Reforming Medicaid

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Executive Summary

Medicaid is enormously expensive. For the second year in a row, spending on Medicaid (for the poor) will exceed spending on Medicare (for the elderly). At $280 billion this year, Medicaid costs almost $1,000 for every man, woman and child in the country — or $4,000 for a family of four. Indeed, it is likely that many taxpayers are paying more in taxes to fund health insurance for the poor than they pay for private health insurance for themselves and their own families.

In the future, the taxpayer burden will get worse. Left unreformed, Medicaid will bankrupt every state in as little as 20 years, possibly absorbing 80 to 100 percent of all state revenues. Delay is not an option. States and the federal government must act now to avoid a real human and fiscal disaster.

Reason for Rising Costs. Why are Medicaid costs rising so rapidly? Part of the reason is that many states are paying for health care in ways that needlessly contribute to rising health care costs. Another problem is that most states have not taken advantage of cost-control techniques widely used in the private sector. For example:

- Because Texas' method of paying for hospital care is largely cost-based, Medicaid pays some Dallas hospitals three times as much as other hospitals for the same services.
- Because Ohio's method of paying for nursing home care is essentially cost-based, the state is paying for 13,000 empty beds.
- In virtually every state, Medicaid pays for inputs rather than outputs. This means that the more physicians and facilities do, the more they earn — even if patients would have been better off if less were done.
- Medicaid patients also have incentives to waste resources; the only way they can realize more benefits is by consuming more health care.

Medicaid from top to bottom is organized in ways that create perverse incentives for those who are supposed to benefit from the system. For example:

- Because Medicaid benefits are conditioned on having a low income, the program penalizes those who succeed; individuals can lose eligibility and therefore health coverage for themselves and their families simply by getting a workplace promotion or a raise.
- Because Medicaid benefits are conditioned on having few assets, the program encourages people to spend rather than save their income.
- Because Medicaid is an alternative to private insurance, the program encourages people to drop coverage for which they or their employers pay and turn to "free" insurance for which all taxpayers pay.

Studies estimate that as much as 75 percent of the expansion of Medicaid nationwide has been offset by a reduction in private insurance. This is one reason why the number of uninsured in America keeps rising, despite the expansion of costly public programs.

Traditional Solutions. In order to participate in Medicaid and receive matching funds from the federal government, states must provide minimum benefits to certain categories of people. Nationwide, however, about 70 percent of all Medicaid spending covers either beneficiaries who do not have to be

covered or services that do not have to be covered or both. Thus one alternative is to eliminate "optional" people and "optional" services. There is also an ever-present pressure to lower payments to providers. Cutting costs in these ways, however, is easier said than done:

- Most of the optional people are likely to be uninsured after they are dropped from the rolls. And evidence from Texas suggests that regions that spend less on Medicaid spend more on free care for the uninsured and vice versa.
- A major optional benefit is coverage for prescription drugs. Yet because drug therapy often substitutes for more expensive hospital and doctor therapies, eliminating coverage for drugs may not save the state any money.
- Another large optional benefit is mental health care. But mental health services are also often a substitute for other health services, and without Medicaid the state may have to spend money on many of the beneficiaries anyway — but without federal matching funds.
- Reducing payments to providers will disproportionately hurt rural and inner-city areas at a time when the nation's safety net of local clinics, hospitals and charities is overburdened and threadbare.

A New Approach. The time has come for a "pro-patient" approach to health care. The following are some elements of that approach.

Choice. Medicaid is a *defined benefit* program, under which the state determines the covered health services, and patients and doctors decide how much to spend on those services. It should be converted into a *defined-contribution* system, under which the state determines how much it is willing to spend and patients (along with their doctors) choose how to spend it.

Competition. Most of the problems with Medicaid and Medicare stem from the fact that these two programs have changed very little since they were created in 1965. By contrast, private insurance is continually evolving in response to changes in medical science and changes in consumer wants and needs. Medicaid enrollees would benefit enormously if they had access to private sector plans, including the plans of their employers.

Portability. At least a quarter of all Medicaid eligibles move in and out of the program each year, as patients are tossed from physician to physician multiple times. As a result, many find the hospital emergency room more convenient than having a primary care physician. A better approach is private, portable insurance — where enrollment continues even after eligibility for Medicaid has lapsed.

Empowerment. Arkansas, New Jersey and Florida have obtained federal waivers under which disabled Medicaid beneficiaries manage some of their own health care dollars and make decisions on how to spend those dollars. These experiments have been highly successful and much more needs to be done. Enrollees need access to private sector Medical Savings Account (MSA) plans. Those who remain in traditional Medicaid need access to something similar: a Medicaid Benefit Account (MBA).

Paying for Results. Whenever possible, the state should pay for outputs, not inputs; for results, not for efforts made to achieve those results. At a minimum this means abandoning variations on cost-plus reimbursement and adopting some of the payment methods used by private insurers instead.

Devolution. For those who remain in traditional Medicaid, another useful idea is to give local communities more control, say through a block grant of funds. Under the current system, Texas reimburses

El Paso hospitals at rates that are above the state average, while a typical primary care clinic lacks an X-ray machine or even a lab and must send patients to a hospital for simple diagnostic tests. As a result, El Paso's low-income population overutilizes hospital care and underutilizes outpatient care. The city and its people would be better off it were free to reallocate funds from inpatient to outpatient care.

More Radical Devolution. Despite a raft of studies claiming that being insured affects access to health care, there is no difference in services rendered to those who seek care — at least at Parkland Hospital in Dallas. The insured, the uninsured and the Medicaid patients who are treated there enter the same emergency room door, see the same doctors and receive the same care. As a result, patients have no reason to fill out the lengthy forms and answer the intrusive questions that Medicaid enrollment requires. Similarly, the doctors and nurses who treat these patients get paid the same, regardless of the patients' enrollment in an insurance plan. This is part of the reason why at least 10 million people who are theoretically eligible for Medicaid have not bothered to enroll.

If the patients and the doctors who treat them do not care who is enrolled in which program, why should policymakers care? Why not just give Parkland Hospital a sum of money each year and let it deliver indigent health care? Our primary goal should be to enroll people in private sector plans. But to the degree that we fall short, we should make access to care as easy as possible.

The Need for Federal Waivers. In order to take full advantage of private sector techniques and private sector opportunities, states should apply for a federal waiver, called a HIFA waiver. For example, a waiver might work like this:

- All "mandated" Medicaid enrollees would have the opportunity to enroll in employer plans or other private sector plans with premium subsidies from the state.
- To qualify, the private insurance would have to be similar to the plans currently offered to state employees.
- Those beneficiaries who do not qualify for an employer plan would have the opportunity to enroll annually in a plan of their choice through an insurance exchange (a health mart), organized and operated by the state.
- At least one of the plans offered would make use of a Medicaid Benefit Account (MBA), which would be similar to a medical savings account, except that the funds could be used only to pay health care expenses or health insurance premiums, now and in the future.
- Projected savings (in a static sense) from these changes would be used to enroll additional, "optional" people in Medicaid (this is a necessary condition to get approval for a HIFA waiver).
- The optional enrollees, consisting of additional people with disabilities and low-income families, could be offered a limited set of benefits (e.g., primary care benefits only) or they could be given the same options as other Medicaid enrollees — with premium support from the state diminishing as family income rises.

Expected Results. The HIFA waiver, combined with other recommendations in this report, would allow the state to take advantage of the full range of techniques employed by the private sector. It also would allow the state to move large numbers of people from state-funded insurance to insurance largely paid by employers and — since employer-provided benefits are earned by working — by the beneficiaries themselves.

Introduction[1]

Medicaid, the joint federal/state health care program for the poor, is in crisis. At a time when state revenues are frozen or declining, Medicaid costs per enrollee have almost doubled in the last five years — with projected spending increases rising even faster.[2] Medicaid, unreformed, threatens to take every new state tax dollar. As a result, an out-of-control Medicaid program is a threat to education, agriculture, highways, the environment, parklands and every other program funded by state government. Medicaid reform is everyone's concern because it affects everyone and every issue.

"Medicaid is in crisis."

Problem: Escalating Costs. The National Governors Association claims that 49 states, faced with stagnant revenues and exploding Medicaid costs, are in a real fiscal emergency.[3] Medicaid and other health expenses already account for about 20 percent of state spending nationally, and those costs rose 13 percent last year — "the largest increase in a decade," according to a National Governors Association report.[4] Left unreformed, Medicaid will bankrupt every state in as little as 20 years — absorbing 80 to 100 percent of all state revenues.[5] Delay is not an option. States and the federal government must act now to avoid a real human and fiscal disaster. What can be done?

Traditional Solutions. The Kaiser Commission on Medicaid and the Uninsured has reported that 49 states plan to cut Medicaid benefits, restrict eligibility, increase copayments or reduce provider payments.[6] Already, 37 states have cut a combined $12.6 billion from their Medicaid budgets.[7] More cuts will follow. According to the Kaiser Commission:[8]

- 18 states plan to tighten Medicaid eligibility rules in fiscal year 2003, compared to 8 in 2002;
- 15 states are cutting Medicaid services this fiscal year, compared to 9 last year; and
- 40 states are reducing the amount they will pay for prescription drugs or are implementing preferred drug plans.

These traditional responses all seek to further restrict access to quality health care to save money. At best, they are stopgap measures. At worst, they will fail to halt what may be Medicaid cost increases as high as 15 percent this year.[9]

States have considerable flexibility in determining the number of people and the types of services that are covered by Medicaid. Nationwide, about 70 percent of all Medicaid spending is "optional," covering either beneficiaries who do not have to be covered or services that do not have to be covered or both.[10] Since the average state currently spends 19.6 percent of its budget on Medicaid,[11] almost 14 percent of Medicaid spending could be saved in an average state by eliminating optional people and optional services. There is also an ever-present pressure to lower payments to providers. But are these options wise?

Traditional Option: Reduce the Number of People Who Are Covered by Medicaid. People who must be covered by Medicaid under federal law are "mandatory" populations. Those enrolled at each state's discretion are the aforementioned optional populations. For example, as of September 2002, states are required to grant eligibility to all children living in poverty, regardless of their age.[12] Unfortunately, paring people from the Medicaid rolls may save less than the states expect. For example, among the 11 health regions of Texas spending per Medicaid recipient in 1998 varied from a high of $4,425 to a low of $2,101 — a difference of about $2,300. But the variation falls to about half that amount when per capita spending on free care for the uninsured is considered. [See Table A-1 in the appendix.] It appears that non-Medicaid health care spending substitutes for Medicaid spending, as regions that spend less on Medicaid tend to spend more on free care and vice versa. Reducing the amount spent on one program just increases the amount spent by the other.

Traditional Option: Reduce the Services Covered by Medicaid. Each state must offer 14 mandatory benefits (e.g., hospitals, physicians, etc.) but can decide which of 34 optional benefits it wishes to cover, including prescribed drugs, diagnostic screening, preventive and rehabilitative services, clinic services, dental care, dentures, physical therapy and related care, prosthetic devices, TB-related care, and primary care case management.[13]

"Traditional responses try to reduce access to care and/or lower provider payments."

Trying to eliminate these expenditures, however, may prove penny-wise and pound-foolish. For example, drug therapy is often a less expensive and more effective alternative to doctor therapy and hospital therapy. A study by Columbia University professor Frank Lichtenberg found that in the health care system an increase of 100 prescriptions is generally associated with 1.48 fewer hospital admissions, 16.3 fewer hospital days and 3.36 fewer inpatient surgical procedures. Overall, a $1 increase in pharmaceutical expenditures is associated with a $3.65 reduction in hospital care expenditures.[14] Mental health and physical health services are also often substitutes for each other. In one study, an employer who reduced spending on mental health saw more than offsetting cost increases in other health services.[15]

Traditional Option: Reducing Payments to Providers. As financially stressed as states and taxpayers are, the newspapers daily report on struggling hospitals, nursing homes and physicians who see Medicaid patients. Reducing their reimbursements will disproportionately hurt rural and inner city providers. It will also have an economic ripple effect, since Medicaid dependent providers are also the chief (and sometimes only) economic engine for growth in these same rural and inner city neighborhoods.

Traditionally, hospitals have covered losses that arise from people who can't pay for their care and less generous reimbursement from Medicaid and Medicare by overcharging other patients. But as the medical marketplace becomes more competitive, these overcharges are shrinking. Cost shifting is virtually impossible in so competitive a market.

