



Medicaid Reform: Mending the Holes in Pennsylvania's Health Care Safety Net

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Medicaid Reform:

Mending the Holes in Pennsylvania's Health Care Safety Net

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Introduction

Medicaid, the joint federal/state program that was created to provide health care for the poor, celebrated its 40th birthday in 2006. There was no party for the program, however.¹ In Pennsylvania and around the nation, Medicaid is growing at an unsustainable rate and threatens both state and federal budgets. Medicaid represented 2% of Gross Domestic Product (GDP) in the year 2000 and is projected to rise to 9% by 2075.² This, combined with unfunded liabilities in Social Security and Medicare, will require a devastating doubling of federal taxes and enormous increases in state funding.

Indeed, Medicaid is now larger than education—and any other program—in many state budgets, including Pennsylvania's.³ Over the last 25 years, Pennsylvania's Medicaid spending increased approximately 8% annually, versus approximately 6% for overall medical spending.⁴ In 1980, Medicaid represented around 12% of the state budget. As of 2007, that total had increased to almost 26%.⁵ At this rate of growth, Medicaid will consume 94% of the Pennsylvania budget in the year 2075!⁶

Unfortunately, the enormous fiscal problems facing Medicaid often overshadow its other major flaw: a well deserved reputation as a low-quality provider of health care. The program delivers episodic treatment, provides poor preventive care, and offers low-quality services to many beneficiaries. The plan produces some tragic health outcomes for America's most vulnerable populations.⁷ It is routinely abused by both providers and beneficiaries. This ranges from Medicaid "mills" to outright theft. There have been estimates that as much of 40% (over \$100 billion) of Medicaid spending involves abuse and fraud.⁸

How did a well meaning government program that attempts to provide quality health care for the poor end up as a bankrupt plan that delivers poor-quality care? While the problems facing Medicaid are complex, the root of the problem is simple: There is no real marketplace for the vast majority of health care in the United States. When buyers have no incentive to economize and sellers have no incentive to be efficient, any product or service will face ever-escalating costs. This is the fundamental problem of Medicaid, Medicare, and much of the private medical sector. Failure to design a program that maximizes incentives to be cost-efficient dooms that program to failure.

What's Wrong with Medicaid?

Medicaid is intended to serve those who fall between the cracks in our health-care system, providing medical services and care to three major groups: acute care for the poor and near-poor, the disabled population, and long-term care recipients. These groups have difficulty obtaining affordable coverage in the traditional health market because of their low incomes and, in some cases, the chronic nature of their health needs. Unfortunately, a system that bankrupts the Commonwealth of Pennsyl-

vania and the federal government while providing low-quality care serves no one's interests. Medicaid must be rebuilt on a sound fiscal foundation.

But first, the problem must be properly diagnosed, and the fundamental problem of Medicaid lies in its flawed design. Medicaid does not rely on buyers and sellers acting in their own interests in a decentralized marketplace, but instead uses an “administered pricing” system. That is, the “prices” that Medicaid pays for services to its enrollees are determined not by the marketplace but by various politically dictated schemes, and all such schemes are fundamentally flawed due to the “knowledge problem.”

What is the knowledge problem? In order to know where resources should be directed, price setters need to know both what goods and services people want and how those goods and services can be most cheaply produced and/or supplied. But this knowledge is held only in the minds of individual consumers, businesses, and providers, not in the filing cabinets and computers of a government planning agency such as Medicaid. The only practical way for consumers and providers to relay this knowledge to each other is through a decentralized system of market-determined prices.⁹

Instead, a cost-based formula in which government planners decide the “right” cost for things is often applied to care provided under the Medicaid system. For example, nursing homes may receive a bureaucratically dictated reimbursement, which likely bears no relation to the *actual* cost of nursing home care, and the resulting disconnect removes the traditional market incentive to economize, creating distortions in the cost and supply of care. An unrealistically high reimbursement, for instance, encourages heavily leveraged facilities with high operating costs, resulting in an excess of nursing home capacity as marginal providers are subsidized rather than allowed to fail as they otherwise would in a free market. Ultimately, the quality of care suffers and costs increase across the board as a glut of substandard, tax-supported providers proliferates.

To re-emphasize, it is important to note what happens when the administered price for care does not reflect economic realities. If the price is set too high, there will be surpluses and excess capacity charged to taxpayers. If the price is set too low, there will be shortages and a lack of services. Since both Medicaid and Medicare use administered pricing schemes, and these programs represent such a large share of the health care market, the entire system is rendered economically inefficient, ultimately resulting in substandard levels of care.

The perverse incentives in the “cost-plus system” described above were supposedly addressed in 1983 when hospital reimbursements were switched to “prospective payments.” In theory, these payments were a fixed reimbursement-like price that would encourage providers to deliver services more efficiently. In reality, the government simply switched from one administered pricing scheme to another. Hospitals under Medicare and Medicaid are now compensated with a Diagnosis Related Groups (DRG) payment system whereby consultants to Medicaid determine appropriate DRG rates for various services and procedures around the state.¹⁰ Unfortunately, the DRG payment system, like other Medicaid pricing schemes, suffers from the same flaw: That is, administrators and their consultants can never know the “correct” price for a bypass in Erie or an appendectomy in Beaver. Only a decentralized market with free, independent buyers and sellers can determine accurate prices. Since the DRG rates set by Medicaid are almost all certainly “wrong,” the impact on the health-care system is again to produce surpluses, shortages, inefficiency, and substandard care, including failure to treat illnesses properly as well as long waiting times for receiving services.¹¹

Payments to physicians are also calculated under an administered price scheme called Resource Based Relative Value Scale (RBRVS), or some variant of this method.¹² Developed by researchers at the Harvard School of Public Health, RBRVS is based on a point system involving how much physical and mental effort a physician expends providing a particular service. Leaving aside the impossibility of actually being able to measure such things, payments calculated under RBRVS also neglect how much demand exists for various services. This scheme is nothing more than a variant of the long-discredited “Labor Theory of Value” espoused by Karl Marx.

Another outcome of reimbursements being set too low is cost-shifting to those paying for health care outside the government-controlled programs. When Medicaid providers are paid below-market rates, they attempt to offset this loss by increasing rates to private payers. This has the impact of making Medicaid (and Medicare) look cost-effective relative to the private sector as Medicaid managers produce data that show their costs increasing at a lower rate than the private sector in the last few years.

These assertions, however, are extremely misleading. Part of Medicaid’s “plan” for dealing with its budget problem has involved freezing payments to providers. This results in (1) low-quality or even no care for beneficiaries and (2) price inflation in the private sector due to cost shifting. The Lewin Group researched stingy government payments and the possibility of cost shifting and found that low public reimbursements correlated about -.75 with private payment ratios. This research indicates that Medicaid’s “low cost” is actually a catalyst of medical price inflation in the private sector. It is important to understand that reforming Medicaid so that the plan pays actual market rates will produce benefits through reduced private-sector cost shifting.¹³

Medicaid also asserts that its overhead rate of about 4% compares favorably to the private sector. Profits to private insurers and HMOs are considered an excess cost that is avoided by public provision of services to Medicaid beneficiaries. The logical end of this line of thinking is to nationalize all of our industries to get rid of “wasteful” profit overhead. The reason Medicaid’s effective overhead rate seems low, however, is that many of the costs of running the program are simply passed on to providers. For example, a drug/alcohol center director recently informed the author that he must wait approximately six months for reimbursements from Medicaid. Additionally, if the center provided \$1 million in services, it would be forced to carry \$500,000 in accounts receivables. This gentleman is essentially operating a bank that lends to Medicaid in addition to running a rehab center.

