AUTHENTICATED
U.S. GOVERNMENT
INFORMATION
GPO

STATE FISCAL RELIEF: PROTECTING HEALTH COVERAGE IN AN ECONOMIC DOWNTURN

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON ENERGY AND COMMERCE
HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

TUESDAY, JULY 22, 2008

Serial No. 110–139

Printed for the use of the Committee on Energy and Commerce
energycommerce.house.gov

U.S. GOVERNMENT PRINTING OFFICE
58–304 PDF WASHINGTON : 2008

For sale by the Superintendent of Documents, U.S. Government Printing Office
Internet: bookstore.gpo.gov Phone: toll free (866) 512–1800; DC area (202) 512–1800
Fax: (202) 512–2104 Mail: Stop IDCC, Washington, DC 20402–0001

COMMITTEE ON ENERGY AND COMMERCE

JOHN D. DINGELL, Michigan, *Chairman*

HENRY A. WAXMAN, California
EDWARD J. MARKEY, Massachusetts
RICK BOUCHER, Virginia
EDOLPHUS TOWNS, New York
FRANK PALLONE, JR., New Jersey
BART GORDON, Tennessee
BOBBY L. RUSH, Illinois
ANNA G. ESHOO, California
BART STUPAK, Michigan
ELIOT L. ENGEL, New York
GENE GREEN, Texas
DIANA DEGETTE, Colorado
Vice Chair
LOIS CAPPS, California
MIKE DOYLE, Pennsylvania
JANE HARMAN, California
TOM ALLEN, Maine
JAN SCHAKOWSKY, Illinois
HILDA L. SOLIS, California
CHARLES A. GONZALEZ, Texas
JAY INSLEE, Washington
TAMMY BALDWIN, Wisconsin
MIKE ROSS, Arkansas
DARLENE HOOLEY, Oregon
ANTHONY D. WEINER, New York
JIM MATHESON, Utah
G.K. BUTTERFIELD, North Carolina
CHARLIE MELANCON, Louisiana
JOHN BARROW, Georgia
DORIS O. MATSUI, California

JOE BARTON, Texas
Ranking Member
RALPH M. HALL, Texas
FRED UPTON, Michigan
CLIFF STEARNS, Florida
NATHAN DEAL, Georgia
ED WHITFIELD, Kentucky
BARBARA CUBIN, Wyoming
JOHN SHIMKUS, Illinois
HEATHER WILSON, New Mexico
JOHN SHADEGG, Arizona
CHARLES W. "CHIP" PICKERING, Mississippi
VITO FOSSELLA, New York
ROY BLUNT, Missouri
STEVE BUYER, Indiana
GEORGE RADANOVICH, California
JOSEPH R. PITTS, Pennsylvania
MARY BONO MACK, California
GREG WALDEN, Oregon
LEE TERRY, Nebraska
MIKE FERGUSON, New Jersey
MIKE ROGERS, Michigan
SUE WILKINS MYRICK, North Carolina
JOHN SULLIVAN, Oklahoma
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee

PROFESSIONAL STAFF

DENNIS B. FITZGIBBONS, *Chief of Staff*
GREGG A. ROTHSCHILD, *Chief Counsel*
SHARON E. DAVIS, *Chief Clerk*
DAVID CAVICKE, *Minority Staff Director*

SUBCOMMITTEE ON HEALTH

FRANK PALLONE, JR., New Jersey, *Chairman*

HENRY A. WAXMAN, California
EDOLPHUS TOWNS, New York
BART GORDON, Tennessee
ANNA G. ESHOO, California
GENE GREEN, Texas
DIANA DEGETTE, Colorado
LOIS CAPPS, California
Vice Chair
TOM ALLEN, Maine
TAMMY BALDWIN, Wisconsin
ELIOT L. ENGEL, New York
JAN SCHAKOWSKY, Illinois
HILDA L. SOLIS, California
MIKE ROSS, Arkansas
DARLENE HOOLEY, Oregon
ANTHONY D. WEINER, New York
JIM MATHESON, Utah
JOHN D. DINGELL, Michigan *(ex officio)*

NATHAN DEAL, Georgia,
Ranking Member
RALPH M. HALL, Texas
BARBARA CUBIN, Wyoming
HEATHER WILSON, New Mexico
JOHN B. SHADEGG, Arizona
STEVE BUYER, Indiana
JOSEPH R. PITTS, Pennsylvania
MIKE FERGUSON, New Jersey
MIKE ROGERS, Michigan
SUE WILKINS MYRICK, North Carolina
JOHN SULLIVAN, Oklahoma
TIM MURPHY, Pennsylvania
MICHAEL C. BURGESS, Texas
MARSHA BLACKBURN, Tennessee
JOE BARTON, Texas *(ex officio)*

CONTENTS

	Page
Hon. Frank Pallone, Jr., a Representative in Congress from the State of New Jersey, opening statement	1
Hon. Nathan Deal, a Representative in Congress from the State of Georgia, opening statement	3
Hon. John D. Dingell, a Representative in Congress from the State of Michigan, opening statement	4
Prepared statement	6
Hon. Michael C. Burgess, a Representative in Congress from the State of Texas, opening statement	10
Hon. Tammy Baldwin, a Representative in Congress from the State of Wisconsin, opening statement	11
Hon. Jan Schakowsky, a Representative in Congress from the State of Illinois, opening statement	12
Hon. Henry A. Waxman, a Representative in Congress from the State of California, opening statement	13
Hon. Darlene Hooley, a Representative in Congress from the State of Oregon, opening statement	14

WITNESSES

Robert Tannenwald, Ph.D., Vice President and Director, New England Public Policy Center at the Federal Reserve Bank of Boston	15
Prepared statement	17
James Frogue, State Project Director, Center for Health Transformation	29
Prepared statement	32
Gerald W. McEntee, International President, American Federation of State, County, and Municipal Employees	43
Prepared statement	45
Robert B. Helms, Ph.D., Resident Scholar, American Enterprise Institute	51
Prepared statement	53
Heather Howard, Commissioner, New Jersey Department of Health and Senior Services	68
Prepared statement	70

SUBMITTED MATERIAL

American Academy of Pediatrics, statement for the record	86

STATE FISCAL RELIEF: PROTECTING HEALTH COVERAGE IN AN ECONOMIC DOWNTURN

TUESDAY, JULY 22, 2008

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON ENERGY AND COMMERCE,
Washington, DC.

The subcommittee met, pursuant to call, at 2:08 p.m., in room 2322, Rayburn House Office Building, Hon. Frank Pallone, Jr., (chairman of the subcommittee) presiding.

Present: Representatives Pallone, Waxman, Baldwin, Schakowsky, Hooley, Dingell (ex officio), Deal, Murphy, and Burgess.

Staff Present: Elana Leventhal, Robert Clark, Amy Hall, Bridgett Taylor, Hasan Sarsour, Brin Frazier, Lauren Bloomberg, Brandon Clark, Ryan Long, and Chad Grant.

OPENING STATEMENT OF HON. FRANK PALLONE, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY

Mr. PALLONE. Good morning.

The subcommittee is having a hearing today on State Fiscal Relief: Protecting Health Coverage in an Economic Downturn, and I will initially recognize myself for an opening statement.

I know that the members present today made a concerted effort to be here as there are no votes until later this afternoon. So I do want to thank everyone for being present for this very important discussion.

Medicaid, as you know, provides over 61 million Americans with access to medical care and specialized supports and services. It protects our most vulnerable populations, our poor, and our disabled. Unfortunately, due to converging economic factors and the ensuing, growing fiscal pressures, the Medicaid programs in many States are threatened and millions of American citizens are in danger of losing access to the health care coverage they desperately need.

Already, 13 States, including my home State of New Jersey, have considered or implemented changes to their Medicaid program that affect eligibility criteria. These cuts affect not only those already on Medicaid but also those who will come to need it as the economy continues to decline. Higher unemployment rates and, therefore, decreases in employer-sponsored health care coverage will force more people to turn to Medicaid for their health care needs.

In fact, a study conducted by the Kaiser Family Foundation found that increasing the national unemployment rate by 1 percentage point increases Medicaid and SCHIP enrollment by 1 mil-

lion. At a time when States are already struggling to balance their budgets, this type of change in unemployment rates would increase State spending by approximately $1.4 billion.

Adding insult to injury, cuts to State Medicaid programs not only impact Medicaid-eligible individuals but they also adversely effect the health care job market. Medicaid cuts translate into health care job losses. Cutting Medicaid, therefore, only contributes to a State's unemployment rate and a need for Medicaid services, exacerbating the worsening fiscal crisis.

With the economy declining, it is crucial now more than ever that we in Congress ensure that those hardworking American families who are negatively impacted by the economic downturn have this safety net to protect them.

To alleviate some fiscal pressures and to halt negative trends, I, along with my colleagues Mr. Dingell, Mr. King and Mr. Reynolds, introduced a bill to temporarily increase each State's Federal Medical Assistance Percentage, or FMAP, during this economic downturn to ensure that States can continue to provide critical services instead of cutting them.

Our legislation provides a temporary FMAP increase of 2.95 percentage points, with the condition that States do not change eligibility criteria. It also includes a hold harmless and Federal contributions for States that are slated for decline in their Federal contribution. In addition, the legislation provides a temporary increase of the Medicaid FMAP by 5.9 percent to the territories.

This bill is very similar to what was passed by a Republican Congress and signed into law by President Bush in 2003 as part of the Jobs and Growth Tax Relief Reconciliation Act. The FMAP increase we provided in 2003 was a success. Studies have shown that the temporary increase provided the funding needed to avert or limit cuts to the Medicaid program, to avoid provider payment cuts, and to reverse any cuts States had already enacted.

I believe it is once again the responsibility of Congress to ensure that Medicaid, a vital public health safety net, is protected. Medicaid is a joint Federal and State effort, and the Federal Government needs to do its part to protect the 61 million Americans who already rely on Medicaid to get their health care services, as well as the millions more who will need these services as the economy continues to decline and unemployment rates rise. Temporarily increasing the Federal matching payments in Medicaid is a proven strategy for stimulating the economy.

I want to thank each of our witnesses for being here today to talk about the current fiscal situation States are facing; and I especially would like to welcome Heather Howard, the Commissioner of the New Jersey Department of Health and Senior Services. Some of you remember her as the Chief of Staff for Governor Corzine when he was a Senator.

And, obviously, we are pleased that you all were able to come on relatively short notice.

And, again, I want to thank the members who are here today, too. Because, as I said before, we don't vote until 6:30. The very fact that they are present earlier in the day is testimony that you are considering this important issue.

I yield now to our ranking member, the gentleman from Georgia, Mr. Deal.

OPENING STATEMENT OF HON. NATHAN DEAL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF GEORGIA

Mr. DEAL. Thank you, Mr. Chairman.

I want to thank you for holding this hearing on a very important subject that will determine the future direction of the Medicaid program and to consider proposals to increase the Federal Medical Assistance Percentage rate.

I want to thank the witnesses who have agreed to be here this afternoon, all of whom have been selected for their unique perspective and their individual expertise on the issue. I appreciate the input that they will have and will provide today.

The Federal Medical Assistance Percentage, or FMAP, is the formula used to determine the Federal share reimbursable to States each quarter. This formula is specifically constructed to allocate higher FMAP reimbursements to States with lower per capita incomes relative to the national average. Alternatively, States with higher per capita income levels receive lower FMAP reimbursement rates. Regardless of this formula, however, no State may be subject to an FMAP below 53 percent or in excess of 83 percent as defined by statute.

According to the States' own enrollment data, over 63 million Americans were enrolled in Medicaid in 2005, and we expect the program to cost the American taxpayers over $370 billion this year. In addition, the Congressional Budget Office's latest budget and economic outlook indicated Medicaid and Medicare will be the primary determinant of the Nation's long-term fiscal balance, noting that the Medicaid program alone will cost the American taxpayers over $5.7 trillion over the next 10 years.

First and foremost, I am concerned about funneling an additional $15 billion of Federal taxpayers' dollars into a welfare program without doing anything to increase the levels of innovation, accountability or efficiency in the Medicaid program. Without question, the fact that Medicaid spending continues to increase at a rate that is over three times the rate of inflation is unsustainable and will result in inadequate resources to meet our current and future obligations.

The combination of a retiring baby boomer generation and longer life expectancies are clear indicators that Congress must address this vital issue with fundamental reforms, not merely through a patchwork of superficial measures that will sadly fail to fix inflated entitlement spending in this country.

The current economy is no doubt having an impact on all Americans, and Congress must act responsibly to provide assistance to families in need. Stagnant capital markets, declining home prices, increasing unemployment, and the rising price of food and gasoline has forced families to drastically scale back on spending where possible. While saving the Medicaid program for future generations of beneficiaries is going to require some significant structural changes, there are several changes we can make now that would improve its financial viability.

I am certain with the collaboration of all members of this committee we can reach a bipartisan, long-term solution that addresses the fundamental flaws with Medicare and Medicaid and will rein in fraudulent and wasteful spending. Furthermore, as an open-ended entitlement program, States' savings that may result from an FMAP increase could be used for a variety of purposes that are not restricted to Medicaid.

If we are going to substantially increase FMAP reimbursement rates as this legislation aims to do, we, as good stewards of taxpayers' dollars, must ensure these funds are used for the purpose for which they are intended. Together, we are reform this program; and the first step we must take is to say no to another costly, short-term fix while ignoring the core problem for a later day. The American people have waited long enough.

I thank you for holding this hearing, and I look forward to a discussion of these vital and important issues that affect families across this country.

I yield back.

Mr. PALLONE. Thank you, Mr. Deal.

I next recognize for an opening statement the chairman of the full committee, Mr. Dingell.

OPENING STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF MICHIGAN

The CHAIRMAN. Mr. Chairman, I thank you for your courtesy and I commend you for focusing attention on the continuing problem of State fiscal relief. I want to begin by expressing my appreciation to you and to our witnesses today for their presence, especially my friend, Mr. McEntee.

Earlier in the year, Mr. Chairman, you introduced legislation, H.R. 5268, to provide temporary and targeted State fiscal relief through enhanced Federal Medicaid funding. The subcommittee held a number of hearings related to Medicaid and State Children's Health Insurance Programs, SCHIP, during which time the issue of Medicaid as a vehicle for State fiscal relief was discussed.

As the current economic downturn continues and the House begins its work on a second economic stimulus package, today's hearing will provide a timely insight into how Medicaid can be an integral part of it. For every dollar the State spends on Medicaid, the Federal Government contributes between $1 and $3.17. This funding not only contains and sustains health coverage but it is critical for supporting jobs and wages throughout the State.

Unfortunately, the situations that the States are confronting is dire. Twenty-nine States face a total fiscal budget shortfall of at least $49 billion in 2009. Michigan, for example, has a $472 million budget gap to close, nearly 5 percent of the general fund of the State. Nearly half of these States facing deficits have implemented or proposed cuts that will affect the eligibility for health insurance programs or access to health services.

When the Census Bureau releases its new release in late August, we expect to see a rise in the number of uninsured. This in turn means increased pressure on State Medicaid programs. A 1 percent increase in unemployment, which is roughly equal to what hap-

pened in June, 2007, to June, 2008, would translate into approximately 1.1 million new uninsured and an increase in approximately 1 million new Medicaid and SCHIP enrollees. I would remind the committee that SCHIP improvements, which would have covered additional children, was vetoed by the administration.

So if we want to protect existing coverage and make sure that the program can serve those who are affected by the downturn, an increased Federal commitment to Medicaid is necessary. Not only is the well-being of the States at stake but so also is the well-being of many citizens who will have no place else to turn for health care.

In addition to helping secure health coverage, Medicaid can stimulate the economy in another way. The injection in new Federal dollars through Medicaid has a measurable fact on State economy, including generating new jobs and wages. It is also enormously helpful to health institutions and providers within several States, because without this they will confront the problem of providing more health care to people who cannot afford to pay it.

For example, if the provisions of your bill, the Pallone-King bill, Mr. Chairman, were to take effect this October, Michigan will receive an additional $324 million in Medicaid funding, which will generate $539 million in additional business activity and create 5,400 additional jobs and mean $201 million in additional wages just for my State.

We know that the temporary Medicaid fiscal relief funding was effective in instigating the 2003 economic downturn. The Federal funds helps States avoid Medicaid cuts. States have already adopted a wide range of cost-containment strategies during the last economic downturn, and there are fewer policy options to reduce spending without significantly harming coverage or access to care.

I look forward to hearing from today's witnesses about the fiscal condition of the States and how increased Federal assistance can protect health coverage and stimulate the economies of several States. I believe that before the fall is here we will have a second stimulus package that will include a targeted and temporary increase in Federal assistance for Medicaid. It is very much needed.

Thank you, Mr. Chairman.

[The prepared statement of Mr. Dingell follows:]

STATEMENT
OF
THE HONORABLE JOHN D. DINGELL
SUBCOMMITTEE ON HEALTH HEARING
ON "STATE FISCAL RELIEF: PROTECTING HEALTH COVERAGE IN AN ECONOMIC DOWNTURN"

July 22, 2008

I begin by commending the Chairman for refocusing attention on the issue of State fiscal relief. Earlier in the year, Chairman Pallone introduced legislation, H.R. 5268, to provide temporary and targeted State fiscal relief through enhanced Federal Medicaid funding. The Subcommittee held a number of hearings related to Medicaid and the State Children's Health Insurance Program (SCHIP) during which the issue of Medicaid as a vehicle for State fiscal relief was discussed.

As the current economic downturn continues, and the House begins work on a second economic stimulus package, today's hearing will provide a timely insight into how Medicaid can be an integral part of it. For every dollar a State spends on Medicaid, the Federal

Government contributes between $1.00 and $3.17. This funding not only sustains health coverage, but is critical for supporting jobs and wages throughout the State.

Unfortunately, the situation States are facing is dire. Twenty-nine States face a total budget shortfall of at least $48 billion in 2009. Michigan, for example, has a $472 million budget gap to close – nearly 5 percent of its general fund. Nearly half of those States facing deficits have implemented or proposed cuts that will affect eligibility for health insurance programs or access to health services.

When the Census Bureau releases its new report in late August, we expect to see a rise in the number of uninsured. This, in turn, means increased pressure on State Medicaid programs. A 1 percent increase in unemployment, which is roughly equal to what occurred from June 2007 to June 2008, would translate into approximately 1.1 million new uninsured and an increase in approximately 1 million new Medicaid and SCHIP

enrollees. If we want to protect existing coverage and make sure that the program can serve those who are affected by the downturn, an increased Federal commitment to Medicaid is necessary.

In addition to helping secure health coverage, Medicaid can stimulate the economy another way. The injection of new Federal dollars through Medicaid has a measurable effect on State economies, including generating new jobs and wages.

For example, if the provisions of the Pallone-King bill were to take effect this October, Michigan would receive an additional $324 million in Medicaid funding, which would generate $539 million in additional business activity, create 5,400 additional jobs, and $201 million in additional wages.

We know the temporary Medicaid fiscal relief funding was effective in instigating the 2003 economic downturn. The Federal funds helped States avoid Medicaid cuts.

States have already adopted a wide range of cost containment strategies during the last economic downturn, and there are fewer policy options to reduce spending without significantly harming coverage or access to care.

I look forward to hearing from today's witnesses about the fiscal condition of the States and how increased Federal assistance can protect health coverage and stimulate their economies. I believe that before the Fall we will have a second stimulus package that will include a targeted and temporary increase in Federal assistance for Medicaid.

Mr. PALLONE. Thank you, Chairman Dingell.

I next recognize for an opening statement the gentleman from Texas, Mr. Burgess.

OPENING STATEMENT OF HON. MICHAEL C. BURGESS, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF TEXAS

Mr. BURGESS. Thank you, Mr. Chairman.

I appreciate you holding the hearing today, and I appreciate you not starting at 11 o'clock this morning. It is a more reasonable time of 2:00 in the afternoon. I think it certainly boosted attendance on our side.

I think we all agree we need to take a hard look at Medicaid, the Medicaid funding. We will probably not all agree on where the solution lies.

One of the issues before us today is whether it may be feasible in the near term, midterm or long term for the Federal Government to provide States with a fiscal bailout, given the state of the economy. The Ben Bernanke of our committee, Chairman Pallone, has already issued a forecast that the economy will continue to decline. I hope Wall Street wasn't paying strict attention when you made that statement, but nevertheless, we will see.

But at this juncture it is, I think, interesting to point out a couple of things. Fiscal year 2008, State revenue collections were up 1.7 percent. A total of 29 States report that they will either meet or exceed their revenue projections; 20 States will fall below revenue projections. Budget stabilization funds, so-called rainy day funds, remain sufficient in most States. In aggregate, State balances are at around 8 percent for fiscal year 2008. It is down somewhat from the 11.5 percent of 2006 but still positive.

The last time Congress intervened in the State budget crisis was 2003. At that time, 40 States faced revenue collections that fell short of planned budget expenditures. This economy is not great, but I wonder if it might be premature for this committee or this Congress to begin thinking about a multi-billion dollar bailout for State Medicaid programs. Certainly, reviewing the data, it seems to show the relative health of State budgets isn't nearly as dire as it was in 2002. While I wouldn't advocate allowing it to become dire, I think keeping it in context is helpful.

It is a little disappointing—we have a great panel, many esteemed guests in front of us. I am grateful for that, Mr. Chairman. But, really, it would be good if we had a representative from, say, the National Governors Association or National Association of State Budget Officers to discuss the fiscal issues that are actually facing the States.