There is ample evidence that this problem is not trivial. For example, preliminary findings from a RAND study show that safety net spending by the nation's hospitals is not keeping pace with the overall increase in per capita spending.[16] A National Academy of Sciences Institute of Medicine study found that the safety net of local clinics, hospitals and charities is "overburdened and threadbare," and "could collapse with disastrous consequences."[17]

A New Approach. What is needed is a new solution, one that does not seek to solve the states' Medicaid fiscal crisis on the backs of the poor, disabled and blind. What is needed is a "pro-patient" solution.

"What is needed is a pro-patient solution."

A History of Failed Reforms

Medicare (Title 18 of Social Security) and Medicaid (Title 19) were passed in 1965 at the height of President Johnson's Great Society and War on Poverty initiatives. They signified the high-water mark of postwar liberalism. The appearance of former President Truman at the signing ceremony signaled that they were intended to be first steps, culminating in a universal national health insurance program similar to the state-run systems in Europe.

The year 1965 was also the high-water mark of faith in the federal government and strong mistrust of the states. Only two years after Martin Luther King's "I Have a Dream" speech, one year after the Civil Rights Act and in the same year as the Voting Rights Act, "state's rights" was almost synonymous with racism and segregation. This explains Medicare and Medicaid's strong federal orientation.

By 1966, we were in an unpopular war that eroded confidence and consensus. The administration's "guns and butter" approach attempted to fight a war and proceed on Johnson's ambitious domestic agenda. It was not successful and costs and inflation got out of control. By 1970, Medicare and Medicaid were spending what Congress had estimated they would cost two decades later, in 1990. This was only the first of many underestimates of future spending.

In efforts to control costs in the 1970s, states centralized health planning, issued certificates of need, and imposed wage and price controls and moratoriums or restrictions on hospital and nursing home beds. All of these initiatives sought to control the supply of health care while the demand for it increased. Many politicians were surprised when costs skyrocketed.

In the 1980s, President Reagan's "New Federalism" proposed a swap: the federal government would take all of Medicaid and return other programs to the states. The idea was discarded when the Office of Management and Budget Director Stockman looked at Medicaid's astronomical out-year costs. Other regulatory reform proposals were defeated by a combination of seniors' lobbies and liberal legislators. In the 1982 elections, Sen. Claude Pepper sent

out a nationwide letter stamped "Important Social Security Information Inside" and looking exactly like an official Social Security Administration document. It claimed that Republicans were trying to dismantle Social Security (and by implication Medicare and Medicaid). Most election analysts believed this was a primary reason why the Republicans lost 26 congressional seats and why the Reagan administration abandoned further Medicaid and Medicare reform efforts.

The 1980s also was a decade in which states tried numerous bookkeeping schemes to "enhance" the federal match, using methods that are now illegal or discouraged. [See the sidebar on "The Texas Experience."] Enhancing or maximizing the federal match has become a cottage industry for some Washington, D.C., think tanks, but the real culprit is the match itself.

In the 1990s, concern about Medicaid funding was superseded by concern for the uninsured. Health care became a major national issue when, in 1991, Pennsylvania's little-known Harris Wofford defeated the sitting U.S. attorney general for a U.S. Senate seat. Wofford's campaign manager, James Carville, took the issue to the governor of Arkansas for use in his campaign for U.S. president in 1992.

The result of these three decades is an astonishingly bare record of successful reform. Although America has changed greatly in 37 years, Medicare and Medicaid remain essentially the same programs that were enacted in the 1960s, that distant and different social and economic time.

Medicaid Today

"The nation is now spending more on Medicaid (for the poor) than it spends on Medicare (for the elderly)."

The Office of Management and Budget estimates total Medicaid spending will be $280 billion in Fiscal Year 2003, serving about 40 million poor, elderly and disabled. Medicare, by comparison will serve 40 million at a cost of $230 billion.[18] This means Medicaid will spend more than Medicare for the second time in history (FY2002 was the first).

Medicaid versus Medicare. Medicare is a single federal health care program with a single national eligibility, benefits and reimbursement structure. By contrast, Medicaid is actually 56 separate state and territorial welfare programs with distinct eligibility, benefit and reimbursement rules.[19] A person eligible for Medicaid in one state will not necessarily be eligible in another. Since upward of 70 percent of services and people are optional, the mix of eligibles, benefits and costs are unique to each state.[20]

Another difference between Medicare and Medicaid is that Medicare pays almost exclusively for acute care. It has no long-term care or drug benefit and is insulated from many of the problems of an aging America. Medicaid, by contrast, pays for two-thirds of all nursing home residents and 50 percent of all long-term care costs nationally. Although most people tend to think of Medicaid as the health insurance plan for welfare mothers, most of the money is spent

The Texas Experience: A Lesson about Maximizing Federal Funds

In the late eighties, the fiscally conservative state of Texas faced various economic woes, including expanding entitlement caseloads, budget shortfalls, and other needs that could not be addressed without major tax increases. Health care costs were escalating, as they are today. To address these issues, state budget officials decided to maximize federal matching funds. Specifically, the state sought to obtain Medicaid matching funds for existing expenditures that were not being matched by the federal government and to expand Medicaid eligibility. The first effort did not cost additional tax dollars, at least initially. The second did.

To accomplish the first, state officials devised a way to convert money that was being spent on charity care for indigent patients but was not matched by federal Medicaid dollars into expenditures that qualified for a federal match. The conversion was relatively simple: Texas counties sent funds to Austin one day and the state returned the funds the next. On paper, the one-day bookkeeping transaction converted county spending into state spending, satisfying federal requirements under the Disproportionate Share Hospital (DSH) program. This program was set up to compensate hospitals that treat not only a disproportionate share of Medicaid patients and receive state payments below market rates but also treat uninsured patients from whom they receive less than the amounts they bill.

The state also expanded Medicaid eligibility, primarily to pregnant women, infants, and children. This enabled Texas to qualify for even more matching funds, but it also increased the demand for state matching dollars.

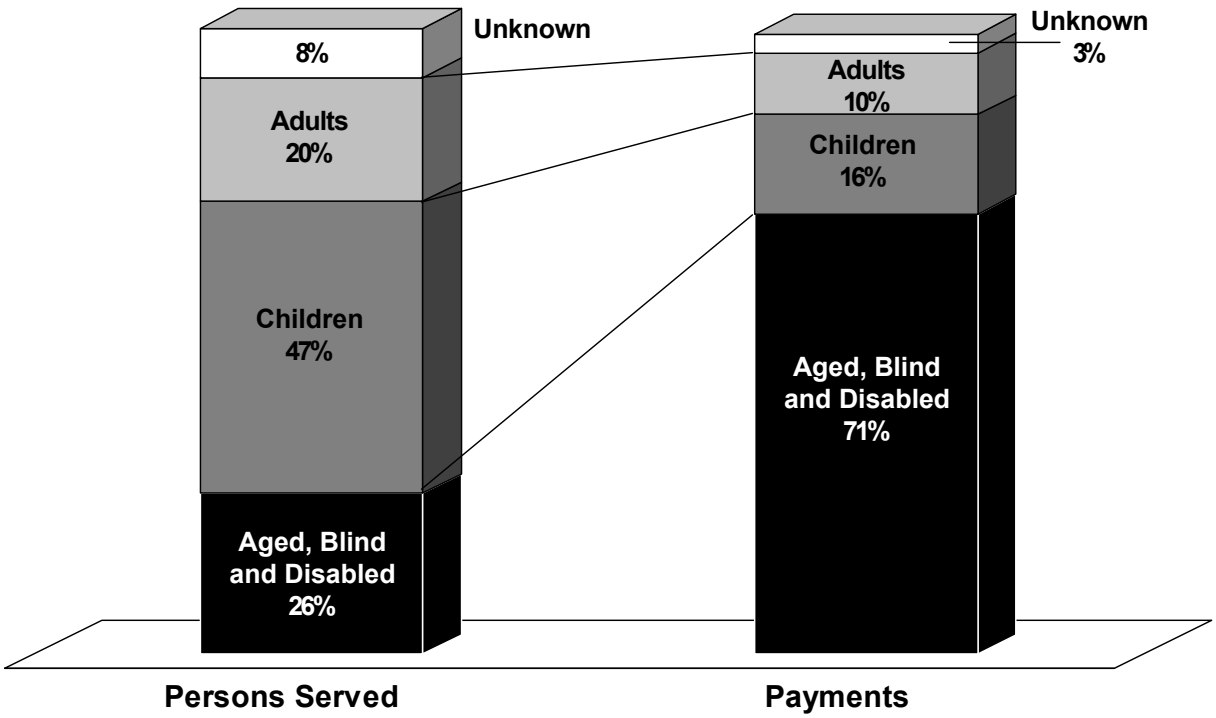
In all, Texas added a billion dollars a year to its DSH program, expanded eligibility to pregnant women and infants under Medicaid, and added to Medicaid some other needy populations.

The results were immediate and dramatic. It had taken about 20 years, from 1968 to 1988, for total Medicaid spending in Texas to reach $2 billion a year. Medicaid spending reached $7 billion — a three-and-one-half-times increase — in just five more years. And it doubled to $10 billion over the next 10 years.

FIGURE I

Distribution of Medicaid

(1998)



Note: (1) Totals may not equal 100 percent due to rounding; (2) "Payments" are direct Medicaid vendor payments and Medicaid program expenditures for premium payments to third parties for managed care, but they exclude DSH payments, Medicare premiums, and cost-sharing on behalf of beneficiaries enrolled in both Medicaid and Medicare; and (3) disabled children are included in the aged, blind, and disabled category shown above.

Source: Health Care Financing Administration, "A Profile of Medicaid: Chartbook 2000, Health Care Financing Administration," U.S. Department of Health and Human Services, September 2000, Figure 2.10.

on others. For example, long-term care accounts for more than 43 percent of all Medicaid costs but is used by only 9 percent of all enrollees. The elderly, blind and disabled combined account for about one-fourth of enrollees and almost three-fourths of all costs. Any successful reform must address this massive imbalance.[21] [See Figure I.]

"The aged, blind and disabled account for one-fourth of the beneficiaries, but almost three-fourths of the spending."

In theory, Medicare is supposed to be a federal program, paid for by the federal government. However, there is a class of Medicare recipients called dual eligibles. They initially qualify for Medicare, but because of their low incomes and few assets they can also receive Medicaid. Although Medicare is the primary payer, states must pay for any benefits Medicare doesn't cover if Medicaid does cover them.

The issue of dual eligibles sounds obscure, but recall that Medicare does not have a long-term care benefit and Medicaid does. Also, Medicare does not have a drug benefit, but Medicaid usually does. As a result, these huge costs

are born by the states. The states have no control over Medicare eligibility, but they are automatically responsible for Medicaid payment. The National Governors Association estimates that more than one-third of all Medicaid costs are for dual eligibles and has made this their principal issue with the federal government.[22]

Medicaid's Federal Match. As stated above, Medicaid is designed as a joint federal/state program. Currently, the federal government pays about 57 percent of all Medicaid costs (or $159 billion in FY2003) with states paying the rest (about $121 billion). The percentage each state pays varies. A complex formula called FMAP (Federal Medicaid Assistance Percentage or the "federal match") is used to calculate each state's relative per capita income. In "rich" states like New York, state spending is evenly matched by the federal government (each pays 50 percent). In "poor" states like Mississippi, the match has been as high as 83-17 percent.[23]

The average cost per Medicaid beneficiary nationwide is about $7,000.[24] But because New York offers almost all optional benefits to all levels of enrollees, it spends almost double the national average. Mississippi, which has a less generous benefit package and confines coverage mostly to the "mandatory" poor, spends just about half the national average.

"New York receives twice as much federal money per enrollee as Mississippi — even though Mississippi's need is much greater."

The result is that New York receives about twice as much federal money for each enrollee as Mississippi, even though the need is much greater in Mississippi. This is why "block granting" Medicaid funds to the states has proved difficult politically. Block granting federal funds now being spent would lock in place a system in which the federal government continues to send the most money to the places that least need it.[25] It is also the reason the Government Accounting Office (GAO) in 1995 declared the FMAP a failure in reallocating resources from rich to poor states.[26]

Medicaid's Impact on Economic Behavior. Although Medicaid was designed to assist people who need assistance through no fault of their own, the program offers perverse incentives. For example:

- Because Medicaid benefits are conditioned on low income, the program penalizes those who succeed; individuals can lose eligibility and therefore health insurance for themselves and their families simply by getting a workplace promotion or a raise.
- Because Medicaid benefits are conditioned on having few assets, the program encourages people to spend rather than save their income.
- Because Medicaid is an alternative to private insurance, the program encourages people to drop coverage they or their employers buy and rely instead on "free" Medicaid.

