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## Reforming Florida's Medicaid Program With Consumer Choice and Competition

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### Executive Summary

Florida's Medicaid Program is in serious trouble. It suffers from major quality issues as well as a rapid and unsustainable growth in spending. Although Medicaid is a needed program for those who otherwise would "fall between the cracks" in our health-care system, the current plan perversely encourages people to "fall between the cracks."

At the heart of the problem is the lack of a free market in the payment for and delivery of health services to beneficiaries. The system is fundamentally flawed because it uses a centrally administered pricing scheme to pay providers. This payment framework ensures that reimbursements are not set at market levels, and it renders the program inherently inefficient in terms of both quality and cost. The quality issue is as crucial as cost because, in general, no one receives lower quality care than fee-for-service Medicaid patients.

In short, there is no marketplace in a traditional sense for Medicaid. The solution lies in the creation of a market similar to those for other products. This involves creating an Insurance and Provider Exchange (IPE). It would give buyers incentives to economize on the use of health care services, and it would take advantage of providers' desire to maximize their incomes. In this state-operated health mart, Medicaid would promote competition among providers, generate easy-to-understand information for beneficiaries, and set the rules in terms of minimum benefit packages and quality requirements.

HMOs, provider networks, nursing homes, and others

interested in offering services to the Medicaid population would submit bids for various levels of coverage. Medicaid would award "grants" to beneficiaries equal to the lowest bid for each type of service needed in each area. Administered pricing would be replaced by market prices. Enrollees would be free to upgrade to more expensive plans or purchase care with their own funds. This process would reward efficient, low-cost providers and produce competition that would force cost savings, quality enhancements, and innovations in the delivery of Medicaid services.

Beneficiaries also would be free to use their grants to enroll in private health plans. Beneficiaries whose incomes are above the poverty line would be awarded grants on a sliding scale to encourage them not to drop private health insurance. An additional reform might allow small-group private firms to purchase at the IPE. This would reduce Medicaid enrollment by allowing these firms to offer lower cost insurance. It would also assist in providing more choices to Medicaid beneficiaries if firms wishing to sell in the small group market were required to offer products to enrollees as well.

These reforms, along with modern risk adjustment tools, would prevent any significant risk selection. In addition, market distorting practices such as formularies and certificate of need determinations would be eliminated. One such broad-based Medicaid reform proposal has already been submitted by the State of South Carolina.

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## INTRODUCTION

### A. MEDICAID'S COSTS: UP, UP, AND AWAY

This can't go on. If the explosive growth in Florida's Medicaid spending continues, it will consume a greater and greater share of the state budget. If that happened, other priorities would suffer — and pressure surely would build to raise taxes or else make Draconian cuts in essential programs. Either scenario risks damaging Florida's vibrant economy, which has been a national leader in job creation.

How serious is the problem? Consider this: The state's Medicaid spending grew to \$12.7 billion in FY 2004 from \$418 million in FY 1980.<sup>1</sup> That's a growth rate of 13.5 percent a year. By contrast, nationwide health spending grew during the same period at an annual rate of slightly over 8 percent.<sup>2</sup> Moreover, during this period, the state budget increased at an annual rate of 8.8 percent, to \$53.9 billion in FY 2004 from \$7.1 billion in FY 1980.<sup>3</sup> Therefore, Medicaid's share of the state budget grew to 23.6 percent in 2004 from only 5.9 percent in 1980.

As disturbing as this trend is, the future could be even bleaker. Governor Jeb Bush's budget analysts project that unless major changes occur, Medicaid spending in Florida will top \$40 billion by 2015. If overall state spending during the same period grew at an

annual rate of 7 percent, Medicaid would consume more than 35 percent of the state budget in that year, which is less than a decade away (see Figure 1).

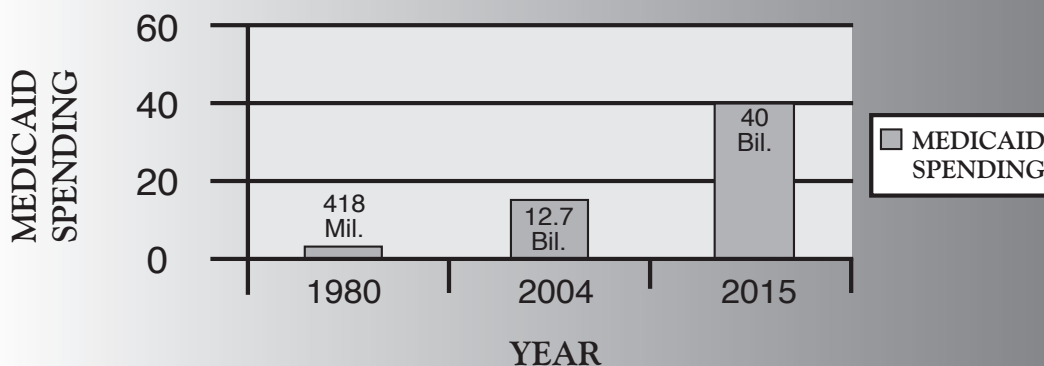
Worse, as "baby boomers" reach retirement age, Florida's aging population will continue to drive up health-care spending. If you take that into account and extrapolate the current trends to 2035, Medicaid would consume more than two-thirds of the state's budget if no changes were made. The inescapable conclusion: The State of Florida is on a fiscal collision course unless these trends are reversed.

What's driving the dramatic increase in Medicaid spending? Three factors: More people are enrolling, they're using more of Medicaid's services, and the prices for those services are steadily increasing.

As Figure 2 shows, Florida's number of Medicaid beneficiaries increased to 2.1 million in 2004 from 500,000 in 1980.<sup>4</sup> That's a growth rate averaging more than 6 percent a year. Yet the annual growth rate in Florida's Medicaid spending was 13.5 percent. This means that the rapid growth in the number of beneficiaries isn't the only factor driving up the program's total cost. In addition, the usage and the cost of services have both been increasing at a rate of about 7 percent a year. That explains the rapid growth (13.5 percent a year) in the total cost of Florida's Medicaid program during a period when medical inflation generally was below 7

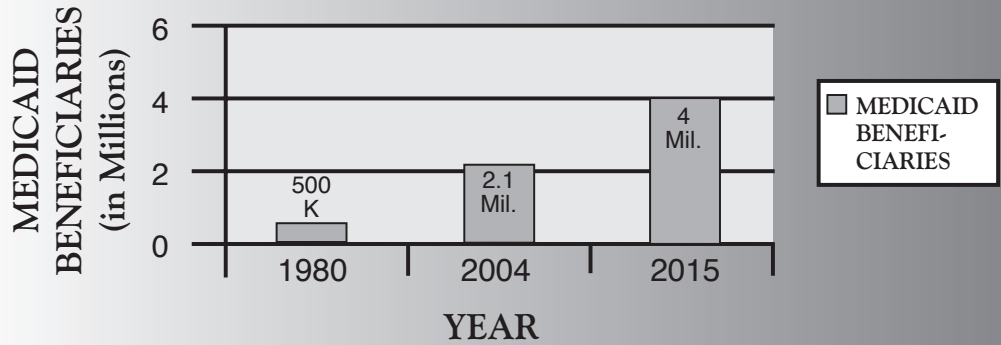
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FIGURE 1 FLORIDA MEDICAID SPENDING



*Medicaid expenditures are very highly skewed towards disability and long-term care.*