If it is the goal of this committee to address this issue this year, it almost seems like we will need more information than this hearing will provide to justify us moving forward.

It is important that Mr. McEntee should note that the skyrocketing energy crisis are putting pressure on State, county, and city governments. That is an economic issue and economic reality that is already at crisis stage. We have in our power in Congress the ability to address this issue head on, but all we have seen out of Congress for this year and last year is talk, talk, talk.

Our sum total of energy policy in the past 18 months has been to ban the incandescent bulb. And, yes, if anyone is interested, I relinquished all the incandescent bulbs from my office last week under an order from the Speaker. I think our time would be better spent working on energy prices, quite frankly, and coming back to deal with State fiscal issues under the Medicaid system at another time.

I think we are going to hear some interesting testimony today that perhaps adding additional money may not be the answer but being more frugal and more sensible about how those monies are allocated and really doing our job with oversight to ensure that we get the inefficiency and duplication out of the system.

But, nevertheless, Mr. Chairman, an interesting topic, and I look forward to lively discussion this afternoon.

Mr. PALLONE. Thank you, Mr. Burgess.

Next I recognize for an opening statement the gentlewoman from Wisconsin, Ms. Baldwin.

OPENING STATEMENT OF HON. TAMMY BALDWIN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF WISCONSIN

Ms. BALDWIN. Thank you, Mr. Chairman.

Thank you for holding this important hearing and particularly since it is on an issue of great urgency, in my opinion.

I also want to thank our panel of witnesses for being with us today. I look forward to hearing your testimony.

As we look across the country, every State is facing serious economic difficulties. But we are here today to ensure that States are not forced to respond to these tough times by restricting access to health care to those most in need.

In my home State of Wisconsin, people are struggling with recovery from recent floods and, as elsewhere, also with skyrocketing gas surprises, high food prices, plant closings, and job losses—and now, more than ever, the cost of health care.

When I surveyed my constituents recently and asked them about the state of the economy, almost 40 percent said that their family finances were significantly affected by the price of prescription drugs, just one component of health care costs. We know from past experiences that during recessions and when health care costs are high more American workers find that they must use Medicaid as their safety net. The increased enrollment in Medicaid is a sign that the program is working, but it puts a huge strain on tight State budgets.

My State is one of the 29 which Chairman Dingell just referenced, in which the government revenues are expected to fall short of the amount needed to support the current services that are offered in the next fiscal year. Since the beginning of 2008, the number of individuals eligible for Medicaid in the State of Wisconsin has increased by over 10 percent, especially among children, parents, and pregnant women.

Unlike the Federal Government, State governments are required to balance their budgets, and so they must do something to address the shortfall in revenues in this economic downturn. And we know

that this "something" will likely involve cutting services, social services, leaving vulnerable Americans without a safety net.

Cutting back on Medicaid coverage means that many will be unable to afford health care. It means that our most vulnerable families are at even greater risk both in terms of their health and their finances.

We must do everything that we can to ensure that States can support continued access to health care. When our Nation faced economic challenges in 2003, the Federal Government stepped in and supported States through an increase in the Federal matching program for Medicaid. Because of this temporary fiscal relief, States were able to maintain health care services for their most vulnerable residents, even with that weak economy.

Like many of my colleagues, I am proud to be a co-sponsor of the chairman's bill, H.R. 5268, which provides for a temporary increase in the Federal Medical Assistance Percentage under the Medicaid program. I strongly believe this bill should become law as quickly as possible and join with many of my colleagues in urging our House leadership to include this language in the upcoming stimulus or supplemental. The health of our most vulnerable Americans depends upon it.

Thank you, Chairman Pallone, for your leadership on this issue and for holding this hearing today.

Mr. PALLONE. Thank you, Ms. Baldwin.

I next recognize for an opening statement the gentlewoman from Illinois, Ms. Schakowsky.

OPENING STATEMENT OF HON. JAN SCHAKOWSKY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF ILLINOIS

Ms. SCHAKOWSKY. Thank you, Mr. Chairman.

You continue to lead on issues of improving health care, and this committee is particularly well-served by your commitment to safeguard coverage for low-income children and women and persons with disabilities and senior citizens on Medicaid.

Today's hearing couldn't be more timely. In Springfield, Illinois, and in State capitals all across the country legislatures are meeting to determine how to meet the growing need for Medicaid at a time when State revenues are in decline.

In Illinois about 2.5 million people rely on Medicaid and yet we are facing a $1.8 billion budget gap in 2009. As a result, our State is delaying payment to Medicaid providers in order to contain costs after having frozen most rates for the past several years. This will only serve to reduce the number of providers willing to care for Medicaid beneficiaries.

In this economic downturn, when State budgets are stretched thin, we can expect more cutbacks in benefits, payments, and eligibility unless we act. That is why we need to pass a temporary FMAP increase as soon as possible, not only to protect healthcare for our constituents but to help stimulate the sagging economy.

It was mentioned already that, in 2003, States faced substantial economic challenges; and it was necessary to provide temporary fiscal relief as a result. A wide range of economists tell us that increased match rates of routed cuts to the Medicaid program stabilized budgets and stimulated the economy.

The situation for States is worse now than it was in 2003. Not only are costs of health care rising exponentially but the number of uninsured is up and access to the employer-based system is down. States are also feeling the strain of the housing crisis and can't depend on property taxes to manage education costs, forcing States to stretch their health care dollars even further.

Providing States with a temporary increase in Federal assistance for Medicaid will not only protect 61 million Medicaid recipients—women, children, seniors, and the disabled—but will reap positive economic returns for a State budget.

So I am grateful that we are having this hearing today; and when I listen to my colleagues on the Democratic side of the aisle express compassion for the people who rely so much on Medicaid I am very, very proud.

I want to respond to something that Mr. Deal said, that he was reluctant, essentially, to give more money to a welfare program that lacks proper accountability. I just have to say I wish the same standards were applied to private contractors in Iraq like Halliburton or KBR or Blackwater who overcharged taxpayers and put our soldiers in danger. Or closer to home on this subject to the Medicare Advantage program or Medicaid-managed care plans, and I could certainly go on.

So I thank our witnesses for being here today. I would particularly like to acknowledge and thank Mr. McEntee for continuing to be a champion on this issue.

And, with that, I yield back.

Mr. PALLONE. Thank you.

Next for an opening statement the gentleman from California, Mr. Waxman.

OPENING STATEMENT OF HON. HENRY A. WAXMAN, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF CALIFORNIA

Mr. WAXMAN. Thank you very much, Mr. Chairman, for calling this hearing and for your leadership on this important issue. I am pleased to join you as a co-sponsor of the legislation.

We know the States are facing difficulties. The revenues are slowing down because of the downturn in the economy. The States, as our partners in taking care of the most vulnerable citizens, the most vulnerable population for health care needs, the States have discretion; and if they don't have the funds, the only way they can exercise their discretion is by cutting back on provider reimbursement or taking a lot of people and no longer making them eligible for Medicaid.

Well, that is an untenable position. We shouldn't want that to happen. The States don't want that to happen. And we have tried this in the past to give them an extra matching rate so that they can get through the responsibility to take care of Medicaid-eligible people during a time of recession. We know it worked last time, and I think we can say with confidence it will work again this time.

So I would strongly support the legislation that you have suggested and proposed, and I hope other members will join together on a bipartisan basis. We shouldn't want to see the very poor have the safety net yanked out from beneath them when they get sick,

and that is exactly what will happen if we don't help the States meet their Medicaid responsibility and, in effect, watch them create a hole in that safety net.

I want to yield back the balance of my time. I am pleased all the panelists are here today. I welcome all of them and look forward to what they have to say. And, more importantly, let's work on a bipartisan basis as we did in this committee in the past, recently, to stop some very egregious rules from going into effect on Medicaid. We ought to help the States as we did on a bipartisan basis in 2003.

Mr. PALLONE. Thank you, Mr. Waxman.

The gentlewoman from Oregon, Ms. Hooley, is recognized for an opening statement.

OPENING STATEMENT OF HON. DARLENE HOOLEY, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF OREGON

Ms. HOOLEY. Thank you, Mr. Chair; and thank you for holding this hearing.

I have a very brief statement. I just want to talk a little bit about what is happening during our last recession in Oregon, which was hit quite hard.

Oregon DHS saw their caseload for the poor and needy increase rapidly, way beyond expectations. I think most of us know the reason why. It was loss of jobs, resulting in unemployment, high unemployment, and shifts in the levels of population groups that form that client base. I think it is very clear that we are looking at the same circumstances today.

This is a time that we can't back away from helping our neediest and helping our poor. I think this hearing is timely. I look forward to the testimony, and I think we need to do everything we can to help our States.

I yield back and look forward to, again, those of you testifying.

Mr. PALLONE. Thank you.

I think that concludes members' opening statements. We will now turn to our witnesses, and we have one panel. Let me welcome you and introduce each of you, from my left to my right.

Starting on my left is Dr. Robert Tannenwald, who was Vice President and Director of the New England Public Policy Center at the Federal Reserve Bank of Boston. Next is Mr. James Frogue—I hope I am pronouncing that properly—who is State Project Director for the Center for Health Transformation here in Washington, D.C. And next is Mr. Gerald—or Gerry—McEntee, who is International President for AFSCME, American Federation of State, County, and Municipal Employees. Thank you for being here with us today. And then we have Dr. Robert Helms, who is a Resident Scholar for the American Enterprise Institute here in Washington, D.C. And last but not least is our own Heather Howard, who is the Commissioner for the New Jersey Department of Health and Senior Services for the State of New Jersey.

Thank you all for being here today.

I think you know the drill. We have 5-minute opening statements. Those statements become part of the hearing record, but each witness may, in the discretion of the committee, submit additional statements in writing for inclusion in the record.

I will start from my left with Dr. Tannenwald.

STATEMENT OF ROBERT TANNENWALD, PH.D., VICE PRESIDENT AND DIRECTOR, NEW ENGLAND PUBLIC POLICY CENTER AT THE FEDERAL RESERVE BANK OF BOSTON

Mr. TANNENWALD. As the first witness, I am not going to say anything about Medicaid. I understand my role is to talk about the fiscal conditions of the State and—

Mr. PALLONE. I think maybe your mike is not on.

Mr. TANNENWALD. Sorry.

Mr. PALLONE. Do you want to bring it closer to you.

Mr. TANNENWALD. Sorry. This is my first congressional hearing.

Mr. PALLONE. That is quite all right.

Mr. TANNENWALD. I am going to talk about the fiscal conditions of the States and some of the factors that might be responsible for it. And I think I was chosen because my field is State and local public finance. I talk quite a bit with people from the National Governors Association and NASBO, even advise them at times, and they advise me.

In a nutshell, the fiscal conditions of the States is weak. The latest official statistical snapshot of their fiscal condition was taken in the first quarter of 2008, three-quarters into the last fiscal year for most States. Fiscal year-to-date tax revenues in that quarter were only 2.6 percent above their year-ago level. Given sharp rises in the cost of delivering State and local public services, that translates into about a 3 percent revenue drop in inflation-adjusted terms.

Revenue growth has been slowing with each passing quarter. The nationwide turmoil in housing markets, soaring energy prices and food prices, and falling employment have combined to hit sales tax collections especially hard. While income tax growth has been stronger, it could very well weaken soon, if history is any guide.

Much of the variation in this tax source over the past decade has been driven by the stock market. The bull market that fueled robust income tax growth in recent years has given way to a bear market that is likely to slow or possibly even shrink income tax collections in coming quarters. And sharply falling housing prices, the implication of that for property tax revenues is self-evident.

Compounding the fiscal challenges posed by current economic conditions are long-term trends that have eroded State tax bases and intensified demand for State and local services. The long-running transition from a goods to a service economy has slowed growth and sales tax bases since services are difficult to tax politically and administratively. Higher energy and food prices are probably here to stay for a long time, boosting State and local costs and syphoning dollars away from taxable sales. Intensifying competition for jobs in industry has locked State and local governments into a bidding war, diverting public resources from other uses.

Tax planners have become increasingly aggressive in sheltering their clients from tax liabilities. Public infrastructure badly needs repair and modernization, and the demand for improvement and educational outcomes is stronger than ever. The cost of health care, as this committee knows too well, continues to soar.

Despite these challenges, inflation-adjusted State and local spending per capita has fallen during the past 5 years. But such simplistic indicators are not much help in judging the degree to which State and local governments have spent too much or too little. In making such a judgment nothing can substitute for a careful evaluation of the conditions confronting State and local government that, through no fault of their own, compel them to spend more per unit of service delivered, augment the array of services they must provide, erode their traditional tax bases and complicate tax enforcement.

In short, State and local governments are in serious fiscal trouble, most of them, not all of them, largely not through their own fault; and simplistic statistics aren't much help in resolving the problem.

Thank you, Mr. Chairman.

Mr. PALLONE. Thank you, Dr. Tannenwald.

[The prepared statement of Mr. Tannenwald follows:]

FEDERAL RESERVE
BANK OF BOSTON ™

NEW ENGLAND PUBLIC POLICY CENTER

600 ATLANTIC AVENUE • BOSTON MA 02210
WWW.BOS.FRB.ORG

TESTIMONY OF ROBERT TANNENWALD BEFORE THE SUBCOMMITTE ON HEALTH OF THE HOUSE SUBCOMMITTEE ON ENERGY AND COMMERCE
"State Fiscal Relief—Protecting Health Coverage in an Economic Downturn"

July 22, 2008

The views expressed in this testimony are my own. They do not necessarily represent those of the Federal Reserve Bank of Boston or the Board of Governors of the Federal Reserve System.

The fiscal condition of the states is weak. The latest official statistical snapshot of their fiscal condition was taken in the first quarter of calendar year 2008, three quarters into the last fiscal year for most states. Fiscal year-to-date tax revenues in that quarter were only 2.6 percent about their year-ago level. Given sharp rises in the costs of delivering public services, that translates into about a 3 percent revenue drop in inflation-adjusted terms. Revenue growth has been slowing with each passing quarter.

The nationwide turmoil in housing markets, soaring energy prices, and falling employment have combined to hit sales tax collections especially hard. While income tax growth has been stronger, it should weaken soon if history is any guide. Much of the variation in this tax source over the past decade has been driven by the stock market. The bull market that fueled robust income tax growth in recent years has given way to a bear market that is likely to slow or possibly even shrink income tax collections in coming quarters.

Compounding the fiscal challenges posed by current economic conditions are long-term trends that have eroded state tax bases and intensified demand for their services. **The long-running transition from a goods to a service economy** has slowed growth in sales tax bases, since services are difficult to tax both politically and administratively. **Higher energy prices** are probably here to stay for a long time, boosting state and local costs and siphoning dollars away from taxable sales. **Intensifying competition for jobs and industry** has locked state and local governments into a bidding war, diverting public resources from other uses. Tax planners have become increasingly aggressive in sheltering their clients from tax liabilities. **Public infrastructure** badly needs repair and modernization. **The demand for improvement in educational outcomes** is stronger than ever. And **the cost of health care** continues to soar.

Despite these challenges, **inflation-adjusted state and local spending per capita has *fallen* during the past five years**. But such simplistic indicators are not much help in judging the degree to which state and local governments have spent too much or too little. In making such a judgment, nothing can substitute for a careful evaluation of the conditions confronting state and local governments that, through no fault of their own, compel them to spend more per unit of service delivered, augment the array of services they must provide, erode their traditional tax bases, and complicate tax enforcement.

FEDERAL RESERVE
BANK OF BOSTON™

NEW ENGLAND PUBLIC POLICY CENTER

600 ATLANTIC AVENUE • BOSTON MA 02210
WWW.BOS.FRB.ORG

TESTIMONY OF ROBERT TANNENWALD BEFORE THE SUBCOMMITTE ON HEALTH OF THE HOUSE SUBCOMMITTEE ON ENERGY AND COMMERCE

July 22, 2008

Thank you for the opportunity to testify before you this afternoon. For the record, I am a vice president of the Federal Reserve Bank of Boston, where I have worked for 26 years. I am director of the Bank's New England Public Policy Center. I have published extensively in the field of state and local public finance and have counseled many state and local officials and their advisors on issues concerning public finance. I have served as research director or member of five different state tax task forces convened within the New England region. I am immediate past president of the National Tax Association, widely considered to be the nation's foremost organization of tax professionals dedicated to advancing the theory and practice of public finance.

I will assess fiscal conditions in the nation's state and local sector and discuss factors, both short-term and long-term, that are complicating state and local governments' task of balancing their budgets while providing adequate services.

The views expressed in this testimony are my own. They do not necessarily represent those of the Federal Reserve Bank of Boston or the Board of Governors of the Federal Reserve System.

Current Fiscal Conditions in the Nation's State and Local Sector

- **Recent growth in state tax revenues has been weak.**

  Three quarters of the way into state fiscal year 2008 (FY2008), state tax receipts were only 2.6 percent above their FY2007 level for the corresponding period (Figure 1). In the third quarter of FY2008, which ended on March 31, tax collections grew by only 1.4 percent on a

FEDERAL RESERVE
BANK OF BOSTON ™

NEW ENGLAND PUBLIC POLICY CENTER

600 ATLANTIC AVENUE • BOSTON MA 02210
WWW.BOS.FRB.ORG

year-over-year basis. The rate of growth in state tax revenues has not been this slow in five years.[1]

- **The cost of delivering state and local services has been increasing rapidly. As a result, in inflation-adjusted terms, state tax revenues have fallen steeply.**

The implicit state and local price deflator, estimated by the U.S. Bureau of Economic Analysis, tracks the cost to state and local governments of delivering a "unit" of public services. According to this measure, state and local costs increased at an annualized rate of 6.1 percent during the first three quarters of FY2008. The comparable rate of growth for the first quarter of calendar year 2008 (CY2008:Q1) was 7.4 percent. When adjusted for these rising costs, state tax receipts shrank over the first three quarters of FY2008 by 3 percent relative to the comparable year-to-date level for FY2007 (Figure 2). In CY2008:Q1, inflation-adjusted state tax revenues were 4.5 percent below their year-ago level.

Over the past three quarters, the state and local implicit price deflator has risen at almost twice the rate of the deflator for the federal government, and at almost three times the rate of inflation for the whole economy.[2]

- **Growth in local tax revenues, although faster than that of state revenues, has also decelerated markedly.**

Local tax revenues were up by 4.1 percent in the first three quarters of FY2008 on a year-over-year basis. CY2008:Q1 receipts were up only 2.6 percent relative to CY2007:Q1.[3] While

[1] U.S. Census Bureau. Data for the last quarter of the FY2008 are not yet available.
[2] U.S. Bureau of Economic Analysis, National Income and Product Accounts.
[3] U.S. Census Bureau.

FEDERAL RESERVE
BANK OF BOSTON ™

NEW ENGLAND PUBLIC POLICY CENTER

600 ATLANTIC AVENUE • BOSTON MA 02210
WWW.BOS.FRB.ORG

showing stronger growth than state tax receipts, local collections have also not kept pace with the rising cost of service provision.

- **States have turned to deep reserves built up over the past several years.**

  According to the National Association of State Budget Officers (NASBO) and the National Governors Association (NGA), state governments had built up reserves equal to 11.5 percent of state spending by the end of FY2006, the highest percentage since 1979, the year that NASBO and NGA began to track this statistic. NASBO and NGA estimate that by the end of FY2008 these reserves were 8 percent of state spending.[4]

- **In a spring survey conducted by the National Conference of State Legislatures, budget officials in several states reported large projected deficits for FY2009, even assuming no increase in state service levels.**

  Twenty-three states projected deficits, ten in excess of 5 percent of general fund spending, and five in excess of 10 percent of such spending. Reports are still coming in concerning how states resolved these imbalances in crafting their budgets for the current state fiscal year, which began in most states on July 1. On the other hand, energy-producing states are generally doing well, enjoying robust revenue growth and projected surpluses.[5]

Cyclical Economic Factors Exacerbating Fiscal Stress in the State and Local Sector

While no set of factors neatly explains the fiscal woes of every state and municipality, some recent economic developments have exacerbated the fiscal stress on the state and local sector.

[4] National Governors Association and National Association of State Budget Officers, *The Fiscal Survey of the States,* June 2008.
[5] National Conference of State Legislatures, *State Budget Update*, April 2008.

FEDERAL RESERVE
BANK OF BOSTON™

NEW ENGLAND PUBLIC POLICY CENTER

600 ATLANTIC AVENUE • BOSTON MA 02210
WWW.BOS.FRB.ORG

- **The sharp contraction in housing has cut into the base of the sales and property taxes, two of the three most important sources of state and local tax revenue.**

The nation's housing sector is in the midst of a severe contraction. From CY2007:Q1 to CY2008:Q1, nationwide residential investment fell by 21 percent,[6] home sales declined by 22 percent,[7] and residential housing values declined by 14 percent.[8]

Housing's difficulties have played a large role in dampening growth in revenues from state sales and gross receipts taxes. In FY2007, this source accounted for almost one third of state tax revenues. Over the first three quarters of FY2008, receipts from these taxes were only 1.5 percent above their level in the corresponding period of FY2007 (Figure 3). These receipts grew only 0.4 of a percent in CY2008:Q1 on a year-over-year basis.