Very little research documents the ways in which people have responded to these incentives. But that modest research confirms what common

sense would predict. Medicaid beneficiaries have behaved in a rational manner. They have dropped private insurance coverage, saved less and consumed more.[27] Any attempted reform of state Medicaid plans needs to understand the perverse effects of the program already in place.

There is also empirical documentation of a "crowding out" effect of Medicaid on private health insurance. Nationwide, the percentage of children who can receive Medicaid increased by more than 50 percent between 1987 to 1992 and the number of women eligible for Medicaid if pregnant more than doubled. Thus, Medicaid coverage increased by more than 2.3 million. However, this increase was accompanied by a significant drop in private insurance, offsetting from 50 to 75 percent of the increase in Medicaid coverage. The vast majority of this reduction came from workers deciding to drop private coverage (particularly for dependents) rather than because their employers stopped insurance coverage.[28]

Medicaid's Impact on Health Behavior. An oft-cited argument for Medicaid is that by making health care virtually free at the point of consumption the program encourages preventive care and potentially reduces overall health care costs. Unfortunately, there is little evidence that this occurs.

"From 50 to 75 percent of the increase in Medicaid coverage is offset by a reduction in private coverage."

Studies suggest explicit attempts to encourage Medicaid beneficiaries to use preventive care are generally unsuccessful. For example, outreach programs in North Carolina found a statistically significant but very small impact on utilization.[29] Another study found that providing Medicaid benefits for a year increased the probability of children receiving checkups by only 17 percent. The researchers concluded that "factors other than insurance and income, such as the low educational attainment of low-income mothers, explain approximately 80 percent of the gap between low-income and other children in their well-child visits."[30] Research from the University of Washington found no evidence that prenatal care pays for itself by reducing future health care costs.[31]

Additionally, no definitive evidence links infant mortality rates to Medicaid coverage, and no evidence shows that becoming eligible for Medicaid significantly improves immunization rates.[32]

Elements of State Reform

A reformed Medicaid system must be based on a new philosophy. The following are the central elements of that philosophy.

Choice. All insurance programs have three essential elements: eligibility, benefits (coverage) and cost (reimbursement). How they are organized will determine the ultimate structure of the plan.

In a defined benefits entitlement plan, eligibility and benefits are fixed and costs are the variable. In other words, if you are *eligible* then you are "entitled" to all the *benefits* regardless of *cost* to the government or taxpayers

(hence the term "entitlement program"). Supporters of defined benefit welfare entitlements have always stressed the ethical need to cover the needy and uninsured, regardless of cost.

This is why cost containment has failed in Medicaid. The problem is structural rather than administrative. In the last 37 years, both political parties have exacerbated this defect by increasing benefits and broadening eligibility. As a result, Medicaid has grown from $1 billion and 10 million enrollees in the 1960s to $280 billion and 40 million enrollees during four decades of almost uninterrupted prosperity. And it kept right on growing through the 1990s, even though the welfare rolls were cut by more than half.

The alternative is a defined contribution program. Under this approach, eligibility and costs are fixed and it is the benefit package that is variable. Enrollees choose between a variety of competing private health benefit plans that fit their individual needs. For example, nursing home residents don't usually need maternity benefits and infants rarely need bypass surgery.

"The government should fix the cost of Medicaid, then let enrollees choose their benefits."

Usually, the amount spent by the government or an employer is the same, regardless of the choice of plan. But plans differ in how they allocate the funds among alternative benefits. If a plan costs more than the defined contribution amount, enrollees usually must make up the difference with their own funds.

An example of a defined contribution approach is the Federal Employees Health Benefits Program (FEHBP), a plan almost a half-century old. Even though the federal workforce is not necessarily a good risk pool — it is generally older and has more health problems — the premiums have been comparable to other, private sector insurance and federal employees have an annual choice of a dozen or so health plans.

One objection to allowing Medicaid beneficiaries to exercise choice is that the poor, elderly, blind and disabled either lack the ability to choose between plans or may be hood-winked by unethical sales people. Although this may be true of certain populations, it isn't true for the vast majority of Medicaid recipients. Evidence shows that for certain services, the poor have just as much ability to choose as the middle class.[33]

In a Medicaid program, a counselor/independent broker can be responsible for enrollment and education to assure proper access to the health care system. As an intermediary between the state and insurers, the counselor/broker can give independent advice and education. Also, they can continually screen the eligibility roles and make certain the potential enrollee is in the proper program.

Competition. One of the problems in both Medicaid and Medicare is the absence of a variety of private sector alternatives. This is the principal reason why both programs have failed to keep pace with developments in private health insurance.

For example, when Medicaid and Medicare were created in 1965, most private insurance plans (including the most common Blue Cross/Blue Shield plans) did not include coverage for prescription drugs. Since the government programs largely copied the design of private insurance, they also excluded prescription drugs. After a third of a century of developments in medical science, private insurance today is quite different. Virtually all major medical plans in the private sector cover drugs and, for reasons given above, most see drugs as an inexpensive alternative to hospital and physician therapies. But because the government programs were creatures of politics, insulated from competitive pressures, they have not changed. Medicare still does not cover most prescription drugs, and drugs are still an option under Medicaid.

In order for Medicaid enrollees to participate in, and benefit from, insurance that meets the market test and evolves as medical science evolves, beneficiaries need access to the same options that are routinely available to other citizens. How can they gain that access?

"Founded in 1965, Medicaid has not adapted to changes in medical science."

On entering office, President Bush and Health and Human Services (HHS) Secretary Tommy Thompson announced a streamlined section 1115 waiver process named the Health Insurance Flexibility and Accountability (HIFA) initiative. The section 1115 waiver, granted by the Centers for Medicare and Medicaid Services (CMS), has traditionally been the chief research and demonstration process to test innovative comprehensive Medicaid reform. The idea is to enable states to perform as "laboratories for democracy." Since August of 2001, states have had the opportunity through waivers:[34]

- To reduce some benefits in return for increases in other benefits;
- To reduce benefits in return for increases in the number of people eligible for those benefits; or
- To reduce benefits for some people in order to create a new set of benefits for others.

Suppose a state wants to expand eligibility to a new population (and qualify for federal matching funds for its spending on that group) without increasing the total amount of federal spending on health care. Under a HIFA waiver the state can have access to three sources of funds to pay its share of costs for the newly eligible:

- Disproportionate Share Hospital (DSH) funds, which are federal and state funds available to hospitals treating a disproportionate share of Medicaid and charity care patients.
- Unspent State Children's Health Insurance Program (S-CHIP) funds.
- Savings from the reduction of Medicaid benefits for currently eligible populations or the reduction in eligible populations.

Furthermore, the benefits created for the newly eligible group can be more limited than the benefits that were available to the previously eligible group.

There are certain restrictions on the waivers.[35] Usually, they are valid for three years (although they can be renewed). They must be budget neutral (the federal government must not expect to expend any additional funds). The state must be trying to "research an idea" (not just cutting costs). Certain populations must be "held harmless" (usually pregnant mothers and children). Certain benefits must be protected.

"States can attain flexibility through waivers."

Essentially, however, states can adjust almost all the benefits, eligibility and reimbursement standards. They need only CMS approval, not any congressional or judicial approval. If the waiver proves unsuccessful at any time, the state can unilaterally cancel after not adding any new enrollees for six months.

The intention of the 1115/HIFA waivers is to find ways to expand eligibility while not spending any more money. Tried as a defined contribution approach, it can be successful and provide quality care and patient satisfaction. For example, a reformed system under a wavier might work like this:

- Compare the present Medicaid program (benefits and cost) to some other health plan, such as a private plan routinely made available to state employees.
- Calculate what Medicaid would save if it paid only for the benefits of the private program (assuming no change of behavior); say the savings is 10 percent.
- Then for every 10 Medicaid enrollees that choose to join the private plan, the state could afford to extend coverage to one more potential Medicaid enrollee and stay budget neutral.
- If savings were greater than 10 percent (say, because of actual behavioral changes), the state could return the surplus to the taxpayers, support "safety net providers," or spend it on something else.
- If the Medicaid enrollee is able to obtain the same type of plan from an employer, the state could significantly reduce expenses by paying only the employee's share of the premium.

Any governor or legislature considering these waivers should note two caveats. First, these programs must be monitored carefully to see that projected savings appear. Otherwise, all the waiver will do is increase enrollment and costs.[36] Second, a bureaucracy can kill any new initiative.[37] It is usually not in the interest of an agency to admit that a better way exists or to implement it. The waiver should be administered directly from the governor's office or some new independent agency/board. For example, the Federal Employees Health Benefits Program is not administered at CMS. It is administered in the

White House Office of Personnel Management by an appointee reporting directly to the President. If a new Medicaid program is structured using private insurance, perhaps it should be administered by the State Commissioner of Insurance rather than the present Medicaid bureau.

Portability. There are serious quality and continuity of care problems in the present Medicaid program. At least a quarter of all Medicaid eligibles are in and out of the program each year.[38] As a result, patients can be tossed from physician to physician multiple times a year. Many find using a hospital emergency room more convenient than having a primary care physician. Lack of portability also is a disincentive to find work and leave the Medicaid rolls.

"Ideal health insurance is portable insurance."

Of course, the easiest way to obtain portability is to allow Medicaid beneficiaries to enroll in plans their employers offer. The key to good health care is continuity of care: keeping one's physician, knowing one's hospital and understanding how best to access the system for oneself and one's children. Quality also depends on providers wanting to provide that care, which is more likely if patients are exercising choice. It is even more likely if patients are managing some of their own health care dollars.

Empowerment. Arkansas, New Jersey and Florida were the first states to receive Section 1115/ HIFA waivers (described above) that provided disabled Medicaid recipients direct cash payments to purchase needed services. This program, "Cash and Counseling," encompasses the essential elements of a defined contribution approach. The patient is given a set dollar contribution and is free to choose his or her providers.

The program also involves counseling to assure that the patient is well-informed. Previously, the states selected the providers without patient input. Now the patient can choose his or her own provider. Unbelievably, patient satisfaction is almost 100 percent.[39]

"Ideal health insurance empowers patients."

Another promising idea is the use of a Medical Benefit Account (MBA), an idea similar to Medical Savings Accounts (MSAs), except that funds in an MBA would be restricted to health care and health insurance premiums and could not be withdrawn as cash.[40] Through this account, beneficiaries would manage some of their own health care dollars and thus would have incentives to make prudent health care choices. Opponents believe that the poor will forgo needed health care to accrue more cash. However, through a debit card, the state could ensure that the recipient completed certain medical procedures such as child immunizations or prenatal care before accessing any cash. The recipient could then use his or her remaining MBA funds for other health, social, child education or job training needs.

Paying for Results. The cost control methods the private sector plans use will be those that survive the market test. However, even for those who remain in traditional Medicaid, more can be done to insure that taxpayers get their money's worth.

The first and most important goal is to pay for services rendered rather than paying for the cost of producing those services. Only a few decades ago, our entire health care system was based on cost-plus finance.[41] Blue Cross and most other private insurers paid hospitals based on their costs. So did Medicare. So did Medicaid.

Today, almost no private insurers pay hospitals based on their costs. And the federal government pays hospitals under Medicare on a DRG system — with fixed fees for treating different categories of illness, regardless of actual costs.[42]

The exception is Medicaid. All too often state Medicaid programs pay hospitals, nursing homes and other facilities based on some version of cost-plus finance. For example, Table A-I shows the basic rate Medicaid pays hospitals in Dallas County. As the table shows, the state pays different hospitals very different amounts for what are essentially the same services. Private insurers, by contrast, tend to contract with hospitals selectively, steering patients to facilities that charge the lowest prices, other things equal.

Nursing home care reimbursement also is in urgent need of reform. Under Ohio's cost-based method of payment, for example, the state is paying for 13,000 empty beds. To make matters worse, Ohio's method of reimbursement encourages churning (wherein operators sell nursing homes back and forth to each other) and even encourages bankruptcy. [See the sidebar on "Paying for Long-Term Care in Ohio."]

The second goal is to take advantage of evidence-based disease management and care coordination[43] to assure that services provided are necessary and appropriate.[44] Where treatment protocols do not exist, the state should foster their development in conjunction with academic institutions and practitioners. Doctors still would retain the right to make treatment decisions for their patients, but when they chose to prescribe treatments other than those in the protocols, they would know they have a higher burden of justification. [See the sidebar on "Smart Buying in Texas."] Protection from liability, or at least limited liability, could be the reward for following protocols.

"Medicaid should pay for results, rather than reimbursing for costs."

