

Avoiding Medicaid Nightmares: Basic Principles for Safe Reform

Colorado's Consumer Directed Assistant Support program, one that involves patients in making their medical decisions and lets them gain financially from smart ones, is one of the few programs known to have unambiguously reduced costs.

When Medicaid is expanded, the population brought in will always be more expensive than predicted, and more expensive than that of apparently equivalent commercially insured populations.

States cannot control the spending that results from Medicaid expansions. Top down utilization controls, including priority lists, managed care, gatekeepers, and prescription drug lists have not been effective in controlling costs without denying care.

The uninsured do not necessarily want health insurance, even with subsidized premiums. Thanks to Congress, care at emergency rooms is "free."

Subsidizing Medicaid via tax revenues from entities other than the state reduces the costs to the state and fuels irresponsible Medicaid growth.

Given choice, up to 50% of patients may switch to commercial arrangements from Federally Qualified Health Clinics.

A Sampling of Medicaid Nightmares:

Kentucky—Use insurance to pay for the sick. 1994 Kentucky legislature passed insurance and health care reform. Insurance reform included community rating, guaranteed issue, standard benefit plans, and a risk-adjusted payment system that favored Anthem BCBS. A statewide health purchasing alliance called Kentucky Kare was created to serve as insurer of last resort for the uninsured ineligible for Medicaid.

By 1996, 45 insurers had left the state, Anthem BCBS reported an underwriting loss of \$60 million and Kentucky Kare, suffering a \$30 million loss raised premiums 28 percent.

The system rapidly degenerated into a pay-as-you-go plan for the sick. Out-of-pocket expenses rose, average premiums rose 35 to 165 percent for 850,000 Kentuckians. While

the number of uninsured people rose 9.7 percent between 1993 and 2002 for the U.S. as a whole, in Kentucky it rose 22.6 percent. Kentucky destroyed a system that served 95 percent of its citizens well in order to take care of the remaining 5 percent. Hoping to revive its moribund health insurance market, Kentucky passed legislation in 2004 that banned new state mandates for three years, eliminate standard benefit plans, and repeal its bureaucratic burden.

Tennessee—Remove financial barriers to care by extending Medicaid to all. Put the experts in control and enjoy the savings that will result from better health. Between January 1, 1994 and February 14, 1995 Tennessee almost doubled its Medicaid enrollment, covering 1.2 million people. By 1995 the state announced that it had managed to collect just \$11.1 million of the \$54.4 million in premiums owed by TennCare clients. The managed care plans set up to provide care for TennCare enrollees began losing money in 1997. Hospital payments were kept artificially low, covering about 72 percent of costs. Rural acute care hospitals came under particular pressure because most of their patients were TennCare clients and they could not make up their losses by charging private payers more.

As hindsight makes clear, TennCare proponents lowballed the cost of the program in order to get it passed. In 1999, outside experts said that TennCare capitation rates would have to be raised by 5 to 35 percent in order to stabilize the Medicaid system. Physicians received about 34 percent of their billed charges even though most informed observers agreed that physicians need about 50 percent of billed charges just to cover their basic costs. Federally funded community health centers got the best pay, 85 percent of costs which was enough to expand given their federal subsidy.

Year after year, TennCare made payments for people who had been dead for more than a year, made double payments to people who enrolled multiple times, enrolled people not resident in Tennessee, and paid for prescriptions not authorized by a physician. Years of audit reports documenting these deficiencies produced no measurable change. A November 2004 Medicaid audit identified 19,000 FY 2003 claims totaling almost \$2.1 million that were for Medicaid services apparently delivered to a patient after he had died. In January 2005, Tennessee Governor Phil Bredesen cut 323,000 from the TennCare roles and instituted limits on hospital days, prescriptions, and doctor visits for those who remained.

New York—Medicaid run wild, counties are taxed to pay for it. In 2005, Erie county's Medicaid bill from the state was roughly the same as its property tax revenues. New York requires counties to pay for 10 to 25 percent of total Medicaid spending. From the state point of view, each dollar spent on Medicaid yields two dollars from other sources. New York has the highest Medicaid spending per capita, 20 percent of its population enrolled in Medicaid, and large amounts of fraud. In a budget deal worked out with its counties the state will cap the percentage increase in the county Medicaid share. Up to 25 counties have sales tax growth that is less than the cap. They may decide to have the state keep a fixed percentage of their sales taxes in return for eliminating other Medicaid payments. This will

increase Albany's budget troubles.

