we found that when our employees participate in Lifesteps as active employees, they are more likely to participate in these programs as Medicare-eligible retirees. So as our employees retire and move into Medicare, we are providing Medicare with a more health-conscious member and likely a healthier member.

Another GM initiative that focuses on prevention and disease management is the Greater Flint Health Care Coalition Heart Failure Task Force. The goal of this program, which covers almost 200,000 General Motors employees, retirees and their families in the greater Flint, MI area, is to encourage more physicians to follow established clinical guidelines in order to reduce health risks and readmission rates, and offer a better quality of care.

We are pleased that early results show a significant improvement in the use of appropriate medications, better documentation and compliance with guidelines. For example, of 2,500 heart patients, those treated at the eight participating hospitals had significantly lower mortality and readmission rates, than those treated at six non-participating hospitals.

GM has also had an extensive health education campaign for all of our employees, retirees and their families to help them become better health care consumers. Back in 2001, we began to emphasize to our employees and retirees the high quality and value of generic drugs. As a result, we have been able to gain over 90-percent generic substitution, again with the support of union leadership. Each percentage increase in generic use saves General Motors $4 million a year.

We also offer all of our employees and retirees many publications, including this comprehensive Health Care 101 guide that addresses major issues facing the health care system. We are also helping our employees and retirees become better consumers by

providing them with more information about providers and plans in their communities.

This August, GM, along with other employers, will launch the Dayton, Ohio Consumer Information Transparency Project. The program will give more than 70,000 local health care consumers some key shopping tools, like cost and quality information about their health care providers. The goal is to educate patients to make better-informed and effective health care choices and to create competition among providers based on cost of service and quality of service.

Starting in 2006, GM began offering salaried workers and early retirees a choice of two high-deductible health care plans with health savings accounts. These plans have been very well received and give GM employees and early retirees greater control over their health care dollars, flexibility to choose their own providers and tax-favored ways to save for current and future health care costs.

Another critical tool to help patients become better health care consumers is health information technology. We have projects in several of our communities, including a collaborative effort with Ford, DaimlerChrysler and Medco Health, which is supported by the UAW and the State of Michigan. This Southeast Michigan Electronic Prescribing Initiative encourages physicians to adopt wireless hand-held devices to look up formularies and other prescription drug information, write prescriptions and send them directly to the pharmacy for filling. As a result, we have seen a significant reduction in adverse drug events and an increase in generic drug use by over 7 percent.

As I mentioned earlier, it takes collaboration by stakeholders in the public and private sectors to develop a quality health care system. While there are numerous collaborative efforts that GM supports, I want to highlight two that are showing great promise.

In Michigan, GM is working with local health care providers, businesses, unions, hospitals and the Greater Detroit Health Care Council on a program called Save Lives, Save Dollars. The goal is to make hospitals more financially accountable for their performance and give consumers price and quality information on physicians. We believe that this will drive our health care cost system to achieve higher levels of performance, which will help save lives, and greater overall efficiency, which will help save dollars.

The Save Dollars component will pay hospitals based on their meeting established performance measures. When care and outcomes are improved, we expect to spend fewer dollars. This is something we know from our own extensive experience in manufacturing. As you improve quality, you lower costs.

Another quick example of collaboration is the implementation of the General Motors production system within health plans, hospitals and physician groups. GM has found that approximately 80 percent of a process, regardless of the industry, is comprised of non-value-added activities. Since 1994, GM has held workshops in over 400 hospitals to help those in the health care industry learn how to be more efficient and eliminate waste. Average results have yielded a 60-percent productivity increase, a 46-percent inventory reduction and a 51-percent lead time improvement.

So as you can see from all this, GM is investing considerable resources to find innovative ways to improve the quality and cost of health care services. However, we also believe that much more can be done with the support and engagement of Congress and other public and private sector stakeholders.

Several key public and private initiatives that deserve attention are a rigorous and robust, competitive prescription drug market in which everyone has access to the full range of affordable pharmaceuticals, including generic biopharmaceutical drugs; policies that give consumers and physicians information on the relative effectiveness of different drugs and treatments so they can compare and distinguish treatment options; implementation of national health IT legislation; release of the complete Medicare claims data base; and, finally, a better public-private effort on high-cost cases. Just 1 percent of the population with chronic and serious illnesses accounts for almost 30 percent of total health care expenditures.

So in conclusion, GM is proud of the positive health care efforts we have been making in our communities for our employees, retirees and their families. However, we all can and must do even more to improve quality, reduce cost and get greater value for our health care dollar. At GM, we are committed to working with both public and private sector stakeholders to develop the solutions that will improve the health care market for everyone.

Thank you again for the opportunity to share GM's experiences with you today.

[The prepared statement of Mr. Wagoner follows:]

Written Testimony Before the

Special Committee on Aging

United States Senate

Presented by

Mr. G. Richard Wagoner, Jr.
Chairman and Chief Executive Officer
General Motors Corporation

July 13, 2006

"From Medicaid to Retiree Benefits: How Seniors Impact America's Health Care Costs"

Thank you Chairman Smith, Senator Kohl, and Members of the Committee for the opportunity to testify about the innovations GM is supporting in the private marketplace to manage health care costs for our employees, retirees, and their families. My name is Rick Wagoner, and I am the Chairman and CEO of General Motors Corporation. General Motors leads several programs to improve the delivery and efficiency of health care services for our employees and retirees. Today, I would like to highlight a few of those efforts, and also discuss some ways that we can work to improve the cost and quality of private and public health care services. I have also provided a more detailed description of our key initiatives within this material. I am interested in listening to the health care challenges faced by Arizona Governor Napolitano and her state, and the initiatives she has undertaken to address them. Corporate America and our state governments can learn a lot from each other on this important topic.

I. BACKGROUND

General Motors is the largest private purchaser of health care in the United States, paying the health care costs of 1.1 million employees, retirees and dependents. Of those 1.1 million, approximately 530,000 are age 60 and over, representing over 1% of the U.S. population over 60. In 2005, General Motors spent $5.3 billion for health care. That's more than we spend on steel. $1.9 billion of that cost was spent on prescription drugs, and represents a 335% increase in prescription drug costs over the past 12 years.

GM is not alone in facing huge health cost pressures. In a Business Roundtable survey of its CEO members, 58 percent cited health care as their companies' most meaningful cost pressure.

As you know, the U.S. spends more on health care as a percentage of GDP than any other industrialized country, and health care costs continue to rise. However, despite all that we spend, basic quality indicators show that the U.S. does not have the best health outcomes. Of 16 key health indicators, the U.S. is second to last among 13 industrialized nations. For example, in 2002, the U.S. had 6.8 deaths per live birth, compared to Japan which had 3 deaths per live birth and France which had 4.1 deaths per live birth.

Another statistic of concern is medical errors. Back in 1999, the Institute of Medicine cited that 98,000 people die per year due to medical errors in hospitals alone. For GM, this translates to 488 GM workers, retirees, and their families who may die each year because of a preventable medical error. This is more than one per day! While there has been progress since the IOM report and the enactment of the Patient Safety and Quality Improvement Act of 2005, the results are still insufficient. Quite simply, we need greater value for our health care dollar. We need a high quality health care system that is productive, efficient and error-free.

For years, GM has attempted to balance the demands of global competition with our efforts to offer quality health care. We have made improving the delivery and affordability of the health care system for our employees and retirees one of our top priorities. We want to work with our employees and all the stakeholders within our communities to improve the health care that is delivered.

To do this, we at GM continuously examine the costs and quality of health care. We believe there is NO single solution or a one size fits all approach to reducing the costs and improving the quality and outcomes of the care delivered. Instead we recognize the complexities of the health care system and the diverse population of GM, and that to achieve positive change, numerous and varied approaches must be taken that require the collaboration of stakeholders on many levels.

In our analysis, we found that our employees and retirees need 1) Better information on effective treatments; 2) Better tools to identify effective and efficient health care providers and to achieve provider accountability; and 3) Community and employment-based education and outreach to prevent disease and better manage chronic illnesses. To address these needs and to find innovative ways to create a better health care delivery system for all, GM is leading over 30 initiatives throughout communities across the country.

Today, I am pleased to highlight a few of these initiatives and discuss what GM and our workers and retirees have learned and what we are bringing to our communities to make health care delivery safer, more effective, and affordable. It is our hope that Congress and other stakeholders will work with us to improve the quality of health care for all Americans.

I. GETTING EMPLOYEES HEALTHY; WELLNESS AND DISEASE PREVENTION

The most important key to keeping health costs down, and to keeping your beneficiaries out of hospitals, is to keep them healthy or improve their health status. As

such, we have in place a number of programs and educational tools to help our employees, retirees, and their families stay healthier and manage their diseases better.

Let me first talk about fitness. We are encouraging our employees to get in the best possible shape by educating them on how to stay fit and giving them the tools to manage their health risks. Currently 20 percent of GM's population exercises less than 20 minutes per week. In order to help change that, GM has built in-house fitness centers in many of our facilities to make it easy to exercise before or after work. As an alternative for those who don't want to exercise so close to the workplace, we offer a discount fitness network called "GlobalFit" that offers memberships to clubs nationwide at substantial savings.

Lifesteps

GM's flagship wellness program is called Lifesteps. Back in 1996, GM, along with the UAW, launched LifeSteps, a comprehensive health and wellness program for our 1.1 million employees, retirees and dependents. This program is designed to help individuals identify controllable health risks, develop plans to reduce those risks, and modify lifestyles. It offers personal health risk appraisals, health fairs and screenings, wellness support programs and health-related news and publications. Today, more than 75 percent of GM employees and a very substantial number of retirees have participated in LifeSteps. It has led to more than one million health risk appraisals and the reduction of more than 185,000 specific health risks. The Lifesteps program also has published more articles than any other employer-sponsored wellness program in America. In 2004, the U.S. Department of Health and Human Services awarded the GM-UAW Lifesteps program the "Innovation in Prevention Award."

One of the rewarding outcomes is that when our employees participate in LifeSteps as active employees, we have seen that they are more likely to participate in these programs as Medicare eligible retirees. We have also determined that as our employees retire and move into Medicare, they exceed the National Guidelines for Preventive Services in nearly every category. This indicates that we are providing Medicare a more health-aware and, likely, healthier member. This benefits the Medicare program and taxpayers that support it.

Cancer Efforts

In the field of treatment and prevention, a particular concern is cancer. For pre-65 year old beneficiaries, cancer-related costs make up 8.1% of total health care expenditures. Costs per beneficiary with cancer averages $16,246 a year, which is five times higher than the annual medical costs incurred by those without cancer. Full costs over the entire treatment period are roughly $83,084, and indirect costs include absenteeism, lower work productivity, and reduced performance. The cancer survival rate is now over 60 percent, but is still the second leading cause of death in the United States.

For the last 27 years, GM has been on the front lines in the efforts to eradicate cancer. Through the GM Cancer Research Foundation, we annually honor and award those who conduct research on cures, and donate millions of dollars to cancer research. Within the GM family, over 100,000 people a year are screened or treated for cancer through our Lifesteps program.

Diabetes and the Worksite / Diabetes Disease Management Pilot Program

Another condition of concern to GM is diabetes. Diabetes is the fifth leading cause of death by disease in the U.S. and also contributes to higher rates of morbidity as people with diabetes are at higher risk for heart disease, blindness, kidney failure, extremity amputations, and other chronic conditions. Consequently, it is an extraordinarily expensive disease. In the U.S., expenditures attributable to diabetes in 2002 were estimated at $132 billion – one out of four Medicare dollars.

As a result, GM instituted the "Worksite Diabetes Disease Management Pilot Program." The project is free to employees, confidential, and voluntary. We offer in-plant screening, testing, and free follow-up. The program also seeks to make the workplace diabetic friendly by offering healthier entrees in the cafeteria, making the workplace smoke-free, and providing convenient, private, and sanitary places for insulin injections. The project also links together the myriad of wellness and health promotion programs.

Greater Flint Health Coalition Heart Failure Taskforce

A key aspect of prevention is proper management across all health care settings. For this, GM instituted the "Greater Flint Health Coalition Heart Failure Taskforce." This program, which covers almost 200,000 General Motors employees, retirees, and their families, was implemented with the Greater Flint Health Coalition in Flint, Michigan (overseen by the University of Michigan and sponsored by the American College of Cardiology). The goal is to increase adherence of physicians to the American College of Cardiology/American Heart Association Guidelines for Evaluation and

Management of Chronic Heart Failure. Evidence shows this leads to lower death risks, lower readmission rates and better quality of care for patients.

Early results have shown significant improvement in the use of appropriate medications, documentation of vaccines, discharge instructions and compliance. Of 2,500 heart failure patients, those treated at the eight participating hospitals had a lower mortality and readmission rate than those treated at six hospitals that did not participate. Thirty day readmission rates fell 22% at the eight participating hospitals, compared to a slight increase at non-participating hospitals. Thirty day mortality rates fell 27% at participating hospitals compared to a slight increase among non-participating providers.

II. GIVING CONSUMERS BETTER INFORMATION

In addition to our preventive and disease management programs, another way in which GM is attempting to improve health care is by providing our employees and retirees with a broad range of tools to become better health care consumers. It's troubling that consumers know more about a potential vehicle purchase than they do about the doctors they see, the hospital they may visit, or the prescription drugs they may take.

Education Tools

Patients want and need to become better consumers. GM has an extensive education campaign for all our employees, retirees, and their families to help them better understand the health care delivery system and become better informed health care consumers. For example, in 2001, GM began a comprehensive education campaign to inform employees and retirees about the high quality effectiveness of generic drugs.

Since the program began, we have been able to obtain over 90% generic substitution. Each percentage increase in generic use saves $4 million per year.

We also offer all our employees and retirees a "Health Care 101" publication online and in print that educates them and others about major health care issues facing the health care system. Also, throughout the year we publish information on various health care topics via the web and newsletters to help our employees, retirees, and their families make better and more efficient choices.

Dayton Consumer Information Transparency Project

Another way GM is helping our employees and retirees become better consumers is by providing them with pricing and quality information about providers and plans in their communities. This August, GM is launching a program called the "Dayton Consumer Information Transparency Project." The project will give patients consumer shopping tools, provider level cost and quality information, and member out-of-pocket cost information. The goal is to educate patients to make informed and effective health care choices, and to create competition among providers based on cost of service and quality. The project will allow more than 70,000 people to make the best health care decisions possible, whether it's for cancer-related or cold treatments.

Empowering Consumers through Health Care Spending Accounts

Starting in 2006, GM began offering salaried workers and early retirees a choice of two high-deductible health plans with Health Savings Accounts, in addition to the traditional health insurance plan options. These plans give GM employees and early retirees greater control over their health care dollars, flexibility to choose their own providers, and allow them to save for current and future health care costs on a tax-free

basis. In the first year, 4,150 active employees selected high deductible health plans, 2,120 non-Medicare retirees selected high deductible health plans, and 2,810 Medicare retirees selected high deductible health plans.

Health Information Technology

Another critical tool to help patients become better health care consumers is health information technology. Having a health care system that is electronically based and streamlined will help make health care information readily accessible to consumers and providers, and improve the overall safety and quality of care while reducing inefficiencies and administrative waste.

Currently we have several projects that will help move health care to a technology-based system. Two of these are the Southeast Michigan Electronic Prescribing Initiative, or SEMI, and the Southeast Michigan Health Information Exchange.

Southeast Michigan E- Prescribing Initiative

The Southeast Michigan Electronic Prescribing Initiative is a collaborative effort with Ford, DaimlerChrysler, and Medco Health, and is supported by the UAW and Michigan government. It is designed to increase the adoption of health information technology by providing incentives to physicians to adopt e-prescribing tools in the ambulatory setting. Physicians are given hand-held devices to look up formularies and other prescription drug information, write prescriptions, and send them directly to the pharmacy for filling. These devices help give important safety and coverage information when a physician is making prescribing decisions. They help improve patient safety,

reduce costs, and increase generic drug usage. As you can imagine, it is drastically reducing errors associated with pharmacists reading physicians' handwriting.

Launched in February 2005, SEMI covers approximately 208,000 GM employees, retirees, and family members in Southeast Michigan, and 860 physicians have enrolled in the program. Participating physicians wrote almost 600,000 prescriptions, of which 110,000 were changed or cancelled due to drug-to-drug interaction alerts. 72,000 prescriptions were changed or cancelled due to formulary alerts, and over 7,000 prescriptions were changed or cancelled due to drug or allergy warnings. Under this initiative, generic drug use has increased by over 7%.

Southeast Michigan Health Information Exchange

A second IT initiative in which GM is taking a leadership role is the Southeast Michigan Health Information Exchange. GM is active in regional health care information organizations in all our large communities.

The Southeast Michigan Health Information Exchange is a collaborative effort by GM, other employers, hospitals, and Michigan state officials. It will implement an electronic regional health care information organization that will affect all 4.8 million residents in the Southeast Michigan area, including the 208,000 GM employees, retirees, and family members I just mentioned. While the exchange is still in the early stages of development, we are encouraged that so many stakeholders have come together in a fairly short time in what is a large and complex market.

III. CREATING AN IMPROVED AND EFFICIENT HEALTH CARE SYSTEM

As I mentioned earlier, it takes collaboration by all stakeholders to achieve positive change and develop a quality, efficient health care system. To make health care more affordable and accountable, reduce waste in the system and improve care, the health care industry, government, employers and consumers must come together. While there are numerous collaborative efforts that GM supports, I would like to highlight two that are showing great success and promise.

Save Lives Save Dollars

In Michigan, GM is working with local health care providers, businesses, unions, hospitals and the Greater Detroit Health Care Council on a program called "Save Lives Save Dollars." The program is aimed at improving the cost and quality of care and giving consumers better information about their health care providers and medical facilities. The goal is to make hospitals, physicians and other providers more financially accountable for their performance and give consumers price and quality information on physicians, helping to drive our health care system to achieve higher levels of performance and greater efficiency.

The intention of the "save lives" side of the program is to achieve 100% adherence to selected clinical guidelines. The "save dollars" component is differential reimbursement through paying hospitals based on 100% adherence to the established guidelines. When care and outcomes are improved, we expect to spend fewer dollars. This is something we know from manufacturing – as you improve quality, you lower costs.

When launched later this summer, the program will include a web site that the public can access for reports on the performance data of hospitals in the region, helping beneficiaries in Southeast Michigan become better-informed health care consumers. Differential pay for performance for hospitals begins in July 2006, and will continue to roll out for other health care providers over the next year and a half.

GM Production System (Lean, Go Fast, and Value Stream Mapping)

Another example of how GM has worked with others to help the health care system become more efficient and productive is the implementation of the GM Production System at various health plans, hospitals, and physician groups. GM has found that approximately 80% of a process, regardless of the industry, is comprised of waste and non-value added activities. Since 1994, GM has held workshops in over 400 hospital systems and other health care organizations to help those in the health care industry learn how to be more efficient, and identify and eliminate waste. The goal is to drive health care system improvements in the areas of quality, operational effectiveness, capacity utilization, patient safety and customer satisfaction.