A third goal is to eliminate errors. Some of the more costly problems include drug misuse, antibiotic overuse, preventable hospital-acquired infections, and the under-diagnosis and mistreatment of chronic conditions.[45] Medical errors are dangerous and costly. Elimination of errors in diagnosis and care provides better treatment at lower cost. Everyone wins.

A fourth goal is to create evaluation and payment systems with incentives to lower cost and achieve desired outcomes. If the state paid only for outcomes it deemed worthwhile,[46] it could reap significant savings in such areas as mental health care, substance abuse treatment and purchases of durable medical equipment.[47]

Paying for Long-Term Care in Ohio

In Ohio, institutional care in nursing homes and intermediate care facilities for the mentally retarded currently accounts for 39 percent of all Medicaid spending. Moreover, the state's long-term care costs are a billion dollars higher today than a decade ago, even though the number of patients is smaller. Ohio spends about $2.5 billion annually on nursing home care and, absent reform, annual spending will jump another $400 million by next year, bringing the amount spent per patient per year to about $55,600.[1] But examining the numbers in detail reveals much wasteful spending. For example:

- Ohio pays for long-term care beds, not patients; as a result, taxpayers are subsidizing nearly 13,000 empty Medicaid beds.
- Ohio rewards long-term institutional care over less expensive community care.
- Ohio's method of determining who is eligible for long-term care nourishes a cottage industry of lawyers who set up Miller Trusts to help beneficiaries satisfy the asset test and avoid the apparent legislative intent.[2]
- Ohio's cost-based method of reimbursing long-term care encourages nursing home sales by allowing each new buyer to depreciate property already depreciated by the previous buyer; the resulting churning of facilities threatens quality of care.
- Ohio's method of reimbursement even rewards bankruptcy; by allowing bankrupt owners to continue operations until a new buyer is found, Ohio allows the sellers to shed their debts and rewards the buyers with a higher (reimbursable) cost basis.

To make matters worse, long-term care probably generates the most dissatisfaction of any major Medicaid expenditure category. Although one in three adults over 55 is likely to use long-term care, few choose it and most express ongoing concerns about its quality.

[1] Under current law, nursing home spending automatically increased by 9.6 percent in fiscal year 2002 and will increase 7.5 percent in fiscal year 2003, adding $400 million to Medicaid spending.

[2] Miller Trusts allow individuals who have too much income for Medicaid eligibility to receive care — providing other requirements are met — by putting the money into a trust that limits their income. If state legislators want this loophole, they should clarify their intent.

Smart Buying in the Texas S-CHIP Program

Texas has contracted with a private insurer, Clarendon National Insurance Company, to run the state's Children's Health Insurance Program (S-CHIP) in rural areas. While the state's health insurance costs are rising by double digits in the private sector and in Medicaid, they are not rising for this program since the private contractor assumed the risk under the contract. Furthermore, Clarendon returns millions of dollars a year under an agreement that allows the state a major share of any profits that are earned.

Why is this insurance plan so profitable while others are incurring losses? Why is this insurance plan able to control costs while others have failed to do so? The answer is application of a few commonsense ideas.

One idea is to maintain a 24-hour nurse consultation hotline. Whereas Medicaid patients often go to emergency rooms and wait long hours for an expensive physician's diagnosis, Clarendon strives to keep children and their parents out of emergency rooms. The company's free telephone advice line is, in many cases, much better and cheaper — not to mention more convenient for patients and their families. Moreover, Clarendon does not always wait for patients to call in. Sometimes the nurses call the patients. For example, if the company finds that a patient is not refilling a prescription at the appropriate interval, a nurse may phone the patient to find out if there is a problem and to offer a reminder. When a teenager fills a prescription for prenatal vitamins, the pharmacist notifies Clarendon so a nurse can help the young woman enroll in the high-risk maternity program.

Clarendon's approach is to identify potentially high-cost problems and find low-cost ways of averting them. Take the treatment of asthma, for example. The company knows that controlling the cost of childhood asthma requires the help of a parent. So Clarendon invests in parental education — making sure, for example, that a mother recognizes the symptoms of an attack and understands the role of drugs in treatment. How well does this approach work? Approximately 150,000 children are enrolled in the asthma program, and in one six-month period not a single child was treated at an emergency room for asthma.

The company also monitors the practice patterns of doctors. Many rural physicians were trained decades ago, and some procedures have changed dramatically over time. Claredon does not tell physicians how to practice medicine. But it does work to ensure that doctors are aware of the newest, most appropriate, and most effective methods of treatment.

Texas' experience of providing cost-effective health care to rural children shows that it is feasible to improve health and cut costs at the same time.

Some might argue that the achievement of these goals was supposed to be the purpose of managed care. Yet during the 1980s, all too often managed care consisted of little more than negotiating price discounts, even though the managed care organizations (MCOs) claimed they were instituting efficiencies and eliminating waste. Actually, a lot of dollars can be saved without a large managed care bureaucracy by simply using common sense. [See the sidebar on "Smart Buying in the Texas S-CHIP Program."] [Full disclosure: One of our authors, Ronald Lindsay, is involved with this project.]

Devolution. For those who remain in traditional Medicaid, another useful idea is to give local communities more control, say through a block grant of funds. An example of a community that could benefit from more flexibility is El Paso, Texas.[48] As Table A-I shows, El Paso (the Upper Rio Grande area) has a low utilization of Medicaid, but a high level of spending for uncompensated care. Moreover, under Texas reimbursement formulas, El Paso hospitals are paid at rates that are above the state average, while primary care clinics are starved for resources. A typical primary care clinic, for example, lacks an X-ray machine or even a lab and must send patients to a local hospital for simple diagnostic tests.

"Our primary goal should be to place people in private health plans."

As a result of these factors, El Paso's low-income population overutilizes hospital care and underutilizes outpatient care. The city and its people would be better off it were free to reallocate funds from inpatient to outpatient care. But restrictions on the use of funds apparently make this difficult, if not impossible.

More Radical Devolution. How far can devolution go? In searching for an answer to that question, consider first one of the most perplexing questions about Medicaid. An estimated 3 million adults in the United States are eligible for Medicaid but do not bother to enroll. An estimated 6.8 million children who are eligible for S-CHIP or Medicaid are not enrolled.[49] Yet if these health insurance programs are valuable, and given the amount of money they spend, they must be, why do people choose not to enroll?

A visit to the emergency room of Parkland Hospital in Dallas suggests an answer. This is the primary portal into the health care system for Dallas area residents who are on Medicaid and also for those who are uninsured. However, Parkland often fails to achieve its enrollment goals for the uninsured. The question for public policy is this: If the patients and the doctors do not care who is enrolled in which program, why should policy-makers care? Why not just give Parkland hospital a sum of money each year and let it deliver indigent health care?

"For those who remain in the public sector, we need block grants to local communities."

Most communities receive health care funding from both the state and the federal government. These funds flow through such programs as Medicaid, S-CHIP, DSH, etc. Each program has its own set of rules, narrowly prescribing how the funds may be spent. Local communities have no power to allocate resources in ways that would maximize their impact.

For example, in one community the greatest return on health care spending may come from fluoridating the water supply. In another, the greatest return may come from improving sanitation. Yet local communities have no authority to use their diverse health care funding to achieve these goals. Ideally, cities should be able to combine all their public health care dollars and freely allocate them so as to achieve maximum health impact.[50] Our primary goal should be to enroll people in private sector plans. But to the degree that we cannot, we should make access to care as easy as possible.

A Specific Waiver Proposal

A HIFA waiver alone, without any cost-control efforts, would be unwise. But an HIFA waiver could be coupled with market incentives to improve quality and reduce costs and with other appropriate cost-control activities. Furthermore, phasing in parts of the HIFA waiver and limiting eligibility expansions until each phase has been evaluated can limit unanticipated financial risks.[51] What follows is a specific proposal.

1. Medicaid Benefit Changes. Medicaid has a very rich benefit package. Consistently, Medicaid benefits exceed most private insurance benefits in most states. As a result, taxpayers generally have lower benefits in their own health insurance plans than those provided to Medicaid enrollees at taxpayer expense.

This is unfair and unwise. It is unfair because taxpayers should not be forced to provide others with health benefits more generous than they can afford to purchase for themselves and their families. It is unwise because the Medicaid population is largely insulated from many of the cost-controlling, quality-improving innovations that are available to private sector plans.

"Medicaid enrollees should be allowed to join private plans, including employer plans and individually owned insurance."

Medicaid enrollees should be allowed to enroll in private sector plans, including employer plans and individually owned insurance plans. To qualify to accept Medicaid enrollees, a health plan should have to offer benefits at least as generous as any of the plans currently offered to state employees. In addition, the state should authorize a new type of plan that incorporates a health care savings account.

Although the private sector plans may appear less generous on paper than the current Medicaid program, they usually would allow enrollees access to a greater range of providers and facilities. Put differently, this proposal would allow Medicaid enrollees to participate in the same kinds of health plans as other citizens.

2. Eligibility Changes: As noted above, the benefits provided to a new group of eligibles under a federal waiver do not have to be identical to the benefits provided to the currently eligible. Nor does the state subsidy have to be the same. One option is to follow Utah's example and provide primary care

only to the newly eligible population. [See the sidebar on "The Utah Experience.] Another option is to allow the new eligibles access to an insurance exchange (see below) but subsidize the insurance on a sliding scale, with additional income reducing the premium subsidy.

To discourage crowding out of private coverage, the state could impose a waiting period between the time individuals lose private coverage and the time they are eligible for Medicaid. In a more extreme manner, the state could deny Medicaid coverage to any individual whose employer offered private insurance. Since Medicaid payments often are made on behalf of individuals who have private health insurance, workmen's compensation and/or liability insurance, the state should vigorously attempt to recover these funds from the appropriate carriers.

3. Marked-Based Cost Control Devices. In order to take full advantage of cost-controlling, quality-improving innovations in the private sector, Medicaid enrollees need access to health plans that compete for customers in the marketplace. One way to provide that access is to allow Medicaid beneficiaries to enroll in employer plans for which they qualify at Medicaid's expense. Provided the plan satisfies the benefit requirements described above, Medicaid should be willing to pay the standard employee contribution or 50 percent of the premium, whichever is less.

[Note: To enable employers to offer the same type of insurance to their employees that is available to state employees, such employer plans must be free from state mandates and other cost-increasing regulations.]

Those beneficiaries who do not have access to employer plans should be able to participate in a state-operated insurance exchange, or health mart, to directly enroll in individually owned health insurance plans. [See the sidebar on "Making Health Marts Work."] The carriers participating in the insurance exchange would offer a host of competing health plans. Participants could purchase an HMO type plan, a preferred provider plan or a plan combining significant patient cost-sharing with a Medicaid Benefit Account (see below).[52]

"Structured properly, competition can help meet patient needs."

The insurance exchange would have the following features. The role of the state would be to organize the exchange, solicit information from a host of health plans and make information available to the beneficiaries. This would make the plan similar to the federal government employee health insurance system.[53] Health plans would be required to accept enrollees at risk-adjusted premiums based on age and sex. Those failing to make a plan choice would automatically be enrolled in the "no frills" plan with limited choices (probably a closed-panel HMO). The exchange could be contracted privately, with Medicaid overhead reductions financing the operation. Health plans offered through the exchange would be exempt from state small-group market reforms and laws mandating health benefits. This could significantly lower the cost of coverage.

The Utah Experience: Testing the Limits of Federal Waivers

A revolutionary use of a HIFA waiver is modeled by Utah. Utah uses unexpended federal matching funds for its Children's Health Insurance Program (CHIP), reduces benefits for currently eligible Medicaid recipients, and expands eligibility to cover low-income workers who lack insurance.

The Utah model qualifies for a HIFA waiver by attaining budget neutrality while expanding eligibility to new populations; the change in mandated populations is balanced by changes in mandated benefits and unused federal funds. The state also uses fact-based evaluations to guide disease management and care coordination in ways that achieve the desired outcomes. For example, by providing appropriate treatment during pregnancy, the states can significantly reduce the number of low-weight births. Instead of sick babies, healthy babies result. They require less intervention — so while the outcome is better, the cost of services is lower.

On the cost-reduction side, Utah replicates the benefit package of the Utah Public Employees Plan (Utah PEP) rather than the more generous Medicaid design.[1] Utah also has changed its laws so that private insurers can offer employers plans with the same benefits as PEP. Thus the state can buy Medicaid enrollees into employer plans — relying on the private market rather than expanding public programs and saving money for the state because employer premium payments substitute for Medicaid spending. The Utah waiver permits an enrollment fee and copayments up to 11 percent of annual income.[2]

On the cost-expansion side, Utah extended eligibility under the waiver to cover two groups: (1) parents with children enrolled in Medicaid or CHIP whose family income is below 150 percent of poverty and (2) childless adults with the same income level. The significance of the Utah waiver is monumental. By following Utah's example, other states can exercise greater control over their Medicaid costs. States can now make budget neutral changes in one year that reduce Medicaid expenditures in succeeding years.