Medicaid also involves significant tax revenue and budgeting and auditing costs that show up under spending for different agencies and governments; additionally, there are substantial compliance costs placed on providers in terms of time and overhead needed to meet the paperwork burden imposed by Medicaid. Medicaid in its current form imposes even further costs in unnecessary utilization and reduced quality. Since a large portion of Medicaid is fee-for-service, with very little or no cost sharing, the result is a significant increase in the demand for health care services. Furthermore, setting payment levels that are too low to providers produces either reduced quality of care or outright shortages of services. In addition, the excess burden of the income taxes used to finance all or part of Medicaid may be over 20%.¹⁴ When all of these and other costs of the Medicaid design are factored in, the program has substantially higher overhead than the private sector. One estimate placed the effective overhead as much **two-thirds higher than private insurance**.¹⁵

In an effort to control rising costs, many state Medicaid plans have attempted to enroll benefi-

ciaries in managed care plans. The supposed advantage of managed care is that it is prepaid, so the provider has an incentive to eliminate unnecessary care. In reality, there are substantive problems with this type of health plan. While federal law requires that beneficiaries be given at least two choices in managed care plans, often there is little effective choice for beneficiaries (see the section on TennCare, below). Furthermore, the plans' "choices" are usually determined by selective contracting. Essentially, bureaucrats decide which managed-care plans get the business, resulting in an intensely political process. The selected plans know that their real "customer" is the government, not the beneficiaries. And often what the government wants is to spend very little on effective health care. The result is poor quality.

Another problem with managed care plans is that many state Medicaid programs mandate a broad package of benefits. On paper, they are often more generous than private health plans. Medicaid then determines a per beneficiary premium that the plan will receive. This, as with DRG and RBRVS payments, is established bureaucratically. As would be expected, it can become a balancing tool for states when budgets are tight, as happened in the early part of this decade in numerous states. When budgets are tight, states often cut Medicaid reimbursements to managed care providers but usually do not change the required package of services.¹⁶ The result is rationing of care despite bureaucratic attempts to maintain quality. In the worst case scenario, the plans simply leave the market.¹⁷

The current Medicaid system is an inherently inefficient program because it relies on administered prices as opposed to a free, decentralized marketplace. No government has ever been able to effectively set prices for anything, and health care is no exception. The result of this system is provider inefficiency, explicit and implicit shortages of health care, and higher private sector medical inflation. Unless the system is drastically reformed, the long run budgetary impact on the Commonwealth of Pennsylvania will be nothing less than dire.

Fixing the Problem

The solution to quality and cost problems in government-run plans like Medicaid and Medicare, as well as plans in the private sector, involves opening the markets and leveling the playing field. For example, employers could band together and create "insurance exchanges" where employees can choose from numerous competing plans. Employers would provide funding for employees to spend at these exchanges. This line of thinking is also the solution to the problems Medicaid confronts.

States should create insurance and provider exchanges for the provision of services to beneficiaries. Unlike the current price control system, **those eligible for Medicaid will receive risk-adjusted credits to purchase services from competing plans.** This would turn Medicaid into a real market in which buyers act in their own interest and providers compete to enroll beneficiaries and would also produce gains in efficiency that would make Medicaid sustainable in federal and state budgets and, just as importantly, improve the quality of health care that beneficiaries receive.

While this exchange model may seem worlds away from Pennsylvania's current Medicaid program, it is a realistic reform within our grasp. The state of Florida received approval from the federal government to begin converting their Medicaid plan to an exchange model. In its early stage, these reforms are working well. It is time for Pennsylvania to look to bold reforms for Medicaid along these free-market lines.

Medicaid Reform: What Are Other States Doing?

The Commonwealth of Pennsylvania is looking for ways to deal with the dual Medicaid challenges of unsustainable spending growth and low-quality service. One area that legislators should investigate is the types of reforms that have been initiated in other state plans. These reforms offer Pennsylvania a framework for not only improving its plan but also for avoiding bad policy decisions. The physician's dictum of "first, do no harm" certainly applies to reforming the complex Medicaid system. Below is a discussion of various Medicaid reform plans that Pennsylvania policymakers may wish to consider—and some they should reject. The latter are detailed first, below.

What Not to Do: TennCare

TennCare, a dramatic alteration of Medicaid, was quickly passed by the Tennessee legislature and signed into law in 1993 by then-Governor Ned McWherter with very little in the form of legislative hearings and public comment. The plan received a five-year federal waiver from the Health Care Financing Administration (HCFA), the federal agency that runs the Medicare and Medicaid programs, and took effect in 1994. This waiver permitted the state to leave the Medicaid program but use that money to fund TennCare. The federal government required the state to expand coverage to all Tennesseans who qualified for Medicaid, plus the currently uninsured and uninsurable. TennCare covered 1.1 million people: the 766,000 residents then enrolled in Medicaid and an additional 340,000 who were uninsured or uninsurable. Today, it covers 1.3 million people—about the same number of Medicaid-qualified residents, plus 550,000 others.

TennCare did not go through a normal legislative process to give proponents and opponents, special interests, and the public an opportunity to comment on it and allow the legislature to make needed changes based on that information, and this rush to "do something" was unfortunate. Legislators had hoped that, by enacting TennCare, the state could offer one health insurance safety net to cover all poor or uninsured residents at a lower cost than the state would spend on Medicaid.

Governor McWherter and supporters of TennCare in the legislature—such as President Clinton and congressional supporters of his plan—argued persuasively that the state's current patchwork health insurance system was expensive and inefficient. According to the governor, the key to improving the problems was to shift everyone into managed care and provide close government oversight. The seductively simple theory was that, once the state controlled the money and the care provided, existing inefficiencies would disappear. Everyone would be covered, and the state would spend less.

But TennCare has been a failure. On November 10, 2004, current Tennessee Governor Phil Bredesen announced, "I have set in motion a process to dissolve TennCare and replace it with a traditional Medicaid program." The governor estimated that 430,000 low-income Tennesseans could lose TennCare coverage if the state eliminates the eligibility expansions instituted under its TennCare waiver and reverts to a more traditional Medicaid program. What happened, and how can Pennsylvania avoid these unfavorable results?

To start, TennCare's philosophy flowed from the failed Clinton national health plan, which would have set up a "managed competition" system. Under this system, consumers would purchase prepaid coverage from competing managed care firms for a basic package of benefits, as opposed to networks of providers who provide discounts to buyers. (Prepaid plans have an incentive

to reduce unnecessary medical utilization since the savings flow to their bottom line, whereas networks are still essentially fee-for-service plans.) The ability of consumers to switch to alternative coverage plans would supposedly create a real market in which providers would innovate to provide better quality care and lower cost delivery systems (or risk losing customers). Initially the lower costs would be reflected as higher profits, but competition would ultimately force these efficiency gains into lowered medical cost inflation.

In reality, TennCare, like the Clinton plan, was flawed from the start. First, the plan did not make adequate provisions for promoting managed competition in rural areas. The impact of this was essentially no competition in some parts of the state. Second, the plans were “one size fits all,” with all beneficiaries receiving the same package of benefits despite the enormous variability of needs within the Medicaid population. This redundancy, along with lack of specialization and division of labor among providers, limited the ability of the marketplace to innovate and deliver quality care more efficiently over time.

Another flaw in TennCare was its overly generous benefits package. Tennessee made TennCare a very attractive plan, including, for example, prescription drug coverage, which was quite uncommon at the time. Since the plan was open to anyone who was uninsured, many signed up. This forced the state to limit enrollment of high-risk beneficiaries because of higher-than-projected costs.

And finally, payments to providers were not adjusted for the marginal risk of each beneficiary in the acute care and behavioral health groups. This is a prescription for adverse selection, with providers preferring to enroll healthier beneficiaries; even though such “cherry picking” among beneficiaries is forbidden, there clearly are attempts to do so, such as by directly contacting potential beneficiaries and offering services above the basic benefits package that appeal to healthy individuals. While risk adjustment may have been a slight issue at the onset of TennCare, rapid developments in risk-adjustment software now make this practice readily available to all state Medicaid plans.¹⁸

Not Learning from TennCare: Vermont

Although the lessons of TennCare were instructive, some states failed to learn. Vermont implemented very generous eligibility provisions with coverage for children up to 300% of the poverty level, 185% for their parents, and 150% for childless adults. The state has agreed to a federal funding cap based on its belief that it can control spending. The mechanism for this is the establishment of a state-run managed care organization (MCO), which is an expansion of an existing demonstration project.