For example, at the HMHP Hospital System in Youngstown, Ohio, nine workshops were completed with a total of 60,000 lives impacted through enhanced levels of care and operational efficiencies. In another example, at the Genesys Health Systems in Flint, Michigan, attendees improved their coding and billing process time from 330 minutes to 97 minutes, and the process itself dropped from 17 to 6 steps. Average results in other settings have yielded a 60% productivity increase, a 46% inventory reduction and a 51% lead line reduction.

Community Based Hospital Negotiations

GM also works with insurers to identify hospitals that are restricting competition in the marketplace. We offer support to insurers to assist in the negotiations by leveraging resources to collect and analyze data and evaluate information. The goal is to enable carriers and hospitals to cooperatively deliver high quality, cost effective health care to community residents. In Dayton, Ohio for example, GM worked with the Tri-River Health Care Coalitions, IUE/CWA and other labor unions, the Dayton Chamber of Commerce, Local Health Departments and local universities. More than 300,000 individuals benefited, including 36,000 GM employees, and GM alone saved nearly $2 million in reduced costs. Overall, it is estimated that the community will save $90 million in one year alone.

Leapfrog Regional Rollout

GM was also one of the founders of the Leapfrog Group, dedicated to using employer purchasing power to create great leaps in patient safety and health care quality. In each of our communities, GM is working with the Leapfrog Group, coalitions, and local hospitals to publish vital patient safety data from hospitals on the Leapfrog website.

This initiative, located in Indiana, is aimed at reducing the number of patients harmed or killed by preventable medical errors. The hospitals are measured on four criteria: computerized physician order entry, Intensive Care Unit physician staffing, evidence-based hospital referral, and the Leapfrog safe practice score. If all U.S. hospitals were to follow Leapfrog's practice guidelines, it is estimated that 65,000 lives and approximately $41.5 billion would be saved.

IV. PUBLIC POLICY NEEDS TO BE ALIGNED WITH THESE CHANGES

GM is investing considerable resources to find innovative ways to improve the quality and costs of health care services and to ensure that our GM families are getting value-based health care. However, GM also believes that this is just a beginning, and that much more can be done with the support and engagement of Congress and other public and private-sector stakeholders to make health care more affordable, accessible, and accountable on a comprehensive, national basis. We believe there are several key public and private initiatives that deserve attention:

- A vigorous and robust competitive prescription drug market in which everyone has access to affordable pharmaceuticals, including generic biopharmaceutical drugs.
- Policies that give consumers and physicians information on the relative effectiveness of different drugs and treatments so that they can compare and distinguish treatment options. Armed with this information, physicians and consumers can ensure that only the most effective drugs and treatments are provided, and help reduce inappropriate, ineffective, and costly care.
- Implementation of National Health IT legislation. S.1472, the Health Care Wired Act, sponsored by Senators Enzi and Kennedy, should be enacted into law this year.
- Release of the complete Medicare Claims Database. I have joined my colleagues at the Business Roundtable asking that the Federal government disclose all Medicare data on the cost and quality of physicians and hospitals across the country. By getting price and quality information about physicians, hospitals, and

other providers available to the public, consumers can make better choices about the health care they receive. This is increasingly important as consumers spend more of their own money on health care. This information will enhance quality and efficiency in the delivery of Medicare services as well as health care services overall.

- Finally, a stronger focus on high-cost cases. Just one percent of the population with chronic and serious illnesses accounts for about 30% of total health care expenditures. These cases pose a significant burden on both private and public payers. We need a better public/private effort to address these high-cost cases to improve their care and reduce overall costs, and to create a more competitive health care market.

CLOSING

In conclusion, GM is proud of the positive efforts we have been making in our communities for our employees, retirees, and their families. However, we must all do more to reduce costs and get greater value for the money we are spending. As we move forward, we are committed to working with all public and private stakeholders to develop solutions that improve the health care marketplace.

I appreciate the opportunity to share GM's experiences with the Special Committee on Aging. As you evaluate private and public initiatives, please consider GM a resource and a willing partner.

General Motors Corporation
Health Care Initiatives

General Motors Corporation provides health care for more than 1.1 million workers, retirees and family members at a cost in 2005 of $5.3 billion. GM has a comprehensive strategy to improve quality and manage costs which includes providing leadership in many community-based initiatives and a long-established wellness approach toward curbing health care costs among its employees by encouraging the use of smoking cessation, fitness programs, and generic prescription drugs, which are less expensive than name brands but equally safe and effective. Notwithstanding those efforts, GM continues to incur unsustainable health care costs. The following provides a brief summary of GM's ongoing efforts to continue providing high quality health care in the face of ever-increasing costs.

Program	Description
LifeSteps	GM's flagship wellness program is designed to promote wellness, safety, and quality of life by providing health services that prevent and control illness. The program covers all GM employees, spouses and dependents. Jointly funded by the UAW from 1994-2004, the program is now fully funded by GM. The estimated medical savings for the intensive program is estimated to be $97 per participant over a four year period. It is estimated that if all active employees were to participate in the program, there is a potential of $40 million in savings due to decreased disability and absence. Since the inception of the program, over 800,000 (78% of population) individuals have been touched by LifeSteps. Over 356,000 individuals have actively participated in some trackable segment of the program and have completed over 1,000,000 health risk appraisals (HRA). The HRA has identified 815,000 risks and over time participants have reported a gross reduction of 185,000 risks. The Lifesteps program has published more articles than any other employer-sponsored wellness program in America. In 2004, Department of HHS awarded the GM-UAW Lifesteps program the Innovation in Prevention Award.
Greater Flint Heart Failure Task Force Initiative	The Greater Flint Health Coalition Heart Failure Task Force focuses on implementing best practices guidelines in heart failure care. The goal is to increase adherence of physician practices to the American College of Cardiology/American Heart Association Guidelines for Evaluation and Management of Chronic Heart Failure, lower the readmission rates for heart failure patients, and lower the risk of death. The project was implemented in eight participating hospitals (Genesee, Lapeer, Saginaw, Bay, Midland and Ingham counties) and covers almost 200,000 General Motors' employees, retirees or dependents. Preliminary results showed a significant improvement in the use of standardized orders, discharge documents and critical pathways' compliance. In the aggregate, the eight hospitals experienced significant advancements in the use of beta blockers and aldosterone inhibitors. Also increased was documentation of discharge instructions and smoking cessation counseling. Results include a 30 day reduction in the readmission rate of 22%, and reduction in mortality rate of 27%.
Community Based Hospital Negotiations	GM works closely with insurers to identify hospitals that are seeking high levels of reimbursement and restricting competition in the marketplace. GM offers support to insurers to assist in the negotiations by leveraging resources to collect and analyze data and evaluate information. The goal is to enable carriers and hospitals to cooperatively deliver high quality, cost effective health care to community residents. In Dayton, Ohio, GM worked with the Tri-River Health Care Coalitions IUE/CWA and other labor unions, the Dayton Chamber of Commerce, Local Health Departments and local universities. More than 300,000 individuals, including 36,000 GM employees, benefited and GM alone saved nearly $2 million in wasted costs. Overall, it is estimated that the community will save $90 million in one year.

The Dayton Consumer Information Transparency Project	In August 2006, GM is launching a program called the "Dayton Consumer Information Transparency Project." The project will give patients consumer shopping tools, featuring easy to understand information such as services and procedures of interest to members, provider level allowed cost and quality information, and member out-of-pocket cost information. The goal is to educate consumers to make informed and effective health care choices and to create competition among providers based on cost, service, and quality. The Program will be available to more than 70,000 people in the Dayton market.
GM/AHRQ Collaborative to Reduce Avoidable Hospitalizations	Recently, AHRQ and HHS approached GM in an effort to connect large employers with the AHRQ Quality Indicators (QIs). The AHRQ QIs were developed to utilize hospital discharge data and incorporate severity adjustment methods to create indicators of quality of community care. Indicators include prevention of hospital admissions, preventive care, inpatient performance and patient safety. The pilot initiative will be conducted through the Greater Flint Health Coalition in Flint, Michigan and will impact over 90,000 GM employees, retirees or dependents. This initiative offers an opportunity to identify areas for improving health care quality and reduce avoidable hospital admissions and procedures.
Leapfrog Regional Rollout	GM is one of the founders of the Leapfrog Group, dedicated to using employer purchasing power to create great leaps in patient safety and health care quality. In each of our large communities, GM is working with the Leapfrog Group, coalitions, and local hospitals to publish vital patient safety data from hospitals on the Leapfrog website. This initiative, located in Indiana, is aimed at reducing the number of patients harmed or killed by preventable medical errors. The hospitals are surveyed on four categories: computerized physician order entry; ICU physician staffing; evidence based hospital referral; and the Leapfrog safe practice score. The program could potentially impact all 86,000 GM participants in Indiana and is supported by 154 business organizations. If all U.S. hospitals followed Leapfrog's practice guidelines, it is estimated that 65,000 lives and approximately $41.5 billion would be saved.
On-line Physician-Patient Communication (OPPC)	Implemented April 1, 2006, the OPPC is a two year pilot to provide online patient/physician communication, which is HIPPA-ready and internet secure. The project enables physicians to communicate online with their established patients for non-urgent conditions and provides a clinically structured communication process that supports medical office workflow. The project covers all GM salaried employees and early retirees in central Indiana with PPO coverage. Reimbursement for e-visits would be $25 less $5 member co-pay, or approximately one-half of a normal office visit. If an e-visit substitutes for an office visit and office visits do not increase as a result of the greater convenience for patients or providers, the cost of office visits could be cut in half. Also, availability of e-visits may act to reduce emergency room visits, saving many times the cost of the visit. In a study conducted by Stanford on two years of claims, e-visit technology decreased total health care costs by $3.69 per member per month. The study found no increase in pharmaceutical spending.
Quality Health First	The purpose of the Quality Health First initiative is to develop and implement a community-wide pay for performance system to reward physicians for achieving measurable improvements in quality of care. The program is being coordinated by the Employers Forum of Indianapolis and the Indiana Health Information Exchange. The goal of the program is to improve the quality and efficiency of care. Quality will be measured across different payers and populations, using evidence-based standards. Comparative reports and actionable information will be provided that will allow providers to improve care processes and outcomes. Provider efforts to improve quality and efficiency will be supported by constructing a multi-payer pay for performance system to reward providers for continuously improving quality of care.

	The program will impact approximately 540,000 lives, including approximately 40,000 GM participants in the greater Indianapolis area. Program quality reporting will begin at the end of 2006 and will continue to be rolled out in 2007.
Implementation of GM Production System (Lean, Go Fast and Value Stream Mapping) at Health Care Initiatives	Since 1994, GM has held workshops in over 400 hospital systems and other health care organizations to help those in the health care industry to be more efficient, and identify and eliminate waste and non-value added efforts. The goal is to drive health care system improvements in the areas of quality, operational effectiveness, capacity utilization, patient safety, and customer satisfaction. In Ohio, a total of nine workshops were completed in the Warren/Youngstown and Dayton areas with a total of 60,000 people impacted through improved level of care and operational improvement. Institutions such as Johns Hopkins Medicine, Mayo Clinic and Cleveland Clinic have embraced GM's processes. Examples of results include reported 60% productivity increases, 46% inventory reduction, and 51% lead time reduction.
Health Savings Accounts	Starting in 2006, GM began offering all salaried workers and early retirees a choice of two high-deductible health plans with Health Savings Accounts, in addition to the traditional health insurance plan options. In the first year, approximately 10% of the active salaried population and 3% of the salaried retirees enrolled in high deductible health plans (4,150 active employees, 2,120 non-Medicare retirees, and 2,810 Medicare).
HMO Value-based Purchasing	GM's HMO purchasing strategy includes evaluation of quality and cost tied to differentiated pricing for salaried employees and retirees. Those electing higher performing health plans (higher quality, lower price) experience the lowest monthly contribution, thereby steering GM's population into better health plans. This strategy results in rewards for the health plans delivering the best value and provides an incentive for health plans to improve. The elements included in the quality evaluation are HEDIS/CAHPS (NCQA's clinical quality and satisfaction metrics) and the National Business Coalition on Health's eValue8 RFI. This strategy is supported by a large number of coalitions and employers across the country and helps to drive change and quality improvement in the health care market place. Results include significant performance improvement in key health plans and significant migration in to better performing plans.
Worksite Diabetes Disease Management	Diabetes is the fifth leading cause of death by disease in the U.S. and an extraordinarily expensive disease. In the U.S., expenditures attributable to diabetes in 2002 were estimated at $132 billion – one out of four Medicare dollars. As a result, GM instituted a worksite diabetes disease management pilot program. The project is free to employees, confidential, and voluntary. GM offers in-plant screening, testing, and free follow-up. The program also seeks to make the workplace diabetic friendly by offering healthier meals in the cafeteria, making the workplace smoke-free, and providing convenient, private, and sanitary places for insulin injections. The project also links together the myriad of wellness and health promotion programs. Of the 560 diabetics in the GM population, 237 are active program participants.
Generic Initiative	In 2001, GM began a comprehensive educational campaign to inform the community about the high quality and cost effectiveness of generics. This emphasis continues today with GM working with other insurance carriers and our PBM to educate retail pharmacists, physicians, and enrollees. At the beginning of the project, GM looked at the top 10 states with a goal to increase the use of generics. Approximately 750,000 GM covered dependents benefit from the ongoing initiative. GM has seen a significant increase in generic use as a result of this and other programs. Since the program began, GM has been able to obtain over 90% generic substitution, of which each percentage increase in generic use saves $4 million per year.

Southeast Michigan Health Information Exchange	The Southeast Michigan Health Information Exchange is a collaborative effort by GM, other employers, hospitals, physicians, insurers and Michigan state officials. It will implement an electronic regional health information organization (RHIO) that will affect all 4.8 million residents in the Southeast Michigan area, including 208,000 GM lives. The primary purpose of a RHIO is the secure electronic facilitation of clinical and administrative data across multiple stakeholder sites to improve the quality and cost effectiveness of the health care delivery system. Covisint, a subsidiary of Compuware, has brought together stakeholders from the employer, physician, carrier, and health system perspectives to discuss functionality and value propositions. Participants are currently working toward the creation of a more community-based decision-making structure in order to develop a business plan, funding structure, and operational plan.
Southeast Michigan Prescribing Initiative (SEMI)	SEMI is designed to increase the adoption of health information technology by providing incentives to physicians to adopt e-prescribing tools in the ambulatory setting. E-prescribing tools include decision support at the point of prescribing, which drives improved quality and cost effectiveness. Quality is enhanced through the identification of potential drug-drug interactions and appropriate dosing. Cost is reduced through the increased use of generic and preferred brand drugs. In addition to impacting cost and quality through decision support, the administration and safety of prescribing is enhanced via electronic submission of prescriptions to the pharmacy. This addresses safety issues such as illegible handwriting and streamlines the administrative process for physician office staff and patients. Launched in February 2005, SEMI covers approximately 208,000 GM people and 860 physicians have enrolled in the program. Participating physicians wrote almost 600,000 prescriptions, of which 190,000 prescriptions were changed or cancelled due to alerts for drug to drug interactions, formulary alerts, drug or allergy warnings, and errors. Under this initiative, generic use has increased by over 7%, which alone will save $3.1 million in annual pharmacy costs. Other business partners in SEMI include Ford Motor Company, DaimlerChrysler Corporation, BCBSM, Health Alliance Plan, Medco, RxHub, Surescripts, and several point-of-care technology vendors.
Save Lives Save Dollars (SLSD)	The SLSD program is aimed at improving the cost and quality of care and giving consumers better information about their health care providers and medical facilities. The goal is to make hospitals, physicians and other providers more financially accountable for their performance and give consumers price and quality information on physicians, helping to drive our health care system to achieve higher levels of performance and greater efficiency. The intention of the "save lives" side of the program is to achieve 100% adherence to selected clinical guidelines. The "save dollars" component is differential reimbursement through paying hospitals based on adherence to 100% of the established guidelines. Differential pay-for-performance for hospitals begins in July 2006, and will continue to roll out for other providers over the next year and one half. When launched later this summer (2006), the program will include a web site that the public can access for reports on the performance data of hospitals in the region, helping beneficiaries in Southeast Michigan become better-informed health care consumers. GM is working with local health care providers, businesses, unions, hospitals, and the Greater Detroit Area Health Council to implement SLSD.

The CHAIRMAN. Thank you, Mr. Wagoner.
Governor.

STATEMENT OF HON. JANET NAPOLITANO, GOVERNOR, STATE OF ARIZONA, PHOENIX, AZ

Governor NAPOLITANO. Well, thank you, Mr. Chairman and members of the Committee, for inviting me to be with you today. I am sorry I can't be there in person, but as the Chairman referenced, I had a family obligation that I could not move.

I must say as the Governor of a Western State that using the videoconferencing facilities to testify is a great service because it allows me to stay in my State and do the day-to-day work of government and to provide you with information that I think will be helpful. Indeed, I think I sit here in a unique position because normally Governors come to the Senate and they testify and they say we need more money, we need more help.

I am here to say I think I can offer you some suggestions on the policy side that will end up saving money for the country as a whole. Indeed, there was a recent Lewin study that looked at Arizona's Medicaid program and said that if this were adopted nationally, it would save you $83 billion over the next 10 years. So I thought what I would do in my testimony is highlight some of the elements of that and why it works and why we think you don't have to choose between cost containment and quality of care. You can do both.

In Arizona, as you may know, we were the last State to adopt a Medicaid program. That was in 1982, and we decided to design a program different from all others. In fact, we have been operating under a huge waiver since our beginning. We utilize managed care, full risk-based capitation, effective procurement and market forces to control costs. Our waiver allows us to use these tools and serve seniors and other populations in a cost-effective way.

Now, without a doubt the most important component of our program is the partnership between the public and the private sectors. This is the cornerstone of our model. Arizona contains costs while providing high-quality services through use of managed competition with private sector managed care organizations, known as MCOs.

Another key component of the model is that the MCOs we contract with are capitated at full risk for all services, including pharmaceuticals. The full risk contracting encourages MCOs to leverage purchasing power, to establish their own formularies, to case-manage members and to appropriately manage health care utilization. The model not only allows, but incentivizes MCOs to establish formularies that mandate use of generic drugs.

While other States average a 50-percent rate of generic drug usage, Arizona has a rate of 71 percent, and that is just for our long-term care population. The Lewin study found that Arizona's per-capita drug spending is the lowest in the Nation, without compromising quality.