**FIGURE 2 FLORIDA MEDICAID BENEFICIARIES**



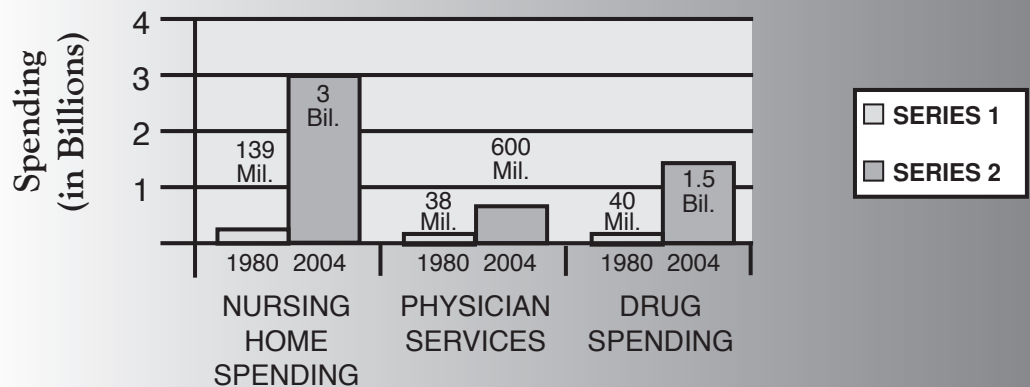
percent a year. Moreover, because that growth is a byproduct of all three of the factors cited above (number of beneficiaries, number of services used, and the price of those services), all three of those factors must be addressed if this pressing problem is to be solved.<sup>5</sup>

What kinds of services are increasing the fastest? The answer is evident in Figure 3, which shows various categories of spending increases since 1980. For example, Florida Medicaid nursing and home health care increased to more than \$3 billion in 2004 from \$139 million in 1980. In the same period, spending on physician care rose to more than \$600 million from \$38 million, and spending for drugs increased to \$1.5 billion from \$40 million.<sup>6</sup>

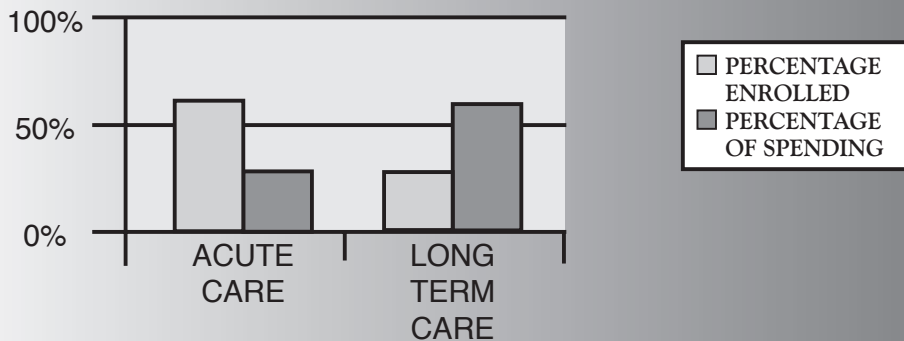
Who's using Florida's Medicaid's services the most? Around 50 percent of the beneficiaries are children, 20 percent are adults in acute care, and most of the rest are elderly, blind, and/or disabled. As Figure 4 indicates, however, those last groups – the elderly and disabled — account for about 75 percent of the total spending.<sup>7</sup> Thus, Medicaid expenditures are very highly skewed towards disability and long-term care.

Why the rapid increase in the number of beneficiaries and their spending? For one thing, the state's total population has grown steadily, to 15.9 million at the time of the 2000 Census from 9.7 million in 1980. That's a growth rate of 2.5 percent a year. Moreover, Florida's growth is expected to continue for the foreseeable future,

**FIGURE 3 SPENDING BY CATEGORY**



**FIGURE 4 SPENDING AND ENROLLMENT BY ACUTE & LONG TERM CARE**



even if the pace slows somewhat. Indeed, the population projection for 2030 is 25.5 million.<sup>8</sup> While that represents a lower growth rate (1.6 percent) than in the recent past, it's still well above the projected growth rate for the United States as a whole.

Furthermore, the nature of the state's population is changing. Especially notable is the growth in the proportion of the state's population older than 65. That age group is projected to comprise 25 percent of Florida's total population by 2030. Back in 1980, that age group accounted for 18 percent of the total population. If that jump in the over-65 population — to 25 percent in 2030 from 18 percent in 1980 — seems less than a seismic shift, consider this for perspective: 25 percent of 2030's projected population of 25.5 million would be 6.3 million seniors. In contrast, 1980's over-65 population — 18 percent of 9.7 million — was a mere 1.7 million. In raw numbers, then, Florida is looking at a 369 percent increase in its over-65 population.

Because of this trend, immigration from less developed nations, changes in eligibility requirements, and various other factors, the percentage of Florida's total population using Medicaid has increased dramatically. In 1980, only 5.1 percent of the Florida's residents received Medicaid services. By 2000, this figure had increased to around 13 percent.

Not only are more people using more of Medicaid's services, but health care prices have been rising at a faster rate than general inflation. Between 1980 and 2004, for instance, general consumer price inflation was 3.4 percent a year while medical inflation was 6.1 percent a year.<sup>9</sup> Yet spending per Medicaid beneficiary rose even faster: 7 percent a year. This reflects the fact that Medicaid recipients were using more services.

### B. MEDICAID'S IMPACT ON ECONOMIC BEHAVIOR

Any attempt to control Florida's Medicaid costs needs to recognize that beneficiaries' behavior is impacted by the nature of the program. For example:

- 1.) Eligibility for benefits is dependent on having a low income. Therefore, the program penalizes those who increase their earnings.
- 2.) Eligibility for benefits also is dependent on have few assets or none. Therefore, the program encourages people to spend rather than save and/or to conceal any assets that they do manage to accumulate.
- 3.) Beneficiaries perceive Medicaid as a low-cost or "free" alternative to private health care coverage, be it standard health insurance,

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long-term care insurance, or other types of private sector coverage. Therefore, the Medicaid program has the unintended consequence of discouraging beneficiaries from obtaining or maintaining private coverage.

Research has documented this perverse impact of Medicaid. Studies show that beneficiaries have saved less and consumed more.<sup>10</sup> They have also dropped private insurance in favor of Medicaid coverage. The percentage of children eligible for Medicaid increased by more than 50 percent between 1987 and 1992, while the number of pregnant women covered more than doubled. Between 50 percent and 75 percent of these “new” beneficiaries dropped private health insurance.<sup>11</sup> It is estimated that as many as 90 percent of Medicaid’s beneficiaries in nursing homes are “sheltering” assets in order to qualify for coverage and avoid using their own funds to pay for services.<sup>12</sup>

In other words, Medicaid’s beneficiaries have behaved in an economically rational manner when confronted with the system’s perverse incentives! Any attempted reform of Medicaid needs to recognize this fact.

### C. MEDICAID’S IMPACT ON HEALTH BEHAVIOR

From the above example, we may safely conclude that most Medicaid beneficiaries will respond to incentives in a predictable manner. An argument is sometimes made that making Medicaid “free” at the point of entry will therefore produce higher quality health results. However, some evidence suggests that this may not be true. For example, outreach programs in North Carolina found a statistically significant but very small impact on utilization.<sup>13</sup> Another study found that providing Medicaid benefits for a year increased the probability of child checkups by less than 20 percent.<sup>14</sup>

University of Washington researchers concluded that there was no conclusive

evidence that Medicaid-funded prenatal care pays for itself by reducing future health care costs.<sup>15</sup> There is also no strong evidence that Medicaid coverage reduces infant mortality rates. Nor does Medicaid have a significant impact on immunization rates.<sup>16</sup> There is some evidence that “free” coverage has some health benefits, particularly in controlling high blood pressure. These findings, however, are from a controlled experiment where the low-income Medicaid participants were given private health insurance, so the results may differ from those produced by having “free” Medicaid coverage.<sup>17</sup> Further, as will be seen, the nature of Medicaid reimbursements may significantly reduce the quality of the care actually delivered to beneficiaries. In summary, making Medicaid “free” at the point of entry may not produce better health outcomes among beneficiaries.