Housing exerts such a big effect on sales tax collections because consumer durables and construction materials account for a disproportionately large fraction of sales tax bases. Purchases of big-ticket items and building materials are strongly affected by the pace of housing sales and construction. When a house is sold, the buyer often purchases new appliances and makes other improvements. When a house is built, contractors pay sales tax on the construction materials they acquire and the appliances they install.

Plummeting housing values have further curtailed consumer spending, as households become more cautious in the face of slowing wealth accumulation or declining net worth. Falling residential values have also cut into the bases of property taxes, which account for 75 – 80 percent of local taxes. Local governments have yet to feel the full brunt of shrinking home

[6] U.S. Bureau of Economic Analysis, National Income and Product Accounts.
[7] National Association of Realtors.
[8] Case-Shiller Home Price Index.

FEDERAL RESERVE
BANK OF BOSTON™

NEW ENGLAND PUBLIC POLICY CENTER

600 ATLANTIC AVENUE • BOSTON MA 02210
WWW.BOS.FRB.ORG

values, since tax assessors tend to revalue property with a lag. Furthermore, nonresidential property values have remained strong relative to their residential counterparts, although their growth has slowed, too. The bases of property taxes could come under further pressure if housing prices continue to decline, a likely scenario in the near term.

- **The rising price of energy has further curtailed consumption of taxable goods and services, as households devote a rising share of their budgets to gasoline, electricity, and home heating oil.**
- **The recent decline in the value of stocks is beginning to slow growth in state personal income tax receipts.**

Like sales and gross receipts taxes, the personal income tax accounts for about one-third of state tax revenues, although the degree to which states rely on it varies greatly. While growth in income tax receipts has slowed nationwide in recent quarters, in CY2008:Q1 they stood 3.2 percent higher than their value four quarters earlier.

Over the past decade, the volatility of state income tax revenues has increased sharply (Figure 4), mostly reflecting increased volatility in the value of equities. Capital gains and stock-related sources of income, such as stock options, have grown as a percentage of total state taxable income. The correlation between personal income tax collections and stock values has increased accordingly. State income tax revenues soared during the late 1990s and the year 2000 in tandem with the run-up in the value of equities, only to plummet in 2002 when stocks retreated sharply. State income tax receipts could be on a similar roller coaster ride now. The performance of income tax collections in CY2008:Q2 will be especially telling, since this quarter included April 15, the tax filing deadline.

FEDERAL RESERVE
BANK OF BOSTON™

NEW ENGLAND PUBLIC POLICY CENTER

600 ATLANTIC AVENUE • BOSTON MA 02210
WWW.BOS.FRB.ORG

Long-term fiscal challenges facing state and local governmental tax systems

While these challenges are many and varied, some of the most prominent include:

- **The shift in both consumption and production from goods to services.**

  Over the past several decades, the nation's mix of both consumption and production has shifted steadily away from goods towards services. This shift has diminished the revenue productivity of state and local sales taxes, since the taxation of services is difficult for both political and administrative reasons. Furthermore, intermediate purchases, which account for roughly 40 percent of state sales tax receipts, have shrunk in value relative to Gross Domestic Product, further eroding sales tax bases. An increasing share of these transactions takes place overseas, beyond the jurisdiction of state sales tax officials.

- **The rising share of business and household purchases transacted electronically.**

  While in principle electronic commerce transacted across state lines is taxable under state use taxes, in practice, the taxation of such purchases is difficult to enforce. Moreover, in light of recent court decisions, attempting to collect taxes on such commerce from sellers located in a state other than the customer's state of residence is illegal. As e-commerce has grown as a share of total sales, expansion of sales tax bases has been constrained accordingly.

- **Intensifying inter-jurisdictional economic competition and increasingly aggressive efforts at tax avoidance.**

  As firms have become increasingly mobile and the geographic scope of many markets has become global, state and local governments find themselves under increasing pressure to keep taxes low and to enter into bidding wars for businesses by offering generous tax incentives, loans, supportive firm-specific infrastructure, and training programs at local vocational schools

FEDERAL RESERVE
BANK OF BOSTON ™

NEW ENGLAND PUBLIC POLICY CENTER

600 ATLANTIC AVENUE • BOSTON MA 02210
WWW.BOS.FRB.ORG

colleges, and universities. Competition among states and municipalities can enhance operational efficiency and induce governments to grow their jurisdictions' economies. Some have argued, however, that competition has become so intense that state and local governments have been locked into a "zero-sum" or "negative sum" game, in which all the players either gain nothing or lose in the long run. None is willing to quit, however, unless everyone agrees to do so. Meanwhile, the revenue foregone on tax incentives and spending devoted to recruitment and retention of business detract from the provision of other services that constituents need and want.

In addition, the expanding geographic scope of economic markets and increasing complexity of corporations' organizational arrangements have created new opportunities for avoidance of state and local taxes. Sophisticated tax planners have taken advantage of these opportunities. Partially as a result, state and local corporate income taxes as a percentage of pre-tax profits have declined over the past 30 years (Figure 5). Some states have enacted laws and regulations in recent years that have attempted to curb tax avoidance practices.

Have State and Local Governments Been Spending "Excessively"?

It has been argued that state and local governments, though faced with formidable fiscal challenges, are still at least partially responsible for their own fiscal problems by spending excessively. One frequently cited indicator designed to gauge this degree of excess is the extent to which the rate of inflation-adjusted growth in state and local spending has exceeded the rate of growth in the nation's population. The implicit underlying premise of this indicator is that the need for state and local public services increases only with population, regardless of its composition in terms of age, household size, and income distribution, and regardless of the severity of such challenges confronting state and local governments as deteriorating

FEDERAL RESERVE
BANK OF BOSTON™

NEW ENGLAND PUBLIC POLICY CENTER

600 ATLANTIC AVENUE • BOSTON MA 02210
WWW.BOS.FRB.ORG

infrastructure, environmental pollution, and the constitutional requirement to adequately educate the nation's school-aged children. In the past, analysts have focused on the period from 1990 to 2002. During that period, inflation-adjusted per capita total state and local spending, as measured in the National Income and Product Accounts, grew at an annualized rate of about 1.75 percent per year. However, this was a period during which the share of the nation's population accounted for by children between the ages of 5 and 18 grew substantially, a factor increasing demand for local educational services. From 2002 until 2007, by contrast, inflation-adjusted state and local spending grew more slowly than the population. During this period, real per capita state and local spending fell at an annualized rate of 0.5 percent.

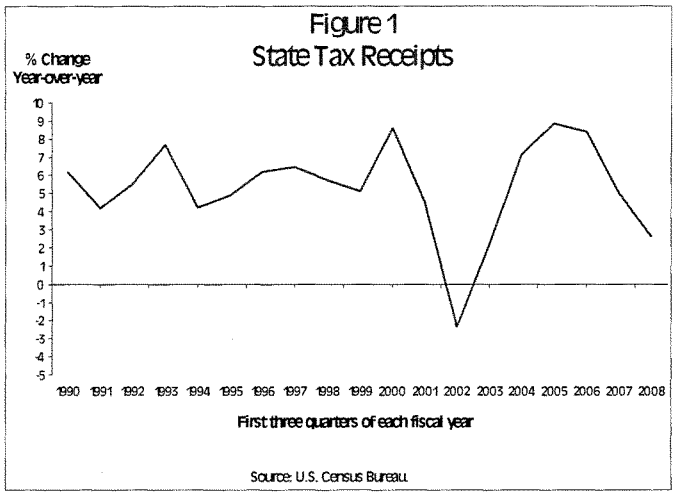
Another frequently cited statistic to gauge the fiscal prudence of state and local governments is the extent to which their inflation-adjusted rate of growth exceeds that of the federal government. Again, in the 1990 – 2002 period, the federal government's spending grew considerably more slowly than that of state and local governments, primarily because defense spending fell sharply with the demise of the Soviet Union. By contrast, from 2002-2007, inflation-adjusted spending grew far more slowly than its federal counterpart, in part because of the nation's military efforts in Afghanistan and Iraq.

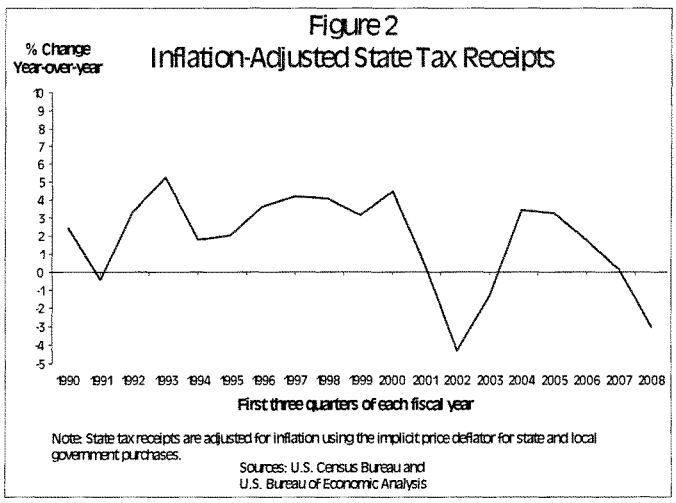
Neither of these statistics is especially helpful in gauging excess because they do not take into account the particular fiscal needs and stresses operating on each level of government. No simple ratio or number can take the place of a careful assessment of such needs and stresses in evaluating the adequacy or profligacy of government spending.

FEDERAL RESERVE
BANK OF BOSTON™

NEW ENGLAND PUBLIC POLICY CENTER

600 ATLANTIC AVENUE • BOSTON MA 02210
WWW.BOS.FRB.ORG

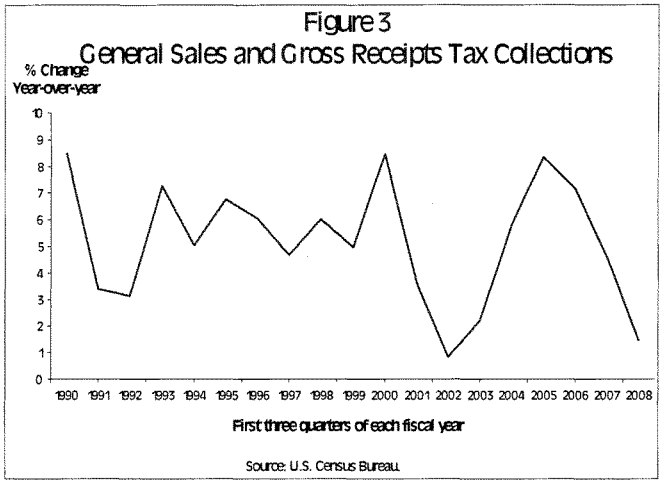


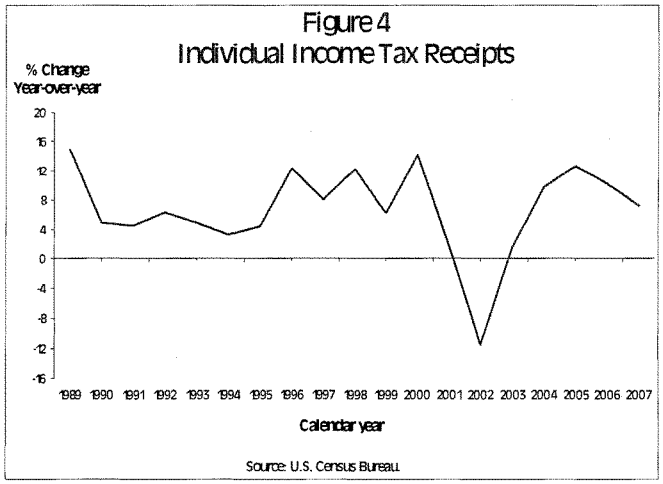


FEDERAL RESERVE
BANK OF BOSTON ™

NEW ENGLAND PUBLIC POLICY CENTER

600 ATLANTIC AVENUE • BOSTON MA 02210
WWW.BOS.FRB.ORG





FEDERAL RESERVE
BANK OF BOSTON™

NEW ENGLAND PUBLIC POLICY CENTER

600 ATLANTIC AVENUE • BOSTON MA 02210
WWW.BOS.FRB.ORG

Figure 5
State and Local Corporate Net Income Taxes
as Share of Corporate Profits

Note: Corporate profits are before taxes and with inventory valuation and capital consumption adjustments.
Sources: U.S. Census Bureau and U.S. Bureau of Economic Analysis.

Mr. PALLONE. Mr. Frogue.

STATEMENT OF JAMES FROGUE, STATE PROJECT DIRECTOR, CENTER FOR HEALTH TRANSFORMATION

Mr. FROGUE. Chairman Pallone, Ranking Member Deal and members of the committee, thank you for the opportunity to testify today. My oral and written remarks reflect solely my own views and not necessarily those of the Center for Health Transformation, its staff or members.

This committee is considering legislation that would send an additional $15 billion to the States for Medicaid costs that they have incurred. There is one simple action this committee could lead that would be low cost and go a very long way towards improving the care received by 50 million plus people on Medicaid, while eliminating much of the waste, fraud and abuse that is largely responsible for States having chronic financial trouble with Medicaid in the first place.

Legislation should be put forward by this committee that would require States to post their Medicaid patient encounter data on the Internet for all to see. Specifically, this is the set of claims that Medicaid providers send to the State for reimbursement for the treatment of patients. This is administratively cheap, simple and would have a profoundly positive impact on the quality of care delivered by Medicaid. It would dramatically increase accountability for how the dollars are spent.

How many dollars the Federal Government sends each State annually is a known number. Each State's FMAP is a known number. There is some very simple arithmetic that gives policymakers in the tax-paying public the target figure for the sum total of Medicaid claims, plus a reasonable amount for administrative overhead.

Of course, it must be stated very clearly and emphatically up front that this data should only be released in the public if it is a patient de-identified way. Patient privacy is sacred. Fortunately, there are multiple safeguards. Use of the right algorithms to scramble patient identities is routinely successful in similar studies of large employer groups and other programs like Medicare.

States already collect Medicaid patient encounter data, so uploading it to the Internet would require minimal costs and effort. This incredibly rich data set would then be open to policymakers, academics, clinicians and the widest possible range of people with expertise in medicine, pricing practices, technology, accounting, fraud detection and a vast array of other disciplines relevant to modernizing this important program. Call it "Open Source Medicaid".

The data would lay bare to all whether or not people on Medicaid are getting the appropriate medical care. Of statistics revealed by patient encounter data, for example, is what percentage of women over 50 are getting annual mammograms? That figure should be 100 percent. In one State, the data revealed that only 17 percent of women on Medicaid in this age group were getting annual mammograms.

The same State's data showed 4,000 people who had gotten six or more OxyContin prescriptions. Less than half of children were

received well child checkups. It even showed one beneficiary who had been at the emergency room 405 times in a 3-year span. It also appeared the State was overpaying for the very expensive drug therapy this individual was receiving, probably to the tune of hundreds of thousands of dollars.

In another claims review in a different State, a hospital was found billing Medicaid for pneumonia treatments, at a rate of 80 percent bacterial, 20 percent viral. In nature, the ratio is about the reverse. So the study revealed either that, A, there was a highly unusual and worrisome outbreak of bacterial pneumonia or, B, there was fraud. In either case, it is important to know right away.

Claims data shows outliers, trends, adherence to evidence-based medicine, best practices, disease patterns and outbreaks, and pricing among other key points. It is theoretically impossible for any one State's Medicaid administration to do a better job maximizing the value of this information than would the collective wisdom of everyone else who may view it. Hence the need to put this information in the public domain to leverage the potential of mass collaboration, also known as wikinomics.

Medicare claims data has been given to select researchers and institutions for decades and has yielded extremely valuable information about patient quality and red flags about facilities who have higher costs without corresponding better health benefits. The Dartmouth Health Atlas is one good example.

Transparency is apparent around Congress. You have the Coburn-Obama transparency bill. Even staff salaries posted on Legistorm.

Medicaid has a problem with waste, fraud and abuse; and the people hurt the most by this are poor Americans who see their access to care eliminated. The GAO has documented this for decades. The most recent study was entitled, Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Programs. This title alone is cause for concern, not to mention the fact this fits a decade's long pattern.

A New York Times article in 2005 uncovered breathtaking amounts of fraud in that, the largest Medicaid program in the country. The former Inspector General estimated up to 40 percent of all Medicaid claims there in New York State are questionable. A single doctor in 1 year prescribed $11 million of a drug intended for AIDS patients most likely diverted to body builders, one Brooklyn dentist billed for 991 claims in 1 day, and of 400 million Medicaid claims paid in 2004, State investigators uncovered only 36 cases of suspected fraud.

The horrific levels of fraud suggested by this New York Times series was confirmed by an outside study of New York's Medicaid claims that was completed in 2006 and delivered to a handful of officials in New York's health department. It found that a full one-quarter of New York's Medicaid program cannot be explained. One-quarter of the $44 billion spent on New York in 2005 was $11 billion.

Medicaid's chronic financial problems are well-known and guaranteed to continue unabated absent real change. If Congress chooses to bail out the States as it did again—and at the very least it should require States to prove they're using the dollars optimally—

the best, easiest, cheapest way to do this is to require States to post their Medicaid patient encounter data on the Internet for all to see.

Congress should require the same for SCHIP. State officials and providers with nothing to hide should have no objections.

Mr. Chairman, thank you very much.

Mr. PALLONE. Thank you.

[The prepared statement of Mr. Frogue follows:]

Testimony to House Energy and Commerce Committee Subcommittee on Health

"State Fiscal Relief: Protecting Health Coverage in an Economic Downturn"

Chairman Frank Pallone (D-NJ)
Ranking Member Nathan Deal (R-GA)

By James R. Frogue
State Project Director
Center for Health Transformation

Tuesday, July 22, 2008

Chairman Pallone, Ranking Member Deal and Members of the Committee, thank you for the opportunity to testify today. My oral and written remarks reflect solely my own views and not necessarily those of the Center for Health Transformation, its staff or members.

This Committee is considering legislation that would send an additional $15 billion to the states for Medicaid costs they have incurred. There is one simple action this Committee could lead that would be low cost and go a very long way toward improving the care received by 50 million people on Medicaid while eliminating much of the waste, fraud and abuse that is largely responsible for states having chronic financial trouble with Medicaid in the first place.

Legislation should be put forward by this Committee that would require states to post their Medicaid patient encounter data on the Internet for all to see. Specifically, this is the set of claims that Medicaid providers send to the state for reimbursement for treatment of patients.

This is administratively simple, cheap, and would have a profoundly positive impact on the quality of care delivered via Medicaid. In addition, it would dramatically increase accountability for how Medicaid dollars are spent thereby decreasing the likelihood that state leaders would return to seek still more money from Congress.

How many dollars the federal government sends to each state annually is a known number. Each state's FMAP is a known number. Therefore some very simple arithmetic gives policymakers and the taxpaying public the target figure for the sum total of Medicaid claims, plus a reasonable amount for administrative overhead.

Of course it must be stated clearly and emphatically up front that this data should only be made public in a patient de-identified way. Patient privacy is sacred. Fortunately there are multiple safeguards that can and must be put in place to ensure that individual patient names, or information that would identify an individual, are not revealed to unauthorized persons or entities. Use of the right algorithms to scramble patient identities is routinely successful in similar studies of large employer groups and other public programs like Medicare.

States already collect Medicaid patient encounter data so uploading it to the Internet would require minimal cost and effort. This incredibly rich data set would then be open to policymakers, academics, clinicians and the widest possible range of people with expertise in medicine, pricing practices, technology, accounting, fraud detection and a vast array of other disciplines relevant to improving and modernizing this important program. Call it, "Open Source Medicaid."

The data would lay bare to all whether or not Medicaid beneficiaries are getting appropriate medical care. Among the many thousands of statistics revealed by patient encounter data, for example, is what percentage of women over 50 are getting annual mammograms. The figure should be 100 percent. In one state, the data revealed that only 17 percent of women on Medicaid in this age group were getting annual mammograms. That exceedingly low figure, heretofore unknown to the public at large, means that these women are at severe risk of undetected breast cancer. It also means that the overall cost to taxpayers is likely to be much higher down the road because relatively low-cost screenings today could eliminate the need for much higher-cost interventions in the future.

The same state's claims data showed 4,000 people who had gotten six or more Oxycontin prescriptions. Less than half of children received well child check ups. It even showed one beneficiary who had visited the emergency room 405 times in a three year span. It also appeared that the state was overpaying for the very expensive drug therapy this individual was receiving, probably to the tune of hundreds of thousands of dollars.

Obviously this person was suffering unnecessarily by getting uncoordinated, haphazard care, while costing the state millions of dollars unnecessarily.

In another claims review of a different state, a hospital was found billing Medicaid for pneumonia treatments at a rate of 80 percent bacterial and 20 percent viral. In nature, pneumonia tends to be 80 percent viral and 20 percent bacterial. So this study revealed that either there was a highly unusual and worrisome outbreak of bacterial pneumonia or there was fraud. In either situation, it is important for policymakers and the general public to know immediately. It turned out that Medicaid reimbursed treatment for bacterial pneumonia at a much higher rate in this state and this hospital had been engaged in fraud.

Claims data shows outliers, trends, adherence to evidence-based medicine, best practices, disease patterns and outbreaks, and pricing, among many other key points. It is absolutely theoretically impossible for any one state's Medicaid administration to do a better job maximizing the value of this information than would the collective wisdom of everyone else who may view it. Hence the need to put this information in the public domain to leverage the potential of mass collaboration, a concept known as "wikinomics."

