Chapter V

TEN STEPS TO REFORMING MEDICAID

A National Center for Policy Analysis study, "Opportunities for State Medicaid Reform," discussed in detail how Medicaid can be radically reformed. Many of the ideas in that report are included in the following summary.[1]

Step No. 1: Free the Patients.

The Deficit Reduction Act of 2005 allows 10 state Medicaid programs to set up 5-year demonstration projects to provide Medicaid recipients with Health Opportunity Accounts (HOAs), similar to Health Savings Accounts (HSAs) used in the private sector.[2] The idea is to allow Medicaid enrollees to control some of their own health care dollars and become empowered consumers in the medical marketplace. The states that choose to participate will receive federal matching funds to contribute up to $1,000 per

Cash Accounts for Disabled Medicaid Patients

Disabled Medicaid enrollees often need assistance performing activities of daily life, including help with meal preparation, bathing and dressing.[1] A number of states have received federal waivers that allow them set up personal cash accounts so that these patients can manage their own health care dollars and have direct control over the purchase of needed services. All told, about half of the states have these programs, often called "cash and counseling."[2] The patient is given a set dollar contribution and is free to choose his or her providers. The programs also involve counseling to assure that the patient is well-informed.

Under traditional Medicaid, the states select the providers without patient input. Under this program, the patients can now hire and fire their own providers. Surveys of participants in the program show that they have a higher quality of life, with fewer unmet health needs.[3] Although initially the accounts were used only to purchase custodial services, in many states their use has expanded to cover conventional health services as well. Remarkably, patient satisfaction is almost 100 percent.[4]

[1] Stacy Dale et al., "The Effects Of Cash and Counseling On Personal Care Services and Medicaid Costs In Arkansas," *Health Affairs*, Web Exclusive W3-566, November 19, 2003.

[2] Jeffrey S. Crowley, "An Overview of the Independence Plus Initiative to Promote Consumer-Direction of Services in Medicaid," Kaiser Commission on Medicaid and the Uninsured, Henry J. Kaiser Family Foundation, Issue Paper, November 2003.

[3] Leslie Foster et al., "Does Consumer Direction Affect the Quality of Medicaid Personal Assistance in Arkansas?" Mathematica Policy Research, Inc., March 2003.

[4] James Frogue, "The Future of Medicaid: Consumer-Directed Care," Heritage Foundation, Backgrounder No. 1618, January 10, 2003. Available at http://www.heritage.org/research/healthcare/BG1618.cfm. Access verified August 10, 2006.

child and $2,500 per adult into the HOAs. These funds can be used to purchase a variety of medical goods and services, and unused funds will be available for future use by participants.[3] Moreover, if patients become ineligible for Medicaid, they have up to three years to use up to 75 percent of their HOA balances to purchase private health insurance.[4]

One objection to cash-balance accounts is that people will forgo needed health care to accrue more cash. However, unlike private-sector HSAs, the use of personal health accounts can be limited by Medicaid. By allowing enrollees to access their HOA funds with a debit card and by monitoring the debit card activity, a state could better ensure that recipients obtain such medical services as child immunizations or prenatal care.

As noted in Chapter III, a special type of health savings account is now widely used by Medicaid disabled patients. Under pilot programs that are active in more than half the states, these patients manage their own funds and can hire and fire the people who provide them with services. Although initially restricted to custodial care, the program has expanded to include conventional health care services in many states. [See the sidebar on disabled patients.] The recipient can then use unspent funds for health care, social services, child education or job training needs.

Case Study: Diabetes. Patients who manage their own health care dollars are in a better position to reap the benefits of managing their own care. Patients can be taught to inject insulin, monitor and maintain a log of blood glucose levels, and use the results to adjust their dietary intake, activity levels and medicine doses.[5] Numerous studies have shown considerable benefits from self-management by for patients with Type 2 diabetes.[6] By one estimate, nearly $2.5 billion in annual hospital costs for diabetes complications could be averted with appropriate self-managed care.[7]

Many diabetics can reduce their reliance on medications and control their diabetes completely by adhering to a meal plan, losing weight and exercising.[8] At the other extreme, some patients have diabetic complications that require continuous monitoring and a complex drug regimen

administered throughout the day.[9] Since it would be impossible for these patients to seek the expertise of a physician on a daily basis, self-management of care is essential.