In effect, Medicaid acute care will be delivered via payments to a state monopoly MCO. Although the Vermont plan does provide for subsidies to low-income workers through employer-purchased insurance plans, it seems highly unlikely that this scheme can produce delivery innovations needed to curb the long-term growth rate of Medicaid. Given the funding cap, Vermont may face additional Medicaid costs, requiring both more state funding and matching federal dollars. The likely outcome of this plan, as with existing single-payer schemes like Canada’s, is artificially low capitation payments that produce low-quality care and outright rationing.¹⁹

What Not to Do, Part II: Maine's Dirigo Plan

Maine's Dirigo Plan, passed into law in June 2003, has been hailed by some as a major step forward in health care insurance coverage. In reality, it is another pitfall that Pennsylvania and other states should avoid. The plan vastly expanded Medicaid, set up a government-run health insurance plan for the small group market, and imposed significant new health care regulations. Medicaid was already a major expenditure for the state in 2003: It covered over 200,000 residents—approximately 20% of the population. In the previous 10 years, the plan's expenditures had grown at almost 10% annually.

The Dirigo Plan expanded coverage to childless adults with incomes up to 125% of poverty level and parents with incomes up to 200% of the poverty level. It was estimated that 78,000 new beneficiaries would enroll because of this expansion, an increase of over 33%. By leveraging federal matching dollars, Maine officials asserted that the plan was budget-neutral. The enrollment changes would give Maine the highest Medicaid enrollment percentage in the country. The plan was enacted, amazingly, against the backdrop of a budget shortfall of over \$1 billion.

The effects of the Dirigo Plan on Medicaid were predictable. The enrollment expansion was much larger than anticipated and, given a limit on federal matching funds under the waiver for the plan, Maine placed a cap on enrollments of childless adults. In addition, the state placed limits on coverage to this population. State Medicaid spending increased from \$540 million to \$725 million in two years, even without full expansion of enrollment eligibility. This growth rate of 16% is astonishing. Combined with the effective state monopoly in providing health care coverage in the small group market, the Dirigo Plan is expected to blow a huge hole in Maine's budget in the near future.²⁰

Maine's response to the plan's failure was to expand it. Under a new "Dirigo 2.0" plan, Maine will put even more funding into this failed plan. According to the Maine Heritage Policy Center:

The Administration proposes to eliminate the controversial Savings Offset Payment in favor of three new taxes. The taxes include a new premium tax on HMO health insurance products, a new tax on inpatient hospital costs, and a new insurance mandate tax. The taxes are proposed to begin next year and total \$67.75 million per year.

"I find it troubling that in order to protect a political pet project like Dirigo Health, the Governor proposed to increase health care costs, increase health insurance costs, and raise taxes," said Tarren Bragdon, director of health reform initiatives for The Maine Heritage Policy Center. "As costly and ineffective as the original Dirigo Health was, Dirigo 2.0 is much worse."

Dirigo Health has failed to meet its stated goals of eliminating all the uninsured by 2009 and has cost Mainers tens of millions of dollars. It is time to move beyond the proven failure and enact proven reforms that will lower health insurance premiums and save taxpayers money.

In addition to the new taxes in the proposal, Dirigo 2.0 would institute a new purchasing mandate on Maine residents and small businesses. The mandate would require all residents earning over 400% of the federal poverty level, or \$40,800 for an individual, to purchase health insurance. The Maine Heritage Policy Center has urged policymakers to use caution, especially when state regulations already have helped make health insurance premiums in Maine among the most expensive in the nation.

"Maine health insurance premiums are some of the most expensive in the country due to excessive government regulation. Apparently, Maine residents were not interested in buying Dirigo Choice voluntar-

ily, so the Governor’s solution is to mandate that they buy it or pay a fine. Now, the government wants to force Mainers to buy health insurance products that have, through state regulations, been made artificially expensive,” said Bragdon. “This seems to me to be a very troubling and perverse policy proposal.”

The policy answers that will lower Maine’s high health insurance premiums, The Maine Heritage Policy Center contends, are located in some of the best practices being implemented in other states. While the sale of health insurance policies is universal in most states, the regulations that ultimately dictate the price the consumer pays greatly varies depending on the residential jurisdiction.

Stated Bragdon, “The answer to making health insurance more affordable is by giving individuals more private insurance options and allowing more affordable products to be sold in Maine. The elimination of certain state-imposed regulations on health insurance will allow Mainers to purchase more affordable health insurance.”²¹

Pennsylvania needs to avoid these types of public policy disasters. Instead of expanding the government role in health care, the Commonwealth should move to promote competition and free enterprise in both Medicaid and the small group insurance market.

Balancing Medicaid Expansion with Benefit and Administrative Changes

The states of Iowa, New Mexico, Oklahoma, Utah, and Arkansas have used federal Section 1115 waivers to expand Medicaid coverage. Under the original interpretation of these waivers, the cost to the federal government could not increase, so adding recipients would be financed by benefits package reductions and innovations in lowering delivery costs. These changes rely on a host of financing mechanisms to expand enrollments to the near-poor.

Iowa

Iowa, for example, negotiated a change in its intergovernmental transfer system that qualifies it for more federal matching dollars. The state will use the revenue to expand coverage for adults aged 19 to 64 who are at or below 200% of the federal poverty level (FPL). A useful reform from the waiver is the allowance of higher criteria for admission to nursing homes in an effort to encourage enrollment in lower-cost home care programs.

New Mexico

New Mexico established a program in which the state contracts with managed care plans to provide coverage to lower income workers. The five-year demonstration program, which began in July 2005, is expected to provide health care coverage to an estimated 40,000 uninsured adults aged 19 to 65 with incomes below 200% of the FPL. Uninsured parents of children covered by Medicaid or the State Children’s Health Insurance Program (SCHIP), as well as childless adults ineligible for Medicaid, are eligible for the new program.

Employers pay \$75 per person per month. No premiums are required from participants with incomes up to 100% of the FPL (\$9,570 in 2005; \$19,350 for a family of four). Individuals with incomes above the FPL pay monthly premiums of up to \$35, based on income. Participants are subject to co-payments on a sliding fee scale based on family income, with out-of-pocket charges limited to 5% of family income. The co-payments range between \$5 and \$30 for specific primary care services. For example, an individual with annual income of \$14,355 (150% of FPL) pays \$5

for a doctor visit, or \$25 per admission for hospital inpatient care.

The benefit package includes primary and specialty care; inpatient and outpatient hospitalization; physical, occupational and speech therapy; behavioral health and substance abuse services; and pharmacy, lab, and x-ray. Medicaid benefits such as optometrists, podiatrists, dental, dentures, and eyeglasses are not covered. Also not included are long-term care, personal care services, transportation, case management, hospice, or ICF/MR services. The plan is funded by unused monies from SCHIP and the regular federal match, which in New Mexico is 75% for its Medicaid plan.

Oklahoma

A similar plan has been adopted in Oklahoma. The state expects to enroll between 50,000 to 70,000 Oklahomans in O-EPIC. O-EPIC is open to employers with 25 or fewer workers, including companies that currently offer health insurance. Workers and spouses are eligible if their income is at or below 185% of the FPL. Costs are covered by employer/employee contributions, state general fund revenues generated by the tobacco tax, and federal funds.

Employers must contribute 25% of the monthly premium; employees pay up to 15% of the premium, not to exceed 3% of household income. Employees also pay applicable deductibles and co-payments, but out-of-pocket annual maximum requirements cannot exceed \$3,000. The maximum annual deductible for pharmacy cannot exceed \$500; an office visit co-payment cannot exceed \$50. An employer's plan must cover a minimum of hospitalization, physician, and pharmacy services.