Medicare claims data has been given to select researchers and institutions for decades and has yielded extremely valuable information about best practices while raising some red flags about facilities that have much higher costs without corresponding better health outcomes. The Dartmouth Health Atlas is just one good example. There are many others. If Medicare claims data were available to the general public, anyone could study it and

the result would be exponentially more solutions for more effective and more efficient care.

The idea to request that states release their Medicaid patient encounter data is consistent with the transparency movement that is sweeping through government. Members of Congress are familiar with the required transparency for campaign donations from the Federal Elections Commission and your staff is certainly familiar with their salaries being posted on Legistorm, as two examples.

The most conservative and most liberal United States Senators, Tom Coburn and Barack Obama respectively, successfully pushed through the Coburn-Obama Transparency Act in 2006 which requires the Office of Management and Budget to have a single web portal where citizens can get information on the recipients of all federal funds including all grants and contracts. This was an important first step. Future versions could have ever-more granularity that would allow for real time tracking of dollars. Taxpayers have the right to know how their money is being spent.

Medicaid also has a serious problem with fraud, waste and abuse. It is actually difficult to know exactly the scope of the problem because data is so scarce, but examples and vignettes we do get indicate very troublesome levels of misuse and inefficiency. The people hurt the most by this are poor Americans who see their access to health care services restricted or eliminated, providers who must deliver care at average

reimbursement rates that are well below even those in Medicare, and taxpayers who must foot the excessive bill.

The Government Accountability Office has documented questionable Medicaid financing schemes by states going well back into the 1980s. Please see the attached chart of selected studies at the end of this testimony. The most recent report in May of 2008 requested by Senator Charles Grassley was entitled, "Medicaid: CMS Needs More Information on The Billions of Dollars Spent on Supplemental Payments." That title alone is cause for serious concern. Of cause for greater concern is that this fits a decades-long pattern. There is far too little sunlight on how states spend Medicaid dollars, over half of which are from the federal government. States posting their encounter data online would be a major step toward rooting out intentional or unintentional misuse of money meant to finance health care for poor Americans.

The *New York Times* ran a series of articles in July, 2005 that uncovered breathtaking amounts of fraud and abuse in New York State's Medicaid program, which is the nation's largest both in per capita and overall spending. Consider:

- James Mehmet the former inspector general estimated that up to 40 percent of all Medicaid claims are questionable.
- Michael Zegarelli, another former top official said the system, "almost begs people to steal."
- One Buffalo school official sent 4,434 kids to speech therapy in a single day.

- A single doctor in one year prescribed $11.5 million dollars of a drug intended for AIDS patients that was likely diverted to bodybuilders.
- One Brooklyn dentist billed for 991 claims in one day in 2003 and over $5 million that same year for services that were never performed (for contrast, there is not a McDonald's franchise anywhere on the planet that sold 991 phantom cheeseburgers or a Federal Express delivery truck that invented 991 packages)
- Of 400 million Medicaid claims paid in 2004, state investigators uncovered only 37 cases of suspected fraud.

The horrific levels of fraud suggested by this *New York Times* series was confirmed by an outside study of New York's Medicaid claims that was completed in 2006 and delivered to a handful of officials in New York's health department in Albany. It found that a full one-quarter of New York's Medicaid program cannot be explained. One-quarter of the $44 billion spent on New York's Medicaid program in 2005 was $11 billion.

The Congressionally-created Medicaid Commission had its first meeting one week after this New York Times series ran. One of the Commission's principle objectives was to find $10 billion in scorable federal Medicaid savings over five years. They were literally handed the answer to their 18 month quest by the *New York Times* on day one – that all $10 billion could have been found in New York state fraud alone in a mere two years (considering New York's 50 percent federal match rate). Instead the Commission recommended a series of cuts that would have mostly impacted honest providers and reduced access to care for Medicaid beneficiaries.

A model for what would happen if states posted their Medicaid claims is the Goldcorp Challenge. In March of 2000 the CEO of a Canadian mining company named Rob McEwan was frustrated by his geologists' inability to strike gold. He had recently attended a conference and learned about Linus Torvalds who founded Linux, the open-source software. Inspired, Mr. McEwan placed all of his geological data on-line and announced a global contest with $500,000 in prize money. His in-house geologists were appalled.

Goldcorp's data was downloaded 1,400 times in the next several weeks. It became clear that those people who eventually sent in their contest entries spent combined time and resources that were orders of magnitude beyond the $500,000 purse. The winners were from a small Australian company, none of whom had ever even been to Canada. Goldcorp ended up finding an astounding eight million ounces of gold and the company quickly catapulted from a $100 million sleeper into a $9 billion juggernaut.

Medicaid's chronic financial problems are well known and guaranteed to continue unabated absent real change. If Congress chooses to bailout states again as it did five years ago then at the very least it should require states to prove that they are using taxpayer dollars optimally. The best, easiest and cheapest way to do this is to require states to post their Medicaid patient encounter data on the Internet for all to see. Congress should require the same for SCHIP. State officials and providers with nothing to hide should have no objection.

Again, thank you Chairman Pallone and Ranking Member Deal for the invitation to be here today. I look forward to your questions.

Medicaid Financing Schemes Used to Inappropriately Generate Federal Payments and Federal Actions to Address Them (partial list)
Source: GAO

Financing Arrangement	Description	Action Taken
Excessive payments to state health facilities	States made excessive Medicaid payments to state-owned health facilities, which subsequently returned these funds to the state treasuries.	In 1987, the Health Care Financing Administration (HCFA) issued regulations that established payment limits specifically for inpatient and institutional facilities operated by the state.
Provided taxes and donations	Revenues from provider-specific taxes on hospitals and other providers, and from provider 'donations,' were matched with federal funds and paid to the providers. These providers could then return most of the federal payment to the states.	The Medicaid Voluntary Contribution and Provider-Specific Tax Amendments of 1991 essentially barred certain provider donations, placed a series of restrictions on provider taxes, and set other restrictions for state contributions.
Excessive disproportionate share hospital (DSH) payments	DHS payments are meant to compensate those hospitals that care for a disproportionate number of low-income patients. Unusually large DSH payments were made to certain hospitals, which then returned the bulk of the payment to the state.	The Omnibus Budget Reconciliation Act of 1993 placed limits on which hospitals could receive DSH payments and capped both the amount of DSH payments states could make and the amount individual hospitals could receive.
Excessive DSH payments to state mental hospitals	A large share of DSH payments were paid to state-operated psychiatric hospitals, where they were used to pay for services not covered by Medicaid or were returned to state treasuries.	The Balanced Budget Act of 1997 limited the proportion of a state' DSH payments that can be paid to state psychiatric hospitals.
Upper payment limit (UPL) for local government health facilities	In an effort to ensure that Medicaid payments are reasonable, federal regulations prohibit Medicaid from paying more than a reasonable estimate of the amount that would be paid under Medicare payment principles for comparable services. This UPL applies to payments aggregated across a class of facilities and not for individual facilities. As a result of the aggregate upper limit, states were able to make large supplemental payments to a few local public health facilities, such as hospitals and nursing homes. The local government health facilities then returned the bulk of the state and federal payments to the states.	The Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 required HCFA to issue a final regulation that established a separate payment limit for each of several classes of local government health facilities. In 2002, CMS issued a regulation that further lowered the payment limit for local public hospitals.
Federal financial participation (FFP) rates	FFP is the funding mechanism used to reimburse agencies with federal funds for certain Medicaid activities. States would overpay governmental healthcare providers, above and beyond the costs of services provided to Medicaid beneficiaries.	In May 2007, CMS enacted a rule that would place a ceiling on payments to governmental healthcare providers, not to exceed the costs of services provided, serving as an additional check for UPLs. The rule would also prohibit states from requiring non-governmental providers (e.g., non-profit hospitals) to return part of their Medicaid payments to the State.

Summary of James Frogue's Testimony
July 22, 2008

- This Committee should request that states post their Medicaid patient encounter data on the Internet.

- This requirement is administratively simple, low cost and would have a profoundly positive impact on the quality of care delivered via Medicaid. In addition, it would dramatically increase the accountability for how states spend their Medicaid dollars.

- How many dollars the federal government sends to a state each year is a known number. Each state's FMAP is a known number. Therefore some very simple arithmetic gives policymakers and the taxpaying public the target figure for the sum total of Medicaid claims, plus a reasonable amount for administrative overhead.

- This data should *only* be made public in a patient de-identified way. Multiple safeguards to protect patient privacy are critical. Fortunately, there are many examples from studies conducted of Medicare claims data and large employers groups where information that could lead to identifying individuals was eliminated.

- Policymakers, academics, clinicians and the widest possible range of experts in medicine, pricing practices, technology, accounting, fraud detection and other disciplines relevant to improving this important program could share thoughts. Call it, "Open Source Medicaid," or leveraging wikinomics.

- Transparency is sweeping government: Coburn-Obama Transparency Act, FEC campaign reporting requirements, staff salaries on Legistorm

- Examples of uncoordinated, haphazard care and waste, fraud and abuse:

    - Only 17 percent of women on Medicaid over 50 got annual mammogram
    - Less than half of children got well child check ups
    - One person visited emergency room 405 times in three years
    - Former New York inspector general James Mehmet estimated that up to 40 percent of claims in New York Medicaid are questionable
    - A single doctor prescribed $11.5 million of one drug in one year
    - One dentist billed for 991 claims in one day
    - One quarter of New York's Medicaid program cannot be explained.

Mr. PALLONE. Mr. McEntee.

STATEMENT OF GERALD W. MCENTEE, INTERNATIONAL PRESIDENT, AMERICAN FEDERATION OF STATE, COUNTY, AND MUNICIPAL EMPLOYEES

Mr. MCENTEE. Thank you, Mr. Chairman.

If I could make maybe three points before I get into my actual testimony, I guess just about a week or a week and a half ago a survey—massive survey came out by the Rockefeller Foundation and Time Magazine called the Campaign for American Workers. I just want to make a couple quotes. And I quote all of these—they sound like my language, but I quote all of these that came from the survey.

"After a generation of politicians telling us that government is the problem, the failure of that ideology is plainly evident. Americans are ready for some real solutions to bring security back into their lives so they can reach for big goals and achieve them. Overwhelming majorities of the public support new investments by the public sector to get America working again. Public works project, new energy efficiency measures, more access to health care, Americans favor each of these initiatives by margin of 3:1 or more. Seventy percent of Americans favor the government and employers providing the social safety net basics like health care and retirement."

Now they aren't our union's words. They are from the Rockefeller Foundation and Time Magazine.

The economic problems confronting our States—and I think we have already heard—are growing. More than half the States are facing budgetary shortfalls. The deficits total at least $48 billion for the fiscal year, which started in July. State revenues are plummeting. Overall State tax collections have fallen to the lowest level in nearly 5 years. Skyrocketing energy prices and nose-diving property tax values place an additional strain on State and local budgets. Unlike the Federal Government, States must balance their budgets each year, requiring service cuts or tax increases, actions which add to the economic downward spiral.

When the economy goes south, demand for Medicaid goes up. In the last year, the unemployment rate has gone up 1 percentage point. This level of job losses translates into 1 million new people in need of Medicaid and SCHIP and another 1.1 million Americans becoming uninsured. The rise in the unemployment rate means a drop in State revenues and an additional $3.4 billion in health care costs, and Wall Street is projecting more job losses.

If there is one point I hope you will take away from my testimony today, it is that Medicaid matters to us all and must be protected and sustained. A short-term increase in Federal support for State Medicaid programs will stave off cuts, help revive our economy and I would submit it is a moral imperative as well.

With the Medicaid program, we come together as a Nation to care for each other. Because of Medicaid, we make sure that economic hardship does not damage the health of our neighbors and family members who have no other options for health care.

Medicaid is also the backbone of our Nation's health care system and a major component of State economies. It is a significant

source of funding for hospitals and community health centers across our country. Medicaid also plays a crucial role in training the next generation of doctors.

Faced with budget shortfalls, States are considering changes in eligibility and services which could directly hurt beneficiaries. Such harsh changes are usually considered as a last resort, but States are running out of options.

In the last downturn, States already lowered or froze provider payments and reined in prescription drug spending. In this recession, core program cuts are more likely to be on the chopping block. And you have heard various examples from various representatives here about their States, whether it is Illinois or whether it was Oregon or whether it was Wisconsin.

We believe that Congress must act now to pass H.R. 5268, bipartisan legislation introduced by Chairmen Pallone and Dingell and Representatives King and Reynolds to prevent additional cuts in Medicaid. We believe it is an effective way to stimulate State economies and protect our Nation's health care system.

I thank you for the opportunity to testify and would be believed to answer any questions when the time comes.

I would like to make one comment now to Representative Burgess, who talked about having the NGA or State budgetary officials here. Maybe everybody knows this, but at least for your information, in January, the National Governors Association did send a letter asking—and this is January of 2008, did send a letter asking for an increase in Medicaid to address the economic pressures on State budgets.

Thank you.

[The prepared statement of Mr. McEntee follows:]

Testimony of Gerald W. McEntee, International President of the American Federation of State, County, and Municipal Employees (AFSCME) for the Hearing on State Fiscal Relief: Protecting Health Coverage in an Economic Downturn before the U.S. House of Representatives Committee on Energy and Commerce Subcommittee on Health July 22, 2008

Mr. Chairman and members of the Subcommittee, I am Gerald W. McEntee, President of the 1.4 million member American Federation of State, County and Municipal Employees (AFSCME). I would like to commend the Subcommittee for holding this hearing focusing on the fiscal crisis facing state and local governments and how it is affecting the health care safety net.

States, cities, counties and school districts are crucial partners in our federal system of government. They are on the front lines in protecting our families and communities, safeguarding public health, educating our children and providing services upon which the American public relies to ensure our common good. But today state and local governments are facing a fiscal crisis of major proportions.

We all know that the economic problems confronting our nation are growing but there has been insufficient attention to how this crisis is affecting the delivery of health care and other vital services administered by state and local governments. According to the Center on Budget and Policy Priorities, 29 states are facing a budget shortfall of at least $48 billion in fiscal year 2009. Most states are facing a significant loss in tax revenues and coping with rising unemployment. Overall state tax collections in early 2008 are at their lowest level in nearly five years. But now states are also experiencing the pinch of skyrocketing energy prices and nose-diving property tax revenues. These additional pressures will place an additional strain on state and local budgets. And unlike the federal government, states must balance their budgets each year, requiring service cuts or tax increases – actions which may further exacerbate the economic downturn.

The fiscal crisis confronting states poses a particular risk to the delivery of health care services upon which tens of millions of Americans depend. Due to declining state economies, our Medicaid system – which is a federal-state partnership – is experiencing particularly corrosive pressures. Even before the recession, the effect of rising Medicaid costs has been devastating on state budgets. Although states have worked to keep Medicaid costs under control, the growing strain of the rising number of uninsured Americans adversely affects other important public services. States have not been able to adequately invest in education or meet basic infrastructure needs because of rising Medicaid costs.

The demand for Medicaid increases during an economic downturn as people lose their employer-sponsored health coverage, or because their declining wages push them into poverty. Our nation's unemployment rate has increased by one percentage point since last year, and more job losses are projected. A recent analysis by the Kaiser Commission on Medicaid and the Uninsured indicates that a one percent rise in our nation's unemployment rate translates into increased Medicaid and SCHIP enrollment of approximately one million and results in another 1.1 million Americans becoming uninsured. This will cost states a three to four percent drop in revenues and in increased health care spending of at least $3.4 billion.

If there is one point I hope you will take away from my testimony today, it is that Medicaid matters to us all and must be protected and sustained. A short-term increase in federal assistance to state Medicaid programs to stave off cuts during this economic downturn is a vital economic investment in our nation – and I would submit – a moral imperative as well.

It is for this reason that we strongly support the bipartisan legislation (H.R. 5268) introduced by Chairmen Frank Pallone and John Dingell and Representatives Peter King and Thomas Reynolds. The bill is modeled after the approach Congress and President Bush took in the last recession. It proved effective as a stimulus then and succeeded in preventing deeper cuts to Medicaid, and we believe it will prove effective again today.

Through the Medicaid program we come together as a nation to care for each other by protecting the health of nearly 59 million vulnerable neighbors and family members who have no other option for health care. Because of Medicaid we make sure that economic hardship does not damage the health of our fellow Americans. Our investment of public funds in Medicaid is also a reflection of the promise of the American dream – our families, communities and nation are stronger and there are more opportunities for a better life when we keep Americans healthy and well.

Medicaid serves one in four children. Through Medicaid programs we give children born with lifelong disabilities such as cerebral palsy and developmental disabilities, children of laid-off workers and children of lower-income parents whose employers do not offer health care coverage access to the miracles of preventive care and modern medicine.

Medicaid serves one in five individuals with disabilities. People with disabilities are able to live independently and have fuller and more productive lives in our communities because Medicaid funds provide vital medicines and long-term supports and services.

Medicaid is the backbone of our nation's health care system and a major component of state economies. Medicaid funds 16 percent of national spending on health services and supplies. Medicaid provides hospitals with 17 percent of their patient revenues on average. Community health centers rely on Medicaid for nearly 40 percent of their patient revenues. Medicaid also plays a crucial role in training the next generation of medical providers by supporting graduate medical education and training. Cuts in Medicaid payments to hospitals and providers threaten access to needed health care and further weaken our health care delivery system. Moreover, Medicaid is a crucial component of state budgets, representing approximately 22% of state spending.

To trim budgets during this fiscal crisis states are looking to cut public services and contain rising Medicaid costs. In the last recession, cuts in Medicaid eligibility or covered services were considered as a last resort. Because states have already implemented various cost savings such as freezing provider payments, cuts in eligibility and access to care may be considered sooner as budget shortfalls expand with a deteriorating economy. We are already seeing the harsh reality of how the state budget crisis is adversely affecting state Medicaid programs.

California is slashing its Medicaid and SCHIP programs by $1.1 billion. This includes a 10% cut in provider reimbursement rates. The state already has one of the lowest reimbursement rates in the nation. This cut will almost certainly weaken access to needed care by discouraging provider participation and by triggering a reduction in services at county hospitals across the state.

The cuts in California also include changes in eligibility levels and the application process designed to block those in need from receiving Medicaid coverage. California's Department of Health Care Services estimates that 430,000 parents will lose coverage by 2011 as a result of lowering the income eligibility threshold from $18,656 for a family of three to $10,736 in 2008. Nearly 472,000 children and 35,000 adults would lose coverage when they are sick because of new procedural requirements that they demonstrate their eligibility every 90 days.

Florida has cut reimbursement rates to nursing homes, which will lead to staffing reductions and other actions that harm patient safety and quality care.

Illinois is delaying paying providers which will adversely affect access to care.

New Jersey has instituted an 18% cut in funds to help reimburse hospitals that provide charity care to the state's 1.3 million people who lack insurance. This cut – which the governor has called "heartbreaking" – will inflict pain on families and compound the economic losses to hospitals already at risk of closing due to high rates of uncompensated care.

Tennessee will limit eligibility to its medically-needy program, which covers individuals with life-threatening and serious medical conditions (such as cancer, kidney disease and diabetes) who have high unpaid medical bills but whose income is over the threshold to otherwise qualify for the state's Medicaid program. Some 50,000 Tennesseans use this life-saving program but it is expected that 40,000 to 45,000 will lose coverage as a result of the new eligibility policies.

Other states also are making major cuts. As the economy continues to push the unemployment rate higher and state revenues decline, states almost certainly will be forced to further limit access to medical care.

When states cut Medicaid and other public services to balance their budgets, it hurts individuals, communities and the economy. An analysis of the Medicaid cuts made in Oregon during the 2003 recession found that more than 50,000 low-income adults lost health care coverage which, in turn, spurred a $253 million increase in uncompensated care for Oregon's hospitals because of increased use of emergency rooms and hospitalizations.

H.R. 5268 recognizes that the state fiscal crisis will further weaken our health care delivery system and that immediate action by the federal government is necessary to prevent additional health care cuts in Medicaid. By temporarily investing additional federal dollars in Medicaid, the bill focuses assistance to those hit hardest by the economic downturn and protects our nation's health care infrastructure.

In 2003, when Congress provided states with a similar temporary and targeted increase in federal assistance for Medicaid, it helped stave off additional cuts to health care and stimulated the economy.

Various studies support the conclusion that H.R. 5268 is an effective way to stimulate state economies. One analysis by Families USA, using the Department of Commerce's computer model to project how investments in state economies can multiply economic activity, found that the legislation would mean additional state business activity and jobs. I have attached its state-by-state report.

Another recent analysis by Mark Zandi, chief economist of Economy.com, demonstrates that of all the options available to Congress, helping state governments through general aid or a temporary increase in the Medicaid matching rate to state governments generates one of the greatest economic returns. Specifically, every $1.00 increase in spending for general aid to state governments will generate $1.36 in increased real gross domestic product (GDP). Similarly, earlier this year, the Joint Economic Committee concluded that increasing the federal medical assistance percentage (FMAP) is one course of action to alleviate increased fiscal demands on states because it would "help buffer the impact of the economic slowdown to preserve Medicaid coverage as people lose their jobs and health insurance, as was done during the last economic downturn."

For the foregoing reasons, we strongly support this bipartisan legislation to temporarily increase federal Medicaid assistance to the states. It worked in 2003, and it is urgently needed again.