Case Study: Asthma. Uncontrolled asthma is another costly chronic disease.[10] The Asthma and Allergy Foundations of America estimates nearly 20 million Americans suffer from asthma — resulting in 500,000 hospital stays each year.[11] More than 2.5 million school-age children suffer from asthma, missing nearly 15 million school days per year. The economic loss averages out to nearly $800 per child per year.[12]

Yet, 75 percent of asthma admissions are preventable. Patients who properly manage their own asthma fare better than those who rely on conventional care.[13] A Dutch study comparing self-management to standard care with a primary physician found that the treatment costs of those patients who monitored their own asthma were about 7 percent less than conventional care the first year and 28 percent less the second year.[14] In consultation with a physician or a nurse, patients can develop a self-management plan, which is essentially a list of established guidelines indicating which actions to take in response to various symptoms.[15]

Asthma patients can use a spirometer to measure the speed and volume of their exhalations to determine their peak air flow. They can then enter the readings into a computer software system called Asthma Assistant to monitor their condition on a daily basis. The program analyzes the data and alerts the patient to conditions that can trigger symptoms.[16] Such biometric data can be transmitted over the Internet from a patient's computer to a physician's office computer for evaluation by a doctor or technician (a process called telemonitoring).

Step No. 2: Free the Providers.

As noted, all too often our health care system rewards high-cost, low-quality care and penalizes low-cost, high-quality care. Clearly, this incentive

system needs to be turned on its head, and the people who are in the best position to respond to appropriate incentives are doctors. It should be easy for doctors to get paid a different way by Medicaid if they propose to repackage and reprice their services in ways that raise quality and lower taxpayer costs.

Take diabetes, for example. Care tends to be delivered in discrete bundles, each with its own price. No one provider is responsible for the end result (fewer ER visits, lower blood sugar level, etc). This is because no one has bundled "diabetic care" as such — taking responsibility for final outcomes over a period of time — in return for a fee.[17]

To appreciate how different diabetes care could be, imagine a conversation in which a doctor says to a diabetic patient: "You do not need to come to my office as often as you do. Most of our communication can be by telephone or e-mail. For these consultations you will pay less. I need to put your records on a computer so that I can take advantage of safety protocols and order your prescriptions electronically. For these quality improvements, you will pay a bit more. I'm also going to teach you how to manage your own care and I'm going charge for the instruction. But you'll get your money back through fewer consultations. Also, I'm going to show you how to cut your drug costs by shopping in a national online marketplace and I'm going to charge you for that advice as well. But you'll get that money back too through lower drug prices."

This conversation cannot take place in the current system. Why? Because each of the bundles of care mentioned above are services Blue Cross does not pay for. (No e-mail, no telephone, no electronic records.) Medicare doesn't pay for these bundles either. Nor do most employer plans. But this conversation, and thousands of others just like it, would take place if doctors were free to repackage and rebundle their services and get paid.

So how do we get from here to there? A reasonable reform might work like this. A state Medicaid office announces that it welcomes offers from doctors, hospitals and other providers to repackage and reprice their ser-

vices. The parameters are: (1) the repriced, repackaged services must not increase total spending by the state, (2) the quality of care received by patients must not decline and (3) the provider/entrepreneur must propose a way to measure cost and quality to make sure that requirements (1) and (2) are satisfied.

For the reform to be workable, the transactions must be easy to negotiate and consummate. Paperwork and time delays are the enemy of entrepreneurship. However, given a willing state administrator, the process of reform should not take long. There are already low-cost, high-quality pockets of excellence just waiting to be replicated.