[1] This more limited benefit package is also the package made available under Utah's CHIP program.

[2] Enrollment under the Utah waiver will be restricted until program evaluations can be completed on: (1) the success of the plan in reducing health problems for the populations served; (2) the impact on the use of emergency rooms; and (3) the effect on "crowd-out" (the extent to which public insurance is substituted for private insurance for which the insured and/or the insured's employer paid).

The introduction of an insurance exchange would put the marketplace to work to reduce costs and encourage innovation, allowing beneficiaries to choose among private sector plans. This would also make it easier for those leaving public assistance to keep medical coverage, since they or their employer could simply substitute private premium payments for the state subsidy. Other advantages of this plan: reasonably priced coverage for the poor and near poor, continuity that permits the poor to keep their coverage when they leave public assistance, an entry point for Medicaid beneficiaries into the private insurance system, and the publication and distribution of easy-to-understand information about each plan.[54]

The state would move from being a health insurer to a health financier. Its role would be to set the ground rules, determine what minimum benefits private insurers would have to offer, solicit insurers to join, collect information about plan benefits and costs, and provide the information to prospective enrollees through the state insurance exchange.

"Patients should be able to control some of their own health care dollars through Medicaid Benefit Accounts."

4. Patient Power Cost-Control Devices. When patients have first-dollar coverage for health care services, they have no incentive to avoid waste or insure that they get a dollar's worth of value for each dollar they spend. To the contrary, if the out-of-pocket costs are zero, patients have an incentive to utilize health care services until their value approaches zero, at the margin. Similarly, doctors treating patients with first-dollar insurance coverage have an incentive to provide services as long as those services offer any positive medical benefit (or probability of benefit), even if the value of the benefit is well below its cost.

Managed care arose to try and counteract these perverse incentives. But all too often managed care consisted of an impersonal bureaucracy that put cost control ahead of patient welfare. As an alternative, many employers across the country are empowering employees by letting them manage some of their own health care dollars and experience the costs and benefits of prudent health care consumption.[55]

State Medicaid programs need to follow this example. Beneficiaries should have access to plans that combine patient cost sharing with a health care saving account called a Medicaid Benefit Account (MBA).

Since these accounts would be wholly or partly funded with taxpayer dollars, they should probably by restricted to the payment of medical bills and insurance premiums. Beneficiaries who consumed health care wisely and saw their MBA balances grow through time would not be able to withdraw these balances for non-health care spending. However, they would be able to use the funds for medical services not covered by their health plan. And in the future, they would be able to use unspent balances to pay insurance premiums and buy medical care directly after they left the Medicaid rolls. [See the sidebar on "Medicaid Benefit Accounts."]

Making Health Marts Work

Under the Federal Employees Health Benefit Plan (FEHBP), federal employees and their employer, the federal government, pay community-rated premiums to enroll in competing private sector health plans. The competitors are not allowed to charge premiums that reflect an individual's expected health care costs. Because of this community-rating requirement, the healthy are overcharged and the unhealthy undercharged.

Thus FEHBP health plans have strong incentives to underprovide to the sick and overprovide to the healthy.[1] Risk-adjusted premiums can ameliorate this problem somewhat, but risk adjustment cannot eliminate the problem and under some circumstances can make it worse.[2]

In designing a health mart or insurance exchange for Medicaid, we must not repeat this design error. We need FEHBP-type competition in which the competitors have good rather than bad incentives. How can we assure that?

Under the FEHBP system, federal employees join health plans for a period of 12 months; once a year, they reselect their health plan during an "open season." A better structure is to have long-term enrollment — lasting, say, three to five years. Under this arrangement, enrollees could establish long-term relationships with physicians and health care facilities through their relationships with the health plans that contract with those physicians and facilities.

During the contract period, enrollees could switch health plans. However, a switch of plans would require consent of both the new and the old plans and would almost always necessitate a lump sum payment from one plan to the other. For example, if a sick and high-cost enrollee switched from Plan A to Plan B, A would have to compensate B for the extra costs B would expect to incur over and above the annual premium B would receive. If a healthy and low-cost enrollee switched from Plan A to Plan B, B would have to compensate A for the difference between the premiums it collected and the health care costs it likely would have incurred.

Under this system, health plans could not dump their sick enrollees on other plans without compensating the other plans for their expected losses. Nor could health plans lure healthy enrollees from another plan without compensating the other for its lost profit. In such a system, health plans would have an incentive to compete for the sick instead of actively trying to avoid them.

[1] John C. Goodman and Gerald L. Musgrave, "A Primer on Managed Competition," NCPA Policy Report No. 183, April 19, 1994, National Center for Policy Analysis.

[2] John C. Goodman, Mark Pauly and Phil K. Porter, "The Economics of Managed Competition," unpublished. Available from the National Center for Policy Analysis, 12655 N. Central Expressway, Suite 720, Dallas, Texas 75243.

Medicaid Benefit Accounts

The idea behind a health care savings account is that individuals should be able to control some of their own health care dollars and profit from efforts they make to control costs and eliminate waste and inefficiency.

In the United States, a federal government pilot program allows certain individuals access to a tax-free Medical Savings Account (MSA) that is associated with a high-deductible insurance plan. Individuals use their MSA funds to pay costs below the deductible and rely on third-party insurance to pay costs above that amount.[1] In South Africa, flexible MSA policies are quite popular. In a typical South African plan, the deductible is zero for hospital services (on the theory that patients exercise little discretion in that setting) but is $1,100 or $1,200 for outpatient care (on the theory that patients exercise a lot of discretion in that setting). A zero deductible may also apply for drugs for certain chronic conditions (on the theory that if the patient skimps on the drug, his or her health costs may soar).[2]

For U.S. Medicaid beneficiaries, we recommend a flexible account called a Medicaid Benefit Account (MBA). Health plans that offer these accounts should have low or zero deductibles for drugs, devices, or services we want to encourage. But the MBA plans should require the insured to share substantially in the costs of products and services over which they can safely exercise discretion.

Patients who do not spend all of their MBA money on health care necessities can spend the rest on dental care, eye care, and other noncovered medical expenses. They can even use any remaining funds for future medical insurance and health expenses, tuition, housing, transportation, or other expenses that help Medicaid beneficiaries move up from public support.

Giving individuals and families funds to meet their most pressing needs reduces waste and encourages self-reliance. (These accounts should not be subject to asset testing.) States such as Michigan and Massachusetts, which have consumer-directed Medicaid models, have found that beneficiary satisfaction is higher and costs often lower than for state-administered programs. For example, in Michigan two-party checks are used to pay attendants for the elderly and disabled and other providers of home health care. The requirement that the patient or a guardian cosign the paycheck of the personal care attendant ensures that the latter works for the patient rather than the government and creates incentives for the prudent use of goods and services. It also tends to reduce costs.[3]

[1] John C. Goodman, "MSAs for Everyone, Part I," National Center for Policy Analysis, Brief Analysis, No. 318, March 31, 2000; Greg Scandlen, "MSAs for Everyone, Part II," National Center for Policy Analysis, Brief Analysis, No. 319 March 31, 2000; and John C. Goodman, "MSAs for Everyone, Part III," National Center for Policy Analysis, Brief Analysis, No. 356, April 19, 2001.

[2] Shaun Matisonn, "Medical Savings Accounts and Prescription Drugs: Evidence from South Africa," National Center for Policy Analysis, NCPA Policy Report No. 254, August 2002.

[3] The Michigan Home Care Program uses two-party checks to discourage fraud. Used to pay in-home caregivers, these checks must be signed by both the caregiver and the care recipient. See "Grant Results Report: Studies of Cash Disability Allowances for Long-Term Care," the Robert Wood Johnson Foundation, September 1998.

Expected Benefits from the HIFA Waiver. The HIFA waiver recommendation is based on the twin principles of free markets and personal responsibility.[56] A number of significant benefits can result from this approach:

- First, moving to a market-based system can provide greater freedom and efficiency than the present system allows.
- Second, individual recipients and providers can be given incentives to improve quality and lower costs, to benefit them and other taxpayers.
- Third, the effects of these improvements and resulting savings can continue to accrue over time.
- Fourth, Medicaid can begin moving from Washington to the states, which better know their own needs.
- Finally, draconian cost increases can be reduced or avoided during a period when available revenue is limited.

Reforming Medicaid for People with Disabilities

Covered Families with Children (CFC) is a fairly homogenous group of Medicaid beneficiaries. It is also a fairly healthy group. This is one reason why states have had considerable success in moving this group into private, managed care programs. It is also the reason why we anticipate success in moving this group into other private sector insurance, including employer plans. People with disabilities pose a harder problem because their problems range from schizophrenia to mental retardation to blindness. Further, this has been an area of exploding costs. [See Figure II.]

"To care for people with disabilities, we need to contract with the private sector."

Contracting with the Private Sector. The many different health needs of these groups make it unlikely that a private insurer will insure the whole group, as a group. The state of Florida has had some success in finding private sector entities who will contract to care for people with specific types of disabilities. States need to explore such opportunities. For example, disparate providers could serve the mentally ill, the physically disabled, the drug addicted and so forth. The comparative advantage of these various providers would serve to reduce costs and possibly increase the quality of service.[57]

Empowering Patients. As noted above, several states have had some success with "Cash and Counseling," which gives beneficiaries control over some of the health care dollars and allows them tdiscretion in using those dollars. More such empowering programs are needed.

Monitoring Eligibility. A large number of people with disabilities access Medicaid benefits by qualifying for federal Supplemental Security Income (SSI). This program has a history of being riddled with fraud and

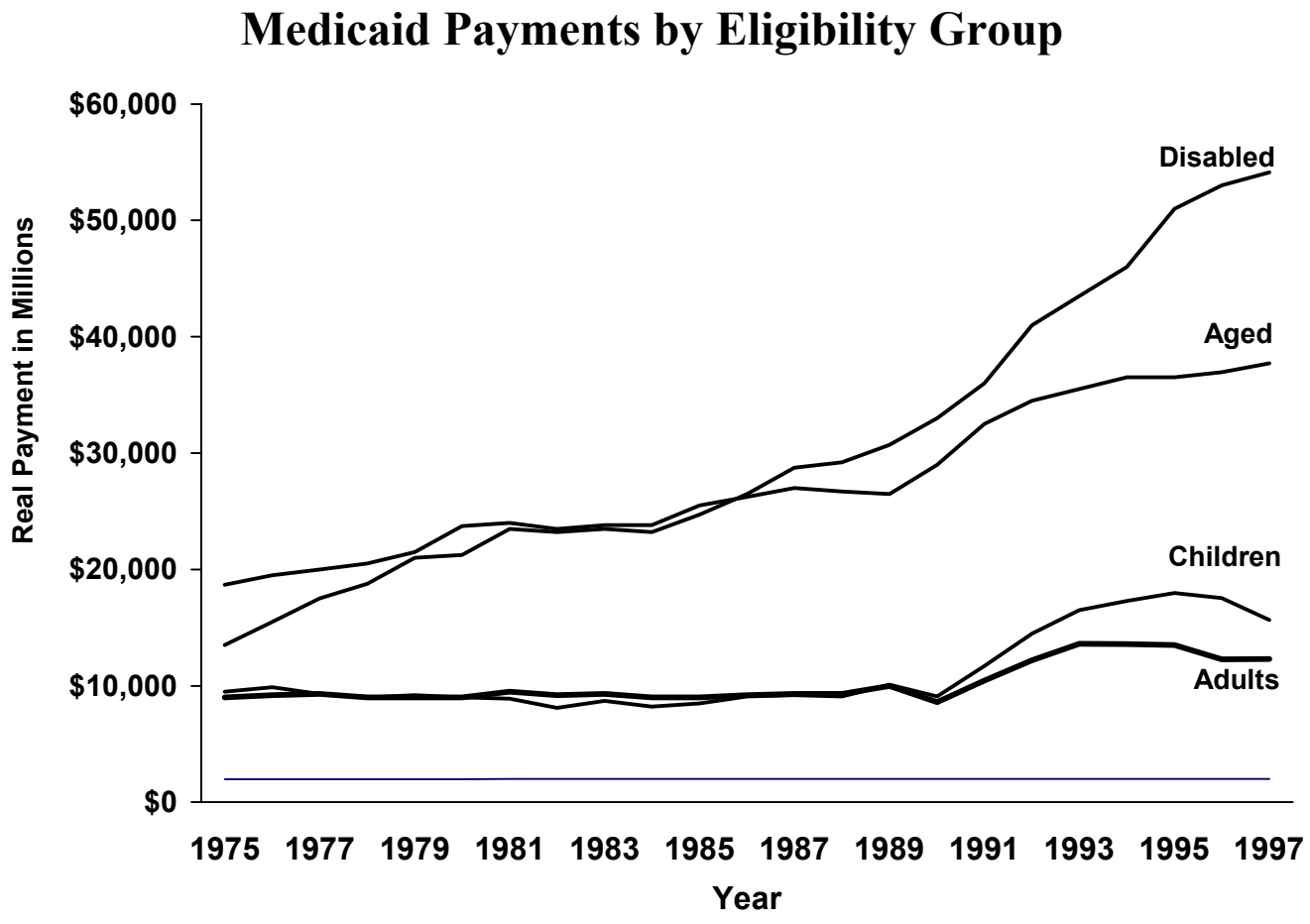
abuse.[58] It is not difficult to understand why. Since coverage often is related to medical conditions that are fairly easy to fabricate or exaggerate, individuals and parents have incentives to misrepresent their medical conditions. Unlike the poor and near poor, whose income and assets can be documented, these recipients can "game" the system to obtain coverage.

