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MEDICAID: CREATIVE IMPROVEMENTS FROM THE FIELD

HEARING

BEFORE THE

FEDERAL FINANCIAL MANAGEMENT, GOVERNMENT INFORMATION, AND INTERNATIONAL SECURITY SUBCOMMITTEE

OF THE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENTAL AFFAIRS UNITED STATES SENATE

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OCTOBER 28, 2005

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MEDICAID: CREATIVE IMPROVEMENTS FROM THE FIELD

FRIDAY, OCTOBER 28, 2005

U.S. SENATE,
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION, AND INTERNATIONAL SECURITY,
OF THE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10 a.m., at the College of Charleston, Wachovia Auditorium, Ground Floor of the School of Business and Economics, 5 Liberty Street, Charleston, South Carolina, Hon. Tom Coburn, Chairman of the Subcommittee, presiding.

Present: Senator Coburn.

OPENING STATEMENT OF SENATOR COBURN

Senator COBURN. We will ask for your attention, please, if we could have it.

This is the start of the hearing of the Federal Financial Management Subcommittee of the Committee on Homeland Security and Governmental Affairs. We are having this hearing today because of the problems that those who are dependent on us face in our country in terms of healthcare.

I am a practicing physician. I have delivered over 4,000 children in the last 23 years. I will deliver two babies this weekend—I'm going to try to get out of here real quick so I can do what I need to do this weekend. And over 50 percent of the babies that I have delivered have been Medicaid babies, and so I know a whole lot about caring for those people who need our help.

This hearing is not about money. It is about quality. It is about access. It is about care. It is about prevention. And if we don't have those things, the costs go way up. If we do better on prevention, access, quality and care, the costs go down.

So what this hearing is about is, how do we, in the future, develop plans that create dignity, access, quality care, and prevention for those that are dependent upon us.

Several States have wonderful ideas. My own home State is struggling with the costs associated with Medicaid, the lack of access, the lack of prevention, the lack of quality, the higher risk nature of obstetrics and the NICU visits that so many babies through Medicaid go to that people who are not in Medicaid, for some reason, their children do not end up there.

So what I want to do is to make sure we understand the purpose of this hearing. This is not the only State we are going to be doing this in. But there is a dollar figure associated with it, and the fact is that the Federal Government, and I suspect South Carolina, is on this unsustainable course.

Today, not looking at Medicaid but looking at Social Security and Medicare alone, we have unfunded liabilities that will place the young people who attend the College of Charleston in extreme risk. Those unfunded liabilities at this time are over $40 trillion, not looking at Medicaid. What that means for our country and for our children and grandchildren is that we will abandon the heritage that was left for us and leave a legacy of debt, a legacy of lost opportunity, a legacy of lack of college education, home ownership, job realization, and progression.

So I welcome each of you here. We are very serious. This is the 19th Subcommittee hearing that my Subcommittee has had since April 1. We are working hard to look at the options and the problems that are facing our country from a financial aspect, but I take a very personal interest in terms of the healthcare aspect of it because I happen to be very much involved with it.

Before we ask your Governor to testify, with the following event that took place yesterday, I would ask each of you, if this is how you want us to solve the problems.

The Committee on Indian Affairs yesterday decided that the Alaskan natives who have their healthcare service through the Indian healthcare, because we cannot create opportunity and access, we have decided to give them less than standard care. We decided that we would allow people who are trained 2 years in New Zealand to do their root canals, their pulpotomies, their tooth extraction and their curettage repair.

So I lost the vote in terms of trying to change that and put money to that program rather than lessen the quality of care, but it portends what is about to happen in our country as we face the financial difficulties in front of us.

And I would ask us all to look at our hearts and say, is it right that the way we are going to meet our obligation to those people who are dependent on us is to give them less than what we are going to have for ourself in terms of opportunity, access, quality, and prevention? If that is what we chose to do, then we have undermined the very spirit of what we call America.

So this is an important hearing in terms of what we need to do, how we need to look at things, and the quality and the way we treat those that are dependent on us.

Many have said that you cannot change Medicaid because it will not work. Well, I would remind you that many people said we cannot change welfare, it will not work. This country has had a tremendously successful process of giving people back their dignity who happen to be caught, through no fault of their own, and trapped, and the same people are saying the same thing about healthcare reform and Medicaid reform today.

[The prepared statement of Senator Coburn follows:]

PREPARED STATEMENT OF SENATOR COBURN

Back in 1965, Medicaid was originally designed as a safety net for those in need. We have strayed far from our original objective: Medicaid now covers one out of every six Americans (46 million) and costs $338 billion a year. This antiquated entitlement program has not only compromised quality of care and eliminated consumer choice, it has also managed to bankrupt Federal and State budgets. Something has to change. The longer we do nothing about the crisis, the more difficult the inevitable decisions will be.

I want to applaud Governor Sanford for recognizing the need for intervention and for proposing reform measures that might help prevent the program from going bankrupt in South Carolina. South Carolina's Medicaid reform proposal implements free-market principles to improve healthcare quality and curb waste.

THE STATUS QUO HURTS PATIENTS

As a practicing physician, I see fewer and fewer of my colleagues willing to accept Medicaid patients. Physicians lose money by participating in the program. For every dollar we spend on a Medicaid patient, we are reimbursed 62 cents by the program. But it costs us in time too. Interacting with the bureaucracy is an onerous burden for over-scheduled providers. Our experience isn't unique. MedPAC reports that "approximately 40 percent of physicians restricted access for Medicaid patients." The problem is worse among specialists.

Let me be clear: My complaint isn't about our reimbursement rates. Nobody's planning on getting rich on a safety net program for the poor. The main reason why the flight of physicians is a problem is because it means Medicaid patients have fewer and fewer options when it comes to finding a doctor and getting an appointment once they find one. We all know how frustrating it can be when you call for a doctor's appointment and they can't fit you in for months. With 40 percent of providers trying to limit their Medicaid patients, imagine how much longer these folks have to wait, if they get in at all. Or maybe they have to pick a doctor who is much further away, or who doesn't speak their language.

These delays and restrictions are nothing more than a form of health care rationing. Inevitably, as State governments seek to control costs, they must restrict access to services. This is most visible in the restriction of prescription drug formularies, which handicaps doctors and limits patients. There are other restrictions as well—South Carolina has had to place a cap on the number of visits a beneficiary may make to an emergency room each year.

It's no surprise that nobody wants to be on Medicaid. A Commonwealth survey found that 65 percent of Americans would prefer private coverage, and only 10 percent actually preferred Medicaid or Medicare above private insurance—most of those never experiencing private care. Patients are well aware of the stigma and the other problems with Medicaid. Elected officials have a moral obligation to end dependency on inferior State-run programs whenever possible. And for those who must depend on Medicaid, compassion demands that we do whatever we can to make the program effective, efficient, and equal in quality to that received by those not covered by Medicaid. Some would argue that the poor or indigent are incapable of taking control of their health care. I disagree. It's arrogance to assume that Medicaid beneficiaries or their caregivers are incapable of intelligent decision-making about their own health.

Medicaid creates a variety of perverse incentive structures. One of those is the so-called "job lock." There is a point at which the value of the Medicaid benefits a person will lose by getting a better-paying job is more than his increased income from that job. Some people are forced to choose between free health care and a better paying job. This "job lock" keeps Medicaid recipients trapped in their dependence on the State.

There are other perverse incentives in Medicaid, such as an under-emphasis on prevention and an over-emphasis on acute and emergency care. If you were trying to help out your diabetic mom or your child with a disability, wouldn't you want to pre-empt a medical crisis by investing more in preventive services and disease management, rather than having to visit your loved one in the ICU after an ER admission? Wouldn't it be better to structure Medicaid more like many private insurance plans—which place an emphasis on prevention?

WE CAN'T AFFORD THE STATUS QUO

As a physician, I'm most worried about how Medicaid compromises patient care. We might be able to bear increased costs of a growing Medicaid program if these increases weren't also associated with such sub-standard options for patients. But

I'm also a father, grandfather, and a Senator, and so I'm also losing sleep about how we're going to afford the program.

Federal spending and deficits are out of control. This year, the Medicaid alone will cost Americans $338 billion. Medicaid, Medicare, and Social Security—the "big 3" of entitlement programs—consume 42 percent of Federal spending (CBO) and that number will continue to eat up our children's future if something doesn't give.

I've talked about the sub-standard quality of the Medicaid system. At the same time that quality has been decreasing, the program's funding has more than doubled over the last 10 years. We're heading towards a cliff. I worry that the political will does not exist to avert this looming crisis—and that States will be on their own. As it stands now, they are drowning in Medicaid bills.

It used to be that police and schools were the biggest slices in the State budget pie. Now, it's Medicaid—eating up 22 percent of State budgets. By the year 2035, Medicaid will eat up half of the South Carolina's State budget. Doing nothing is not an option. States don't have as much fat as the Federal budget. What will you do—stop building roads? Stop supporting public schools? If something doesn't give, the legacy left by the so-called "Greatest Generation" will be a crushing debt-load on our children and grandchildren.

A SOLUTION TO THE STATUS QUO

We might be able to learn some lessons from welfare reform efforts during the last decade. The reform bill successfully transformed welfare from an entitlement program into cash assistance in the hands of the States. Back then, as today, critics feared that a change to the status quo would threaten the most vulnerable Americans. Instead, the welfare caseload actually decreased by 58 percent during the new model's first 6 years. Today, welfare is more a temporary hand-up on the road to self-sufficiency and less a way of life.

Although almost every State is in a Medicaid crisis, not every State has a leader with the courage to risk his own political neck in order to confront the problem head-on. With critics circling, Governor Sanford has shown courage to admit that Medicaid could bankrupt South Carolina and propose ideas that could pre-empt a Medicaid train-wreck in South Carolina. His proposal is better for patients and for taxpayers.

Instead of a defined benefit model, South Carolina proposes a defined contribution for Medicaid beneficiaries. South Carolina's proposal harnesses the consumer-driven ideas that made America great. Under the proposal. Medicaid beneficiaries will have ownership over their health care services through the creation of the Personal Health Account. Patients will be able to select private insurance and enroll in a plan just like other South Carolinians. This proposal treats the poor with the dignity they deserve by providing them choice and autonomy over their own health care. Not only is this approach the right thing to do morally, but it will curb inefficiency by moving the program from centralized government control to the marketplace. This environment will free providers and insurers from unnecessary bureaucracy and allow them to focus on the most important things—the patient, the relationship between the patient and the provider, and the high quality of care that citizens of the wealthiest and most innovative nation on earth have come to expect.

I look forward to learning the details of this innovation from its chief architect: Governor Mark Sanford. We've also got witnesses from the South Carolina legislature, the provider community and the academic community. Thanks to all of you for being here.

Senator COBURN. So it is with great pleasure, and also a great friend of mine I happened to serve in the U.S. House of Representatives with your Governor, Mark Sanford, welcome. Thank you for your leadership, and we await anxiously your testimony.

TESTIMONY OF HON. MARK SANFORD,[1] GOVERNOR OF STATE OF SOUTH CAROLINA

Governor SANFORD. Sir, thank you very much for being here. Thank you very much for coming down here on your 19th field hearing in helping us to further deliberate what I think is one of the most important public policy issues facing our State. I would

[1] The prepared statement of Governor Sanford with attachments appears in the Appendix on page 33.

say that this is on the front burner of top issues that will confront the Palmetto State on three different levels.

One, it directly impacts the health of 850,000 South Carolinians. Second, that it is fundamentally tied to our ability to stay competitive in the global climate that we live in. If we cannot stay healthy economically, we can't have the revenue stream that only pays for healthcare and education and other things. And third, this is fundamentally tied to our ability to, as you correctly pointed out, maintain spending in other categories of government that are very important to the people of South Carolina.

So on a variety of different fronts, thank you very much for being here. Before I go any further, thank you for the way that you have been standing up for the notion of making choices and setting priorities in the U.S. Senate. Fundamentally, to govern is to choose, but one of the tragedies at work in today's political process is that nobody wants to choose.

And so I would like to submit for the record a *Wall Street Journal* article [1] talking about how you dare to use the P word, which were priorities, in looking at offsets for a sculpture garden in Washington State, an art museum in Nebraska, a Rhode Island animal shelter, and now the infamous bridge to nowhere wherein you suggested an offset. We're talking $4.5 million per resident for the 50 residents versus a 7-minute ferry ride. And you had said, why don't we take some of these moneys and put them into needs that exist after Hurricane Katrina. That, fundamentally, to me, is governing that notion of making choices. So I would submit that for the record.

Fundamentally, what we are about in this Medicaid proposal that we have before the Federal Government is one that is policymakers making better choices so that, indeed, people end up with better quality healthcare within the Medicaid population; and, second, it is about allowing individuals to make choices so that they can, indeed, end up with a better healthcare system that works better for them and their families.

Let me go back to those three thoughts that I just quickly ran through. First of all, the ability to maintain spending. It is important to know that in South Carolina in the year 2000, one of every $7 spent in State government was spent on Medicaid. By the year 2005, it is one of every $5; by the year 2010, it is projected to be one of every $4; and by the year 2015, it is projected to be one of every $3.

I have here a number of charts that I will submit for the record. This is a chart showing the growth of Medicaid at 9.5 percent each year, 1998 through 2004, versus our State revenue growing at 2.4 percent.

Another chart shows our overall expenditure, which is roughly 19 percent of our budget currently, moving quickly to 29 percent over the next 10 years.[1]

Another chart that shows by the year 2010, Medicaid will consume 121 percent of new revenues coming into State government,[2]

[1] The article from the *Wall Street Journal* appears in the Appendix on page 34.
[1] The chart appears in the Appendix on page 36.
[2] The chart appears in the Appendix on page 37.

121 percent which means there has to be a substantial tax increase or a substantial lessening of other goods and services of government, or a substantial cut to Medicaid.

I would also submit this note, which I think is interesting.[3] This is written by a Democratic Maryland Legislator John Houston, President of the National Council of State Legislators, and says this: I am a Democrat, a liberal Democrat, but we can't sustain the current Medicaid program. It's fiscal madness, it doesn't guarantee good care, it's a budget buster, we need to instill a greater sense of personal responsibility so the people in need can find themselves better care.

These are a couple of charts to which you alluded to; unsustainable at the Federal level.[4] If you look at the growth curve on entitlement spending on a variety of different fronts, and I will submit those for the record.

Senator COBURN. Without objection.

Governor SANFORD. Thank you, sir. And where does that leave us? It leaves us with one of two avenues. I have here a list of other States. For instance, as recently as October 25, Kentucky had announced that it was going to stop paying for non-emergency care done in hospital rooms.

Maryland has just cut $7 million in Medicaid funding for newly-arrived legal immigrants to their—let me say that in English—newly-arrived legal immigrants and pregnant women in the State of Maryland.

Michigan's Governor Granholm, Democratic colleague of mine, just announced they were going to include a $40 million cut to healthcare providers.

Missouri actually voted—the State senate voted to sunset Medicaid in the year 2008 before finally settling to take 90,000 people off the rolls of Medicaid in Missouri.

In Tennessee, another Democrat colleague, Phil Bredesen, Governor of Tennessee, proposed taking 323,000 people off the Medicaid rolls before settling for the 190,000-person cut.

Now, one option here in dealing with these budget realities that I just enumerated is to make these kinds of cuts, as outlined by these colleagues of mine, in other States. I think a far better way for Medicaid, the system itself, and most importantly for the recipients of Medicaid, is to look at reform.

Jeb Bush, just this last week, was able to get a waiver through along the lines of what we have proposed. In Illinois, a Democratic colleague of mine just announced this week, Rod Blagojevich, who we served with in the U.S. House, has shifted 1.7 million people over to a managed care proposal.

Brad Henry, Governor of your home State of Oklahoma, along with a Senate task force, has actually asked Robbie Kerr to come and testify before that committee on reforms. Vermont, which comes from arguably a more progressive political structure than the State of South Carolina, has gotten through a Medicaid waiver September 27 that would allow for managed care and changes to the system.

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[3] The note appears in the Appendix on page 38.
[4] The charts appear in the Appendix on page 39.

We think a far better proposal is to allow reforms to take place in the system so that it is, one, sustainable; and, two, it allows more choices, better quality of care for the population served.

Going to my second point, that reform to Medicaid is fundamental to our ability to stay competitive in the State of South Carolina. I really believe that Thomas Friedman's flat world is here and that we are on an international playing field; we directly compete not just with other States but with other countries around the globe.

And toward that end, I would make two notes. One is that the Congressional Budget Office has shown at the Federal level, your level, as you correctly pointed out with the contingent liability you just alluded to, Federal spending will go from 20 percent, which is basically a GDP, which basically where it has been over the last 50 years, since World War II, to 34 percent in the year 2050, unless changes are not made to the entitlement systems.

So the reality is we know a change is coming. The question is, are we going to make it one that is most suited to individual needs that exist, versus a blanket system? We think the individual needs is very important. And toward that end, I will submit to the record, the recent bankruptcy filing by the automaker Delphi, which is the largest bankruptcy in automotive history in the United States of America. It, in large part, went Chapter 11 because of some healthcare contingent liabilities. And one of the things that I think is important, and this is a *Wall Street Journal* editorial of October 19, 2005, is their note here, the better idea is to introduce more competition into the healthcare marketplace.[1]

A few years ago, a supermarket chain by the name of Whole Foods switched to a consumer-driven healthcare plan in which its 32,000 employees were allowed to pick from a menu of care options. After 3 years, the company's healthcare costs rose by only 3.3 percent, compared with national averages in the double digits, but more importantly, job turnover plummeted and there was better healthcare.

So I think that it is as well about how do we stay competitive in this global climate that we are living in so that we can have a vibrant economy and, therefore, have the revenue that will pay for the healthcare, education, and other fundamental needs.

The last point though is the most important one, and that is the one that you correctly identified, which is about quality access and prevention. We are talking about 850,000 South Carolinians' lives, and we are talking about, one, how do you better coordinate care for 850,000 folks? I have a variety of sheets which I will again, as well, submit to the record.[2]

These are claim sheets pulled from Robbie Kerr's office, HHS, that show a variety of different visits to a single person in need. And I think you, as a doctor, would be the first to say, if you have a half a dozen different people coming by to visit you, you do not have coordinated care. And the notion that you are not going to look holistically at one's health is a tragic mistake in terms of a

[1] The article from the *Wall Street Journal* appears in the Appendix on page 42.
[2] The information appears in the Appendix on page 43.

quality care. And we do not have coordinated care in the present system.

So you literally have these tear sheets that I can pull from Robbie that will show a half a dozen different agencies coming by to visit one Medicaid patient in the course of a month, and the result, relatively poor care because it is not coordinated. To look only at one's hand or one's foot or one's eye or one's arm is not the whole look that you have got to have if you want to have a good healthcare delivery system.

So, one, this is about coordination. It is as well about prevention. How do you spend more dollars earlier so that you can avoid some of the very costly procedures that come at the later stages of disease that could have been avoided if you had been more in the war to prevent it.

I would say second this is about outcomes. We are about average in what we spend per capita on healthcare, about 25th, but we are 47th in the Nation in healthcare outcomes. That coordination, we believe, is absolutely crucial to bettering the quality of care for South Carolinians, and as well for doing what we have tried to consistently stress with the variety of fitness challenges and other things of spending more money earlier in the healthcare process as opposed to simply reacting to disease.

The third thing that I think is so important about this from a healthcare standpoint is that, right now in South Carolina, I suspect in Oklahoma and other States as well, there is real racial disparity on healthcare outcomes in our State. And I think that this is fundamentally an issue of social justice. Because if you look at the divide in healthcare outcomes, in a lot of ways there have been gaps closed with the civil rights movement in income or in education or in housing, but the health issue has been persistent with regard to a consistent divide between where whites end up and where blacks end up. And so I would just give you a couple of statistics.

In South Carolina, for instance, infant mortality rates are basically two-and-a-half times higher for blacks. In South Carolina, life expectancy—and this is nationwide—is about 10 years less. Blacks have significantly higher mortality rates as a result of heart disease, stroke, and cancer. The bottom line is that nationwide, about 85,000 African-American deaths could be prevented if you close that gap that now exists.

A Harvard study came out recently that showed if you look within the minority population, with the black population, if with Medicaid you simply move toward a managed care system, seven of nine different indices, the gaps begin to close in terms of healthcare outcomes.

And I would say that it is for those reasons that we are asking for a reform to the system so that we update, and I stress the word update, the way that Medicaid is delivered in the United States of America. And I say this particularly because if you look at the CMS Journals, what they would show is about 39,000 pages of regulations and manuals for the administration of Medicare and Medicaid, and that stands in stark contrast to the 208 pages that regulate the Federal Employee Health Benefits Program which covers

about nine million workers at the Federal level; everybody from literally a janitor on Capitol Hill to a Senator like yourself.

So fundamentally, what we're asking for in this waiver is, can we have an increasing degree of choices for the Medicaid population that right now exist for nine million Federal workers, again, ranging from the janitor on Capitol Hill to the Senator. We believe that notion of choice, that everybody's healthcare needs are fundamentally different, is very important to bettering healthcare in our State.

Just a couple of other things that I want to throw out at you and submit as well for the record. One is that we have a long history of waivers in South Carolina. Robbie and his department—I have here one, two, three, four, five, six, seven, eight, nine, ten, eleven waivers since 1984 that have been granted by the Federal Government to HHS across a wide swath of different healthcare outcomes. We think that this waiver is certainly in line with those others that have been granted in the past.

I would also say not only have we had a history of doing waivers in the past in South Carolina, if you look at the number of waivers occurring in other States around this country, a wide array. I have here a Thursday, August 18, *Wall Street Journal* article called Rocky Mountain Medicaid.[1] It's about a Colorado disability program, CDAS, the State's experiment with Consumer-Directed Attendant Support for the severely disabled that began in 2002. What is important to note is that it has gone so well that the Legislature just approved opening the system statewide to 33,000 Medicaid recipients.

And what is particularly telling is the story of Linda Storey, who is a 51-year-old rocker who has been battling multiple sclerosis for 30 years. Her quote is this, "It gives you your life back. I'm more in control of my health now."

I think it is relevant to point out what is stated here is in the first 2 years of the Colorado CDAS pilot program, showed that monthly spending actually went down.

People deserve choices. These are the words of the Speaker Pro Tem Cheri Jahn, who is a Democrat in Colorado. "People deserve choices." With those choices comes not only greater dignity for the individual, but also better incentives for the system itself. Colorado has a working example with the Medicaid waiver right now.

I will give you one other Medicaid waiver, and that is what is called "Cash and Counseling," which began in Arkansas. It quickly expanded to Florida, and New Jersey. It has from there expanded to 11 other States across this country. It is about disabled long-term care needs. There has been a reduction in the neglect and there has been enhanced satisfaction to the customers, the Medicaid recipients themselves, as a result of this program.

So I could show other examples of things happening with Medicaid waivers in other States, but I know I am running up against time.

In brief, our plan is to allow money to go into a personal healthcare account, and then from there people could pick from a wide array of different choices from managed care, to medical home

[1] The article from the *Wall Street Journal* appears in the Appendix on page 45.

network, to buying into their own healthcare plan if they happen to be working for an employer that has a healthcare plan, to a self-directed plan. It is fundamentally based on ownership, people owning their own account. It is based on the notion of consumer-directed plans, which is what you see in most cases at work in the larger healthcare marketplace. It has with it essential safeguards, and the government would still approve each of these plans, and it would be required of each of the plans that it will require mandatory services.

Fundamentally, it is about this: Do you allow, with Medicaid, a change so that we can fill the cup of each person's healthcare needs and allow them to select a plan that works for them, or does everybody have to drink out of the same Federal healthcare cup in meeting those needs? They are two different paradigms, but one that I think is very much built around the individual and the very disparate needs that exist with healthcare at the individual level is our plan.

I will call it quits with what you called it quits with, and that was, I pulled here a quote from Tommy Thompson, 1992. He said, "for every one of my welfare reform programs that I've put into law or was able to get a waiver for from the Federal Government, there have been critics and there have been nay-sayers, but they want to keep the status quo."

