GOVERNOR
ASA HUTCHINSON

FOR IMMEDIATE RELEASE
January 22, 2015

Transcript of Governor Asa Hutchinson's Healthcare Speech

LITTLE ROCK – Below is the transcript of Governor Asa Hutchinson's Healthcare Speech. The letter from HHS Secretary Sylvia Burwell is attached.

Governor Hutchinson speech on healthcare and Medicaid reform in Arkansas | January 22, 2015 | 10 a.m. | Jackson T. Stephens Neurosciences Institute, UAMS | Fred Smith Auditorium

Thank you. Thank you, Dr. Rahn for your introduction and especially for your leadership at the University of Arkansas for Medical Sciences and for this forum and this venue to talk about healthcare and its future in Arkansas.

I am delighted that there are a few people interested in this topic. The fact that you're here reflects the importance of this issue for our state, and I'm grateful for your presence here today. I'm particularly glad to see so many legislators that are in the room. I want to recognize Senator Jonathan Dismang for his leadership on the Senate side. He's been a great partner and leader in this effort as well as Speaker Jeremy Gillam. He's done likewise on the House side. He's been a major player in the development of this issue and will be in the future. I also wanted to recognize Senator Cecile Bledsoe, who is the chairman of the Senate Health Committee, as well as Representative Kelley Linck, chairman of the House Health Committee. They have played key roles as we look to this issue and the future. Thank you for your guidance on this issue.

I'm delighted today to introduce the new surgeon general of Arkansas, Dr. Greg Bledsoe. I'm a newly minted governor. He's a newly minted surgeon general. He just got sworn in about 30 minutes ago. Thank you for being here Dr. Bledsoe. You'll be a key advisor on healthcare.

I want to start by thanking the physicians, the nurses and healthcare providers who have labored in the trenches of healthcare in Arkansas, improving our quality of life, working with those who need care. You have been on the front lines. You are committed. You are passionate. And I am grateful for you. And that's important to say at the outset because you came out of your training with a heart for patients, and all of a sudden you find yourself inundated with government regulations and having to spend hours and hours each day and week on matters that do not deal with patient care. And so I am grateful for you. I'm thankful for you and your work, and your sacrifice needs to be recognized.

A college professor that I had always gleefully began each lecture with the phrase, "A moment of review, and then on we go." And that's important in history and it's important today. So I want to spend a moment in review and then we will talk about the future.

It all starts with the Affordable Care Act. The Affordable Care Act had four major parts. Very simply articulating it. One, it was the individual mandate that every person had to have insurance. Secondly, it was the employer mandate that employers in a certain category had to provide insurance. The third part of it was the health insurance exchanges in which middle-income earners and others could go in the marketplace and obtain insurance that could be subsidized with taxpayer money. The fourth part of it was the Medicaid expansion, which led us to the debate that we're having today.

I opposed the Affordable Care Act. I did because I thought the individual mandate was an infringement upon freedom. I thought the employer mandate was not good for business and the growth of jobs in America. I thought overall it was taking control away from physicians and healthcare professionals and got the government too much involved.

And guess what? I lost that debate. I urged that the law be challenged. And it was challenged and heard in the Supreme Court, and the Supreme Court, to our surprise, affirmed all of the Affordable Care Act except for one part — and that was the Medicaid expansion that was left to the states to debate and determine. And so all those who did not believe it was the right direction for America were left with the frustrating option of: What do we do with this?

Arkansas was at the center of this debate on Medicaid expansion. We came up with our own creative options, and this led to the Private Option solution. It was innovative, and I'll talk about that, but the solution of the Private Option has divided our state and dominated the political debate.

My nephews illustrate that. I have two nephews in the General Assembly. Both are conservatives. Both are thoughtful. One voted for the Private Option. One voted against it. Now, that could have been mirrored all across the legislature.

This morning, I want to share my perspective on the Private Option. I want to talk about its benefits, its future costs to the state. I want to talk about the profile of those on the Private Option, and then I want to talk about where we go from here.

Now I know you came here today to hear one simple statement as to where we go from here. Please be patient. Because the facts and the data are important as to the direction we'll go. I want to spend some time on the background of this, and the pros and cons, because it helps shape the debate for the future

Let's look at the Private Option. It is innovative. The sponsors of the Private Option legislation should be recognized for their hard work in fighting for a solution with market principles. There are conservative principles in play.

U.S. Supreme Court Justice Louis Brandeis, in a famous decision, described how the states are laboratories of experiment, laboratories of democracy, places to look at innovative ideas. That is appropriate and that's what we have done in Arkansas

But those who opposed the Private Option were just as equally committed. They had a different perspective. They were wise in asking questions about the costs. They were wise in wondering whether the federal government could keep its promises. And whether the state of Arkansas could afford this innovation and expanded healthcare.