Attachment

Attachment

Effect of an Increase in Federal Medicaid Matching Payments on State Economies (as proposed in H.R. 5268), October 2008 - December 2009

State	Additional Federal Support for Medicaid	Additional Business Activity	Additional Jobs	Additional Wages
Alabama	$144,099,000	$242,700,000	2,600	$88,300,000
Alaska	$64,106,000	$96,800,000	900	$35,400,000
Arizona	$340,875,000	$578,600,000	5,300	$217,600,000
Arkansas	$150,142,000	$236,700,000	2,600	$86,700,000
California	$1,442,915,000	$2,873,600,000	25,000	$1,021,400,000
Colorado	$116,806,000	$226,200,000	2,100	$80,100,000
Connecticut	$167,572,000	$280,400,000	2,500	$100,900,000
Delaware	$44,085,000	$66,800,000	500	$21,400,000
Florida	$783,103,000	$1,389,300,000	14,100	$518,900,000
Georgia	$243,976,000	$480,300,000	4,400	$168,700,000
Hawaii	$60,444,000	$101,900,000	1,000	$37,900,000
Idaho	$47,432,000	$77,100,000	900	$28,800,000
Illinois	$448,135,000	$896,000,000	7,900	$307,800,000
Indiana	$216,699,000	$377,300,000	3,700	$133,400,000
Iowa	$104,131,000	$168,900,000	1,900	$60,900,000
Kansas	$85,721,000	$145,200,000	1,500	$49,300,000
Kentucky	$179,076,000	$294,800,000	2,900	$101,800,000
Louisiana	$317,679,000	$540,800,000	6,100	$196,200,000
Maine	$78,784,000	$132,400,000	1,500	$50,100,000
Maryland	$217,318,000	$386,200,000	3,300	$132,900,000
Massachusetts	$438,530,000	$765,400,000	6,600	$271,500,000
Michigan	$321,901,000	$539,800,000	5,400	$201,300,000
Minnesota	$268,308,000	$476,700,000	4,400	$175,200,000
Mississippi	$158,686,000	$250,300,000	2,800	$90,200,000
Missouri	$278,013,000	$490,800,000	4,600	$160,800,000
Montana	$30,886,000	$49,300,000	600	$18,400,000
Nebraska	$62,072,000	$100,700,000	1,100	$36,200,000
Nevada	$81,530,000	$126,700,000	1,200	$46,300,000
New Hampshire	$42,978,000	$71,100,000	600	$24,300,000
New Jersey	$290,807,000	$548,200,000	4,400	$182,500,000
New Mexico	$134,429,000	$214,100,000	2,300	$79,000,000
New York	$1,805,626,000	$3,004,800,000	25,100	$1,040,600,000
North Carolina	$386,858,000	$677,600,000	7,000	$247,800,000
North Dakota	$25,240,000	$38,400,000	400	$13,500,000
Ohio	$487,671,000	$875,100,000	8,700	$312,400,000
Oklahoma	$187,613,000	$338,500,000	3,900	$122,800,000
Oregon	$128,247,000	$215,800,000	2,100	$77,300,000
Pennsylvania	$629,954,000	$1,184,900,000	10,600	$406,600,000
Rhode Island	$66,546,000	$106,800,000	1,000	$36,600,000
South Carolina	$139,070,000	$248,000,000	2,700	$88,700,000
South Dakota	$22,866,000	$35,000,000	400	$12,900,000
Tennessee	$280,620,000	$505,100,000	4,500	$176,600,000
Texas	$1,110,201,000	$2,242,500,000	21,300	$790,700,000
Utah	$68,853,000	$130,400,000	1,400	$46,900,000
Vermont	$40,580,000	$59,900,000	600	$22,100,000
Virginia	$206,307,000	$358,100,000	3,200	$123,000,000
Washington	$247,214,000	$442,600,000	4,100	$157,800,000
West Virginia	$101,173,000	$147,700,000	1,500	$51,600,000
Wisconsin	$195,631,000	$328,300,000	3,300	$121,000,000
Wyoming	$17,738,000	$24,900,000	300	$9,400,000

Families USA calculations, July 2008. Calculations are based on the 2007 Regional Input-Output Modeling System (RIMS II) and Center on Budget and Policy Priorities' estimates of federal funds states would receive from H.R. 5268. RIMS II is produced by the U.S. Department of Commerce, Bureau of Economic Analysis.

Summary of Testimony of Gerald W. McEntee
International President
of the
American Federation of State, County, and Municipal Employees (AFSCME)
July 22, 2008

- State fiscal crisis is affecting the delivery of health care and other vital services administered by state and local governments. Most states are facing a significant loss in tax revenues and coping with rising unemployment. Overall state tax collections in early 2008 are at their lowest level in nearly five years. Unlike the federal government, states must balance their budgets each year, requiring service cuts or tax increases – actions which may further exacerbate the economic downturn.

- The demand for Medicaid increases during an economic downturn. A one percent rise in our nation's unemployment rate translates into increased Medicaid and SCHIP enrollment of approximately one million and results in another 1.1 million Americans becoming uninsured. This will cost states a three to four percent drop in revenues and in increased health care spending of at least $3.4 billion.

- Medicaid matters to us all and must be protected and sustained. Medicaid serves one in four children. Medicaid serves one in five individuals with disabilities. Medicaid is the backbone of our nation's health care system and a major component of state economies. Medicaid funds 16 percent of national spending on health services and supplies. Medicaid provides hospitals with 17 percent of their patient revenues on average. Community health centers rely on Medicaid for nearly 40 percent of their patient revenues. Cuts in Medicaid payments to hospitals and providers threaten access to needed health care and further weaken our health care delivery system. Moreover, Medicaid is a crucial component of state budgets, representing approximately 22% of state spending.

- The state fiscal crisis will further weaken our health care delivery system. Immediate action by the federal government is necessary to prevent additional health care cuts in Medicaid. By temporarily investing additional federal dollars in Medicaid, the H.R. 5268 focuses assistance to those hit hardest by the economic downturn and protects our nation's health care infrastructure. The bill is modeled on the stimulus signed by President Bush in 2003.

- Studies support the conclusion that H.R. 5268 is an effective way to stimulate state economies. One analysis by Families USA, using the Department of Commerce's computer model to project how investments in state economies can multiply economic activity, found that the legislation would mean additional state business activity and jobs. The state-by-state report is attached to testimony. Another analysis by the chief economist of Moody's Economy.com concluded that every $1.00 increase in spending for general aid to state governments will generate $1.36 in increased economic activity.

Mr. PALLONE. Mr. McEntee, thank you. Without objection, if you have a copy of that letter, I would like to enter that into the record.

Mr. MCENTEE. Sure.

Mr. PALLONE. So ordered.

[The information requested was not provided at the time this document went to print.]

Mr. PALLONE. I also should mention, before I forget, that we have a statement from Congressman Luis Fortuno that I would like to enter into the record without objection.

So ordered.

[The information requested was not provided at the time this document went to print.]

Mr. PALLONE. And I do want to thank you, also, Mr. McEntee. I know you had to change your plans to make very special arrangements to get here today, so thank you for doing that.

Mr. MCENTEE. Thank you.

Mr. PALLONE. Dr. Helms.

STATEMENT OF ROBERT B. HELMS, PH.D., RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE

Mr. HELMS. Thank you, Mr. Chairman.

Shortly before I came over here, I discovered in table 1 of my testimony some numbers had been inserted there that were slightly different from the ones I had intended. It doesn't change my testimony in any way, but I would like to be able to substitute the correct numbers, if you will, later.

Mr. PALLONE. That is in your written testimony?

Mr. HELMS. Yes.

Mr. PALLONE. Sure. Without objection, so ordered.

Mr. HELMS. OK.

The views I express here today really reflect the reasons I dissented from the recent Medicaid Commission report. I want to join several decades of academic think tank experts and government, particularly the GAO, who have been complaining about the FMAP as an inappropriate mechanism for distributing Medicaid and reimbursement for Medicaid.

If you look at the history of the program, I would admit it probably served a good function of inducing the States to expand the program in its formative years. But I do think it has outlived its usefulness. This criticism of the FMAP is truly bipartisan and comes from all ideological points of view, and the main criticism that I have of the FMAP formula is that it creates two strong perverse incentives.

When a State has the money, there is a very large incentive to keep expanding Medicaid, because the Federal Government is always going to pay at least 50 percent. But when the State gets into trouble, as I clearly agree with the other testimony that a lot of States are in trouble with their budgets now, when they have to cut back—and several governors have told me that they do this—the last thing they want to cut is a match program like Medicaid.

So you have over time sort of two rachet effects going on here to increase the Federal expenditures for Medicaid and the State expenditures, too. But this rachet effect is really more prevalent depending upon the wealth of the State.

If you look at figure 1 in my prepared testimony—it is on page 7—I have tried to take a per capita Medicaid expenditure. And what I did was I took the total Federal expenditures and divide them by the number of poor people at 125 percent of poverty. You could change that, but you still get pretty much the same distribution. You get sort of like a three times dispersion between the lowest States and the highest States. And I have arrayed these by the percent of the population in the State that is in poverty, and what you get is a negative relationship with what I would call the Katrina States over to the right. Basically, the poorer the State, the less money they get per poor person.

The Families USA has conveniently provided the committee with their estimates of the additional money that would go to each State. So I was able to take that and also divide it by the number of poor people in the State and that is in figure 2. Again, you have a very similar distribution where the poorer the State, the less they get on a per capita basis.

The other point I would like to make is your hold harmless provision that prevents the State's FMAP from decreasing ends up protecting those States with relatively highest increases in per capita income. You could easily correct this. If you wrote the bill to be the standard of what happens to a State's per capita income, then you would end up holding harmless the States who are having the most economic trouble, the largest declines. You can change that statement around to relative changes, and I think the logic still holds.

So my plea is I urge the Congress, assuming that you have the money and you want to do this, to consider a way that would get around these sort of marginal effects that you get from the FMAP. In other words, give them a fixed cash payment and, if you can, figure out a better way to distribute the money so that it goes to the States that have the largest populations of poor and disabled.

Thank you.

Mr. PALLONE. Thank you, Dr. Helms.

[The prepared statement of Mr. Helms follows:]

State Fiscal Relief: Protecting Health Coverage in an Economic Downturn

Subcommittee on Health
Committee on Energy and Commerce
United States House of Representatives

Testimony of
Robert B. Helms*
Resident Scholar
American Enterprise Institute

2:00 PM
Tuesday, July 22, 2008
2322 Rayburn House Office Building

Contact information:
Robert B. Helms
Resident Scholar
American Enterprise Institute
1150 Seventeenth Street, NW
Washington, DC 20036
202-862-5800
rhelms@aei.org

*The views expressed here are my own and not those of my employer or any of my colleagues at AEI.

TESTIMONY OF ROBERT B. HELMS

Thank you for the opportunity to testify before the Subcommittee on Health as you consider a proposal to temporarily increase the Federal Medical Assistance Percentage (FMAP) to provide additional federal assistance to the states to cover the costs of their Medicaid programs. For the purposes of this testimony I will take it as given that the Congress wishes to provide additional support to the states and those funds can be found to do so. I will concentrate on the policy implications of the proposed method of boosting the FMAP. My position is that this is not the best approach for aiding the states and that the proposed policy will make an already flawed policy even worse. This is not in the best interests of the millions of poor and disabled Americans that the Medicaid program is intended to help.

To understand my objection to this approach, it is first necessary to look at how the FMAP system works, the incentives it creates for the states, and how the formula has affected the flow of federal funds to the states.

The FMAP Formula

The FMAP formula was written into the original Medical legislation in 1965 and reflected both the politics and the availability of economic data at that time. Wilber Mills (AK), Harry Byrd (WV), and Russell Long (LA) were some of the powerful committee chairmen who adopted a formula that assured a higher federal matching rate for the poorest states like those that they represented. They based the formula on each states per capita income, a convenient statistic already provided by the government as part of the national accounts. By squaring the ratio of a state's per capita income relative to the national average, the formula worked to boost the federal matching rate of all the states

whose per capita income was below the national average.[1] To protect the highest income states, a provision was added that no state would receive less than a 50 percent match. In FY 2008, Mississippi has the highest matching rate (76.3 percent); 13 states have matching rates at 50 percent.[2]

Unlike Medicare that established federal funding for individuals who were aged or disabled, Medicaid was established as a joint federal-state program to be run and partially funded by the state. As intended, the states have had extensive latitude to expand both the medical benefits and the populations covered by their state plan. Since the federal matching system is open-ended, this created two strong incentives for each of the states:

- The incentive to increase state Medicaid spending when the state could afford to do so. Since each state received at least 50 percent reimbursement from the federal government, a state could expand its program without bearing the full burden of the additional expenditures. This has given states a reason to expand Medicaid relative to other state priorities.
- The incentive not to reduce Medicaid expenditures even when state finances create pressures to reduce state expenditures. A state with a 50 percent matching rate would have to reduce total Medicaid expenditures by $2 million in order to reduce state spending by $1 million. Mississippi would have to reduce total

[1] A scaling factor was also included in the formula to assure that the federal government provided 55 percent of the total funding for Medicaid. For an historical account of the passage of Medicaid in 1965 and its early years, see Robert Stevens and Rosemary Stevens, *Welfare Medicine in America: A Case Study of Medicaid* (New York: Free Press, 1974). For a more complete description of the FMAP formula and procedures, see Vic Miller and Andy Schneider, *The Medicaid Matching Formula: Policy Considerations and Options for Modification* (research report 2004-09, Public Policy Institute, AARP, Washington, DC, September 2004), available at http://assets.aarp.org/rgcenter/health/2004_09_formula.pdf, accessed December 30, 2006.

[2] Kaiser Family Foundation, State Health Facts, http://www.statehealthfacts.org/comparetable.jsp?ind=184&cat=4

spending by approximately $4.17 million in order to reduce state spending by $1 million. This creates a strong incentive to cut non-matched programs relative to Medicaid when it becomes necessary to cut back.

The FMAP system of funding creates two kinds of ratchet effects. First, as economic activity expands and contracts, a state's revenue base also expands and contracts. When the state has funds to expand spending, the incentive is to expand Medicaid (and other matched programs) relative to unmatched programs. When economic conditions make it necessary for a state to reduce spending, there is an incentive to cut unmatched spending rather than matched Medicaid spending.

While this ratchet effect occurs in all states, it occurs in some states more than others. The states with the highest incomes have a larger tax base which they can use to support all state activities. While an original objective of the FMAP system was to help the poorer states relative to the wealthier states, the result has been just the opposite. The wealthier states have been able to expand their Medicaid programs to a greater extent than the poorer states. Even with higher federal matching rates, most of the poorer states have not been able to provide the level of coverage provided in the wealthier states.

The Effects of the FMAP

One common procedure for comparing state performance is to divide total Medicaid expenditures in each state by that state's Medicaid enrollment.[3] This measure

[3] Kaiser Family Foundation, State Health Facts, available at http://www.statehealthfacts.org/comparetable.jsp?ind=183&cat=4
This comparison has been used by the Foundation for Health Coverage Education to identify the "ten best" and the "ten worst" states in terms of FY 2005 total Medicaid expenditures per enrollee. Disregarding the District of Columbia and Alaska who have special matching rates, they identify New York ($7,733), Maine ($7,961), and North Dakota ($7,496) as spending the most per enrollee and California ($2,701), Arizona ($3,066), and Georgia ($3,560) as spending the least. www.coverageforall.org

is useful as a crude indicator of the extent of coverage and benefits in a state and the relative efficiency of state programs. However, using Medicaid enrollment is not independent of a state's benefit and enrollment policies. This allows states that severely limit enrollment to appear to be relatively generous and states that expand enrollment to appear to be more efficient.[4]

To find a denominator that is independent of state Medicaid policies, and to focus on the efficiency of federal funding, I have divided FY 2006 (the latest CMS data available) federal Medicaid payments to each state by that state's population of people in poverty (less than or equal to 125 percent of the Federal Poverty Line, FPL). The number of people in poverty in each state is readily available from the Census Bureau, is independent of a state's Medicaid policies, and represents the population of people that the original Medicaid legislation singled out as the target population for assistance. This per capita calculation yields a national average of $3,626 federal Medicaid expenditures per person in poverty, with a range from $2,014 for Nevada on the low end to $7,753 for Vermont on the high end. The District of Columbia ($7,891) and Alaska ($8,123) are higher, but they have congressionally mandated matching rates so are not subject to the FMAP per capita income formula. Figure 1 shows these state per capita amounts (on the vertical axis) in a scatter diagram where the states are arrayed from left to right by the percent of the state's population in poverty. As a central tendency, this chart illustrates that there is a negative relationship between the degree of poverty in a state and the amount of federal Medicaid money sent to the states. The poorer, mostly southern, states

[4] Since the cost of treating the disabled exceeds the cost of treating children, the cost per enrollee in each state would be largely affected by the composition of the enrolled population.

receive relatively low federal payments per poor person while the wealthier, mostly northeastern, states receive payments more than three times as high as the lowest state.

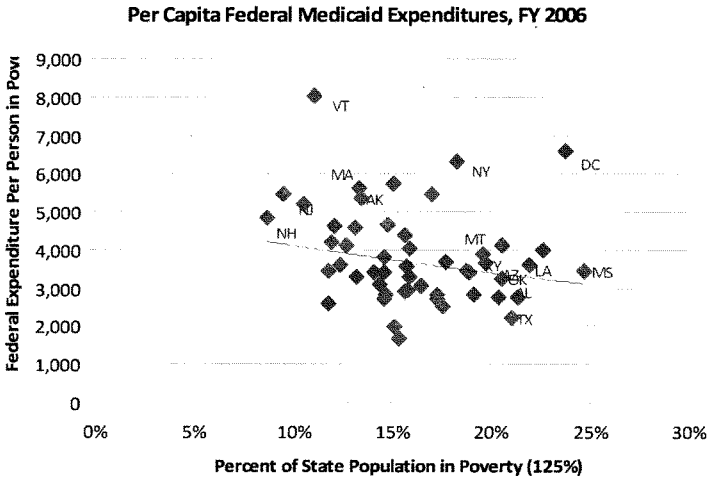


Figure 1: Federal Medicaid Expenditures from CMS, Form 64 data, FY 2006; Population figures from the Census Bureau. See Table 1 for the data and references.

What effect would the proposed addition to the FMAP have on this distribution? Families USA has conveniently provided you with their estimates of the addition federal dollars that would flow to each of the states.[5] Assuming that these estimates are approximately correct, we can use then to calculate the additional amount that each state would receive per person in poverty. This shows that on average the proposed addition to the FMAP will add $160 per person in poverty through Medicaid expenditures and that this will range from a low of $154 in Georgia to a high of $564 in Vermont.[6] The

[5] Families USA July 2008 submission to the Subcommittee on Health, available at http://energycommerce.house.gov/FMAP/EconImpact.HR5268.pdf

[6] No estimate was given for the District of Columbia. Alaska, not subject to the standard FMAP formula, would receive $782 per person in poverty.

distribution of these estimated additional payments are illustrated in Figure 2 and show again that there will be a negative relationship between the additional per capita federal payments and the degree of poverty in the various states. The proposed addition to the FMAP will make the present disparity in state payments even larger. The largest share of the proposed new FMAP money would go to the states with the highest incomes and highest per-person Medicaid spending and the smallest share of the money would go to the poorer states.

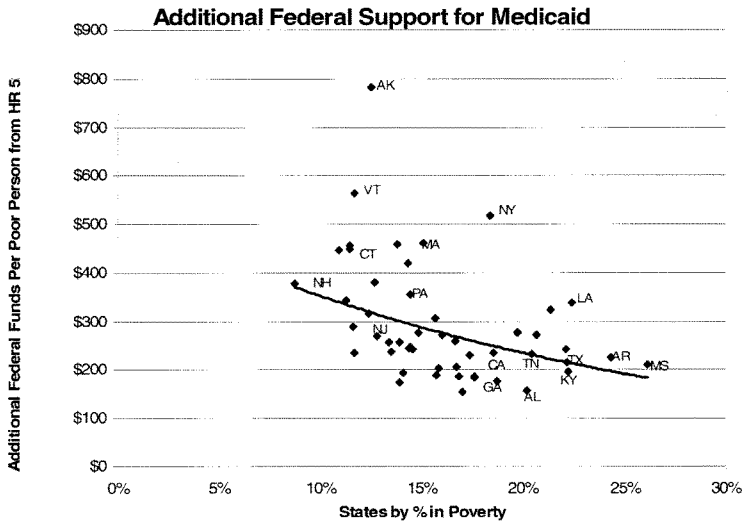


Figure 2: Additional Federal Support for Medicaid from Families USA; Population figures from the Census Bureau. See Table 2 for the data and references.

This result is not surprising given the provision in the bill that prevents a state's matching rate from declining in the five quarters of Fiscal Years 2008 and 2009. The FMAP formula is based on a state's per capita income *relative* to the national average.

The main reason that a state's matching rate would go down would be that it was a state whose per capita income *increased* (or declined less) relative to the national average. As currently written, this hold-harmless provision of the proposal ends up giving additional help to all the states whose per capita income will increase and no help to all the states with declining per capita income.[7] This provision could easily be corrected if the standard were the relative change in a state's per capita income rather than the FMAP matching rate.