### REFORMING FLORIDA MEDICAID’S CURRENT SYSTEM

Would-be reformers of Medicaid are sometimes discouraged by the fact that it’s a joint federal-state program that is bound by federal rules and mandates. Nonetheless, there is sufficient flexibility to consider certain kinds of reforms. Nationwide, for instance, approximately 70 percent of Medicaid spending goes to provide services that are optional.<sup>18</sup> That is, the money goes to provide services for beneficiaries who are not required to be covered and/or to provide services that are not mandated by law. There are five non-mandatory groups,<sup>19</sup> and more than 20 non-mandated Medicaid services.<sup>20</sup>

Which groups are required to be covered? They include persons who meet the AFDC requirements in effect before welfare reform; pregnant women and children under age 6 with incomes up to 133 percent of the federal poverty level; all children under age 19 in families with incomes below 100 percent of the federal poverty level; SSI recipients; children receiving foster care or adoption under Title IV-E; and certain low income Medicare beneficiaries

*An argument is sometimes made that making Medicaid “free” at the point of entry will therefore produce higher quality health results.*

Which services are required to be covered? They include inpatient/outpatient hospital services; physicians services; medical/surgical services of a dentist; lab and X-ray services; nurse practitioner and nursing facility services; home health services; rural health clinics; family planning; and nurse-midwife services

So there's a limit to Medicaid's flexibility. Medicaid is an entitlement. By law, the covered services must be provided to members of the covered groups. This sometimes exacerbates Medicaid's fiscal impact on state budgets because Medicaid, like certain other entitlement programs, is also countercyclical. Medicaid spending tends to increase during economic downturns –the very times when state tax revenues flatten or decrease. Reducing Medicaid expenditures by dropping non-mandated beneficiaries and services would be one way to deal with the fiscal problems that Medicaid creates, but that would but involve very difficult choices and would certainly be politically controversial.

Moreover, reducing costs by eliminating covered services sometimes backfires, resulting in higher costs to the state. One study, for example, found an interesting statistical correlation between prescriptions provided and other services used. It found that an increase of 100 prescriptions was associated with 1.48 fewer hospital admissions, 16.3 fewer hospital stay days, and 3.36 fewer inpatient surgical procedures. Overall, spending \$100 on drugs reduced expenditures by \$365.<sup>21</sup>

An especially sensitive concern in reducing covered items is in the area of mental health. Evidence suggests that reduced expenditures in this area were more than offset by increasing health costs in other areas.<sup>22</sup> Physicians also report numerous health problems related to restrictive Medicaid formularies.<sup>23</sup>

In short, it will be very difficult to reform Florida's (or the nation's) Medicaid program in its current form by reducing eligibility and/or benefits. Instead, it's time for Florida and the rest of the nation to recognize that nothing less than fundamental changes in the program will place it on a sustainable basis.

## WHAT'S WRONG WITH MEDICAID (AND MUCH OF HEALTH CARE)

It has been demonstrated that Medicaid is unsustainable, that it is full of perverse incentives, and that reforming it will be difficult in its current form. Medicaid, as well as much of America's health care system, suffers from complex problems. But in one sense the problem of ever rising program costs is actually quite simple: Americans, regardless of their incomes, want the best healthcare that someone else's money can buy.

Any economic product and/or service where buyers have no incentive to economize and the sellers have no incentive to be efficient will face ever escalating costs. This is the fundamental problem of Medicaid and, for that matter, Medicare and much of the private medical sector. Failure to deal with a program design that maximizes the above desire is doomed to fail. This is basic. All else is confusing rhetoric.

How does Medicaid work? Medicaid is responsible for providing medical services and care to three major groups: acute care for the poor and near-poor, the disabled population, and long-term care. These are groups that would not be able to obtain coverage in the traditional health market because of their low incomes and/or the chronic nature of their health needs.

Medicaid is thus a needed program for those who would fall "between the cracks" in our health care system. Remember, though, the current Medicaid system encourages people to "fall between the cracks."

Although the ideals underlying Medicaid are in the great American tradition of helping the less fortunate, any system that bankrupts the state and diverts funding from other public services serves no one's interests.

The fundamental problem of Medicaid is its flawed program design. Medicaid does not rely on a "market" in the traditional sense of buyers and sellers acting in their own interest in a decentralized market place. Instead, it is an "administered pricing" system

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where various schemes are used to determine reimbursements. In Florida this system ranges from cost-based reimbursement for nursing homes to prospective payments for acute care. This is the “Achilles heel” of the current program. Any efforts to fix Medicaid need to address this payment system.

In the United States, the pricing of virtually all of the goods and services we need to provide for ourselves is “economic” in nature, responding to the forces of supply and demand. If a product is in short supply, for example, the price rises, giving producers an incentive to supply more of it. If there is a glut of a product on the market, the price falls, providing buyers an incentive to purchase more of it. This kind of pricing system not only serves to allocate goods and services to those who will pay, but it also directs production towards what consumers value the most — and it does so efficiently, since efficient producers earn more by controlling their costs. Because of the demonstrated success of the free-market system — and the dismal failure of “command economies” such as North Korea, Cuba, and the old Soviet Union — an overwhelming majority of today’s economists believe that only a free, decentralized marketplace will produce the efficient distribution of goods and services that leads to rising living standards over time.

Most also believe that any “administered price system” such as those the old “command economies” is doomed to fail, even if it’s embedded in an otherwise free and prosperous economy. Such failed systems do not rely on freely determined prices but rather “administer” them through bureaucratic edict. Unfortunately, all administered pricing schemes are fundamentally flawed due to the “information problem.”<sup>24</sup> Centralized systems and price determination often appear attractive. In reality, they suffer from this basic problem. In order to know where resources should be directed, the central planners and price determiners need to know both what goods and services people want and how they can most cheaply be produced. But

this knowledge is held in the minds of individual consumers, businesses, and providers, not in the filing cabinets or computers of a government planning agency such as Medicaid. The only practical way for consumers and providers to relay this knowledge to each other is through a decentralized system of market-determined prices.<sup>25</sup>

Medicaid is a prime example of the flawed “administered price” system. The “prices” that Medicaid pays for services to its enrollees are not determined in a marketplace. They are administered prices using various schemes. For example, nursing homes in Florida are reimbursed on a modified cost-based formula. The result is excess nursing home capacity and the survival of marginal providers who would fail in a free market. If providers are paid on the basis of “costs,” the traditional market incentive to economize and become more efficient is removed. The current Florida system tends to reward heavily leveraged facilities with high operating costs at the expense of well financed facilities with low costs and overhead.

The problem of perverse incentives in the above cost-plus system was “dealt” with initially by Medicare in 1983, when hospital reimbursements were switched to “prospective payments.” In theory, these were a fixed reimbursement like a price that would encourage providers to deliver service more efficiently. In reality, the government simply switched from one pricing scheme to another. Hospitals under both Medicare and Medicaid are compensated with a DRG payment (Diagnosis Related Groups) system. Consultants to Medicaid determine appropriate DRG rates for various services and procedures around the state.<sup>26</sup>

The DRG system is fundamentally flawed because Medicaid and its consultants can never know the “correct” price for a bypass in Miami-Dade County or an appendectomy in Tallahassee. Only a decentralized market with buyers and sellers can determine accurate prices. Since the DRG rates set by Medicaid are almost all certainly “wrong,” the impact on

the health care system is to produce surpluses, shortages, and inefficiency.

Payments to physicians are also an administered price scheme called Resource Based Relative Value Scale (or some variant of this method).<sup>27</sup> While quite impressive on paper, this scheme is nothing more than a variant of the outdated and discredited “Labor Value Theory” developed by Karl Marx, the world’s worst economist. Imagine: Medicaid actually uses Marxist principles when determining what to pay doctors to provide services to Medicaid beneficiaries!

It’s important to remember what happens when an administered price is not “correct.” If the price is set too high, there will be surpluses and excess capacity. If the price is set too low, there will be shortages and a lack of capacity. Since both Medicaid and Medicare account for a huge part of the health market and both use administered pricing schemes, the entire health care system is inefficient. This problem is exacerbated by some private payers

copying the government’s pricing schemes or, at best, using them as a starting point in price negotiations. See “The Impact of Medicaid Price Controls,” on page 19.

In the case of Medicaid, it appears that payments are often set below the going rate that would exist in a real market. This indicates that there should be outright shortages of services to beneficiaries, and sometimes there are — with individuals who use Medicaid finding it very difficult to find providers to serve them. But with heterogeneous services like health care, the “shortage” may arise in the form of low quality. These include failure to treat illnesses properly as well as long waiting times for receiving services. In one study, researchers pretending to be Medicaid patients suffering from a broken arm called 50 orthopedic doctors asking for treatment. Only three physicians offered to treat them!<sup>28</sup> In general, no one receives lower quality care than fee-for-service Medicaid beneficiaries!