The initiative also includes a Public Product Health Care Plan (state-sponsored insurance) for self-employed persons, unemployed persons currently seeking work, and workers not eligible to participate in their employer's health plan or whose employer does not offer a group health plan. Another part of the plan offers coverage to disabled low-income workers with incomes above Medicaid eligibility but no more than 200% of the FPL. Persons in both categories are able to buy coverage directly from the state under this program.²²

Utah

The Utah waiver was, until recently, the most innovative of the state Medicaid reforms. The reforms were undertaken by then-Governor Michael Leavitt, now Secretary of Health and Human Services in the Bush Administration. The state set up a Primary Care Network (PCN) for persons whose incomes are less than 150% of the FPL and a related Covered at Work program for low-income workers eligible for but not participating in a company health plan. The PCN inducement to uninsured adults is an annual fee of \$50 or less, based on income, and low co-payments for services, while Covered at Work provides up to \$50 annually as a stipend for low-income workers to participate in an employer-sponsored health plan. PCN is open to adults aged 19 to 64 who have no health insurance and do not qualify for Medicaid, and whose incomes do not exceed 150% of the FPL.

The PCN emphasizes primary and preventive care by offering limited coverage, with a goal of reducing acute care hospitalizations and emergency room visits. Coverage includes primary care provider visits; up to four prescriptions a month; dental exams, x-rays, and cleaning and filling; one eye examination a year; laboratory services and x-rays, and some emergency room visits and

emergency medical transportation. Immunizations and screenings, such as mammograms, are other features of the plan. Examples of co-payment amounts include up to \$5 for a visit to a primary care provider, for immunizations, and for eye examinations.

Covered at Work combines employer, employee, state, and federal funds to provide private health insurance to those who are not eligible for PCN and cannot afford to enroll in insurance plans offered through their employers. Also, workers already participating in an employer-provided plan who pay more than 5% of their income for coverage can switch to Covered at Work.

A key feature of the reform is the increased flexibility given to Utah to fund the Medicaid expansion, with new service limits on some current participants. For example, for certain adults enrolled in Medicaid, hearing and speech therapy services were no longer part of the state plan benefit package, podiatry was limited to essential procedures, and dental services were limited to relief of pain and infection.

Arkansas

In March 2006, the Centers for Medicare and Medicaid Services (CMS) approved the Arkansas plan to expand coverage to up to 50,000 uninsured adults over a period of five years. This plan targets small to medium-sized employers—those with fewer than 500 employees that have not provided group health insurance coverage to employees in the last year. The Arkansas Safety Net Benefit Program, a HIFA 1115 waiver, offers qualifying employers the opportunity to participate in the program. The program provides limited coverage to adults who work for a participating employer. The state will use Title XIX and Title XXI funds, as well as funds from the state tobacco settlement and fees from participating employers to finance the program.

Arkansas will use Title XXI funds to cover approximately 30,000 parents and spouses of Medicaid and SCHIP children. The state will use Title XIX funds to cover 20,000 childless adults and spouses between 19 and 64 years of age with incomes up to 200% of the FPL. Adults covered through the program will receive a limited benefit package, which the state expects to cover most basic health care needs of the target population. The benefit package includes six outpatient visits per year, seven inpatient acute care hospital days per year, two outpatient hospital services per year, and two prescription drugs per month. In addition, the program will extend certain services including smoking cessation and other preventive services to enrollees. Enrollees in the state Connect Care 1915(b) program will transition to the new HIFA program, but their benefits and service delivery will not change.

Enrollees will be required to pay a portion of their health care costs, including a monthly premium of up to \$15, a \$100 deductible, 15% co-payment for all services except for pharmacy services, and a \$1,000 out-of-pocket maximum per year. The state will solicit competitive bids from private insurance companies to offer the safety net benefits to employers that elect to participate in the program. Employer participation is voluntary; however, the state will require participating employers to achieve coverage among 100% of employees.

The program will be rolled out in two phases. The first phase began in early 2007 and was limited to 15,000 enrollees. The state will modify the program based on experiences in Phase I, and in Phase II, enrollment levels will likely increase.

The state anticipates that this program will reduce the uninsured rate by 4%. CMS requires

that the state address in its quarterly reports the state progress towards reducing the rate of uninsured. In addition, CMS requires the state to monitor any changes in employer-sponsored insurance that may result from the HIFA waiver.

All of these proposals suffer from expanding the role of government in providing health insurance. But the Utah plan in particular was important in that it showed the federal government's willingness to provide flexibility in altering the benefits package for those currently eligible for Medicaid.²³

Real Reform I: Idaho, West Virginia, Kentucky

Idaho

Idaho joins a small group of states that are taking advantage of new federal flexibility (afforded by the Deficit Reduction Act of 2005) that allows states to modify their Medicaid programs. The Centers for Medicare and Medicaid Services approved Idaho's groundbreaking reform plan in May 2006 and gave the state approval to target specific benefit packages to specific categories of enrollees, resulting in different benefits for children, people with disabilities, and dual-eligible beneficiaries. Among the state's goals for the reformed Medicaid program:

1. Encouraging prevention and wellness to improve enrollees' health and reduce future costs;
2. Promoting responsible use of the health care system to reduce unnecessary services that are often costly; and
3. Using limited resources wisely and investing carefully in targeted services to achieve long-term savings.

To accomplish these goals, the Idaho Department of Health and Welfare will deliver targeted benefit packages to people based upon their similar health care needs. Enrollment in one of the targeted plans is voluntary, and enrollees can opt out of one of the plans at any time and return to standard Medicaid. The three targeted plans include:

Benchmark Basic Plan: Serves healthy children and adults and covers cost of standard Medicaid benefits, except long-term care, organ transplants, and intensive mental health treatment. Children under 19 continue to receive all of these and other benefits through a mandatory feature of the Medicaid program. The goal of this plan is to achieve wellness by emphasizing prevention and proactively managing health. One feature of this program includes incentives for healthy behaviors, including an option to set up a personal health account.

Enhanced Benchmark Plan: Serves individuals with more complex health care needs, such as the elderly and disabled. This plan covers all the traditional Medicaid benefits, including long-term or institutional care. Individuals who are covered in the Basic Plan but need additional benefits that are not covered are transferred to the Enhanced Plan.

Coordinated Benchmark Plan: Serves Medicaid enrollees who are also eligible for Medicare. This group is required to enroll in the Medicare outpatient coverage plan, or Part B, as well as the new prescription drug benefit, or Part D. The goal for this program is to finance and deliver cost-effective individualized services integrated with Medicare coverage.

Under the State Plan Amendment, certain individuals are responsible for premiums and co-

payments, depending on family income. All of the new benefit packages listed above include some new benefits, including preventive and nutrition services and preventive health assistance to help certain individuals, such as the obese and smokers, to adopt healthier lifestyles.²⁴

West Virginia

In May 2006, the Centers for Medicare and Medicaid Services approved West Virginia's request to modify its Medicaid benefit package for certain enrollees. The West Virginia State Plan Amendment provides enrollees with a basic plan, which includes all federal and state mandatory services, or an enhanced plan that offers additional health care services to members who elect to sign and comply with a member agreement.

The agreement outlines member rights and responsibilities. Members who choose to sign the agreement must agree to several conditions, including:

1. Going to a medical home for check-ups;
2. Arriving on time for check-up appointments; and
3. Using the hospital emergency room for emergencies only.

In exchange for signing the member agreement, these individuals receive a richer package of benefits. For example, under the enhanced benefit plan, adults have coverage for chiropractic services, cardiac rehabilitation, smoking cessation programs, diabetes care, emergency dental services, and limited chemical dependency and mental health services—all services not covered under the basic plan.

The HMO or medical home monitors the extent to which members are fulfilling their responsibilities. Remaining in the enhanced category requires meeting the following four responsibilities:

1. Screenings as directed by the health care provider;
2. Adhering to health improvement programs as directed by the provider;
3. Keeping appointments; and
4. Medication compliance.

If a member does not comply, he or she is moved to the basic benefit plan, although members have an opportunity to appeal this decision. After one year in the basic plan, enrollees have an opportunity to sign the member agreement and re-enroll in the Enhanced Plan. In other words, there will be movement between the benefit packages, and this will be determined by member compliance as well as a member's decision to sign the agreement.