Two sides of the same debate coming from good directions, conservative convictions, reaching different conclusions. I recognize that good people were on both sides of this debate and were struggling with how the state should navigate this issue.

Over time, it became clear once the Private Option had been implemented that there were two key benefits: One is the obvious. We have approximately 210,000 individuals in Arkansas who have never had health insurance before and now have access to healthcare and insurance. That is a benefit to the state of Arkansas. Secondly, you have a benefit to urban hospitals, such as UAMS, and rural hospitals all across this state. Those two benefits are facts that we cannot deny, should not deny, and should rejoice in.

The facts pertaining to those benefits are these: There has been a 10-percent drop in the uninsured in Arkansas; Arkansas hospitals saw a reduction of $69 million in uncompensated care during the first half of 2014 compared with the same period of time in the previous year. Many of these rural hospitals, by the way, are listening today to this by remote broadcast. I welcome them. I have been to your communities and understand what you have communicated to me as to the importance of the Private Option and the economic viability of the hospital that serves your community.

The number of hospital visits by uninsured patients fell by some 47 percent. These equate to greater financial benefits to our rural hospitals. The state has also been a beneficiary of the Private Option in terms of shifting more of the Medicaid costs to the federal government. It's still taxpayers' money. But it's been a shift of cost and a benefit to our budget.

In 2015, the state is going to save roughly $88 million, which is a combination of shifting traditional Medicaid in some categories to the Private Option, which is 100 percent paid for at the present time. It is also a savings because the reduction of uncompensated care payments to several agencies — from UAMS to the Department of Correction, the Department of Health, Community Health Centers — have saved the state about $33 million.

All of that is taxpayers' money. But it has been a benefit to the state of Arkansas in terms of our budget.

But the long-term costs and the funding remain legitimate questions. And the facts are that the required match of 10 percent for the Private Option, when it becomes the responsibility of the state, will cost the state over $200 million. To put that into context, that's two $100 million prisons. Now that doesn't get anybody excited. But that $200 million is almost one-third of the budget for all state higher-education institutions. And so there are budget consequences real to our institutions and other services.

And then there are unintended consequences to the Private Option. I don't know that anybody anticipated that parolees coming out of prison are put on the Private Option. That's a good thing. But it is not something that was talked about or we were aware of in the beginning. We were not aware that many charitable healthcare programs in this state would no longer exist. One was called Operation Walk, in which surgeons donated a weekend to provide free knee and hip surgeries to those who had no insurance and could not afford them. It is the finest tradition of the medical profession. Arkansas was among the nation's leaders in the number of free surgeries our doctors provided. This past December, there was no Operation Walk in Arkansas. Why? Because the Private Option made it unnecessary and irrelevant.

This story is the same across Arkansas. What once was done by medical volunteers was transferred to the government. Now some see this as a good thing, that the government can do it well. It takes the burden off our medical professionals who are volunteering so much time. Others worry about this shift to the government sector.

But most importantly as we look at the Private Option and the impact of it, whether you are for or against the Private Option, there is a deep and abiding concern for those without health coverage. In other words, the human side tugs at our heartstrings and rightfully is a factor in this debate.

Donna Foster is a 44-year-old mother of two who makes $8.65 an hour as a caregiver attendant for the elderly in Morrilton. She typically works 40 hours a week. She is a single mother. She divorced when her now-grown children were small. For at least 10 years, she could not afford health insurance.

Donna suffered from high-blood pressure. She was able to purchase generic blood pressure medicine, but she often could not afford the $186 it cost for an office visit and checkup. She suspected that her blood sugar was high. Donna was supposed to be tested for diabetes. She couldn't afford that either.

Recently, she secured health insurance through the Private Option. The first thing she did was go back to her doctor, get back on her blood pressure medication and get tested for diabetes. She tested positive, and now she is being treated for it. Health insurance made a difference in her life. And it most likely saved future medical costs to the state of Arkansas.

This debate that we are going through is not unusual in American politics: Do the benefits that we recognize exist outweigh the costs? While the question was basic, a divide was created in our state.

Over the course of the past two years, our state has been wrapped around the political axle. The phrase Private Option itself has become politically toxic, so much so that it's almost impossible to have a constructive conversation about healthcare reform without passions rising and folks taking sides.

Ladies and gentlemen, debate is good. Conviction is good. But let's remember what we are trying to do here — and that is to build a healthy Arkansas. Not to politicize a phrase to the point where its very utterance becomes an invitation to fight. My goal is to broaden the debate to the larger Medicaid budget.