Why? When fee-for-service Medicaid

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## THE IMPACT OF MEDICAID PRICE CONTROLS

Introductory economics explains that prices are determined by the interaction of supply and demand. Under Medicaid, however, prices are “administered” instead of determined in a free market. Since Medicaid cannot possibly know the supply and demand schedules for various services, it cannot know the “right” price for those services. Various pricing schemes are therefore nothing more than sophisticated price controls.

When the administered prices are off the mark, there are adverse consequences. If Medicaid sets its prices too “low” there will then be a shortage of services. With homogeneous products such as gasoline, the result of price controls is an outright shortage of the product, with resultant long lines at service stations. With heterogeneous services such as health care, the shortage may take the form of lower quality. If the fee that Medicaid pays physicians for giving physical exams is too low, for instance, some will be tempted to abbreviate the exams in order to see more patients. The average time spent with each patient declines, and the result is obviously a lower quality medical service. As has been shown earlier, the low quality of Medicaid care is well documented.

In addition to diminishing the quality of care

provided to Medicaid patients, price controls may well have fiscal consequences that are not what the program’s administrators intended. Presumably, Medicaid has artificially low reimbursements to “save” money. Because providers may respond to the lower reimbursements by seeing more patients for shorter periods, the budget savings from stingy reimbursements are far less than anticipated. These illusionary budget savings are in addition to the negative quality impact born by beneficiaries. Another possible outcome in the face of low Medicaid reimbursements is for providers to “shift” costs to private payers.

The above analysis involves short-run impacts of administered pricing by Medicaid. The longer-run impact is to make it undesirable to provide quality services in the health care market. As fewer resources are devoted to medical care, the long-term supply of health care declines, causing an actual increase in medical costs. The reduced supply of providers and competition reduces innovation and productivity, which further increases medical costs. The bottom line is that Medicaid price controls actually lower health quality and increase costs in the long-run.

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beneficiaries are treated, there is a major incentive for providers to attempt to offset stingy reimbursements, which are often set 30 percent to 50 percent below Medicare reimbursements — which in turn are often below private sector payments. This often results in over-treatment as the physician tries to recoup the cost of seeing a Medicaid patient. This leads to a bizarre paradox: While it is often difficult to get treatment when you're on Medicaid, it's easy to be over-treated if you can find a provider!<sup>29</sup> Since over-treatment has little or no financial impact on a fee-for-service patient under Medicaid, the patients rarely complain about it. As the noted economist Walter Williams wryly observed, "When someone else is buying, we are all drinking top shelf!"<sup>30</sup>

Another outcome when administered pricing systems set reimbursements "too low" is cost shifting other patients, mostly those covered through the private sector. When Medicaid providers are paid below market rates, they attempt to offset this loss by increasing rates to private payers. This has the impact of making Medicaid (and Medicare) look cost effective relative to the private sector. Most Medicaid plans consistently argue that they are a more cost effective provider than the private sector, and produce accurate data showing their costs increasing at lower rate in the last few years.

While technically correct, these assertions are extremely misleading. Part of many Medicaid plans for dealing with their budget problem recently has involved "freezing" payments to providers. How many private sector buyers have been able to "freeze" their premiums in the last few years? Medicaid simply does not pay the going rate, and then erroneously believes it is a "value buyer." The first result is lower quality care to beneficiaries; the second is higher inflation in the private sector because of cost shifting.

The Lewin Group researched stingy government payments and the possibility of cost shifting. It found that low public reimbursements correlated about -.75 with

private payment ratios.<sup>31</sup> This research strongly indicates that Medicaid's "low cost" actually is a driver of private sector medical inflation. It's important to understand that reforming Medicaid so the plan pays actual market rates will produce benefits partially through reduced private sector cost shifting.<sup>32</sup>

Cost shifting is an old trick of government-run health plans, which attempt to promote their "cost effectiveness" vs. private provision of medical care. Of course, in national health insurance plans such as Canada's there is no one to shift costs to, with the result of long waiting periods and serious quality issues.<sup>33</sup>

Another major problem of Medicaid nationally is that it is an open-ended "match" program where the Federal Government provides funding based on a formula dependent on state income. States must comply with onerous federal rules mandating whom to cover and which services must be provided. These rules are administered by a cumbersome federal bureaucracy, the Center for Medicare and Medicaid Services (CMS). In order to maximize Federal funding states often "game" the system. Their tactics include excessive payments to state health facilities, provider taxes and donations, excessive disproportionate share hospital payments, and upper payment limit for local government health facilities. Because most states attempt to maximize the Federal match, the overall program cost increases. In most instances this is good for the state but costs Federal taxpayers more. Some attempts to maximize the match by expanding eligibility have backfired.

In short, the current Medicaid system is an inherently inefficient program because it relies on administered prices as opposed to a decentralized marketplace. No government anywhere has ever been able to set prices effectively in any field, and health care is no exception. The result of this system is provider inefficiency, explicit and implicit shortages of health care, and higher medical inflation in the private sector.

## HOW TO FIX MEDICAID

Because the fundamental problem facing Medicaid is the lack of a real marketplace, the solution is straightforward: Create one! That is, Medicaid needs to create a decentralized market where buyers and sellers may buy and sell health care. This will require the use of Section 1115, Health Insurance Flexibility and Accountability (HIFA) demonstration initiative and other waivers to dramatically alter the existing Medicaid program.

Medicaid would be transformed into a modern, efficient health care plan with state financing and block grants from the Federal government. While the waiver presumes that efficiencies gained from waiver approvals are used to expand coverage for beneficiaries, officials at the U.S. Department of Health and Human Services have indicated that they are willing to look at other dramatic restructurings unrelated to expanding coverage.

The development of a real marketplace for Medicaid would involve eight steps:

**Step One:** Medicaid Creates an Insurance and Provider Exchange

Florida Medicaid would create an Insurance and Provider Exchange (IPE) where beneficiaries would purchase acute care, long-term care, and care for the disabled. An IPE is nothing more than a health mart where various packages of services would be offered by competing providers.

**Step Two:** Florida Medicaid Establishes 'The Rules of the Game'

Florida Medicaid (FM) would establish minimum benefit levels and quality requirements consistent with the federal Medicaid law and the waivers obtained from the Federal Government. Florida Medicaid then would assist eligible beneficiaries in selecting plans that best suit their needs through direct assistance and by requiring providers to lay out clearly the benefits available to those covered. Given the type of population that Medicaid covers, such issues as helping to promote linguistic competence and health literacy among beneficiaries

would be important responsibilities of Florida Medicaid.

**Step Three:** Florida Medicaid Solicits Sealed Bids from Potential Providers

Each year, Florida Medicaid would solicit sealed bids from various providers for the different Medicaid populations for their county and contiguous counties or within a geographic area determined by Medicaid. Florida Medicaid would also solicit bids for various levels of coverage ranging from the minimum allowed under law and the waiver to more generous levels of coverage. This would assist Florida Medicaid in determining what amount of coverage can be "afforded," given budget constraints.<sup>34</sup>

**Step Four:** Medicaid Selects the Lowest Cost Services Consistent With Its Budget

In each geographic region where bids are solicited, Florida Medicaid would select the lowest cost package consistent with the program's budget. For example, suppose four providers have submitted bids for four different levels of acute care coverage ranging from primary care and hospitalization to dental and eye care. Medicaid would select the low cost bid for a coverage level that can be handled under current State and Federal funding. If funds are short because of tight budgets or increasing required coverage, as often happens during an economic downturn, the budget would be balanced by selecting a less generous benefits package or by reducing eligibility. The process of balancing the budget by paying providers below-market rates would end. For the reasons previously cited in this report, prices dictated by the government rather than by the marketplace are a counterproductive relic of Marxist thought, which most economists quite correctly have relegated to the dustbin of history.