"Care for the people with disabilities has experienced the fastest growth."

Most states could better determine who qualifies for Medicaid disability coverage by separating it from SSI coverage. States can provide additional resources to the appropriate screening bureau or create a panel to judge whether individuals are truly disabled. Savings from removing the unqualified from the rolls would serve as the funding source.

Tailoring Benefit Packages. Given varying degrees of disability, the benefits package could be constrained so as to pay only those health costs related to the disability, depending on the severity of the health problem, and could offer premium support on a sliding scale.

FIGURE II



Note: Expenditure are expressed in 1997 dollars.

Source: Health Care Financing Administration, "A Profile of Medicaid: Chartbook 2000, Health Care Financing Administration," U.S. Department of Health and Human Services, September 2000, Figure 2.11.

Paying for Long-Term Care

As noted above, many states could substantially reduce their long-term care expenses by abandoning cost-plus reimbursements and all its variations. The state should pay for services received rather than paying for the cost of delivering those services. The following are some additional suggestions.

Encouraging Cost-Effective Alternatives. Cost savings could be realized in some cases with home health care services instead of a medical center. However, efficient screening for eligibility would be needed. For example, an individual with disabilities might resist applying for coverage if it implies residence in a nursing home but opt to do so if eligible for home health care. When less costly services also are more attractive, they can have the effect of increasing demand.

Enforce the Asset Tests for Eligibility. The asset tests for eligibility for Medicaid long-term care should work as intended by the legislature. Although legal, establishing Miller Trusts to circumvent income tests for eligibility for Medicaid long-term care is an abuse of legislative intent and is driving up costs.[59] If Miller Trusts are not what the legislature intended, the law should be changed. If existing trusts are what were intended, additional statutes should exclude trusts that reduce current income and should set clear income eligibility standards.

Encourage Community Care Rather than Institutional Care. In general, care in a home or small facility is preferable to care in a large institution. At a minimum, no bias towards institutional care should exist. Where comparable services are more cost-effective in the community, services should be provided there.

To appreciate the opportunities for reducing costs, consider that Oregon, Washington and Wisconsin expanded home- and community-based care to help control rapidly increasing institutional care expenditures. These states were able to provide services to more people with the available budget. Home- and community-based services have helped them control the growth in overall long-term care spending. For example, between 1982 and 1992 the combined number of beds in Oregon, Washington and Wisconsin declined by 1.3 percent, while total nursing facility beds in the U.S. increased by 20.5 percent.[60]

"We can get better long-term care if we pay for results."

Base Payments on Outcomes. In general, it is better to pay for outputs (i.e., quality of care and consumer satisfaction) than for inputs (i.e. beds, staff, etc.). To get results, a payment system should only pay for what is desired. Quality and satisfaction is what recipients and their families want. An index of quality-of-care indicators should be constructed and used to distribute total funds. Three factors could be averaged to create the index. One-third could be based on resolved complaints, one-third on customer satisfaction

surveys of patients or their guardians and one third on such performance measures as changes in number and severity of pressure sores (adjusted for acuity level of population), use of restraints, odors, food, etc.[61] A facility that scored 50 percent higher on this index than another facility would get a 50 percent larger share of payments (per patient, adjusted for acuity). Nothing improves quality quicker than paying for it.

This recommendation is consistent with a recent National Academy of Sciences report, which recommended that all federal health programs pay providers based on objective assessments of quality for the treatment of 15 health conditions.[62]

Reducing Fraud, Waste and Abuse

Since its inception, fraud, waste and abuse have plagued Medicaid programs. For example, a 1993 investigative report of the Illinois Medicaid system by the Chicago Tribune found that:

- In one year, 71,064 Medicaid patients had more than 11 visits to a doctor's office (compared to a national average of six visits per year), while four patients had more than 300 visits in one year.
- In one day, one patient saw five doctors, made seven visits to a pharmacy and had 22 prescriptions filled with 663 pills.

The report also uncovered some "Medicaid mills," whose freely prescribed drugs, syringes and other medical products were bought with American tax dollars and sold on the street.

A decade ago, opportunities for reducing fraud nationwide appeared to be much larger. But in the intervening years, activity in this area has been minimal. Efforts to eliminate fraud, waste and abuse should be constantly reviewed to make sure they are up-to-date and cost-effective.

"Since its inception, Medicaid has been plagued by fraud, waste and abuse."

Fraud. Medicaid is especially vulnerable to fraud. It is a large program with a rapidly growing budget. It generates more than $1 billion in medical claims per year, nationwide. The General Accounting Office estimates that fraud and abuse may be a high as 10 percent of Medicaid spending.[63]

State Medicaid agencies claims data and other medical information could be used to identify fraud abuse, overuse and unnecessary care, but it seldom is. Most abuse is identified through tips or other unreliable means. The numerous jurisdictions having responsibility in a fraud case confounds detecting and prosecuting fraud.

In addition to the little chance of being caught, the penalties for fraud have been light. Perpetrators often have plea bargained or accepted pretrial diversion wherein their court records were sealed if they abided by court-approved probation for a short time. Financial penalties have been very light,

even for providers who have billed into the millions. More than 50 percent of cases resulted in restitution of $5,000 or less, which the providers could easily pay. Where higher restitution has been set, actual collections have usually amounted to only a small percentage of the total.

Further, those convicted of fraud are usually free to re-offend. There apparently is little follow-up to ensure that the perpetrators of fraud are barred from the health care system. A major problem is that these individuals/groups relocate and become providers in new, unsuspecting states. Establishment of a state Medicaid-provider information exchange would be useful.[64] The que tam provisions of current law that allow private citizens to obtain up to triple damages for any proven fraud also may be of use.

What, then, is legally required to prosecute and convict a perpetrator? First, the activity must be clearly illegal. Second, it must be persistent. Third, it must have significant impact. Aside from worker compensation-type fraud, very little recipient fraud exists. The difficulty of overcoming all three hurdles may explain why there are so few convictions. For example, in Texas, recipient fraud has exceeded 1 percent of claims only once. Provider fraud may be more prevalent, but it tends to be committed by small groups that move from area to area and state to state before routine audits identify them.

Abuse. With respect to fraud, clear legal standards must be met. The same is not true of abuse. All too frequently, "abuse" is defined as what someone finds offensive. For example, putting stainless steel caps on the baby teeth of a child is abuse to some. But according to the Medicaid rules, it is not.

Medicaid rules are very complex and can be less than clear. (Remember: The same kind of bureaucracy that develops income tax forms develops Medicaid rules and regulations.) One result is that many providers are unsure of what is required of them. The ensuing confusion and attendant publicity give rise to a popular conception that abuse is pervasive in Medicaid. However, Medicaid provider abuse is rarely proven and should not be expected to generate significant savings.

Waste. The potential for reducing Medicaid costs through controlling waste is real and significant. Medical errors are more prevalent than anyone would like to admit, and the threat of tort liability makes it dangerous to be entirely candid when an error occurs. Some believe the reduction of errors may be the greatest opportunity for reducing health care costs.[65] As noted above, evidence-based evaluation systems should be developed, starting with those procedures that generate the most spending. Done properly, disease management and care coordination can reduce costs and improve quality of care in ways acceptable to providers and patients alike. Major savings could be realized.

"The potential to reduce costs by controlling waste is significant."

Also, as in the case of fraud detection, the introduction of MBAs would give Medicaid patients an economic incentive to detect and reduce some of the waste that occurs.

How the Federal Government Can Help

What is the ideal amount of federal oversight and control? None. Since Medicaid is a welfare program, it would be logical for states to include Medicaid into their "welfare package." Indeed, leaving Medicaid as the exception to returning welfare to the states undercuts welfare reform.

Those who seek to continue federal control often cite the need for retaining federal quality standards. This argument should be reversed. Quality of care has not been the hallmark of 37 years of Medicaid. It certainly should not be the only criterion for continued federal meddling in the program. The states are capable of administering Medicaid and are more interested in quality than is the remote, Medicare-oriented CMS.

Even short of a no-strings-attached block grant to the states, federal oversight should be significantly reduced. States should not have to go through a lengthy, time-consuming waiver process to enact essential reforms.

Conclusion

An alternative to uncontrolled Medicaid growth exists. It is not simple, and in many ways it is unsettling. It will require expanded eligibility for certain populations. It will require standing up to powerful interest groups. It will require dedicated staff. The alternative will not stop Medicaid budget growth, but it will lower the rate of that growth. It will provide policy-makers with significantly greater control over costs and health outcomes. It will introduce some of the efficiency of the marketplace into Medicaid programs. And it will allow patients and providers to make more of their own decisions.

"An alternative to uncontrolled Medicaid growth exists."

Out-of-control increases in Medicaid costs are not inevitable. But if reforms are not made soon, the question in a few years will be: Why didn't policy-makers take control of our destiny when they had the chance?

NOTE: Nothing written here should be construed as necessarily reflecting the views of the National Center for Policy Analysis or as an attempt to aid or hinder the passage of any bill before Congress.

Notes

[1] "Medicaid's architects envisioned a program that would provide poor people with mainstream medical care in a fashion similar to that of private insurance. As the decades have passed, that vision has largely faded…poor people continue to rely on providers that make up the nation's medical safety net: public and some not-for-profit hospitals and clinics [that] by virtue of their location or social calling provide a disproportionate amount of care to the poor." John K. Iglehart, "The American Health System-Medicaid," *New England Journal of Medicine*, Feb. 4, 1999, pp. 403-08.

[2] www.whitehouse.gov/omb/budget/fy2003/bud15.html.

[3] Amy Goldstein, "State Budget Woes Fuel Medicaid Cuts," *Washington Post,* Oct. 11, 2002, p. A1.

[4] "The Fiscal Survey of States," National Governors Association and National Association of State Budget Officers, November 2002.

[5] American Council of Life Insurance, April 1998.

[6] www.kaisernetwork.org/daily_reports/rep_hpolicy.cfm; posted Jan.14, 2003.

[7] *American Health Line*, November 26, 2002.

[8] Vernon Smith et al., "Medicaid Spending Growth: Results from a 2002 Survey," Kaiser Commission on Medicaid and the Uninsured, Report No. 4064, September 2002.

[9] For example, the federal government contemplated allowing HMOs to restrict Medicaid patients' access to hospital emergency rooms but dropped the proposal in response to a political backlash. See Amy Goldstein, "Bush Abandons Rule On Limiting ER Use," *Washington Post*, January 23, 2003, p. A3. Maine Rx, a state program that seeks to obtain additional pharmaceutical rebates, is being litigated before the U.S. Supreme Court. See Charles Lane, "High Court Considers Cost of Prescriptions," *Washington Post,* January 23,2003, p. A2.

[10] "HIFA: Will it Solve the Problem of the Uninsured?" National Health Law Program, HIFA Talking Points, February 28, 2002.

[11] "The Fiscal Survey of States," National Governors Association and National Association of State Budget Officers, November 2002.