Case Study: Surgery with a Warranty in Pennsylvania.[18] As noted, patients on the average receive recommended hospital care — such as an aspirin after a heart attack or antibiotics before hip surgery — only about half the time. There is also a lot of variation in quality. In Pennsylvania alone, the mortality rate for heart surgery among hospitals varies from zero to 10 percent. Even more surprising, hospitals usually profit from their mistakes. When patients have to be readmitted to deal with complications from the initial surgery, the hospital is in a position to bill again.

Geisinger Health System in central Pennsylvania has discovered a better way — better at least for patients and their insurers. It offers a 90-day warranty, similar to the type of warranties found in consumer product markets. Specifically, Geisinger charges a flat fee that includes three months of follow-up treatment. Even if the patient returns with complications in that period, Geisinger promises not to send the patient or the insurer another bill.

The problem is that Geisinger loses money on the proposition. Right now, its 90-day warranty saves money for Medicaid, Medicare and private insurers. What is needed is a Medicaid administration willing to pay more for such guarantees than it would pay for surgery without a warranty. In other words, Medicaid should be willing to pay more to hospitals that save taxpayers money.

Case Study: Efficient Treatment of Back Pain in Seattle.[19] Virginia Mason Medical Center in Seattle has a modest goal: To produce health care as efficiently as Toyota produces cars. In fact, the senior staff has actually traveled to Japan to witness Japanese auto production firsthand. Continuous quality improvement is part of its company mantra.

Treatment of back pain, a source of considerable medical spending nationwide, is an example of how Virginia Mason is changing its approach to health care. Under the old system, a patient with back pain would first receive an MRI scan and other tests before referral to a physical therapist. Today, patients are referred to a therapist first, and only if therapy doesn't work are they scheduled for an MRI scan. The result: The cost of care is cut in half.

The trouble is, Virginia Mason loses money by treating back pain efficiently. So far only Aetna has been willing to increase its payments to reward the center for lowering Aetna's overall costs. Yet Aetna makes up only a small part of the Center's revenues. As in the case of Geisinger, the state could play a useful role by making new contracts with centers like Virginia Mason quick and easy to consummate.

Step No. 3: Substitute Less-Expensive for More-Expensive Therapies.

Treatment in outpatient settings, such as doctors' offices, is generally less expensive than treatment in a hospital. However, Medicaid patients have limited access to physicians other than in public health clinics or hospital emergency rooms. Paying higher physician fees for examinations, tests and procedures that can be performed in a doctor's office would increase patients' access to health care and reduce unnecessary reliance on hospital emergency rooms.

Performing more procedures in outpatient settings that were formerly performed in hospitals (such as minor surgeries that don't require an over-

night stay) is a common way of reducing costs.[20] A Pennsylvania study found that about 10 percent of all hospitalizations for patients under age 65 are potentially avoidable. Caring for these patients in lower-cost, more-appropriate settings could have saved the state about $2.8 billion in 2003. In some cases, procedures performed in hospitals could have been done in outpatient clinics. In other cases, inpatient care could have been avoided by timely physician care.[21]

Step No. 4: Substitute Less-Expensive for More-Expensive Providers.

Why pay more when the same quality of care is available for less? Private-sector health plans routinely contract selectively, choosing to direct enrollees to providers who charge less for the same level of quality. These plans typically require enrollees to use facilities and physicians that are "in-network," or to pay a larger share of the cost if they use providers that are "out-of-network."

Medicaid could selectively contract for specific high-cost procedures with centers of Excellence — hospitals that perform a high volume of particular procedures for which there is a demonstrated relationship between volume and quality. Hospitals that do not receive contracts would not be reimbursed unless the services were preauthorized or the patient was admitted due to an emergency. This is a modest reform that is long overdue.[22]

Selective contracting provides opportunities to negotiate discounts for most medical services. Many states use competitive bidding and selective contracting for eyeglasses, medical equipment, transportation and other services.[23] For example, Medi-Cal, California's Medicaid program, began selective contracting for hospital services in the early 1980s. Four years later the state was spending nearly 8 percent less than it was projected to spend without selective contracting.[24] The Centers for Medicare and Medicaid Services (CMS) found that contracting reduced the daily cost

of a hospital stay about 16 percent below what it otherwise would have been. The greatest savings were in areas with robust competition among hospitals.[25]

At the other end of the treatment spectrum is the walk-in clinic, discussed above. These clinics are spreading like wild fire around the country and they developed entirely outside the third-party payment system. Entrepreneurs created their own bundles and set their own prices. They charged half the normal fee and provided better quality. (More adherence to protocols.) Some third-parties are now reimbursing MinuteClinic and RediClinic and other walk-in clinic fees because they have concluded the services are cheaper than the alternatives. Others do not.