Arizona's model also has seen significant savings from serving our aging members in home and community-based settings. Arizona has been able to reverse previous trends and now serves more than 63 percent of our aging population in home and community-

based settings rather than more costly nursing facilities. This is not only cost-effective, but it offers more options to our members in how they receive their care and how they continue to live effectively and independently in their own homes.

I think we all agree that the most basic goal is to ensure that Medicaid endures and it endures to serve our seniors and others who rely on this program for their health care. I believe the Arizona model offers opportunities that other States and the Federal Government should be encouraging.

Again, I want to thank you for this opportunity to testify before you today and I would be happy to answer any questions that you have. I have a more complete statement that I have submitted to the Committee and I hope that you will include it in your deliberations.

[The prepared statement of Governor Napolitano follows:]

Written Testimony of Janet Napolitano, Governor of Arizona

Senate Special Committee on Aging

United States Senate

Thursday, July 13, 2006

"A Review of the Arizona Medicaid Program: Utilizing a Managed Care Approach to Address the Needs of a Growing Senior Population"

SENATE SPECIAL COMMITTEE ON AGING

GOVERNOR JANET NAPOLITANO'S TESTIMONY

JULY 13, 2006

Good morning.

I would like to thank Senator Smith and the other members of the Special Committee on Aging for inviting me to speak about Arizona's best practices in addressing some of the challenges that states and the federal government face with Medicaid. Congress has spent the last two years debating a variety of measures to stem the cost of Medicaid. Those efforts resulted in several cost containment measures found in the Deficit Reduction Act of 2005 (DRA). Although the DRA provides some tools for cost containment, the states themselves have developed best practices that will go farther than the DRA to reduce Medicaid spending while avoiding a reduction of services, or higher copayments that yield only nominal savings.

Mr. Wagoner's testimony this morning, which focuses on the impact that escalating health care costs have on the United States' business competitiveness, highlights the fact that health care reform must look to both the public and private sectors for solutions. I am reminded that the challenges we face with an increasingly aging population affect the employer retiree system as greatly as they affect Medicaid and Medicare. Solutions for providing health care for our aging population, however, must not involve cost shifting between the public or private sector. Rather, we must design a comprehensive approach with long-term cost containment strategies, but without sacrificing quality of care for the most medically vulnerable. Using the Arizona model we can both save states money and increase the quality of care for our aging population.

While my focus today is on specific areas for Medicaid reform, I want to caution all of us to avoid viewing the Medicaid program in isolation, but at the role Medicaid plays as part of the continuum of the entire health care system. Medicaid has moved well beyond its original mission in 1965 and the program must be both recognized as such and modernized to meet its changing role. After a period of sustained growth in the Medicaid program, it is now the largest insurer in the nation, covering the health care costs of half of all children, half of all nursing homes, and increasingly the health care costs of low-income workers.

Although Medicaid's growth has slowed in the last year, the pressures on Medicaid funding will continue to grow due to the following cost drivers:

- **Growth in the aging population**. The first baby boomers are turning 60 this year, notably former president Clinton and – just last week—President Bush. Estimates of the number of seniors in 2050 sound nearly apocalyptic. Therefore, we need to institute the right programs now that will create the capacity for future growth.
- **Growth in the 85+ year olds**. Not only are baby boomers turning 60, but the fastest growing segment of the aging population are those over 85 years of age. Advances in health care have lead to longer life spans and greater health care costs.
- **Chronic disease epidemic**. We are all aware of the epidemic of obesity in the country, which contributes to greater incidence of chronic conditions such as diabetes and heart disease. The growing prevalence of obesity and diabetes in our children have experts predicting that children under the age of 18 will be the first generation not to live longer than their parents.
- **The uninsured.** Lack of health insurance does not prohibit the uninsured from receiving health care services. They access services thought the largest primary care system in the

nation—the emergency room. Health care providers cannot remain profitable with the high cost of uncompensated care, so they are forced to negotiate increased reimbursement from other payors to offset these costs, including Medicaid. The financial pressures on our entire health care system that the uninsured present must be addressed.

- **Personalized medicine.** Innovations in health care research will provide medical treatments that are tailored to an individual's genetic profile. While this ensures the best outcomes, it also could mean higher medical costs.
- **Medical services inflation.** Medicaid, like all payors, must contend with annual inflationary increase for health care services—especially prescription drugs.

Because of these cost drivers, both states and the federal government recognize that Medicaid is not sustainable in the long term in its current form. Therefore, thoughtful and rational Medicaid reform is necessary to preserve the intended purpose of the program as a safety net, and to preserve its increasing role within the entire health care system. The federal budget deficit is one natural first impetus for addressing Medicaid reform; however, sound public policy-making beyond the budget process must be the vehicle for real reform to ensure both fiscal responsibility and the best solutions for the public good.

How can Arizona's Medicaid program offer some solutions? It can't solve the problem of the uninsured, or the broader fiscal and moral issues of personalized medicine. These issues must be the subject of a national debate that I hope this committee will precipitate. Arizona however, can offer its best practices in Medicaid management to other states while the larger issues of health care reform are debated.

Arizona's Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), provides a robust, cost effective model for other states as they and the federal government seek alternative models that can sustain the Medicaid program. Expanding the Arizona model to new populations could cut Medicaid spending without eliminating services, limiting enrollment, or increasing cost sharing for the poor. Its proven best practices in purchasing prescription drugs, managing the health care of persons eligible for Medicare and Medicaid, and expanding home and community based (HCB) placements for those at risk of institutionalization deserve broad consideration.

Prudent Purchasing

AHCCCS is a national leader in cost effective purchasing of health care services. At its inception in 1982, the federal government granted Arizona an 1115 waiver, which gave it the authority to enroll every Medicaid eligible person into managed care organizations (MCOs). In 1989, that authority was extended to persons receiving long-term care services. AHCCCS' waiver creates an integrated, flexible health care system that has matured into a high quality, innovative, cost effective component of Arizona's entire health care infrastructure.

The hallmark of AHCCCS' success in containing costs while providing high quality health care services is the use of managed competition with private sector MCOs when contracting for services. Using market forces achieves the best quality for the best price. In addition to competing for contracts with AHCCCS, MCOs also compete for membership and provider networks. The need for a critical mass of enrollment and quality provider networks while remaining profitable forms a three-way tension that drives the necessary balance for high quality and cost effectiveness.

In addition to employing market forces to control costs, AHCCCS capitates the MCOs at full risk for all services, including pharmaceuticals. Full risk contracting means that MCOs are paid a fixed amount each month per enrollee to provide all medically necessary care. With fixed reimbursement, MCOs are at full financial risk for those health care services. Therefore in order to remain profitable, the plans are incentivized to manage a member's care to ensure that only medically necessary services are provided. Additionally, they are incentivized to use their purchasing power to negotiate favorable contracts for the most cost-effective services. Full risk contracting is a critical component in incentivizing cost effective care because it aligns the financial incentives of MCOs and the provider community with those of AHCCCS. What Arizona has known about the benefits of capitated contracts for nearly 25 years, has been formally recognized in a report issued by the Lewin Group in April of this year. Lewin estimates that full use of capitated contracting in Medicaid would save the program $83 billion over 10 years.

Full risk contracting also provides a flexible environment for effectively managing benefits. AHCCCS MCOs have the flexibility to:

- establish their own formularies based on evidence based medicine;
- leverage their purchasing power to negotiate for provider rates below AHCCCS' fee for service rates;
- case manage recipients in order to avoid expensive hospital and institutional care, and replace it with home and community based services; and
- establish prior authorization and utilization management processes that reduce unnecessary care and assure appropriate access to specialty care.

In 2003, the Lewin Group studied the Arizona model and prescription drug spending. The study's key finding was that Arizona's per capita drug spending was the lowest in the nation without compromising quality—38% below the national average. Generic drug utilization is an important factor in controlling drug spending. Arizona has achieved a 72% generic fill rate for its acute care population and a 71% fill rate for its long-term care population. This compares to around 50% or less for other states. These data show that MCO contracting and drug management are a best practice for controlling drug costs in Medicaid. This best practice is directly attributable to the MCOs' capitated, full risk contracts.

Long-term Care

Arizona is particularly successful using the managed competition model for its long-term care population. Arizona is the only state that has all of its long-term care recipients and dual eligibles enrolled into managed care plans. This is the best model for integrating all necessary care with a personalized case manager. The case manager is a degreed social worker or nurse who coordinates the full compendium of health care and behavioral health services for the member including planning and monitoring nursing home and home and community based care. This model integrates all services into a seamless delivery system that maximizes independence, dignity, and choice.

Under the 1115 waiver, Arizona is granted the flexibility to place persons in home or community settings when those are the appropriate level of care. Arizona has eliminated the oft-quoted concern of increasing the covered population through a woodwork effect by implementing a rigorous medical eligibility tool.

To illustrate Arizona's successful transition from traditional institutional placements for long-term care to home and community settings, please refer to Attachment A. This movement

away from institutionalization was mainly achieved by developing financial incentives from the state to the MCOs. In Arizona, AHCCCS pays the MCOs an average rate per person for all nursing facility and HCB costs. The rate is based on a set targeted percentage for HCBS placements, which are far less costly than nursing facilities. If the MCO achieves a higher HCBS placement percentage than what is factored into the monthly capitation rate, they get to keep a portion of the savings to the state. Conversely, if they don't meet their targeted percentage, they have to absorb a portion of the losses attributed to a higher institutionalized population. The federal government should identify similar appropriate incentives for states and their delivery systems to facilitate similar results.

Attachment A illustrates the results of good public policy making, and Attachment B shows the financial rewards. This graph shows the difference that AHCCCS pays MCOs for different placement settings. Since 1999, the increase in home and community placements has saved Arizona and the federal government an estimated $420 million through the end of fiscal year 2006. These are scorable savings that result from the sound policies of allowing people to age in place, in the least restrictive setting.

Medicare and Medicaid integration

One of the most recent innovations approved by the Centers for Medicare and Medicaid Services is the concept of the Medicare Advantage "special needs plans" (SNPs). SNPs are fully integrated Medicare and Medicaid MCOs that serve the dual eligible population. Nearly all of Arizona's Medicaid MCOs have either been approved to be a SNP or are partnering with a SNP for Medicare services. This is an important development in breaking down huge federal institutional silos to integrate care for our most vulnerable population. With the dual eligible prescription drug benefit moving from Medicaid to Medicare, the SNP model is necessary to

maintain the full integration of care that was provided prior to passage of the Medicare Modernization Act. Steps should be taken now to streamline this new authority and make it permanent so that this model can be expanded in conjunction with managed care.

Health Information Technology

No discussion of health care reform is complete without at least a nod to the dire need for modernizing how America delivers health care. An interoperable health information technology (HIT) system is critical in eliminating waste and inefficiency, and improving health care outcomes and patient safety.

Last year, I created the Arizona Health-e Connection initiative to develop a statewide interoperable health information technology and health information exchange system within five years. My steering committee developed a roadmap to achieve this goal, and Arizona is well on its way. In many cases, Medicaid has a captive audience with health care providers and therefore, should take the lead in implementation. Much of the benefit of an interoperable system accrues to payors, so both states and the federal government should have a strong interest in being the prime mover in developing interoperable systems through leveraging the right incentives.

I applaud the commitment of this subcommittee to continue exploring solutions to make Medicaid more modern and fiscally sound. Because it is the largest insurer in the nation, thoughtful reform that is driven by policy decisions and not merely quick budget solutions will be necessary to ensure that the benefits of Medicaid continue for the health of our most vulnerable citizens and to support the health care delivery system as a whole.

Arizona can help lead the way by offering its best practices in purchasing health care services through managed competition and capitated contracts, increasing home and community

placements so our seniors can age in place, embracing new innovative programs such as special needs plans, and engaging key stakeholders in developing interoperable health information technology.

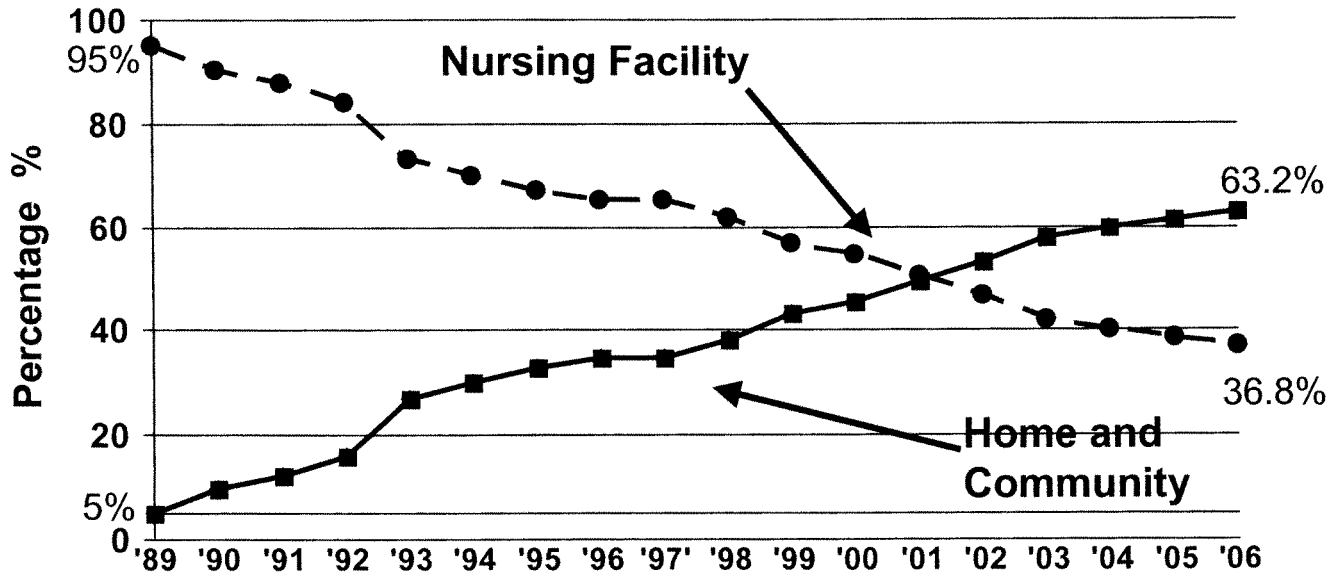
I am committed in my role as incoming Chair of the National Governors Association to work with states and Congress to continue to develop meaningful reform that includes not just the public sector, but also the engagement of the private sector for solutions that improve the health of our health care system

Thank you.

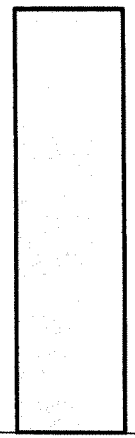
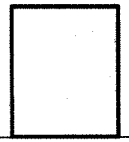
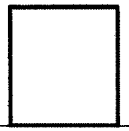
ATTACHMENT A

Effective Use of Home and Community Based Care

ALTCS Trend in HCBS Utilization



ATTACHMENT B
Fiscal Year 06 Monthly Cost Based on Setting

	Nursing Facility	HCBS Assisted Living Facility	HCBS In-Home
☐ Monthly Capitation	$4,176	$1,283	$1,156

The CHAIRMAN. Thank you, Governor, and we will include your full statement and we value very much your participation and your insights.

Did you say that the number of savings for the Federal Government nationwide would be $83 billion?

Governor NAPOLITANO. Yes. This is based on a study done by the Lewin Group looking at how we manage our health care costs versus other States in the Medicaid area, and they said if you followed Arizona's model, those are the types of savings you would incur.

But again, Mr. Chair, and to echo what you said in your opening comments, it is not just about a budget number; it is about providing health care for people. I think the key point of that is you can create those savings and still provide quality health care.

The CHAIRMAN. Well, that has been my point all along through the Medicaid debate earlier in this Congress, and I have to say $83 billion is—by the way, it is $83 billion over how many years?

Governor NAPOLITANO. Ten.

The CHAIRMAN. Ten years. That is enough even to get the attention of the U.S. Senate. But I think even more important than the budget number, my point in my opening statement was, look, Medicaid needs reform. I think Arizona has shown a light as to how you can reform it without compromising health and quality. I can't thank you enough for that example and sharing it with us.

I guess the question I have for you is what has the Deficit Reduction Act of 2005 done to your ability positively or negatively. I would be very interested in how we can mitigate any damage done and not just replicate some of the good things you have done.

Governor NAPOLITANO. Mr. Senator, I think it is a little too soon to know what the DRA really has done. What I do think we need to communicate to HHS and the administration on the Medicaid program is the need for flexibility in the States.

Our waiver has been in existence since 1982. It works, but we still spend an ordinate amount of administrative time going back to CMS to justify the waiver even though from a cost containment perspective and a quality of care perspective this is probably one of the most, if not the most effective Medicaid program in the country.

The CHAIRMAN. Are other States learning from you, asking these questions, and specifically the State of Oregon?

Governor NAPOLITANO. I can't speak to Oregon, but I can say that States and other Governors have been speaking with me. Of course, we are all speaking with the Congress now because we are all concerned that in the effort to reduce the Federal deficit, decisions will be made about Medicaid and other programs that are budget-driven as opposed to policy-driven. I think from the view of the Governors, we think, make the policy changes and then let the budget work its way out.

The CHAIRMAN. Well, obviously the way you have worked it out, it serves health, Medicaid and the budget, and I think that that is the better approach to Medicaid reform and my point from the beginning.

As we go forward, Governor, and the Deficit Reduction Act is implemented, I would be very anxious to learn from you what its neg-

ative positive impacts are in terms of flexibility so that we can be responsive in a timely way and undo any damage that may have been done.

Governor NAPOLITANO. Thank you, Senator, and I would be happy to be speaking with you as we go through the implementation of the Deficit Reduction Act. I am the incoming chair of the National Governors Association, so I am sure I will be hearing from my colleagues around the country.

The CHAIRMAN. Well, that is terrific, and I hope that my Udall cousins are all treating you well. Turn them over to me if they are not.

Governor NAPOLITANO. Your Udall cousins are treating me very well and we could use more of them. Thank you.

The CHAIRMAN. I think I have about 5,000 of them in Arizona.

Mr. Wagoner, thank you again. You know, as I listened to your testimony and have considered some of the remarkable things you have done, frankly, they almost seem to replicate many of the things which the State of Arizona is trying to do. She has given us a potential score from a study that was done. Have you been able to score budgetarily or in health outcomes what your programs have meant?

Mr. WAGONER. We haven't, Senator, added them up. Frankly, I think as the Governor mentioned, it is a little bit of, in some sense, a dicey practice of doing it because we are really trying to do two things. We are trying to improve quality of health care and quality of people's lives, and the cost of providing that. So the accounting for it is—we try to be a little careful about being overly, let me say, bean-counterish about it.