The plan is being phased in gradually throughout the state, and eventually it will operate state-wide for eligible members, which will include healthy children and healthy adults on Medicaid. In addition to the specified services, enrollees will receive wrap-around or additional benefits for people under age 19 to guarantee that early and periodic screenings and diagnostic and treatment services are provided when medically necessary. The State Plan Amendment was implemented on July 1, 2006.²⁵ Results are not yet available.

Kentucky

Kentucky is among the latest states to receive approval from the Centers of Medicare and

Medicaid Services (CMS) to transform its Medicaid program. As a continuation of Kentucky's recent Medicaid modernization efforts that focused on improving technology infrastructure and pharmacy and care management, the Cabinet for Health and Family Services, with public input, developed the KYHealth Choices waiver application.

The waiver goals include stretching resources to meet the needs of Kentucky's nearly 700,000 beneficiaries and encouraging personal responsibility. The principle of accountability also applies to Medicaid providers, who will be required to utilize best practices and adhere to performance-based contracts. The KYHealth Choices waiver, approved by CMS on January 18, 2006, specifies the following six components that will help the Commonwealth achieve its goals:

Targeted Benefits: KYHealth Choices provides tailored benefit packages to four categories of beneficiaries, including the general population, children, elderly, and beneficiaries with disabilities or mental retardation. All beneficiaries receive a standard benefit package. However, optional benefits may be targeted toward the needs of specific recipients. The standard benefit package, known as Global Choices, provides basic medical services for most members, including mental health services. Other packages target services to the needs of children and individuals requiring long-term care. Benefits may vary in amount, duration, and scope of services and may include certain limits, such as dollar limits or limits on the number of office visits.

Cost Sharing: The waiver requires most members to pay a portion of their covered services through co-payments and premiums on an income-based sliding fee scale. (Cost-sharing requirements do not apply to certain member categories, such as pregnant women, children, and members who have already reached their annual cap.) Beneficiaries have co-payments for preventive services, such as annual check-ups and vaccinations. Members who reach an annual cap on co-payments are not required to share in additional costs.

Enabling Beneficiaries to Enroll in Employer-Sponsored Health Insurance: KYHealth Choices requires beneficiaries to enroll in employer-sponsored private health insurance if it is available and if it is more cost-effective for the state. The Health Insurance Purchasing Program helps enrollees pay premiums and wrap-around commercial coverage with Medicaid services.

Integrating Care: The Medicaid program draws from private-sector experiences and uses best practices to coordinate mental health, physical health, and mental retardation and developmental disabilities services.

Disease Management: KYHealth Choices implements disease management programs for chronic conditions such as cardiovascular disease, pulmonary disease, and pediatric obesity, and diabetes.

Get Healthy Accounts: KYHealth Choices provides incentives to beneficiaries who are engaging in healthy behaviors. Funds are deposited in accounts to offset specific health care-related costs, such as co-payments, smoking cessation, and weight loss programs. Initially, participation in the program is limited to pulmonary disease, diabetes, and cardiac conditions.

In addition, the federal waiver offers a consumer-directed option to certain individuals who are enrolled in a long-term care benefits package. To be eligible, individuals must be able to direct their own care and understand the risks and responsibilities associated with managing their own care. Members who chose this option may access non-medical and non-residential services, such

as home adaptations, to enable them to stay at a location that best meet their needs.

The Kentucky Department for Medicaid Services began implementing the 1115 waiver in March 2006. The department will evaluate the program to determine its impact on access to care, quality of care, and cost savings.²⁶ No results are available at this time.

Cash and Counseling Waivers

Several small market-based programs have shown great success. One of these is the “Cash and Counseling” approach attempted in a few states. Florida, for example, operates a program in which beneficiaries who are eligible for home- and community-based services receive a monthly budget. They may use this to hire caregivers or purchase services. Surveys of participants indicate that 96% were “very satisfied” with the service they received, and 97% would recommend the program.

A comparable program in Arkansas called Independent Choices produced a correspondingly high degree of customer satisfaction, with 93% of the participants recommending the program to others. New Jersey has a related program called Personal Preferences. An amazing 99% of beneficiaries reported “satisfying” relationships with their caregivers, and 97% would recommend the program to others. Medicaid’s more traditional programs do not produce these types of outcomes. Although such programs are relatively new and limited in scope, the success of “Cash and Counseling” shows that the idea of allowing beneficiaries to buy their care in the market can work.²⁷

Real Medicaid Reform II: Florida’s Demonstration Project

The state of Florida received federal approval for the broadest-based reform in the history of Medicaid in October 2005. The plan involves real managed competition as well as an innovative health savings account devised for beneficiaries. It also allows for much more predictability in Medicaid spending and is unprecedented in allowing providers flexibility in designing benefits packages for the diverse needs of enrollees. The plan is initially a demonstration project in Broward and Duval counties.

Under the Florida waiver, beneficiaries receive a risk-adjusted credit to purchase health care from competing prepaid plans. Fee for service is effectively eliminated. This is an important detail, because fee for service plans cannot effectively control use without significant cost sharing, which is impractical in plans for low-income groups. This is a major improvement over existing Medicaid managed care programs (recall the problems with TennCare described above).

The credit is used to purchase two types of coverage: comprehensive care and catastrophic care. The beneficiary only sees a particular plan and its benefits. Comprehensive care is essentially routine care needed by most individuals. Catastrophic coverage is used to pay for very high medical bills. The purpose of the split is to encourage a host of providers to enter the marketplace and compete for beneficiary credits. Large HMOs in urban areas enrolling tens of thousands of beneficiaries receive little or no catastrophic payment since they are well capitalized and, due to the law of large numbers, able to reasonably predict the costs of providing services. Smaller groups receive a much higher credit for catastrophic coverage since a few very sick individuals would quickly bankrupt them because they must operate as prepaid plans.

The comprehensive-catastrophic care split helps produce real managed competition, as pro-

viders now have an incentive to enroll any part of the healthy or sick Medicaid population due to risk-adjusted payments. Furthermore, the catastrophic coverage portion of the plan allows smaller groups of health care innovators to enter the marketplace. Competition is spurring efficiency gains that are slowing the cost inflation in Medicaid. The ability of beneficiaries to switch providers if they are unhappy with their care gives providers a strong incentive to treat their customers well or lose actuarially fair payments from them. This ability, in effect, creates a real marketplace for health care.

Since everyone will have a gatekeeper physician with an incentive to control costs, care providers may be expected to focus their resources on preventive care that could reduce or eliminate Medicaid's major cost drivers. Unlike the Medicare population, which by definition is older, much of Medicaid's large costs are behavioral in nature. For example, the inability to obtain good prenatal care sometimes results in low birth weight babies with huge expenses. Another factor in Medicaid's growing costs is obesity and the health problems it can cause. Current Medicaid managed care gives providers an incentive to "cherry pick" rather than manage diseases and prevent them when possible, but the risk-adjusted, competitive model that Florida has developed reduces those perverse incentives.

The establishment of an enhanced benefits program provides another incentive for beneficiaries to adopt healthy behaviors. This is essentially a "reverse health savings account" into which enrollees receive credits if they follow healthy practices. These practices may include obtaining immunizations, blood pressure checks, diabetes spots, and other preventive treatments that reduce major problems down the road. These funds may be used to purchase additional medical services or to buy employer or individual health insurance upon leaving Medicaid.

A further innovative aspect of the Florida demonstration project is the ability of prepaid providers to design different benefits packages. In all previous Medicaid plans, the state was required to provide a minimum benefits package as established by the federal government and expand that based on state choices. Once established, all providers were required to offer the entire package. This "one-size-fits-all" approach is a great impediment to the efficient, low-cost delivery of medical care. Under Florida's new approach, however, providers have great flexibility in designing packages for specific parts of the Medicaid population. One group may wish to enroll the mentally ill, another those afflicted with AIDS, and a third may focus on providing OB/GYN services. Since their payments from Medicaid are related to the risk of enrolling beneficiaries, there will be little incentive to "cherry pick." The catastrophic portion of the plan—essentially reinsurance above certain cost amounts—will allow niche providers to specialize in offering care to some of Medicaid's most challenging beneficiaries such as the mentally disabled. Florida also has mandated a prepaid plan for long-term care for the elderly. A waiver for this plan has been approved by CMS, and action is currently under consideration by the Florida legislature as of May 2007.