I don't want to keep the status quo. The status quo doesn't work. Give us in Wisconsin the chance to be flexible, the opportunity to change it, and we'll show the way for the country to follow.

As it turns out, his words were prophetic because, as a result of that incubation, that change that occurred at the State level, ultimately Federal welfare reform occurred.

I think that States really have become the incubators of many national changes. I think that what is happening with Florida with Jeb Bush, what's happening in Georgia with Sunny Perdue, what's happening in a wide array of different changes is very important to this incredibly important national debate. I appreciate the time to testify.

Senator COBURN. Thank you, Governor.

No previous Governor has proposed such a bold Medicaid reform in your State. You could easily leave this problem to successors instead of suffering the criticism in the media. Why are you risking your political neck for Medicaid reform?

Governor SANFORD. I think it goes back to what I was talking about, which is we spent a lot of time—I have spent, you know, a ridiculous amount of time riding a bike across South Carolina for a couple of different weekends, dragging Jenny and the kids, talking about how if we do a couple of little things differently in terms of getting a little bit more exercise, a little bit more activity, we can end up with very different healthcare outcomes in the State of South Carolina if we simply do a few things differently. We've been trying to raise awareness on that front.

Medicaid is an extension of that larger thought process of, we need to do a few things a bit differently if we're going to end up with different outcomes. The old saying is if you keep on doing what you've been doing you're going to keep on getting what you've been getting. I think that any time that you try and have one-size-

fits-all with regard to something as personal as one's healthcare, you are going to have problems. Indeed, the statistics have certainly shown that and they have showed that particularly in some different populations more than others.

I think this about fundamentally how do you better quality of care, how do you better access. In some parts of rural South Carolina, doctors will not take Medicaid patients anymore because we have capitated what the doctor can get. And so it is about quality, it is about access, and most of all it is about prevention. How do you spend more of the dollars earlier.

Senator COBURN. I was interested in your projections that in 2010, 23 percent, I believe you said, of the increased revenue that South Carolina would be required to take of Medicaid. I've got a surprise for you. The money is not at the Federal level. There is not going to be significant increases after about 2008 in Medicaid FMAP programs. The money is not there.

And so not only will there be that 23 percent out of your increased revenues, there probably will be a lessening share from the Federal Government. There is no way that we can keep the commitments at the Federal level to what we said we were going to do.

Now, we could say we are going to do that. And if you look at the growth projection, not just the growth but the velocity of growth in Social Security and Medicare, it will consume any flexibility that we would have in Medicaid. And by the year 2018, the vast majority of the Federal Government won't have any other services, significant services or growth in any service whatsoever except Medicare and Social Security. Not Medicaid, not defense. The largest growing and fastest growing component of the Federal budget today is interest, and it's going to continue to grow. That's why pain and making the priorities are so important.

So what you are really saying is South Carolina's going to have to cut everything else if you do not reform Medicaid; is that correct?

Governor SANFORD. Correct.

Senator COBURN. So every other area of South Carolina is going to be in decline in terms of revenues based on the mandatory match that you have today with Medicaid?

Governor SANFORD. Correct.

Senator COBURN. One of the things that I have read in the press, your reforms have been accused of being risky and untested. How would you assess the level of risk in your reform versus the risk by staying with the current system?

Governor SANFORD. Anything that's ultimately unsustainable comes to an end. I think that what you pointed out, what I pointed out with the graphs and charts, is that we're on an unsustainable course. What we do know is that there will be changes in the system, it is just a question of how the system will change.

We think that going the route that some governors have gone is a mistaken one where you simply say we are going to capitate, we are going to take 300,000 people off the rolls, we will take 190,000 people off the rolls, is not the desired choice. We think that you can reform the system such that people have more control over their

healthcare outcomes, and by having competition in the system will ultimately better it. We think that is by far the better route to go.

But are things going to change? Yes. I mean, that is a certainty.

Senator COBURN. Let me, if I may——

Governor SANFORD. And that is why it was as well raised—you talk about risk. It is important to note what has happened with other Federal waivers, whether it is in Colorado, whether it is in the 15 States that I outlined with the long-term disability program. There have been a whole host of waivers, and in every instance, whether it is with the Whole Foods example in the private sector side, the cases where you have allowed the customer, the Medicaid recipient, to have more control over how they spend their healthcare dollars, care has gone up, access has gone up, and quality has gone up. And I think that those are the things, the ultimate matrix of measurements that anybody should look at when they look at defining risk.

Senator COBURN. Let me invite Representative Tracy Edge, South Carolina General Assembly, to join the Governor on this.

Representative Edge has served in the South Carolina House of Representatives since 1996. He is currently a member of the House Ways and Means Committee on which he chairs the subcommittee with jurisdiction over the Medicaid Program, Health and Human Services, Medicaid and Environmental Control.

Representative Edge, welcome.

TESTIMONY OF HON. TRACY R. EDGE,[1] A REPRESENTATIVE IN THE SOUTH CAROLINA HOUSE OF REPRESENTATIVES AND MEMBER, AMERICAN LEGISLATIVE EXCHANGE COUNCIL

Mr. EDGE. Thank you very much. It is my pleasure to be here today, and I am thankful that you were able to come here to South Carolina and give us this opportunity to explain our waiver to you.

Mr. Chairman, my name is Tracy Edge, and I represent the 104th House District in South Carolina's House of Representatives. I am also the Chairman of the South Carolina House Ways and Means Subcommittee on Health, Human Services and Medicaid.

In addition, I am also a member of the American Legislative Exchange Council, or ALEC, and ALEC is the Nation's largest nonpartisan individual membership organization with both State Legislators and Members of Congress encompassing all 50 States. ALEC's mission is to advance the Jeffersonian principles of free markets, limited government, federalism, and individual liberty, which are also features of our Medicaid waiver.

It is my pleasure to be here before you today in support of South Carolina's Medicaid waiver proposal, which I believe is a step in the right direction toward empowering South Carolina's Medicaid beneficiaries.

We have to act now to curb Medicaid's skyrocketing costs. South Carolina spends more than $4 billion annually, or about 19 percent of our entire State budget. As our Governor pointed out, that is 9 percent more than where we were 5 years ago, and our projections have us at about 30 or 31 percent within 10 years. I believe it could actually happen earlier than that, based upon numbers that I have

[1] The prepared statement of Mr. Edge with attachments appears in the Appendix on page 52.

been given by our Budget Control Board just this morning. This poses a real threat to other funding priorities, such as K through 12 education or law enforcement or environmental control.

In my opinion, Medicaid's problems can be directly attributed to the perverse fiscal incentives imposed by its financial structure. State governments to doctors to patients, Medicaid does not give any incentive to provide or consume healthcare efficiently. In fact, the opposite is true. Medicaid's financing structure actually rewards inefficiency with more dollars. We see that in our budgeting every day when it pertains to how we structure our healthcare financing to match Federal dollars.

As you know, the Federal Government pays more than half of all Medicaid spending through the Federal Medical Assistance Percentage, otherwise known as the Federal match. The Federal match gives South Carolina Medicaid spending a guaranteed return-on-investment. In South Carolina, the Federal match is 69 percent. We typically say three-to-one when we talk in terms of match dollars. This means that every Medicaid dollar we spend yields about $2.85 in Medicaid benefits.

Ironically, it is the Federal match that is causing Medicaid spending to spiral out of control. Medicaid's Federal match triggers a wasteful and inefficient spending spree, since States need to spend more in order to get more Federal money.

We often hear about leveraging State Medicaid dollars with Federal funds, and we've been very creative at times in trying to draw down those Federal dollars by using what I believe are risky schemes in order to provide State dollars for our Federal matches. Federal dollars are not free. All taxpayers, including Medicaid recipients, pay Federal, State, and local taxes.

Low provider reimbursement rates also directly contribute to Medicaid's costs and limit much-needed access to care. A major problem that I've battled during my term as chairman of the House subcommittee, and in my prior service as well in the House, has been, how do we combat physicians who will stop seeing Medicaid patients because the reimbursement rates are so low? So access has been a critical problem.

Because of this, providers have the incentive to tack on unnecessary tests or stop seeing Medicaid patients altogether just to stay in business. We have seen high levels of fraud here in the last few years. There was one medical practice in my home county of Horry County that was found to have billed the government for $30 million over a 6-year period through Medicaid alone by ordering tests that were not needed and prescribing drugs that were not necessary.

It is crucial that patients have a stake in their own healthcare spending. Unfortunately, South Carolina's Medicaid current fee-for-structure system largely shields beneficiaries from the consequences of their own healthcare decisions. Simply stated, our State's Medicaid system pays claims first, and if it asks questions, it asks the questions later.

It is clear that the case for Medicaid reform has a lot to do with money, but more importantly, however, there is a strong moral case for Medicaid reform. We cannot and should not confine our most needy citizens to an almost-bankrupt system. And by almost

bankrupt, I could get into some of the financing that we are facing for our coming year's budget later. Instead, we should put Medicaid beneficiaries on a road to self-sufficiency by empowering them to take greater responsibility for their own healthcare needs. Shielding people from liberty and the ability to make their own decisions, in my sense, is immoral, and I think we should do everything possible to give them greater responsibility.

We have a map for the road to self-sufficiency, and the example, obviously, is welfare reform. Before the Welfare Reform Act of 1996, there was an eerie similarity between the Medicaid and welfare programs. Both Medicaid and welfare were means-tested entitlement programs. Both programs were funded by an open-ended, Federal-State spending match, and both programs conferred a legal right to benefits.

Now, almost 10 years later, the two programs could not be more different. Block-grant funding has caused welfare rolls to drop dramatically. Meanwhile, the Medicaid entitlement continues to keep the poor locked in a cycle of government dependency in several ways.

First, it is likely that the mere existence of Medicaid could crowd out private sector healthcare alternatives. The Robert Wood Johnson Foundation found that of the 22 studies they reviewed on the issue, more than half concluded that the expansion of public health coverage was accompanied by reductions in private coverage. Here again, we find that you have government interference in the free market system which crowds out the free market.

More importantly, Medicaid and other entitlements do not give the poor an incentive to save and invest, as beneficiaries have to remain under certain income levels in order to qualify for the benefits. As a result, it is possible that some of the beneficiaries may choose to stay below the poverty level, thereby locking them into an entitlement system. In other words, the government traps them and they don't know how to get out of the cycle.

There is no reason why welfare reform should not serve as a model for Medicaid reform, and that is why our Medicaid proposal here is so important. Only South Carolina, not bureaucrats in Washington, know how to best serve South Carolinians on Medicaid.

Governor Sanford's Medicaid waiver empowers beneficiaries to tailor their own healthcare dollars for their own healthcare needs. Each Medicaid beneficiary will receive a Personal Health Account so that they can fund their own healthcare in a variety of ways, either through Health Savings Accounts, by purchasing a managed care plan, by purchasing health insurance from their employer, or by joining a medical home network.

This choice not only turns beneficiaries from government dependents into empowered healthcare consumers, but it also accomplishes the laudable goal of transitioning beneficiaries to self-sufficiency and independence through private coverage. Medicaid beneficiaries should have the same access to high-quality, private health insurance as many of us enjoy.

Just like welfare reform 10 years ago, there are critics who maliciously accuse Governor Sanford, myself, and others who are leading the fight on this proposal as being cruel or heartless. I have

to reject that notion. Giving South Carolinians the opportunity to pull themselves out of poverty will work for them and it will work for Medicaid, just as it did for welfare reform in the 1990s.

Mr. Chairman, there are some here today who have screamed over the last 3 months from the highest mountaintops that we should not pursue the waiver. However, if we would have enacted Medicaid cuts like the State of Florida has done over the last 2 years, they would also be screaming from the same mountaintops. In other words, you can't have it both ways.

The problem that I, as chairman of the House subcommittee which writes the budget for eight healthcare-related agencies has, is that every year we are faced with claiming and mounting costs that we have to match in order to keep from cutting services. Luckily, we have not had to do what Florida has done. We have been able to, by various means, carve together enough money in order to finance our growth in Medicaid and other healthcare programs.

What happens when we cannot do that and we have to make the cuts like Florida has? Then we have people who are trapped in an inefficient system, no longer getting the services that they once were getting.

I appreciate the opportunity, Mr. Chairman, to appear before you today. I take the job that I have quite serious. And I know that scenarios that we have had in the past may also continue to haunt us. For instance, 2 years ago we had a $400 million shortfall in revenues compared to expenses in our State budget, yet that same year, the growth in Medicaid alone was $180 million. In other words, we actually had a reversal of $580 million of revenue.

What did we have to do to cover Medicaid that year? We had to cut law enforcement, we had to cut security in our prisons, we had to cut environmental control, and cut back the resources that protect the natural resources of our State. We cannot continue to do that. I can tell you, I cannot sit at my dining table with books thicker than this year after year and figure out how we are going to pay for healthcare at the expense of education and other programs that we have.

That is why we are pursuing the waiver that we have today. I am not going to claim that the waiver is going to have an automatic savings tomorrow, but I do believe that it will curb the rate of growth in Medicaid, and that is what is important to me. It is important to me to know that in the future we will be able to pay for healthcare through Medicaid and other programs that we have without having to cut the balance of our budget and cut services that other people need.

Mr. Chairman, I appreciate the ability and the opportunity to be here for you today.

The American Legislative Exchange Council and the Heritage Foundation and others have been very supportive in our Medicaid reform and the proposals that are contained in Governor Sanford's plan. I'm proud to sit with him here today, and I'm proud to be before you and say that we need to have the plan approved, not only for the fiscal responsibility for our State budget, but also to empower our citizens to make the choices that they need to have the ability to make.

Again, I will say that some people do not want to give them that ability, and the reason is that they want to trap them and keep them into the system that they have so that they will be dependent upon this particular philosophy or this particular way of life. I think that is cruel, and I think we need to break away from that system.

I would be happy to answer any questions that you have, and again, I thank you for being here.

Senator COBURN. Thank you, Representative Edge.

Give me 5 years ago in South Carolina, what was the growth of Medicaid? What was happening? Can you tell me?

Mr. EDGE. What was happening——

Senator COBURN. In Medicaid growth. Were you seeing the same kind of growth, and were there attempts to fix the access and the quality, or was access and quality not a problem then?

Mr. EDGE. It was very difficult to try to do that because, at the time, we were having the beginning of 5 years or 4 years, rather, of revenues that were going under expenditures. So the toughest job that we had was just maintaining the current system.

We now have a conservative-controlled House, a conservative Governor and a conservative-controlled Senate. Quite frankly, many reforms that we proposed out of the House pushed by Governor Sanford were blocked because the philosophy in the Senate was a little bit different. So, no, we were not able to really pursue reforms that we needed to.

We tried to pass a Medicaid reform proposal for the last 2 years. It's been very difficult to do. It does not go anywhere near as far as the waiver goes, however, there were certain controls that we were trying to put in place that many in our government were fighting because of the change in status quo.

The status quo is not going to balance our budget in years to come when we consistently need $100 million to $150 million of new money just for Medicaid, year after year after year.

Senator COBURN. Let me come back. If we had all the money in the world and we had this system, you still would not have dignity for the patient, you still would not have access, you still would not have care, you would still have the same problems.

So, it is not just a money problem. It is an access problem that people who are using and have to utilize Medicaid today are getting less access, and overall, in this country, less quality and, for certain, less prevention.

And so there are a lot of reasons to be doing this. And as a physician, one of my main reasons for doing it is, because I have seen it and worked in it for 22 years, I have seen what Medicaid does and the stigmatization of somebody that has a Medicaid card versus somebody that walks in with an insurance card. Why can't they have the same thing that everybody else has? By the time you compile the dollars and you make the mix, why can't we give them access? Why can't we give them access to prevention? Why is it that somebody who has a mortality rate, infant mortality rate two-and-a-half times better, why is it that they do not have the access to the same prenatal care? The system has a lot to do with that. And it is not just money.

It is the government control of the system and the inability to have the market-allocated resource, and then let's look at how the market is failing and supplement that rather than controlled managed healthcare.

I thank you for your testimony.

Governor, I have known you for a long time, and one last question for you is: A lot of people say, well, he is kind of this policy-walking numbers guy. In your heart, why do you want to fix this? What is your motivation for fixing this?

Governor SANFORD. I mean, I would go back to what I said earlier, and I want to be sensitive because you have got some great folks to come up here and testify.

But I would simply go back to what I said before, which is: I believe in the fundamental and the dignity of the individual, and I believe that God makes every single person out there different, which means that every person fundamentally not only has different emotional needs but, frankly, they have different physical needs when you talk about one's health. And, therefore, the idea of a system that expands the number of choices so that people can pick for them and their families what makes the most sense based on their healthcare needs is fundamentally empowering to the individual, but also, I think, a way of creating better quality care for this important population of 850,000 South Carolinians.

If you look at the number that you just cited, which is infant mortality two-and-a-half times with one population versus another, then why in the world wouldn't you want an expanded level of choice so that particular group might be able to come up with a package of benefits based on very different needs that they have versus another population? That's very difficult to do with a one-size-fits-all program, and that is what gets back to the multiple conversations that I have had with Robbie Kerr on how do you better Medicaid which is so critically important to thousands upon thousands of South Carolinians?

Senator COBURN. Thank you very much. This panel is dismissed.

We are going to take a 5-minute break so we can set up. I would also ask that our next witnesses please limit their testimony to 5 minutes.

I would ask that the materials for the records offered by Governor Sanford be included in the record and in the printed final record.

[Recess.]

Senator COBURN. The hearing will come to order.

As I said before, first of all, let me thank each of you all for being here. So that you all know how we select hearings—my Ranking Member is Senator Tom Carper, and all four hearings are divided up Republican and Democrat. We always, whenever we go into a State, we allow the State executive to have the option to testify, and then because there is a majority and a minority, we have a certain number of majority witness, and we always have at least one minority witness, and we have that again today.

So I want to welcome those that are here to testify. Ms. Solomon joined the Center for Budget and Policy Priorities in January 2005 as a Senior Fellow specializing in Medicaid and SCHIP. Prior to her current position she was Senior Policy Fellow with Connecticut

Voices for Children, and Executive Director of the Children's Health Council. She graduated from the University of Connecticut, and then Rutgers University Law School in New Jersey. She also currently lectures at the Yale University School of Medicine in New Haven, Connecticut.

Ms. Solomon, thank you very much for being here.

We also have Dr. Donald Tice. Dr. Tice is a Member of the Board of Medical Examiners in the State of South Carolina. He has specialized in family practice medicine for over 20 years, has firsthand experience with patient care under the present Medicaid system. He is elected by his peers and appointed by Governor Sanford to the South Carolina Board of Medical Examiners.

Also is Dr. Regina Herzlinger, Nancy R. McPherson, Professor of Business Administration, Chair, at the Harvard School of Business. Dr. Herzlinger was the first woman to be tenured and chaired at Harvard Business School, and the first to serve on a number of corporate boards. She is widely recognized for her innovative research in healthcare, including her early predictions of the unraveling of managed care and the rise of consumer-driven healthcare and healthcare focused factories, two terms that she coined.

Also with us is Ed McMullen, President of the South Carolina Policy Council. Mr. McMullen is head of South Carolina's only research and education foundation devoted to promoting principles of limited government and free enterprise in the Palmetto State, public policy. He has previously served with the Heritage Foundation in Washington, DC, which does promote limited government, economic freedom, and individual liberty.

I want to thank each of you for being here. You will be recognized for 5 minutes. Your complete statement will be made a part of the record. And, Ms. Solomon, if you would be so kind to begin.

TESTIMONY OF JUDITH SOLOMON,[1] SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES

Ms. SOLOMON. Yes. I would like to thank the Chairman and Ranking Member Senator Carper for allowing me to testify today.

I think it is important at the outset to say there is a lot that we agree on. I think we all agree that Medicaid beneficiaries should have choices, including provider networks, managed care plans, and as many providers as possible who participate in the program; that quality, improving quality in the program should be the goal of any reform.

For example, the new emphasis in South Carolina on medical homes is a great idea for ensuring access and avoiding unnecessary trips to the emergency room. Provider payments impede access; they're too low. I think we agree on all those things. But I think where we part company is how to go about making changes in the program. I think many of the goals that have been listed do not need a waiver; they can be done within the existing rules and structures in Medicaid.

Medicaid is of tremendous importance in this State and throughout the country. In South Carolina, 40 percent of South Carolina's children, and 30 percent of seniors, rely on Medicaid for vital

[1] The prepared statement of Ms. Solomon appears in the Appendix on page 82.

healthcare services. Nationwide, when asked in a large public survey from the Kaiser Commission on Medicaid and the uninsured, over three-quarters of those responding supported the program and opposed cuts in benefits.

Medicaid provides critical support to hospitals, nursing homes and other healthcare providers, and it does this in a really efficient way. In fact, we were talking earlier about preventive care. In my written testimony, we cite a study where Medicaid actually provides better preventive care than private insurance to children. Through its EPSDT program, it has a tremendous emphasis and puts a lot of responsibility on States to make sure our kids are getting that preventive care.

And, yes, Medicaid costs are going up and this is a problem, but this is a healthcare problem. Healthcare costs are going up, and Medicaid is an important part of the healthcare system.

As we look at changes in Medicaid, we have to realize anything we do is going to ripple out over to the larger healthcare system. The costs are going up because prescription drugs are going up. Enrollment is increasing because employers are not able to afford to provide care any longer for many employees. It is not crowd-out.

Medicaid has provided the safety net that has kept the overall rate of uninsurance from going up in this country, and that was shown again in the most recent census information at the end of August.

But our States and the Federal Government struggle with the costs. As I said, care really has to be taken to avoid harm to beneficiaries. In South Carolina, almost everyone who relies on the Medicaid program is poor, with income below the poverty line. People on Medicaid do not have the ability to absorb costs. A substantial body of research shows that even modest cost sharing decreases utilization of effective care, of important care, and also affects health outcomes in a negative way.

So here are the problems that we see with what South Carolina is proposing. First off, it is attempting to save money by looking at only 40 percent of the cost of the program. The Medicaid program, children and parents in Medicaid, non-disabled adults, are about 80 percent of the beneficiaries in this State, but the cost of providing services to them is only one-third of the program costs. And that is primarily who would be covered by the waiver. Those receiving long-term care services and those who are eligible for both Medicare and Medicaid take up about 40 percent of the overall cost of South Carolina's program, but they are outside of the waiver.

So you are starting with this smaller portion of the program covering the majority of people, and you are trying to extract savings. But at the same time, the proposal has a whole list, and I have listed them in my testimony, of new entities that the State will have to contract with: Managed care plans, administrative service organizations, a vendor to develop electronic cards, an enrollment counselor, an extremely vital function but very labor-intensive providing counseling to beneficiaries. All of these are going to be private companies, and rightfully will be expecting to make a profit.

So you are looking at 40 percent of the program covering 80 percent of the people in a very efficient way, primarily because the

provider payments are already very low, and you are going to have to extract all that new administrative expense. South Carolina's administrative expenses are very low right now for its Medicaid program; it is lean and mean. And I know I have heard Mr. Kerr, the Medicaid director, talk about the struggles they have for keeping up with that. But be that as it may, every dollar that will have to now be spent on administrative costs is going to come out of the benefits going to individuals and the payments to providers.

South Carolina is not a State with, either in the private market or in Medicaid, with a large managed care presence, so there are a disconnect here. This idea that there is going to be many managed care companies coming in is really speculation, but yet the proposal is based on that.

And the personal accounts that the State is proposing actually will cost money. The House Energy and Commerce Reconciliation bill has a demonstration program to allow 10 States to have programs of Health Savings Accounts. When the CBO scored that proposal, it actually costs money. Because by giving people Personal Health Accounts, or HSAs, in some ways you are allowing them to keep them when they go off Medicaid, which is not a bad thing to do, but if we are looking at efficiency and saving money, they are going to have money that would not have otherwise been spent. At the same time, you still have to cover everybody's heath costs, and that is why that proposal scored and that is why this proposal would not save money.