But for each of the programs that we do, as I indicated in my testimony, we have a pretty good sense of what the cost would have been in the absence of that program. Sometimes, it is cost-saving to us. Sometimes, it is better health treatment. We would be more than glad to sit down with the staff of the Committee and really work through initiative by initiative those that I mentioned and others that we filed in the written testimony that perhaps could give you some insights on which kinds of activities generate which kinds of savings.

The CHAIRMAN. Are you mindful of Fortune 500 companies or perhaps even your competitors following similar enlightened models as General Motors is in health care?

Mr. WAGONER. Yes. I think different companies have begun to seriously focus their best thinking on health care costs at different times because I think, to be honest, for some companies with different profiles of retirees, for example, it might not have been a big cost item for them. But I would be surprised if there are many large companies that don't have fairly sophisticated efforts going on to try to both improve quality and reduce the cost of health care, because it is frankly such an issue in global competitiveness today.

But I think maybe even more interesting, Senator, it is not just large companies. We have, obviously, many suppliers of all sizes, large and small, local and global, and dealers which tend to be medium or smaller businesses. We find that health care costs for many of them is a very important issue because they find simply

that it is a benefit their employees very much appreciate and really want. Yet, the cost of it is unmanageable.

So they are very interested in having access to these ideas, as well, but they obviously don't necessarily have the capability to have the staffing or, as you referred to earlier, the purchasing power that we do. I think it highlights to me the importance of what you are doing on the Committee, which is not just improving health care for General Motors, but focusing on can we do for the whole system of health care costs in the United States.

The CHAIRMAN. Richard, 2 weeks ago we had in this Committee a most fascinating hearing on a topic called medical tourism. We had testimony from an ESOP-owned, a union-owned company, in which they had come to an agreement with employees within their union, within their company, to access health care in India. It is called IndUS. This IndUS company—India U.S., I assume the acronym means—is staffed by Indians who are trained in American medical schools and in American business schools and have replicated in India the finest medical facilities that you could find in America.

The union representative told us of one employee who had a heart issue. The cost of the heart surgery in North Carolina was $96,000. In India, with equal care, competent physicians, and legal rights, the cost was $6,000. Is this an issue that you all are looking at?

Mr. WAGONER. I have to say I am familiar with it, having read about stories such as those you are citing, but it is not something that we have studied.

The CHAIRMAN. Is it something you will have to look at?

Mr. WAGONER. It is not something that we are looking at in detail right now. I would say just from the practical perspective, as we see it, because of our size, we have felt that items like medical care—for the most part, our employees would prefer to do it, if at all possible, at a convenient location to where they live. Given the number of people we insure, we hadn't really thought of the practicality, to be honest, of shipping high volumes of people overseas.

The CHAIRMAN. All the pre-ops were done by teleconferencing, like we are doing with Governor Napolitano.

Mr. WAGONER. Right.

The CHAIRMAN. I was astounded by what I learned in that hearing and I just simply note it to you because there is a lot of difference between $6,000 and $96,000.

Mr. WAGONER. I think, Senator, if I could comment, I think perhaps something that we would learn from that is why can they do that for $6,000. Certainly, there may be lower wage rates involved, things that we could not replicate here, but I would suspect it is a much more sophisticated systems-based answer than that, and I think gets at the issue that I think bothers so many of us, which is why can't we deliver the kind of health care system that people want here at a much more efficient cost, because the costs of some of these treatments like you are citing seem to be almost unimaginable.

It does suggest that if we put a number of these initiatives in place which have been discussed, we really should have an opportunity to provide the kind of health care people want at a much

lower cost. I think that is one of the things that I know you are working on here and we applaud it.

The CHAIRMAN. Well, there are a lot of Republican and Democrat Senators wondering the same thing. So, anyway, my time is up and I want to note Senator Hillary Clinton has joined us. We welcome you, Senator, and we will just go in order of appearance and thank you for being with us.

Senator Kohl.

Senator KOHL. Thank you very much.

Mr. Wagoner, you talked about the cost of health care spending, of course, and the fact that almost 40 percent of your health care spending is on prescription drugs. You talked about generic drugs and the opportunities that they present you and, by extension, our country to do something about the staggering costs of health care.

Will you talk about a little bit more generic drugs, their importance, in your opinion, to our Nation, the things that we need to do here in Washington to see to it that generic drugs get full access to the marketplace and not prevented from providing that kind of cost saving to our country?

Mr. WAGONER. Senator, I think you have stated our position very well. Our experience is as you suggest and we do think there has been progress in enhancing the availability of generic drugs, and we do see that as a significant element of cost control with no sacrifice in quality.

I think an area where we are seeing an opportunity to expand generic options would be in the biopharmaceutical drugs, which today do not have the proactive attention that traditional drugs do, chemical-based drugs. We see that as an area where, frankly, health care expenses are rising from a low base, but at an alarming rate. So that would be an area, for example, that—specific focus on providing the resources where those drugs could be reviewed and opened up to generics on a timely basis—would be a good example of an area where we see significant additional opportunity to provide the kind of treatment that people want and need, but at a much more effective cost than the current model provides.

Senator KOHL. In your statement, did you give us an estimate on, in your judgment, what generic drug usage in your company is saving you?

Mr. WAGONER. Well, yes. We said that of all of the formularies that offer generic drugs, generic alternatives, we have had about a 90-percent success rate in converting from branded to generic. For each point on that scale that we move, it saves us about $4 million. So assuming this against a base of $1.9 billion, that would be a savings of roughly $400 million, very significant in total.

I would say just from my own experience, from drug to drug you could see savings even greater than that. I would also think, to be honest, that having greater access to generics would also help to keep the pricing of the brand name pharmaceuticals perhaps in a more competitive light as well.

Senator KOHL. So can I conclude that you would suggest that we need here—to the extent that we are in a position to influence the process, we need here in Washington to see to it that everything is done to open up the market to generic drugs which, as you pointed out, have absolutely no downside with respect to quality?

Mr. WAGONER. Our experience has been very good. It has got, obviously, to be done on a thoughtful basis. I think that has worked out very well from our experience. I want to be clear. I think prescription drugs do play an important role in the whole health care system, too. So in no way, shape or form are we "anti" those. We think they play an important role, but our experience is by enabling greater access to generics, making sure consumers understand the value equation in generics, those sorts of things can really help to provide, as the Governor said, very high-quality health care at much lower cost. I think that is really what we are all talking about here.

Senator KOHL. Thank you very much, Mr. Wagoner.

Governor Napolitano, some States that have expanded home and community-based services, such as your State, have experienced cost increases which you have not, apparently, in what is called the woodwork effect, which is that people who might not have participated in the State health care system join, as you know, when they are offered programs that allow them to stay in their homes and in their neighborhoods.

How have you managed to avoid this cost increase?

Governor NAPOLITANO. Yes, Senator, thank you. We have avoided the woodwork effect because we use a pre-assessment screening tool, which is a very effective device. We interview people. We ascertain whether they are eligible for or would qualify for institutionalization or not, and it is those that would qualify for institutionalization that we then look to—yes, you qualify, but would you be better off in your own home, in your own setting, and have our services delivered to you?

The use of that tool—and this has been evaluated by a number of entities—has allowed us to increase the percentage of our seniors who can stay in their homes and have services delivered to them. Like I said in my testimony, two-thirds of our seniors who are in the long-term care program are getting long-term care at home, as opposed to the majority of States where it is actually the reverse statistic. But it is the use of this tool that allows us to screen early and that prevents the woodwork effect from driving up our costs.

Senator KOHL. Do you think that the relatively smaller size of your State, as opposed to the really larger States in our country, gives you a somewhat greater ability to do this kind of screening, or do you think that does not affect it at all?

Governor NAPOLITANO. We are the 17th largest State in the country, so we are at least medium, and we have a large senior population. In fact, by the year 2020, 25 percent of our population will be 65 or older. So it is to our interest to really think through long-term care, think about it for ourselves, actually, because as the baby-boomer ages, we need to think about the long-term care models we want to employ, but then set up a system that allows us to enable people who are capable to stay in their homes and live as freely and independently and comfortably as possible.

Senator KOHL. That is very good.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Senator Kohl.

So you won't think we are rude, they have called a vote. I would propose that Senator Kohl and I rush over and vote and come back while Senator Wyden and Senator Clinton ask questions, and we will make sure we hold the vote open for our colleagues.

Here is the gavel, Ron.

Senator WYDEN [presiding]. Mr. Chairman, thank you.

Mr. Wagoner, as you know, since 1945 and Harry Truman, this country has been trying to come up with a way to make sure that all Americans could get essential, affordable health care. We thought we had a shot at it in the early 1990's, as you know, and at that time many corporations said we are not sure we can survive if there is comprehensive health reform. What I hear a lot of companies saying now is we can't survive without comprehensive health reform.

My first question to you is do you think we are at the point again, a tipping point, when the companies would be willing to work with the Congress in a bipartisan way for comprehensive reform, getting beyond these incremental steps?

Mr. WAGONER. I obviously can't speak for everybody, Senator. I can say from General Motors' perspective—and certainly I talk to my colleagues in the auto and auto supply business—this is a huge issue for us and I think I can assure you that we all would be most interested in that form of engagement.

I can also tell you at the quarterly Business Roundtable survey of the CEOs of the largest companies, which extends obviously far beyond auto and auto supply and even manufacturing, they ask us each quarter what are the toughest challenges you face in your business, and health care, in the last number of surveys, has come up as the biggest challenge that business faces—health care costs.

So that would suggest to me that I think a fairly broad base of the business community is very concerned about this issue. So I believe they would be willing to engage proactively, and I assure you we would be.

Senator WYDEN. Tell me your thoughts about the idea of shared responsibility, that there is a role for a government, there is a role for the private sector and there is a role for the individual. This obviously was a big topic of debate when Massachusetts, for example, considered their proposal.

What do you think the Congress ought to be pushing employers to do as part of comprehensive health reform and saying to the employers, you are going to have be part of this as well; everybody is going to have to be part of the equation? What can the Congress expect employers to do in this regard?

Mr. WAGONER. Well, obviously, our model, Senator, is one that involves the three parties really working together to fund the health care expense, and it is one that we have had at GM for many years.

My personal view on the matter to your broader question is I do think there are things the Congress can act on right now which would help to get at the broad-based issue of reducing health care costs while improving quality. You are familiar with the list and I mentioned a number of them today.

Obviously, the development of a sophisticated information technology center in health care would be worth billions of dollars to

all providers, but does require some strong leadership. The use of all of the data that we have on cost and quality—there is no data base that is as comprehensive, as high-quality, as good as the Medicare claims data base. If we were able to provide that information, I think you would see significant improvements. There are many, many more things, and my philosophy, frankly, has been we should really push to get on those things that I think everyone can agree on.

Senator WYDEN. I think you are right, and my seat-mate, Senator Clinton, has done very important work in the technology area, but I do want to come back to this question of what the Congress ought to expect from employers. I and others have been reluctant to just impose mandates because if you just heap on mandates, you can put people out of business.

But if we are going to have shared responsibility—and I am prepared to tell individuals they are going to have to pay a portion of health costs in the future—what should the Congress ask of employers?

Mr. WAGONER. Well, again, I don't think I am in probably a position to tell you what should be required of all employers. You know what we do. My experience is the more we can let market forces work even in areas that are not purely market-type businesses, which health care isn't, I think that is the better prescription. So I think to be honest, I better leave it to you all to decide the specific contribution you expect of business.

We are contributing a lot. In fact, I think you would see, Senator, that the direction that has been going on in businesses is businesses are reducing or even eliminating the health care benefits because they are so expensive particularly, for example, to retirees. My preference is to resolve that, rather than specifically legislating that businesses should provide it—I think the fundamental issue is we need to get our arms around the cost issue.

Senator WYDEN. Let me ask you about one idea that I am looking at with respect to the role of the employer. I hear constantly from businesses that their employees very often have to take a full day off in order to get health care. In other words, their appointment was for ten o'clock. They show up at ten o'clock, they wait until noon, and essentially the worker and the company lose a full day of productivity.

What do you think about the idea of essentially bringing health care to the worksite? As we look at the role of the employer in a shared responsibility system, we might try to look at this partnership so that the employer and government and the individual might do something that was in everybody's interest, which is essentially to bring health care to the worksite so that we don't lose a day of productivity. Is that something you might think is fruitful?

Mr. WAGONER. Well, I know that some companies have done that. We have done that at specific sites and I think have had some success doing it. I think basic demographics, things like that, will drive whether it is economically attractive for everyone. If you have a small business, perhaps it wouldn't be something that would make sense from a stand-alone basis.

But I think it is something that a number of companies have done at specific sites where there are enough people and the work

is time-sensitive and things of that sort. So we certainly don't rule that out as one of the things that might help improve the productivity of the system.

Senator WYDEN. My time is up and, as you know, my seat-mate has a longstanding interest in this issue, as well, and I am going to give her the gavel and hope to come back.

Mr. WAGONER. Thank you.

Senator CLINTON [presiding]. Thank you. It is good to see you again, Mr. Wagoner. Governor, welcome. We are delighted to have you be part of this hearing as well.

Governor NAPOLITANO. Thank you.

Senator CLINTON. GM does business all over the world. You obviously are an American company with global reach and we hope that continues. You have employees in how many countries, Mr. Wagoner?

Mr. WAGONER. I would say we have employees probably in 40, 45 countries.

Senator CLINTON. Have you done an analysis of your health care costs in those other 44 countries?

Mr. WAGONER. We have. It is concentrated primarily on the, let me say, 20 countries where we have most of the employees.

Senator CLINTON. Do those include Canada, European countries, as well as Asian countries?

Mr. WAGONER. They do, Senator, yes.

Senator CLINTON. Is that information that could be made available to this Committee in some non-proprietary way for a basis of comparison?

Mr. WAGONER. We would be glad to share that information with the Committee.

Senator CLINTON. Obviously, what I am trying to get at is that I think American companies are being put in an impossible position when it comes to a global economy. Ten years ago, if you had been here, I think we would be talking on a slightly different plane about what the challenges were, but 10 years is a lifetime when it comes to the pace and speed of global competition with respect to American jobs and American productivity and America's standard of living.

I think that when we look at health care costs, it is apparent that you compete against companies in countries where individual businesses don't provide health care costs, where that is provided across the board, where everyone has to make a contribution through the tax system. Some preliminary analyses that I have seen show that if you add all of the costs on American business, which include taxes, health care, worker's comp, et cetera, the costs that you are paying are considerably higher than what is paid for health care in comparably advanced countries where everybody pays into the system.

On the other side of the equation are those companies in countries that don't provide health care, where basically it is every person for himself. There is a rudimentary system, but there is no organized way, and therefore the costs are commensurately lower.

I have become increasingly convinced that we are getting a bad deal in America and that GM is getting a bad deal and most of the other companies that are doing the right thing by insuring employ-

ees are getting a bad deal. But certainly companies like yours which essentially bear the social contract of the last 50 years are getting an especially bad deal because you are paying for what are now considered retired employees, therefore unproductive employees who certainly did a great service to you and to our country, but no longer are in the workforce.

I don't think this is a sustainable position, and I read your testimony and I really commend you for the many innovative programs and the efforts that you have undertaken to try to squeeze down your costs. I would be interested again, if this is not proprietary, if you could provide this Committee with some sense of what the costs are for running all these programs—the huge benefit-managing departments that large companies have to have, the costs of third-party payers that large companies have to pay.

We spend $1.7 trillion on health care in this country. We spend 50 percent more than any other country and we don't even have the highest results in terms of quality of health care when you look across the board. So one of my continuing questions is why does American business take such a bad deal. I mean, basically, you are getting a really bad deal.

The cost of administering Medicare is much less than the cost of administering your health care programs. The average cost of private insurance is considerably higher than the administrative costs of Medicare. I don't know how it much it costs to pay for benefit managers and the whole bureaucracy you have to pay for, but I assume it is considerable.

So why is it that American business doesn't just rise up and say there has got to be better way here, and why don't you bring not just your market power to bear, but your political power to get some changes in this dysfunctional, overly expensive, unproductive health care system that we all are paying for?

Mr. WAGONER. Senator, I share many of your views and I think your analysis is correct that if you compare the cost of health care that we pay for employees in the U.S. versus any other country where we have significant production operations, it would be anywhere from somewhat to a lot higher, and I suspect that is true for many businesses.

I think individual businesses probably look at your question along the following lines. If they are like us, they see the high cost of health care and so they are faced with several choices, such a investing in other lower-cost locations. That is good for some businesses, but it is not good for the U.S. economy because we lose jobs. Or they may perhaps tradeoff and say rather than giving significant wage increases, we will put that money into health care costs for the employees. Or they may choose to not offer health care benefits or reduce the amount of health care benefits which they offer, which I think is definitely a trend we see in business.

Senator CLINTON. Mr. Wagoner, I am so sorry, but they have told me if I don't go to vote, I am not going to get to vote. I would love to get the rest of your answer perhaps in writing and the information that you kindly offered to provide us.

Mr. WAGONER. I would be glad to do that.

Senator CLINTON. Thank you so very much for being here.

Mr. WAGONER. Yes, ma'am. Thank you.

The CHAIRMAN [presiding]. Thank you, Senator Clinton.

Before we let you go, just a couple of follow-ups I had. Governor, I am interested to know in Arizona how you have made sure that private managed care organizations are focusing on managing care and not managing costs. I am sure you know the difference. If they are managing costs by saving money through delaying or denying needed care, what is your role in that? How does the government make sure that care is managed instead of costs being managed?

Governor NAPOLITANO. One is we are really one of the largest purchasers of health care in the State and that gives us some market power. What we do is we have within our AHCCCS department, which is the acronym for our Medicaid area, a whole division that is designed to make sure that quality of care is not sacrificed for cost.

We also write into our vendor contracts a number of quality of care provisions, including a provision that says you have to spend 84 percent of your capitated costs on direct rendition of services, not on other expenditures. So both by oversight and by contract, we endeavor to maintain the quality of care even as we try to control costs.

The CHAIRMAN. Did I understand you to say that you are the purchaser of prescription drugs as well?

Governor NAPOLITANO. Well, that is part of the capitated costs. It is a full-risk, capitated program, and part of that is the pharmaceuticals. So we leave it to the MCOs and the market to figure out how to provide medically adequate care in the sense that they get the capitated costs. If they are able to achieve some savings someplace, they get the benefit of that. If not, they assume the risk of that, and pharmaceuticals are a part of that calculation.

The CHAIRMAN. Richard, as you are no doubt aware, the Centers for Medicare and Medicaid Services have tried without a great deal of success to publish cost and quality information for various sectors of the health care industry. It hasn't been very successful, but it appears like you might have been successful in the program you described.

How were you able to secure participation of these groups and how helpful have your employees and retirees found the information?