While other states have used aspects of their Medicaid plans to subsidize employer-based health care for non-Medicaid individuals, Florida's proposal goes a step further and allows enrollees to purchase health care from their employers using the value of their risk-adjusted credit. This plan moves some individuals back into the labor market and, in some instances, into better jobs that offer health coverage to employees. The prepaid nature of the program may be expected to reduce the fraud and abuse that is rampant in Medicaid. Finally, like all private-sector coverage, there is an overall benefits limit to beneficiaries. This, along with the defined contribution nature of the plan, will increase the predictability of Florida's Medicaid spending in the future.²⁸

How Broad-Based Medicaid Reform Is Working: Initial Results from Florida

Florida's Medicaid reform demonstration project has now been operating for over two quarters. Initial evidence is limited, but what we do know is mostly positive. There are four key points.

First, the demonstration in Broward and Duval County has increased the number and types of plans available to beneficiaries. In Broward County, enrollees can choose from 15 competing plans, including one special needs provider, while those in Duval County have six choices. Contrast this with the nearly 80% of individuals in the private sector who have only one choice in their employer-based health coverage.

Second, all of the reform health plans have offered expanded or additional benefits, which were not previously covered under Medicaid requirements. The most popular expanded benefit programs offered by these plans were over-the-counter drug benefits and adult preventive dental benefits. Expanded benefits available to enrollees include, but are not limited to, over-the-counter drug benefits of between \$10 to \$25 per household per month, adult preventive dental, circumcisions for newborns, acupuncture and medicinal massage, additional adult vision with up to \$125 per year for upgrades such as scratch resistant lenses, additional hearing plans with up to \$500 per year for upgrades to digital canal hearing aids, and home delivered meals for a period of time after surgery. From the point of view of additional services and benefits, Florida Medicaid reform has been a success in its initial stages.

The question remains whether or not the increase in plan choices and larger benefits packages have improved beneficiary health. We do not have a solid answer yet. Information is currently being collected through a set of standardized performance measures designed to ensure that purchasers and consumers have the information they need to make a reliable comparison of the performance of managed health care plans. We also do not have data on beneficiary satisfaction. However, we do know that there have been no grievances filed yet with the reform plans and only 13 complaints about choice counselors hired to assist beneficiaries with plan selection and information.

Third, the demonstration's innovative Enhanced Benefits Program (essentially, a reverse health savings account) is growing rapidly. These are zero-balance accounts in which beneficiaries can earn credits by engaging in healthy behaviors. Those earning credits have increased from under 1% to over 8% in just two months. Unused balances are now around \$250,000.

Fourth, the reform's opt-out provision is small and growing slowly. This reform allows individuals to use the actuarial value of their Medicaid benefit to buy into an employer health plan. As of May 2007, only seven individuals had opted into employer coverage.

A major goal in the reform is to make beneficiaries active participants in their own health care. At this time, around 60% of new enrollees in the demonstration have made an active selection of the plan in which they want to participate. The remaining 40% were assigned coverage by a choice counselor. Again, although initial results are limited, they do point to greater competition among providers and more benefits for enrollees. This is precisely what proponents of reform had predicted.²⁹

What Should Pennsylvania Do?

The above summary of attempts at Medicaid reform offer some guidance to Pennsylvania as it deals with the challenge of fixing this broken system. Four key principles are obvious:

1. Dramatic expansion in eligibility is almost certainly a budget buster;
2. Attempts to regulate the problem through onerous rules and decrees will almost certainly make the situation worse;
3. One-size-fits-all health plans are unworkable for the enormously diverse Medicaid population; and
4. Government payment schemes end up being price controls that harm beneficiaries and promote inefficiency.

A real reform plan would use market forces to deliver care to those eligible for Medicaid. This would require four key reforms:

1. Buying power needs to go to the beneficiaries.
2. Credits must be risk-adjusted.
3. All plans must be prepaid to control unnecessary utilization and provide incentives for innovation.
4. Providers must be given the freedom to design specific products for the host of medical issues facing Medicaid's enrollees.

Given the quality and cost difficulties facing Medicaid in Pennsylvania, significant reform is absolutely vital if the program is to survive. Fortunately, with the above core principles and lessons emerging out of the experience of other states, the threat of venturing into completely unknown waters no longer remains. There is no reason for Pennsylvania policymakers to continue pursuing a course of minor adjustments and passive observation. It is time to learn from the failures and successes of others and begin crafting a truly sustainable Medicaid program that adequately addresses the needs of Pennsylvanians.

Reforming Medicaid in Pennsylvania: A Market-Based Approach

Reform Step #1: Create an Insurance and Provider Exchange and Medicaid Health Credits

The Pennsylvania Office of Medical Assistance Programs (OMAP), which administers Medicaid, should establish an Insurance & Provider Exchange (IPE). The IPE would be nothing more than a state-run market from which Medicaid beneficiaries would purchase their health care. Providers could offer packages of services to the enrollees at the IPE. The role of the state will change from being the buyer of the health care to facilitating a real marketplace in Medicaid.

Beneficiaries would receive a Medicaid Health Credit from OMAP to buy the coverage they want at the IPE from competing providers. This may be an HMO, a network plan, an HSA-type product or some hybrid product. OMAP will mandate minimum required benefits and services from providers. OMAP also will require complete transparency on the part of providers with regard to the services that they offer to enrollees and will assist beneficiaries in selecting health products that best meet their needs (but the actual choice will be made by the enrollees).

Reform Step #2: Actuarially Risk-Adjust the Medicaid Health Credit

Insurance companies are in the business of managing risk. Better drivers pay lower car insurance premiums. Teenagers, as a group, are not better drivers and pay higher premiums. Younger people live longer, and thus pay lower life insurance costs. Women live longer than men and also receive lower rates for life insurance. In a properly designed health insurance market, sicker beneficiaries would pay more than healthier beneficiaries. Due to quirks in policy-making, there effectively has not been a real market for health insurance. Many traditional carriers practiced community rating in which equalized rates encouraged sicker people to enroll and healthier people to drop out of the insurance pool. Second, tax laws encourage the purchase of health care through employers. Employer-based insurance is, therefore, just a reallocation of employee compensation to health insurance instead of wages, in order to minimize income taxes.

Effective Medicaid reform must involve beneficiaries buying prepaid plans from competing providers. Existing Medicaid “managed care” plans are generally set up through selective contracting. Theoretically, there may be choices for beneficiaries, but as a practical matter they tend to wind up in one plan over time.³⁰ The payment to the plan from Medicaid is an administered price, or price control, and is not risk-adjusted for each enrollee. While enrollment in the plans is guaranteed, the failure to risk-adjust payments encourages cherry picking by prepaid plans. With the advent of easy-to-use software, it is a relatively simple task to risk-adjust the Medicaid Health Credit. Even though risk adjustment is not perfect, it significantly reduces the incentive to enroll only healthy beneficiaries.

In the past, risk adjustment was not widely practiced and not particularly effective. Indeed, the difficulty in doing it was one of the reasons for actuarially unsound community rating. Risk adjustment is now much more effective and economical to implement. A perfect example of this is Medicare Advantage, which is the new Medicare Part C managed care plan. Medicare Part C was very ineffective primarily because the payment schedules were based entirely on demographics such as age, sex, employment status, Medicaid and disability eligibility, and institutional status, so Medicare implemented a new risk-adjustment system called the CMS Hierarchical Condition Category (CMSHCC).