Before I conclude by just giving a couple of ideas of what could be done, I just want to talk about the Cash and Counseling, which has been cited as a precedent for this approach. Cash and Counseling has been a very effective demonstration project, but it is a very limited approach that cashes out a very predictable benefit provided to people with disabilities in Medicaid who are not even really a part of this proposal, for the most part, and it allows them to budget and direct their own personal care services, which are predictable; you know how much you are going to need for a personal care attendant. That has increased satisfaction, it has been successful, but is not a model for cashing out the entire Medicaid benefit where people's healthcare expenses—and I know, Dr. Coburn, you know this as a physician—are not predictable. For the most part, your health can change radically from one day to the next. So these are very important things to take into consideration.

Senator COBURN. Can you wrap up for me in about 30 seconds?

Ms. SOLOMON. I can.

Senator COBURN. Thank you.

Ms. SOLOMON. So what can be done? I think efforts to develop medical homes encourage preventive care. Coordinate care. If you are finding through your data, as the Governor said, that you have people using care, there are plenty of tools in the existing program around disease management and care coordination to do that.

Ask providers and beneficiaries what they think. I think they have not been part of this planning process. I think it is very important that they be asked. Start small and proceed carefully. The program is just too important to take chances with risky and untested reforms. Yes, we have said that.

Senator COBURN. Thank you. All right. Dr. Tice.

TESTIMONY OF DONALD TICE, D.O.,[1] MEMBER, SOUTH CAROLINA BOARD OF MEDICAL EXAMINERS

Dr. TICE. Yes, sir. Thank you, Dr. Coburn, for the opportunity to address this panel.

I have been a primary care physician for approximately 23 years and have worked with Medicaid as a portion of my practice during that entire time.

Medicaid, in my experience, is a prompt payer of claims. They do rightly hold the authority to audit records at any time and hold physicians accountable.

Here, though, I would like to present a perspective from the private physician provider standpoint. Medicaid recently updated its Medicaid Provider Manual. The manual is clear and concise for users. Regretfully, my staff has great difficulty reaching a Medicaid representative at any time when an unusual situation arises. Voice messages left are rarely or never returned. When a call is returned, the representative typically refuses to be put on hold while our staff member is brought to the phone.

This is a most unfortunate condition and discourages field staff from calling the representatives for assistance. There is currently no designated customer service unit to provide a claims resolution for any particular account. Consequently, providers will write off charges rather than trying to invest an inordinate amount of time getting the issue resolved. The State benefits, but the providers have just another reason why he or she does not want to take any additional Medicaid recipients into their practice.

Recently, Medicaid introduced the Select Health Program. Patients were required to read informational materials notifying them that their children were placed under the care of a physician that was not known to them. A lot of parents never received the materials, some because the database was not current and they did not have the current addresses.

Parents were asked to make an affirmative decision to disenroll in the program if they did not want this new physician. The burden of informing, educating, and trying to correct a parent's misunderstanding of their benefits then fell upon the provider's staffs. Medicaid officially did meet their burden of information and education, but really did the parents a disservice by enrolling them into a program without an affirmative choice being made.

The Medicaid system sometimes interferes with decisions affecting the quality of care given to its recipients. Specifically, private offices are not reimbursed for the cost of their supplies. in many cases. When patients need immunizations, they have to be referred to the Public Health Department because providers are not reimbursed for those services. This fragments the care for the patient, and often these patients are non-compliant with medical direction.

Another primary example where medical care is interfered with is when medications need to be injected or infused. Often, administration of products in the office setting could be done at a far reduced cost over that of a hospital setting. Both Medicare and Medicaid could realize tremendous savings if private offices were al-

[1] The prepared statement of Dr. Tice appears in the Appendix on page 89.

lowed to treat more aggressively and not have to hospitalize patients that could be treated in an outpatient setting.

Physical therapy modalities cannot be offered in a private office because they are not reimbursed. A very common complaint of the general population, much less adult Medicaid population, is back, neck and joint problems. These services are very difficult to address in the primary care office because most of the services that we provide for those are not reimbursed. The patient has to be sent to a much higher-expense physical therapy setting or referred to the hospital. Continuity of care and considerable cost savings could be realized if the care was moved out of the hospital and back into the primary care physician's offices.

Private outpatient offices are not and cannot be operated like the more expensive hospital-based offices or ER fast tracks with their much higher administrative costs. If we operated our offices like that, we could not survive.

Patient dignity and sanctity of the provider/patient relationship is undermined when patients over 65 with Medicare/Medicaid coverage has had to suffer the loss of healthcare services when Medicaid costs shifted the financial burden of the 20 percent co-pay insurance to the physician providers by denying payment when Medicaid is a secondary payer. Providers in mass are no longer taking Medicaid as a secondary payer, thereby making the patient responsible for a much greater financial burden, which they are unable to afford.

Senator COBURN. For time's sake, I will give you one more minute, if you could sum up for us, please.

Dr. TICE. Fraud and abuse are also a major problem in the current system. Many patients are working in service industries or construction jobs for unreported wages. They are making very good livelihoods, but they have Medicaid coverage for themselves and their family. People who work and report their earnings and who come into contact with these individuals on a regular basis are aware of this, including the physician's office staff. There is currently no good way to report these people, and if the report is made, it seems like nothing is really happening.

I do want to say that possibly a Health Care Savings Account might benefit the system and put the recipients more in charge of their own healthcare. But caution has to be exercised in that education of Medicaid recipients has historically been difficult, at best. That is not only education as far as their benefits are concerned, but as far as their diabetes and hypertension and other healthcare issues. However, education will be the key to that success.

There are two important items to remember. One is the responsibility for educating the patients cannot be borne by the outpatient offices. Changes in the inequity of the system towards the providers must be addressed. Everyone has to feel that they can make a difference by being able to help the State curb the abuses that are so obvious. Trust and cooperation must exist between the State system and its providers. I appreciate your time and attention. Thank you.

Senator COBURN. Thank you. Dr. Herzlinger.

TESTIMONY OF PROFESSOR REGINA E. HERZLINGER,[1] NANCY R. MCPHERSON, PROFESSOR OF BUSINESS ADMINISTRATION, CHAIR, HARVARD BUSINESS SCHOOL

Dr. HERZLINGER. Thank you so much, Dr. Coburn and Senator Carper, for giving me this opportunity to testify.

The Medicaid program is a great program. It provides a much-needed health insurance safety net for 52 million of our Nation's poor and medically needy, but its price tag threatens the financial stability of States, growing at almost 10 percent in 2004 alone, far in excess of revenues.

What is a fiscally-responsible State Governor or State Legislature to do? They can either raise taxes, cut the expenses of other programs, cut the benefits or the number of beneficiaries in Medicaid—Tennessee, for example, cut 190,000 people out of its Medicare rolls—or do something else.

Governor Mark Sanford is to be commended for choosing a different path, for trying to find a different way out of this problem; not by cutting, but by turning to the innovations in healthcare. Because this plan is likely to become a national model if it is adopted, it has drawn the attention, national attention, of policy analysts who question the concept of choice in Medicaid, and especially the consumer-driven option. In this testimony, I would like to respond to both of these points.

What about choice? Well, in the rest of our economy we have a wide choice of goods and services. Choice is not only what consumers need and want, but choice creates competition, and competition is the key to controlling costs. Most Americans want a choice in healthcare, but South Carolina's Medicaid recipients currently have all too little choice, very few physician networks that are organized to treat those with special needs—people with diabetes, with AIDS, with hypertension, with sickle cell disease, treatment limited to the physicians who are willing to take on Medicaid enrollees, and virtually no managed care.

Furthermore, because Medicaid nationally pays providers only 65 percent of what they receive for treating the State's employees, 30 percent of all physicians refuse to accept any new Medicaid enrollees. And Medicaid enrollees experienced, according to a recent *Journal of the American Medical Association* article, much more difficulty in scheduling visits for follow-up care than those with other types of insurance. Medicaid recipients have more unmet healthcare needs than similar adults with private insurance.

Critics of the Governor's plan contend that choice cannot materialize in South Carolina because it has so few Medicaid-managed care providers currently. But when Georgia requested bids for Medicaid-managed care, 10 firms responded. When Ohio had a conference for its potential conversion to Medicaid-managed care, it drew nine new managed care firms into the State, including very well-established and well-known firms like Aetna, United Health and Anthem, which is the arm of Wellpoint.

Now, the people who worry about giving Medicaid recipients choices are especially concerned about the consumer-driven option.

[1] The prepared statement of Dr. Herzlinger appears in the Appendix on page 94.

They contend that Medicaid enrollees are too poorly educated and that they lack access to sources of information.

Now, first of all, these critics may well believe that when people have a choice they overwhelmingly opt for a consumer-driven option. That is not correct. There has been a fairly long history of giving employees choice, and only about 5 to 20 percent of employees, when they are given a choice of health insurance plans, choose consumer-directed ones. Switzerland, which has had a consumer-directed plan for a 100 years, in Switzerland, low-income people typically chose plans that give them the most insurance, understandably.

Nevertheless, what happens when people who are not well-educated, allegedly, use consumer-driven plans, can they use them to advantage? The experiences of the disabled who opted for the government based Cash and Counseling programs indicate that they derived greatly enhanced satisfaction while controlling costs, even though many of the participants had intellectual impairments.

Senator COBURN. Thirty seconds, please, Doctor.

Dr. HERZLINGER. Participants substantially increased their satisfaction and unmet need, and as one program participant noted, I am not under anyone's thumb anymore.

As for the private sector's consumer-driven experiences with low-income populations, the experience of Whole Foods, which is the supermarket chain, is very instructive. As of 2004, its employees, primarily blue collar, saved $14 million for themselves in their own savings accounts, turnover plummeted, and costs rose only 3.3 percent in contrast to the rest of the healthcare system.

These plans have transformed how enrollees approach their healthcare. They do spectacularly well with people who have chronic medical problems. They change behavior from, I do this because my health plan covers it, to, I do it because if I catch an issue early, I will save money in the long run. Thus the firm McKinsey, which has no stake in this, not under contract, found that 75 percent of the enrollees in a consumer-driven program complied with medicine regimen as opposed to 63 percent of those in other forms of insurance.

Medicaid enrollees are currently treated like second-class citizens. Some providers choose either not to see them or to treat them only after considerable delay because of the program's low payment rates, and enrollees have little access to the managed care, and no access to the consumer-driven plans available to the rest of the population.

Senator COBURN. All right. Thank you very much. Mr. McMullen.

TESTIMONY OF ED McMULLEN,[1] PRESIDENT, SOUTH CAROLINA POLICY COUNCIL, EDUCATION FOUNDATION

Mr. MCMULLEN. Mr. Chairman, thank you for the opportunity to speak with you today. My name is Ed McMullen, and I am President of the South Carolina Policy Council, which is a 20-year-old non-profit, non-partisan public policy research organization here in South Carolina.

[1] The prepared statement of Mr. McMullen appears in the Appendix on page 104.

I am here to present an overview of the innovative solutions that are being proposed to improve Medicaid in our State. There is no question that Medicaid must be reformed. It already consumes 20 percent of our State budget, and that is up 10 percent from 1995. By the year 2015, Medicaid costs are projected to consume 30 percent of our State's budget. That is a growth rate that cannot be sustained.

In addition, you mentioned the Federal Government will likely change the way it sends dollars back to the States. One plan proposes block grants instead of matching funds for States. Such a system would provide greater stability for the States, and take away the perverse incentive for them to spend more tax dollars to get more tax dollars.

Our State would ultimately benefit from the change, because the current matching formula is based on a system that compares our State's per capita income to the U.S. average. And that means as our economy grows, and it is, our matching funds will decrease. Already, South Carolina's Federal matching ratio for fiscal year 2006 is 3.5 percentage points lower than it was in fiscal year 2004.

In the long run, economic growth will shrink Medicaid rolls, but not in time to stem the massive growth in the program.

Fortunately, there is progress toward reform in our State. The new waiver proposed by Governor Sanford is an innovative market-based plan to provide quality healthcare to patients that is affordable to taxpayers.

You have heard about that plan today to provide Personal Health Accounts, or PHAs, for Medicaid patients. PHAs would offer greater access to quality care, allow patients to choose their doctors, decrease the number of emergency room visits through preventative care, and empower special needs populations with more choices.

We also know that Health Savings Accounts work in the private sector, resulting in decreased premiums and lower out-of-pocket expenditures.

There is also research on other plans that provide more choices to those on government assistance. In States such as Arkansas, Florida and New Jersey, participation among elderly and disabled populations show high rates of satisfaction, as high as 90 percent. Clearly, these consumers are receiving high quality care, and they also believe it is an improvement over their previous plans.

It is important that this plan have the companies in South Carolina, including one managed care company that currently serves 60,000 Medicaid patients, indicate they are eager to participate in this proposed plan.

Just yesterday I was up in the mountains of South Carolina with a group of insurers. We heard today that we're worried about them coming into South Carolina. When they heard this plan, presented by Dr. Kerr, they were excited, they were eager, they were anticipating great opportunities for better quality healthcare.

Healthcare companies support this plan. Consumers indicate their preference for more choices, not just in other States, but here in South Carolina, when a managed care program for Medicaid receives high marks from patients. Physicians have long argued for the need for comprehensive primary care, which this plan does allow.

So who opposes the PHA plan? Frankly, the self-described advocates, many of whom are from out of State, who argued against our welfare reform in 1994 in South Carolina. Those who fought the change in the 1990s made some of the same arguments we hear today, including that the children will suffer.

Those dire predictions have simply not come true. A 2001 study for the South Carolina Department of Social Services found that of those who left welfare because they were earning money through newer, better jobs, 75 percent were still employed a year later. Only 10 percent of all those leaving welfare believe their children suffered after leaving the program.

A subsequent study in 2003 found that 65 percent of all who had left the welfare rolls were working 40 hours a week or more, and 95 percent of them felt that leaving welfare created no hardship. I would call that good success.

In spite of the doom-and-gloom scenarios, welfare reform is a success in this State. Furthermore, the Department of Social Services has become more efficient. And as the *Charleston Post and Courier* reported, South Carolina has been among the national leaders in cutting welfare rolls, earning high performance Federal bonuses in the process.

We have to create that kind of positive change in South Carolina's Medicaid program. Neither patients nor taxpayers can afford the cost of this status quo. Medicaid patients deserve high quality care, and they should be able to choose it for themselves. They should not have to rely on overwhelmed emergency rooms that cannot possibly serve them as well as their own private doctors could.

Medicaid patients are every bit as capable as other consumers when it comes to making informed decisions for themselves and their families; they do it every day. They must be given that opportunity again in healthcare.

The proposed waiver plan is patient centered. It is based on successful approaches to healthcare. It is also cost effective, but most importantly, it is a step toward higher quality healthcare for those who are often denied the best available services. Such innovation clearly deserves a chance in South Carolina.

Mr. Chairman, thank you for your time.

Senator COBURN. Thank you, Mr. McMullen.

Let me ask each of the panelists something. Is there any doubt in any of your minds that we have an obligation to help those that need us to help them with their healthcare? Does anybody disagree with that?

[All panelists shake their heads.]

Number two, is there any doubt in any of our panelists' minds that people ought to be able to have some say in their healthcare? Anybody disagree with that?

[All panelists shake their heads.]

That part of being a part of this country is having choice and freedom and expressing of your will.

Would all of the panelists agree that part of the problem with this, the controversy over this might be the fear that somebody might be left behind, that somebody might not get what they need to get? Does anybody disagree with that?

[All panelists shake their heads.]

So let me come back and try to understand. If we do not have as good access now, and if we do not have as good a quality now, and we certainly do not have as good a prevention—we may have some in terms of EPDST programs in children, but we certainly do not have it with adults in Medicaid anywhere in this country like we need to have it, and it certainly does not equate to some of the prevention programs that people who are in the private insurance sector have, why in the world wouldn't we want to try to fix that?

And I do not know if this is the right program or not. What I know is Medicaid almost everywhere is broken, and it is broken because those who are counting on us, we are saying, here is your healthcare, but it is less than the rest of us are getting, and the access is less, and the quality is less, and on basic, on average, the outcomes are less.

So my question to each of our panelists is, what are the alternatives to what has been proposed today? What should we do as a Nation? Not just in South Carolina, but how do we fix this? How do we fix healthcare? Is choice and competition of allocate and resource and really let competition go for quality and outcome and availability and access? Why shouldn't some doctor in South Carolina be able to say, you are on Medicaid for an X fee? I am going to take care of your family all year? Why shouldn't they be able to do that, and that family spend less money and be able to keep that for themselves to incentivize to do something else? Why would we not want to do something like that?

Ms. Solomon, I'll just let all of you go down the line.

Ms. SOLOMON. Well, as I said, I think it is clear we all have similar goals here. The problem is, we pay providers less in Medicaid, and that has an impact on access. So when we are talking about trying to save money here, which really is what this proposal is attempting to do, how are we going to do it if we take—first of all, we are focusing on the people where the money is not, we are focusing on primarily the healthy people, we are not focusing on long-term care, creating new options for long-term care.

Senator COBURN. Is it not true, in South Carolina, long-term care is a separate budget? It is not considered because they have already decided that is how they are going to care for that patient. That is not part of this plan.

Ms. SOLOMON. That is not part of the waiver but it is 40 percent of the cost of Medicaid.

Senator COBURN. I understand that. I would love to talk about long-term care——

Ms. SOLOMON. Right.

Senator COBURN [continuing]. Because I think we ought to incentivize people to help keep their parents with them, not in a nursing home.

Ms. SOLOMON. But that is what I am saying, that is where maybe we could save some money. But when you are talking about 80 percent of the beneficiaries and one-third of the cost, and then you are talking about building tremendous new administrative structures——

Senator COBURN. What are the estimates for the administrative cost for this plan?

Ms. SOLOMON. I have not seen any.

Senator COBURN. So we don't know?

Ms. SOLOMON. No, we do not know. But we know that there is a myriad of new private companies that will be involved, and all have to support employees and so on as part of this structure.

I am just saying, so the reality is, to get where you want to be is going to cost more money and we would not disagree on that, but how are you going to give the cost of Medicaid in South Carolina for the people that are covered by this waiver, primarily is about $2,000 per person per year. The cost of individual health insurance this year is over $4,000. The cost of family coverage in the private market is $10,000. So there is your disconnect. It is costly, but there is not enough money in the system. So this proposal, I don't think, addresses, regardless of the goal——

Senator COBURN. So what is the answer? If it is not this, what?

Ms. SOLOMON. Well, I think you have to look at the whole program, I think you have to look at the heavy hitters, if you will. Look where you have—if people are using the emergency room—I was involved in a project in Virginia where they were very concerned that children were ending up in the emergency room. So what they did is they began to look at the data. Well, children were ending up in the emergency room, but on nights and weekends. So they called the provider's offices on nights and weekends, and they found that is what people were being told. So what they did was they brought in a 24-hour nurse advice line to talk to people, talk them through the problem and get them to the next day. That solved the problem.

Look at the data, look at the problem, look at the issues. We do not need these large-scale reforms yet. I mean, we are not there yet, I do not think.

Senator COBURN. OK. Mr. McMullen.

Mr. MCMULLEN. That's exactly what this plan does. So, I mean, when you look at the Governor's waiver, you clearly have two options. You have, in South Carolina, explosive healthcare costs in Medicaid. The Governor clearly stated it, we are either going to raise taxes or we are going to start cutting necessary programs that are education and safety programs, or we are going to restructure this system.

We were faced with very similar dilemmas in 1994 with welfare reform, and the same advocates from out of State came to South Carolina and created this horrible scare tactic of what we can expect with children and families in the streets. And what really happened is exactly the opposite of what they projected to happen. It is a working systemic change, and that is what we need in Medicaid.

Senator COBURN. Dr. Herzlinger.

Dr. HERZLINGER. I would like to respond as well.

People who support a single payer typically make this administrative argument and they say it is so much cheaper if you have only a single payer rather than having all these different private plans competing with each other.

Well, that is an interesting argument. If that is so, why don't we have the Federal Government buy our houses, buy our homes, buy our foods? Certainly the administrative costs would be lower. But the question is, what happens to total costs when you have a single

payer, and what happens to total cost if you do not have the kind of innovation that Ms. Solomon was just talking about? What kind of innovation can give a better value for the money in Medicaid?

For example, Duke physicians devised a program for congestive heart failure, which is a big problem for Medicaid recipients. In 1 year, they saved 40 percent, and they saved 40 percent not by saying to the doctors I'm going to pay you less, not by saying to the recipients you can't see a specialist; they found a better way of delivering healthcare, so they made it better and cheaper.

Consumer-driven plans have drastically reduced the rate of increase of healthcare costs while they have given even the sickest kinds of enrollees much better health status.

So the answer is not to limit the purchaser to one buyer, who as able and as well-intended as they are, simply cannot do what a multiplicity of different individual participants in the Medicaid market can do. Our economy is built on competition. You cannot have competition with only one buyer.

Senator COBURN. Dr. Tice, any comments?

Dr. TICE. Yes. The impetus has to be to try to get the patient back into the private care facilities, because we really can deliver medicine with much better continuity of care than in an emergency room which is very disjunctive care, and we can deliver it at a much lower cost.

Medicaid recipients have been given the opportunity to go to the emergency rooms at night or on weekends, wherever they so desire. Anyone with a third-party insurance is going to pay more to do that. If you want to bring the Medicaid recipients up to the same level as the people that have private insurance, then they should have the same disincentives as people with private insurance.

Senator COBURN. All right. Let me give you all an example. I held a town hall meeting in Enid, Oklahoma about 6 weeks ago. And a farmer there was limping up on crutches and he had a total knee replacement and he got an infection in his knee. And he is a Medicare patient, but same rules apply on Medicare and Medicaid as far as CMS in terms of outpatient drug therapy. And he was offered the option to go spend 30 days in an outpatient hospital, in a hospital setting to get his IV antibiotics twice a day and Medicare could pay for that, or he could pay for it himself and stay at home.

Well, the difference in the cost was $30,000 versus $4,200, but our government policy is, because we have a one-size-fits-all, we cannot seem to figure out a way to make a good way for good judgment to be used in terms of how dollars are spent.

Well, he was fortunate enough to have had a good wheat crop, so he chose, rather than to spend 30 days in a hospital and cost the government $30,000 for him to just get IV antibiotics that a nurse could give him twice a day at home through a PIC line, he chose to spend that money himself.

Now, he saved all of us $30,000, which I thanked him for. But this is the problem with single-payer systems that are trying to manage care. And I would ask you that, couldn't we use that $25,000 better to make sure a baby does not hit a NICU unit, to make sure that somebody who has diabetes who is on Medicaid gets the kind of counseling that they need so that they never end

up in diabetic ketoacidosis and in the ICU because they did not have continuity of care and did not have the opportunity, even though we have said we are going to take care of you, but did not have the continuity of care.

So I do not know what the answers are to our problems, but I know what we are doing now is not going to work. And I think innovation and attempt at competition—I am not just a doctor, I ran a pretty good-sized business, I have a degree in accounting and production management, and I became a doctor after my first episode with cancer. It changed my life, and as it does many of the people in this room who have ever experienced cancer, it changed my life. But what I do know is that with government oversight, markets work well to allocate resources and to save us money, and I do not think we ought to be extremely afraid of it.

I would note that Ms. Solomon's organization was one of the leading critics of welfare reform, for good reasons, because what the worry was is you are going to hurt people, you are not going to help them, you are going to hurt them. And that is an admiral goal to voice that opposition. But the choices, I think, that Governor Sanford outlined for us is, not just in South Carolina but as a Nation as well, but we either get a cutback, we are either going to raise taxes, or we are going to limit options by cutting back everything else in government to meet a commitment.

And change is tough for all of us. But I will outline to you that, right now our children are on the hook for about $80,000 of Federal debt. That is my children. My children range in age from 35 to 28. But my grandchildren are on the hook for about a quarter million right now. And what we have to do is work together for those that have the heart to make sure we never hurt anybody, and those that have the numbers that say can't we do it better, we have to find a way in our country to bring those two thoughts together so that we can accomplish a legacy for our kids and our grandkids that was left for us.