**Step Five:** Medicaid Becomes the Health Care Financier for Low-Income Patients

Utilizing the legal latitude gained through these reforms, Florida Medicaid would award grants to eligible beneficiaries equal to the low cost bid in their geographic area. Funds

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*Nursing homes would no longer be reimbursed on a cost basis. Instead, they would be paid for the services they provide.*

would never actually be placed in the hands of the beneficiaries. Rather, Florida Medicaid would pay the providers directly. Vigorous competition among providers would produce quality health care at reasonable costs. Providers submitting prices above the low bid for the area could easily find themselves losing thousands of “customers”. Thus, Florida Medicaid’s buying power, in tandem with competition among providers, would serve as a powerful market force in controlling medical inflation along the lines of the Federal Employee Health Benefits Plan.<sup>35</sup>

Moreover, providers would also have a strong incentive to improve the quality of care or face the loss of enrollees. Beneficiaries would be able to purchase more “expensive” plans with their own resources. A not-so-pleasant part of the current Medicaid problem is that a significant number of beneficiaries have assets and income that could be used to purchase medical services, particularly in the long-term care market.

**Step Six: Providers of Long-Term Care and Care for the Disabled Are Paid Directly**

Nursing homes and providers of services to the disabled would be paid directly by beneficiaries using grants determined by the annual low cost bid in their areas for packages of services requested by Medicaid. Nursing homes would no longer be reimbursed on a cost basis. Instead, they would be paid for the services they provide. This would give them an incentive to increase quality and control costs. As an incentive to keep costs low, Florida Medicaid would also solicit home care service bids for eligible beneficiaries, as opposed to expensive nursing home care. Providers for the disabled (including government providers) would offer various packages for this diverse group ranging from comprehensive coverage for the mentally ill to low cost “carve outs” such as alcohol rehab services for the otherwise healthy. These providers would also be paid with grants to beneficiaries based on low cost bids. The beneficiaries would be evaluated by

### HOW MAXIMIZING THE MEDICAID “MATCH” CAN BACKFIRE

In the late 1980s, Texas (a very fiscally conservative state) faced many of the same problems that other states confront today: Policymakers had to address a variety of economic woes, including expanding entitlement caseloads, budget shortfalls, and other needs that could not be addressed without major tax increases. Further, its situation in the health care cost cycle was similar to today’s. To address these issues, Texas decided the solution was to maximize federal matching funds.

Two basic approaches were used: obtaining Medicaid matching funds for already-existing expenditures that were not being used for a Medicaid match and expanding Medicaid eligibility. The first did not cost additional direct state tax dollars, at least initially. The second did.

The first approach converted money that was already being spent on charity care for indigent patients (but with no federal match) into expenditures (which qualified for a federal match) through paper transactions. To accomplish this result, Texas counties sent funds to the state on one day, and the state returned the funds the next day. This one-day bookkeeping transaction converted (at least on paper) county spending

into state spending – thus satisfying federal requirements and turning county spending on indigent care into state Medicaid spending under the Disproportionate Share Hospital funds. This program, which qualifies for federal matching funds, was set up to compensate hospitals that treat a disproportionate number of Medicaid patients (for which they receive state payments that are below market rates) and uninsured patients (from whom they receive less than the amounts billed). The state also expanded Medicaid eligibility, primarily to pregnant women, infants, and children, thus qualifying for even more matching funds. But that decision also increased the demands for state matching dollars as well.

All in all, approximately a billion dollars a year were added to DSH program alone; eligibility to pregnant women and infants under Medicaid was expanded; and other needy populations were selectively added to Medicaid.

The fiscal consequences 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. Yet it reached \$7 billion – a 250 percent increase – in just five more years. And it doubled to \$10 billion over the next ten years.

Medicaid to determine the severity of their disability, and a grant would be awarded based on that determination. Both nursing home and disabled beneficiaries would be free to purchase more expensive services with their own funds. Medicaid would create quality indices that would be available to inform beneficiaries when they're choosing their providers.<sup>36</sup> An important part of this reform would involve allowing beneficiaries to pay family members for providing services.<sup>37</sup> Because of the emotional bond involved, allowing this option can produce significant increases in the quality of care at far less cost than in an institutional setting.

The disabled portion of Medicaid is a particularly difficult area to reform. Some of these conditions are fairly easy to exaggerate or even fabricate in an attempt to obtain coverage. It is therefore important that resources be made available to Florida Medicaid to judge whether applicants for disability benefits are truly disabled and, if so, to what degree. A large portion of the persons with disabilities gain access to Medicaid benefits by qualifying for Federal Supplemental Security Income (SSI), a program with a history of being riddled with fraud and abuse.<sup>38</sup> Since the ability of SSI recipients to qualify for Medicaid usually rests at the state level, restricting eligibility to the truly needy could result in significant savings. In order to encourage cost-effective use of these funds beneficiaries and/or their guardians would receive an account to purchase the services and items they need. Unused funds could be rolled over for future use or converted to a private sector health savings account for other medical expenses.

In order to encourage private managed care plans and providers to offer services to Medicaid beneficiaries, Florida Medicaid would act as "re-insurer" to these private plans in the acute care market. Because a significant number of Medicaid beneficiaries sign up for coverage when they become ill, a traditional insurance market would suffer from significant "adverse selection." It would be difficult to induce private carriers to participate in this market.

To manage this "guaranteed issue" problem, Florida Medicaid would reimburse these private carriers and HMOs for an arbitrary percentage above a certain amount of claims or average beneficiary costs. For example, Florida Medicaid might pay 80 percent of the costs above \$5,000 per covered individual for selected health issues such as low birth weight treatment, transplants and so-forth. It is important that this group of providers be required to maintain some financial risk so as to have incentives to provide care at the lowest possible cost. An additional incentive for providers to offer services to Medicaid would be a subsidy system where providers who enroll a "high cost" beneficiary receive a mandatory payment from the original provider. These two plan designs should effectively eliminate "cherry picking" and, along with the freedom to set rates annually, should produce a great deal of private sector interest in enrolling beneficiaries. The resulting competition would produce low cost provision of services along with higher quality of care.

**Step Seven: Medicaid Enrollees Are Free to Join Employer-Provided Plans**

Medicaid enrollees would be free to use their grants to join existing employer provided plans. The grant amount would be the lower of low bid from the IPE or the cost of joining the private plan. Given that a significant number of new Medicaid enrollees in the last 15 years dropped family coverage, this could be a low-cost way of offering coverage to these groups. Since many of them are above the poverty level, Florida Medicaid could offer grants to them on a sliding scale, with high amounts for near poverty and lower amounts for incomes near the arbitrary established poverty level. Eligible Medicaid beneficiaries failing to make a plan selection would automatically be enrolled with the low cost provider for their category in their region.

Related to this, another possible reform is to allow individuals and small business to purchase private health plans from the IPE. This would generate four potential benefits.

*Medicaid enrollees would be free to use their grants to join existing employer provided plans.*

*As economic theory predicts, the more something costs, the less of it people will use.*

First, it could reduce Medicaid enrollments by moving some beneficiaries back into private sector coverage. Second, it will induce more firms to offer health insurance by lowering the insurance overhead cost that exists in this market. Third, it will also reduce insurance costs by creating a larger pool of buyers with more purchasing power and reduced annual claims uncertainty. Finally, private providers seeking to sell to private firms/individuals would be required to sell in the Medicaid market as well. This will increase the number of firms competing for Medicaid beneficiary dollars.

**Step Eight:** All Market-Distorting Practices and Policies Are Discontinued

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

#### IV. WHAT HAPPENS IN FREE MARKETS FOR HEALTH CARE?

Would the free enterprise system really help Medicaid's beneficiaries and improve Medicaid's fiscal situation? Or is the purchase of health care simply too sophisticated for most people to deal with, especially the poor? Fortunately, we have some evidence on this issue. The Rand Research Corporation conducted a huge study of the impact of financial incentives on the use of medical services between 1974 and 1982. The study included a large group of families and individuals nationwide and included a wide range of family incomes, from as \$100,000 (in today's dollars) down to the poverty level.<sup>39</sup>

We're simplifying the actual study here, but some participants were given "free" health

care while others had to pay a deductible of up to \$1,000 (around \$4,000 in today's dollars). The conclusion of Rand Researchers:

- "The more families had to pay 'out of pocket,' the fewer medical services they used."
- "The percentage reduction in expenditure caused by cost sharing did not differ strikingly by income group...."