Switching Medicare reimbursement of private plans to CMSHCC has had very desirable effects. Indeed, private firms under Medicare Advantage are able to market directly to those with chronic illnesses under what are called Special Needs Plans. Instead of attempting to cherry pick healthy enrollees, the market is now functioning to provide care to the chronically ill since they receive a significantly higher payment from Medicare. This accomplishes two things. First, it makes the sick desirable customers. Second, it will accelerate medical innovation in dealing with higher cost patients; because the plans are prepaid, providers have an incentive to find ways to keep enrollees healthier.³¹

In addition to risk-adjusted Medicaid Health Credits, an actuarial payment from one provider to another if a chronically ill enrollee switches plans must also be required. First, this will further minimize a plan’s incentive to avoid signing up ill beneficiaries. Second, it will encourage the provider with which they are currently enrolled to offer quality care focused on disease management. The combination of risk adjustment and a transfer of actuarial payment will give plans a strong incentive to compete vigorously for all beneficiary business.

Reform Step #3: Allow Medicaid Beneficiaries to Buy Into Private Plans

Medicaid enrollees should be free to use their Medicaid Health Credits to join existing employer-provided plans. Given that a significant number of new Medicaid enrollees in the last 15 years dropped family coverage, this could be a low-cost way of offering coverage to these groups. Since many of them are above the poverty level, OMAP could offer grants to them on a sliding scale, with high amounts for the poorest and lower amounts for incomes near the arbitrarily established income limit.

Another possible reform is to allow individuals and small businesses to purchase private health plans at a state-initiated health market.³² This would generate several potential benefits. First, it could reduce Medicaid enrollments by moving some beneficiaries back into private-sector coverage. Second, it would induce more firms to offer health insurance by lowering the insurance overhead cost that exists in this market. Third, it would reduce insurance costs by creating a larger pool of buyers with more purchasing power and reduced uncertainty in annual claims.³³

Reform Step #4: Prepay All Plans

One of the major problems facing Medicaid is the large-scale use of fee-for-service delivery systems. Essentially, the beneficiaries find a doctor or emergency room or get admitted to a hospital for services. OMAP then pays the provider a fee.

But fee for service has three major flaws. First, there is no effective way to limit usage with arbitrary bureaucratic mandates. Health care is complicated, and no bureaucracy can effectively design a rationing system to control usage in an effective manner. Since the beneficiaries pay little or nothing out of pocket, they certainly have no incentive to economize on unnecessary care. In addition, providers have an incentive to deliver services that are not appropriate.

The second flaw with the fee-for-service system is that the prices paid to providers are not determined by supply and demand but are set bureaucratically through government schemes. They are, in effect, price controls. If the rates are set too high, there will be too much health care delivered (a surplus). If they are set too low, there will be too little care provided (a shortage). In services like health care, where quality is important, these shortages can take the form of low quality (5 minute office visits), long waiting periods, and inability to obtain services. Furthermore, rates set below market prices cause fewer providers to deliver services and suppress the competition needed to lead to innovative medical practices.

The third flaw with the fee-for-service system is that it often produces episodic health care utilization where problems are treated after they have developed instead of being prevented in the first place. Prepaid plans benefit financially from patients having better health and have an incentive to provide preventive care that reduces major health problems in the future. Moreover, they have an incentive to cost effectively manage existing conditions because their profits will be higher. It is much more cost effective to provide a pregnant beneficiary with proper prenatal care than it is to spend a fortune on treating a low birth weight baby. In addition, many individuals with high health costs suffer from a multitude of health problems. They are likely to derive better care and lower costs from an integrated health plan where differing specialists can work together to deal with the patient's issues.³⁴

Reform Step #5: Provide “Reverse” Health Savings Accounts to All Beneficiaries

Incentives matter. The failure of policymakers to recognize this is one of the major contributors to rising costs in Medicaid and, indeed, all of health care. An effective reform plan will implement the right incentives, which, in turn, will produce more cost-effective, higher quality care for the poor.

One way to give beneficiaries proper incentives is for OMAP to give every Medicaid beneficiary a Reverse Health Savings Account (RHSA). The accounts will have a zero balance initially. OMAP would then add dollars to the account when beneficiaries use health care in an effective and responsible manner. Medicaid in many states, for example, suffers from a significant problem of enrollees using hospital emergency rooms for non-life threatening illnesses. OMAP could pay beneficiaries a portion of the savings when beneficiaries use a physician for their primary care. Large amounts of money could be saved by paying pregnant women to obtain proper prenatal care and avoiding low birth weight babies. The same is true of obtaining a full panel of immunizations for children and for diabetes spots and blood pressure checks for adults.

Furthermore, funds in the account could be used to purchase additional medical care or rolled over for future purchases. They could also be used to pay for medical care when the beneficiary leaves Medicaid. The RHSA would be set up to be a money-saver for OMAP with credits to the account being a fraction of the expected actuarial savings from discouraging “bad” behavior and encouraging “good” behavior. This is crucial, given that unhealthy behavior is one driver of high health care spending.³⁵ In addition, since funds may be rolled over and taken out of the accounts at a later time, they would produce a reverse working capital effect for Medicaid. The state of Florida’s reform plan has RHSAs as part of its design.

Reform Step #6: Reinsure Smaller Plans

A central tenet of Medicaid reform is the idea of creating a competitive marketplace in which beneficiaries can obtain their health care. Monopolies and oligopolies are bad for consumers in any industry, including health care, so in order to make reform work in Pennsylvania it is imperative that choices exist for enrollees. It is also necessary for providers to be prepaid to control utilization and create incentives for cost-reducing, quality-promoting innovations.

But the benefits of prepaid plans also raise a potential problem for smaller providers who may wish to enter the marketplace. A significantly large pool of customers (say 5,000) must exist for a provider to have a reasonable idea of what health costs will be in a current year. Larger prepaid plans will have an incentive to offer coverage to Medicaid beneficiaries if the enrollees’ buying power is risk-adjusted and there is flexibility on the benefits package. Although many larger providers are indeed effective and innovative, history shows that revolutionary new methods and products are often developed by start-up entrepreneurs. The problem is that a prepaid practice of, say, ten innovative doctors who enroll 1,000 beneficiaries could be wiped out if they are unlucky enough to sign up a few very high-cost patients. Thus, good ideas that could reduce Medicaid costs and improve its quality may never make it to the marketplace. This problem is particularly acute in rural areas of Pennsylvania.

The solution to this problem involves OMAP reinsuring smaller practices if they run into high costs. Actuarially, the risk to a prepaid plan becomes greater given a smaller number of enrollees. OMAP could use a sliding scale framework with very small plans having a much smaller effective

stop-loss limit than medium-size providers. Large prepaid groups would not receive reinsurance. To maintain the incentive for providers to control un-needed utilization there would need to be some financial risk once the reinsurance begins. As with the reinsurance itself, this should be set up on a sliding scale with smaller groups being required to cover a smaller proportion of expenses in the reinsurance range.

Providers also need to have flexibility in designing their product. The current Medicaid system has a federally required minimum benefits package with states having the ability to expand the services that must be covered by providers. Generally, states have operated with a one-size-fits-all mentality on the mandated benefits package. This makes no sense, given the diverse population that Medicaid covers. Providers should be allowed to market to specific groups, as is the practice in the private sector. While the plans would have different benefits, they would be required to be actuarially equivalent; that is, each plan would have the same dollar value. This specialization and division of labor would increase efficiency and lower price inflation. Just as important, it would improve the quality of care for beneficiaries. Since payments for beneficiaries would be risk-adjusted, plans will have an incentive to enroll both sick and healthy beneficiaries. Practices specializing in the treatment of those afflicted with AIDS could develop alongside those that provide OB/GYN services. As in the private sector, plans may implement an overall benefit limitation.

Reform Step #7: Enroll Disabled and Elderly in Prepaid Plans

As with the acute care population, disabled and elderly Medicaid beneficiaries will enroll in prepaid plans. They, too, will receive risk-adjusted Medicaid Health Credits. The purpose of the prepaid plan is to limit unnecessary usage and create incentives for innovations in the delivery of care. The disabled and elderly population is a minority in state Medicaid plans, but it accounts for a majority of expenditures. As such, it is crucial that providers for this population deliver quality care in a cost-effective manner, so this population would also receive RHSAs to encourage appropriate medical behavior that results in savings.