Policy Objections to the Increase in the Medicaid Federal Matching Rate

There is now a large literature of academic[8] and governmental studies critical of the FMAP formula and calling for its reform.[9] This criticism has been truly bipartisan and coming from all ideological prospectives.[10] My criticism, expressed in my dissent to the Medicaid Commission report,[11] is that the open-ended nature of the formula creates a set of perverse incentives that encourages states to engage in accounting and taxing

---

[7] It is possible for a state to receive a lower matching rate if its per capita income increases at a lower rate than the national average, but this is unlikely to be the case if national per capita income is actually declining.

[8] See for example, Thomas W. Grannemann and Mark V. Pauly, *Controlling Medicaid Costs: Federalism, Competition, and Choice* (Washington, DC: AEI Press, 1983), 30–41; John Holahan and Alan Weil, "Toward Real Medicaid Reform," *Health Affairs Web Exclusive,* February 23, 2007, pp. w254-w270.

[9] Miller and Schneider, *The Medicaid Matching Formula.* Miller and Schneider list the following Government Accounting Office (GAO) studies: GAO, *Changing Medicaid Formula Can Improve Distribution of Funds to States*, GAO/GGD-83-27, March 9, 1983; GAO, *Medicaid Matching Formula's Performance and Potential Modifications,* GAO/T-HEHS-95-226, July 27, 1995; GAO, "Medicaid Formula: Effects of Proposed Formula on Federal Shares of State Spending," memo to Senator Daniel Patrick Moynihan (D-N.Y.), GAO-HEHS-99-29R, February 19, 1999; and GAO, *Medicaid Formula: Differences in Funding Ability among States Often Are Widened*, GAO-03-620, July 2003.

[10] see: John R. Graham, "Taming the Medicaid Monster," *Health Policy Prescriptions* 4, no. 8 (August 2006); Tommy G. Thompson, *Medicaid Makeover: Four Challenges and Potential Solutions on the Road to Reform*, (Washington, DC: Medicaid Makeover, 2006), available at http://www.medicaidmakeover.org/MedicaidMakeoverPlan.pdf (accessed December 29, 2006); Pamela Villarreal, "Federal Medicaid Funding Reform" (brief analysis 566, National Center for Policy Analysis, Dallas, TX, July 31, 2006, available at www.ncpa.org/pub/ba/ba566/ (accessed December 29, 2006); Holahan and Weil, "Toward Real Medicaid Reform."

[11] U.S. Department of Health and Human Services, Medicaid Commission, *Final Report and Recommendations: Medicaid Commission*, December 29, 2006, available at http://aspe.hhs.gov/medicaid/122906rpt.pdf (accessed on July 19, 2008). A longer version of my dissent explaining the methodology behind these charts is at http://www.aei.org/publication25434.

schemes to increase federal funding rather than trying harder to improve the efficiency and medical effectiveness of their programs. The result is the uncontrollable growth of federal outlays and the continuing diversion of federal funds away from the areas of the country with the highest rates of the uninsured. In addition, this set of incentives creates constant conflict between congressional and administrative budget officials and state officials, what Alan Weil and his colleagues at the National Academy for State Health Policy refer to as, "The Tug of War."[12] The proposed temporary increase in the FMAP does nothing to reform these perverse incentives and, if fact, makes them worse by rewarding this kind of behavior with an even higher matching rate. The proposal does nothing to target the additional federal funds toward the states with the worst economic problems or states with the most uninsured, disabled, and poor people.

Some states may put the additional funds to good use, but there is no guarantee they will use this money in their Medicaid program. Medicaid federal matching funds are made on a retrospective basis to reimburse states for past expenditures. Anticipating the higher match allows the state government to use the additional funds anywhere in the state budget that it desires. If this proposal is implemented, it will be the second time this decade that such a "temporary" approach has been used. This sends a strong message to the states that they do not have to plan ahead for a rainy day. The result is to exacerbate the ratchet effect from the FMAP formula and make eventual reform even more difficult.

Conclusion

If the Congress decides that it wants to provide additional assistance to the states, I urge you to rewrite the proposal so that you provide the available funds in the form of a

[12] Sonya Schwartz, Shelly Gehshan, Alan Weil, and Alice Lam, *Moving Beyond the Tug of War: Improving Medicaid Fiscal Integrity* (Portland, ME: National Academy for State Health Policy, 2006), available at www.nashp.org/Files/Medicaid_Fiscal_Integrity.pdf (accessed December 29, 2006).

fixed grant to the states. This approach would provide temporary financial assistance to the states without making the present incentives worse. If the funds could be allocated to the states on the basis of their economic performance and their populations of the poor and the disabled, the chances of improving the health and well-being of our most vulnerable populations would be greatly improved. This exercise could also provide a useful experiment to inform us how to reform the entire FMAP system, a task that almost every thoughtful person knows must eventually be done.

Table 1: Per Capita Federal Medicaid Expenditures, FY 2006

$y = -7827.6x + 5105.3$
$R^2 = 0.0537$

State	Federal Expenditures	Number of People in Poverty	Poverty Per Capita Federal Expenditure	Total State Population	Percentage of State Population in Poverty
Alabama	$2,700,967,002	983,000	$2,747.68	4,599,030	21.37407236
Alaska	$481,497,204	90,000	$5,349.97	670,053	13.43177331
Arizona	4,149,825,039	1,268,000	$3,272.73	6,166,318	20.56332482
Arkansas	2,135,705,184	550,000	$3,883.10	2,810,872	19.56688174
California	17,123,678,712	6,304,000	$2,716.32	36,457,549	17.29134342
Colorado	1,436,608,204	721,000	$1,992.52	4,753,377	15.1681636
Connecticut	2,106,535,911	461,000	$4,569.49	3,504,809	13.15335586
Delaware	474,151,263	103,000	$4,603.41	853,476	12.06829483
District of Columbia	911,452,079	138,000	$6,604.73	581,530	23.73050402
Florida	7,516,141,360	2,665,000	$2,820.32	18,089,888	14.73198728
Georgia	4,145,566,884	1,650,000	$2,512.46	9,363,941	17.62078595
Hawaii	647,345,292	154,000	$4,203.54	1,285,498	11.97979305
Idaho	729,856,542	215,000	$3,394.68	1,466,465	14.66110681
Illinois	5,059,312,648	1,875,000	$2,698.30	12,831,970	14.61194189
Indiana	3,573,709,742	996,000	$3,588.06	6,313,520	15.77566872
Iowa	1,663,399,473	436,000	$3,815.14	2,982,085	14.62064294
Kansas	1,255,087,925	434,000	$2,891.91	2,764,075	15.70145528
Kentucky	3,032,088,057	830,000	$3,653.12	4,206,074	19.73336656
Louisiana	3,392,559,252	941,000	$3,605.27	4,287,768	21.94615007
Maine	1,228,880,509	225,000	$5,461.69	1,321,574	17.02515334
Maryland	2,500,243,069	695,000	$3,597.47	5,615,727	12.37595773
Massachusetts	4,848,448,502	860,000	$5,637.73	6,437,193	13.35986042
Michigan	4,690,350,973	1,595,000	$2,940.66	10,095,643	15.79889463
Minnesota	2,833,088,547	546,000	$5,188.81	5,167,101	10.56685364
Mississippi	2,485,518,470	719,000	$3,456.91	2,910,540	24.70331966
Missouri	4,011,209,497	917,000	$4,374.27	5,842,713	15.69476372
Montana	512,040,099	181,000	$2,828.95	944,632	19.16090075
Nebraska	917,210,545	224,000	$4,094.69	1,768,331	12.66731172
Nevada	644,878,157	384,000	$1,679.37	2,495,529	15.38751904
New Hampshire	553,359,348	114,000	$4,854.03	1,314,895	8.669893794
New Jersey	4,542,152,040	830,000	$5,472.47	8,724,560	9.51337374
New Mexico	1,771,739,805	442,000	$4,008.46	1,954,599	22.61333399
New York	22,356,111,181	3,526,000	$6,340.36	19,306,183	18.26357908
North Carolina	5,803,302,491	1,574,000	$3,686.98	8,856,505	17.77224763
North Dakota	331,863,581	101,000	$3,285.78	635,867	15.88382476
Ohio	7,335,948,175	1,825,000	$4,019.70	11,478,006	15.89997426
Oklahoma	2,018,919,356	732,000	$2,758.09	3,579,212	20.45142897

Oregon	1,810,793,988	639,000	$2,833.79	3,700,758	17.26673292
Pennsylvania	8,539,372,688	1,834,000	$4,656.15	12,440,621	14.74202936
Rhode Island	923,837,269	161,000	$5,738.12	1,067,610	15.08041326
South Carolina	2,820,615,484	813,000	$3,469.39	4,321,249	18.81400493
South Dakota	395,284,240	129,000	$3,064.22	781,919	16.49787254
Tennessee	3,881,396,336	1,142,000	$3,398.77	6,038,803	18.91103253
Texas	10,989,110,232	4,957,000	$2,216.89	23,507,783	21.08663331
Utah	1,042,460,577	302,000	$3,451.86	2,550,063	11.84284467
Vermont	554,255,615	69,000	$8,032.69	623,908	11.05932285
Virginia	2,327,057,578	901,000	$2,582.75	7,642,884	11.78874362
Washington	2,789,684,150	846,000	$3,297.50	6,395,798	13.22743464
West Virginia	1,531,912,228	374,000	$4,096.02	1,818,470	20.56674017
Wisconsin	2,682,481,604	784,000	$3,421.53	5,556,506	14.10958613
Wyoming	228,527,310	74,000	$3,088.21	515,004	14.36882044

Sources:

Centers for Medicare and Medicaid Services, Form 64, FY 2006

U.S. Census Bureau

Table 2: Additional Federal Support for Medicaid
October 2008 - December 2009

$y = -1312.9x + 505.68$
$R^2 = 0.1775$

State	Additional Federal Funds from HR 5268	State Population	Population <125% FPL	Additional Federal Funds per #<125%FPL	% Under 125% FPL
Alabama	144,099,000	4,532,000	914,000	$158	20.167696
Alaska	64,106,000	658,000	82,000	$782	12.462006
Arizona	340,875,000	6,256,000	1,231,000	$277	19.67711
Arkansas	150,142,000	2,748,000	669,000	$224	24.344978
California	1,442,915,000	36,160,000	6,279,000	$230	17.364491
Colorado	116,806,000	4,797,000	667,000	$175	13.904524
Connecticut	167,572,000	3,457,000	376,000	$446	10.876482
Delaware	44,085,000	858,000	98,000	$450	11.421911
Florida	783,103,000	18,029,000	2,883,000	$272	15.990904
Georgia	243,976,000	9,334,000	1,585,000	$154	16.98093
Hawaii	60,444,000	1,254,000	159,000	$380	12.679426
Idaho	47,432,000	1,472,000	233,000	$204	15.828804
Illinois	448,135,000	12,633,000	1,838,000	$244	14.549197
Indiana	216,699,000	6,334,000	845,000	$256	13.340701
Iowa	104,131,000	2,913,000	420,000	$248	14.418126
Kansas	85,721,000	2,719,000	457,000	$188	16.80765
Kentucky	179,076,000	4,106,000	911,000	$197	22.187043
Louisiana	317,679,000	4,206,000	942,000	$337	22.396576
Maine	78,784,000	1,313,000	188,000	$419	14.318355
Maryland	217,318,000	5,607,000	631,000	$344	11.25379
Massachusetts	438,530,000	6,324,000	953,000	$460	15.069576
Michigan	321,901,000	9,953,000	1,749,000	$184	17.572591
Minnesota	268,308,000	5,145,000	588,000	$456	11.428571
Mississippi	158,686,000	2,887,000	755,000	$210	26.151715
Missouri	278,013,000	5,797,000	907,000	$307	15.646024
Montana	30,886,000	930,000	174,000	$178	18.709677
Nebraska	62,072,000	1,765,000	253,000	$245	14.334278
Nevada	81,530,000	2,530,000	341,000	$239	13.478261
New Hampshire	42,978,000	1,308,000	114,000	$377	8.7155963
New Jersey	290,807,000	8,650,000	1,006,000	$289	11.630058
New Mexico	134,429,000	1,939,000	414,000	$325	21.351212
New York	1,805,626,000	19,021,000	3,487,000	$518	18.332369
North Carolina	386,858,000	8,847,000	1,639,000	$236	18.526054
North Dakota	25,240,000	615,000	91,000	$277	14.796748
Ohio	487,671,000	11,297,000	1,881,000	$259	16.650438
Oklahoma	187,613,000	3,489,000	770,000	$244	22.069361
Oregon	128,247,000	3,705,000	619,000	$207	16.707152
Pennsylvania	629,954,000	12,326,000	1,777,000	$355	14.41668

Rhode Island	66,546,000	1,054,000	145,000	$459	13.757116
South Carolina	139,070,000	4,224,000	742,000	$187	17.566288
South Dakota	22,866,000	770,000	121,000	$189	15.714286
Tennessee	280,620,000	5,916,000	1,207,000	$232	20.402299
Texas	1,110,201,000	23,208,000	5,140,000	$216	22.147535
Utah	68,853,000	2,536,000	357,000	$193	14.077287
Vermont	40,580,000	618,000	72,000	$564	11.650485
Virginia	206,307,000	7,532,000	878,000	$235	11.65693
Washington	247,214,000	6,310,000	779,000	$317	12.345483
West Virginia	101,173,000	1,810,000	373,000	$271	20.607735
Wisconsin	195,631,000	5,471,000	760,000	$257	13.891428
Wyoming	17,738,000	516,000	66,000	$269	12.790698

Source: Families USA, Census Bureau

State Fiscal Relief: Protecting Health Coverage in an Economic Downturn

Summary of Testimony of
Robert B. Helms
American Enterprise Institute

- This testimony focuses on the policy reasons why the proposed increase in the FMAP is a misguided approach for giving temporary aid to the states. It accepts as given that the Congress desires to help the states and has the additional funds to provide such help.

- The present FMAP formula creates two strong perverse incentives:
    - For states to expand Medicaid expenditures relative to unmatched state priorities when they have the state funds to do so;
    - For states to reduce state Medicaid expenditures relatively less than expenditures on unmatched parts of the state budget when economic conditions force states to reduce expenditures.

- The two ratchet effects are more prevalent in wealthier states than they are in poorer states. When federal Medicaid expenditures to the states are compared on a per capita basis (Federal Medicaid Expenditures per persons under 125 percent of poverty), the higher income states receive per capita payments more than three times as great as the poorest states.

- By boosting the FMAP, the proposal makes the perverse incentives worse and increases the dispersion in per capita payments. On average, the additional federal funding will help the states with the lowest number of people in poverty relative to the states with more poverty.

- The hold-harmless provision that prevents a state's FMAP from decreasing ends up protecting those states with the relatively higher increases in per capita personal income compared to those states whose economies are having the most trouble.

- I urge the Congress to consider putting an upper limit on the additional funding and finding a way to allocate the funding to the states that need it most.

Mr. PALLONE. Ms. Howard.

STATEMENT OF HEATHER HOWARD, COMMISSIONER, NEW JERSEY DEPARTMENT OF HEALTH AND SENIOR SERVICES

Ms. HOWARD. Good afternoon, Chairman Pallone and distinguished members of the committee. I am pleased to be here to discuss the importance of maintaining our health care safety net during a time of national recession.

First, though, I would like to take the opportunity to thank you and the bipartisan Members of Congress for your leadership and hard work in enacting a moratorium on the many harmful Medicaid regulations. We appreciate very much, from a State perspective, your doing so.

Mr. Chairman, I would like to thank you also for sponsoring H.R. 5268, bipartisan legislation that would provide New Jersey and the rest of the Nation with a temporary but urgently needed increase of nearly 3 percent in the Federal Medical Assistance Percentage, or FMAP.

Mr. Chairman, States are clearly experiencing the effects of the economic downturn. According to the nonbipartisan Center on Budget and Policy Priorities, more than half of the States are facing budget shortfalls and more are likely to have deficits in the coming months.

Because most States cannot operate in a deficit, unless Congress intervenes enacting a temporary increase in FMAP, States my be forced to reduce health care services and eligibility for our most vulnerable.

This bipartisan proposal can be enacted quickly, as there is precedent from the 2003 economic stimulus package that Congress enacted, and it is timely, temporary and targeted to helping the working families who are struggling in the failing economy.

The decline in the national economy—and, therefore, most State economies—means rising unemployment, escalating Medicaid costs and more families in need of health care service. More employers will be forced to reduce or eliminate health care coverage for their employees, exacerbating the negative trend in employer-provided health insurance.

We heard the statistics a couple of times, but I think it bears repeating. According to the Kaiser Family Foundation, nearly every 1 percent increase in unemployment results in 1.1 million more uninsured and an additional 1 million—400,000 of them children—enrolling in Medicaid. And since Medicaid eligibility lags 6 months behind unemployment figures, the full impact for increasing demand for Medicaid services may not be known for some time.

These new developments could not come at a worse time from a health care perspective. There are now 47 million uninsured Americans, up from 40 million just 8 years ago. Mr. Chairman, this is a national problem that calls for a national response from Congress, and I am grateful the committee is meeting today to discuss this issue.

Earlier this year, as Mr. McEntee noted, the National Governors Association in a bipartisan vote strongly endorsed a temporary increase in the Federal matching rate for Medicaid along with flexible block grant funding, stating, "Such efforts were effective in the

past to stabilize the economy and maintain health care service for the most vulnerable populations."

I have a copy of that letter for you.

Let me be clear. Now that a majority of States are facing significant budget shortfalls, many will be considering drastic spending cuts as a result. In these hard economic times, not only are States seeing reduced State revenues, more and more people are qualifying for need-based benefit programs, further exacerbating those State shortfalls.

In response, some States have already implemented cuts to public health programs and, clearly, more will be forced to do so unless Congress provides this temporary relief.

In New Jersey, as in many other States, the health care system is in distress. We have seen seven hospitals close in the last 18 months, and half of those that are remaining are operating in red. Over 1.3 million people have no health insurance.

New Jersey's Medicaid program is the safety net for more than 1 million low-income families and individuals who depend on Medicaid for vital health care service. They need our help now more than ever.

And what does Medicaid mean in real terms? Medicaid covers nearly one-third of all child births in the State of New Jersey. It covers half of all HIV/AIDS treatment. It covers childhood immunizations, critical cancer screening and treatment, pharmaceuticals for the mentally ill, and specialized care for the blind and disabled.

Governor Corzine has taken bold steps to address our State's structural deficit, including real reductions in State spending, eliminating State departments, and cutting the operating budget of every State department. But our State's fiscal crisis still made it necessary to propose significant and painful cuts to a variety of programs, including aid to hospitals and nursing homes. We tried to craft these cuts in such a way as to protect the most vulnerable, but as the recession worsens we may need help from the Federal Government to forestall worse cuts.

And while we have shown we are willing to take steps to get our fiscal house in order, we and other States may not be able to maintain that critical safety net in the face of a deepening national recession.

As has been noted, in 2003 Congress provided a temporary increase in FMAP, and according to the Kaiser Commission on Medicaid and the Uninsured, that increase was effective in averting additional Medicaid cuts and even allowed some States to reverse previously enacted cuts.

The proposal before you today would provide New Jersey nearly $280 million in additional funding and help preserve that safety net.

In sum, I would urge you to pass a temporary increase in FMAP. It would prevent States from having to make deep reductions in vital Medicaid services at the very time that more and more of our citizens are needing them.

Thank you.

[The prepared statement of Ms. Howard follows:]

STATEMENT OF HEATHER HOWARD

Good afternoon Chairman Pallone and Distinguished members of the House Energy and Commerce Health Subcommittee.

I am pleased to be here to discuss the importance of maintaining our health care safety net during a time of national recession.

First, though, I would like to take this opportunity to thank you and the many members of Congress for your leadership and hard work in enacting a moratorium on many of the harmful Medicaid regulations the Administration issued over the past year. Those regulations threatened critical funding for hospitals and other health care providers and would have impacted the care provided to the most vulnerable. I know you worked together in a bipartisan fashion to prevent the regulations from taking effect and want to commend your efforts.

And Mr. Chairman, thank you for your sponsorship of H.R. 5268, which would provide New Jersey and the rest of the nation with a temporary-but urgently needed-increase of nearly 3 percent in the Federal Medical Assistance Percentage or FMAP. This legislation has bipartisan support and I am hopeful it will have the same success as the moratorium on the Medicaid regulations.

States are clearly experiencing the effects of the economic downturn. According to the nonpartisan Center on Budget and Policy Priorities, more than half of the states are facing budget shortfalls and more are likely to have deficits in the coming months.

Because most states cannot operate in a deficit, unless Congress intervenes enacting a temporary increase in FMAP, states may be forced to reduce health care services and eligibility for the most vulnerable.

This bipartisan proposal can be enacted quickly, as there is precedent from the 2003 economic stimulus package Congress enacted. And it is timely, temporary and targeted to helping the working families who are struggling in this failing economy.

Mr. Chairman, the decline in the national economy-and therefore most state economies-means rising unemployment, escalating Medicaid costs and more families in need of health care services. More employers will be forced to reduce or eliminate health coverage for their employees, exacerbating the negative trend in employer-provided health insurance. According to the Kaiser Family Foundation, nationally every 1 percent increase in unemployment results in 1.1 million more uninsured and an additional 1 million—400,000 of them children—enrolling in Medicaid.

And, since Medicaid eligibility lags 6 months behind unemployment figures, the full impact of increasing demand for Medicaid services may not be known for some time.