Mr. WAGONER. We have been able to do this successfully, I would say, on a limited basis, in areas where obviously we have concentrations, high numbers of employees, so we can create data bases that are meaningful and accurate. I think it has been very helpful.

Just from personal experience, you look through and if you have to go into some sort of elective surgery and there are eight hospitals in your area and you can look and see how many surgeries they have done and what has been the success rate of those surgeries, I think it is the kind of thing that is very helpful. I don't think that the average consumer of health care is used to doing that sort of thing, which we find incredibly ironic.

When you go buy a car, one of the things you might do is go on a website and try to get things like warranty performance or resale values. People do that as second nature, and yet when they are going to get some form of medical care, because that information

isn't easily available, they don't do that. So this is where I think use of the Medicare claims data base in a thoughtful way would really help make everyone out there a smarter consumer.

I think as the Governor mentioned, we don't discount the role of individuals and the private enterprise system reacting to opportunities, and we think there is nothing like data on cost and quality of outcomes that would really help to drive people to the efficient and low-cost and high-quality providers of various services.

The CHAIRMAN. Senator Kohl has a follow-up.

Senator KOHL. Thank you.

Just a word from each of you, if you would, on the importance of health information technology programs, their startup costs, but the payment that you get and how important you think these programs are in controlling the cost of health care and the sense of urgency or importance that you attach to it.

We will start with you, Governor.

Governor NAPOLITANO. Thank you, Senator Kohl. Over a year ago, I issued an executive order and what I did through that executive order was create task force that was called the Health-e Connection. What it was designed to do was to bring together public and private providers to look at how we input technology and have a statewide technology basis to our health care system.

We are now in the process of implementing the recommendations of that group and our goal is within the next few years to have medical records online, accessible to providers. It is a quality of care issue, it is a cost containment issue and it is the wave of the future.

One of the amazing things we found out as we went through the task force work is how paper-driven the medical industry is. For all the science that underlies medicine, their recordkeeping is in the 19th century. So to convert everything to a system that is universally accessible that allows us to transfer records on a real-time basis so that doctors and ER physicians have real-time information is a great development, I think, that the States are doing this. The Federal Government could help us by incentivizing that and providing grants or whatever to other States to do the same thing.

Senator KOHL. Very good.

Mr. Wagoner.

Mr. WAGONER. I wholly endorse what the Governor said. I think she laid out the benefits. The case is compelling. You would be sensitive from your own background. The application of information technology, while it has taken a while, has moved across every sector of our economy—manufacturing, services, now into education. Health care has been, for a variety of reasons, very slow to embrace the opportunity. It is gold lying on the streets and we really need to get at it.

Things like enacting the bill sponsored by Senators Enzi, Kennedy, Frist and Clinton for example, with a sense of urgency would be a great way to begin to capture more and more the benefits here. But it is just viewed by everyone I talk to—professionals in the field, our own business experience—that the benefits are huge. It does require some investment, as you say, but the return is going to be terrific.

Senator KOHL. Those are good answers. I thank you both very much.

I thank you, Mr. Chairman.

The CHAIRMAN. Richard Wagoner and Governor Napolitano, we can't thank you enough for sharing your time on this very important issue, an issue that eventually will be better reformed because of the work that you are doing and the Federal Government needs to do. So for that, we extend to your our heartfelt gratitude. With that, we wish you a good day and we will call up our second witness.

Mr. WAGONER. Thank you very much.

Governor NAPOLITANO. Thank you, sir.

The CHAIRMAN. Thank you.

Mr. Don Marron is the acting director of the Congressional Budget Office.

We welcome you. Thank you, Don.

He will present a new CBO report that examines the cost implications seniors have on America's health care system, with a special focus on the Medicaid program and how its cost growth will fuel significant challenges for the entire Federal budget.

Thank you, and the mike is yours.

STATEMENT OF DONALD B. MARRON, ACTING DIRECTOR, CONGRESSIONAL BUDGET OFFICE, WASHINGTON, DC

Mr. MARRON. Thank you, Mr. Chairman. It is a pleasure to be here today to discuss the Medicaid program and the challenges it faces as a result of rising health care costs and demographic pressures. As you mentioned, my written testimony today is, in essence, a primer on Medicaid and some of the forces that are driving spending increases in it, and both looking back where we have been and looking forward to where we may be going.

To start with—and this will come as no surprise—Medicaid is a very large program both in terms of enrollment and spending. In fiscal 2006, Medicaid will cover about 60 million people—1 in 5 Americans—making it the largest Government health insurance program by enrollment. Federal spending for the program this year will total about $190 billion. That is about 7 percent of the overall Federal budget and about 1.5 percent of the overall U.S. economy. Including State spending, which itself is more than $100 billion, Medicaid spending is comparable in size to the net outlays for Medicare. It is a very large program.

Now, in thinking about the size of the program, it is important to distinguish between who the enrollees are and where the money goes. It turns out that most Medicaid enrollees by numbers are children, their parents, and pregnant women. Together, those groups comprise about three-quarters of Medicaid enrollment, but they only comprise about 30 percent of the benefit spending. The aged and the disabled, on the other hand, have much higher costs than those other groups. So while they comprise only one-quarter of Medicaid enrollment, they are the ones who account for about 70 percent of Medicaid benefit spending.

As you know, Medicaid costs have risen rapidly in recently decades. These increases reflect both increases in enrollment—a growing population and expanded enrollment in the programs—and ris-

ing costs per enrollee. The growth in enrollment has been particularly pronounced among disabled beneficiaries.

Looking ahead over the next 10 years, for which CBO constructs projections as part of our baseline exercise, we project that rising costs per enrollee—that is, so rising health care costs per person—will play the dominant role in driving Medicaid's overall cost growth.

The factors that drive Medicaid cost growth and the challenges the program faces are similar in many ways to those that face the U.S. health care system as a whole. As you know, health care spending generally in the United States has risen much faster than the economy in recent years. It now accounts for almost 16 percent of the GDP, up from 8 percent back in 1975.

Most analysts agree that the bulk of this growth reflects increasing use of new medical technologies, or more generally the increased capabilities of medicine. Those advances enable us to treat new conditions, to improve upon existing treatments and to treat more people. Other factors have also contributed to the growth in spending—aging, increasing incomes, deeper insurance coverage. But, together, those explain much less of the spending increases.

As an economist, I should emphasize that increased spending on health care is not necessarily a bad thing. The key issue—and this was discussed on the first panel—is whether that spending provides essential value and benefits that are commensurate with the spending. If it makes sense for the U.S. people and the U.S. economy to spend more on health care because it is delivering benefits that are worth it, that is fine.

The chief concerns, however, are: A) that there may be concerns that we are not getting benefits commensurate with the spending, and that, B) we have a system in which there is a significant amount of Federal spending for health care. So, obviously, as that spending rises, it places pressures on the rest of the Federal budget.

You mentioned earlier on, Mr. Chairman, that it is important to think about the interactions between Medicaid and the health system as a whole. What I would like to emphasize is that the factors driving health care spending generally are important for Medicaid because as capabilities and standards for the delivery of care increase generally in the health care system, they tend to be incorporated into Medicaid as well. In part, that reflects the choice of administrators about what procedures to cover, and in part it reflects the tendency of physicians to provide a comparable level of care to all of their patients.

As this Committee is well aware, the rapid growth in Medicaid spending will occur at a time when the Federal budget will face increasing pressures due to health care costs and the aging of the population. As I mentioned earlier, CBO estimates that Medicaid spending this year will be about 1.5 percent of GDP. CBO projects that under current law Federal spending for Medicaid will reach about 2 percent of GDP in 10 years, by 2015, and under intermediate assumptions about future health care costs, could reach 4 percent of GDP by 2050.

So under current trends, under current law, the Medicaid program would take up a larger and larger share of the U.S. economy

and, in addition, a larger and larger share of the Federal budget. Such potential cost growth is a particular challenge since Social Security and, in particular, Medicare will experience significant cost growth at the same time.

Under CBO's projections, Social Security spending might increase by about 2 percent of GDP by 2050 and Medicare spending might increase by about 5.5 percent of GDP. Together, again, under current law, those three programs would take up about 19 percent of GDP several decades out, which is about what overall Federal spending today is when you strip out interest on the debt.

Now, I should emphasize that these estimates are subject to great uncertainty. Demographic trends can be projected with some confidence, but future growth of health care costs is highly uncertain. It is easy to imagine scenarios in which the growth of health care costs is higher than our intermediate projections, and it is entirely possible that it will turn out to be lower as well.

Still, these projections highlight the long-term budget challenges that we face, and again I want to emphasize they are primarily, it turns out, driven by rising health care costs per enrollee. That is the predominant contributor to it, and changing demographics are also an important but secondary factor.

Because of these looming fiscal pressures, there has been increasing interest on ways to control spending in these programs. In thinking about Medicaid in particular, there is sort of a basic menu of choices that you could have. Since it is a joint State-Federal program, obviously one line of direction of pursuing savings for the Federal Government is to shift more costs onto the States. Another obvious approach is to have beneficiaries of the program bear more costs. That would reduce Federal spending and it also might induce some people to demand fewer services through the Medicaid program.

Or you could try to pursue ways to make the delivery of care more efficient so that you have the possibility of having less spending and a higher quality of care. The challenge with those approaches is that finding mechanisms that accomplish that are actually quite challenging. Reference was made on the earlier panel about the woodwork effect. The woodwork effect comes from a situation in which there was a desire to pursue a more efficient way of delivering care in which you move people from an institutional setting to a community or home-based setting.

That has the effect of being more efficient, lower-cost per beneficiary, but in many implementations of that you discover this woodwork effect that more beneficiaries come forward. Then as a result, if your concern is Federal spending, you may not——

The CHAIRMAN. It gets its name from people coming out of the woodwork for it?

Mr. MARRON. Exactly.

The CHAIRMAN. All right.

Mr. MARRON. You may not get the reductions in overall spending that you might have thought just by comparing the per-capita costs of the two systems. Again this also raises an issue raised earlier about to what extent you want to focus just on the budget side versus kind of the delivery and efficiency of care.

With that, I am happy to take any questions you have.

The CHAIRMAN. Well, on that issue—and I know that has been the problem with home care, is the woodwork effect, and yet it does seem to me if they are entitled to be a part of the program and they come out of the woodwork and they are there are under law and it is more efficient and perhaps even better care and less cost, I guess that is the catch–22 we are in.

I want to take you back to a comment, if you were here, from Governor Napolitano about the Lewin Group report.

Mr. MARRON. Yes.

The CHAIRMAN. Their report has shown that the Medicaid program would secure $83 billion over 10 years in savings if all the States moved to a full capitation, managed care model. I am wondering, do you value that study, do you agree with that study? Could you comment on the viability of their projections, whether CBO has done any related research that would verify that kind of a number?

Mr. MARRON. Certainly. We took a very quick glance at the study this morning. We have not reviewed it in any great detail. What I took from it from a quick glance is the $83 billion number that you mentioned. That would be for the Medicaid program as a whole. For the States involved, it turns out that the FMAP is about 56 percent, on average, so that translates into about $46 billion in potential savings for the Federal Government over the next 10 years.

I guess, first, just going back to—and this is one of these classic issues with these programs about what is a big number and what is a small number. Forty-six billion dollars is in one sense an astronomical number. It is interesting. When you compare it to the 10-year spending in the Medicaid program at the Federal level, it still works out to be less than 2 percent. So it is relatively small compared to the overall program, but obviously a significant amount of money.

The CHAIRMAN. Yes.

Mr. MARRON. As I understand it again basically just from a quick glance, their analysis presumes that these changes would essentially happen overnight. Obviously, any policy initiatives that would try to pursue them—presumably, there would be some phase-in period over which they would occur. So I would expect lower savings just for that reason.

States at the moment currently have the flexibility to pursue many kinds of managed care programs on their own, and so you face sort of the classic question about why isn't this already being done.

The CHAIRMAN. Why isn't it?

Mr. MARRON. Well, it is interesting. Arizona is clearly a very special case. As the Governor mentioned, they were the last entrant into the Medicaid program, and they are by far the most intensive users of managed care. For me, this sort of raises this classic issue with a program like Medicaid.

Medicaid has this great sort of laboratories of democracy approach, in which it gives the individual States a great deal of freedom to try to choose what works best and it gives the other States an opportunity to learn from that. But it also gives the States an

opportunity to design programs that best fit their culture, their population, their needs, their health care delivery system.

It raises, then, a question about how well can you transfer the results in one State that has specifically chosen that approach to other States that for various reasons haven't. I think that would be the key issue in trying to figure out whether——

The CHAIRMAN. Can you give me an example of some challenges, say, hypothetically Arkansas would have adopting what Arizona has? Are there States that you could compare that would have particular challenges evolving to such a capitated system?

Mr. MARRON. I think the primary challenge would be that Arizona has worked at managed care since 1982.

The CHAIRMAN. Managed care isn't as accessible in other States?

Mr. MARRON. That not every other State has chosen to go that far. So it is not something where you can easily just switch from a more fee-for-service-oriented delivery system.

The CHAIRMAN. It takes a more mature industry in health care to deal with their system.

Mr. MARRON. Yes, and then there may also be differences in the population covered, but I am afraid I don't have those details at my fingertips.

The CHAIRMAN. Do you ever do studies that actually make recommendations to CMS on these kinds of things or encouragement to give these kinds of waivers because something is working and something is not?

Mr. MARRON. We at CBO studiously avoid recommendations of any kind, if possible. Our job is essentially to serve you and to give you the kinds of information that will be helpful for guiding policy decisions, and we are happy to assist you in that way.

The CHAIRMAN. Well, obviously, we are going to have to do something continually on the whole entitlement category because eventually we will have no choice, because the entitlement side of the ledger is going to consume everything on the discretionary side. I think that is unsustainable to the American people, as well.

Your analysis is appreciated today. It has been helpful and I have found this hearing very worthwhile. I hope maybe you have got a few ideas you can distill for us to make some recommendations to the Congress, and then maybe to OMB, too. I know there is always that fight, too.

Thank you very much, Don, and we are grateful for your presence, and for all of you who have participated.

[The prepared statement of Mr. Marron follows:]

CBO TESTIMONY

Statement of
Donald B. Marron
Acting Director

Medicaid Spending Growth and Options for Controlling Costs

before the
Special Committee on Aging
United States Senate

July 13, 2006

This document is embargoed until it is delivered at 10:00 a.m. (EDT) on Thursday, July 13, 2006. The contents may not be published, transmitted, or otherwise communicated by any print, broadcast, or electronic media before that time.

CONGRESSIONAL BUDGET OFFICE
SECOND AND D STREETS, S.W.
WASHINGTON, D.C. 20515

Chairman Smith, Senator Kohl, and Members of the Committee, it is my pleasure to appear today to discuss the Medicaid program and the challenges it faces as a result of rising costs for health care and demographic pressures. The Congressional Budget Office (CBO) projects that under current law, federal spending for Medicaid will nearly double over the next 10 years—growing from $190 billion in fiscal year 2006 to $363 billion in 2015, at which point it will account for about 2 percent of gross domestic product (GDP). Spending by the states for Medicaid will increase correspondingly, placing further demands on states' budgets. But rising health care costs are also a significant issue for private payers and the economy as a whole, with the overall share of GDP spent on health care now projected to climb from 16.5 percent in 2006 to 20.0 percent in 2015.

My testimony today makes the following main points:

- Although 75 percent of Medicaid enrollees are children and their parents, 70 percent of spending for benefits goes toward care for the program's elderly and disabled enrollees.

- Past increases in spending for Medicaid have been driven partly by growth in enrollment but primarily by growth in costs per enrollee. In CBO's projections of future spending under current law, rising costs per enrollee play an even larger role, and those projections indicate that federal Medicaid spending will reach 4 percent of GDP by 2050.

- Medicaid spending per enrollee is determined by many of the same factors that continue to push up total U.S. health care costs, and the principal cause of those rising costs is the spreading use of new medical technology.

- Although a number of options are available for reducing federal Medicaid costs in the future, many of them involve shifting costs to the states or to enrollees.

- Because enrollees generally have low incomes and few assets, their ability to pay more for their care in many cases is limited. However, there is some evidence that Medicaid coverage discourages enrollees with higher incomes from buying private insurance or saving more to pay for their long-term care costs.

Overview of the Medicaid Program

Medicaid is a joint federal/state program that pays for health care services for a variety of low-income individuals. All those who meet the program's eligibility criteria are entitled to its benefits. In fiscal year 2006, federal spending for the program will total $190 billion, CBO estimates, $170 billion of which will cover benefits for enrollees. (In addition to benefits, Medicaid's spending includes payments to hospitals that treat a "disproportionate share" [DSH] of low-income patients as well as costs for the Vaccines for Children program and administrative costs.) The federal government's share of Medicaid's benefit spending varies among the states

but currently averages 57 percent. Although it is difficult to determine precisely how much the states spend on Medicaid (for reasons that are discussed later), CBO estimates that total federal and state spending for the program will exceed $300 billion for this fiscal year.[1] CBO also estimates that the Medicaid program currently covers 60 million people, or about 20 percent of the U.S. population.

Medicaid is thus the federal government's largest health care program in terms of enrollment, covering more people than Medicare does. In addition, total state and federal Medicaid spending is comparable to Medicare's net outlays. Several examples indicate the large role that Medicaid plays in the U.S. health care sector as a whole:

- It pays for about 40 percent of all births in the United States and covers about one-third of all children;
- It covers, according to surveys, about one-third of people whose income falls below the poverty level; and
- It finances about two-thirds of all nursing home stays by the time of a patient's discharge.

States administer their Medicaid programs under federal guidelines that specify a minimum set of services that must be provided to certain poor individuals. Mandatory benefits include inpatient and outpatient hospital services, physician and laboratory services, and nursing home and home health care. Mandatory eligibility groups include poor children and families who would have qualified for the former Aid to Families with Dependent Children program, certain other poor children and pregnant women, and elderly and disabled individuals who qualify for the Supplemental Security Income program. In general, a Medicaid enrollee must have both a low income and a low level of assets, although the minimum financial thresholds vary depending on the basis for an enrollee's eligibility.