As economic theory predicts, the more something costs, the less of it people will use. Note that the study's low-income participants changed their behavior along with the middle- and upper-income participants.

It is important to note that there were some adverse health outcomes among the low-income participants when they were required to pay some of the cost rather than receiving the services free of charge. For instance, when blood pressure screenings were provided at no cost to the patient, mortality rates declined by about 10 percent. In addition, participants who entered the study with serious symptoms were less likely to leave them untreated when treatment cost was not a factor.

Recall, however, that most of the medical delivery system in this period (1974-82) was a standard fee-for-service plan. Nowadays, the adverse health outcomes cited above could easily be dealt with by HMOs and provider networks, which recognize the health and financial value of certain types of preventive care. Indeed, competition among providers for beneficiary dollars could be expected to raise the quality of care to the poor.

Broad market-based reforms are virtually non-existent in Medicaid. In the past, Washington bureaucrats would have looked unfavorably on significant reforms. While attempts have been made to utilize HMOs, these continue to suffer from administered pricing schemes where reimbursements to providers are set too low, causing providers to drop out of the system.<sup>40</sup> Now, however, a new, more receptive attitude in Washington opens up the possibility of dramatically changing the system. Nonetheless,

thus far no broad-based reforms have been undertaken at the federal level.

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

A similar program in Arkansas called Independent Choices showed a similarly high degree of customer satisfaction, with 93 percent of the participants recommending the program to others. New Jersey has a related program called Personal Preferences. An amazing 99 percent of beneficiaries reported “satisfying” relationships with their caregivers, and 97 percent would recommend the program to others. Does anyone believe that Medicaid’s more traditional programs produce these types of outcomes? While such programs are relatively new and limited in scope, we believe the success of “Cash and Counseling” shows that the idea of allowing beneficiaries to buy their care in the market can work.<sup>41</sup>

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

In cash medical markets such as for cosmetic care, the results are what would be expected. Along with continuing advances in

quality, innovations, and comfort, the discipline of the market controls costs. Medical inflation between 1992 and 2001 was three times as high as that of cosmetic care, and these type of services rose in cost at a lower rate than general inflation. Eye care costs and services where there is not nearly as much third party payment rose at 33 percent between 1990 and 2002, while general medical costs increased at 75 percent. This is in a period when there were dramatic advances in technology and services such as LASIK. In addition, the cost of other types of medical services such as podiatry and chiropractic care (which are often not insured) rose at 43 percent between 1990 and 2002.<sup>42</sup>

## V. A MARKET-BASED MEDICAID WAIVER CONCEPT

Reforming a program as large and as complicated as Medicaid is an enormous and difficult task. From above, to this date Medicaid market-based reforms have been extremely limited but encouraging. Naturally, state legislators and Medicaid administrators have been hesitant to seek dramatic reforms in their programs, despite the obvious fiscal and quality need for them. It would be reassuring if Florida and other states could look to an actual Medicaid overhaul in one of their sister states. Fortunately, one state has stepped forward to ask the federal government for a dramatic market-based waiver for its Medicaid plan.

The following is a lengthy concept letter, dated October 15, 2004, from the State of South Carolina to the Center for Medicare & Medicaid Services, requesting authority to make dramatic changes in the program there:

*Since its inception, the South Carolina Medicaid program has been providing health care coverage to poor, elderly, and disabled South Carolinians. This care has been delivered in a “fee-for-service” manner where a provider delivers a service to a beneficiary and subsequently bills Medicaid for payment. Under this traditional method, beneficiaries and providers are isolated from the basic economic forces that drive most markets. The Medicaid beneficiary’s incentive is*

*While the private sector suffers from many of the same problems as the public sector, we can see how a free market in medical care would operate.*

*The challenge is to bring the benefits of market place incentives to a publicly funded program like Medicaid.*

*just the reverse of a normal economic incentive. They have unlimited buying power and only benefit from the program when they are using (or when the government buys) health services. The incentives for providers, due to low reimbursement rates, are to either reduce quality or maximize the number of services charged to each recipient.*

*We believe this structure contributes to a significant disconnect between recipients and those delivering and paying for their care. And, while not the only factor, it is certainly a major contributor to the rise in Medicaid costs. It is desirable to bring marketplace principles to the Medicaid program. It is essential to both enable and require that the Medicaid beneficiary participate as a prudent buyer of health care services. The Medicaid beneficiary, just like other Americans, needs to be vested as a purchaser of health care.”*

#### **The Private Market Place**

*Individuals in the private market place with health insurance often have a menu of plans from which they can choose. The plans vary in both cost and benefits usually including indemnity and managed care offerings. Options range from low premiums with high deductibles to high premiums with full services. Relatively new options now available are medical savings accounts where the individual either deposits their own money or some combination of their own money and an employer’s contribution. The beneficiary pays from this account to cover medical costs. Funds not expended on medical care inure to the benefit of the beneficiary. This may be combined with a catastrophic medical policy that covers medical cost after a high level of defined deductible.*

*In this environment, beneficiaries are able to make market place decisions regarding the plan that is most advantageous to them. In doing so, they have the incentive to control their medical costs, maintain their health and, thus, reduce their out of pocket expenses. The beneficiary has the incentive to consider the value in the use of the health care system, just as they do with all other purchases they make. The provider has an incentive to provide quality care in order to attract the customer. True Medicaid reform must free individuals and providers to operate in a more open market.*

#### **Bringing Medicaid into a Consumer Directed, Market Based Environment**

*The challenge is to bring the benefits of market place incentives to a publicly funded program like Medicaid. It is our intent to create a new Medicaid coverage plan that integrates personal health accounts, personal health incentives and true options for consumer choice. We hope to create the environment where providers and insurers are freed from unnecessary bureaucratic requirements and can compete for the consumer’s dollar. In this concept three general categories of care are addressed: acute or general medical care, community care for the disabled and frail elderly, and institutional long-term care.*

#### **Acute Medical Care Coverage Plan**

*Under this plan, each beneficiary will be given a Personal Health Account (PHA) to pay for part of his or her health care expenses. The account will be accessed using a debit or “swipe” card and will function under the same premises of existing flexible spending accounts. The beneficiary will not be restricted by current service limits and can use the card at any health care provider. The beneficiary is free to determine what is most important to them in relation to their health care. The account will be funded with an actuarially determined amount generally based on current fee for service average expenses less the actuarially equivalence of the catastrophic or major medical benefits described below. The amount will be risk adjusted for eligibility categories as well as age and gender. It is expected that the account will be available on an individual basis as well as family groups. Unexpended annual funds will be allowed to roll over to the following year. Additional incentives could be implemented that might include retention of a percentage of unexpended funds into a personal Health Savings Account (HSA) should they leave the Medicaid program.*

*In addition to the PHA, each beneficiary will be provided catastrophic and preventive benefit coverage. This coverage will be a safety net of limited benefits for those individuals. These benefits include inpatient hospital coverage, physician visits, some drug coverage, limited lab and x-ray, and*

certain clinical and durable equipment coverage. This is a preliminary estimate of the duration and scope of catastrophic/preventive coverage and is, of course, subject to change during waiver development. Alteration of this coverage however, will change the amounts available for the PHA.

Important to this waiver concept will be the ability of beneficiaries to use the PHA to upgrade to more robust managed care plans or combine with pharmacy or dental plans. In these cases, the beneficiary could use funds in their account to purchase a full "coverage" plan from a managed care organization (MCO) in which case the Medicaid agency will also pay the MCO the actuarial equivalent value of the catastrophic/preventive coverage. The beneficiary is free to shop for plans that best meet their coverage needs. The intent is that plans will now compete for the beneficiary's business by creating an array of attractive coverage packages or pricing. For example, a drug store may offer set discounts to Medicaid recipients to attract their business. Another example is the need for the MCO to offer services in a way that the beneficiary can best utilize the care they need. MCOs may offer special assistance in transportation or more convenient hours for access to preventive services.