To accomplish that, we have to reach agreement on a comprehensive reform that works for the state of Arkansas. The goal is to have affordable, competitive, market-based solutions on the conservative principles of choice, competition, improved quality of care and consumer responsibility. To accomplish that, we have to reach agreement. The challenge for us in Arkansas and in this political environment is that agreement is defined by three-fourths vote, or a super-majority, in the Arkansas General Assembly.

Now I mentioned the importance of the profile of those on the Private Option. I've talked about this a long time, and the information was not available until very very recently. Well, now we have some data to share:

About 40 percent of the enrollees, at the time of application for the Private Option, showed no income. That means they were unemployed.

Seventy percent of those on the Private Option were employed at some point in time, which tells me they were trying to get a job. That tells us that most are working but cannot find the steady work that is needed.

Young people were more likely to have work than those who were over 45.

Women were more likely to have work than men. This tells us that the older male population should be targeted for work. These might be men who've been laid off or who need to learn new skills to transition into another career.

It's interesting that 10 percent of those on the Private Option are considered medically frail. And that population seems to me, if the Private Option were to end, would qualify for traditional Medicaid.

This is all helpful information because it's the data that guides our debate.

Now let's talk about the future for a moment. A large point of what I'm trying to say is that the Private Option is a small part of the debate and a very large part of the discussion.

(Pie Chart)

Looking to the future. In 2021, when Arkansas pays 10 percent of the Private Option costs, which is over $200 million, that is the red part of the pie. That's been the focus of our debate. But look at the blue? How large that is. And this is the $1.8 billion that's devoted to our traditional Medicaid budget.

So if we're going to look at the future costs to this state, would it not be wise to focus on the entire pie?

If you combine the data of the profile of the participants with the knowledge that our future liabilities as a state are dependent on the entire Medicaid budget, then you have a starting point for future reform.

I believe that there are some principles that should frame the debate. One of them is work and responsibility. I want our social programs in Arkansas to be an incentive for people to work as opposed to an incentive for people not to work. Arkansans want to work. And when they work, they should get ahead. And when they work real hard, they should climb up the economic ladder. I believe the vast majority of Arkansans want to work. Nobody who's able to work wants to stay on government healthcare. They want a job. And while it's encouraging to see so many folks now insured who did not have health insurance before, I'd like to see us reduce that number. And we can reduce that number as we move people to work and they move up the economic ladder.

Secondly, we need to have incentives for preventive care. People need to own more responsibility for their healthcare decisions. They need to be engaged in preventive care.

We need to emphasize the role of the private sector and charity care. It is not any group's responsibility. It is all of ours collectively. And there is a role for charity care, too.

As a rural state, there has to be access to healthcare in the rural areas. And that involves telemedicine so we can make sure that those in the less-affluent areas of our state have access to the highest quality healthcare. Through telemedicine a knee or hip specialist or neurologist in Little Rock or Northwest Arkansas can be brought to somebody in the Delta. We can share our expertise across the state. We have to continue to use technology to assure quality healthcare.

Another principle that should guide us is cost control. Look at the history of the cost of our social programs. Fifty years ago this summer, the Medicare and Medicaid programs were signed into law by President Johnson. Nobody, not even conservatives, thought those two programs would grow so uncontrollably. In fact, in 1965, Medicare had been projected by a House Committee to cost $12 billion by 1990. What did it actually cost? $110 billion. How's that for government estimates?

Meanwhile, costs for individual and group insurance have skyrocketed. Many people cannot afford insurance and they go without health care. For that reason, some 60 percent of personal bankruptcies filed in this country result from medical bills.

Clearly, our healthcare system needs more attention and continued efforts at reform.

And finally, and very importantly, we need to have flexibility at the state level, the laboratory of innovation.

So today in Arkansas we are at a juncture. Which way do we go? We recognize the hospitals and healthcare providers cannot face a traumatic cliff every year when it comes to renewing the Private Option. We need more consistency. We need more reliability. We need more predictability. So that we can plan.

Secondly, we want to have a healthcare system that we can afford, that we know is not going to absorb greater and greater amounts of general revenues. We want to have a system that looks for a way to help those Arkansans who are covered by the Private Option and assure access to healthcare in the future for those.

We are Arkansans. And we look out for each other.

Just days after the election, I received a letter from a woman named Christine Smith, who lives in Fayetteville. Christine began: "I am writing to you as an Arkansan, but more importantly, as the mother of a 19-year-old son who has just been diagnosed with cancer."

Christine's son went in for a regular physician's visit when the doctor noticed that his neck felt a little swollen. They ran some tests and discovered that the boy had a tumor. They performed surgery to remove the tumor and followed up with treatment.