These new developments could not come at a worse time from a health care perspective. There are now about 47 million uninsured Americans—up from 40 million in 2000.

Mr. Chairman, this is a national problem that calls for a national response from Congress, and I am grateful that the committee is meeting today to discuss this critical issue.

This year, the National Governors Association, in a bipartisan action, strongly endorsed a temporary increase in the federal matching rate for Medicaid, along with flexible block grant funding, stating that "such efforts were effective in the past to stabilize the economy and maintain health care services for the most vulnerable populations."

Let me be clear: a majority of states are now facing significant budget shortfalls, and will be considering drastic spending cuts as a result. In these hard economic times, not only are states seeing reduced state revenues, more people are qualifying for need-based benefit programs, further exacerbating state shortfalls.

In response, some states have already implemented cuts to public health programs, and clearly more will be forced to do so as the recession worsens, unless Congress approves temporary, increased Medicaid funding.

In New Jersey as in many other states, the health care system is in distress. Seven hospitals have closed in the past 18 months and half of those that remain are operating in the red. Approximately 1.3 million people have no health insurance. According to the American Hospital Association, last year 35% of urban emergency departments were over capacity, and 56% of urban hospitals and 64% of teaching hospitals had spent time on ambulance diversion status, in many cases for long stretches.

New Jersey's Medicaid program is the safety net for more than one million low-income families and individuals—including 40,000 elderly nursing homes residents—who depend on the health care services that Medicaid provides. They need our help now more than ever as they struggle with spiraling fuel prices and higher food costs.

Medicaid pays for one-third of all births in the state of New Jersey, half of all HIV/AIDS treatment, childhood immunizations, critical cancer screening and treatment, pharmaceuticals for the mentally ill, and specialized care for the blind and disabled.

Governor Corzine has taken bold steps to address the State's structural deficit. The recently-enacted budget represents a $2.9 billion reduction in spending, $600 million below last year's spending level—the largest actual dollar, year-to-year reduction in state history. It also reduces the size of government by 3,000 workers through early retirement and attrition, cuts the operating budgets of every state department by an average of five percent, and eliminates altogether two state agencies.

The state's financial crisis made it necessary to propose significant and painful cuts to a variety of programs, including state aid to hospitals and nursing homes. The cuts, however, were crafted in such a way as to protect the most vulnerable. For example, safety net hospitals serving the greatest number of the uninsured received the smallest cut, and the nursing homes serving the highest percentage of Medicaid patients received a full cost of living update.

As the recession worsens, however, we may need help from the Federal Government to forestall worse cuts. Indeed, while New Jersey has shown that it is willing to take strong steps to get its fiscal house in order, we and other states may not be able to maintain our critical safety net in the face of a deepening national recession without temporary and targeted assistance from the federal government.

As you know, in 2003 Congress provided a temporary increase in the FMAP. According to the Kaiser Commission on Medicaid and the Uninsured, that temporary increase was effective in averting additional Medicaid cuts and also allowed some states to reverse previously enacted cuts. A similar temporary increase in the FMAP of 2.95 percent would mean nearly $280 million in additional funding for New Jersey today and would enable us to preserve Medicaid and other health care safety net programs and prevent us from having to cut vital services or reduce eligibility.

In conclusion, if the recession continues, as expected, states may be forced to make additional cuts to health care services for working families. This is a critical time for the millions of Americans struggling with escalating health care costs.

Therefore, I would urge you to pass a temporary increase in FMAP. It would prevent states from having to make deep reductions in vital Medicaid services and help us to preserve the safety net for our most vulnerable residents.

Thank you again Mr. Chairman for this opportunity to testify. I would be happy to answer any questions from the members of the subcommittee.

Mr. PALLONE. Thank you. I want to thank all of you for your statements and for being here today.

We will now move to questions. I recognize myself initially for some questions, and I am going to start with Dr. Tannenwald.

You did an excellent job of laying out the current economic landscape facing States and the Nation and basically said the situation doesn't look very promising, which I share. Right now, Congress is again discussing a second economic stimulus package that would include additional temporary target assistance for States. And as you look to the horizon do you believe that this downturn is going to reverse course or do you for see continued economic distress?

Mr. TANNENWALD. Let me start first by making a statement—

Mr. PALLONE. And all of that in 1 minute. No.

Mr. TANNENWALD. Let me start by making a statement I should have made initially, that my views are my own, not necessarily those of the Federal Reserve Bank of Boston or the Board of Governors of the Federal Reserve System.

I don't have privy to the internal economic forecast of the Fed, the Board. I am not cleared to see it. But the bulk of economic forecasters that I follow are saying that we are looking at probably, through the first quarter of 2009, either weak or negative economic growth in the Nation. When the negative quarters will hit, if at all, there is a lot of disagreement.

Mr. PALLONE. OK. Well, as you know, in the spring, the Democratic Congress enacted a fiscal stimulus package; and it provided some relief. However, even with that, more States are feeling pressures or have a declining tax base and budget troubles. Do you believe additional Federal spending targeted in the right way will be helpful in alleviating State pressures and pulling State economies out of a slump? In other words, a second stimulus package that might include FMAP?

Mr. TANNENWALD. Sure, it could help. How this whole thing should be structured, it brings in a lot of issues. In theory, if the goal is to help State governments per se, the States have a vital role in our Federal system that suggests not targeting. But if the idea is to relieve fiscal stress, then the aid should be targeted at those who are most stressed.

Now, in practice how to measure fiscal stress is very controversial and difficult. So then you go to the second criteria, like is the program up and running, where if you put the money in, you know it is going to get there and it is somewhat related to some sort of stress.

Also, is it a program where the Federal Government has already expressed a vital interest in the health care for low- and moderate-income people it has.

So all those factors should be taken into account in deciding how to do it. I think the last time around in the last recession there was a mixture of targeted and nontargeted aid, including FMAPs, which seemed to try to reconcile all these different concerns.

Mr. PALLONE. Thank you.

Now I am going to go to Heather Howard.

In our current economic situation with rising joblessness and rising inflation, what happens to the Medicaid rolls and what has New Jersey's experience been?

And I guess the second part of this is that I know there are some that criticize Medicaid's flexibility that allows the program to grow as need grows. But could you talk about how Medicaid functions as a countercyclical program and why FMAP or a Federal matching formula is so important?

A lot of questions in one.

Ms. HOWARD. Thank you. Yes.

I will start off by saying, yes, we are very concerned about the effect of the downturn on our Medicaid program and what it is going to mean. As I mentioned, we are seeing more employers dropping coverage because they can't afford it, and that means more people will be qualifying for the program. As I mentioned, Medicaid eligibility lags unemployment numbers, so we are going to be starting to see it. And that is why it is so important to start the stimulus soon before we have to make the cuts.

You mentioned the fact that it is countercyclical, and I think what you are getting at is the fact that in a time of economic downturn when State revenues tend to decline, our State spending on health care needs to increase because our Medicaid rolls are increasing as more and more employees lose their jobs and more people become uninsured.

So States are facing greater and greater constraints in terms of our revenues. Our only options are to raise taxes or cut spending,

which would exacerbate the downturn. And so that is why we need the Federal Government to step in and provide this very temporary and targeted assistance, so that we can prevent these very dramatic cuts that we would have to consider otherwise.

Mr. PALLONE. Just one comment, I think it may be obvious, but if it isn't, I will say it. Obviously, I think we should do a second stimulus package, and the question is what is in it. And I feel that FMAP is something, as I think Dr. Tannenwald was alluding to that should be included, because it does have an immediate impact, not only in terms of helping the States but also money that goes to health care and that creates jobs as well.

But I will now defer to my ranking member, Mr. Deal.

Mr. DEAL. Thank you.

Ms. Howard, first of all, it is good to have you here.

I understand that your Governor Corzine has been very supportive of some of the Medicaid flexibilities that were built in in the Deficit Reduction Act and that he has been a strong advocate for these kinds are flexible accounts. And you have used them in emergency room co-pays for nonemergency care, for enforceable nominal co-pays for certain prescription drugs and some long-term care insurance partnerships.

Have all of those been a way in which you can use and make the money go further in a more efficient and effective manner?

Ms. HOWARD. They are. And I want to thank you; I know you were very involved in the crafting of the Deficit Reduction Act. And as a State official now, we do look to that for tools in how to manage the growth.

Of course, everybody is dealing with exploding growth of healthcare costs. It is not unique to government, obviously; it is true in the private sector as well. And the DRA has provided us with some of those tools, such as the long-term care partnership.

I should clarify that they did reject them, but he did try and make—and try again. But we had definitely looked to the DRA for ways to manage the growth.

Mr. DEAL. What is your match rate in New Jersey?

Ms. HOWARD. Our match rate is only 50-50. We have the lowest match rate.

Mr. DEAL. You are one of those rich States then?

Ms. HOWARD. You know, I think that is technically true, but we really—and Congressman Pallone knows this—have a real diversity of experiences in New Jersey. We have the poorest city in the country, Camden. So we obviously have a high average income but we have real pockets of poverty and real pockets of need.

Mr. DEAL. But you are at the lower level in terms of the match rate?

Ms. HOWARD. Yes, that is right.

Mr. DEAL. Dr. Helms, were some of those reforms that were in the DRA the kind of things that you are alluding to in general terms of being able to make the program more efficient?

Mr. HELMS. Yes. It is one of the things from 18 months from that Medicare commission. We looked at a lot of things the States were doing, and we were pretty impressed. There were States trying out new things and particularly in coordinating critical care in really

expensive populations and so on. I think there is a lot of potential for that.

I guess, as a general matter, one of my complaints about the FMAP, that the margin is that it gives not only—some States may use the money well, they may put it back into Medicaid. I don't think there is any guarantee of that, because the FMAP is a retrospective payment. So, at the margin, there is an enormous incentive when you have decades of history of this, of people playing accounting games and coming up with anything you can do to get some State expenditure over into the Medicaid column, means that you would qualify for the matching waiver.

So my general feeling is if States could put as much effort into trying to improve the care and coordinating care and those kinds of things, I think it would be far better for the really, truly poor and disabled.

Mr. DEAL. Do you agree with the proposal of the transparency provisions that Mr. Frogue was talking about? Would that be something that would assist in this effort?

Mr. HELMS. Very much so. Jim, to his credit, has been making this case for several years now. I think it would be an easy thing for the Congress to do.

Mr. DEAL. Mr. Frogue, in that regard, the transparency that you suggested, could you give us an idea of how that information translates into making adjustments within the programs that actually will save States like New Jersey and others money in the process?

Mr. FROGUE. Well, I think the first and most important reason to do it is it can help States figure out what kind of outliers there are. There is some really low-hanging fruit, but there is not a lot of waste, fraud and abuse.

But the number one point to make is you can't manage what you can't measure. And if States aren't doing this and measuring it already, then it is impossible to manage a program.

So this isn't something that should have a whole lot of partisan boundaries. And, again, the number one reason to do it is you will be able to find States where only 17 percent of women over 50 are getting annual mammograms when it should be 100 percent.

Mr. DEAL. Have you looked at the issue that Dr. Helms raised about the current FMAP formula being disproportionately punitive for States with low-income individuals in terms of the dollars that translate per individual in those low-income States? Have you looked at that issue?

Mr. FROGUE. The larger and more inefficient the State Medicaid program, the more money it gets under this proposal, yes.

Mr. DEAL. And that is one of those perverse incentives I think that Dr. Helms was talking about. I would hope that at some point this subcommittee and this full committee would have an opportunity to look at some of these reforms that I think really would cut across political boundaries and simply do the kinds of things that we all acknowledge have to be done if we are going to keep this program solvent, not only for the Federal program, also for the States.

Ms. Howard, I was a little intrigued by one comment you made. You said the State only has two options: to raise taxes or cut spending. Sometimes we are faced with those same options up

here, as well, and especially since we are in a deficit situation already.

The third option I would suggest and one that has already been suggested here is to try to make the programs we have more efficient. And as I indicated in my first question, I think Governor Corzine is to be commended for taking advantage of the options that we have provided under the DRA to make the programs more efficient.

And I think those are the kind of things that we ought to hopefully work toward, as we move forward with looking. This is certainly one bill, but long-term changes that all of us can agree on I think are out there.

I would yield back, Mr. Chairman.

Mr. PALLONE. Thank you, Mr. Deal.

The gentlewoman from Wisconsin is recognized for questions.

Ms. BALDWIN. Thank you, Mr. Chairman.

Thank you to all the witnesses for their testimony.

I wanted to start with a couple of questions for Ms. Howard.

You said in your testimony that your State made cuts to social services, but they were made in a way that protected the most vulnerable, and that those protections are somewhat threatened at this point. Can you elaborate a little bit so that we can know the strategies New Jersey was using?

Ms. HOWARD. Sure. Thank you. Thank you for that question, Congresswoman.

For example, the Governor cut over $100 million from the Charity Care Program, which is our program for reimbursing hospitals for uncompensated care for the sick and uninsured. So, although we had to take the very unfortunate step of cutting that funding, with the remaining funding we targeted the safety net hospitals, the hospitals that see the highest percentage of uninsured, and made sure they felt the smallest cut. So, although the pie was smaller, we made sure that those safety net hospitals got the most money.

Another example was that, as we were unfortunately forced to look at cutting nursing-home funding, we made sure that the nursing homes that have the highest percentage of Medicaid occupancy, therefore the highest percentage of the poorest seniors, we made sure they got the full inflationary update that we were not able to provide for those nursing homes that don't have as many of those high Medicaid occupancy.

But those are the kind of tactics we are having to look at. And, of course, in a time of rising uninsured, the last thing you want to be doing is cutting funding to hospitals that are treating the uninsured. So it was very difficult choices.

Ms. BALDWIN. Along a similar vein, in recent months, as I said in my opening statement, the State of Wisconsin has seen a dramatic increase in the enrollment of working parents in Medicaid, often a group that doesn't typically access Medicaid except in times of economic duress, like we are seeing right now.

Is that also a trend that you are experiencing in New Jersey? And if so, what sort of initiatives have you undertaken to enable your State to cover new eligibles?

Ms. HOWARD. Well, one of the reasons we had to make cuts in programs was anticipating—we have already anticipated growth, a caseload growth. And, of course, working with a lot of social services organizations, those that are really community-based, we get the strong feeling that we are going to see an influx of people coming in.

As I mentioned, people have to exhaust their unemployment benefits. And you all have—and I want to commend you—provided an extension of unemployment benefits, which is terrific, but that just means that it has extended the time before people start coming to us to apply for Medicaid. So we fully anticipate that we are going to see a strong wave of people coming in.

And, actually, I think Chairman Pallone asked about the open-ended nature of Medicaid. I think that is one of the benefits of having an open-ended nature of Medicaid, is we are able to accommodate an increase. If people are needing the services of the program, we want them to come in. And that is one of the benefits of Medicaid being an entitlement program; it gives us that flexibility. If our caseloads were capped, we wouldn't be able to deal with the increase of people coming in and needing services.

Ms. BALDWIN. Mr. McEntee, in your testimony you gave a real good overview of the likely short-term effects of the economic downturn that we are experiencing, such as States cutting Medicaid eligibility or reducing services.

I am wondering if you can look out a little further and what you see as the long-term effects of these short-term strategies to balance budgets at the State level.

Mr. MCENTEE. Well, I think the short-term strategies, obviously, are very, very necessary. But there is a long-term structural problem in regards to our States and in relationship to the Federal Government and our States and counties and cities and school boards. Not to get partisan, but with all the tax cuts that took place in terms of the Federal budget, the Federal Government finds itself in a tremendously minus state in terms of money. And I believe that all will have to come together and be corrected in some way for the economy to be able to move forward.

I think that over time, once we get some short-term fixes into the States, they will be able to begin to handle some of their problems. But we have to understand that the Federal Government is like the battleship in this war, and that battleship has to be structured properly in the long run for the country to move forward.

Ms. BALDWIN. Thank you.

Mr. Chairman, I appreciate the time for questioning. I know that the hearing is focusing on State fiscal relief, but, obviously, underlying all of this is the health and well-being of our citizens. So I thank you again for holding this hearing. I yield back my remaining time.

Mr. PALLONE. Thank you.

The gentleman from Texas, Mr. Burgess?

Mr. BURGESS. Thank you, Mr. Chairman.

Ms. McEntee, I am not sure that I heard you correctly. Were you arguing that we should be working toward a balanced budget situation at the Federal level in your last statement? Or am I misconstruing what you said, that the debt load that—

Mr. MCENTEE. Working toward a balanced budget. I think a balanced budget is a good thing, but I think it will take, with the kind of shape that we are in now in the Federal Government, will take an extensive period of time and a lot of courage to do that.

Probably some of us recall that when Clinton left, we had a tremendous surplus in terms of Federal Government, where it was not only balanced but we had this tremendous surplus, and then we find ourselves in a great deficit.

I think of course a balanced budget is a good thing. I think that offsets are a good thing. But sometimes the situation cries for more and faster solutions, so they have to be put aside.

Mr. BURGESS. It is my understanding, Mr. Chairman, is this offset, this bill that we have been—the Pallone bill that we have under discussion?

Mr. PALLONE. Well, if the gentleman will yield?

Mr. BURGESS. Yes, I would be happy to.

Mr. PALLONE. What I am proposing—and I am sure you have heard a lot of this—is that there be a second economic stimulus package, which would be essentially like the first one, an emergency supplemental, and would not be offset because it is an emergency.

Mr. BURGESS. OK. Reclaiming my time—I was afraid of that.

Mr. Frogue, let me just ask you—you gave some very intriguing testimony, and I think we heard some intriguing testimony from Mr. Helms. But if you were—this legislation that we are considering were to increase the Federal spending of Medicaid by $15 billion over five calendar quarters. If you had the ability to construct this any way you wanted, how would you direct that money so it would have the greatest impact on the system, not just for solving the problems of today, but leaving a Medicaid system that was in less disrepair for the future?

Mr. FROGUE. Well, first and foremost, I would always keep in mind that the Medicaid program is about health first and spending second. And if you had encountered data out there in a patient deidentified way, you could find out if people are actually getting healthier. That is the number one goal of this program. The spending is important, but we should always remember it is for health and for improving health status.

So my proposal is the most efficient thing this committee could do that would require almost no cost would be to require States to post that data, but, at the very least, as a condition of the bailout or the FMAP temporary increase, that States not get the money unless they agree to post that data.

Mr. BURGESS. I will just say from my own experience in the past—and it wasn't with Medicaid, it was with another insurance company that shall remain unnamed but rhymes with "united"—they sent me data. It was individual data about just the issue you mentioned, about only having 17 percent of patients having a mammogram under the Medicaid system. I am happy to report my percentage was much higher. But even those one or two that were identified to me were quite a shock.

First, I was incensed that the insurance company would even have that data and collect that data and be able to report that data back to me. But after getting over that concept, the fact that, yes,

we have a way to actually act as another backstop so that this information could be made available to the clinician and then ultimately improves patient care and, as you so correctly point out, delivers the correct kind of care, care that costs the cheapest dollars, which are on the front end, as opposed to the crisis side, where the dollars are most expensive.

So I really thank you for bringing that information with you today. I think that is terribly intriguing information.

Now, it is my understanding that you work with a lot of States around. Have you seen any enthusiasm for incorporating this idea at the State levels?

Mr. FROGUE. Yes. Actually, I sent the testimony around shortly before coming here, and I got some rather quick responses from half a dozen State health secretaries, who said they thought it was a fantastic idea.

And States can do it unilaterally. They don't need the Federal Government to demand them to do it. And some actually are beginning to do this, is my understanding.

Mr. BURGESS. But the advantage of having the Federal Government do it, then, is because the data is collected in one way and one location and then can be accessed by anyone so long as the data is properly de-identified and aggregated?

Mr. FROGUE. Again, properly de-identified, yes. But if you are going to do this package, then the lever to get the data would be: You get the money if you release the data; otherwise, you don't get the money.

Mr. BURGESS. Well, Mr. Helms—and, again, I was intrigued very much by your testimony as well. Obviously, your answer to Mr. Deal's question earlier, you would see value in perhaps incorporating what you have discussed with a different way of approaching the FMAP along with this ability for States to access data quickly and be able to identify the outliers and what was described as low-hanging fruit. Is that correct?

Mr. HELMS. Yes, if I understand your question.

Mr. BURGESS. What I am getting at—in talking to Mr. Frogue, yes, we are going to pay $15 billion over five quarters, which is a significant, significant investment for us to make. OK, if we get the transparency that Mr. Frogue is talking about, perhaps we could also get some reform to the FMAP formula in general, which, going forward, would lead us to a better place ultimately with our Medicaid system.

Mr. HELMS. Right. I have actually given some thought about—I couldn't get the Medicaid commission to really deal with this, because I think it came up too late. And it is a big issue, and it is controversial, I admit. You know, it puts one State against another.

But I do think, even if you look at the SCHIP allocation formula for SCHIP, in addition to being an add-on to the FMAP, it has three additional requirements about considering the number of uninsured in the State—uninsured children—the number of poor children in the State, the number of uninsured in the State, and also the relative cost of care in the States. I have tried to do this same distribution with the SCHIP money, and it is much more even. So that just illustrates that there are other kinds of formulas.

I guess my preference, if you could go to some kind of allocation system that would be based on the population that you are really trying to target this help to, the statistics on the number of disabled and those kinds of things probably aren't as good, but I do think we could probably come up with a better allocation that would target the money more to where these populations of people are.