And because I have a great deal of interest in obstetrics, it is atrocious that Medicaid in a minority population, neonatal rates are what they are. And it is because of access. It is not because of the patients. I treat tons of Medicaid patients. It is because of access. They cannot get the available care. And so consequently, their child ends up with a problem. We spend $200,000 in a neo-natal ICU unit because they did not have access. We can fix that. We can do better.

And so I will summarize with this: That I would challenge everybody that is here on either side of this issue to think about the patients, think about those that we have made a commitment to, and figure out that the numbers do not work now. So how do we come together and solve this problem for those people that we said we are going to commit to help? And you can make this polarizing or you can bring this together and fix it. We can make it polarizing in the U.S. Senate, in the U.S. Congress, or we can come together and fix it.

I believe partisanship stinks in our country. I think it is killing us. And I believe it is time for leadership. And I believe that the people of South Carolina has a problem with Medicaid. I know the people of Oklahoma do. And we have to figure out how we meet

the commitments, both for those in Medicaid, but all the rest of our country. And I will say, it may involve raising taxes. We may have to do it. Because, remember, if we don't pay for the things that we are doing today, that is a tax increase on our kids, and that does not fit with the heritage of our country or the legacy that we want to leave.

So I would just put forward and ask that the people in this State start working together to try to figure out how do you best do that. It is easy to say this will not work and that cannot work, but I would hope that you would come together and be a model for the rest of us as a Nation. Show us the invasion that can occur. Take some risks, make sure the safety net is there. Take some risks and try it, try it with a third, try it with a half, try it with two-thirds, but don't continue the status quo.

Mr. MCMULLEN. Senator, let me just say one thing to that effect, because I think it is important to note. This has been a year-and-a-half long process, and what has been fascinating to watch is how Dr. Kerr over at HSS in South Carolina has worked aggressively to bring all the groups together. Yesterday, for the first time, I actually saw Democrats on one side, Republicans on the other, in the House and Senate leadership coming together at a table saying, we have finally made the changes in South Carolina to bring the people to the table to deal with the issues and concerns. And if South Carolina, left to its own devices without all the other clamor going on in Washington, I am convinced that with a Governor and leader like Mark Sanford, and with the leadership in the House and Senate, Republicans and Democrats, coming together as we saw yesterday in the mountains of South Carolina, we have a great future ahead of us in this issue.

Senator COBURN. Thank you. Any other comments from our panelists?

Thank you all for being here. Your complete statement will be made in the record. If there are people in the audience that would like to make a statement, we will leave the record open for 2 weeks. You can address it to the Federal Financial Management Oversight Committee of the Homeland Security Committee, and we will make your comments a part of the record.

With that, the hearing is adjourned.

[Whereupon, at 11:52 a.m., the Subcommittee was adjourned.]

APPENDIX

Governor Mark Sanford
U.S. Senate Committee on Homeland Security and Governmental Affairs
Subcommittee on Federal Financial Management, Government Information, and International Security
October 28, 2005

- Across the country, Medicaid is consuming an ever-increasing piece of state budgets. Governors, regardless of political party, are having to deal with the challenge of Medicaid funding's unsustainable growth. The problem is real.

- In South Carolina:
  - In 2000, $1 out of every $7 that South Carolina spent went toward Medicaid.
  - In 2005, it's $1 out of every $5 spent.
  - In 2010, it's $1 out of every $4 spent.
  - By 2015, nearly $1 out of every $3 goes to Medicaid.

- In addition, South Carolina currently ranks near the bottom in overall health outcomes, including high rates of diabetes, stroke, and lung cancer. We need to derive more value from our healthcare dollars.

- Given the traditional options of cutting services, cutting beneficiaries, or substantially raising taxes, we'd like to try a different approach - bringing the benefit of marketplace principles to Medicaid.

- Since the Department of Health and Human Services put out the preliminary reform proposal in June, the Administration has solicited and received some excellent feedback, and is refining the proposal. The revised proposal, called South Carolina Healthy Connections, should be out sometime in the coming weeks.

- In very brief summary, our program will seek to:
  1. Provide Medicaid recipients with real buying power and a financial incentive to make healthy choices.
  2. Offer recipients a menu of different healthcare plan options (along with reliable information from trained enrollment counselors) and allow them to choose the option that works best for them. Plans would compete for business on the basis of price, quality and convenience.
  3. Ensure more recipients have a medical home so they can receive more personal, proactive and coordinated care. Better coordinated care can lead to better health results for patients while reducing unnecessary expenses.

- South Carolina Healthy Connections will bring the benefits of personal ownership, market competition and consumer choice to South Carolina's Medicaid system in order to improve the long-term fiscal health of Medicaid and the physical health of its beneficiaries.

Mark Sanford

From: Scott English [senglish@gov.sc.gov]
Sent: Thursday, October 27, 2005 11:28 PM
To: Sanford Mark
Subject: Coburn the Barbarian

WSJ.com THE WALL STREET JOURNAL. ONLINE

October 21, 2005

REVIEW & OUTLOOK

Coburn the Barbarian

October 21, 2005; Page A14

On current trends, freshman Tom Coburn of Oklahoma is soon going to need a food taster to accompany him to the Senate dining room. Which is all the more reason for the rest of us to admire his political nerve.

Mr. Coburn yesterday took to the floor not once, but twice, to force his colleagues to defend some of their more egregious "earmarks," or pork projects they plan to funnel to home states. The Republican dared to use the "p" word ("priorities") and suggested that taxpayers might be better served if hurricane relief was offset by deleting earmarks for a sculpture garden in Washington state, an art museum in Nebraska, and a Rhode Island animal shelter, among other national necessities.

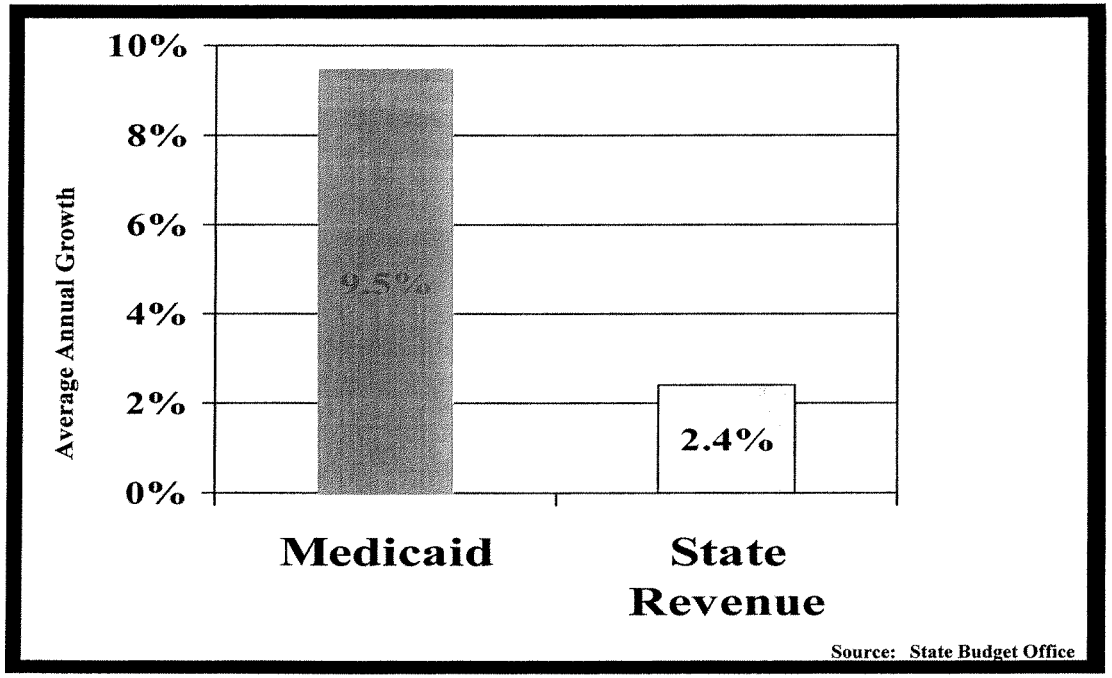
Washington Democrat Patty Murray escalated immediately to Defcon 1, vowing that if her colleagues so much as blinked at her sculptures she'd personally see to the untimely demise of their own projects. Mr. Coburn lost 86-13. The miracle is he got 13.

Senator Non Grata returned to the floor later in the day, this time to suggest shifting $223 million from the infamous "bridge to nowhere" in Alaska to a bridge over Lake Pontchartrain that was damaged by Hurricane Katrina. Alaska's alleged Republican Lisa Murkowski responded that the very idea of refusing to spend $4.5 million per each of the 50 residents on Alaska's Gravina Island -- so that they would no longer have to take a seven-minute ferry -- was, well, "offensive." As we went to press last night, the vote on this amendment was still being tallied, but you already know how it turned out.

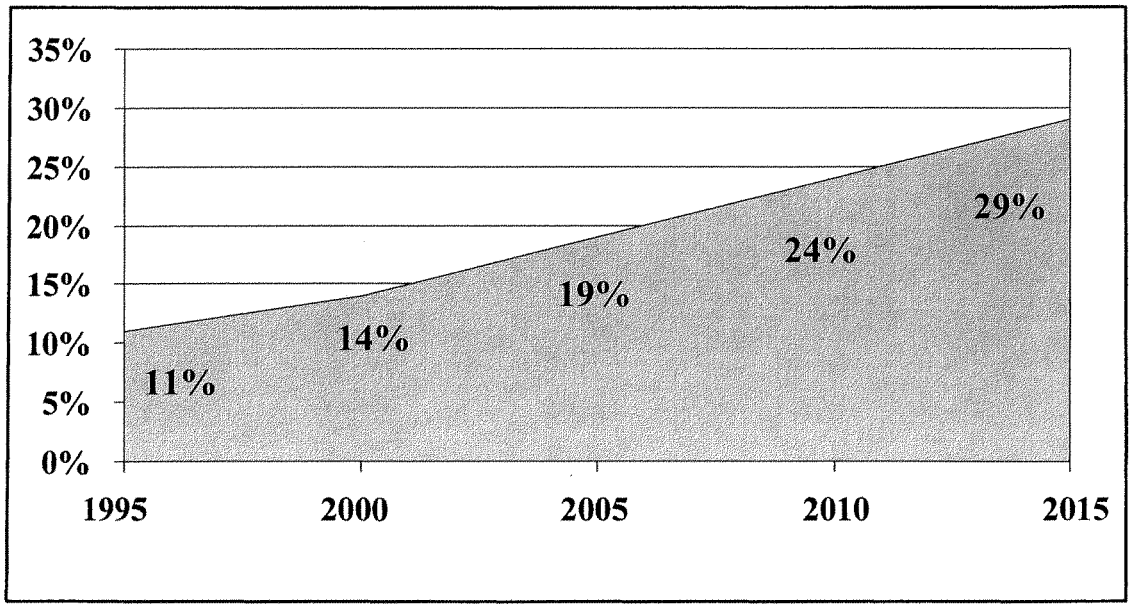
Rest assured that none of this is making Mr. Coburn popular with his colleagues, Republicans or Democrats. The Senate is a club and one thing that is beyond ideology is "earmarks." They're almost considered to be a perquisite of service, like a golf membership for a CEO (at least before Sarbanes-Oxley). Mr. Coburn is risking his dinner invitations by daring to shine a public light on his fellow Senators as they practice their everyday, routine outrages. Good for him, but he'd better hire a bodyguard.

Average Growth in Total Medicaid Expenditures vs. Average Growth in Total State Revenue

South Carolina Fiscal Years 1998 - 2004

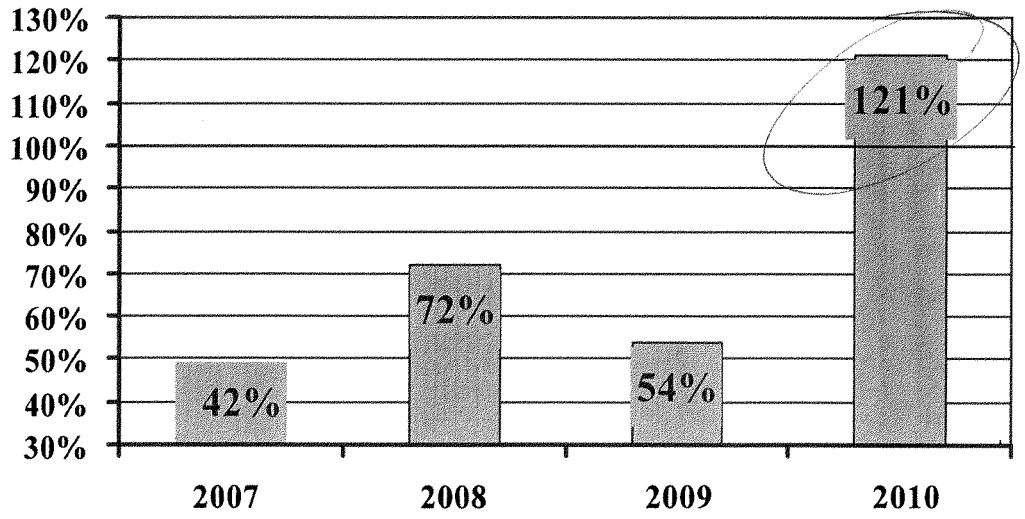


Medicaid Matching Expenditures as a Percent of Total State General Fund Revenue



Source: South Carolina Budget and Control Board, Office of Research and Statistics

Estimated Percent of New State Tax Revenue That Increased Medicaid Funding Will Consume



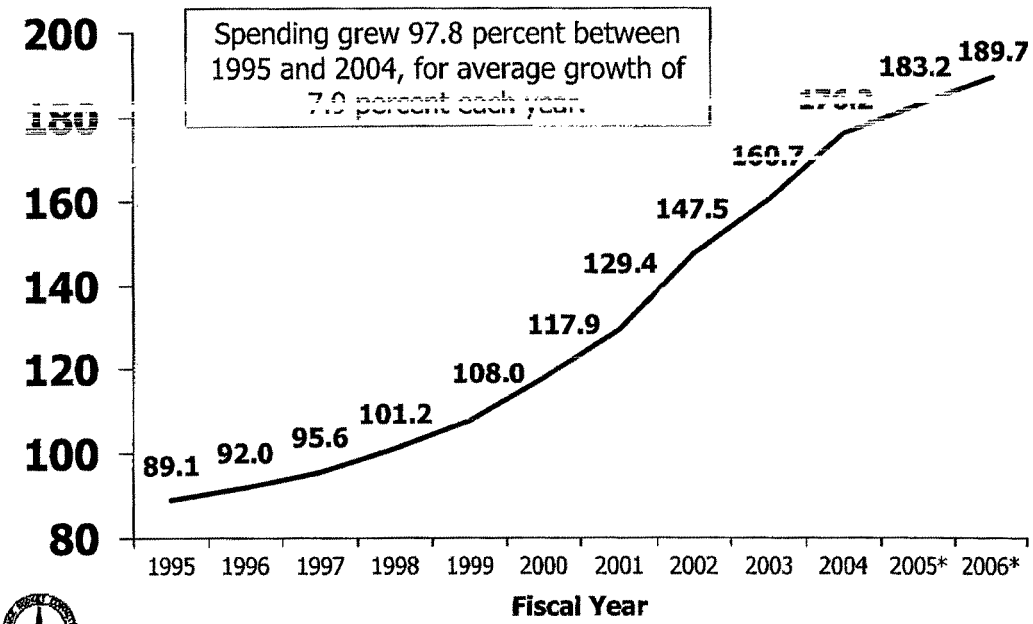
Source: South Carolina Budget and Control Board, Office of Research and Statistics

‘I’m a Democrat, a liberal Democrat, but we can’t sustain the current Medicaid program. It’s fiscal madness. It docsn’t guarantee good care, and it’s a budget buster. We need to instill a greater sense of personal responsibility so people understand that this care is not free.”

Democratic Maryland Legislator John Huston, President of National Council of State Legislatures

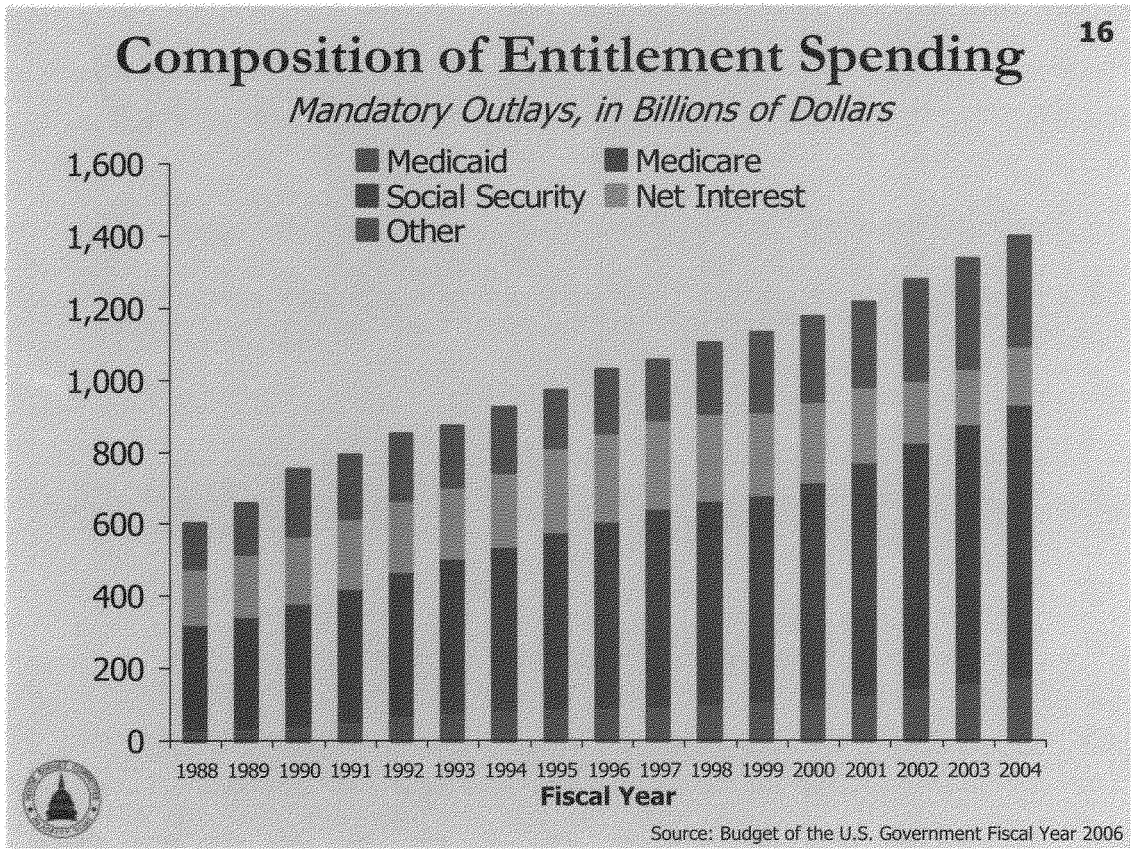
Medicaid

Federal Outlays in Billions of Dollars



*Assumes enactment of administration Medicaid proposals.

Source: Budget of the U.S. Government Fiscal Year 2006 and CBO


16
Composition of Entitlement Spending
Mandatory Outlays, in Billions of Dollars
Medicaid
Medicare
Social Security
Net Interest
Other
1,600
1,400
1,200
1,000
800
600
400
200
0
1988 1989 1990 1991 1992 1993 1994 1995 1996 1997 1998 1999 2000 2001 2002 2003 2004
Fiscal Year
Source: Budget of the U.S. Government Fiscal Year 2006

MEDICAID CHANGES IN OTHER STATES

We can cut ...

Kentucky announced on October25, 2005 that its Medicaid system would stop paying for non-emergency care done in hospital emergency rooms.

Maryland cut $7 million in Medicaid funding this year for coverage of newly arrived legal immigrant children and pregnant women, citing spiraling spending on the program for the poor. An estimated 4,000 women and children were affected. (Gov. Ehrlich later restored $1.5 million to cover pregnant immigrant women already in the program.)

Michigan, Gov. Granholm unveiled a new budget on October 23, 2005 including $40 million in rate cuts to healthcare providers – and the providers were thankful it wasn't worse.

Missouri State Senate this year actually voted to sunset the Medicaid system in 2008 before finally settling on removing some 90,000 people from the rolls and instituting premiums for the State Children's Health Insurance Program (SCHIP).

Dumond

Tennessee Gov. Phil Bredesen asked for a 323,000 person removal from the Medicaid roles before settling for a 190,000 person cut.

... Or we can reform.

Florida Gov. Jeb Bush was approved for a Section 1115 Medicaid Waiver last week.

Georgia Gov. Sonny Perdue is working with Newt Gingrich on a Medicaid waiver plan that is expected to rely heavily on managed care and prevention

Illinois Gov. Rod Blagojevich announced on October 24, 2005 that he wants to shift 1.7 million people covered by Medicaid, the state health insurance program, to a managed-care structure called primary-care case management. About 150,000 of these people already are served by HMOs, and the rest — the vast majority — use a more traditional fee-for-service program.

Brad Henry

Oklahoma has had a State House of Representatives Task Force meeting for the past few months on how to transform Medicaid. (They actually asked Robby Kerr to come speak to them, which he regretfully declined.)

Vermont was approved for a Section 1115 Medicaid waiver on September 27, 2005, that ~~will~~ allow them to move part of their population to managed care and institute higher premiums on certain optional Medicaid populations. They accepted a 5-year limit on growth. (ie. If even liberal *Vermont* (albeit with a Republican Governor) can accept a limit on the 5-year growth rate in order to get a waiver, it should not frighten people in South Carolina so much.)

THE WALL STREET JOURNAL.

REVIEW & OUTLOOK

Rip Van UAW

Two cheers for the United Auto Workers, who this week woke up to the realities of competition in agreeing to a deal that will help General Motors save $15 billion or so in health-care costs. We hope it's the beginning of wisdom about the global economy for the American labor movement.

The union decides to act before GM is in Chapter 11.

No doubt the immediate wake-up call was last week's bankruptcy filing by auto-parts maker Delphi, the largest in the history of the American automotive industry. The UAW could see Delphi in GM's future if it didn't do something. It also realized that GM's management, urged on by major shareholder Kirk Kerkorian, was finally gearing up to play hardball.

Still, this is a watershed concession by the American industrial workforce in the middle of a contract that doesn't expire until 2007, and it will certainly save jobs. Ford is currently in talks with the UAW about lowering its own health-care burdens and both it and DaimlerChrysler have already made it known that they expect equal treatment.

The details of the accord probably won't be announced until tomorrow at the earliest—and they must be approved by the union's membership and a federal court before they can take effect. But we already know the realities of GM's health-care costs, which keep going up even as the number of people covered keeps going down. Some 1.1 million Americans currently have health insurance courtesy of GM, which expects to spend $5.6 billion on their care this year. Ten years ago it cost the company only $3 billion to cover 1.2 million workers, retirees and dependents.

Meanwhile, GM's 106,000 hourly employees continue to receive benefits that most American workers haven't seen in years, if ever, with little or no co-pays or even deductibles. This year the company's hourly workers will pay just 7% of their total health-care bill, compared with 27% for salaried workers; the corporate America average is 32%. GM CEO Rick Wagoner said Monday that salaried workers' cost share will rise to 31% in 2006.

GM management shares the blame for agreeing to these gold-plated benefits back in the days of its market dominance. The company began to offer health insurance to employees in 1950 and expanded the system to retirees in 1961, adding bells and whistles as the years went on. The tax code made it easier by subsidizing employer-paid health care, and the benefits helped buy labor peace.

But these costs are unsustainable now that GM has only one worker for three retirees, and when Honda and Toyota aren't burdened by the same unionized benefit levels in Tennessee and Ohio, much less in Nagoya. Change should have begun long ago, but for years the UAW was more willing to shed jobs than bend on benefits. Let's hope this week's concession is a sign of more management-labor cooperation to come.