Critical to the success of this effort will be the agency utilizing enrollment counselors during the eligibility process. These counselors will help explain the menu of options that will be available to recipients. In fact, the agency's role will evolve from primary claims processor to more education and coordination. The agency's role will help the beneficiary become a wise shopper for health care, a real market place participant. The beneficiary will be able to define what quality health care means to him, and through his purchasing power, influence the kinds of services that are available to him.

Another significant advantage of the PHA is the ability to provide for preventive health incentives. Though incentives have not yet been determined, they could take the form of additional deposits to the account for using preventive care or be based on achieving certain prevention milestones. For example, completion of certain

screenings or maintaining cholesterol levels below certain points. Future developments of this system may offer opportunities for coverage for small businesses and uninsured populations.

### **Community Care Plan for Disabled and Frail Elderly**

Most plans to reform Medicaid focus only on families and children. The most expensive Medicaid beneficiaries and the beneficiaries that most need to direct their own care are left out of acute care reform proposals. These are the disabled and frail elderly.

Medicaid covers many disabled and frail elderly individuals who could be cared for in an institution, but who choose to remain in the community. For these individuals, Medicaid provides a variety of services to enable them to remain in the community. Many have basic health care coverage through private insurance. Others could choose one of the options above for their acute care coverage. Currently, individuals in this group can get the specific items or services for which Medicaid pays. These services are standard services that often are not tailored to the individual's need. What they really need may not be on the list of services available. The patchwork of services may cost a lot while the quality of their care suffers. The disabled and frail elderly need to be able buy what they need, not use some set of predefined items and services. The services used by the disabled and frail elderly are expensive and account for most of the Medicaid budget. Again, giving patients control over their health care dollars and allowing access to any available service will increase quality and reduce cost.

An alternative that would better meet the needs of the disabled is a payment into their Health Savings Account. Frequently, a disabled individual can spend less money and procure goods and services on the open market that would better meet their needs. The individuals will have an additional deposit into their Personal Health Account. This Personal Health Account will be similar to the PHA under the Acute Care Plan, but will have broader purchasing power. The amount can be determined by the level of service

*The disabled and frail elderly need to be able buy what they need, not use some set of predefined items and services.*

that Medicaid would have provided. Both the beneficiary and Medicaid win.

- The Disabled become the full consumers in every sense of the word. They decide what goods and services best meet their needs. They shop for best prices and use their funds to best meet their needs. They can decide if supplies such as adult diapers can best be bought from Wal-Mart or from a traditional medical supplier. They decide whether an expensive piece of medical equipment for help in mobility best meets their needs or whether construction of something tailored from PVC pipe specifically designed around their home and their abilities best serves the purpose. They decide how to spend their dollars to best improve the quality of their lives.
- The expensive bureaucracy of public funded programs is reduced.
- Providers can offer their services in a true economic arena.

As in the Acute Care Plan, the agency's role shifts to beneficiary education and guidance.

#### **Institutional Long Term Care Plan**

Long-term care services that are provided in an institutional setting (nursing facility or nursing home) offer a different opportunity for economic purchasing than community-based services. For community-based services, many individual services or commodities are purchased to meet the care needs of the beneficiary. However, in the institutional setting, the common unit purchased is a day of care. Because the commodity being purchased is basically the same across the industry and the beneficiary market, this program lends itself to a low bid process to achieve the best buy for the taxpayer.

Changing to a bid approach would offer several advantages over the current system. The current system is flawed in the following ways.

- In order to limit the cost of the nursing home program, SC has used an obtuse approach of combining certificate of need and administrative rules. This has eliminated new players in the market that could otherwise bring in an element of competition. In a sense it has resulted in a kind of monopoly represented by the set of providers who entered the Medicaid market prior to the time this system was adopted, more than a decade ago.
- Because the market has been closed, new nursing homes willing to take Medicaid patients cannot enter the market. Thus when a patient who is in a facility that is excluded from the current Medicaid system and has been private-pay and has exhausted their resources, they must move to a different facility that has been authorized to participate in Medicaid. The absurdity of this rule is demonstrated when several nursing facilities have common ownership. Some are included in the Medicaid "monopoly" group; some are not. The owner is not allowed to shift a Medicaid sponsored bed from one of his facilities to accommodate a patient in another of his facilities across the state who needs to change from private pay status to Medicaid. He can require that the patient move across the state to the location of a facility where he does have Medicaid sponsored beds.
- Payment is related to quality in only a limited way.

Medicaid beds can be bid on the open market. Allocating beds from the lowest bid until all of the Medicaid funding is allocated would still control total expenditures. Nursing facilities bidding the lowest price would be allocated all of the Medicaid beds they wanted. The next lowest would then receive beds, and so on until the funding cap is reached. This system would need to be modified in order to avoid patient disruption. Actually distributing the beds to the lowest bid homes as vacancies occur can easily do this. The rate of patient turnover in nursing home

*For community-based services, many individual services or commodities are purchased to meet the care needs of the beneficiary.*

beds is high enough to allow transition to a full bid system within five years.

The purchasing system for nursing home care would then look like this.

- Distribute beds based on lowest bid
- Assure adequate quality by enforcing survey and certification standards
- Bid three years at a time to stabilize the system
- Promote improved quality by tying rate increases over the three year period for each nursing home to quality performance standards for each nursing home

Additional advantages:

- Providers would not be plagued by after-the-fact audits of cost and dependent on varying bureaucratic interpretations of definitions of rules and could offer a better buy to the state
- The state could procure the service based on lowest cost
- The consumer is not locked into an arbitrary and closed system of bed placement across the state
- All providers have an equal opportunity to participate
- The cost of state government to run the program would be reduced since post audits, reimbursement methodology development and cost report review would be eliminated
- State and federal resources could be focused on assuring and improving quality

### **Conclusion**

We recognize that South Carolina Medicaid Choice represents a bold concept for integrating consumer-directed and market-based principles into a government program previously shielded from such forces. We also believe this is a groundbreaking opportunity to remove the disconnect between Medicaid beneficiaries and delivering and paying for their care.

Overall, we believe embarking on a journey toward such change is vital to the long-term fiscal health of Medicaid and physical health of the program's beneficiaries. South Carolina is committed to successfully completing this journey.

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The South Carolina proposal represents the most significant waiver request in the history of Medicaid. It also offers innovative methods for converting Medicaid to a market-based system. It shows that the courage does exist to tackle the difficult problems facing Medicaid. It also offers a framework for states such as Florida to step forward to reform their own plans.

Some additional information on the South Carolina proposal is useful. Its acute care reforms are determined in the following manner. The state currently has a managed-care plan that has been in existence for several years, although it covers fewer than 10 percent of Medicaid's total participants. While this plan involves administered pricing where the State determines the annual reimbursement, the fact that the provider has continued to do business with South Carolina indicates that the payment levels may be close to a market rate.

South Carolina intends to take the amount it pays this managed-care company and use that figure as the basis for paying the patients who use a fee-for-service plan. For example, suppose the managed care cost for a typical family is \$2,000 a year. The fee-for-service plan for hospital and doctors services might have a cost of \$1,200 (determined by their actuaries). The remaining \$800 would be placed in the personal health account (PHA). Because the existing fee-for-service plan suffers from no control on utilization, since service is "free" at the point of entry, the reformed plan would have significant co-pays for office visits and hospitalization (say, \$10 for an office visit, \$100 for inpatient surgery). The PHA would be used to cover these co-pays. Medical services such as immunizations, blood pressure screening, diabetes tests, and so forth with

*The South Carolina proposal represents the most significant waiver request in the history of Medicaid.*

*We propose that Medicaid become a privately delivered plan where prices are determined in a free market restrained by the market forces of competition.*

high cost-saving potential would not have co-pays. The PHA could also purchase optional items such as drugs (or a drug plan), podiatry, optical and other services. A portion of unused funds would belong to the beneficiary when leaving Medicaid. They would be rolled over to a private-sector health savings account. This would give beneficiaries some “skin in the game” and change their behavior.