However, this should be a no-brainer for Medicaid. It should immediately cover the services of walk-in clinics, encouraging enrollees to get convenient, high-quality (and often preventive) primary care.

Step No. 5: Substitute Less-Expensive for More-Expensive Drugs.

Private-sector managed care plans use a variety of techniques to control drug costs, including preferred-drug lists, formularies, negotiated prices with drug companies and single-source drug distributors. For example, many plans require enrollees to use a specific mail-order drug supplier to avoid higher copays. Health plans frequently contract with a pharmacy benefit manager (PBM) to handle drug benefits. PBMs require enrollees to obtain a preauthorization to purchase brand-name drugs that aren't on their list of preferred or formulary drugs, or to use a non-network pharmacy.

Medicaid managed care plans generally also use PBMs to manage their drug benefits. However, some states have rules and regulations that limit the ability of PBMs to control drug costs. For instance, some states have laws that prevent a PBM from requiring the substitution of generic drugs for expensive brand-name drugs.[26] Bills have occasionally been intro-

duced in other states to further limit PBMs. For instance, during the 2006 legislative session, several bills were introduced in the New York State Legislature that would have limited the ability of PBMs to require the use of mail-order pharmacies. A separate bill would have also required PBMs to reimburse any pharmacy willing to meet the prices negotiated by the PBM with pharmacies in its network.[27] Pharmacy chains or mail-order pharmacies will agree to deeper discounts on drugs if they are the sole provider (or part of a small group) because they can spread their costs over a larger volume of sales. If PBMs must give the same terms to "any willing provider," they cannot offer as great a volume of sales to their network or sole-source provider. As a result, the PBMs will not be able to negotiate as steep discounts as they would be able to otherwise, and consumers will pay higher prices for drugs.

Additionally, states should encourage the use of less-expensive drug alternatives when quality is the same — including therapeutic, generic and over-the-counter substitutes. Patients who prefer brand-name drugs should be able to choose them if they pay more, as they do in many private insurance plans.

In the past few years, a number of prescription drugs have become available over the counter at a much lower cost and without a prescription. For example, when Claritin, a prescription drug used by allergy sufferers, became available over the counter, the price fell substantially. Unfortunately, Medicaid (and Medicare) will not pay for over-the-counter drugs!

Note there is a danger that drug formularies will become bureaucratic obstacles to needed therapies, particularly for patients who cannot pay higher copays for nonformulary drugs. Economist Linda Gorman of the Independence Institute reports that substituting generics for brand-name drugs can adversely affect patients. For example:[28]

- A survey of 200 physicians in Tennessee's TennCare program found that two-thirds of doctors reported they had patients who had serious adverse reactions, including death and stroke, when they were switched to generic substitutes.

- In a British Columbia survey, 27 percent of doctors reported admitting patients to hospital emergency rooms as a result of having switched them to drugs mandated by government formularies.

One way to resolve these problems is to allow Medicaid patients to control some of the funds for their own health care, as discussed above.

Step No. 6: Contract with the Private Sector.

Instead of paying for Medicaid services on a fee-for-service basis, states could contract with hospitals, clinics and physicians for specific services and therapies. This would allow the program to coordinate care and establish quality standards.

Disease Management and Care Coordination. Many patients have multiple illnesses that require treatment by different specialists or in different facilities.[29] Unfortunately, these health care providers often have little (if any) contact with one another. The lack of coordination leads to poor-quality health care and medical errors, such as harmful drug interactions.