It worked. Christine's son is now finished with his treatment. He's feeling well. And he's now a student at the University of Arkansas studying environmental science.

When I received Christine's letter and heard this story, I immediately thought she must have been insured through the private option as she urged me to keep it for the "health of the citizens of Arkansas."

But the Smiths already had insurance. She was writing because while she was going through this ordeal she "couldn't imagine how families do it who don't have coverage." That's just like an Arkansan — to think about others.

I want to assure Mrs. Smith, and all Arkansans, that I want us to have a system that is compassionate, affordable, fits Arkansas and provides access to care.

I agree with you, Christine.

And now is the time for me to be more specific. As governor, I will ask the legislature to take the following action:

First of all, to fund the Private Option this fiscal year and continue it through December 31, 2016. This avoids harm to the 200,000-plus on the Private Option and it assures our hospitals and provides of financial stability.

Secondly, I'm asking the legislature to create a Health Reform Task Force that will make recommendations for the future. And the purpose of this task force is to find an alternative health coverage model to ensure healthcare services for vulnerable populations currently covered by the Private Option.

So hear me clearly. We're going to continue the Private Option through 2016 and create a Health Reform Task Force that will make recommendations for the future. And that will include a compassionate and reasonable cost-effective response for care of those currently on the Private Option.

The task force should also be charged with exploring and recommending to the Legislature options to modernize the entire Medicaid program currently serving the indigent, aged and disabled.

Guidelines should govern any task force. The guidelines I would suggest to the Legislature should include, among others that they very well may add:

- *Minimize or eliminate the need to raise additional general state revenues for continued investment in this. Obviously, you'll want to adjust for inflation but you want to minimize or eliminate the need for the state to raise additional general revenues.*

- *More flexibility for managing the state Medicaid program. Flexibility is critical. We fought for that. We want to continue to fight for that. Including consideration for block-grant type waivers or authority so that we can have the maximum amount of flexibility in Arkansas.*

- *Strengthen the employer-sponsored health insurance market.*

- *Increase employment of healthy recipients of taxpayer-funded healthcare services. Encourage work as they receive that benefit. Increase accountability and personal responsibility.*

- *And, finally, provide access to health services in rural areas of the state.*

These are some of the guidelines that should govern the task force as it goes to work. The timing of this task force is urgent. It's critical. And it's got to move quickly, although thoughtfully and comprehensively. A report will be required from this task force by the end of 2015. They go to work, and by the end of 2015, we've got to have some answers back and some recommendations because we need to allow time for legislative action so that we will have clear direction for our hospitals, our providers, and those who are currently covered. This would allow time to request waivers and necessary approvals from the federal government as well.

We should have our solutions in place by December 31, 2016. I will further direct the Department of Human Services to immediately begin an assessment of opportunities to reform our Medicaid services to better serve our high-cost, high-need populations. And, secondly, to utilize private sector expertise to identify and prevent waste, fraud and abuse in our Medicaid services.

This information from the Department of Human Services will be beneficial to the legislative task force. Data will drive solutions.

Now let me emphasize: In regard to the Private Option, it is time to close this chapter and to start a new one. It is a new day for healthcare in Arkansas. I pledge to work with you to find the right solution for all of Arkansas. And while we are turning the page, and beginning a new effort, our innovative efforts in Medicaid reform will continue.

I want to end by talking about the recent meeting that I had with Health and Human Services Secretary Sylvia Burwell in Washington, D.C. This was an important meeting. And as we met with Secretary Burwell, we made the case that we needed more flexibility in Arkansas to determine our own direction.

Earlier today, I recieved a letter from Secretary Burwell. In summary, she says "I was pleased to learn of your commitment to an effective and affordable approach to coverage for the newly covered adults beyond the current three-year term of Arkansas's Health Care Independence Program demonstration for Private Option and to also move forward on major delivery-system reforms that would apply to the larger Medicaid population."

She goes on to say, "We also understand your desire to encourage employment, and we commit to work with you on how you might achieve this objective while ensuring access to health coverage to eligible individuals." She goes on to say, "We appreciate and support your desire to avoid a piecemeal approach to reform and look forward to working with you on a potential, broad block of changes that could lower costs and improve access and quality in ways that best meet the needs of your state."

I'm gratified that there is an increasing willingness to give the state flexibility.

I noticed that there was not resounding applause at any point during the speech, and I think that simply means that we recognize how important it is.

We're going to do something great for those in need of healthcare. We're going to set the stage.

I'm an optimist. I'm an optimist that the people in this room will work together to do great things.

Thank you.

Contact: J.R. Davis (JDavisAR@gmail.com or 501.353.5297)

###