Alternatively, the beneficiary could take the actuarial value of the fee-for-service plan and the PHA (in this example, \$2,000) and purchase a private-sector plan. This could be a network plan with co-pays or an HMO. These providers would bid at an exchange (suggested earlier). In addition, beneficiaries would be free to use their own funds (in addition to the Medicaid grant) to buy more comprehensive coverage. While some low-income Medicaid recipients could not afford to do this, others do have a high enough income to buy a better product. It is anticipated that as the market grows, the fee-for-service plan with administered pricing will be eliminated, and the amount provided to beneficiaries each year will be the low bid option from private sector firms. At that point, market forces will completely determine the Medicaid grant amount.

One concern of offering beneficiaries a choice of health plans is the possibility of “adverse selection.” For example, a relatively healthy beneficiary may opt for a low cost plan whereas a sicker beneficiary might try to purchase more comprehensive coverage. In reality, this is not likely to be a major problem for two reasons. First, because Medicaid is by definition a guaranteed issue plan, many beneficiaries do not enroll until they are already sick. Thus, providers are already likely to be delivering coverage to a pool of sick individuals. Second, the payments to providers will be actuarially “risk-adjusted.” For example, a health insurance company enrolling a 60-year-old beneficiary will receive a higher payment than one signing up a 20-year-old enrollee. Finally, part of the Medicaid proposal

may involve the State “reinsuring” high cost beneficiaries for certain types of problems that are endemic to this population such as organ transplants and low birth weight babies.

## V. SUMMARY AND CONCLUSIONS

Florida’s Medicaid plan is headed for a fiscal train wreck. Unless strong reforms are undertaken in the near future, the long run budget implications are nothing short of startling. Fortunately, Governor Bush and the Legislature recognized the seriousness of the issue and brought together a talented group to draft proposed solutions to the problem.

It’s our view that nothing short of fundamental market reform will solve the problem. The current system is an out-of-date, price-administered plan that simply cannot work properly. The words of former Sen. John Breaux, D-Louisiana, concerning Medicare are equally true for Medicaid in most states: “Trying to fix this system by giving it more money is like trying to fix a 1960’s junker by putting more gas in it.”

We propose that Medicaid become a privately delivered plan where prices are determined in a free market restrained by the market forces of competition. Medicaid would serve as the umpire, solicit services, promote competition, and provide funding to beneficiaries to buy health care. While our proposals may be considered revolutionary (and some will no doubt consider them to be a bad revolution) we think they are nothing more than good old-fashioned American common sense.

The free enterprise system is the eighth wonder of the world. It produces the highest living standards for the greatest number of people. All across the world, the discredited ideas of socialism and communism lie in an intellectual ash heap as billions of people now look to the marketplace to improve their lives. Isn’t it time that we brought the dynamic, problem solving, cost controlling power of free enterprise to health care as well? As a great

man once said “If not now, then when? And if not us, then who?”

### The Utah Experience: Testing the Limits of Federal Waiver Opportunities

A revolutionary use of a federal waiver is illustrated by the Utah model. Utah uses unexpended federal matching funds for CHIPs, reduces benefits for currently eligible Medicaid recipients, and expands eligibility to cover low-income working individuals who do not have coverage.

The Utah model meets the requirements for HIFA waivers of obtaining budget neutrality while expanding eligibility to new populations. Thus 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 to ensure that the net effects of better care with fewer services achieve the desired outcomes. For example, providing appropriate treatment during pregnancy can prevent a number of low-weight births. Instead of sick babies, the result would be healthy babies. Fewer services would be provided and costs would be lower, yet outcomes would be better.

On the cost reduction side, Utah replicates the benefit package provided to Utah Public Employees Plan rather than the

more generous Medicaid design. State law also was changed so private insurers can offer employers plans with the same benefits as the plan public employees are enrolled in. This allows the state to buy Medicaid enrollees into employer plans – relying on the private market rather than expanding public programs, thereby saving money for the state, because employer premium payments substitute for Medicaid spending. Under the Utah waiver, an enrollment fee and co-pays up to 11 percent of annual income are permitted.

On the cost expansion side, Utah broadened 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.

HIFA waivers are not without risks. Specifically, there is an inherent danger of rising costs under HIFA waivers, because of the eligibility expansion. As the experience of Texas shows (see the sidebar on “The Texas Experience”), eligibility expansions can multiply other cost increases.<sup>44</sup>

*On the cost reduction side, Utah replicates the benefit package provided to Utah Public Employees Plan rather than the more generous Medicaid design.*

- <sup>1</sup> 1980 Data is from the Center for Medicare and Medicaid Services (CMS). 2004 data is from Governor Bush's e-budget site.
- <sup>2</sup> Nominal medical expenditures from the Commerce Department, Bureau of Economic Analysis (BEA)
- <sup>3</sup> E-budget
- <sup>4</sup> CMS and e-budget
- <sup>5</sup> Consumer Price Index for Medical Care, Bureau of Labor Statistics
- <sup>6</sup> *ibid*
- <sup>7</sup> Kaiser Family Foundation, State Medicaid Data
- <sup>8</sup> State of Florida Office of Economic and Demographic Research
- <sup>9</sup> *ibid*
- <sup>10</sup> The expansion of benefits in this period allowed for a natural experiment of the impact of Medicaid on behavior. Researchers found that Medicaid lowered wealth holdings and that asset tests more than doubled wealth reductions. See Jonathan Gruber & Aaron Yelowitz, 1997. "Public Health Insurance and Private Savings," NBER Working Papers 6041, National Bureau of Economic Research, Inc.
- <sup>11</sup> See David M. Cutler and Jonathon Gruber, "Does Public Insurance Crowd Out Private Insurance?," NBER Working Paper No. 5082, April 1995.
- <sup>12</sup> See Stephen A. Moses, "Medicaid and the Future of Long-Term Care Financing," The Center For Long-Term Care Financing, Business Brief, 2003
- <sup>13</sup> See Janet Currie and Jonathon Gruber, "Health Insurance Eligibility, Utilization of Medical Care, and Child Health, NBER Working Paper No. 5052, March 1995.
- <sup>14</sup> Learning From SCHIP and Learning From SCHIP II," Agency for Health Care Policy Research, June 1998
- <sup>15</sup> 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.
- <sup>16</sup> See Janet Currie and Jonathon Gruber, "Saving Babies: The Efficacy and Cost of Recent Expansions of Medicaid Eligibility for Pregnant Women, NBER Working Paper No. 4644, February 1994.
- <sup>17</sup> See Joseph Newhouse, "Free For All? Lessons From The Rand Health Insurance Experiment," Harvard University Press, 1996, pp. 339-340.
- <sup>18</sup> HIFA: Will it Solve the Problem of the Uninsured?, National Health Law Program, HIFA Talking Points, February 28, 2002
- <sup>19</sup> These include the state determined "medically needy", pregnant women and infants from 133% to 185% of poverty level, individuals residing in long-term care medical institutions or community settings whose incomes are less than 300% of SSI, individuals who receive state-only cash supplements, and disabled who are employed
- <sup>20</sup> These include but are not limited to drugs, dental, clinical, ER, personal care, respiratory, transportation, podiatry, optometry, chiropractic, psychological, private duty nurses, physical therapy, speech and hearing, dentures and eyeglasses, diagnostics and screening, ICF/MR
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- <sup>23</sup> "Running on Empty: How Physicians Cope with Medicaid," AMMED News, July 7, 2003.
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- <sup>25</sup> Hayek, F. A. 1945. "The Use of Knowledge in Society." *American Economic Review* 35 (September): 519-30. Reprinted in Hayek, 1948a, pp. 77-91.
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- <sup>28</sup> See John Iglehart, "The Dilemma of Medicaid," *The New England Journal of Medicine*, May 22, 2003.
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- <sup>30</sup> Open lecture at Cleveland State University attended by author
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- <sup>33</sup> See *Waiting Your Turn: Hospital Waiting Lists in Canada*, The Fraser Institute, 13<sup>th</sup> edition, October 2003
- <sup>34</sup> For a possible framework for Medicaid fee for service provision during the transition period see the waiver proposal from South Carolina at the end of this report
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- <sup>36</sup> See Janet Corigan, Jill Eden and Barbara Smith, "Leadership By Example: Coordinating Government Roles in Improving Health Care Quality," National Academies Press: Washington DC, 2002.
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- <sup>41</sup> See [www.cashandcounseling.org](http://www.cashandcounseling.org)
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