Coordinating care typically involves a case manager who reviews the patient's medical history and claims data, ensures that providers communicate with each other about the patient's condition and monitors the patient's progress. Disease management involves developing a treatment plan based on current treatment protocols for patients and teaching them how to follow the protocols.[30] As of 2004, nine states had implemented disease management programs. While results are preliminary, these programs appear to reduce costs and improve treatment for chronic conditions:[31]

- In Colorado, average costs for asthmatics participating in disease management programs dropped 37 percent.
- The proportion of asthmatics receiving inhaled steroid treatment increased from 49 percent to 95 percent.
- In Washington, a diabetic disease management program saved $900,000 in its first year, and the percentage of diabetics taking

daily aspirin or other blood thinners increased from 41 percent to 64 percent.

Here again, the best results are likely to be produced by innovation on the supply side rather than on the demand side. There are already examples of efficient, coordinated care delivered to low-income populations. For example, Community Health Works in Forsyth, Georgia, has a program under which patients use 40 percent less hospital care and 18 percent less emergency room care compared to a national control group.[32] What Medicaid needs to do is make sure it rewards entities like this that save taxpayer dollars. Ideally, Medicaid should encourage competition among provider groups for low-income, chronic care patients.

Caring for Special-Needs Patients. The problems of people with disabilities and chronic conditions range from schizophrenia to mental retardation to blindness to diabetes. These conditions require special therapies and specialists that many Medicaid patients may have difficulty accessing. Ideally, care should be provided by a provider or provider group that agrees to provide a full regimen of care — not disconnected bundles of care delivered by unrelated specialists. (See the discussion of diabetic care above.) But if payments to provider groups are not adjusted for the cost of caring for these patients, the plans will have an incentive to avoid enrolling them or to skimp on care. Medicaid should pay risk-adjusted premiums based on the cost of care and let specialists with specialized facilities compete for these patients. Medicaid should also be ready to reward providers who are able to provide higher quality services for less cost. For example, a group that provides psychiatric patients with outpatient therapy and drug treatment rather than more costly institutional care to achieve the same therapeutic outcomes should be rewarded for doing so.

Florida contracts with various private-sector entities to serve people with specific types of disabilities. This allows benefits to be tailored to the needs of the individual enrollee.[33] Different providers could serve the mentally ill, the physically disabled, the drug addicted and so forth. The

comparative advantage of these various providers would potentially reduce costs and increase the quality of service.[34] Ideally, the market — rather than bureaucracies — should determine the right product mix. [See the sidebar on Florida's consumer-driven reform.]

Step No. 7: Pay More for Better Results.

A National Bureau of Economic Research study found that with respect to cardiac treatment:[35]

- *Quality matters:* Moving from a low-quality to a higher-quality hospital significantly reduces a patient's risk-adjusted mortality rate.
- *Good Publicity matters:* Patient admissions increased at hospitals with low mortality rates the first year following a favorable report on their cardiac treatment; however, the increased number of cases dropped off after the first year.
- *Bad Publicity matters:* Patient admissions at hospitals identified as having a lower quality of surgery declined by about 10 percent during the year following a poor report; the decline remained stable for three years.
- *Choice matters:* Low-quality hospitals were still performing the same number of emergency surgeries as before the report, indicating that some patients cannot or do not shop around for better-quality hospitals in emergency situations.

Furthermore, the NBER study suggests that since cardiac surgery is profitable for hospitals, they will improve their quality of care to compete for patients.

Also, Medicaid should contract only with providers that institute infection-control programs. Payments to hospitals could be adjusted to reward facilities that achieve low infection rates and penalize those with higher infection rates. Hospital-acquired infections are a type of medical error that should be measured for quality ratings and addressed in contracts with

Florida's Consumer-Driven Medicaid Reform Plan

Florida began implementing an ambitious Medicaid reform plan in 2006 with a federal waiver and the approval of the state legislature.[1] It is designed to cover most Medicaid enrollees, including children, parents, pregnant women and disabled persons who are not institutionalized. Under the plan:

- Private-sector health care provider networks compete to enroll various Medicaid populations by offering different benefit packages to cater to their needs.
- Participants can choose among the plans, or use their state-paid premium to purchase employer-sponsored insurance instead.[2]
- Florida pays the networks a monthly, risk-adjusted premium per patient, and providers compete by offering innovative care, convenient networks and optional services.