Within broad statutory limits, states have the flexibility to administer the Medicaid program and determine its scope. Partly as a result, the program's rules are complex, and it can be difficult to generalize about the types of enrollees who are covered, the benefits that are offered, and the cost sharing that is required. States vary in how they count income and assets in determining eligibility for Medicaid. They may also choose to include additional eligibility groups (such as individuals with high medical expenses who have "spent down" their resources) or provide additional benefits (such as coverage for prescription drugs and dental services) and have exercised those options to varying degrees. Moreover, states often seek and get approval from the Department of Health and Human Services for waivers to provide benefits and cover groups that would otherwise be excluded under Medic-

1. Unless otherwise indicated, all data on program spending or enrollment presented in this testimony are for federal fiscal years.

aid. By one recent estimate, total spending on optional populations and benefits accounted for about 60 percent of the program's expenditures in 2001. Of that total, 30 percent was spent to provide optional benefits to mandatory groups; 50 percent, to provide mandatory benefits to optional groups; and 20 percent, to provide optional benefits to optional groups.[2]

Enrollment

On the basis of administrative data, CBO estimates that about half of Medicaid's 60 million enrollees in 2006 are poor children, and another one-fourth are either the parents of those children or poor pregnant women. The remaining one-fourth of enrollees are either aged, blind, or disabled. (Children and parents who are disabled are included in the latter category.) Additional information about the income or other characteristics of enrollees can be derived from survey data, but it comes with several limitations. Surveys generally exclude people who live in institutions, such as nursing homes—but a large share of nursing home residents are Medicaid beneficiaries. Even after accounting for that fact, surveys tend to underestimate Medicaid's total enrollment. In addition, many surveys measure income on an annual basis, whereas eligibility for Medicaid is generally determined by a person's monthly income, which may fluctuate.[3]

Notwithstanding those caveats, survey data suggest that Medicaid mainly covers people whose income is less than 200 percent of the federal poverty threshold—currently, about $40,000 per year for a family of four. The most recent estimates cover 2004; they indicate that about 54 percent of Medicaid enrollees had a level of family income that was below the poverty threshold; another 29 percent had income that was between 100 percent and 200 percent of that threshold; and 17 percent had higher income. Expressed another way, Medicaid is estimated to cover at least 35 percent of all individuals whose family income falls below the poverty level, about 17 percent of those whose income is between 100 percent and 200 percent of that level, and about 3 percent of the (much larger) group whose income is more than 200 percent of the poverty level.

Although Medicaid is designed primarily to serve poorer individuals and families, many poor people are ineligible for the program. (For example, most poor childless adults do not qualify.) Because eligibility for Medicaid is based partly on income, enrollment in the program by children and families is somewhat cyclical, growing faster when the economy weakens and more slowly when the economy

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2. Kaiser Commission on Medicaid and the Uninsured, *Medicaid Enrollment and Spending by "Mandatory" and "Optional" Eligibility and Benefit Categories* (Washington, D.C.: Henry J. Kaiser Family Foundation, June 2005), p. 11.

3. Survey data may also fail to distinguish between enrollment in Medicaid and enrollment in the State Children's Health Insurance Program (described later) or may compare current insurance coverage with income for the prior year. The figures presented here are CBO's calculations based on data from the March 2005 Current Population Survey of the Bureau of the Census.

becomes stronger. At the same time, according to survey data, many people who are eligible for Medicaid do not enroll in the program, even when they lack other health insurance. For instance, one recent estimate indicated that about one-third of the 10 million children identified by surveys as uninsured are eligible for Medicaid.[4]

The gap between eligibility and enrollment may reflect a lack of awareness about Medicaid as well as the effect of stigma commonly associated with welfare-related programs. At the same time, eligible individuals who require medical care may receive Medicaid coverage for their health care services retroactively, so they have some protection against incurring substantial health care costs even if they are not enrolled in the program. The rates at which eligible individuals "take up" coverage also vary with the extent of the benefits that Medicaid will provide. Take-up rates are very high, for example, among Medicare beneficiaries who are also eligible for full benefits under Medicaid, including coverage of nursing home costs. (Those beneficiaries are referred to as dual eligibles.) Take-up rates are much lower for Medicare beneficiaries who qualify only to have Medicaid pay their cost-sharing requirements under Medicare and their Medicare Part B premiums.

Spending for Benefits

Medicaid's spending for benefits may be classified either by the types of enrollees who receive those benefits or by the types of services such spending purchases. As noted earlier, about three-quarters of Medicaid enrollees in 2006 are either poor children, their parents, or poor pregnant women, and per capita costs for those groups are relatively low. By contrast, expenses per enrollee are higher for elderly and disabled beneficiaries, many of whom require long-term care. Although the elderly and disabled constitute about one-quarter of Medicaid's enrollees, they account for about 70 percent of the program's spending for benefits (see Table 1).

Overall, one-third of Medicaid's spending for benefits in 2006 is projected to go toward long-term care, which includes nursing home services, home health care, and other medical and social services for people with chronic disabilities. Acute care costs account for nearly all of the remaining benefit expenditures—one-third of which go to hospitals, one-sixth to prescription drugs, one-sixth to physicians and other practitioners, and one-third to other acute care services.

Most services covered under Medicaid are paid for on a fee-for-service basis, and states generally determine the payment rates for doctors, hospitals, and other providers of health care to the program's beneficiaries. Analyses of Medicaid's fee-for-service reimbursement rates have found them to be lower than those of Medicare and of private-sector insurers. Over the years, a number of states have

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4. T.M. Selden, J.L. Hudson, and J.S. Banthin, "Tracking Changes in Eligibility and Coverage Among Children, 1996-2002," *Health Affairs*, vol. 23, no. 5 (September-October 2004), pp. 39-50.

Table 1.

Distribution of Medicaid Enrollees and Benefit Payments by Eligibility Category, Fiscal Year 2006

	Enrollees		Benefit Payments	
	Number (Millions)	Percentage	Total (Billions of dollars)	Percentage
Aged	5.7	9.6	38.5	22.6
Disabled	9.9	16.5	78.3	45.9
Children	28.4	47.6	31.9	18.7
Adults	15.7	26.3	21.7	12.7
Total	**59.7**	**100.0**	**170.4**	**100.0**

Source: Congressional Budget Office.

claimed higher payments to providers than they actually made and have used the higher federal matching funds that resulted either to help cover the state's share of Medicaid costs or for other purposes. (Such financing arrangements are part of the reason that it is difficult to determine states' Medicaid costs precisely.) In response, the federal government has tightened regulations related to upper limits on payments for some Medicaid services that are based on payment rates in the Medicare program. Other steps the federal government has taken to control Medicaid spending include limiting the amounts that states may pay for certain prescription drugs and requiring that drug manufacturers that wish to serve the Medicaid population provide substantial rebates to the program.

Currently, about one-third of Medicaid beneficiaries are enrolled in managed care plans that accept a capitated payment (a fixed amount per enrollee) for providing most of the program's acute care benefits. Those arrangements are mainly for families and children and generally do not cover long-term care services. Consequently, those capitation payments account for less than 15 percent of Medicaid's total expenditures for benefits. As an alternative to capitation arrangements, many states have adopted primary care case management models, in which enrollees select (or are assigned) a primary care physician or a group practice that is paid an added fee for overseeing and coordinating their care. Even more popular in recent years have been "carve-out" arrangements, in which states contract with organizations to provide a subset of Medicaid benefits, such as dental services or mental health care.

Cost Sharing

Cost-sharing requirements for enrollees in the Medicaid program are also set by the states, subject to federal guidelines. Before passage of the Deficit Reduction Act of 2005 (DRA), states could require nominal cost sharing on services for certain beneficiaries other than children and pregnant women and faced narrow limits on their ability to charge premiums. Medicaid regulations limited cost sharing to

$3 for most services and barred providers from denying services to individuals who did not pay it. As a result, the majority of Medicaid enrollees did not pay any cost sharing.

The DRA gave states the option to increase the level of cost sharing and require the payment of premiums by many Medicaid beneficiaries whose family income is at or above the poverty level. (Exceptions include children whom states are required to cover under Medicaid rules, pregnant women, and individuals living in institutions.) States may require individuals whose family income is between 100 percent and 150 percent of the poverty level to pay up to 10 percent of the cost of their services; individuals with higher income may be charged 20 percent coinsurance. However, total cost sharing and premiums for all Medicaid beneficiaries in a family may not exceed 5 percent of the family's income. Under the DRA, states may also allow providers to deny services for lack of payment and may require enrollees to prepay premiums before they receive benefits. States are also permitted to increase nominal copayments over time at the rate of medical inflation for individuals whose income is below the poverty level.

State Children's Health Insurance Program

The State Children's Health Insurance Program (SCHIP) offers coverage to uninsured children in families whose income is too high to allow them to qualify for Medicaid but is generally below 200 percent of the poverty level. As with the Medicaid program, states have flexibility in how they administer SCHIP; within broad federal guidelines, they may vary the eligibility thresholds, benefits, cost sharing, and other parameters. The program is structured as a capped entitlement, with federal matching funds available (at a somewhat higher rate than for Medicaid) but subject to an overall annual limit. SCHIP currently covers an estimated 4.3 million children, and federal outlays for the program over the next 10 years are projected to be $52 billion. (Many states have chosen to provide SCHIP coverage through their Medicaid program, but the data presented in this testimony exclude SCHIP and are for Medicaid coverage only.)

Sources of Growth in Medicaid Spending

To understand the main factors that drive Medicaid spending—and how they compare with the forces that affect overall health care spending in the United States—it is useful to examine short- and long-term trends in past spending and in projections of future costs.

Growth of Past Spending

Between 1999 and 2004, federal spending for Medicaid increased by 64 percent, growing from $108 billion to $176 billion. Rising enrollment played a major role in that spending growth: CBO estimates that over the same period, enrollment in Medicaid grew by 36 percent, climbing from 41.9 million to 56.9 million. About seven-eighths of that growth came from increased enrollment of children and

adults. For those two groups, federal spending for benefits per enrollee grew by 25 percent during that five-year period; per capita costs for disabled and elderly enrollees grew by 31 percent. Overall, federal spending for benefits per enrollee grew more slowly—by 21 percent—reflecting the fact that most of the growth in enrollment occurred among groups that have lower per capita health care costs.[5]

The rapid growth of Medicaid spending and enrollment between 1999 and 2004 reflected both the recession that occurred in that period, which increased the number of families eligible for the program, and state-level expansions of coverage and enrollment outreach efforts. Greater state adoption of financing mechanisms to increase federal payments also helped boost spending—particularly in 2001 and 2002, when federal Medicaid costs grew by 11.1 percent and 13.2 percent, respectively. Temporary increases in the federal matching rate during 2003 and 2004 also played a role. CBO estimates that since 2004, enrollment in and spending for the Medicaid program have increased at a much slower rate, reflecting more-rapid economic growth as well as actions by the states to rein in the program's costs.

A longer-term perspective shows that federal spending for Medicaid between 1975 and 2002 grew from about $7 billion to $148 billion, or at an average annual rate of growth of about 12 percent. During that same period, according to the Centers for Medicare and Medicaid Services (CMS), total spending for Medicaid benefits rose from $12 billion to $213 billion—or at an average annual rate of 11.2 percent. (CMS and state agencies jointly administer the Medicaid program.) Note that the latter figures exclude certain Medicaid costs that are not counted as benefits, such as DSH payments and administrative costs, but include reported federal and state payments—which accounts for the difference in the rates of growth of total federal Medicaid costs and total benefit payments for the same period.

Historical data covering Medicaid's spending for benefits may be used to determine the share of cost growth attributable to three factors: increases in the number of beneficiaries who receive services; general inflation in prices; and rising real (inflation-adjusted) costs per recipient. Increases in real costs per recipient reflect a combination of price increases that exceed the rate of general inflation, a rising quantity of services per recipient, and an increase in the intensity, or complexity, of the services provided. If the impact of general price inflation is factored out, the average real rate of growth for total benefit payments from 1975 to 2002 is 7.1 percent (see Table 2).[6] Over that period, about 40 percent of the growth in Medicaid

5. Another reason for the relatively slow growth of overall costs per enrollee is that some states implemented expansions of coverage that provided only a limited set of lower-cost services (for example, family planning). The interaction of rising enrollment and rising federal costs per enrollee accounts for the remainder of the 64 percent increase in federal spending.

6. The count of recipients represents the number of individuals actually using some form of covered health care service from Medicaid during the year; the total number of program enrollees is slightly larger. Comparable data on Medicaid spending and recipients of services by eligibility group are not readily available before 1975 or after 2002. As a result, the remainder of this historical analysis focuses on the span of those years. Spending figures were adjusted for inflation using the GDP price deflator.

Table 2.

Sources of Real Growth in Federal and State Medicaid Spending by Eligibility Group

(2002 dollars)

	1975	2002	Average Growth Rate (Percent)	Share of Total Cost Growth (Percent)
Aged				
Number of Recipients (Millions)	3.6	3.9	0.3	0.6
Cost per Recipient (Dollars)	3,302	13,358	5.3	22.7
Total Cost (Millions of dollars)	11,937	51,924	5.6	23.3
Disabled				
Number of Recipients (Millions)	2.5	7.4	4.2	21.4
Cost per Recipient (Dollars)	3,496	12,475	4.8	27.4
Total Cost (Millions of dollars)	8,615	92,414	9.2	48.8
Children				
Number of Recipients (Millions)	9.6	23.2	3.3	8.5
Cost per Recipient (Dollars)	624	1,545	3.4	8.9
Total Cost (Millions of dollars)	5,988	35,890	6.9	17.4
Adults				
Number of Recipients (Millions)	4.5	11.3	3.4	7.2
Cost per Recipient (Dollars)	1,247	2,100	1.9	3.3
Total Cost (Millions of dollars)	5,648	23,635	5.4	10.5
All Eligibility Groups				
Number of Recipients (Millions)	20.2	45.8	3.1	37.7
Cost per Recipient (Dollars)	1,593	4,453	3.9	62.3
Total Cost (Millions of dollars)	32,188	203,863	7.1	100.0

Source: Congressional Budget Office based on data from Centers for Medicare and Medicaid Services, *Health Care Financing Review Statistical Supplement 2004* (April 2006).

Note: Figures exclude a small share of recipients whose eligibility is categorized as "other/unknown" and spending for those recipients. Dollar amounts were adjusted for inflation using the GDP price deflator.

spending resulted from a rising number of recipients, and about 60 percent was due to real increases in treatment costs per recipient. (Thus, the period from 1999 to 2004, in which enrollment growth was so rapid as to outweigh growth in costs per enrollee, is an exception to the general trend.)

Spending Growth by Eligibility Group. The historical data on Medicaid spending reveal significant differences in the levels and sources of real spending growth among the program's four basic eligibility groups: children, adults, aged people, and disabled individuals. Total spending has grown most slowly—by about 5.5 percent per year, in real terms—for adults and for the aged, but for different rea-

sons. Among adults, costs per recipient have risen relatively slowly (although that trend could also indicate that adults who have recently enrolled in Medicaid have lower average health care costs than those who met the earlier eligibility criteria). By contrast, the number of elderly beneficiaries who receive some type of Medicaid-covered service has scarcely grown over the past three decades; virtually all of the increase in spending for that group can thus be attributed to rising costs per recipient. Spending for children has grown more rapidly, and that growth is due about equally to an increase in the number of recipients and an increase in costs per recipient. Among disabled beneficiaries, however, the number of recipients has grown at an even faster rate, averaging 4.2 percent per year since 1975. Costs per disabled recipient have grown even more rapidly—at an average real rate of 4.8 percent per year.

Another way to analyze the rise in spending in the Medicaid program is to consider the share of the growth of real benefit spending accounted for by increases in the number of recipients and in costs per recipient for each eligibility group. Even though enrollment of children has grown dramatically—partly reflecting substantial expansions of eligibility—their rising participation accounts for less than 10 percent of the total cost growth in the program since 1975. Of that growth, the largest share (fully half) is attributable to disabled beneficiaries. Because they have been more expensive to treat than nondisabled adults and children—and about as expensive, on a per recipient basis, as elderly Medicaid enrollees—their rising numbers and growing costs per recipient have each contributed substantially to the increases in Medicaid spending. Higher costs among the elderly also accounted for a large share of the program's total cost growth, despite the small increases for that group in the number of service recipients. Spending for the elderly represented nearly 40 percent of total costs in 1975, so their rapidly rising costs per recipient have had an outsized impact on the program's finances.

Spending Growth by Service Category. Data from CMS show that during the 1975-2002 period, real spending growth also varied considerably among the different types of health care services that Medicaid purchases (see Table 3). Growth of total state and federal payments to hospitals (including DSH payments) was relatively slow—6.7 percent per year in real terms, compared with an overall rate of 7.2 percent for payments to providers. Growth of payments to physicians and other health care professionals was also slower than overall Medicaid spending—but faster than that of the economy as a whole. Real spending growth has been most rapid for prescription drugs, causing their share of total Medicaid payments to nearly double. Even so, such spending accounted for about one-eighth of total state and federal Medicaid costs by the end of the period.

Projected Growth of Spending

CBO projects that under current law, federal spending for Medicaid benefits will double in nominal terms over the next 10 years, increasing from $179 billion in fiscal year 2007 to $361 billion in 2016, for an average annual rate of growth of

Table 3.

Real Medicaid Spending by Type of Service

(Millions of 2002 dollars)

	1975		2002		Average Growth Rate (Percent)
	Total Spending	Percentage	Total Spending	Percentage	
Hospital[a]	14,238	40	83,014	36	6.7
Physician, Dental, and Other Professional	6,254	18	30,431	13	6.0
Prescription Drugs	2,386	7	28,650	12	9.6
Home Health, Nursing Home, and Other	12,291	35	90,167	39	7.7
All Services	**35,169**	**100**	**232,262**	**100**	**7.2**

Source: Congressional Budget Office calculations based on National Health Expenditure data from the Centers for Medicare and Medicaid Services.

Note: Data include both federal and state spending. Dollar amounts cover calendar years and were adjusted for inflation using the GDP price deflator.

a. Includes disproportionate share, or DSH, payments (which is the main reason that totals for all services here do not match those for "All Eligibility Groups" in Table 2).

8.1 percent (see Table 4). Key factors underlying that increase in spending include the following:

- Enrollment is projected to grow by about 2.5 percent per year among the aged and disabled, reflecting somewhat faster growth of the overall elderly population as well as the impact of waiver programs to provide community-based long-term care services to the disabled. On average, enrollment of children and adults is not expected to increase substantially under current law both because of slow growth in the eligible population and because states are not likely to further expand eligibility for those groups.

- Projected rates of cost growth per enrollee are comparable among eligibility groups with the exception of elderly people; that group is expected to see a somewhat slower rise in spending, in part because their prescription drug costs are now covered under Medicare. Even so, costs per enrollee in the Medicaid program overall will grow somewhat more quickly (by 7.1 percent per year, on average) than per capita costs for any single eligibility group, reflecting the expectation of faster growth in enrollment for the higher-cost groups. (If those figures were adjusted for general inflation to make them more comparable with the data on past spending growth presented earlier, the projected growth rates would be about 2.5 percentage points lower.)

Table 4.