[12] In general, optional populations include children in families with income above federal minimums, adults with children with income above section 1931 minimums (see below), people with disabilities, elders with income above Supplemental Security Income (SSI) levels receiving home- and community-based services, certain workers with disabilities whose incomes are above SSI levels, elderly nursing home residents with income above SSI levels, pregnant women with incomes above 133 percent of poverty, and the medically needy. Two recent federal changes have expanded the options available to states for covering low-income parents under Medicaid. First, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) created a new category of Medicaid eligibility in Section 1931 of the Social Security Act by requiring states to grant such eligibility to those adults and children who would have been entitled to AFDC under the income and resource standards in effect on July 16, 1996. Additionally, Section 1931 gives states the option to use less restrictive income and resource standards in determining eligibility, allowing states to make families that meet the categorical requirement under the old AFDC program eligible for Medicaid at the higher incomes. You are income eligible to receive SSI if a) you work and have an income less than $1,085 per month per person or $1,587 per month per couple or b) you don't work and have an income less than $520 per month per person or $771 per month per couple, provided you meet other eligibility criteria. Medically needy programs serve those whose incomes are higher than eligibility levels under TANF or one of the Medical Assistance Only (MAO) program for children and pregnant women but are not high enough to cover their medical expenses. The coverage limits are the same as for Medicaid.

[13] Examples of long-term care optional benefits include Intermediate Care Facilities — Mental Retardation (ICF-MR), inpatient and nursing facilities for individuals over age 65 in an institution for mental disease, home health care, case management, respiratory care for ventilator-dependent individuals, personal care, private duty nursing, hospice, Programs of All-Inclusive Care for the Elderly (PACE) and home- and community-based services. Under Early Periodic Screening Diagnosis and Treatment (EPSDT) rules, all of these optional services must be provided to children when shown to be needed based on a screening. See Kaiser Commission on Medicaid and the Uninsured, June 2001. See "Medicaid 'Mandatory' and 'Optional' Eligibility and Benefits," Kaiser Commission on Medicaid and the Uninsured, Policy Brief No. 2256, July 2001. Also see John Holahan, "Restructuring Medicaid Financing: Implications for the NGA Proposal," Kaiser Commission on Medicaid and the Uninsured, Policy Brief No. 2257, June 2001.

[14] Frank Lichtenberg, "Pharmaceutical Innovation, Mortality Reduction and Economic Growth," National Bureau of Economic Research, NBER Working Paper W6569, May 1998.

[15] U.S. Department of Health and Human Services, *Mental Health: A Report of the Surgeon General* (Rockville, Md.: U.S. Department of Health and Human Services, 1999).

[16] *Health Care Financing and Organization: News and Progress,* March 2000, pp. 5-6.

[17] *American Health Line,* March 31, 2000.

[18] www.whitehouse.gov/omb/bud/fy2003/bud15.html.

[19] www.cms.hhs.gov/chart/Medicaid/2Tchartbk.pdf.

[20] "HIFA: Will it Solve the Problem of the Uninsured?"

[21] Ibid.

[22] www.nga.org/nga/legislativeUpdate/1,1169,C_TESTIMONY^D_1949,00.html.

[23] www.hhs.cms.gov/chart/medicaid2Tchartbk.pdf.

[24] www.whitehouse.gov/omb/budget/fy2003.

[25] Over the last 37 years, reform proposals have faltered on the twin problems of long-term care (LTC) and the federal match. The fact that the federal government now transfers Medicare-related costs to the states through dual eligibles exacerbates the problem. And as usual, the real problem is politics, not policy. True LTC reform would mean confronting middle class abuse of the Medicaid benefit as their substitute for private long-term care insurance. Any comprehensive reform has always affected the resultant federal match, creating winners and losers among the states. The result has been almost four decades of incremental, not comprehensive, reforms. Comprehensive reform is only possible if these two problems are solved.

[26] "Medicaid: Matching Formula's Performance and Potential Modifications," T-HEHS-95-228, U.S. Government Accounting Office, July 27, 1995.

[27] The expansion of benefits allows for a controlled experiment on the impact of Medicaid on beneficiary behavior. The major work in this area is from the National Bureau of Economic Research (NBER). NBER researchers related the expanded generosity of Medicaid plans to the household wealth of recipients. They found that in 1993 Medicaid lowered wealth holdings of eligible groups by $1,996 to $2,259. They also found that the existence of asset tests, not surprisingly, more than doubled the wealth reduction from expanded Medicaid eligibility. NBER also found that the expanded generosity and eligibility for Medicaid increased the consumption of this group by 5.2 percent. See Jonathan Gruber and Aaron Yelowitz, "Public Health Insurance and Private Savings," National Bureau of Economic Research, NBER Working Paper No. 6041, May 1997.

[28] David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance?" *Quarterly Journal of Economics*, May 1996, pp. 391-430.

[29] Janet Currie and Jonathan Gruber, "Health Insurance Eligibility, Utilization of Medical Care, and Child Health," *Quarterly Journal of Economics,* May 1996, pp. 431-66.

[30] "Learning from S-CHIP and Learning from S-CHIP II," Agency for Health Care Policy Research, June 1998.

[31] Laura-Mae Baldwin et al., "The Effect of Expanding Medicaid Prenatal Services on Birth Outcomes," *American Journal of Public Health*, Vol. 88, No. 11, November 1998, pp. 1623-1629.

[32] See Janet Currie and Jonathan Gruber, "Saving Babies: The Efficacy and Cost of Recent Expansions of Medicaid Eligibility for Pregnant Women," *Journal of Political Economy*, December 1996, pp.1263-96.

[33] For a discussion on giving Medicaid enrollees choice, see Irene Fraser, Elizabeth Chait and Cindy Brach, "Promoting Choice: Lessons from Managed Medicaid," *Health Affairs,* Vol. 17, No. 5, September/October 1998.

[34] In August 2001, under authority granted by Congress, the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), announced the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative.

[35] www.hcfa.gov/Medicaid/obs7.htm.

[36] If implementing a statewide waiver is politically difficult, another approach is to do so geographically. Carve out similar economic and social geographic regions. Have half continue the present program, have the other half use the new

defined contribution approach. The waiver would measure costs, provider and payer participation, quality of care and patient satisfaction. The waiver could also contemplate block-granting portions of the program to local governments (see the discussion below). This could target inner-city, rural or highly dependent "safety net provider" areas to assure that they are helped or held harmless.

[37] We have seen this most recently when Health Care Financing Administration (HCFA) strangled Medicare+Choice in its bureaucratic cradle. The program was greatly hampered by the restrictive nature of the initial legislation. The regulations implementing the law were so restrictive that its marketplace incentives were smothered.

[38] In a study that examined caseloads in four-month increments, caseload turnover was about 10 percent during each increment, or about 30 percent per year. See Pamela Farley Short, "Single Women and the Dynamics of Medicaid," Health Services Research, December 1998.

[39] www.heritage.org/research/healthcare/BG1618.cfm.

[40] Under the leadership of Gov. Jim Douglas, Vermont is submitting a waiver request that would make Medical Savings Accounts part of the Medicaid program.

[41] John C. Goodman and Gerald L. Musgrave, *Patient Power: Solving America's Health Care Crisis* (Washington, D.C.: Cato Institute, 1992), Chapter 6.

[42] Diagnosis Related Groups (DGRs) include more than 500 common treatments, ailments and protocols based on historic observations. Hospitals receive a DRG payment for treating a patient, regardless of the actual cost of care.

[43] An example of the possible magnitude is shown by a study in *Employee Benefit News* which estimates that the cost of poor quality health care services is $1,350 per employee. If even a fraction of that figure can be saved per Medicaid recipient, hundreds of millions or billions of dollars in taxes can be saved. See, Craig Gunsauley, "Estimate: 30 percent of Health Spending is Wasted," *Employee Benefit News*, August 1, 2002.

[44] "In health care markets, geography is destiny," concluded a 1996 report from Dartmouth Medical School's Center for the Evaluative Clinical Sciences. For example 1.4 percent of elderly women in Rapid City, South Dakota, received breast-conserving surgery for breast cancer. In Elyria, Ohio, 48 percent did. An elderly patient with back pain in Fort Meyers, Florida, was four times as likely to undergo surgery as a man or woman living in Manhattan. And a man with an enlarged prostate in Newark, New Jersey, was twice as likely to have part of his gland surgically removed as if he lived in New Haven, Connecticut. Tonsillectomies provide another example, particularly over time. In the 1950s, children of insured workers had a 50-50 chance of having their tonsils removed, despite an exhaustive review of the medical literature up to that time that found no evidence that a tonsillectomy accomplished its purposes. Today, tonsillectomy is still the surgical procedure most likely to be performed inappropriately. But now, only one in four is unneeded. An 1980 article calculated that the United States could have saved $4.2 billion in 1975 dollars if the rate at which seven common surgical procedures were performed more closely resembled low-usage rates in parts of Maine and Vermont. John E. Wennberg et al., "Dartmouth Atlas of Health Care," Center for Evaluative Clinical Sciences, Dartmouth Medical School, 1996.

[45] One hospital study showed that treatment caused complications in one out of five patients, and about 7 percent of the complications were fatal. As many as eight out of 10 medical practices have never been scientifically validated. See Elihu Schimmel, "The Hazards of Hospitalization," *Annals of Internal Medicine*, January 1964, pp. 100-10.

[46] The National Academy of Sciences recommends that all federal health programs begin paying for quality care rather than paying for services rendered. Initially, the effort would focus on the treatment of 15 health conditions, including diabetes, depression, osteoporosis, asthma, heart disease and stroke. See, Janet M. Corrigan, Jill Eden and Barbara M. Smith, eds., *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality* (National Academies Press: Washington, D.C., 2002).

[47] Moving in the direction of provider networks, as the department is already doing, also can facilitate care coordination in areas that may currently be underserved.

[48] See John C. Goodman, "Minority Report," *Report of the Blue Ribbon Task Force on the Uninsured to the 77th Legislature,* State of Texas, February 2001.

[49] Estimating those eligible for Medicaid but not enrolled is difficult at best. Exact estimates are not very reliable because of the problem of "induced demand." Every time Medicaid has estimated an eligible population, any new benefit would induce demand and create many more eligibles. In one study, just over half (51.4 percent) of eligible, nonelderly adults were enrolled Medicaid in 1997. Of the remaining adults who were Medicaid eligible, 21.6 percent had private coverage while 27 percent were uninsured. Another study found that about seven million uninsured children eligible for either S-CHIP or Medicaid are not enrolled. See Amy Davidoff, Bowen Garrett, and Alshadye Yemane, "Medicaid-Eligible Adults

Who Are Not Enrolled: Who Are They and Do They Get the Care They Need?" Urban Institute, Series A, No. A-48, October 2001. Of those children eligible for Medicaid or CHIP, one-third are eligible for CHIP while two-thirds are eligible for Medicaid. Eight percent of uninsured, low-income children are illegal aliens and, as such, not eligible for either Medicaid or CHIP. See Lisa Dubay, Jennifer Haley and Genevieve Kenney, "Children's Eligibility for Medicaid and S-CHIP: A View from 2000," Urban Institute, Series B, No. B-41, March 2002.

[50] For information on how to devise a safety net that does not unfairly compete with private insurance, see John C. Goodman, "Characteristics of an Ideal Health Care System," National Center for Policy Analysis, Policy Report No. 242, April 2001.

[51] The Utah model limits enrollment until program evaluations can be completed to determine the effect of the waiver on a number of factors such as emergency room use.

[52] Smaller firms could purchase coverage through the state-operated pool. This has been the case in Arizona. See "Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs," General Accounting Office, October 1995.

[53]The Federal Employees Health Benefits Program (FEHBP) has four main features: (1) federal employees in most places can choose among eight to 12 competing health insurance plans, including Blue Cross and a number of HMOs; (2) the government contributes a fixed amount that can be as much as 75 percent of each employee's premium; (3) the extra cost of more expensive plans must be paid by the employee with after-tax dollars, and (4) the plans are forced to community rate, charging the same premium for every enrollee. Public employee health benefit options in Minnesota are similarly organized, as is the California Public Employees' Retirement System (CalPERS).

[54] This is crucial for favorable health outcomes, given some evidence that "poor" families had substandard results when given high deductible coverage. See B. Lyke, "Medical Savings Accounts: Background Issues," Congressional Research Service, May 6, 1996.

[55] See Ronald E. Bachman, "Giving Patients More Control," National Center for Policy Analysis, Brief Analysis No. 399, June 17, 2002; and Greg Scandlen, "Defined Contribution Health Insurance," National Center for Policy Analysis, Policy Backgrounder No. 154, October 26, 2002.

[56] Utilizing a HIFA waiver does not preclude other cost-cutting opportunities.

[57] See "Medicaid Managed Care: Four States' Experiences with Mental Health Carve-Out Programs," U.S. General Accounting Office, September 1999.