The competition among providers is similar to private health insurance plans that offer various coverage options. Three basic packages of Medicaid benefits will be offered:

- Comprehensive Benefits is a basic benefit package covering all mandatory Medicaid services and needed optional services, although the amount, duration and scope of services may vary.
- Catastrophic Care covers those who require more care than is covered by comprehensive benefits plans. These patients will be re-insured for all medically necessary services.
- Enhanced Benefits is an incentive to Medicaid beneficiaries who engage in healthy practices. Qualified recipients may use accumulated funds in their accounts to purchase additional health care services that are not covered by their plan or for employer-sponsored insurance when they become ineligible for Medicaid.

The program is being piloted in Broward County, where beneficiaries have a choice of 14 plans, and in more rural Duval County, where they have a choice of five plans. It will be expanded to three more counties, but the goal is to implement it statewide by 2011, with legislative approval.

[1] See approved waiver proposal, "Florida Medicaid Reform: Approved 1115 Research and Demonstration Waiver Application," Agency for Health Care Administration, Florida Department of Health Care. Available at http://ahca.myflorida.com/Medicaid/medicaid_reform/waiver/index.shtml.

[2] Michael Bond, "Florida's Medicaid Reforms: A Progress Report," James Madison Institute, Backgrounder No. 52, August 2007.

Progress Report on Florida's Medicaid Reform

The first opportunity to conduct a valid evaluation of Florida's path-breaking Medicaid reform occurred after data had been compiled from the pilot project's first six months. What is known so far about the reform is mostly positive.

1. **The pilot project in Broward and Duval Counties has increased the number and types of plans available to beneficiaries.** In Broward County enrollees can choose from 15 competing plans (including one special-needs provider) while people in Duval County have six choices. The plans have somewhat different benefits, which is crucial given the diverse needs of the Medicaid population.

2. **The reform has increased access to services not previously covered by providers.** All of the reform health plans offer benefits which are not mandated by the federal government. These range from over-the-counter drugs to home-delivered meals after surgery. Has the increase in plan choices and larger benefits packages improved beneficiary health? The answer isn't yet known.

3. **The project's innovative Enhanced Benefits Program is growing rapidly.** These are zero balance accounts where beneficiaries can earn credits by engaging in "healthy behaviors." Those earning credits have increased from under 1 percent initially to around 30 percent after nine months of reform. Unused balances now total more than $1,700,000.

4. **The reform's "opt out" provision is small and growing slowly.** This reform allows individuals to use the actuarial value of their Medicaid benefit to buy into an employer health plan. At this time, 10 individuals have opted into employer coverage.

5. **Although the effect on beneficiary satisfaction is not yet known, the signs are positive.** No formal grievances with the reform plans have been filed as of yet and only 20 complaints have been made about counselors hired to assist beneficiaries with plan selection information.

Source: Michael Bond, "Florida's Medicaid Reforms: A Progress Report," James Madison Institute, Backgrounder No. 52, August 2007.

providers. Some hospitals are taking aggressive steps to improve quality of care by reducing infection rates, and both state and federal policies are changing to reduce this spreading epidemic:[36]

- Some hospitals, such as the University of Pittsburgh system, are imposing stiff penalties, including termination and suspension of practice privileges, for staff and doctors who fail to wash their hands.
- Some states have passed laws that publicize a hospital's "infection report card," allowing patients to compare hospital infection rates before surgery; ideally, hospitals would compete for patients by reducing infection rates.

As noted, the best results will be produced by supply side initiatives, rather than demand side efforts. Let hospitals propose to be paid differently provided they raise quality and reduce overall costs — and let the hospital bear the burden of proving the cost and quality objectives have been met.

Step No. 8: Pursue Fraud Aggressively.

