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Prepared Statement

Of

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&
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Committee on Homeland Security and Government Affairs
Subcommittee on Federal Financial Management, Government Information, and
International Security

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Introduction

Good morning Chairman Coburn and Members of the Committee:

My name is Tracy Edge, and I represent the 104th House District in South Carolina's House of Representatives. I am also chairman of the South Carolina House Ways and Means Subcommittee on Health, Human Services, and Medicaid.

In addition, I am a member of the American Legislative Exchange Council, or "ALEC." ALEC is the nation's largest nonpartisan, individual membership organization of state legislators with over 2,400 legislator members from all 50 states and 97 members in the Congress. ALEC's mission is to advance the Jeffersonian principles of free markets, limited government, federalism, and individual liberty.

It is my pleasure to appear before you in support of Governor Mark Sanford's Medicaid waiver proposal, which I believe is a step in the right direction toward empowering South Carolina's Medicaid beneficiaries.

The Fiscal Need for Reform

We must act now to curb Medicaid's skyrocketing costs. South Carolina spends more than \$4 billion dollars annually, or about 19 percent of our entire state budget, on Medicaid alone. According to the South Carolina Department of Health and Human Services, in ten years Medicaid is expected to consume almost 30 percent of our state's budget.¹ This poses a real threat to other funding priorities, such as K-12 education or law enforcement.

In my opinion, Medicaid's problems can be directly attributed to the perverse fiscal incentives imposed by its financing structure. From state governments to doctors to patients, Medicaid does not give any incentive to provide or consume health care efficiently. In fact, the opposite is true. Medicaid's financing structure actually *rewards* inefficiency with more dollars.

As you know, the federal government pays for more than half of all Medicaid spending through the Federal Medical Assistance Percentage, otherwise known as the "federal match." The federal match gives South Carolina Medicaid spending a guaranteed return-on-investment. In South Carolina, the federal match is about 69 percent.² This means that every Medicaid dollar we spend yields about \$2.85 in total Medicaid benefits.

Ironically, it is the federal match that is causing Medicaid spending to spiral out of control. Medicaid's federal match triggers a wasteful and inefficient spending spree, since states need to spend more to get more federal money.

¹ Freking, Kevin. "South Carolina Proposing to Redefine Medicaid," *The State*, Tuesday, August 16, 2005.

² Kaiser Family Foundation. *South Carolina: Federal Matching Rate (FMAP) for Medicaid and Multiplier*: <http://www.statehealthfacts.kff.org>.

We often hear about leveraging state Medicaid dollars with federal funds—but when we attempt to game the federal match, we put the fiscal health of South Carolinians in jeopardy. Federal dollars are not “free.” All taxpayers, including Medicaid recipients, pay federal, state, and local taxes.

Low provider reimbursement rates also directly contribute to Medicaid’s costs and limit much-needed access to care. On average, a doctor who treats a Medicaid patient will get about 62 percent of what they would get for treating a Medicare patient—and Medicare reimbursement rates are still only 80 percent of the average rate paid by private insurers.³

Because of this, providers have the incentive to tack on unnecessary tests or to stop seeing Medicaid patients altogether just to stay in business.

It is crucial that patients have a stake in their own health care spending. Unfortunately, South Carolina Medicaid’s current fee-for-structure system largely shields beneficiaries from the consequences of their own healthcare decisions. Simply stated, our state’s Medicaid system pays claims first, and asks questions later.

The Role of Welfare Reform in Reforming Medicaid

It is clear that the case for Medicaid reform has a lot to do with money. More importantly, however, there is a strong moral case for Medicaid reform. We cannot and should not confine our most needy citizens to an almost-bankrupt system. Instead, we should put Medicaid beneficiaries on the road to self-sufficiency by empowering them to take a greater responsibility for their own health care needs.

Luckily, we have a map of the road to self-sufficiency—the example of welfare reform. Before the Welfare Reform Act of 1996, there was an eerie similarity between the Medicaid and welfare programs. Both Medicaid and welfare were means-tested entitlement programs. Both programs were funded by an open-ended, federal-state spending match, and both programs conferred a legal right to benefits.

Almost ten years later, the two programs could not be more different. Block-grant funding has caused welfare rolls to drop dramatically. Meanwhile, the Medicaid entitlement continues to keep the poor locked in a cycle of government dependency in several ways.

First, it is likely that the mere existence of Medicaid could “crowd out” private-sector health care alternatives. The Robert Wood Johnson Foundation found that of the 22 studies they reviewed on the issue, more than half concluded that expansion of public health coverage was accompanied by reductions in private coverage.⁴

³ Cannon, Michael F. “Medicaid’s Unseen Costs,” Cato Institute Policy Analysis #548, August 18, 2005.

⁴ Gestur Davidson et al. “Public Program Crowd-Out of Private Coverage: What Are the Issues?” Robert Wood Johnson Foundation Research Synthesis Report No. 5, June 2004.

More importantly, Medicaid and other entitlements do not give the poor an incentive to save and invest, as beneficiaries have to remain under certain income levels in order to qualify for benefits. As a result, it is possible that some beneficiaries may choose to stay just below the poverty level, thereby locking them into an entitlement system.

South Carolina

There is no reason why welfare reform shouldn't serve as a model for Medicaid reform—and that is why Governor Sanford's Medicaid waiver proposal is so important. Only South Carolina—not bureaucrats in Washington—knows how to best serve South Carolinians on Medicaid.

Governor Sanford's Medicaid waiver empowers beneficiaries to tailor their own health care dollars to their own health care needs. Each Medicaid beneficiary will receive a Personal Health Account that they can use to fund their own health care in a variety of ways—either through Health Savings Accounts, by purchasing a managed care plan, by purchasing health insurance from their employer, or by joining a medical home network.

This choice not only turns beneficiaries from government dependents into empowered health care consumers—it also accomplishes the laudable goal of transitioning beneficiaries to self-sufficiency and independence through private coverage. Medicaid beneficiaries should have the same access to high-quality, private health insurance that we all enjoy.

Just like the welfare reform fight of ten years ago, there are critics that maliciously accuse Governor Sanford's proposal as "cruel" or "heartless." I reject that notion. Giving South Carolinians the opportunity to pull themselves out of poverty will work for them and it will work for Medicaid, just as it did for welfare reform in the 1990s.

Conclusion

Mr. Chairman, thank you for holding this hearing and for the opportunity to testify. The American Legislative Exchange Council is supportive of Medicaid reform and of the proposals contained in Governor Sanford's plan.

ALEC and I look forward to working with you in the days and months ahead to continue the national discussion of South Carolina's bold and innovative Medicaid proposal.

I would be pleased to answer any questions you might have.