Projected Federal Benefit Spending, Enrollment, and Costs per Enrollee for Medicaid, by Eligibility Category, Fiscal Years 2006 to 2016

	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	Average Nominal Growth Rate, 2007-2016 (Percent)
						Federal Benefit Payments (Billions of dollars)						
Aged	38.5	39.1	41.9	44.9	48.2	51.9	55.8	60.4	65.4	70.7	76.7	7.8
Disabled	78.3	83.2	91.5	100.1	109.0	118.5	129.2	140.4	152.6	165.8	180.3	9.0
Children	31.9	34.1	36.7	39.7	42.4	45.4	48.6	51.9	55.5	59.4	63.7	7.2
Adults	21.7	22.9	24.2	25.9	27.6	29.4	31.3	33.3	35.5	37.8	40.3	6.5
Total	170.4	179.3	194.3	210.5	227.2	245.2	264.9	286.0	309.0	333.8	361.0	8.1
Memorandum:												
Total Federal Medicaid Spending	189.8	199.3	215.3	232.6	250.3	269.5	290.4	312.8	337.0	363.3	391.9	7.8
						Enrollment (Millions of people)						
Aged	5.7	6.0	6.2	6.4	6.5	6.7	6.8	7.0	7.2	7.4	7.5	2.6
Disabled	9.9	10.3	10.7	11.1	11.3	11.5	11.8	12.0	12.3	12.5	12.8	2.4
Children	28.4	28.7	28.6	28.8	28.8	29.0	29.0	29.1	29.2	29.3	29.4	0.3
Adults	15.7	15.6	15.7	15.8	15.9	16.0	16.0	16.1	16.2	16.2	16.3	0.5
Total	59.7	60.6	61.2	62.1	62.6	63.2	63.7	64.3	64.8	65.4	66.0	1.0
						Average Cost per Enrollee (Dollars)[a]						
Aged	6,710	6,510	6,710	7,000	7,370	7,770	8,160	8,620	9,100	9,620	10,180	5.1
Disabled	7,940	8,090	8,530	9,030	9,630	10,270	10,970	11,680	12,440	13,240	14,110	6.4
Children	1,120	1,190	1,280	1,380	1,470	1,570	1,670	1,780	1,900	2,030	2,170	6.9
Adults	1,380	1,470	1,540	1,640	1,730	1,840	1,950	2,070	2,190	2,330	2,480	6.0
Overall Average	2,850	2,960	3,170	3,390	3,630	3,880	4,160	4,450	4,770	5,110	5,470	7.1

Source: Congressional Budget Office.

a. Costs are rounded to the nearest 10 dollars.

Table 5.

Projected Spending for Medicaid, Medicare, and Social Security as a Share of Gross Domestic Product

(Percent)

		2050		
	2006	Lower Spending Path	Intermediate Spending Path	Higher Spending Path
Medicaid[a]	1.5	1.9	4.0	5.9
Medicare	3.0	5.1	8.6	16.0
Social Security	4.2	6.3	6.4	6.6
Total	**8.7**	**13.3**	**19.0**	**28.5**

Source: Congressional Budget Office based on supplemental data from its December 2005 report *The Long-Term Budget Outlook.*

Notes: Projections cover total spending for benefits under current law.

a. Projections incorporate the assumption that enrollment in the program will grow at the same rate as that of the general population.

- As for spending by category of service, payments to hospitals and physicians and for institutional care—which currently account for about half of all benefit payments—are expected to grow by an average of 6.5 percent per year. Payments for prescription drugs and noninstitutional long-term care—which currently account for about one-fifth of spending on benefits—are projected to rise at an average annual rate of 11.2 percent. (Adjusting for general inflation would reduce those rates by about 2.5 percentage points as well.)

Looking beyond the 10-year budget horizon, CBO has projected federal spending for Medicaid and the other major benefit programs through 2050 under various assumptions (see Table 5).[7] Projections for Medicaid all reflect the assumption that enrollment in the program will grow at the same rate as that for the population as a whole. (That assumption is consistent with CBO's 10-year estimates of spending for Medicaid.) In addition, CBO's set of intermediate spending projections incorporate the assumption that health care costs per enrollee will grow more slowly in the future than they have in the past, with the growth rate ultimately reaching a level that is 1 percentage point faster than the growth of GDP per capita.

That assumption presumes a substantial decrease in the growth of health care costs per capita compared with the historical growth rates seen in federal health programs and in the U.S. health sector as a whole. Over the past several decades, the rise of health care costs per capita has typically exceeded the growth of GDP per capita by more than 2 percentage points. (That gap has been smaller in some recent

7. For a more detailed discussion, see Congressional Budget Office, *The Long-Term Budget Outlook* (December 2005).

periods, reflecting in part the combined impact of faster economic growth and greater use of managed care plans in the private health insurance market.) In effect, then, CBO's intermediate projection incorporates the assumption that forces within the health care sector will slow the overall rate of cost growth in the United States and that per capita spending growth in the Medicaid program will generally follow the same trend. There is considerable uncertainty about the likely path of per capita health care costs, however, which is represented by the range of CBO's long-term projections. An additional source of uncertainty surrounding projections for Medicaid is whether states will take more aggressive steps to constrain spending (such as limiting coverage of optional populations or benefits) as costs for the program become a larger and larger share of their budgets.

Even under the assumption that the growth of health care costs will moderate, spending for Medicaid by the federal government alone is projected to account for 4 percent of the economy by 2050, as compared with its current share of 1.5 percent. If, instead, Medicaid's spending per enrollee grew at the historical rate of U.S. health care costs overall—about 2.5 percentage points faster than GDP per capita—federal costs for the program would reach 5.9 percent of GDP in 2050, or nearly the same share as that expected for Social Security. Whichever path Medicaid's spending takes, its future growth will coincide with rising costs for Social Security and, in particular, for Medicare. Those increases—driven by both a burgeoning elderly population and increasing costs per Medicare beneficiary—are projected to put significant pressure on the federal budget and the U.S. economy. Total spending for current-law benefits under all three programs would reach nearly 20 percent of GDP in 2050, according to CBO's intermediate projections.

The impending retirement of members of the baby-boom generation and their increasing life expectancy play important roles in those projections of spending, but uncertainty also exists about the impact that those demographic forces will have on enrollment in Medicaid and on the program's finances. In the near term at least (that is, the next 10 years), newly enrolled seniors will be relatively young and will tend to have lower health care costs than existing elderly enrollees have. Over time, though, the baby boomers' costs for acute health care and their rates of functional impairment are sure to rise. The former will be financed largely by Medicare, but rising costs for long-term care in general and nursing home care in particular will fall primarily on Medicaid.

Yet future rates of nursing home use will be affected by several competing forces. While the elderly population will increase substantially, some studies predict that disability rates at any given age will continue to decline (though others maintain that they will increase). The share of the population ages 85 and older is expected to triple by 2050, and that group has the highest rates of nursing home use. However, the number of nursing home residents (both overall and in the Medicaid program) has grown more slowly than the elderly population as a whole, particularly in recent years. Thus, it is difficult to determine whether the impact of the baby

boomers' retirement on Medicaid's finances will merely be delayed—until they reach more advanced ages—or will ultimately remain limited.

Growth of U.S. Health Care Spending

The factors that drive the growth of costs in the Medicaid program and the challenges that the program faces in controlling those costs are similar in many ways to those for the U.S. health care system as a whole. In calendar year 2004, the United States spent about $1.9 trillion for health care, an amount nearly five times as great in real terms as was spent in calendar year 1975. Real spending per capita increased from about $1,700 in 1975 to about $6,300 in 2004, an average annual rate of real growth of 4.5 percent. The economy as a whole grew over that period as well but not as quickly, with the result that health care spending as a percentage of GDP doubled—rising from about 8 percent in 1975 to about 16 percent in 2004. The mid-1990s saw a brief slowdown in real spending growth per capita, but higher rates of growth have returned in more recent years: from 2000 to 2004, real health care spending per capita grew at an average annual rate of 5 percent, which is similar to its long-term historical average.

Technology and Rising Health Care Costs

Most analysts agree that the bulk of the growth in overall health care spending is associated with the increasing use of new medical technologies, or as one analyst has described it, "the increased capabilities of medicine."[8] Advances in medical technology in recent decades have made available a wealth of new therapies. Some of those advances have made it possible to treat previously untreatable conditions, potentially yielding substantial gains in the quality of people's lives but creating new categories of spending in the process. Other advances have improved medical outcomes relative to older modes of treatment—providing greater benefits but often at an additional cost. In some cases, the cost of a particular medical service may remain the same over time or even diminish; even in those cases, however, higher overall spending may still result as clinical practice patterns evolve and the service is used with greater frequency among a broader range of patients. For example, one influential study found that the price of specific treatments for a heart attack rose at about the rate of general inflation, but the greater use of more-expensive bypass operations caused total spending for cardiac care to grow rapidly.[9]

In some cases, advances in medical technology may lead to reductions in spending. Vaccinations, for example, offer the potential for savings on subsequent treatment costs, and certain types of preventive medical care may help some patients

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8. Joseph P. Newhouse, "Medical Care Costs: How Much Welfare Loss?" *Journal of Economic Perspectives*, vol. 6, no. 2 (Summer 1992), pp. 3-21.

9. David M. Cutler and others, "Are Medical Prices Declining? Evidence from Heart Attack Treatments," *Quarterly Journal of Economics*, vol. 113, no. 4 (November 1998), pp. 991-1024.

avoid costly hospitalizations. Overall, however, examples of new therapies for which long-term savings have been clearly demonstrated are few. As with preventive care, new prescription drugs may help some patients avoid more expensive treatments—but they may also generate new spending for previously untreated cases that would not have become more serious. Improvements in medical care that decrease mortality by helping patients avoid or survive acute health problems may ultimately increase overall spending for health care as those (surviving) patients live to use additional health care services throughout their old age.

Adoption of new technology is not unique to the health care sector, of course, but in other sectors of the economy, businesses and consumers bear the cost of such purchases more directly and will thus be inclined to spend money on them only if the benefits exceed the costs. In the health care arena, two factors may combine to produce a different result: first, payments made by insurers typically buffer patients from the full cost of the medical services they use; and second, the complexity of medical practice forces patients to rely on the judgment of providers who, depending on the reimbursement system being used, may have an incentive to provide more care (under a fee-for-service arrangement) or less care (under capitation). In principle, the health plans that provide insurance coverage have incentives to balance costs and benefits, but views differ about whether and to what extent that balancing occurs in practice. Thus, some uncertainty remains about the value derived from new medical technologies, particularly as they are applied to more and more cases in which the additional benefits may be marginal.

Other Factors That Contribute to the Growth of Health Care Costs

Although the diffusion of new medical technologies is generally considered the primary impetus for the long-term increase in overall spending for medical care, other factors certainly contribute to it as well. One source of cost growth has been the aging of the population. Among adults, average medical spending generally increases with age, so as the share of the population that is elderly grows, health care spending per capita will rise. Over the past half century, however, aging has played a relatively minor role in the very large increases in overall spending that have occurred—accounting for only 2 percent of that growth, by some estimates.[10] The coming retirement of the baby boomers will further increase the elderly's population share and thus have a larger impact than past aging trends have had. Even so, the growth of medical costs per person is likely to remain the predominant reason that health care spending for the country as a whole continues to climb.

Other factors that are contributing to the growth of overall health care spending include real increases in personal income over time and the deepening of health insurance coverage over recent decades. Because medical care is a desirable service,

10. See Technical Review Panel on the Medicare Trustees Reports, *Review of Assumptions and Methods of the Medicare Trustees' Financial Projections* (December 2000), available at www.cms.hhs.gov/ReportsTrustFunds/downloads/TechnicalPanelReport2000.pdf.

demand for it tends to rise as real incomes move upward. At the same time, from the consumer's perspective, health insurance coverage reduces the cost of care, which leads consumers to demand increasing quantities of services. Although the estimated fraction of Americans who have health insurance has not changed dramatically during the past 20 years, private health insurance has covered an expanding share of all private health care costs; such coverage has thus deepened rather than broadened. Even so, the best estimates of the effects of income and insurance coverage on health care costs indicate that those factors, too, fail to explain much of the surge in spending in recent decades.

Impact of Factors on Medicaid

Rising real incomes and the spread of insurance may not seem relevant to an analysis of Medicaid's cost growth, since the program's rules mean that those dimensions do not change substantially for enrollees. Indeed, broad increases in real incomes could be expected to reduce the share of the population that is eligible for Medicaid (because poverty thresholds are indexed to general inflation). Those factors are relevant, though, because as capabilities and standards for the delivery of health care overall increase, they tend to be incorporated into Medicaid as well. In part, that process reflects choices made by program administrators about what procedures to cover, and in part it reflects the tendency of physicians to provide a comparable level of care to all of their patients, regardless of their patients' source of insurance. For the same reason—but perhaps even more directly—new technologies for providing acute medical care are likely to become broadly available to both Medicaid and non-Medicaid populations alike. Thus, the program's spending for such things as hospital care, physician services, medical equipment, prescription drugs, and laboratory tests is driven by the same changes in technology that affect the health care system as a whole.

Somewhat less clear are the factors that are boosting costs for long-term care services. Over the past 30 years, spending for nursing homes that is financed both by the private sector and the Medicaid program has grown faster than the economy as a whole, even though the number of nursing home residents has not kept pace with an expanding elderly population. New technology seems a less likely reason for the increases in costs per resident, although advances in acute care could be extending the lives of some people with serious medical conditions and thus raising the average level of sickness of nursing home residents—making them more expensive to serve. A more certain consideration stems from the fact that such care is labor intensive; average nursing home costs would thus be expected to grow along with average increases in wages and other compensation. Rising incomes and other changes in society may also have led to some substitution of formal long-term care for informal care; however, CBO estimates that informal care still constitutes the largest single source of total long-term care financing. Because of Medicaid's large role in the nursing home sector, it is difficult to determine whether Medicaid spending is tracking private-sector trends or shaping them.

Interactions Between Medicaid and Private Insurance

Medicaid covers many people who otherwise would have considerable difficulty in obtaining private health insurance. For the program's current enrollees, problems of access to such coverage may arise for a number of reasons: because they are not part of the labor force or are not offered employer-sponsored insurance (the primary source of health insurance coverage in the United States); because their health problems make coverage very expensive; or simply because they have low incomes and resources. For some enrollees, however, Medicaid appears to be substituting for certain forms of private insurance, a phenomenon known as crowd-out. Concerns about crowd-out by Medicaid are greatest with respect to children and adults whose family income is above the poverty line and who might otherwise have purchased employer-sponsored insurance, and elderly enrollees who might otherwise have bought private insurance for long-term care—or saved more to cover the costs of such care—when they were younger. To the extent that crowd-out occurs, policymakers may face difficult trade-offs between providing insurance coverage on the one hand and substituting public funds for private funds on the other.

Employer-Sponsored Health Insurance

Several well-designed economic analyses have found that expansions of public insurance for low-income children and families have generated some offsetting reductions in private employer-sponsored insurance coverage for those groups. As a result, the net decrease in the number of uninsured individuals as a result of expansions of public coverage has probably been smaller than the increase in the public program's enrollment. For example, one study examined expansions of Medicaid coverage in the late 1980s and early 1990s and concluded that about 50 percent of the increase in enrollment that occurred was offset by reductions in private health insurance coverage. Other studies, however, have reported lower estimates of crowd-out. More recently, an analysis of SCHIP's implementation found crowd-out rates of 18 percent to 50 percent (once the researchers addressed problems in the reporting of insurance coverage). Lower rates for SCHIP than for Medicaid could reflect the greater efforts that were made during SCHIP's implementation to discourage substitution of public for private coverage.[11]

The extent of and mechanisms for the crowding out of employer-sponsored insurance may vary on several dimensions. Concerns about the phenomenon tend to increase as the income threshold for public programs rises, because a larger share of people who have higher incomes also have private coverage. For example, survey data on insurance coverage from 2005 indicated that for individuals whose family

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11. See David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" *Quarterly Journal of Economics*, vol. 111, no. 2 (May 1996), pp. 391-430; and Anthony T. LoSasso and Thomas C. Buchmueller, *The Effect of the State Children's Health Insurance Program on Health Insurance Coverage*, Working Paper No. 9405 (Cambridge, Mass.: National Bureau of Economic Research, December 2002).

income was between 100 percent and 150 percent of the poverty line, 39 percent were privately insured; that share rose to 54 percent, however, for those whose income was between 150 percent and 200 percent of the poverty threshold and to 65 percent for those whose income was between 200 percent and 250 percent. Moreover, such crowding out may occur in two ways: either employees who are eligible for coverage decline to take it, or employers decide not to offer insurance. (If, instead, employers decided to increase employees' contributions to health insurance premiums, that increase could also lead employees to decline coverage.)

More recently, related concerns have been raised about firms that employ lower-wage workers and the number of those employees or their dependents who have enrolled in Medicaid. It is difficult to gauge the prevalence of that phenomenon or determine the factors that might be causing it to increase. The share of workers who have employer-sponsored health insurance has decreased somewhat since 2000, but according to surveys of employers, that development largely reflects a decline in the percentage of smaller firms who are offering insurance; coverage rates at larger firms have fluctuated over time but were comparable in 2000 and 2005.[12] There is also some evidence that in recent years, employment has shifted somewhat to smaller firms and to industries that are less likely to offer coverage. Analyses that focused specifically on low-wage workers have found that, relative to higher-wage workers, they are less likely to be offered health coverage, are less likely to take it up when it is offered, and are more likely to be enrolled in Medicaid. The factors underlying any recent trends in coverage for low-wage workers, however, are less clear. Also difficult to determine is the extent to which recent state-level expansions of Medicaid have been either a cause of or a response to those declines in employer-based coverage—although some crowd-out seems likely to have occurred, given the large increases in Medicaid's enrollment.

Long-Term Care Insurance

Medicaid generally serves people with very low incomes, but it also provides assistance to impaired people with higher incomes who exhaust all other sources of financing for their health care—in particular, for their nursing home care. That care can deplete private resources quickly: costs for a semiprivate room average more than $50,000 per year, and stays in nursing homes often last longer than a year. According to a 1996 study, about one-third of nursing home patients who had been admitted as private-pay residents became eligible for Medicaid after exhausting their personal finances, and nearly one-half of existing residents had similarly

12. Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2005 Annual Survey* (Washington, D.C., September 2005). Since 2000, employees' contributions to health insurance premiums have risen sharply in dollar terms, but the average share of premiums paid directly by workers has remained relatively constant both for single and family coverage, and take-up rates have not varied significantly.

qualified for Medicaid coverage.[13] CBO estimates that those proportions remain similar for the current nursing home population.