The federal government could also contribute, by recognizing how its policies have driven up health-care costs. Nationwide, the average per-employee cost of health care is $7,323 this year, according to Hewitt Associates, and is expected to rise to $8,046 in 2006. In some quarters, this is a call to turn all health care over to the government, as if Americans want to wait months for an MRI as they do in Canada.

The better idea is to introduce more competition into the health-care marketplace. A few years ago the supermarket chain Whole Foods switched to a consumer-driven health-care plan in which its 32,000 employees were allowed to pick from a menu of care options. After three years, the company's health-care costs rose by only 3.3% a year, compared with national averages in the double digits, and job turnover plummeted, according to researchers Regina Herzlinger and Tom Nerney. Congress could help by enhancing the appeal of health-savings accounts and by passing Congressman John Shadegg's (R., Ariz.) bill to allow Americans to purchase health insurance from vendors in any one of the 50 states.

As for the auto workers, we are going to hear often that its concessions signal the death of the American "middle class." The truth is that these changes are the only way to preserve it. The most secure future for workers isn't the industrial-age labor model with one company providing pensions and health-care benefits for life. Just ask thousands of former steelworkers.

Job security depends on constantly upgrading skills, and financial security requires individuals to have more freedom to negotiate their own health-care and retirement funds, and the ability to transport them from job to job across a lifetime of work. The key is ownership, not paternalism. The UAW isn't there yet, but at least the union appears to have awakened from its long, willful oblivion before one of the Big Three filed for Chapter 11.

RECIPIENT IS A MALE BORN IN 1986

MEDICAID CLAIMS FOR 2002: 394 services $58,704

MEDICAID CLAIMS FOR APRIL: 41 services $6,418

Note: *Service not provided by a state agency

MONTH OF SERVICE	DAY OF SERVICE	AGENCY PROVIDING SERVICE	SERVICE, DRUGNAME OR DIAGNOSIS BASED ON TYPE OF SERVICE	CLAIMS	AMOUNT PAID
April	1	DSS	DSS TCM ISCEDC PRIMARY*	1	$38
April	2	DAODAS	ANCILLARY CASE MANAGEMENT - DAODAS*	1	$27
April	2	DHHS*	FQHC/RHC MEDICAL ENCOUNTER	1	$63
April	2	DSS	DSS TCM ISCEDC PRIMARY*	1	$306
April	2	DSS	FAMILY COUNSELING 30 MIN PER UNIT	1	$30
April	2	DSS	YOUTH COUNSELING PSYCHOLOGIST 30MIN UNI	1	$60
April	2	DHHS*	METADATE CD 20MG CAPSULES	1	$54
April	3	DAODAS	LEVEL I INDIVIDUAL COUNSELING-DAODAS	1	$60
April	3	DSS	CLINICAL DAY PROGRAMMING/ ONE DAY	1	$162
April	3	DSS	MODERATE MANAGEMENT REHAB SERVICES	1	$412
April	3	DSS	RM&BD/COSY& ISCEDC	1	$209
April	4	DAODAS	LEVEL I GROUP COUNSELING-DAODAS	1	$35
April	8	DHHS*	CONTROL NASAL HEMMOR ANTER SIMP(LIMITED)	1	$47
April	8	DHHS*	E/M CONSULT OFFICE CONSULT LEVEL 1	1	$30
April	10	DSS	MODERATE MANAGEMENT REHAB SERVICES	1	$412
April	10	DSS	RM&BD/COSY& ISCEDC	1	$209
April	12	DSS	CLINICAL DAY PROGRAMMING/ ONE DAY	1	$108
April	15	DAODAS	ANCILLARY CASE MANAGEMENT - DAODAS*	1	$27
April	16	DSS	CONSULTATION 15 MINUTES PER UNIT	1	$30
April	16	DHHS*	DEPAKOTE ER 500MG TAB SA	1	[illegible]
April	17	DSS	CLINICAL DAY PROGRAMMING/ ONE DAY	1	$162
April	17	DSS	MODERATE MANAGEMENT REHAB SERVICES	1	$412
April	17	DSS	RM&BD/COSY& ISCEDC	1	$209
April	18	DAODAS	LEVEL I GROUP COUNSELING-DAODAS		
April	18	DAODAS	LEVEL I INDIVIDUAL COUNSELING-DAODAS	1	$60
April	19	DAODAS	LEVEL I GROUP COUNSELING-DAODAS	1	$105
April	19	DMH	PSYCHIATRIC MEDICAL ASSESSMENT	1	$55
April	19	DSS	CLINICAL DAY PROGRAMMING/ ONE DAY	1	$108
April	23	DAODAS	ANCILLARY CASE MANAGEMENT - DAODAS*	1	$27
April	24	DAODAS	LEVEL I INDIVIDUAL COUNSELING-DAODAS	1	$60
April	24	DSS	CLINICAL DAY PROGRAMMING/ ONE DAY	1	$162
April	24	DSS	DSS TCM ISCEDC PRIMARY*	1	$574
April	24	DSS	MODERATE MANAGEMENT REHAB SERVICES	1	$412
April	24	DSS	RM&BD/COSY& ISCEDC	1	$209
April	25	DAODAS	LEVEL I GROUP COUNSELING-DAODAS	1	$35
April	25	DSS	CLINICAL DAY PROGRAMMING/ ONE DAY	1	$108
April	25	DSS	DSS TCM ISCEDC PRIMARY*	1	$38
April	26	DSS	DSS TCM ISCEDC PRIMARY*	1	$77
April	28	DSS	CONSULTATION 15 MINUTES PER UNIT	1	$20
April	30	DAODAS	ANCILLARY CASE MANAGEMENT - DAODAS*	1	$27
[illegible]	[illegible]	[illegible]	[illegible]	[illegible]	[illegible]

South Carolina
Medicaid Waiver History

- 1984 – Community Long Term Care (in effect)
- 1988 – HIV/AIDS Waiver (in effect)
- 1990 – Palmetto Senior Care (now part of State Plan)
- 1991 – Mental Retardation and Related Disabilities (in effect)
- 1994 - Ventilator Dependent Patients (in effect)
- 1994 – Family Planning (in effect)
- 1995 - Head & Spinal Cord Injuries (in effect)
- 1995 – Assisted Living (approved but never implemented)
- 1996 – Medically Fragile Children's Program (in effect)
- 2003 - SC Choice (together w/ Elderly/Disabled Waiver) (in effect)
- 2003 - SILVERxCARD (in effect)

COLORADO – DISABLED RECIPIENTS.

Cross Country / *By John Andrews*

Rocky Mountain Medicaid

Englewood, Colo.

My new favorite CD is "Don't Let It Stop You," by local mother-daughter singers Linda and Jessica Storey and their band, the Alleluia Blues. "Hold onto your dreams, though mountains fall," sings Linda. "Don't ever give up the will to survive."

The song was written after Sept. 11. But it also evokes the life story of this 51-year-old rocker, who has battled multiple sclerosis for almost 30 years. She didn't let that stop her from building a marriage, raising two children, founding Musicians Against MS—and recently, helping to pilot a revolutionary approach to Medicaid in Colorado.

CDAS, our state's experiment with Consumer-Directed Attendant Support for the severely disabled, got started in 2002. The wheelchair-bound Linda Storey was one of its first four clients. The program now has 146 participants, each newly empowered to hire and fire their own caregivers. Quality of care and patient satisfaction are up, costs are down, and legislators approved offering the option for 33,000 Medicaid recipients statewide in 2006.

If there is more alleluia and less blues in the Storeys' music these days, CDAS is a big reason. "It gives you your life back," Mrs. Storey told me. "I'm in control of my health now." Under a federal waiver obtained by Colorado officials, she selects the health aides who come to her house, bypassing the provider agencies otherwise required under Medicaid rules for home- and community-based services.

Jessica, a 21-year-old anthropology student, now gets to be one of those paid caregivers. Nowadays, the entire team of aides is reliable and well qualified, she told me—in contrast to the ill-trained and even scary individuals sent in by agencies over the years. Several even robbed the family, Jessica recalled.

Scheduled agency personnel would often not show, leaving Mrs. Storey alone and desperate. Consumer-directed care has reduced the instances of abandonment almost to zero, she reports. "Since I have been on CDAS . . . I have more freedom to live my life as every American should—and I'm saving the government money."

Linda Storey

With Medicaid expenses surging faster than almost every other budget line in almost every state, such savings are welcome news to policy makers. Taxpayers in Colorado have seen their share of Medicaid—matched dollar for dollar with federal funds—increase almost 33% since 2001. Another 22% jump is predicted by 2010.

Absent a tax increase here (one on the November ballot is trailing in opinion polls), the Medicaid spiral will continue squeezing all other priorities except K-12 education.

The first two years of Colorado's CDAS pilot program, by contrast, showed average monthly spending at 21% *under* budget ($3,925 per client allocated, $3,131 expended). While the sample is tiny, the vector is positive for once. To Medicaid administrators like Aggie Berens and Viki Manley, that brings unaccustomed praise—and proud smiles. To legislators like Speaker Pro Tem Cheri Jahn (D., Arvada), sponsor of this year's bill to expand CDAS statewide, it spells progress.

"People deserve choices," Rep. Jahn says. With those choices comes not only greater dignity for the individual, but also better incentives for the system as a whole. Half of any monthly savings a CDAS client realizes go into a personal fund for approved purchases to further his or her independence. Linda Storey used part of her fund to buy voice-activated phones for her bedside and wheelchair. Philip Rangel of Greeley, another participant in the pilot, bought specialized art equipment with his savings. Though quadriplegic and confined to a ventilator for half his 37 years, he paints by mouth.

Julie Reiskin of Denver is executive director of the Colorado Cross-Disabilities Coalition. After lobbying for the 1996 bill that authorized CDAS and then pushing for the long-delayed federal waiver, she is now herself a pilot client. Raising taxes or reducing services and caseload are not the only alternatives for Medicaid as often assumed, Ms. Reiskin argues. "Instead we should spend more wisely with the existing dollars, as this program does."

Why are the patient-empowerment initiatives in Medicaid so few and so small thus far? Ms. Reiskin blames paternalistic societal attitudes and the economic self-interest of providers. Linda Gorman of the Independence Institute, a Colorado think tank, seconds that. Health care reform boils down to two choices, she told me—"either oppress patients with big-government programs, or liberate them with these consumer-directed experiments."

This means that a success story like CDAS—good for clients and budgets alike—constitutes "a real pain" for the HillaryCare crowd, Ms. Gorman said. Policy analyst James Frogue of the Gingrich Group agreed. "This is a winner for everyone except the left-wing ideologues who want a Canadian-style single-payer system regardless of its ill effects on patients."

Big-brother care took a hit from the Supreme Court of Canada itself this summer. And it is losing ground in several U.S. states as innovative governors push for patient power. South Carolina is in the forefront with Gov. Mark Sanford's proposal to give his state's 850,000 Medicaid clients' personal accounts from which to buy their own health insurance and pay for incidentals. Florida's Jeb Bush, Vermont's Jim Douglas and Arkansas's Mike Huckabee are also driving for reform.

It took Republican Gov. Bill Owens replacing Democrat Gov. Roy Romer in 1999 to kick the Colorado Medicaid experiment into gear. Gov. Owens has played tough defense against single-payer proposals, vetoing two prescription drug bills this year, while going on offense for the market-minded CDAS pilot.

The goal is clear, according to Matt Dunn, a young dentist named by Gov. Owens to the Medicaid oversight board. First give patients freedom to choose. Then align incentives so the choices go less and less toward a demeaning, inefficient government delivery model. "Socialized medicine benefits no one," Mr. Dunn insists with Colorado candor. To which Linda Storey would say alleluia, amen.

Mr. Andrews, a Claremont Institute fellow, was president of the Colorado Senate from 2003 through 2005.

45

CASH + COUNSELING

Helping people improve their quality of life by taking control of their health care

ABOUT US
Program Overview
Partners
Staff
Cash & Counseling States

Program Overview

Begun 1996? Now 15 states

The Cash & Counseling approach provides consumers with a flexible monthly allowance that is based on an individualized budget, which allows them to direct and manage their own personal assistance services and address their own specific needs. In addition, this innovative program offers counseling and fiscal assistance to help consumers manage their allowance and responsibilities by themselves or with the aid of a representative. These main features are adaptable to consumers of all ages with various types of disabilities and illnesses. Cash & Counseling intends to increase consumer satisfaction, quality, and efficiency in the provision of personal assistance services. The vision guiding this expansion is the promise of "a nation where every state will allow and even promote a participant-directed individualized budget option for Medicaid-funded personal assistance services." The National Program Office at the Boston College Graduate School of Social Work coordinates and directs the replication project.

Understand this was for disabled people using Long-Term Care (nursing homes, sotting, stay out) Our waiver isn't the same (i.e. not for acute care) but C&C Counseling showed that consumer-directed care could work. Satisfaction went ↑ neglect went ↓

- Eleven states have been awarded three-year grants of up to $250,000 to implement the Cash & Counseling model and collect information to monitor the effectiveness of these programs. The eleven states include Alabama, Iowa, Kentucky, Michigan, Minnesota, New Mexico, Pennsylvania, Rhode Island, Vermont, Washington, and Pennsylvania. Additionally, Illinois has been funded by the Retirement Research Foundation to implement their own C&C program.

  ① enhanced satisfaction ② 30% reduction in neglect

- Cash & Counseling grants were awarded in October 2004. Each state has been awarded one three year grant.

- Two states with ambitious plans to expand significantly beyond the basic Cash & Counseling model may be eligible for an additional $100,000 over the same three year period. All grants will be awarded in Summer 2004.

Cash & Counseling is a national program sponsored by The Robert Wood Johnson Foundation (RWJF), the Office of the Assistant Secretary for Planning and Evaluation in the United States Department of Health and Human Services (ASPE/DHHS), and the Administration on Aging (AoA). In addition, the Centers for Medicare and Medicaid Services (CMS) reviews states' Section 1115 demonstration or 1915 (c) waiver applications and provides continuing oversight and technical assistance in the waiver process. With the cooperation of the aforementioned agencies and the National Program Office located at the Boston College Graduate School of Social Work, a three state Cash & Counseling Demonstration was implemented to compare the Cash & Counseling consumer-directed model with the traditional agency-

directed approach to delivering personal assistance services.

Due to the success of the Cash & Counseling Demonstration and Evaluation in Arkansas, Florida and New Jersey, interest from other states, a supportive political environment, and President George Bush's New Freedom Initiative, The Robert Wood Johnson Foundation, the Office of the Assistant Secretary for Planning and Evaluation, and Administration on Aging have authorized an expansion of the Cash & Counseling program that provides grants and comprehensive technical assistance to our expansion states that are replicating, and in some states expanding, on this Cash & Counseling model.

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Helping people improve their quality of life by taking control of their health care

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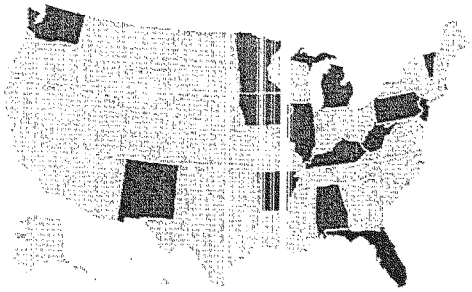

Original States:
- Arkansas
- Florida
- New Jersey

Expansion States:
- Alabama
- Illinois
- Iowa
- Kentucky
- Michigan
- Minnesota
- New Mexico
- Pennsylvania
- Rhode Island
- Vermont
- Washington
- West Virginia

Welcome to Cash & Counseling's Interactive Map, designed to help you identify states that have, or are in the process of developing, Cash & Counseling programs. This map contains information on the populations that each state is intending to serve, the areas in which the program will be available and how to contact the programs for more information. **To begin, click on any highlighted state** or select by name from the list on the right.

DRAFT
Proposal

Personal Health Account Funding

(1) OWNERSHIP –
(2) CONSUMER DIRECTED – different needs.
(3) Essential safeguards –
1. govt approve plan
2. cover mandatory services

	Managed Care Organization	Medical Home Network	Group Insurance Buy Out	Self-Directed
Benefits	*Minimum:* *•Mandatory Services* *• Pharmacy* *• Durable Medical Equip. (e.g. wheelchairs)* *Maximum:* *•Full Benefits*	*Mandatory Services* *Optional Services*	*According to Employer Group Health Plan*	*Major Medical Plan*
PHA Uses	*Plan Premium* *Co-Pays (if any)* *Non-Covered Services*	*Plan Premium* *Co-Pays* *Non-Covered Services*	*Plan Premium*	*Plan Premium* *Co-Pays* *All Other Services*
	Health Plan Options		**Opt-Out Alternatives**	

“For every one of my welfare reform programs that I've put into law or was able to get waivers for from the federal government, there have been the critics and the nay-sayers, but they want to keep the status quo.

I don't want to keep the status quo. The status quo doesn't work. Give us in Wisconsin the flexibility, the opportunity to change it, and we'll show the way for the country to follow.”

Governor Tommy Thompson (1992)

Recipient is a Male Born in 1985
All Medicaid Claims for 2002
Medicaid Claims for 2002: 199 Services $78,863
Medicaid Claims for May: 28 Services $11,815

Medicaid Claims Database South Carolina Budget and Control Board, Office of Research and Statistics

Date of Service	State Agency	Diagnosis	Service or Drugname	Amount Paid
5/1/2002	DMH	PROLONG POSTTRAUM STRESS	CARE COORDINATION	$31
5/1/2002	DSS	ATTN DEFICIT W HYPERACT	DSS TCM INTERAGENCY STAFFING NONISC	$73
5/1/2002	DMH	PROLONG POSTTRAUM STRESS	CARE COORDINATION	$31
5/1/2002	Pharmacy		RISPERDAL 1MG TABLET	$167
5/3/2002	DMH	PROLONG POSTTRAUM STRESS	CARE COORDINATION	$31
5/3/2002	DMH	PROLONG POSTTRAUM STRESS	INDIVIDUAL THERAPY	$110
5/3/2002	DSS	CONDUCT DISTURBANCE NOS	RM&BD/COSY& ISCEDC	$39
5/3/2002	DSS	CONDUCT DISTURBANCE NOS	MONTHLY FEE	$165
5/4/2002	DMH	PROLONG POSTTRAUM STRESS	ASSESSMENT-MHP	$224
5/4/2002	Outpatient Hosp	INTERMITT EXPLOSIVE DIS	E/M EMERGENCY DEPARTMENT SERV LEVEL 4	$40
5/4/2002	Outpatient Hosp	INTERMITT EXPLOSIVE DIS		$54
5/5/2002	Inpatient Hosp	MALAISE AND FATIGUE NEC	E/M CONSULT INITIAL IP CONSULT LEVEL 4	$100
5/5/2002	Inpatient Hosp	IMPULSE CONTROL DIS NOS	PSYCHIATRIC DIAGNOSTIC INTERVIEW EXAM	$65
5/5/2002	Inpatient Hosp	IMPULSE CONTROL DIS NOS		$5,477
5/7/2002	DMH	PROLONG POSTTRAUM STRESS	CARE COORDINATION	$62
5/7/2002	DMH	PROLONG POSTTRAUM STRESS	CASE CONSULTATION	$31
5/7/2002	DSS	ATTN DEFICIT W HYPERACT	DSS TCM INTERAGENCY STAFFING NONISC	$37
5/9/2002	DSS	ATTN DEFICIT W HYPERACT	DSS TCM INTERAGENCY STAFFING NONISC	$402
5/11/2002	Other	IMPULSE CONTROL DIS NOS	E/M IP SERV SUBSEQ HOSP CARE LEVEL 1	$240
5/12/2002	Other	IMPULSE CONTROL DIS NOS	HOSPITAL DISCH DAY MGMT; 30 MIN OR LESS	$75
5/13/2002	DSS	ATTN DEFICIT W HYPERACT	DSS TCM INTERAGENCY STAFFING NONISC	$37
5/13/2002	Pharmacy		SEROQUEL 25MG TABLET	$82
5/14/2002	DMH	PROLONG POSTTRAUM STRESS	INDIVIDUAL LIVING SKILLS-NATURAL ENVIRON	$42
5/14/2002	DSS	ATTN DEFICIT W HYPERACT	DSS TCM INTERAGENCY STAFFING NONISC	$37
5/15/2002	DSS	ATTN DEFICIT W HYPERACT	DSS TCM INTERAGENCY STAFFING NONISC	$110
5/31/2002	DSS	SEPARATION ANXIETY	CASE MANAGEMENT	$544
5/31/2002	DDSN	MENTAL RETARDATION NOS	DDSN TARGETED CASE MANAGEMENT	$235
5/31/2002	COC	ATTN DEFICIT W HYPERACT	WRAP AROUND ISCEDC/COSY TDC DAILY	$3,277
			Total Medicaid Paid Claims for May	$11,815

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

A National Association for America's State Legislators • Jeffersonian Principles in Action!

Prepared Statement

Of

The Honorable Tracy R. Edge
104th District Representative
South Carolina House of Representatives
&
Member
American Legislative Exchange Council

United States Senate

Committee on Homeland Security and Government Affairs
Subcommittee on Federal Financial Management, Government Information, and International Security

October 28, 2005

Introduction

Good morning Chairman Coburn and Members of the Committee:

My name is Tracy Edge, and I represent the 104th House District in South Carolina's House of Representatives. I am also chairman of the South Carolina House Ways and Means Subcommittee on Health, Human Services, and Medicaid.

In addition, I am a member of the American Legislative Exchange Council, or "ALEC." ALEC is the nation's largest nonpartisan, individual membership organization of state legislators with over 2,400 legislator members from all 50 states and 97 members in the Congress. ALEC's mission is to advance the Jeffersonian principles of free markets, limited government, federalism, and individual liberty.

It is my pleasure to appear before you in support of Governor Mark Sanford's Medicaid waiver proposal, which I believe is a step in the right direction toward empowering South Carolina's Medicaid beneficiaries.

The Fiscal Need for Reform

We must act now to curb Medicaid's skyrocketing costs. South Carolina spends more than $4 billion dollars annually, or about 19 percent of our entire state budget, on Medicaid alone. According to the South Carolina Department of Health and Human Services, in ten years Medicaid is expected to consume almost 30 percent of our state's budget.[1] This poses a real threat to other funding priorities, such as K-12 education or law enforcement.

In my opinion, Medicaid's problems can be directly attributed to the perverse fiscal incentives imposed by its financing structure. From state governments to doctors to patients, Medicaid does not give any incentive to provide or consume health care efficiently. In fact, the opposite is true. Medicaid's financing structure actually *rewards* inefficiency with more dollars.

As you know, the federal government pays for more than half of all Medicaid spending through the Federal Medical Assistance Percentage, otherwise known as the "federal match." The federal match gives South Carolina Medicaid spending a guaranteed return-on-investment. In South Carolina, the federal match is about 69 percent.[2] This means that every Medicaid dollar we spend yields about $2.85 in total Medicaid benefits.

Ironically, it is the federal match that is causing Medicaid spending to spiral out of control. Medicaid's federal match triggers a wasteful and inefficient spending spree, since states need to spend more to get more federal money.

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[1] Freking, Kevin. "South Carolina Proposing to Redefine Medicaid," *The State*, Tuesday, August 16, 2005.
[2] Kaiser Family Foundation. *South Carolina: Federal Matching Rate (FMAP) for Medicaid and Multiplier*: http://www.statehealthfacts.kff.org.

We often hear about leveraging state Medicaid dollars with federal funds—but when we attempt to game the federal match, we put the fiscal health of South Carolinians in jeopardy. Federal dollars are not "free." All taxpayers, including Medicaid recipients, pay federal, state, and local taxes.

Low provider reimbursement rates also directly contribute to Medicaid's costs and limit much-needed access to care. On average, a doctor who treats a Medicaid patient will get about 62 percent of what they would get for treating a Medicare patient—and Medicare reimbursement rates are still only 80 percent of the average rate paid by private insurers.[3]

Because of this, providers have the incentive to tack on unnecessary tests or to stop seeing Medicaid patients altogether just to stay in business.