Some states have established Medicaid provider information exchange databases to identify fraud, abuse, overuse and unnecessary care. In other states, most abuse is identified through tips and other unreliable means. Establishing a state database of billing information on Medicaid providers in New York has proven useful. If one provider's Medicaid billing begins to increase significantly, case workers can quickly identify the aberration and check into it.[37] The provisions of current "whistleblower" laws, allowing private citizens who identify fraudulent providers to receive some of the recovered funds may also be useful in fighting fraud.

Software firms have developed information technology to more easily examine Medicaid billings using a number of different criteria. Salient Corporation is working with Chemung County, New York, to better man-

age Medicaid spending. Using Salient's Muni-Minder software, officials can analyze the billings of individual suppliers and track product and service utilization, allowing them to uncover inefficiency, waste and abuse anywhere in the program. For example, Muni-Minder allows investigators to quickly identify the number and cost of prescriptions for brand-name drugs filled when a generic was available. A chart of the amount spent per recipient for any provider is easily created with only a few keystrokes.[38]

Some states have been more aggressive than others in pursuing and prosecuting fraud. In 2003, Texas established an inspector general's office with responsibility for detecting Medicaid fraud. As a result, Texas recovered $441 million in 2005 from erroneous or fraudulent charges.[39] Kansas followed suit by making Medicaid fraud a civil matter, as well as a criminal offense, thereby enabling the state to recover improperly paid Medicaid money through civil court.[40]

Step No. 9: Encourage Private Insurance.

As noted, private-sector plans may appear less generous on paper than the current Medicaid program, but they usually allow enrollees access to a greater range of providers and facilities. Enrollees in a Florida pilot program can opt out of government coverage and use their Medicaid funds to pay some of the premiums for employer-sponsored insurance where they work or choose coverage from among competing private insurers.[41] For some patients, this premium support essentially converts Florida Medicaid from a defined benefit entitlement to a defined contribution plan.[42] The premium payments Florida's Medicaid beneficiaries receive to apply toward the purchase of a health plan are risk-adjusted to reflect their health status.[43] They can also choose from among competing plans with different benefit packages.[44] [See the sidebar on progress in Florida's Medicaid reform.]

Private-sector plans have incentives to control costs and improve quality when they compete for customers in the marketplace. Both the state and the beneficiary benefit from this competition when Medicaid beneficiaries

can enroll in private-sector plans, including employer plans and individually owned insurance.

Step No. 10: Obtain a Block Grant.

Under the current system, every time a state wastes a dollar, at least half of that waste is paid for by the federal government. Every time a state eliminates a dollar of waste, at least half the savings stays in the state, while the remainder is realized in Washington, D.C. Block grants would allow states to realize the full benefits of every dollar saved and pay the full costs of every dollar of additional spending. Put differently, block grants would allow states to realize the full benefits of their good decisions and pay the full costs of their bad decisions.

In 2003, the Bush Administration proposed converting Medicaid's federal match to a fixed block grant to the states.[45] A block grant converts a defined benefit into a defined contribution. Under the former system, payments are based on the state's willingness to spend. Under the latter, spending is based on the federal government's willingness to pay. This is similar to how Congress allocates federal funds for state welfare programs. One of the advantages of a block grant is predictability.[46] It would limit the federal government's financial exposure while allowing states to design programs to meet their unique needs with maximum flexibility.

If five or six states requested a block grant, Congress would probably approve the request. However, some states are concerned that the federal government might renege on a block grant deal, giving the state less money in future years than it otherwise would have received. One solution to this problem is to write into a pilot program the specific formula that would determine how much participating states will receive. For example, if New York currently receives 13 percent of all federal Medicaid dollars, the agreement could specify that it would continue to receive 13 percent of all federal Medicaid dollars for the next few years.

Notes

1 John C. Goodman, Michael Bond, Devon M. Herrick and Pamela Villarreal, "Opportunities for State Medicaid Reform," National Center for Policy Analysis, Policy Report No. 288, September 28, 2006. See also, John C. Goodman, Michael Bond, Devon M. Herrick, Joe Barnett and Pamela Villarreal, "Medicaid Empire: Why New York Spends so much on Health Care for the Poor and Near Poor and How the System Can Be Reformed," National Center for Policy Analysis, Policy Report No. 284, March 20, 2006.