At least in principle, many current nursing home residents would not have become Medicaid beneficiaries (or would have enrolled at a later point) if they had purchased a private long-term care (LTC) insurance policy. Such policies typically promise to pay up to a specified amount per day for nursing home and home health care services for policyholders who develop chronic impairments. (Claims are usually subject to an overall limit on the number of years or the total expenses that will be covered.) LTC insurance is a relatively new product, however, and currently finances less than 5 percent of those services, in CBO's estimation. Depending on the terms of an LTC insurance policy, annual premiums may average $1,000 to $2,000 if the policy is purchased at age 65; premiums increase rapidly for those who wait longer to purchase coverage. (That increase reflects both the higher risk of needing long-term care as a person ages and the fewer number of years in which premiums are likely to be paid.)

Many poorer seniors would have difficulty paying for private LTC insurance, even if Medicaid coverage for long-term care was not available. For those with higher incomes, however, the availability of coverage through Medicaid after they exhaust their own resources discourages them from purchasing or maintaining such a policy. People who buy private LTC insurance substantially reduce the probability that they will ever qualify for Medicaid benefits. In that sense, as people prepare financially for their long-term care needs, they forgo the value of the benefits they might otherwise have received—which effectively raises the relative cost of purchasing a private insurance policy.

Medicaid is not a perfect substitute for private LTC insurance, but the drawbacks to Medicaid's coverage are balanced by several features that are advantageous.

- One drawback is that, as a means-tested program, Medicaid requires eligible applicants to rely on out-of-pocket spending until they use up nearly all of their savings and all but a small share of their income. (Even after exhausting their assets, nursing home residents may have income from other sources, such as a private pension or Social Security.) Private LTC insurance, by contrast, may allow policyholders to protect their resources.

- Another downside to Medicaid is that it generally pays lower fees for services than private insurers pay, so its beneficiaries may not receive the same quality of care as private policyholders or have access to the same facilities.

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13. Joshua M. Wiener, Catherine M. Sullivan, and Jason Skaggs, *Spending Down to Medicaid: New Data on the Role of Medicaid in Paying for Nursing Home Care* (Washington, D.C.: AARP Public Policy Institute, June 1996).

- One major advantage of Medicaid is that from the beneficiary's perspective, its coverage is free—whereas private LTC insurance requires premium payments.

- Another attraction of Medicaid is that it covers most LTC services with no explicit cap on their costs. Private LTC insurance generally provides a specified monetary benefit to pay for care—and in return for a higher premium also includes an adjustment for inflation. But it does not guarantee that the payment will be sufficient to cover the costs of that care if daily charges rise faster than the policy's specified amount or if the policyholder's stay in a nursing home extends for many years.

Some people who are planning for their long-term care needs and considering the purchase of a private insurance policy may thus find Medicaid's coverage a more attractive option. Indeed, one recent study found that if people at various income levels took Medicaid's provisions into account in their financial planning, those provisions would constitute a substantial deterrent to their purchasing private insurance.[14] At the same time, a recent survey of individuals ages 45 and older found that many of them mistakenly believed that Medicare or their medigap supplemental insurance policy would pay for extended nursing home care. (Medicare will cover nursing home care for a specified period following a hospital admission; medigap plans will cover only the cost sharing for that care.) At a minimum, that finding suggests that if Medicaid's coverage rules were to change, it would take some time for individuals to adjust their financial planning to take those changes into account.

One option explored by several states in recent years to address the disincentives that Medicaid creates has been to establish LTC "partnership" programs. Under such programs, enrollees who purchase LTC insurance but exhaust that coverage are allowed to protect a corresponding amount of their assets and still qualify for Medicaid. That approach could be advantageous for individuals; however, it might also increase Medicaid's spending for long-term care. Partnership policyholders would generate more Medicaid expenditures than would holders of conventional LTC policies—because partnership coverage would allow its policyholders to qualify for Medicaid without exhausting all of their assets. The effect on Medicaid's expenditures for partnership participants who would otherwise not have purchased private LTC insurance, as well as the extent of that response, is more difficult to determine.[15]

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14. Jeffrey R. Brown and Amy Finkelstein, *The Interaction of Public and Private Insurance: Medicaid and the Long-Term Care Insurance Market,* Working Paper No. 10989 (Cambridge, Mass.: National Bureau of Economic Research, December 2004).

15. For additional discussion and analysis of long-term care financing issues, see Congressional Budget Office, *Financing Long-Term Care for the Elderly* (April 2004).

Private Saving for Long-Term Care Costs

As an alternative to purchasing LTC insurance (which has other drawbacks), individuals could "self-insure" by saving more when they are younger to cover their own expenses for long-term care in retirement. However, because Medicaid requires enrollees to use up nearly all of their assets and income before they are eligible for coverage, its provisions also tend to discourage such saving.[16] In the event of a long nursing home stay, the fewer assets that an individual has, the quicker he or she may qualify for Medicaid coverage.

The program's requirements also create incentives for people to hide or transfer their assets before applying for the program (and also to use up their funds more quickly in paying for care). Although applicants face penalties for transferring assets at less than their fair market value, individuals have been able to transfer their assets in a variety of ways that reduce or eliminate any penalty. In addition, some assets have not been considered. For example, until the DRA was enacted, all equity held by homeowners had been excluded in determining a person's eligibility for Medicaid. However, the DRA has made it more difficult to transfer assets without incurring a penalty and in most cases has capped the amount of home equity enrollees may have.

At the same time, uncertainty exists about the extent to which individuals engage in such Medicaid "estate planning," and the available data indicate that many seniors who are likely to need nursing home care and qualify for Medicaid have relatively few assets. There are also some indications that those who have more chronic disabilities enter retirement with fewer assets. But as with LTC insurance, changes in Medicaid's rules could over the longer term encourage individuals who had greater resources to rely more heavily on private funding for their long-term care.

Recent Changes in the Medicaid Program

A number of changes to Medicaid that have been enacted in recent years affect the program's level of spending. Such changes include, in particular, key provisions of the Medicare Modernization Act of 2003 (MMA) and the Deficit Reduction Act of 2005. (In addition, the states are pursuing a wide variety of initiatives to curb spending.)

The main provision of the MMA that affects Medicaid costs was the creation of a prescription drug benefit within Medicare. As of January 2006, beneficiaries entitled to full coverage under both programs—about 6.2 million individuals—receive drug coverage through Medicare rather than Medicaid. That change substantially reduces federal and state spending for Medicaid; however, the states' drop in costs

16. Lara Gardner and Donna Gilleskie, *The Effects of State Medicaid Policies on the Dynamic Savings Patterns of the Elderly*, Working Paper No. 12208 (Cambridge, Mass.: National Bureau of Economic Research, April 2006).

is less than it might have been because they are required to make payments to the federal government to cover a portion of the estimated costs they would have incurred if they had continued to provide prescription drug benefits to those dually eligible enrollees. States must pay 90 percent of those estimated costs in 2006; that share gradually declines to 75 percent by 2015, where it will remain. Once the phase-down of the states' share is complete, their payments will depend on the number of dual eligibles they have enrolled and the growth of per capita drug costs for the Medicare population as a whole. Although those payments are not counted as costs under Medicaid, they will continue to affect states' fiscal positions.

More recently, the DRA made several substantial changes to Medicaid. CBO has estimated that those changes will:

- Reduce prescription drug costs, primarily by limiting payments to pharmacies for multiple-source drugs (those that have a generic equivalent available);
- Reduce payments for nursing home care by increasing the penalties imposed on individuals who transfer assets for less than their fair market value in order to qualify for nursing home care and by making individuals who have a substantial amount of home equity ineligible for Medicaid's nursing home benefits;
- Reduce Medicaid costs by giving states greater flexibility to impose cost-sharing requirements and premiums and by allowing states to restrict benefits for certain enrollees; and
- Reduce federal matching payments by restricting states' ability to use revenues from taxes on health care providers to finance their share of Medicaid's costs and by limiting the program's coverage of case management services.[17]

CBO estimated that collectively, those provisions would reduce federal Medicaid spending by $38 billion over the 2006-2015 period.

Other provisions of the DRA will increase the program's spending over that period by about $10 billion, in CBO's estimation. Those provisions include greater coverage of certain disabled children, expanded access to home and community-based services, and a "Money-Follows-the-Person" demonstration project that will increase federal payments under Medicaid for certain services after an enrollee leaves a nursing home. Overall, CBO estimated, the DRA's Medicaid provisions will reduce federal outlays by $28 billion over 10 years.[18]

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17. Congressional Budget Office, "S. 1932, Deficit Reduction Act of 2005: Conference agreement, as amended and passed by the Senate on December 21, 2005" (CBO cost estimate, January 27, 2006), available at http://www.cbo.gov/ftpdocs/70xx/doc7028/s1932conf.pdf.

18. In addition to the provisions described here, the DRA contained other subtitles affecting Medicaid and SCHIP, including $2 billion in spending for health care costs related to Hurricane Katrina.

CBO will continue to closely monitor the implementation of those provisions, but it is too early to tell how their actual effects will compare with earlier estimates. Moreover, some provisions have not yet taken effect, and others are in the early stages of implementation. For example, CMS recently released its regulations governing the flexibility that the states have to require cost sharing and premium payments by certain Medicaid beneficiaries. It is worth noting that, as challenging as it may have been to enact those measures, the estimated net savings constitute 1 percent of overall Medicaid spending during the next 10 years.

Broad Options for Controlling Medicaid Spending

Although the states have wide latitude to determine the scope of the Medicaid program, the federal government has several avenues by which it might reduce the growth of Medicaid's spending. Yet all of them involve difficult trade-offs. One broad option would be for the federal government to reduce its contribution to the program. Alternatively, it could restrict mandatory benefits and eligibility groups and limit the alternatives available to the states for providing coverage beyond the minimum levels. The federal government could also shift some costs to beneficiaries by requiring greater cost sharing or by making the standards for receiving long-term care services more rigorous. Finally, it could try to encourage greater use of lower-cost services (although finding a mechanism that would accomplish that goal and still yield substantial budgetary savings might prove challenging).

Other options that could be considered might have only a limited potential to generate savings for Medicaid, and some proposals to restructure the program could raise federal costs—primarily by shifting expenditures that are now borne by other payers to the federal budget. The option of reducing Medicaid's costs by lowering payments to providers is constrained by the need to get hospitals, physicians, and managed care plans to participate in the program voluntarily. Reductions below the currently scheduled rates, which are already considered low, could lead providers to refuse to accept Medicaid patients and so limit enrollees' access to care. (In any event, most rates for payments to providers are currently set by state administrators.) Alternatively, rearranging responsibilities within the Medicaid program so that states paid all of the costs for children and adults and the federal government paid all of the costs for elderly and disabled individuals would increase federal spending significantly—because the federal government would assume responsibility for the program's most expensive enrollees.

Reduce the Federal Contribution

The amount that the federal government contributes to each state's Medicaid program is set by a formula related to the per capita income in a state. Federal matching rates are thus higher for poorer states, but under current law, no state receives less than a 50 percent match. The federal match could be reduced either through an across-the-board cut or by reducing the minimum rate, which applies to 12 states in fiscal year 2006. (A related option would be to limit states' actions that in-

creased federal contributions and thereby raised the effective federal matching rate. However, in light of the DRA's recently enacted provisions as well as regulatory efforts to prohibit such actions, it is difficult to determine the potential for savings from further legislation in that area.)

Alternatively, some or all of the federal contribution could be converted into a block grant. In order for that approach to reduce federal spending, the government would have to set a limit on the grant that was below the amount it would have otherwise expected to spend (or it could develop a formula for determining the grant's size that would effectively set such a limit). A similar approach would be to make Medicaid a capped entitlement program, like SCHIP. Federal payments would still match states' expenditures, but federal funds would be cut off when the program's specified annual allotment was exhausted.

The impact of reducing federal contributions to Medicaid would depend to a great extent on the mechanism used for setting and updating the size of the federal block grant, contribution cap, or matching rate. Converting part or all of the program into a block grant or capped entitlement would make the federal government's Medicaid spending more predictable. With a capped entitlement, states would still be encouraged to use the whole federal allotment but beyond that point would have stronger incentives to limit the program's spending—because they would keep all of the resulting savings and not just a portion of them. Depending on the stringency of the federal contribution's limit, that approach would also lessen or eliminate states' motivation to employ funding strategies that sought to maximize federal assistance. With a block grant, states would have the strongest incentives to control overall spending, but by the same token, the federal government might not share in those savings.

Reducing the federal matching rate would also shift a greater burden to the states initially, but because states' expenditures would continue to be matched, that approach would still automatically adjust federal payments as the total cost of serving the Medicaid population rose or fell. If only the minimum matching rate (the one assigned to the most affluent states) was reduced, federal savings would be smaller. In that case, however, the states that bore the burden of the reduction would be those whose residents had the highest incomes.

Opponents to those sorts of options argue that reductions in the federal matching rate or conversion of federal payments to block grants will cause some states to cut needy individuals from their Medicaid rolls or to limit (or eliminate entirely) Medicaid's coverage of important health benefits. Depending on the groups that were affected, some of those individuals might be able to afford private insurance coverage; many would probably end up uninsured. In addition, states with balanced-budget requirements might also find it more difficult to respond flexibly to cyclical fluctuations in the number of Medicaid enrollees or to other sudden changes in the program's costs.

Reduce Mandatory Benefits or Restrict Coverage

Rather than reducing its contribution to the program and letting the states decide how to respond, the federal government could directly reduce the program's mandatory benefits or restrict the groups that could be covered and the additional services that states could choose to offer. Those changes might involve the levels of income or assets needed for eligibility, or they could focus on other program criteria, such as the standards for determining disability. The federal government could also stop granting waivers of the Medicaid statute, which permit states to extend coverage to new populations, generally at additional federal expense.

Reductions in benefits or coverage would have an adverse impact on enrollees who would otherwise receive those services through Medicaid, but the nature and extent of that impact—and the magnitude of the budgetary savings—would depend on the services or eligibility groups involved. Although evidence suggests that expansions of Medicaid coverage for children and families have crowded out some purchases of employer-sponsored insurance, particularly for individuals with higher levels of income, many of those enrollees would probably end up without health insurance if they could not enroll in Medicaid. Depending on their income, those enrollees could also find it difficult to pay for services that Medicaid no longer covered.

To reduce Medicaid's spending for nursing home and other long-term care services for the elderly, the federal government could require more assets to be included in the determination of eligibility for the program or place stricter limits on the gross income that enrollees could have—for example, by restricting options for "spending down" to eligibility. With certain exceptions, the Deficit Reduction Act made individuals who have more than $500,000 in home equity ineligible for nursing home benefits under Medicaid (although states may raise that limit to $750,000). Requiring enrollees to use more of their home equity before they could qualify for Medicaid would further reduce program spending. (At the same time, few additional options may be available for restricting or penalizing transfers of assets by Medicaid enrollees.)

Tightening eligibility rules would primarily shift the sources of financing of long-term care, but it might also reduce total spending on such care. As people came to understand that their likelihood of being eligible for Medicaid was significantly lower than it had been under current law, they would be more likely to make their own preparations for impairment in old age—by setting aside savings (if they chose to self-insure) or by purchasing private LTC insurance. And if they did become impaired and were unable to obtain assistance from Medicaid, they would be more likely to seek lower-cost providers and use fewer services as a way to conserve their resources—or they might rely more heavily on informally provided care. Such changes in Medicaid's rules would probably need to be phased in gradually, however, to give individuals time to adjust their financial planning—

because those who are close to entering a nursing home would have limited options for increasing savings or purchasing private insurance.

Increase Beneficiaries' Cost Sharing

Building on the provisions of the DRA, the federal government could take further steps to require Medicaid enrollees to share the costs of services or pay premiums for coverage. The magnitude of the additional savings that would be generated as a result and the option's impact on enrollees would depend on the specific features of the proposal. The primary effect of such changes would be to reduce federal spending by increasing the share of costs borne by enrollees. To the extent that beneficiaries reacted to the higher level of cost sharing by using fewer services, total health care costs would also fall, and federal spending would decline further. However, opponents of such an approach fear that beneficiaries might forgo necessary treatment, which could lead to poorer health and possibly greater demand for more-extensive treatment later. Higher premiums could also discourage some eligible individuals from enrolling in Medicaid.

Encourage Greater Use of Lower-Cost Services

A potentially more appealing option would be to reduce Medicaid's spending by encouraging greater use of lower-cost services while limiting the use of services that were not cost-effective—but achieving savings in that way could prove difficult. For example, the federal government might be able to encourage more use of community-based alternatives to nursing home care, given that community-based care is usually much less expensive per person than is institutional care. The potential demand for community-based services, however, is greater than the demand for institutional care. As a result, expanded coverage of community-based care is likely to substitute for some informal care provided in the home. If the expansion was not well targeted, the costs of meeting that increased demand for care could exceed the savings that might be generated by substituting community-based care for nursing home care.

More generally, Medicaid could seek to focus its spending on cost-effective services and limit or eliminate coverage for specific services that provided only modest benefits. Program administrators could directly implement such an option or rely on managed care organizations to limit the use of low-value services. Under either approach, questions might be raised about how the cost-effectiveness of services was determined and how the coverage rules were applied. Medicaid has already expanded its use of managed care contracts substantially, and insurance companies may not be willing to bear the financial risk of providing Medicaid's other benefits or serving its other enrollees. Whatever approach was taken, an important focus for the future—both in the Medicaid program and in the health sector as a whole—would be to ensure that additional spending brought benefits that were worth their cost.

The CHAIRMAN. With that, this hearing is adjourned.
[Whereupon, at 11:31 a.m., the Committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR KEN SALAZAR

Good Morning.

I want to thank Chairman Smith and Ranking Member Kohl for their leadership and commitment to reform the Medicaid program and to fix our national health care crisis.

The financial sustainablity and reform of Medicaid is a matter of life and death to over 57 million elderly, pregnant women, children, poor, and disabled Americans, who rely on Medicaid for necessary medical care.

In my state alone, over 10% of our population relies on Medicaid to provide critical medical services.

The problems affecting Medicaid are a reflection of the problems plaguing our national health care system.

It is absolutely imperative that we reform our health care system so that all Americans, including our senior citizens, get the health care that they need and so that we stop the crippling effect that rising health care costs has on our citizens, businesses, economy and state and federal governments.

Reforming our system will take the collective wisdom from hearings like this one. It will also take the political will to tackle our entire health care delivery system.

Last year, Senator McCain and I introduced the National Commission on Health Care Act (S. 2007). Its purpose is simple and bold—to fix our broken health care system. It achieves that goal by bringing together elder statesmen and women to study and develop the best reform proposals that will solve our health care crisis.

I look forward to working with the members of this Committee and the witnesses here today on health care reform, whether it is through a commission or other worthy legislative proposals.

I am particularly interested in hearing the testimony and reform proposals of General Motors Corporation CEO, Richard Wagoner, Arizona Governor Janet Napolitano, and Donald Marron of the Congressional Budget Committee.

It will take the concerted efforts of private businesses and leaders at all levels of government to solve the problems plaguing Medicaid and our entire health care system.

Thank you.