It is crucial that patients have a stake in their own health care spending. Unfortunately, South Carolina Medicaid's current fee-for-structure system largely shields beneficiaries from the consequences of their own healthcare decisions. Simply stated, our state's Medicaid system pays claims first, and asks questions later.

The Role of Welfare Reform in Reforming Medicaid

It is clear that the case for Medicaid reform has a lot to do with money. More importantly, however, there is a strong moral case for Medicaid reform. We cannot and should not confine our most needy citizens to an almost-bankrupt system. Instead, we should put Medicaid beneficiaries on the road to self-sufficiency by empowering them to take a greater responsibility for their own health care needs.

Luckily, we have a map of the road to self-sufficiency—the example of welfare reform. Before the Welfare Reform Act of 1996, there was an eerie similarity between the Medicaid and welfare programs. Both Medicaid and welfare were means-tested entitlement programs. Both programs were funded by an open-ended, federal-state spending match, and both programs conferred a legal right to benefits.

Almost ten years later, the two programs could not be more different. Block-grant funding has caused welfare rolls to drop dramatically. Meanwhile, the Medicaid entitlement continues to keep the poor locked in a cycle of government dependency in several ways.

First, it is likely that the mere existence of Medicaid could "crowd out" private-sector health care alternatives. The Robert Wood Johnson Foundation found that of the 22 studies they reviewed on the issue, more than half concluded that expansion of public health coverage was accompanied by reductions in private coverage.[4]

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[3] Cannon, Michael F. "Medicaid's Unseen Costs," Cato Institute Policy Analysis #548, August 18, 2005.
[4] Gestur Davidson et al. "Public Program Crowd-Out of Private Coverage: What Are the Issues?" Robert Wood Johnson Foundation Research Synthesis Report No. 5, June 2004.

More importantly, Medicaid and other entitlements do not give the poor an incentive to save and invest, as beneficiaries have to remain under certain income levels in order to qualify for benefits. As a result, it possible that some beneficiaries may choose to stay just below the poverty level, thereby locking them into an entitlement system.

South Carolina

There is no reason why welfare reform shouldn't serve as a model for Medicaid reform—and that is why Governor Sanford's Medicaid waiver proposal is so important. Only South Carolina—not bureaucrats in Washington—knows how to best serve South Carolinians on Medicaid.

Governor Sanford's Medicaid waiver empowers beneficiaries to tailor their own health care dollars to their own health care needs. Each Medicaid beneficiary will receive a Personal Health Account that they can use to fund their own health care in a variety of ways—either through Health Savings Accounts, by purchasing a managed care plan, by purchasing health insurance from their employer, or by joining a medical home network.

This choice not only turns beneficiaries from government dependents into empowered health care consumers—it also accomplishes the laudable goal of transitioning beneficiaries to self-sufficiency and independence through private coverage. Medicaid beneficiaries should have the same access to high-quality, private health insurance that we all enjoy.

Just like the welfare reform fight of ten years ago, there are critics that maliciously accuse Governor Sanford's proposal as "cruel" or "heartless." I reject that notion. Giving South Carolinians the opportunity to pull themselves out of poverty will work for them and it will work for Medicaid, just as it did for welfare reform in the 1990s.

Conclusion

Mr. Chairman, thank you for holding this hearing and for the opportunity to testify. The American Legislative Exchange Council is supportive of Medicaid reform and of the proposals contained in Governor Sanford's plan.

ALEC and I look forward to working with you in the days and months ahead to continue the national discussion of South Carolina's bold and innovative Medicaid proposal.

I would be pleased to answer any questions you might have.

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The American Legislative Exchange Council's mission is:

- *To advance the Jeffersonian Principles of free markets, limited government, federalism, and individual liberty, through a nonpartisan public-private partnership among America's state legislators, concerned members of the private sector, the federal government and the general public.*

- *To promote these principles by developing policies that ensure the powers of government are derived from, and assigned to, first the People, then the States, and finally the Federal Government.*

- *To enlist state legislators from all parties and members of the private sector who share ALEC's mission.*

- *To conduct a policy making program that unites members of the public and private sector in a dynamic partnership to support research, policy development, and dissemination activities.*

- *To prepare the next generation of political leadership through educational programs that promote the principles of Jeffersonian democracy, which are necessary for a free society.*

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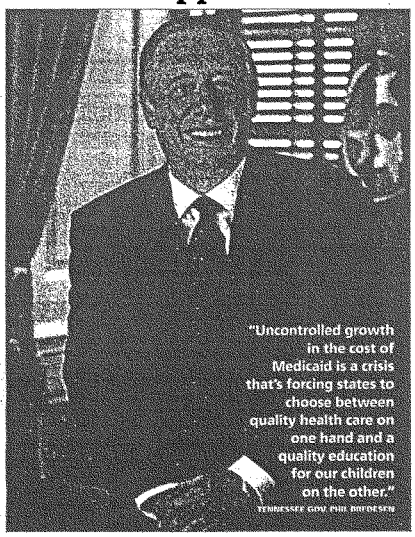
States Grapple with Medicaid Reform



by Susan Konig

Tennessee's Medicaid program, TennCare, "is the most expensive [such] program in the country," Gov. Phil Bredesen (D) told the National Press Club in Washington this June. He said the condition of Medicaid in Tennessee should put his state "on the leading edge" of the reform issue.

The governor advocated an overhaul of Medicaid, according to the Associated Press. TennCare is about to slash 323,000 people from the rolls of the 12-year-old program.

In a June radio speech, Bredesen said, "Let's scrap the old, inefficient version of Medicaid that's led us to spend more and more of our finite resources on a system that never yielded the kind of public health results we'd hoped for. Uncontrolled growth in the cost of Medicaid is a crisis that's forcing states to choose between quality health care on one hand and a quality education for our children on the other."

Legacy of Failure Cited

Last December, testifying before the TennCare Oversight Committee, TennCare Director J. D. Hickey estimated the program will be over its $8.7 billion budget for the 2005 fiscal year. Hickey told lawmakers the program, which enrolls 1.3 million Tennesseans, will be forced to spend an [illegible]

(See "Governor Cuts 320,000 from Ailing Tennessee Health Care Program," *Health Care News*, February 2005.)

"This is not the approach to TennCare reform that I originally envisioned," Bredesen said in a 2004 speech to the state legislature. "But under the legal and economic circumstances, it's our best chance for maintaining care for as many Tennesseans as possible."

"[TennCare] was a fiasco from the beginning. A 1999 state audit found the program had paid $6 million to insure 14,000 dead enrollees. And 16,500 enrollees lived outside the state."
MERRILL MATTHEWS
COUNCIL FOR AFFORDABLE HEALTH INSURANCE

Efforts by Bredesen to reform TennCare were blocked by the American Civil Liberties Union (ACLU), which sued Bredesen in December 2004 for attempting to restrict eligibility, reduce the number of free hospital visits, and lower the number of allowable free prescriptions.

"In 1993, then-Governor Ned McWherter (D) rammed through TennCare, the closest any state came to implementing ClintonCare, without even a vote in the state legislature," Merrill Matthews, director of the Council for Affordable Health Insurance, said. "The program was a fiasco from the beginning. A 1999 state audit found the program had paid $6 million to insure 14,000 dead enrollees. And 16,500 enrollees lived outside the state."

Costs Continuing to Grow

In an April 2005 report, "An Rx for Reform," the Rhode Island Public Expenditure Council (RIPEC) reported, "nearly $0.50 of every new dollar spent by the state since 1996 has been to support entitlement spending. The largest component of the state's grants and benefit program is Medicaid. In 2006, Rhode Island will spend more than $1.8 billion on Medicaid, which will represent nearly 30.0 percent of the state's budget."

The report stated, "Medicaid spending will grow at an average annual rate of 8.2 percent through the end of the decade, with Medicaid spending amounting to $2.6 billion by 2010. By the end of the decade, one in five Rhode Islanders will receive Medicaid benefits."

According to the study, "prospects for slowing down Medicaid enrollments and expenditures ... do not appear to be on the horizon. ... [I]t is likely that Medicaid will continue to grow, and that such spending increases will be at rates exceeding state revenue growth. In other words, growth in Medicaid spending will continue to create a large structural problem in the state's budget unless a vigorous program of entitlement reform and cost containment is pursued."

"Only the free market can cure the Medicaid spending crisis that's plaguing the states," said Christie Raniszewski Herrera, director of the Health and Human Services Task Force at the American Legislative Exchange Council (ALEC) in Washington, DC.

"Medicaid's inefficient and perverse incentives shield individuals from the costs of their health decisions, meaning that beneficiaries want the best health care that someone else's money can buy," she said. "This results in skyrocketing health care costs and confines the truly needy into a bankrupt Medicaid system."

Mississippi Sets Drug Cap

In Mississippi, more than a quarter of the population is eligible for Medicaid, and costs are soaring. In July, the state instituted a cap on prescription drug purchases, the strictest in the country, limiting Medicaid recipients to five prescription drugs, including only two brand-name medicines, according to a UPI report.

Opponents have argued HIV/AIDS patients will suffer from the restrictions. An exception for those patients is being considered.

New York Reform Stalls

Gov. George Pataki (R) called New York's Medicaid program "our biggest budget item" in his 2005 budget address. Nursing home costs are 22 percent of all Medicaid costs in the state. In Monroe County alone in 2004, $830 million was spent on Medicaid—more than the total Medicaid costs of eight states, according to a June article in the *Rochester Democrat and Chronicle*.

Pataki has organized a commission to "right-size" the program, but at present a reform plan is not in place.

In May, the office of the New York State Comptroller discovered that 198 registered sex offenders in the state had received erectile dysfunction drugs through their Medicaid benefits. Auditors had been reviewing expenditures of Medicaid pharmacies when they discovered Medicaid-reimbursed Viagra was provided to level 3, or high-repeat-risk, sex offenders.

"Only the free market can cure the Medicaid spending crisis that's plaguing the states. Medicaid's inefficient and perverse incentives shield individuals from the costs of their health decisions, meaning that beneficiaries want the best health care that someone else's money can buy. This results in skyrocketing health care costs and confines the truly needy into a bankrupt Medicaid system."
CHRISTIE RANISZEWSKI HERRERA
HEALTH AND HUMAN SERVICES TASK FORCE
AMERICAN LEGISLATIVE EXCHANGE COUNCIL

Moreover, comptroller Alan G. Hevesi said in a May statement, "The audits conducted by my staff have ... since 1994, identified more than $826 million in actual and potential overpayments."

More Reforms Called For

"A few states are realizing that the way to save Medicaid is to create a true marketplace within public health insurance," said Herrera of ALEC. "Everyone needs to take a more empowered role in fixing the system.

"Patients should be responsible for choosing their own health plans using a fixed premium amount," Herrera continued, "and they should be given incentives to manage costs. Providers should be allowed the flexibility to offer customized benefit plans that offer innovative, quality care. And state governments should provide a bridge between public and private coverage by allowing beneficiaries to move out of the Medicaid system."

Susan Konig (konig@heartland.org) *is managing editor of* Health Care News.

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

The State Factor

Jeffersonian Principles in Action!

Abolishing the Medicaid Ghetto: Putting 'Patients First'

by Richard Teske

EXECUTIVE SUMMARY

"Many people, since 1965, have called {Medicaid} the 'sleeper' in the legislation. Most people did not pay attention to that part of the bill...{it} was not a secret, but neither the press nor the health policy community paid any attention to it."

— Wilbur Cohen[1]

Medicaid, the federal-state health care program for the poor, remains the stepchild of national health policy to this day. It has gone from a $1 billion program in 1967 to an estimated $226 billion budget-buster in 2001, covering approximately 40 million Americans.[2] The reason for this failure is that Medicaid's original structure remains essentially intact. The result is that the poorest, disproportionately minority, most illiterate, least educated, non-English speaking, blind, disabled, elderly, mothers and children with the least experience choosing a physician or knowledge of accessing the health care system receive the "second tier" level of care. This is a national disgrace.

Every federal administration enters promising Medicaid reform and greater state "flexibility" in its administration. President Bush's Administration and Health and Human Services Secretary Tommy Thompson are no exception. They have reformed and speeded the CMS (HCFA) 1115 waiver process to enable greater state Medicaid experimentation. Called the Health Insurance Flexibility and Accountability (HIFA) initiative, to date it has awarded a waiver only to two states: Arizona and California. Arizona's waiver has only been in effect since late 2001 and California's has not yet been implemented. Thus evaluating HIFA's success is greatly premature.

But HIFA only promises research and incremental—not comprehensive—reform. To address 35 years of failure, Congress must mandate a change from Medicaid's welfare entitlement defined benefits structure to a market oriented defined contribution structure. Consistent with welfare reform in 1996, Congress should give the states all responsibility for implementation and administration of Medicaid. The purpose of this paper is to describe why and how this must be done.

Incremental reforms have not worked. Centralized health planning, certificate of need, construction moratoriums, and wage and price controls in the 1970s didn't work. Deregulation, new federalism and acute care-long term care swaps never got off the ground in the 1980s. Mandatory managed care, block grant and per capita caps weren't the answer in the 1990s. In 2001, HIFA may not lead to successful reform.

The major problem is Medicaid's defined benefits structure. All health programs have three essential elements: eligibility, benefits and cost. How they are designed determines the basic structure. In Medicaid, eligibility and benefits are essentially fixed and costs are the variable. This means that if you are eligible, you are "entitled" to all the benefits regardless of cost to the taxpayer. This is why Medicaid is a welfare entitlement program.

Almost all of Medicaid's problems stem from the welfare entitlement defined benefits structure. There are major problems with Medicaid's benefits structure, including an outdated reimbursement formula, inefficient benefits delivery, and a rigid benefits structure, which offers all benefits to all recipients

regardless of need. There are major problems with Medicaid's eligibility structure, including a history of eligibility "gaps" resulting in large poor populations remaining outside Medicaid; the loss of coverage for the sake of a job, destroying continuity of care and encouraging the use of emergency rooms for primary care, and the growth of the middle class using Medicaid as their long term care insurance by abusing the "spend down" requirements while hiding assets. There are also major problems with Medicaid's financial structure. Doctors and other providers in the Medicaid system often are reimbursed at levels lower than their costs. This however does little to halt Medicaid's huge and ever-growing outlays.

Consistent with 1996s welfare reform, Congress should mandate market based consumer choice reform and return Medicaid's administration to the states. Medicaid is actually 56 separate programs jointly administered and paid for by the federal and state (or territorial) governments. Because almost every past reform proposal rewarded one state at the expense of another, they failed to pass.[3] But by keeping aggregate federal and state financing at present levels, Medicaid could still be freed from the suffocating grasp of the Centers for Medicare and Medicaid Services (formerly the Health Care Financing Administration or HCFA). By mandating consumer choice, but returning full administrative control to the states, this reform provides the maximum state flexibility while retaining federal equity.

States would implement and administer the market oriented consumer choice plan using a defined contribution approach. In a defined contribution program, costs and eligibility are constant and benefits are variable. A variant of this approach has been used in the 40-year-old Federal Employees Health Benefit Program (FEHBP), a popular and successful program that covers members of Congress, congressional staff and about nine million federal workers and retirees. In contrast to the Medicaid program, FEHBP provides high levels of patient satisfaction at a controllable cost.[4] The federal financial participation (FFP) should continue at its present level in the form of a nationally calculated individual refundable tax credit adjusted for age and poverty level that would pay for a catastrophic acute and long-term care policy. States would pay all deductibles and copays up to the catastrophic amount for the eligible poor. Medicaid consumers would then purchase personal insurance from a variety of state approved plans (including medical savings accounts, fee-for-service and managed care) through an independent broker. Since these policies would be personally owned, they would be fully portable to the private sector.

States should also aggressively pass small market insurance reforms. Unlike the mini-Clinton care plans adopted in states like Tennessee, Kentucky and Washington in the early 1990s, the policy goal should be to return as many people to the private market rather than absorb them in a broadened Medicaid program. The goal should be to make health coverage private, portable and not a disincentive to employment. In the past, states combined as many disparate populations (i.e. elderly, children, uninsured, uninsurable) in the same one-size-fits all medical assistance program. We have learned that different populations should be handled differently. For example, certain populations (like the present long term care or mental health populations) may not fit an insurance model. Medicaid reform accompanied with small market insurance reform would provide a seamless and greatly improved "safety net" for the greatest number of Medicaid recipients and providers alike.

Loss of federal quality standards is a non-issue. This will be the favorite tactic to preserve the federal and CMS (HCFA) oversight of the program. The states have every bit as much interest in retaining quality. In fact, it is difficult to explain Medicaid's present lack of quality and then argue for the retention of present federal regulatory oversight. If, after 35 years of federal guidelines, this is the result, then it is time for a new approach. The status quo rewards the bureaucrats and harms the patients. Preserving so-called federal "protections" should not be an issue.

Even without legislation, governors should apply for Section 1115 waivers under HIFA to implement a pilot research program. They can adopt the essentials of the reforms outlined above if Congress fails to act. This would force positive action on Medicaid reform similar to what was achieved by the dramatic leadership of Wisconsin Governor Tommy Thompson in the area of welfare reform.

I. INTRODUCTION

Medicaid, the federal-state health care program for the poor, remains the stepchild of national health policy to this day. Its costs have soared from $1 billion in 1967 to nearly $226 billion in 2001.[5] The reason for this failure is that Medicaid's original structural flaws remain essentially intact. The result is that the poorest, disproportionately minority, most illiterate, least educated, non-English speaking, blind, disabled, elderly, mothers and children with the least experience choosing a physician or knowledge of accessing the health care system receive "second tier" care. This is a national disgrace.

The primary purpose of this paper is to start a national dialogue on Medicaid reform. The remainder if this paper details how and why a "patients first" approach can be designed and be successful. At the very least it provides a market oriented consumer choice alternative to the present welfare entitlement approach.

II. INCREMENTAL MEDICAID REFORMS HAVE NOT WORKED

Passed in 1965, Medicare (Title 18 of the Social Security Act) and Medicaid (Title 19) have little in common. Medicare is a single federally administered health insurance program for the elderly originally modeled on Blue Shield and Blue Cross. Medicaid is actually 56 joint administered federal-state welfare programs (50 state, 5 territorial and the District of Columbia) with unique eligibility, benefits and reimbursement rules.[6] This makes it extremely difficult for policy makers to compare statewide statistics and policies or to propose effective reforms.

In addition, because of the 56 separate programs, comprehensive national Medicaid reform proposals would advantage one state at the expense of another. This explains the failure in the 1990s of the block grant, voucher, and per capita caps reform proposals.[7] The failure of comprehensive reform proposals means that almost every Congressional reform of Medicaid has been incremental. Most Medicaid problems are structural and incremental reforms are not able to address the core problems that relate to benefits, eligibility and cost.

The uncontrolled growth in expenditures means that Medicaid is now the second largest item in most state budgets (next to education), often representing up to a quarter of all expenditures. Medicaid spending only increased 3 to 4 percent in 1996-98 due to welfare reform's impact on eligibles, but greater spending will return as the Congressional Budget Office (CBO) estimates growth to average 7.8 percent to 2009.[8] The CBO states that this percentage could increase significantly as states raise their capitation rates to keep managed care organizations in the Medicaid program.

> Because Long Term Care costs constitute almost half of all Medicaid spending — and Medicaid is such a large part of the budget — it could potentially bankrupt every state government leaving no money for education, highways, etc.

After 2009, the baby boomers will begin to retire and the implications for Medicaid costs grow even dimmer. America's aging population, coupled with increasing costs as aging accelerates, means long term care could sink many Medicaid programs by 2010 and most by 2030.[9] It has been estimated that Medicaid's Long Term Care (LTC) costs will at least quadruple by 2020. Because LTC costs constitute almost half of all Medicaid spending—and Medicaid is such a large part of the budget—it potentially could bankrupt every state government leaving no money for education, highways, etc.

State Reform Efforts in the 1970s. To control costs, states tried centralized health planning, certificates of need, wage and price controls, and moratoriums or restrictions on new hospital and nursing home beds. It was only because politicians stupidly believed that the "market" didn't work in health care, that they thought they could simply ignore the laws of supply and demand. However, supply and demand market forces do work in health care. They tried to keep health care "supply" constant while demand increased- and they were somehow surprised when costs soared.

State Reform Efforts in the 1980s. Many state officials proposed a "swap," under which the federal government would take over Medicaid acute care, leaving the states with all long-term care. A few years later, the reverse swap was proposed. The proposals failed because 1) some states benefited by swapping

acute care, some by long-term care and 2) whoever ended up with long-term care—the feds or the states—was the real loser.

In the 1980s, President Reagan offered Congress and the taxpayers "New Federalism." It promised greater "flexibility" by deregulating much of the health care industry. The first target for regulatory reform was the nursing home industry. This reform proposal failed because of huge resistance among liberal legislators and senior citizens' lobbies. After this defeat, comprehensive regulatory reform was rarely proposed.

"New Federalism" also meant a giant federal-state swap of programs. The states would get a host of domestic programs and the federal government would get Medicaid. This failed as soon as the Reagan Administration understood the astronomical cost projections for Medicaid in the out years. Ever since, politicians at every level of government hope some other politician at another level of government will be naive enough to seriously tackle Medicaid reform.

Creative Bookkeeping by States. Near the end of the 1980s, some states tried creative bookkeeping to increase federal payments. They tried to maximize the Disproportionate Share Hospital (DSH) reimbursement for hospitals (extra funding for hospitals that care for a large number of poor people) in ways that are now illegal. They also instituted "provider taxes" that seemingly increased state spending, thus increasing the federal matching funds. They then rebated the "taxes" in full to the providers. This also is no longer legal, though it was continued in some states like Missouri. The culprit is not the states but the defective "federal match" that discourages real reform while encouraging unnecessary increased spending (described below).

Clinton's Health Plan and the Invisibility of Medicaid in the 1990s. Among policy makers, the plight of the uninsured took precedence over the problems of the Medicaid eligible population. Managed care was the solution du jour to restrain costs in the private sector in the early 1990s. The insurance solution for non-ERISA small employers was to be the formation of Health Insurance Purchasing Cooperatives (HIPCs). The almost inevitable public policy result was the combination of managed care and HIPCs as President Clinton's giant 1993 "managed competition" proposal. Congress quickly learned, however, that a complex bureaucratic plan that risked one-seventh of the nation's economy on an untried theoretical scheme might not be prudent.

Some states, however, like Kentucky, Tennessee and Washington, adopted miniature Medicaid versions of "Clinton Care" to cover the uninsured. They sometimes merged the uninsured and uninsurables into their existing Medicaid program. While the intention was to broaden access to coverage and control costs, the results proved disastrous. By bundling disparate populations with different health needs into a single program, and providing richer benefit packages than many employers, the number of eligibles and costs exploded. This resulted in private insurance plans being "crowded out" by these public programs while small employers dropped their employee coverage.

The managed care/HIPCs experience was replicated in the private sector. After initially saving money, managed care began to cost more as employee dissatisfaction at "HMO rationing" grew exponentially. In addition, HIPCs didn't work because only employers with high-risk employees joined the pools, and insurers quickly learned that the "savings" promised by creating a large pool didn't occur. It is arguable that not a single HIPC was successful.

Medicaid Mandatory Managed Care. Medicaid was no different in the early and mid-1990s. To control the explosion in Medicaid costs, many states applied for Section 1115 waivers to institute mandatory managed care programs. When projected savings failed to materialize, states reduced reimbursement capitation rates and/or instituted strict quality controls.[10] With reimbursement reduced and regulatory requirements increased, managed care companies began withdrawing from Medicaid programs. State officials blamed "the greedy private sector" rather than recognize the mistake of building on the status quo Medicaid "welfare entitlement" structure. The repeal of the Boren Amendment, as part of the Balanced Budget Act of 1997, enabled states to reduce reimbursement even further. The Balanced Budget Act of 1997 also promoted the movement of large numbers of Medicaid patients into managed care plans by eliminating the need for HCFA waiver approval.[11] In truth, the state officials often ignored the underlying structural problems in Medicaid and evidently never understood how managed care companies worked. The result was predictable: providers and plans quickly dropped from the program and Medicaid patients, again, suffered the most.