A key feature of effective reform in this area involves addressing the bottom line of providers. Many institutions that deliver services to Medicaid are paid using a cost-based methodology. This, of course, is just another administered-pricing scheme. And, like other price control schemes, it encourages inefficiency and low quality. The development of the Medicaid Health Credit would make beneficiaries a sought-after “customer,” and competition among providers would lower price inflation.

Nursing homes and other institutions that provide services to Medicaid recipients should instead become prepaid in nature. There are two ways this can happen. One is for the provider to list their services at the IPE. The other is for managed care companies to negotiate with these institutions the same way they negotiate with physicians and hospitals. The marketplace will determine which mechanism is most effective. Prepaid plans would have an incentive to develop innovative methods to deliver needed care in a cost-effective manner.

The RHSA could be used to encourage behavior that lowers costs. For example, the mentally disabled sometimes stop taking medications that allow them to function in a reasonably normal manner and avoid very expensive institutionalizations. Documented care visits and use of effective prescriptions could be rewarded by deposits to the RHSA. Offering RHSA funds to loved ones could allow parents and other family members to care for the mentally and physically disabled in

a non-institutional setting. Here the RHSA would essentially function as a “cash and counseling” program. These limited experiments around the country have proven popular with the disabled and those who care for them.

Providers for the disabled, including government providers, should offer various packages for this diverse group ranging from comprehensive coverage for the mentally ill to low-cost specialty plans such as alcohol rehab services for the otherwise healthy. These providers should also be paid with grants that are risk-adjusted.³⁶ These providers have demonstrated success in dealing with this problem population and have developed innovative programs such as “braided funding” in which multiple sources of coverage are linked together. Under these reforms, the beneficiaries would be evaluated by Medicaid to determine the severity of their disability, and a grant would be awarded based on that determination. Medicaid would create quality indices that would be available to inform beneficiaries when they are choosing their providers.³⁷

An important part of this reform would involve allowing beneficiaries to pay family members for providing services.³⁸ Because of the emotional bond involved, allowing this option can produce significant increases in the quality of care at far less cost than in an institutional setting. Beneficiaries who are eligible for Medicaid coverage of nursing home care could instead receive RHSA funds if they are able to obtain services in a less costly environment. This would allow some patients to stay at home as opposed to moving to assisted living facilities. Here, too, the ability of family members to receive payment from the RHSA could significantly reduce Medicaid’s nursing home costs.

It is, of course, possible that allowing payments to family members could create an “out of the woodwork” effect. That is, individuals currently not enrolled in Medicaid may sign up for the plan to access these dollars. It is crucial that estate recovery efforts be highly effective to minimize this occurrence. It has been estimated that as many as 90% of those enrolled in Medicaid coverage for nursing homes have done some type of asset planning to qualify for their coverage. Further “look-back periods” and recovery programs for those seeking Medicaid nursing home coverage would produce larger potential losses in estates to family members and reduce the incentive to game the RHSA.

Reform Step #8: Discontinue Market-Distorting Practices and Policies

Consistent with a free market, all market-distorting activities and schemes should be eliminated. These include formularies, Certificate of Need (CON) laws, and state-mandated health benefits above the Medicaid requirements. Providers of medical services would directly negotiate with drug companies for discounts. Elimination of CON laws would allow for easy entrance into the long-term care market in response to market price signals and would reduce costs by promoting more competition among providers.

Can Free Markets Improve Quality and Reduce Health Care Costs?

Would a dose of free enterprise really help Medicaid’s beneficiaries and improve Medicaid’s fiscal situation? Or is the purchase of health care too sophisticated for most people to deal with, especially the poor? Fortunately, we have some answers to these questions based upon experience.

It is true that broad market-based reforms are virtually nonexistent in Medicaid. In the past,

federal bureaucrats have looked unfavorably on significant, free-market reforms. While attempts have been made to utilize HMOs, these efforts continue to suffer from administered-pricing schemes where reimbursements to providers are set too low, causing providers to drop out of the system. Now, however, a new, more receptive attitude in Washington may permit dramatic changes in the system.

While the private sector suffers from many of the same problems as the public sector, we can see how a free market in medical care would operate. Most people did not have prescription drug coverage until the 1980s and '90s. They paid out of pocket. The result was a 34% increase in drug costs between 1960 and 1980 contrasted with a 236% increase in the general cost of medical care. After drug coverage became much more commonplace, prescription drug costs rose 336% versus 281% for general health care from 1980 through 2002.

In cash medical markets, such as cosmetic care, the results are what would be expected. Along with continuing advances in quality, innovations, and comfort, the discipline of the market serves to control costs. Cosmetic care rose at a lower rate than general inflation between 1992 and 2001, while general medical price inflation was three times greater. Eye care costs—where there is not nearly as much third-party payment—increased 33% between 1990 and 2002, while general medical costs increased by 75%. This occurred during a period when there were dramatic advances in technology and services such as LASIK. In addition, the cost of other types of medical services, such as podiatry and chiropractic care, which are often not covered by insurance, rose at only 43% between 1990 and 2002 (again versus the general medical inflation of 75%).

What would happen under broad-based market reforms in Pennsylvania? We can surmise that competition and innovation would bend down the long-run growth rate of the Pennsylvania Medicaid Plan. Given that productivity growth has accelerated from essentially zero to around 2% in the service sector since 1995, efficiency gains in the health sector should result from the creation of a real marketplace. If Medicaid reform could produce just half the productivity gain of the private service sector, Medicaid would be half as large as currently projected in the year 2075.

Summary and Conclusion

Pennsylvania Medicaid is in serious trouble. It delivers low-quality health care, and its long term fiscal situation is unsustainable. The systemic problems exist because of the lack of a real marketplace for medical services for beneficiaries. Medicaid is, instead, a vast price control system that is inherently inefficient. Any plan for reform needs to address this fundamental flaw. If changes are not made, the fiscal health of the program will only worsen. The Commonwealth of Pennsylvania faces the unappealing situation of huge cuts in other government spending or dramatic tax increases that would wreak havoc on its economy.

Pennsylvania should move to reform its troubled Medicaid program immediately. The state government needs to create a real marketplace in which buyers act in their own interest and providers have an incentive to deliver quality care in a cost-effective manner. Pennsylvania's Medicaid should create a health care "market," via an Insurance and Provider Exchange, where competing providers offer prepaid services to beneficiaries. Those enrolled in Medicaid will receive actuarially adjusted credits to purchase care they need from competing providers. This will induce new providers to enter the marketplace and focus on treating the sick rather than "cherry picking" the healthy. In order to promote competition in rural areas, OMAP should reinsure

smaller plans. Beneficiaries also should receive Reverse Health Savings Accounts, which would be used to pay them for engaging in cost-saving and health-improving behavior.

The creation of a real marketplace in Medicaid would improve the quality of care for beneficiaries since they can switch to alternative providers offering real choices in care. It would also accelerate innovation in the delivery of medical care and produce efficiency gains in the Medicaid program. Competition would translate these productivity gains into lower program inflation. The compounding effect of this reduced cost growth would make Medicaid far more sustainable in the Commonwealth of Pennsylvania.

ENDNOTES

1. See "Radical Surgery for Medicaid?," *Business Week*, August 8, 2005.
2. Source: Congressional Budget Office.
3. See www.statecoverage.net/pdf/stateofstates2006.pdf.
4. Source: Center for Medicare and Medicaid Services (CMS) and CPI for Medical Care.
5. Commonwealth of Pennsylvania, Governor's Executive Budget, 2007-08.
6. Assumed real Medicaid growth 2% above real state product and real revenue growth.
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30. By law Medicaid Managed Care must offer two plans in a given area. As a practical matter there may be no real competition for several reasons including the same providers being in both plans and geographic location making enrollment in a competing plan impractical.
 31. See Verdier, J., "Medicare Advantage Rate Setting and Risk Adjustment," Mathematica Policy Research, October 2006.
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