Mr. PALLONE. OK. We are over, so we have to move on. Thank you, Mr. Burgess.

And I recognize the gentlewoman from Illinois, Ms. Schakowsky.

Ms. SCHAKOWSKY. Mr. Frogue, and actually Dr. Helms as well, I wanted to understand a little better your formulations. Are you suggesting that if a State is spending more per patient in Medicaid dollars that somehow that differential translates into an inefficiency for those States that are paying more?

Mr. HELMS. I think there is always inefficiency. What I was trying to do, as I discuss a little bit in my written testimony, it is very common—the Kaiser Family Foundation does this—to take the Federal or the total Medicaid expenditures and divide it by the Medicaid enrollment. And that is useful for certain purposes, but it is not independent of the State's decisions. And so you can get, I think, misleading comparisons.

Ms. SCHAKOWSKY. Exactly. That is the point I wanted to make.

And I think you were suggesting that a bit, Mr. Frogue, that Illinois may have a more generous package of benefits that the State legislature has decided to do. And I think that rather than have a downward pressure on States, if we measure efficiency in that way, that that would be a serious mistake, in my view. Because we may have better outcome, healthier poor people as a result of a more generous package.

Mr. HELMS. Well, my point for trying to go with the number of poor people in the State from the Census Bureau is, one, it is a convenient statistic already produced by the Census Bureau and it is independent of the State's eligibility policies. And I think it is an indication of the target population that this legislation was supposed to help.

So I just use it as a way to illustrate that there are variations in this from State to State and the money is not necessarily flowing to the States that have the largest poor populations.

Ms. SCHAKOWSKY. OK.

Mr. McEntee, you had an attachment that talked about the effect of an increase in Federal Medicaid matching payments on State economies. And I am looking at my State of Illinois, the additional Federal support: $448 million. But you have that it would—additional business activity—$896 billion, almost 8,000 new jobs, et cetera.

So I wondered if you would talk a little bit about what we might expect were we to make this investment of an additional $15 billion?

Mr. MCENTEE. I think the attachment speaks for itself. But there is a multiplier effect as this kind of money would move into various States. And the multiplier effect is right there in the appendix and would more than help just the people in terms of health, although I agree that is what the system is all about. But right now we are

also looking at a dual effect, where it would also be a stimulus, and it would help as a multiplier effect in each and every State. But it wouldn't be just the money that is going on, but what would happen in terms of business and everybody else.

Ms. SCHAKOWSKY. I appreciate that, because I don't think we have been looking at that end of it as much as we needed to. And so I appreciate this hearing.

I wanted to ask Ms. Howard a question.

It has been suggested that Congress should not give States in economic distress additional Federal matching funds to help them avoid Medicaid cuts without imposing additional administrative requirements.

And, now, all of us support the notion of accountability for any Federal taxpayer dollars, and we all want them spent efficiently. But I was wondering, Commissioner, if you think Congress needs to impose more administrative requirements on States to achieve efficiency and accountability during this economic downturn?

Ms. HOWARD. You know, I think some interesting issues have been raised, but I wouldn't want debate over those issues to slow down a very needed stimulus. We know the beauty of this kind of stimulus is that you can get it out quickly, and it can help prevent these cuts and, it can help make sure people still have access to health care. And I would hate to see a debate about these issues bog that down.

And I would also want to say for the record that Medicaid is actually very efficient. Its administrative costs are much lower than private insurance has. And so I think there is already a lot of efficiency there.

And I agree with you that every taxpayer dollar should be spent efficiently, but we know this program works, we know this kind of stimulus has worked in the past.

Ms. SCHAKOWSKY. Great.

Thank you.

Mr. PALLONE. Thank you.

The gentleman from Texas, Mr. Murphy, is recognized for questions—oh, from Pennsylvania. I am sorry. I am focusing so much on Texas, because Mr. McEntee gave so many additional jobs to Texas that I—

[Laughter.]

Mr. PALLONE. Mr. Murphy from Pennsylvania?

Mr. MURPHY. Thank you. The great State of Pennsylvania.

Thank you so much to the panel.

Ms. Howard, you just said Medicaid is pretty efficient. Can you explain that? Because this is news to me.

Ms. HOWARD. Sure. Well, medicaid administrative costs are 5 percent, whereas private health insurance—

Mr. MURPHY. Does that include the cost to the States?

Ms. HOWARD. Yes.

Mr. MURPHY. Does that include the overhead of whomever has oversight into that 5 percent?

Ms. HOWARD. Right. Right.

Mr. MURPHY. And would this work through insurance companies as well?

Ms. HOWARD. The comparison is between 15 and above 15 percent for private insurance.

Mr. MURPHY. Does it include the cost to hospitals and physicians for handling Medicaid and any kind of extra paperwork and bureaucracy in dealing with it?

Ms. HOWARD. No, it wouldn't include that.

Mr. MURPHY. Does it include any kind of measures of inefficiency within the system?

Ms. HOWARD. No. And I think those are very serious. And I think Mr. Frogue mentioned that list, and I think we have a lot to learn and a lot of work to do there.

But the main point I was making is that we do know that Medicaid is efficient. Medicare, the percentage is actually even more efficient. So Government-run programs can be efficient.

Mr. MURPHY. Well, let me ask you a question about that, because that begs how we deal with this. Because, as I am reading through this—for example, Dr. Helms, as I was read this, I was reading through the testimony, a discussion with lots of formulas.

Do any of those formulas of how much money States get have any kind of measures based upon quality?

Can you turn the microphone on, please? It is not on.

Mr. HELMS. The ones I have used?

Mr. MURPHY. Well, as I read all these numbers—yes, the ones you used. Any of them based upon any kind of quality measures?

Mr. HELMS. No, they are not.

Mr. MURPHY. Which is a problem.

Mr. HELMS. I would love to get better data, and we would be able to use some sort of quality-adjusted expenditure. That would be great.

Mr. MURPHY. I oftentimes hear—in my work in hospitals, I hear of all these great ideas coming from employees a lot of times. A lot of people say, "I have this idea of how we can save money," and things like that.

But when I look at things like Medicaid, is there anything built in the system that rewards States for reducing some of their costs? Or is it basically you get back a percentage of what you build?

Mr. HELMS. Well, there are CMS programs that attempt to reward States for various—I am sure Ms. Howard could give you more details—but there are rewards for trying to push fraud and abuse. But when you think about the logic—and I have no empirical evidence that this is true—but one of the implications, I think, of the FMAP formula, the way it works is that if a State has a choice of investing anywhere in the State budget about trying to eliminate fraud, anything it saves from a Medicaid fraud, they have to share with the Federal Government. So the rate of return is much greater if they go after something that is not matched.

Now, obviously, they can save some money by going after fraud in Medicaid or a match program. But relative, the rate of return, they are going to give, I think, priority to the nonmatched programs.

Mr. MURPHY. What about in areas—let's look at a couple of other areas where—is there any incentive in the funding—and I would ask anyone in the panel to respond to this—any incentives in Med-

icaid funding if a State greatly reduces its nosocomial infection rates in hospitals?

Ms. HELMS. I don't hear well, so I would have to ask you, could you repeat that?

Mr. MURPHY. I said, is there any incentive for States in funding if they greatly reduce they greatly reduce their hospital infection rates? It costs $50 billion now nationwide.

Mr. HELMS. Right. I think that is one of the kinds of things that people could talk about incentives. But, to me, Medicaid is such a big program—

Mr. MURPHY. I only have a minute left, and I really want—

Ms. HOWARD. I think some States are starting to innovate there. We announced an initiative where Medicaid is no longer going to pay for preventible errors. So I think that is the future and—

Mr. MURPHY. But given that—and that is a good point. And Pennsylvania has also initiated "never events."

Ms. HOWARD. That is right.

Mr. MURPHY. But if they reduce that, do they get any rewards for actually reducing it? Because they used to bill for it. So if you could bill for it, you could get a percentage of that. Why stop it?

Mr. Frogue?

Mr. FROGUE. No. I think that is right. And I think one of the key points is that we have to get the data out there. Again, you can't possibly manage what you can't measure. And if the encounter data was out there, the patient de-identified for all to see, you would find these extreme outliers, including hospital infections, which you are to be greatly commended on for your efforts, Congressman.

Mr. MURPHY. Well, similarly, I look at some things about disease management for chronic illness, the electronic prescribing, what that can point out, in terms of the savings that can lead to, additional staff training. Integrating mental health care for people with chronic illness can reduce spending as well.

One of my feelings is, as someone said, the Government giveth and the Government taketh away, but the Government doesn't innovate. And this is a great opportunity, and I think with legislation such as this, it says, well, we can increase some funding for the States, but I would sure like to see incentives for the States to take an opportunity to ask their hospitals, ask their physicians, ask their nurses, ask their janitors, ask everybody, what do you see that we could do to save money? And if that is the case, can it lead to some rewards for the States so they simply don't give it up as you said, Dr. Helms.

There may not be a real incentive. Some of these programs, they don't really get to share that. They could be using the innovation of hundreds of thousands of employees throughout the Nation, I think would be helpful.

I yield back. Thank you.

Mr. PALLONE. Thank you, Mr. Murphy.

I recognize the gentlewoman from Oregon, Ms. Hooley, for questions.

Ms. HOOLEY. Thank you, Mr. Chair. I have several for all of them, but I will try to restrain myself a little bit.

Mr. McEntee, as I understand it, you talked about Federal support for Medicaid during an economic downturn has a twofold effect. One, it certainly helps those States that are trying to take care of their poorest in need of health care. And the second, the influx of Federal funds would spur economic activity.

Do you want to comment further on that?

Mr. MCENTEE. Yes. If you would look at—and we will present this. If you would look at, after our testimony, we put the effect of an increase in Federal Medicaid matching payments on State economies. And we talk about how much the additional Federal support for Medicaid would be in particular States and then the effect that it would have on generating business activity and additional jobs.

Let me—I will look down here. I am looking for Oregon, and I don't see anything. That would happen to me, wouldn't it?

[Laughter.]

Mr. MCENTEE. All right. Oregon would get $128 million under the proposed legislation, $128 million. And it would, according to our statistics, generate $215 million in business activity and create 2,100 jobs in Oregon, besides just the stimulus for Medicaid.

Ms. HOOLEY. OK. Thank you.

For Ms. Howard I have a question. There was a concern about creating new bureaucracies to get more aid out. Does increasing FMAP do that? And can you elaborate on how swiftly this kind of aid can be delivered to the needy?

Ms. HOWARD. It did not create any new bureaucracy. It won't require any new staff to do it. There are already systems in place. So it is a very efficient way to get money out.

And in terms of how quickly it can happen, as soon as Congress signals that it is going to do it and as soon as Congress passes the legislation and the President signs it, the States then know they don't need to be making these cuts, because they know the relief is coming.

And as we are all struggling with our budgets in dealing with the influx of people applying to these programs, we would be able to immediately forestall cuts.

Ms. HOOLEY. Mr. Frogue, I have a quick question for you. You talked about and gave some examples of fraud and abuse, and you talked about transparency and how that would help.

I also can cite a couple of cases where, as we have gone after fraud and abuse, many times it is after the small company, the doctor, and where they have—I think they were innocent, I don't know, but they got caught in a total nightmare. And yet we have some of these cases out there like the ones that you mentioned.

How do we make sure that that little company or that doctor doesn't get cut in this web where they can't get out of it? In many cases, they, in fact, shouldn't have been caught in that web in the first place.

How do we differentiate, and will the transparency do something different than is currently happening?

Mr. FROGUE. Thank you for that question, Congresswoman.

Yes, absolutely, I think shining that sunlight would be tremendously helpful, and we would also be able to focus anti-fraud resources where they are most needed. Like, for example, if it is true

that $12 billion of New York's Medicaid program is waste, fraud and abuse, that, by definition, affects Oregon, it affects Illinois, it affects New Jersey, it affects Georgia, it affects every State that matters, because they are using it so inefficiently.

But I think they would be able to see some of the biggest fish, some of the lowest-hanging fruit, and leave alone these smaller companies that are rather statistically insignificant unless it is excessive. But in most cases I think it would be very large institutions, if they are two or three or four standard deviations from the mean on treatment, get called out.

Ms. HOOLEY. Thank you.

Dr. Helms, you talked about our system being punitive to low-income States or States that have the greatest need. Do you think reimbursement rates for the same procedure, the same problem, should be the same no matter what?

Mr. HELMS. No. And I don't even think the concept of federalism was written into the Medicaid legislation originally, and I have never argued that the payments should be the same. I am just trying to illustrate that they are anywhere from the same. There are some over three times different on a per capita basis.

And, look, you can use other denominator. If you don't like the number of people at 125 percent of poverty, you could do 100 percent. I have done some of this. You can do it at 150. You still get the same picture. You get a little different numbers.

Ideally, it would be nice—and I would like to do similar work on this myself—to be able to break down the Federal expenditures for different classes of populations and then compare that to the populations of the actual numbers. The trouble is that it is hard to get those kinds of population figures.

So I am not arguing that payments should be the same. Basically the philosophy of federalism is that the Medicaid was set up to be a Federal assistance but to be run by the States. And, over time, all the Federal policy that I have ever been associated with when I was in the Reagan administration was to give the States as much flexibility as we could.

Ms. HOOLEY. Thank you.

Thank you, Mr. Chair.

Mr. PALLONE. Thank you.

And let me thank all of you. We are finished with our questions, and I know that we have to get on to other things, but I want to thank all of you for being here. I know that you went out of your way, in some cases, to get here, and we certainly appreciate that.

Let me just ask unanimous consent to put in this one letter. This is from the National Association of Counties. They just passed a resolution essentially endorsing H.R. 5268, the bill that I have introduced. And I would ask, without objection, that that be included in the record.

So ordered.

[The information requested was not provided at the time this document went to print.]

Mr. PALLONE. Let me also remind members that you may submit additional questions for the record to be answered by the witness. The questions should be submitted within the next 10 days.

And the clerks would then notify your offices that these questions are outstanding, for you to get back in touch with us.

But, again, I want to thank you all.

I know this is a very important issue. We do expect that a stimulus package is going to come forward at some point soon, and I would certainly like to see something like this legislation or some FMAP included in it.

So thank you again.

And, without objection, the meeting of this subcommittee is adjourned.

[Whereupon, at 3:45 p.m., the subcommittee was adjourned.]

[Material submitted for inclusion in the record follows:]

American Academy of Pediatrics

STATEMENT

AMERICAN ACADEMY OF PEDIATRICS

Submitted for the Record of the Hearing Before the United States Energy and Commerce Subcommittee on Health

July 22, 2008

Increased Federal Aid for Medicaid

Department of Federal Affairs
The Homer Building
601 Thirteenth Street, N.W.
Suite 400 North
Washington, D.C. 20005
202-347-8600 / 800-336-5475 / FAX: 202-393-6137

Introduction

This statement on children's health care access and the need to provide states with stable and sufficient federal funding is submitted on behalf of the American Academy of Pediatrics (AAP), which represents more than 60,000 primary care pediatricians as well as pediatric medical and surgical subspecialists. The AAP and its members are dedicated to the health, safety, and well-being of children from infancy through young adulthood. With the economy and health care costs a major concern for many families, the time is right to make the health and well being of America's children a national priority.

Although Medicaid and the State Children's Health Insurance Program (SCHIP) have helped reduce the number of uninsured low-income children by one third over the last decade, more than nine million children and adolescents lack basic health care coverage, and due to the counter-cyclical nature of Medicaid, more children will depend on Medicaid and SCHIP during the current economic recession. A Kaiser Family Foundation analysis shows that a 1 percentage point rise in the national unemployment rate would increase Medicaid and SCHIP enrollment by 1 million (600,000 children and 400,000 non-elderly adults) and cause the number of uninsured to grow by 1.1 million. That would increase Medicaid and SCHIP costs by $3.4 billion, including $1.4 billion in state spending.[1]

There is no better investment than preventing health problems, and promoting healthy development of the nation's children. Congress and the administration must know that children need age appropriate care and reliable preventive services. The Academy would like to thank the Energy and Commerce Committee for its continued commitment to this issue and for the opportunity to submit a statement for the record.

The Cost of Pediatric Care

Since all but one state operates under a mandate to balance its budget, states are regularly forced to make tough decisions about spending. During uncertain economic times states cut costs in order to close budget gaps. Unfortunately, since Medicaid spending comprises a large share of state budgets, second only to education, the Medicaid program is often subject to cuts. During the 2002/2003 recession some of the most common cuts to Medicaid included: freezing or lowering payment rates to physicians, reducing or eliminating "optional" Medicaid benefits like dental or vision services, and, in some cases, scaling back eligibility for Medicaid. Due to the counter-cyclical nature of the Medicaid program, states are cutting the program when beneficiaries need it most. Many of these policies — like cutting eligibility — have obvious adverse consequences because

[1] Stan Dorn, Bowen Garret, John Holahan, Aimee Williams, "Medicaid, SCHIP, and Economic Downturn: Policy Challenges and Policy Responses," The Urban Institute, April 2008, Available at http://www.kff.org/medicaid/index.cfm .

low-income beneficiaries lose insurance coverage. Additionally, cuts to physicians can result in providers being less willing or unable to care for Medicaid beneficiaries.[2]

Pediatric visits are more numerous but less expensive than adult care. In 2004, the cost per average Medicare beneficiary totaled $12,763. In 2005, the medical dollars spent for each non-disabled child in Medicaid was $1,617. Moreover, pediatric preventive care avoids the high costs associated with acute illness. For instance, in 2003 the average immunization visit cost $264; by contrast, a single 2004 case of measles in Iowa cost the state public health infrastructure nearly $150,000 in containment efforts.

Pediatric care is instrumental in reducing systemic and personal health costs, but many families find it difficult to meet their child's health care needs. This is especially true for the 20% of U.S. households containing at least one Child or Youth with Special Health Care Needs (CYSCHN), where parents often cut back on work or quit their jobs to care for their child. The combination of reduced income, declines in employer-sponsored coverage, and increasing health care costs makes it almost impossible for families to afford basic health insurance coverage, let alone the necessary services for a CYSCHN. Public programs, which limit co-payments to families, help poor and near-poor children afford needed medical care.

It is important to note that families poor, near-poor and middle class face overwhelming health care costs. In fact, it is families with private insurance who face higher medical bills: 27% of families with private coverage pay more than $1000 out-of-pocket annually for their child's health care. Such high out-of-pocket payments may lead to families forgoing preventive care and screening, further increasing the ultimate cost to the child's development, the family and the health care system.

In spite of the good intentions of Congress, state and federal policies are denying many eligible children access to care even if they are covered by Medicaid or SCHIP. This is because payment rates clearly impact access to care, and participating health care providers are being reimbursed at rates substantially below those paid to Medicare providers. Very few states have ever reached the Medicare rate and the average reimbursement paid to pediatricians in Medicaid today is 69% of Medicare rates for the sum services. Previous recessions show that many states are forced to make additional cuts to Medicaid physician reimbursement rates, making it significantly harder for physicians to treat Medicaid beneficiaries and provide high quality care. FY 2009 will almost certainly bring cuts to Medicaid provider payments in states across the country.

This is in direct contravention to statutory requirements found in Title XIX of the Social Security Act. The Equal Access Clause of the 1989 Omnibus Budget Reconciliation Act (OBRA) was designed to guarantee Medicaid patients access to care by requiring states

---

[2] Leighton Ku, Melanie Nathanson, Donna Cohen Ross, "State Medicaid Cutbacks and the Federal Role in Providing Fiscal Relief to States," Center on Budget and Policy Priorities, April 2002, Available at http://www.cbpp.org/7-12-02health.htm .

to pay physicians providing medical care for Medicaid patients at the same level that private patients are paying for health services. Most states are failing to meet the OBRA guidelines, and Congress has not stepped in to require the states or the courts to abide by them. This situation is unlikely to change unless Congress acts, especially as states are forced to cut reimbursement levels.

The Need for FMAP Increase

Federal assistance can play a significant role in alleviating the pressure on states to enact damaging cuts, especially in programs that serve low- and moderate-income families. An infusion of targeted funds through an increase in the Federal Medical Assistance Percentage (FMAP) can lessen the extent to which states cut the Medicaid program, and subsequently hurt vulnerable populations. During the 2002/2003 recession, the federal government provided $20 billion in temporary fiscal relief including a temporary, $10 billion increase in the federal share of Medicaid costs and $10 billion in general grants to states, based on their population.

Both uninsured and under-insured Americans are dealing with financial burdens due to high, and at times unaffordable, health care costs. Additionally, numerous indicators point to increasing uncertainty in the United States economy. At this time, 29 states face projected budget shortfalls in Fiscal Year 2009, which are expected to total at least $36 billion. As state revenues continue to decline and low income and moderate income families continue to suffer from the economic downturn, a temporary increase in the FMAP will ensure that states aren't forced to restrict access to health care for the neediest families.

Conclusion

In conclusion, uninsured and under-insured Americans are relying on Congress to address the growing health care crisis. A temporary and targeted increase in FMAP will allow states to continue to provide health care coverage to vulnerable children, adolescents, and families. Previous recessions show that during uncertain economic times many states are forced to make additional cuts to Medicaid physician reimbursement rates, making it significantly harder for physicians to treat Medicaid beneficiaries and provide high quality care. FY 2009 will almost certainly bring cuts to Medicaid provider payments in states across the country. As a result, the time is now for Congress to act to ensure that the nation's safety remains strong.

○