[58] Baldwin et al., "The Effect of Expanding Medicaid Prenatal Services on Birth Outcomes."

[59] Miller Trusts, also known as Qualified Income Trusts, enable people whose income is too high to qualify for nursing home care partially paid for by Medicaid. This is accomplished by assigning income to the trust, the wording of which can limit how the income is distributed. The trust, for instance, can use the income to make certain payments including insurance, support for a spouse, and $60 per month in personal needs. The excess funds, after the aforementioned payments, are then used for nursing home care with the balance being picked up by Medicaid. This allows some people with incomes too high to qualify for Medicaid to obtain subsidies equal to the proportion of nursing home care they could not otherwise have afforded. See Ronald Lipman, "Trust Helps Person Qualify for Medicaid Nursing Care," Houston Chronicle, August 11, 2002.

[60] See "Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs," U.S. General Accounting Office, August 1994.

[61] All payment systems are subject to manipulation, but using these three factors would make manipulation of all the components more expensive than improving quality. At the same time, the administrative burden would not be too large.

[62] Janet M. Corrigan, Jill Eden and Barbara M. Smith, eds., *Leadership by Example: Coordinating Government Roles in Improving Health Care Realtiy* (National Academies Press: Washington, D.C. 2002).

[63] Leslie G. Aronovitz, "Medicaid Fraud and Abuse: Stronger Action Needed to Remove Excluded Providers from Federal Health Programs," U.S. General Accounting Office,GAO/HEHS-97-63, March 1997.

[64] See Sarah F. Jaggar, "Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse," U.S. General Accounting Office, GAO/T-HEHS-95-110, March 22, 1995.

[65] Michael L. Millenson, *Demanding Medical Excellence: Doctors and Accountability in the Information Age* (University of Chicago Press: Chicago, 1997).

TABLE A-I

Spending on Medicaid and Uncompensated Care in Texas

1998

	Number of Uninsured	Uncompensated Hospital Care*	Uncompensated Physician	Spending Per Capita	Medicaid Eligible	Cost of Care	Spending Per Capita	Medicaid Eligible & Uninsured	Total Expenditure	Per Capita Cost	Regional Average Variance
High Plains	181,301	$81,266,048	$34,677,838	$640	99,668	$314,232,120	$3,153	280,969	$430,176,006	$1,531	$109
Northwest	110,881	$102,621,438	$43,790,608	$1,320	67,311	$297,876,430	$4,425	178,192	$444,288,475	$2,493	$1,071
Metroplex	1,394,754	$565,182,731	$241,174,707	$578	376,823	$1,256,551,900	$3,335	1,771,577	$2,062,909,400	$1,164	($258)
Upper East	241,743	$113,353,301	$48,370,107	$669	123,461	$491,178,158	$3,978	365,204	$652,901,566	$1,788	$366
Southeast	145,464	$42,192,887	$18,004,544	$414	103,067	$400,186,448	$3,883	248,531	$460,383,878	$1,852	$430
Gulf Coast	1,113,003	$597,689,268	$255,045,893	$766	430,086	$1,177,985,000	$2,739	1,543,089	$2,030,720,100	$1,316	($106)
Central Texas	424,106	$132,887,808	$56,705,870	$447	183,163	$709,836,236	$3,875	607,269	$899,429,914	$1,481	$59
Upper South	506,804	$243,995,560	$104,117,756	$687	284,757	$828,812,633	$2,911	791,561	$1,176,925,900	$1,487	$65
West Texas	138,687	$61,056,518	$26,054,030	$628	71,986	$236,872,893	$3,291	210,673	$323,983,441	$1,538	$116
Upper Rio	33,954	$53,308,195	$22,747,666	$2,240	139,530	$293,177,276	$2,101	173,484	$369,233,137	$2,128	$706
Lower South	554,734	$148,516,868	$63,375,100	$382	444,934	$1,133,040,000	$2,547	999,668	$1,344,932,000	$1,345	($77)
Total	4,845,431	$2,142,070,622	$914,064,119		2,324,786	$7,139,749,200		7,170,217	10,195,884		
Texas Average				$631			3,071			$1,422	

Source: Texas Medicaid Expenditures by County, and uninsured care are based on estimates from Texas Department of Health.

* Based upon 1998 Texas Department of Health analysis of unreimbursed cost.

** Unreimbursed physician care is allocated based upon the proportion of uncompensated hospital care in each reason. (does not include $319,174,000 in uncompensated physician care at university hospital.)

*** Does not include $65.87 per capita in uncompensated physician care provided at university hospitals.

TABLE A-II

Dallas County Medicaid Hospital Rates

Hospital	Average Case Adjusted Fee[1]
Baylor Institute for Rehabilitation	$3,651.44
Baylor Medical Center at Garland	$3,171.90
Baylor Specialty Hospital	$1,600.00
Baylor University Medical Center	$4,393.27
Charlton Methodist Hospital	$3,145.04
Children's Medical Center	$3,264.93
Compass Hospital of Dallas	$4,061.18
Dallas-Fort Worth Medical	$3,434.75
Dallas Southwest Medical Center	$4,688.29
Doctors Hospital	$3,470.16
Garland Community Hospital	$4,393.27
Irving Healthcare System	$3,674.20
Kindred Hospitals of Dallas	$3,651.44
Lake Pointe Medical Center	$3,674.20
Las Colinas Medical Center	$4,611.55
Mary Shiels Hospital	$3,651.44
Medical City Dallas Hospital	$5,199.09
Medical Center of Mesquite	$4,248.88
Mesquite Community Hospital	$3,236.63
Methodist Medical Center	$4,037.42
Our Children's House at Baylor	$3,264.93
Parkland Memorial Hospital	$3,540.98
Presbyterian Hospital of Dallas	$4,919.14
RHD Memorial Medical Center	$5,280.31
Select Specialty Hospital	$3,446.83
St. Paul University Hospital	$5,491.13
Trinity Medical Center	$5,491.13
Zale Lipshy University Hospital	$4,736.13

[1] The Texas Department of Health uses a Texas-based Diagnosis Related Group (DRG) method of reimbursing hospitals. The reimbursement rate is calculated by multiplying the DRG's relative weight by the hospital's Standard Dollar Amount (SDA). A hospital's SDA represents its average cost per Medicaid patient, standardized by each hospital's respective case mix index. A hospital's case mix index is a measure of the complexity the service it provides and the acuity of its patients.

Source: "Hospital Rates for Inpatient and Outpatient Care Appendix II, Part I: DRG Hospital Standard Dollar Amounts (SDA)," *Indigent Health Care Program Handbook,* CIHCP 03-01, (Austin, Texas: Texas Department of Health, January 2003).

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John C. Goodman, Ph.D., is President of the National Center for Policy Analysis, a national think tank based in Dallas, Texas. Called the Father of Medical Savings Accounts, Dr. Goodman is author of numerous books, including the textbook *Economics of Public Policy* and the award winning *Patient Power: Solving America's Health Care Crisis* (with Gerald Musgrave). He is the author of over 50 published articles on health policy, tax reform and school choice. Prior to founding NCPA in 1983, Dr. Goodman was a professor of economics at the University of Dallas and has taught or conducted research at Columbia University, Stanford University, Dartmouth University and Southern Methodist University. He earned his Ph.D. in economics from Columbia University.

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Richard Teske is an independent writer and consultant on political and health care policy. For a quarter century he has advised and worked with international, federal and state government leaders and many of the largest managed care, pharmaceutical, biotech, medical technology, long term care and hospital companies. He is recognized as an expert on market-oriented Medicare, Medicaid, Long Term Care and Uninsured Reform, having served for almost eight years in the Reagan Administration in a variety of capacities including Official HHS Liaison to the White House, Principal Deputy Assistant Secretary at HHS, and Associate Administrator for the Health Care Financing Administration (HCFA).

About the NCPA

The NCPA was established in 1983 as a nonprofit, nonpartisan public policy research institute. Its mission is to seek innovative private sector solutions to public policy problems.

The center is probably best known for developing the concept of Medical Savings Accounts (MSAs). The *Wall Street Journal* called NCPA President John C. Goodman "the father of Medical Savings Accounts." Sen. Phil Gramm said MSAs are "the only original idea in health policy in more than a decade." Congress approved a pilot MSA program for small businesses and the self-employed in 1996 and voted in 1997 to allow Medicare beneficiaries to have MSAs. And a June 2002 IRS ruling frees the private sector to have a flexible medical savings account and even personal and portable insurance. A series of NCPA publications and briefings for members of Congress and the White House staff helped lead to this important ruling.

The NCPA also outlined the concept of using tax credits to encourage private health insurance. The NCPA helped formulate a bipartisan proposal in both the Senate and the House, and Dr. Goodman testified before the House Ways and Means Committee on its benefits. Dr. Goodman also helped develop a similar plan for then presidential candidate George W. Bush.

The NCPA shaped the pro-growth approach to tax policy during the 1990s. A package of tax cuts, designed by the NCPA and the U.S. Chamber of Commerce in 1991, became the core of the Contract With America in 1994. Three of the five proposals (capital gains tax cut, Roth IRA and eliminating the Social Security earnings penalty) became law. A fourth proposal — rolling back the tax on Social Security benefits — passed the House of Representatives last summer.

The NCPA's proposal for an across-the-board tax cut became the focal point of the pro-growth approach to tax cuts and the centerpiece of President Bush's tax cut proposal. The repeal by Congress of the death tax and marriage penalty in the 2001 tax cut bill reflects the continued work of the NCPA.

Entitlement reform is another important area. With a grant from the NCPA, economists at Texas A&M University developed a model to evaluate the future of Social Security and Medicare. This work is under the direction of Texas A&M Professor Thomas R. Saving, who was appointed a Social Security and Medicare trustee. Our online Social Security calculator (www.mysocialsecurity.org) allows visitors to discover their expected taxes and benefits and how much they would have accumulated had their taxes been invested privately.

An innovative nationwide volunteer campaign called Team NCPA (www.teamncpa.org) is under way to raise awareness of the problems with the current Social Security system and the benefits of personal retirement accounts. Former Sen. Daniel Patrick Moynihan (D-N.Y.), speaking at an NCPA Sumners Lecture, said that there is no serious proposal anywhere in the United States that would cut benefits for current retirees.

In the 1980s, the NCPA was the first public policy institute to publish a report card on public schools, based on results of student achievement exams. We also measured the efficiency of Texas school districts. Subsequently, the NCPA pioneered the concept of education tax credits to promote competition and choice through the tax system. To bring the best ideas on school choice to the forefront, the NCPA

and Children First America published an Education Agenda for the new administration, policy makers, congressional staffs and the media. This book provides policy makers with a road map for comprehensive reform. And a June 2002 Supreme Court ruling upheld a school voucher program in Cleveland, an idea the NCPA has endorsed and promoted for years.

The NCPA's Environmental Center works closely with other think tanks to provide commonsense alternatives to extreme positions that frequently dominate environmental policy debates. A pathbreaking 2001 NCPA study showed that the costs of the Kyoto agreement to halt global warming would far exceed any benefits. The NCPA's work helped the administration realize that the treaty would be bad for America, and it has withdrawn from the treaty.

NCPA studies, ideas and experts are quoted frequently in news stories nationwide. Columns written by NCPA scholars appear regularly in national publications such as the *Wall Street Journal*, the *Washington Times*, *USA Today* and many other major-market daily newspapers, radio talk shows, television public affairs programs and public policy newsletters. According to media figures from Burelle's, nearly 3 million people daily read or hear about NCPA ideas and activities somewhere in the United States.

The NCPA Internet site (www.ncpa.org) links visitors to the best available information, including studies produced by think tanks all over the world. Britannica.com named the NCPA Web site one of the best on the Internet when reviewed for quality, accuracy of content, presentation and usability. NCPA Web sites average 4 million hits per month.

What Others Say about the NCPA

"...influencing the national debate with studies, reports and seminars."

- TIME

"Increasingly influential."

- EVANS AND NOVAK

"I don't know of any organization in America that produces better ideas with less money than the NCPA."

- SEN. PHIL GRAMM

"Oftentimes during policy debates among staff, a smart young staffer will step up and say, 'I got this piece of evidence from the NCPA.' It adds intellectual thought to help shape public policy in the state of Texas."

- FORMER TEXAS GOV. (NOW PRESIDENT) GEORGE W. BUSH

The NCPA is a 501(c)(3) nonprofit public policy organization. We depend entirely on the financial support of individuals, corporations and foundations that believe in private sector solutions to public policy problems. You can contribute to our effort by mailing your donation to our Dallas headquarters or logging on to our Web site at www.ncpa.org and clicking "An Invitation to Support Us."