2 Enrollees will face a deductible before they can access Medicaid benefits. States will contribute deposit funds in a health opportunity account (HOA), from which enrollees will pay out-of-pocket for care up to the deductible. The deductible can be no more than 110 percent of the state's contribution to the HOA and no less than 100 percent of the annual contribution. The maximum average annual contribution to an HOA is $2,500 for adults and $1,000 for children (indexed in future years). States may provide preventive care coverage without a deductible. In spending from their HOA, individuals may purchase services from Medicaid-participating providers at Medicaid rates, and from nonparticipating providers at 125 percent of Medicaid rates.

3 Three-fourths of the unused balances in the HOA account is available to the individual for three years, and may be used to purchase health insurance or (after participating for one year) for such services as job training and tuition expenses. Not everyone is happy with the arrangement. For a critical review, see Edwin Park and Judith Solomon, "Health Opportunity Accounts for Low-Income Medicaid Beneficiaries: A Risky Approach," Center for Budget and Policy Priorities, November 1, 2005.

4 Medicaid Health Opportunity Account Act (H.R. 3757) was signed into law as part of the Deficit Reduction Act. See Rep. Mike Rogers, "The Truth About Medicaid Reform: Puts America's Most Vulnerable Families on Road to Self-Sufficiency," Letter, U.S. House of Representatives, November 7, 2005.

5 Teresa Pearson, "Getting the Most from Health-Care Visits," *Diabetes Self-Management*, March/April 2001.

6 Susan L. Norris, Michael M. Engelgau and K. M. Venkat Narayan, "Effectiveness of Self-Management Training in Type 2 Diabetes," *Diabetes Care*, March 2001.

7 "Economic and Health Costs of Diabetes," Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services, Healthcare Cost and Utilization Project Highlights, No. 1, AHRQ Pub. No. 05-0034, January 2005.

8 Patti Bazel Beil and Laura Hieronymus, "Money-Saving Tips: Supplies, Nutrition, and Exercise," *Diabetes Self-Management*, March/April 1999.

9 Gina Kolata, "Looking Past Blood Sugar to Survive with Diabetes," *New York Times*, August 20, 2007.

10 Tjard R. Schermer et al., "Randomized Controlled Economic Evaluation of Asthma Self-Management in Primary Health Care," *American Journal of Respiratory and Critical Care Medicine*, Vol. 166, No. 8, August 2002, pages 1,062-72. For an evaluation of direct medical treatment costs for asthma, see Michael T. Halpern et al., "Asthma: Resource Use and Costs for Inhaled Corticosteroid vs. Leukotriene Modifier Treatment — A Meta-Analysis," *Journal of Family Practice*, Vol. 54, No. 5, May 23, 2005.

11 "Asthma Overview," Asthma and Allergy Foundations of America. Available at http://www.aafa.org/display.cfm?id=8&cont=5. Accessed August 10, 2006.

12 Li Yan Wang, Yuna Zhong and Lani Wheeler, "Direct and Indirect Costs of Asthma in School-Age Children," *Preventing Chronic Disease*, Vol. 2, No. 1, January 2005.

13 Aarne Lahdensuo, "Guided Self Management of Asthma — How to Do It," *British Medical Journal*, Vol. 319, No. 7212, September 18, 1999, pages 759-760.

14 Ibid. Implementation costs were mostly incurred in year one and amounted to about $200.

15 See "Take Control - Q&A to Having a Self Management Plan," AsthmaAssistant.com. For instance, an asthma self management plan could stipulate that if a patient's "peak airflow" falls to 80 percent of their personal best peak airflow, they should increase medications at a pre-established rate and schedule a physician appointment. Patients should go to the emergency room if their peak airflow falls below 50 percent.

16 For information see http://www.asthmaassistant.com.

17 Michael E. Porter and Elizabeth Olmsted Teisberg, *Redefining Health Care: Creating Value-Based Competition on Results* (Boston, Mass.: Harvard Business School Publishing, 2006).

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