Maine—TennCare meets Kentucky Kare. September 2003 the Baldacci administration launches Dirigo Health which expands Medicaid to those under 200 percent of the federal poverty level. DirigoChoice, a taxpayer subsidized health insurance plan run by the state, subsidizes employees with households under 300 percent of the federal policy level. Employers offering DirigoChoice pay higher premiums than individuals buying DirigoChoice. Businesses offering DirigoChoice are mostly sole proprietorships. Supporters projected enrollments of almost 29,000 by the end of 2005. Actual enrollments were closer to 7,400.

The plan has roughly 7,300 people enrolled, roughly 4.5 percent of the insured market. Only 22.4 percent of those enrolled were previously uninsured, about 1 percent of Maine's estimated number of uninsured individuals. To fund the unexpected cost of Dirigo, in November 2005 people with health insurance were to pay a new tax on health insurance claims of 2.408 percent. This is in addition to the 2 percent premium tax already paid on non-HMO insurance plans.

Other Lessons

Oregon—Oregon Medicaid does not pay Federally Qualified Health Centers using cost-based reimbursement for services. It pays health plans and they negotiate with the FQHCs. Cut costs of visits to FQHCs from about \$100 a visit to \$56 a visit. In competitive market, FQHCs lost about 50 percent of patients. State assisted FQHCs with one time assistance package. Any plan that meets Oregon requirements can be a Medicaid provider. Competitive bidding is considered a disservice to patients. The prioritized health plan has not controlled costs, has very high administrative and political overhead. Many in expansion population don't join until hospitalized.

	2002	2001	2003	2002	2003	2003
	2002	2001	Health	Medicaid as	% say limited	B & Disabled
	Medicaid	% Medicaid	spending	% population	activities	SSI % of Pop
	Cost/enrollee	births	as % state			
			product			
Colorado	\$4,653 (17)	31.6	1.8	10 (47)	18.1 (30)	1.0 (46)
Kentucky	4,349 (21)	38.9	3.9	19 (13)	24.8 (2)	4.0 (1)
Maine	4,910 (14)	33.4	5.2	27 (3)	20.6 (12)	2.2 (11)
New York	7,506 (1)	40.5	5.3	22 (8)	18.4 (23)	2.5 (7)
Oregon	3,326 (37)	34.4	3.2	18 (21)	23.7 (3)	1.4 (29)
Tennessee	2,624 (49)	36.9	4.0	29 (1)	18.3 (26)	2.4 (8)
Wisconsin	4,614 (18)	38.3	2.7	14 (35)	17.5 (37)	1.5 (26)

Source: Kaiser Family Foundation, StateHealthFacts.org.

New Proposals: Kentucky, Florida, South Carolina

Kentucky—4 plans: Standard for inpatient/outpatient, nursing facility level care, disabled adults at risk of being institutionalized, family choices for healthy kids. \$225 deductible, copays for physicians and ER visits.

Florida—Heavy managed care, 12 month lock in, forced assignments. Wants to reduce FFS due to widespread fraud. Enhanced benefits if clients participate in various wellness programs. Any plan that meets state standards will be allowed. Specific \$ limits O.K., must be actuarially equivalent to Medicaid for target populations. Utilization reviews. No individual “underwriting” allowed.

2 parts to each plan, the comprehensive section which is based on historical utilization currently covered by mandatory optional services, and the catastrophic section for payments above a certain threshold. State notification required if individual consumes given level of catastrophic coverage.

South Carolina—Individual accounts funded annually, amount actuarially determined based on age, gender, eligibility category. Option out program: Medicaid will pay employer group health premium or can use account amounts to buy major medical plan.

Sticking points for any reform proposals

What will the alcoholic do? Parts of Medicaid population may be unwilling to follow the flow charts. Who should Medicaid pay for?

Pricing (meaning payments) will always be a problem because government always has incentive to short providers. In new proposals states are moving towards using moving averages of historical utilization rather than predictive models. Need better ways to evaluate adequacy.

Given EMTALA, proposals to deny payment may end up bankrupting hospitals. Will limits on hospital days, ER copays stick?

Given that medical care is not the same as insurance, should Medicaid programs focus on reducing the uninsured or on paying for health care?

Do you need to have at least one “public hospital” that is directly subsidized?

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