Child Health Insurance Program (CHIP) Expansion. In 1997, Congress passed Title 21 of the

Social Security Act: the State-Child Health Insurance Program (S-CHIP). President Clinton estimated the number of uninsured children to be almost 10 million.[12] Because Medicaid had become so complex and diverse without being reformed, many Medicaid-eligible children were thought to be without coverage.

Thus, the Clinton Administration was not enthusiastic about trusting the states to enroll new uninsured children in Medicaid because they believed states would not want to find heretofore-undiscovered, and costly, Medicaid eligible children. It was thought that S-CHIP — with $48 billion worth of federal funds and an enhanced "federal match"—would provide the states with the incentive to ferret out these invisible kids. States were allowed to establish SCHIP programs within their Medicaid structure or to establish SCHIP-only programs, which purported to allow for greater flexibility and a greater role for the private sector. When these children didn't immediately materialize, Clinton threatened the governors with federal investigations to explain why states had only found 1.3 million children.[13] Clinton promised to send investigators to every state and make inquiries. So much for greater flexibility.

There was only one problem — the Kaiser Foundation estimated that there were, at best, 2.6 million uninsured children.[14] Either Clinton was wrong, or, to attract enough new "uninsured" to meet the 10 million goal, children with private insurance coverage would need to be "crowded out" and into the public plan. So today, instead of one faulty federal-state program because of faulty numbers and political intrigue, there are now two.

The Health Insurance Flexibility and Accountability (HIFA) initiative of 2001. As previously mentioned, the Bush Administration and HHS Secretary Tommy Thompson announced HIFA to reform and speed the CMS (HCFA) 1115 waiver process. This would enable states to experiment how to better provide coverage to the uninsured using present government funding. This was to be accomplished by: 1) speeding the CMS approval process (giving HIFA applications priority); 2) providing states greater "flexibility"; 3) co-coordinating public and private coverage options, and; 4) expanding coverage by using budget neutral funds. As of May 1, 2002, only two states have been granted HIFA waivers. Arizona's waiver has been in effect since late 2001, and California's is not due to be implemented until late 2002.

It is too early to evaluate this program's success, but States will be understandably skeptical at first. Given past history: 1) CMS bureaucrats will find a way to slow and kill the initiative; 2) the promise of flexibility will vanish; 3) there will be little, if any, coordination resulting in the private sector being "crowded out," and; 4) the increased coverage will result in greater costs but not do much for the uninsured. If this is not the outcome, then HIFA will have been one of the most important reforms in Medicaid's history.

One last policy point: The goal of health care public policy shouldn't be to expand coverage but to have the uninsured return to private sector. If you expand eligibility and coverage for the uninsured using the Medicaid program (as did Tennessee), the results could be catastrophic.

III. THE MAJOR PROBLEM IS MEDICAID'S WELFARE ENTITLEMENT DEFINED BENEFITS STRUCTURE

The few attempts at comprehensive Medicaid reforms and the more numerous incremental proposals have not solved Medicaid's structural problems. To grasp the changes that are needed, members of Congress must understand the present structure of the Medicaid program.

There are three elements to every health plan be it public or private: eligibility, benefits and cost. How you define and design them will determine the underlying structure of the plan. Medicaid is a defined benefits structure. In a defined benefits structure the eligibility and benefits are essentially fixed and costs are the variable. This means that if you are eligible you are "entitled" to all the benefits available regardless of the aggregate cost to the taxpayer. This is why Medicaid is a "welfare entitlement" program. It also explains why costs, by being the uncontrolled variable, have resulted in the program expanding from $1 billion in 1967 to $226 billion in 2001.

Most reform proposals have focused only on cost containment. To enforce cost containment regulations an intrusive regulatory system that concentrates on provider reimbursement, waste, and fraud and abuse is needed. Quality and access are secondary concerns, and price controls are typically the result.

Because almost no reform proposals suggested anything but minor changes in this defined benefits structure, no comprehensive proposals have passed.

Instead, only the incremental reforms above have been tried. Until comprehensive reform of the basic structure is accomplished, costs will continue to explode and the regulatory system will become more intrusive. This is an inevitable result because it is built into Medicaid's defined benefits structure.

The solution is to change Medicaid from a defined benefits structure to a defined contribution plan similar to the Federal Employees Health Benefit Program (FEHBP). The difference in the basic structure is considerable. A defined contribution plan employs a market-oriented consumer choice approach, in which eligibility and costs are fixed, and benefit packages are variable. Regulating the variable (benefits) means the focus is on quality assurance and patient satisfaction. This is because the various plans compete on the basis of offering different benefit packages and managing risk. In today's program, there is almost no penalty for giving second tier care. Beneficiaries have nowhere else to go. In defined contribution programs, there are competitive pressures to maintain and even increase patient satisfaction.

The solution is to change Medicaid from a defined benefits structure to a defined contribution plan similar to the Federal Employees Health Benefit Program.

The remainder of this paper details who, why and how this comprehensive Medicaid structural reform can be done. It is really quite simple: merely put patients first.

IV. PROBLEMS WITH MEDICAID'S BENEFITS STRUCTURE

The Rigidity of Present Mandatory and Optional Benefits Packages. In the Medicaid program, all states must provide 14 mandatory (defined) benefit services.[15] These include inpatient hospital, outpatient hospital, prenatal care, vaccines for children, physician services, nursing facility services for those over 21, family planning services and supplies (but not abortions as dictaded by the Hyde Amendment), rural health clinics, home health care, laboratory and x-ray, pediatric and family nurse practitioner, nurse-midwife, federally qualified health center services and early and periodic screening, diagnostic and treatment (EPSDT) for those under 21.

States may also provide any of 34 designated optional benefits.[16] The most common are: diagnostic services, clinic services, intermediate care facilities for the mentally retarded (ICFs/MR), prescription drugs, prosthetic devices, optometrist services and glasses, nursing facility under 21, transportation, rehab and physical therapy, and home and community-based services.

For states that offer many or most optional benefits, Medicaid offers better coverage than many small employer plans. Medicaid then becomes: 1) a disincentive to move into a private sector job, 2) provides incentives for over utilization because of the rich benefits package, and 3) entices small employers to drop employee coverage because Medicaid "crowded out" their existing private plan.

In addition, because all benefits must be offered to all eligibles (one size fits all entitlements), Medicaid does not get any of the fiscal rewards of "tailoring benefit packages" as does the private sector. Once an optional benefit is conferred upon one eligibility group, it must be conferred upon all eligibles. This is why Medicaid's benefit structure is the exact opposite of sound public policy. The private sector often saves considerable expenditures by tailoring the benefits to specific needs. By not actuarially covering all benefits for all programs, the price for each person can be less. For example, in the private sector, maternity benefits aren't often offered for those over 65, and children rarely need coronary bypass surgery. Medicaid, however, offers all benefits to everyone. This is wasteful, but inevitable, if one uses a defined benefits approach.

This also means that new and better but expensive benefits won't be offered until almost everyone with private plans offers them. The result: Medicaid offers a broad benefits package that almost no one will fully need, but must ignore offering particular benefits to cover specific, but small, patient populations. New therapies, drugs or treatments won't be covered. This seemingly innocuous problem is not good for either patient care or cost savings.

How the Federal Medical Assistance Percentage Discourages Comprehensive Structural Reform. Because Congress permitted individual states to choose richer Medicaid benefit

packages, poorer states were at a disadvantage. Congress tried to equalize the financial resources available to all states through a formula called the Federal Medical Assistance Percentage (FMAP), commonly referred to as the "federal match."

Under this arrangement, each state chooses its optional benefit package and the degree to which they wish to increase eligibility. As mentioned previously, the federal and state governments then share the costs regardless of the expense. The aggregate national amount covered by the federal government is roughly 57 percent. The amount per state, however, is different. Using the complex FMAP formula to calculate a state's per capita income, the ten richest states are matched at a 50-50 rate while the poorest state, Mississippi, is matched at 76 percent.[17]

> Once an optional benefit is conferred upon one eligibility group, it must be conferred upon all eligibles. This is why Medicaid's benefit structure is the exact opposite of sound public policy.

In theory, Mississippi would have an incentive to include more benefits since, for every Medicaid dollar they spent, the federal government would give approximately five more federal dollars. Also, the tax burden on Mississippi residents, theoretically, would be much less. But in reality this has not happened. New York offers most if not all 34 optional benefits, and Mississippi very few. New York even has much broader eligibility criteria.

The reason for creating the FMAP was to "equalize" the different financial capabilities of the states. It did just the opposite. After 35 years, large disparities between the states remain. The Government Accounting Office (GAO) reported in 1995 that by relying on per capita income as a measure of state wealth, the FMAP did not reduce the differences in the state Medicaid programs or the tax burdens to support them. The GAO concluded that large disparities still existed, and the formula must be modified to narrow the disparities.

In addition, the FMAP becomes a Faustian bargain as states try maximizing their federal match dollars. The states dare not cut spending because "they will leave federal money on the table." In this way, the federal match drives policy whereas policy should drive the match.

By replacing the FMAP with a nationally calculated, refundable tax credit, you can break the link between state and federal spending. If the states want to spend more money or broaden benefits, it would have no effect on total federal spending. States would not be tempted to spend more money or conceive questionable funding techniques to "maximize" the federal match.

Unlinking the federal and state match is crucial. In the past, changing the FMAP formula or the Medicaid fiscal relationship between federal and state government has been politically impossible. Next to long-term care reform, the FMAP has been the most intractable problem blocking comprehensive Medicaid reform. It has literally created a financial incentive for states to spend more, not less. Consider the following:

In 1997, total New York Medicaid spending was over $29 billion, of which half came from the federal government.[18] This provided services for about 3,150,000 recipients at a per capita expenditure of about $9,200.[19] Mississippi spent over $1.7 billion for just over 500,000 recipients at a per capita expenditure of about $3,400 - even though the federal match covered nearly 80 percent of that amount. But this is only half the story.[20]

Imagine a state block grant based on existing federal match rates. In the above example, the federal government would provide New York about $4,600 for each recipient and Mississippi would receive just $2,720 in perpetuity- even though Mississippi has had historically about an 80 percent match. It is hard to imagine the Mississippi congressional delegation accepting this result as an equitable and permanent Medicaid reform. FMAP has become the "Gordian Knot" of Medicaid reform, driving states to "spend more to get more." It discourages comprehensive reform because it creates " winners and losers" between the states.

The False Promise of "Caregiver" Reforms. The replacement of high cost nursing home coverage with alternative "caregiver" services was extremely popular in the 1980s and early 1990s.[21] Such services include: home health, respite care, home and community based services, assisted living, adult day care, custodial and sub-acute care, adult foster homes, and non-medical residential care.

With nursing home expenditures approaching $50,000 per year for the average person,[22] these other less expensive substitute services promised great savings. But the savings were rarely realized for several reasons.

First, these services aren't cheap. On average, Home Health approaches $40,000[23] and Assisted Living $30,000 per year.[24] The explosion of home health costs was a major problem for Medicaid in the 1990s, just as it has been a major fiscal problem in Medicare.

Second, for significant savings to be realized, persons would have to be moved out of nursing homes to alternative settings without opening up new services to new eligibles. This is extremely difficult to do politically, let alone horrible for the continuity of patient care. The result is that caregiver reform inevitably adds new eligibles and increases costs.

Third, policymakers have run into the problem of "induced demand." Eligibility for government caregiver services is usually based upon the number of assisted daily living functions (ADLs) one needs. ADLs are things like the ability to bathe, feed or clothe one's self. Some 80 percent of all elderly have at least one ADL.[25] Problems with two ADLs are usually needed for Medicaid coverage. 5.7 million of our 7.3 million elderly need a caregiver—but 8 of 10 present caregivers are unpaid.[26] Two thirds of the elderly rely on these unpaid caregivers.[27] By providing new services, Congress can "induce demand" and unleash a tidal wave of new expenditures. Paid professionals would replace all the presently uncompensated caregivers. Those presently at home would flood into the newly available institutions.

V. PROBLEMS WITH MEDICAID'S ELIGIBILITY STRUCTURE

Gaps in Medicaid Eligibility after Welfare Reform. With the passage of Welfare Reform, Medicaid eligibility changed. Prior to 1996, people who received public assistance were eligible for Medicaid.[28] This usually meant Aid for Dependent Children (AFDC) and SSI. Since one was eligible for a certain "category" of assistance, one was "categorically eligible" for Medicaid. As a result, a person didn't directly apply to Medicaid, but entered through some other welfare program. This is why Medicaid is sometimes administered in state welfare departments, not health care agencies.

States also had and have the option of covering "medically needy."[29] They were less poor than the "categorically" eligible and usually had enough money to cover the necessities of life, but did not have enough money for unexpected medical expenses. Richer states usually had broader eligibility and larger benefits packages, compounding the big difference between rich and poor states. Big gaps in coverage were not uncommon.

Consider the anomalies of this type of eligibility structure. Consider who is left out. Medicare covers virtually all those over 65. Medicaid, historically because of AFDC, primarily covers women and children. The group not covered by any government program was essentially men aged 18-65.

AIDS helped to focus public officials' attention on Medicaid's eligibility for this neglected group. HIV infected men aged 18-65 were not covered under any "categorical" government program. But regardless of the AIDS phenomena, there was a structural problem in permitting other programs to drive Medicaid's eligible population. By severing the link to the categorical aid programs, states today have more flexibility to determine who Medicaid serves. There are still certain categories states must cover, but these populations do not constitute the major problem.

States now have more flexibility to determine eligibility. Past categorical and medically needy eligibles remain in the program. States have raised the poverty level for certain categories (i.e. children), or included more of certain categories (pregnant women and children). The impact of the late 1980s federal eligibility mandates are still being felt (see below) and states are wary of substantially employing their new flexibility. Until the structure of Medicaid permits expansion without a cost explosion, there should be little change in eligibility. Efforts at encouraging expansion are wrong headed without a plan to eventually provide private coverage. This may be HIFA's Achilles heel.

Congressional Mandates. As referenced above, a larger problem for Medicaid is the huge expansion of eligible populations because of federal mandates. Medicaid had 10 million recipients in 1967.[30] The number of recipients was fairly constant through the 1980s at about 22 million.[31] In the late 80s, largely due to the relentless efforts of Rep. Henry Waxman (D-CA), Congress increased the number of women and children eligible for medicaid. In 2000 there were 41 million people eligible for Medicaid. This 300 percent

increase outstripped the growth of the nation's population. Moreover, these expansions came at a time of unprecedented economic prosperity. The addition of "dual-eligible" Medicare and Medicaid populations (such as Qualified Medicare Beneficiaries- QMB's) also increased the number of persons covered under the program. Because of the 1996 welfare reform law, these numbers have slightly decreased (but not as drastically as the welfare rolls). Politically, of course, progressive Medicaid eligibility expansion is a backdoor way of moving toward a single payer health care system. But Medicaid mandates are still a huge problem. The federal government should have broad powers to describe program goals and rules, but eligibility determinations should be made by the states.

> The worst eligibility problem is the ability of the middle and even upper class to use Medicaid as their long-term care insurance. Contrary to reasonable expectation, one need not be impoverished to qualify for Medicaid.

Quality of Care Problems. In 2000, there were approximately 41 million people eligible for Medicaid, with 31 million recipients in any given month.[32] Not all eligibles are aware of their eligibility, and many others fluctuate in eligibility as their income changes.

The millions moving off and on Medicaid each year constitutes one of the major quality of care problems for today's Medicaid patients. Medicaid is not like private insurance or Medicare. The enrollee does not necessarily keep the same physician. If he lives in an urban area, he may be assigned to a physician across town and have little access to the necessary transportation. If he lives in a rural area, he may have trouble finding a doctor who treats Medicaid patients. If a managed care company withdraws from the Medicaid program, all patients must change doctors and other providers. It is extremely difficult to establish a doctor-patient relationship when the enrollee moves in and out of the system. It totally disrupts the continuity of care that America's middle class simply takes for granted. It encourages use of high cost emergency rooms because the poor may not know how to access care otherwise. Inappropriate use of emergency rooms is a major cost driver. As long as Medicaid continues to completely shield beneficiaries from the cost consequences of their actions, it will remain so. If this is the record of "federal quality standards," those who seek their retention have the burden of proof.

Undercutting Welfare Reform. In the past, if an enrollee left Medicaid for a job, he risked having no health insurance and those who left welfare often got jobs with a small employer where health insurance was not offered. They would be without health care coverage-except for the hospital emergency room. This adverse incentive also worked in reverse. Historically, there has been a preponderance of AFDC single women with children in Medicaid. There is no incentive for a woman with a child, especially if that child is ill, to move to a private sector job where health insurance is not offered. But leaving work to return to Medicaid undermines welfare reform. The arrangement is bad for the mother, bad for the child, bad for the patient, bad for the employer, bad for the taxpayer, and bad for Medicaid. While recent federal law has improved this situation, it cannot remain unresolved. Perhaps HIFA will help this coordination.

This problem can be addressed by returning Medicaid to the states. Medicaid would be managed in concert with other welfare programs. Medicaid shouldn't "stand alone," but be part of a coordinated approach to move people from welfare to work.

Congress, to its credit, has not completely ignored quality problems in Medicaid. Congress enacted the Programs of All-inclusive Care for the Elderly (PACE) in the Balanced Budget Act of 1997. This program enables a team to manage all health, medical and social services for those over 55 who require a nursing level of care.[33] It mobilizes other preventative, rehabilitative, curative and supportive services when needed. This is a good approach for the chronic elderly, but it doesn't address the needs of the vast majority of Medicaid adults and children. These case management systems would be even more effective in a defined contribution program, as will be demonstrated later.

States also have implemented numerous quality and case management measures to assure correct patient placement and care. Such reforms include: integrating acute and long term care, regulatory quality controls and staff training, case and care management, pre-admission screening, uniform client needs assessment,

gatekeepers, and easing access at a single point of entry.

These measures have improved Medicaid patient care. All the quality and case management programs, however, can't address Medicaid's structural problems that provide patients with second tier quality and no continuum of care.

Middle Class Abuse of Medicaid Long Term Care. The worst eligibility problem is the ability of the middle and even upper classes to use Medicaid as their long-term care insurance. Contrary to reasonable expectation, one need not be impoverished to qualify for Medicaid. In most cases, income and/or asset based qualifications are either nonexistent or easily avoidable with the right lawyer. Indeed, a whole cottage industry exists that teaches seniors how to qualify. This gaming of the system by middle class seniors is grossly unfair to taxpayers.[34] Laws to prevent this have unfortunately not been successful.

Federal and state lawmakers, however, have repeatedly tried to deal with this problem. Consider these efforts:[35] The 1993 Omnibus Budget Reconciliation Act (OBRA) that permitted states to get LTC costs from the deceased estate; the 1996 Health Insurance Portability and Access Act (HIPAA) that tightened transfer of asset loopholes; the 1997 Balanced Budget Act (BBA) that targeted estate planners, tapping insurance values like life, IRA's, MIRAs, and MSAs, changing inheritance taxes, seizing liquid assets or savings, threatening assets unless LTC insurance is purchased, providing tax deductions for LTC insurance (HIPAA); and Public/ Private partnerships permitting retention of greater assets if LTC insurance is purchased. Sadly, none of these attempts have even approached a level of success.

The result of the middle class using this loophole is now painfully obvious. Although Medicaid pays for only one-seventh of all national health expenditures, it pays for almost half of all nursing home costs and two-thirds of all home health costs.[36] By comparison, private insurance covers about one-third of all national health expenditures but only 5 percent of long-term care. And because long-term care is so costly, it represents almost 43 percent[37] of all Medicaid expenditures, but only 9 percent of all recipients use the services.[38] Combine the rapid aging of the population with the fact that those over age 85 are the fastest growing part of our elderly population, not to mention the costliest, and the financial picture for America's taxpayers is bleak.

The result is that by 2030 when the baby boomers are fully retired, Medicaid long-term costs will increase at least fourfold in real dollar terms.[39] This is not only a catastrophe for Medicaid, but also for all other statewide programs that will be crowded out of the state budget.

As a matter of equity, permitting the middle class to abuse Medicaid's long-term care eligibility requirements at the expense of the poor is inexcusable. By continuing this abuse, Medicaid will eventually absorb almost all state revenue. This means that if your primary concern is education, Medicaid must be reformed. If it is highways, Medicaid must be reformed. Reforming Medicaid is a prerequisite for states if they wish to fund any other issue in a generation.

Congress should soon find a way to provide incentives for the middle class to stop hiding their assets and to purchase private long term care insurance.[40] Although somewhat outside the thrust of this paper, all people must begin to buy private LTC insurance if this Medicaid catastrophe is to be avoided. The only way to have people rely on private insurance is twofold: 1) provide a refundable tax credit based on age to all Americans over 18 to purchase LTC insurance, and 2) make it a catastrophic plan with a high but knowable deductible that provides incentives for people not to hide assets because they then can know their exact financial exposure. If this is not done, almost any Medicaid reform may be doomed. It is crucial to self-insure the baby boom generation before it retires. Present nursing home populations may not be insurable, but they could be "carved out" with a grandfather clause funding them. Over time, however, as this population decreases, the LTC insured population will remove the catastrophic fiscal time bomb from the Medicaid program in the private sector.

VI. PROBLEMS WITH MEDICAID'S COST STRUCTURE

Managed Care and the Boren Amendment. Because of the rise of managed care and the repeal of the Boren Amendment in the Balanced Budget Act of 1997, doctors and other providers can no longer easily "cost shift" to private payers to cover the losses incurred by Medicare and Medicaid reimbursement and uncompensated care patients.[41] It has been long known that Medicare and Medicaid reimburse at a rate substantially lower than private pay patients. But the

rise of managed care means that private pay patients are no longer as lucrative and contribute less money to "cost shift". The rise of managed care in Medicare and Medicaid has also reduced reimbursement even more. This too means "safety net" providers must devote scarce resources to managed care. And with the repeal of the Boren Amendment in 1997, states no longer have to pay providers a reasonable payment that should cover their costs.

Government Dependent Providers. Another major problem is that many inner city and rural providers are heavily dependent on Medicare and Medicaid. These providers are exactly those who can least afford to be reimbursed substantially below the cost of their care. This is also troublesome for many inner city and rural hospitals (and clinics) where Medicare and Medicaid make up over 90 percent of all patients. This patient mix is also true of nursing homes, where, in some states industry leaders claim that half of all homes are losing money.

States have tried using Disproportionate Share, Sole Community Provider, and Critical Access and Medicare/Medicaid Dependent designations to increase reimbursement, for some providers. The problem isn't solved by merely shoveling more dollars into the system nor by centrally planning which providers are needed and which should close their doors. The solution is an informed consumer who can choose his care based on quality—not cost or proximity.

Strained State Budgets. The problem facing the states is, that although individual providers may be going broke, the cost of Medicaid as a whole is skyrocketing. The problems of benefits, eligibility and cost come together when policymakers analyze who is getting what services in Medicaid. Aged, blind and disabled patients account for almost three-fourths of all Medicaid expenditures but are only one-fourth of recipients.[42] The reverse is true of other adults and children who account for one-fourth of expenditures but three-fourths of recipients.

So, as doctors and other providers complain about lack of reimbursement, states continue to pursue "cost containment." They have tried reducing reimbursement, fee freezes, prior authorization, drug formularies, generic drugs, rebates, certificate of need, construction moratoriums, and extensive (and flawed) fraud and abuse inquiries. It is not working.

As stated earlier, however, Medicaid has grown from just over $1 billion to $226 billion since its enactment in 1965. At present rates, the roughly 40 million recipients would average just under $6,000 per person in health care. This should be more than enough money to cover costs if one compares Medicaid to the average cost of private health insurance. But Medicaid isn't private health insurance rapidly responding to market forces, it is a centrally planned, defined benefit, welfare entitlement program responding to raw and often incompetent political forces.

Medicaid is not private health insurance rapidly responding to market forces, it is a centrally planned, defined benefit, welfare entitlement program responding to raw and often incompetent political forces.

VII. CONSISTENT WITH WELFARE REFORM, CONGRESS SHOULD RETURN MEDICAID'S ADMINISTRATION TO THE STATES

Distrust of States is an Antiquated Political Position. Along with Medicare, Medicaid was passed in 1965 as a major component of President Lyndon Johnson's "Great Society" legislation. At the time, American's trust in the federal government was at its highest and trust in the "state's rights" was at its lowest. It had been only two years since Martin Luther King's "I Have a Dream" speech, one year since the passage of the Civil Rights Act, and the same year as the Voting Rights Act. In retrospect, it is obvious why Congress designed Medicaid as a joint federal-state program with final and powerful oversight powers in the hands of federal bureaucrats.

In recent years, however, the roles of the federal and state governments have been reversed. The states have returned to their traditional role as "laboratories of democracy." (Consider Wisconsin Gov. Tommy Thompson's bold leadership on welfare reform and school choice.) Welfare reform and block grants of many federal programs have already returned many powers to the states. Yet Medicaid remains the largest and almost only federal-state domestic program to remain in the hands of federal bureaucrats.

If the federal government had shown any interest in solving the structural problems in Medicaid in the last 35 years, perhaps we could trust it to implement a market oriented, consumer choice defined contribution plan. It has not and never will because of The Center for Medicaid Services (CMS) (formerly HCFA).

The Center for Medicaid Services (formerly the Health Care Financing Administration or HCFA): An obstacle to structural reform. CMS (HCFA) is the primary institutional obstacle blocking any consideration of different comprehensive structural reforms. It has shown little interest in helping states obtain the type of research and demonstration waivers (Section 1115) to demonstrate comprehensive structural reform. It is impossible to estimate the reforms the states never even submitted because they know CMS's mindset. Perhaps the HIFA initiative will reverse this bias. But as the failure of Medicare+Choice shows, CMS (HCFA) can kill any threatening reform in its bureaucratic cradle.

There are institutional and cultural reasons for CMS's traditional hostility to change. It must be recalled that HCFA, the powerful regulatory agency that runs Medicare and Medicaid, was created March 9, 1977, early in President Carter's Administration. Proponents of consolidating the Medicare and Medicaid programs envisioned HCFA as the administrative platform for enforcing an anticipated government-run, national health care system. Of course, such a government takeover of the health care system was not enacted, but the agency created to administer it lives on as does its deeply rooted policy bias in favor of a central planning "one size fits all" approach inherited at Medicare's birth from its parent, the Social Security Program. When the programs merged in 1977, this buried Medicaid's more flexible state approach. CMS's institutional culture is one of federal bureaucratic control. Thus, the Great Society politics and healthcare policies of the 1960's remain entombed in CMS. Whatever the rationale for retaining CMS for administration of traditional Medicare, it does not follow that it should retain its power over Medicaid, a very different program with very different problems.

Welfare Reform as a Precedent. For Congress, perhaps the single most important step to improve Medicaid would be to free the program from CMS's control and give the administration of the program totally to the states. There is sound precedent for this policy: Congress has already done it and has turned the administration of welfare programs over to the states. All other policy changes pale in comparison.

Liberal political opposition in Congress and elsewhere will be similar to liberal opposition to welfare reform, and will assume predictable lines of argument. For example, it will be argued that ordinary Americans can trust the federal government to do a better job than their state governments; that the political and health care policy lessons of central planning and price controls of the last 35 years—particularly the inflexibility, the waste and inefficiency—should be ignored. It will also be said that Medicaid, even though it is a welfare program, should be an exception to the successful approach of returning other welfare programs to the states.

Lastly, people will try and use the fear of losing "federal quality standards." What welfare reform proves is that the federal government can mandate broad goals and the states can effectively administer and implement them—with no need for a federal "HCFA." The existing federal quality administration has provided second tier medicine for the poor. It is ludicrous to block comprehensive reform because of the loss of federal oversight. It is precisely federal oversight that is responsible for the very obvious deficiencies seen in Medicaid today.

VIII. WHAT CONGRESS SHOULD DO: MANDATE THE MEDICAID 'PATIENTS FIRST' APPROACH

Congress should forge a new policy that would be compatible with the original vision of the Medicaid program. As explained by John Iglehart, editor of Health Affairs, a prominent health care journal:

> "Medicaid's architects envisioned a program that would provide poor people with mainstream medical care in a fashion similar to that of private insurance. As the decades have passed, that vision has largely faded, and several tiers have emerged. Mainstream medical care is provided to people covered by private insurance or Medicare....poor people continue to rely on providers that make up the nation's medical safety net: public and some private not-for-profit hospitals and clinics...by virtue of their location or social calling provide a disproportionate amount of care to the poor. These providers are increasingly stressed as Medicaid diverts funds to managed care plans."[43]

Simply put, real Medicaid reform would restore the original intent of Medicaid's architects. It would remove the poor from the deteriorating multi-tiered levels of care; it would mainstream them into the same quality of care as private insurance; and it would permit safety net providers to use their limited resources for the populations for which they were intended.

Mandate the Patient First Approach and End CMS's Control Over Medicaid by Returning Administration of the Program to the States. The best way, as noted, to establish a patient choice program in Medicaid is to turn the administration of the program to state authorities with as few federal mandates as possible. Let the states contract directly with private plans, just like the U.S. Office of Personnel Management (OPM), the agency that administers the competing system of private plans that covers members of Congress, Congressional staff, and federal employees and retirees, the Federal Employees Health Benefit Program (FEHBP). Like OPM, the state insurance commissioners would contract with these private plans, enforce basic benefit and insurance requirements, and enforce solvency and consumer protection rules. As many members of Congress know, the consumer choice (defined contribution) model has been successful in the program that covers them, the FEHBP.[44] Historically, cost increases have been less than in the rest of the health care system, and highly satisfied Federal employees have not launched any concerted effort to undermine the program (like recent Congressional HMO "patient rights" legislation would undermine today's employer-based managed care arrangements.) It is time for Congress to build on a success, rather than continue on an old path that has a record of failure.

The Six Elements of Medicaid Reform

Six important elements must be addressed to mandate "patient first" reform and return Medicaid to the states:

1) the federal/state relationship
2) financing
3) plan choice and reimbursement
4) benefits
5) eligibility
6) regulation

The "patients first" approach can deal with each of these, and thus achieve the goal of mainstreaming the nation's poor into a superior system of private health plans.

Element Number 1: The Federal-State Relationship

The crucial decision for Congress is the degree to which they permit state flexibility and employ federal mandates. There are four options and each has different policy and programmatic implications.

1. **No Continued Federal Control or Mandates.** This is the most preferable. After initially mandating the market oriented defined contribution approach, the states would have the freedom to implement and administer the program. The federal government would continue existing levels of FMAP and calculate the individual refundable tax credit amount. The states would be completely free to decide eligibility, coverage, reimbursement and regulatory issues. This, however, would be the least politically feasible. The federal government rarely gives up money without control. A few federal mandates would be expected.
2. **Some Residual Federal Mandates and Requirements.** This is similar to the Welfare Reform Act in which certain federal requirements were passed (i.e. the five year limit on eligibility). This is a more likely political and policy outcome, and it still provides most of the advantages of the "patient first" approach. The issue of federal quality standards is one that may continue. In these cases, a "sunset" provision for federal oversight should be examined—especially if continuation provides a rationale for continued CMS responsibilities. The problem is that Congress may not be ready to move to a definitive and comprehensive proposal (even with residual federal mandates) until tested. State health reform is at the stage where welfare reform was in the late 1980s. It may take interim steps to get there.
3. **Freedom from CMS Approval if "Patient First" is adopted by the state.** This is similar to the Balanced Budget Act of 1997 in which Congress lifted the requirement for 1115 waivers if states implemented mandatory managed care programs. So many states desired this waiver, after time it was inefficient to require each state to apply and get CMS approval. Congress could pass a similar law that gives states the flexibility to enact "patient first" legislation. This approach,

however, would continue the FMAP and CMS oversight—the two most important changes in "patient first." This could permit CMS to "kill the baby in the cradle" as it did "Medicare+Choice." Even this approach may still be too much initially. Congress would probably not permit wholesale transformation to consumer choice until proven in at least one state.

4. **A single state gets 1115 waiver approval.** The least preferable policy, but a more likely political outcome, is the granting of a single or few waivers to test "patient first" in a single state. In theory, this should be easier with the HIFA initiative. After success in one state, the reverse of the above order becomes the path of success. In other words, like welfare reform, health reform may take a decade. The problem is that the incentives for individual choice and market competition are skewed if this route is taken. If you are testing a consumer choice system, the best way to kill it is to relegate it to the bureaucratic control of present providers and bureaucrats who have a vested interest in preserving the status quo. Therefore, this approach, although seemingly reasonable, may be the favored way to scuttle consumer choice reform, especially if the federal government retains the power to mandate continuing reforms. Thus, any new consumer choice waiver should be put directly under the control of the federal HHS Secretary and the state governor's office to try to avoid bureaucratic sabotage.

To reiterate the above, Congress' chosen course of reform will profoundly affect the outcome. The remainder of this paper will demonstrate the differing patient outcomes of this choice.

Element Number 2: Financing

Federal Financial Participation (FFP): Refundable Tax Credits vs. FMAP. Under a new patient-based system, the federal government would pay for Medicaid plan premiums through a federal refundable tax credit to individuals. This credit would be calculated nationally and adjusted for age and poverty level. It would also pay the premiums for an individual catastrophic acute and long-term care policy. The state would pay for all coverage for the eligible poor up to the catastrophic deductible payment. Medicaid eligibles would then choose between competing plans using the tax credits/state payments to purchase a portable individual plan that they own.

This change in financing would have several effects:

- It avoids the FMAP problem by retaining the present level of federal and state contributions in a budget neutral way.
- It would allow rational adjustment in the government contribution. The amount of the contribution could be adjusted by age and poverty level/income.
- It would facilitate better state supervision of the program. Since the states would have the power to determine eligibility, they could easily control the cost of the program.
- It eliminates the link between federal and state spending, thus eliminating the Faustian temptation to "maximize the federal match."

The financial base for a new Medicaid choice program is impressive, and can be adjusted over time on the basis of an equitable formula. The 57 percent federal contribution today is $129 billion and would average about $3,000 per person for plan catastrophic acute and LTC premiums. State contributions totaling $97 billion would have about $2,500 per person to cover the deductibles. (These numbers would change, for example, if present chronic long-term care patients were carved out).

The federal refundable tax credit would be calculated by taking the number of poor to be covered nationally using poverty level and age. The existing federal revenues of $129 billion would be divided among the eligibles. Given the present average federal contribution of $3,000/person nationally, the actual deductible left for states to cover would likely be quite low, say $2,500.

The $3,000 federal contribution would purchase as much catastrophic acute and long-term care coverage as possible. States would then be free to model their consumer choice programs in any way they wish with their contributions. States would determine coverage guidelines, set reimbursement amounts, and approve plans wishing to participate. This is true flexibility.

It is unnecessary to calculate the difference between an individual state's existing federal match dollars and what that state's citizens would receive in aggregate

federal tax credits. First, as federal tax policy, all persons should be treated equally with the precedent being the federal income tax personal deduction. No one calculates the aggregate amount of a state's personal income tax deductions. Regardless of where you reside, your amount remains the same. Second, if you seek to retain current federal match amounts in each state, it would lock in existing disparities of federal support in perpetuity. This is unfair to states such as Mississippi as noted previously. Third, if you begin using other rural-urban, health cost or labor adjustments to "balance" the federal credits, you will replicate all the known unfairness of the Medicare managed care and Prospective Payment reimbursement formulas. Fourth, the state retains complete control over eligibility, coverage and reimbursement. The national credit amount in no way diminishes any state's ability to cover whomever they designate as needy. It is just that those decisions won't be rewarded or punished by a distorting federal match, thereby instituting fiscal responsibility.

If Congress does not enact a refundable tax credit for these beneficiaries, the federal government could still continue making direct payments, but to the plans or individuals as vouchers. In effect, the federal contribution would take the form of a direct subsidy or "premium support" arrangement, for the purchase of private plans, just like the financial arrangement that exists today in the popular and successful FEHBP.

The policy trade is good for the states and federal government. Providing an equal refundable tax credit nationally for all needy is budget neutral for the federal government and calculable in advance of the year's expenditures. By giving the states total administrative control over coverage and eligibility the state has control of its costs. If the state wishes to spend more or less or cover more or less it is up to them. But states would not be able to "increase their match" because the FMAP linkage would no longer exist.

Maximizing Private Sector Participation. Next to returning Medicaid to the states, the ability to maximize the private sector is the most important reform that can be accomplished. There are a very few sources of financing for health care (Medicare, Medicaid, Veteran's Administration, Older Americans Act, Private Insurance, out of pocket, etc.). Although these reforms are not the focus of this paper, states should seek to pass incentives for individuals and employers to purchase private insurance. The National Association of Insurance Commissioners has issued papers describing the type of small market insurance reforms that could benefit the uninsured and small employers. Passing these reforms and coordinating them with HIPAA can solve many portability and access problems. Moreover, these reforms keep persons off Medicaid.

Next to returning Medicaid to the states, the ability to maximize the private sector is the most important reform that can be accomplished.

Public programs that are so attractive as to "crowd out" private insurance will be a disaster. The goal of "consumer choice" legislation should be to make the privatization of risk more attractive than public financing. It is necessary to state the obvious when it comes to health care: the state should be the last resort, not the first, when individuals need coverage.

Substituting Vouchers Calculated on Present State FMAP Amount. If a refundable tax credit is not passed, and Medicaid remains a joint federal-state program for the time being, the FMAP amount usually given to the state could be divided into vouchers for Medicaid eligibles. This would still limit federal taxpayers to the projected budget neutral amount. This would not provide the state with the flexibility to design its program since it would lock in present levels based on its FMAP (rather than a nationally calculated tax credit.) It would favor states with an existing large per capita federal match like New York and disadvantage states like Mississippi.

Using Block Grants or Per Capita Caps Calculated on Present FMAP. This would be the worst scenario since it would lock in present levels of federal spending. It would continue the link between federal and state spending permanently locking in whatever inequities exist between states.

Sliding Scale Support for Other Underserved Populations. For populations that need access to health care similar to today's "medically needy" category, a sliding scale of premium support could be calculated. This would enable certain less poor to afford insurance, without providing a full state subsidy, using the federal poverty level (FPL). Their eligibility could also be time limited, like welfare, so Medicaid can't become more attractive than private insurance.

Element Number 3: Plan Choice and Reimbursement

Medicaid Patients to Choose a Private Health Insurance Plan. Just like enrolling in the Federal Employees Health Benefit Plan (FEHBP), Medicaid patients would pick and choose from competing private plans from a state approved list. The structure would be similar to FEHBP, with some differences to better serve the Medicaid population:

- Plans would be approved by the state insurance commissioner.
- Medical Savings Accounts, Managed Care, Preferred Provider Organizations and traditional fee-for-service plans could all be offered. It would be in a state's interest to maximize competition.
- Mandated benefits should be kept to a minimum. The defined contribution approach, by definition, allows the kind of flexibility to provide different benefits for different medical needs.
- Debit Cards could be used to track patient care and preventative services and deter over utilization. If states mandate certain preventative services, such as yearly check-ups, the debit card could keep track better than a regulatory agency. It would also be a check on fraud and abuse.

Do the Poor Know How to Choose: The Need for an Independent Broker. Studies have shown that Medicaid recipients have the ability to choose their plans if an independent broker is used.[45] This has been successful in both Medicaid Managed Care and the CHIP program. In programs using a broker, companies aren't permitted to market directly to the consumer/potential enrollee. The broker is responsible for enrollment and education. Competing plan's marketing information could be part of the state plan approval process, or negotiated by the broker between the state and company. Use of a broker also ensures the beneficiaries are aware of their various options.

This change also has a profound psychological effect. It would put the patient first by removing the stigma of being on Medicaid, a welfare program. The provider will be dealing with private companies—not the Medicaid bureaucracy. The patient would personally own a policy. It also means that doctors, instead of fleeing from Medicaid, would have increased incentive to participate. This would encourage more appropriate use of the system by beneficiaries so they do not rely, as very poor persons often do, on the emergency room for care. Because the private plan is their own, it also provides the type of continuity of care for the poor that doctors strongly recommend. The availability of Medicaid Savings plans could, for those who want them, help reduce the over utilization that some state Medicaid programs have experienced.

Will the Poor Choose Too Well: The Problem of Adverse Selection. In private insurance markets, some states have implemented community rating or guaranteed issue to guard against adverse selection. To the degree states have used this approach, they have destroyed their private insurance markets. A better way is to handle different populations separately (see eligibility section below). By handling Medicaid, children, uninsured, uninsurables, mental health, long term care, self employed and small employers differently, adverse selection would be discouraged. The use of a broker also helps.

Over Utilization. A major problem with Medicaid programs is the over-utilization of services such as the use of emergency rooms for primary care. Case management and primary care gatekeepers can help. These were described earlier and can be used with a defined contribution approach. The use of debit cards could also help address this issue. Co-pays have been less successful because providers do not like being a fee collector for the state and administering the collection of minor fees may cost more than what is collected. There is also no definitive proof that copays have an effect on Medicaid recipient's utilization, although certain states are trying new methods of limited cost sharing (i.e. Minnesota). A better alternative would be medical savings accounts.

Reimbursement and Safety Net Providers. The states should encourage as many types of plans with differing reimbursement systems to compete. The plans would be free to contract with provider networks. States could mandate that safety net providers would get preferential treatment in getting contracts in provider networks. Disproportionate share, sole community provider, Medicare/Medicaid dependent, and critical access designations need not be ended with Medicaid's reform. Some of the dollars accrued from medical savings accounts could be used for safety net, rural health or other needy parts of the health system.

Element Number 4: Benefits and Coverage

There are four types of alternative benefit packages.

1) no mandated benefits
2) a basic benefit package
3) comprehensive
4) catastrophic

Whatever the choice, federal mandated benefits should be avoided. States should be free to choose the type and variety of benefit packages offered, but should be encouraged to mandate as few as possible. The advantages of the four options are:

- **No Mandated Benefits.** Although mandating benefits is usually to be avoided, we are dealing with a poor population being paid for by the state. This means it is in the state's interest to guard against catastrophic acute and long-term care, and not provide a richer benefit package than the private sector offers. This is a simple matter of fairness to the working population as well.
- **Basic Benefit Packages.** The use of a basic package (like Blue Cross/Blue Shield in the FEHBP) can be helpful, but it raises the risk of "escalating benefits packages" as competing special interests try and legislate broadened coverage. If a state does use a basic benefits package, it must keep it lean so as not to crowd out private insurance. The use of today's Medicaid mandatory benefits package without mandating any present "optional" benefits could be the basic package. Today's optional benefits would be offered in different plans and would be the basis upon which the plans would compete. To reiterate, adverse selection by benefits would be greatly reduced by separating the different populations into different program approaches—something the private sector cannot do.
- **Comprehensive Benefit Packages.** Mandating a comprehensive "one size fits all" benefit package for a diverse Medicaid population is unnecessary and cost prohibitive. Tennessee is the most egregious example of a Medicaid expansion gone awry.
- **Catastrophic Coverage.** The best solution is competing private plans in lieu of state mandated benefits, but with mandated catastrophic acute and long term care coverage. All non-catastrophic benefits would be offered in the different competing plans. States would be responsible for choosing the coverage, benefits, eligibility and reimbursement.

Budget Neutral Reform: Calculating the Premiums

- The amount of state expenditures is a mathematical calculation determined by where catastrophic coverage begins and the number of eligibles defined by the state.
- The dollar amount where catastrophic coverage begins is a federal mathematical calculation of those who are to receive the refundable tax credit and the aggregate amount of federal contributions.
- Acute care coverage would be calculated by age and federal poverty level (FPL).
- Long Term Care (LTC) also begins by calculating by age and FPL, but since LTC premiums remain constant, eventually today's youth will carry the lower premiums into old age. Existing Chronic LTC patients will be handled differently because they may be uninsurable. They could be assigned to the private plans based upon the amount of the plan's market penetration. Another approach would be to have the present LTC population carved out and the present system grandfathered for them. Over time these high cost LTC recipients will be replaced by the lower cost insureds.
- Today's Medicaid program's "statewideness" regulation should be continued by the states or they risk having plans that offer insurance only in non-rural and non-poor areas. This defeats the very purpose of a health program for the poor.
- Catastrophic coverage for the poor is excellent wrap-around coverage for needy Medicare recipients as well.

Auxiliary Advantages. The tax credit policy, combined with catastrophic and long term care requirements, can provide a number of auxiliary advantages. A catastrophic-type approach sets a known deductible that the middle class can insure against or self pay if they need to access Medicaid for LTC. This removes the incentive among middle class Americans to hide assets against LTC policies that are time or payout limited since they will know their exact

financial exposure. In addition, catastrophic coverage is the type of insurance that makes sense for a poor population and the taxpayer. More money might be saved because this program does not have to offer all benefits to all people. Because people choose the benefit plan that suits them best, there should be some actuarial savings. Most importantly, it would replace political forces with market forces in determining which plans and providers survive. Different plans could negotiate with provider groups and manufacturers and get better deals.

The key to the success of a defined contribution approach for Medicaid is to understand and treat the different potentially eligible populations according to their needs. This is the exact opposite of the "one size fits all" mini-Clinton care plans in some states in the early 90s.

Element Number 5: Eligibility

The key to the success of a defined contribution approach for Medicaid is to understand and treat the different potentially eligible populations according to their needs. This is the exact opposite of the "one size fits all" mini-Clinton care plans in some states in the early 90s. Many of the following groups should not be included in this Medicaid "patients first" program. They are mentioned here because opponents of a consumer choice approach often use the groups to defeat the proposal. If proponents don't have an answer on how to handle these "exceptions" they may lose the debate.

*(Those with * are the traditional Medicaid populations).*

- Non-elderly Poor Adults and Children*: This is the target group for "patient first" and constitutes almost 3/4ths of today's Medicaid population. Present Medicaid costs are low, perhaps $1,000/ year per adult and $500/ year for children so the state monthly costs can be low.
- Elderly Poor*: They would be eligible, but they also have Medicare. The catastrophic acute and long term coverage is an excellent "wrap around" for poor elderly.
- Uninsured Children *(CHIP population): It makes no sense to continue a separate CHIP program, but because the federal match is "enhanced" until 2007, it may not be politically possible to eliminate it. As long as this program exists, private insurance plans will be "crowded out" of the market. The incentives need to be reversed. Proper reform should provide employers incentives to include children's coverage. But no public program should seek to treat uninsured parents and children separately, but as a family (something CHIP doesn't specifically do.) If they are to have access to medical assistance, it should be on a sliding premium scale, adjusted by parent's income. This could be part of "patients first" or a separate program.
- Uninsured. This is the classic population that needs incentives to return to the private, not public sector. Their primary problem is usually access—not affordability. Consequently, the solution should not be found in a poverty program like Medicaid. There are eight things that should be done: 1) small group market reforms, 2) assuring Medicaid benefits are not richer than in the private sector, 3) time limiting the access to any Medicaid program, 4) having a premium structure or sliding income scale that is higher than the "patient first" population, 5) using a broker to assure proper program and case management, 6) using a broker to assure proper use of HIPAA, 7) establishing buying co-operatives/pools (though previous efforts have had mixed results) and 8) banning anyone from state assistance that has access to private insurance and refuses to take it. (This could entail signing waivers permitting greater access to their income or assets if a person chooses to go without coverage.) All, or a combination of these, could greatly reduce the uninsured. The worst possible alternative is to permit them unlimited access to a rich Medicaid benefits package at a minimal cost when they could be covered by private insurance. Given that the information economy means that employer-based health insurance is becoming an anachronism, the ultimate solution for the American health care system is an affordable and portable individual insurance policy, not inclusion in a taxpayer supported assistance plan.
- Self-employed. These people have many of the same problems as the uninsured. Since insurers

experience much greater costs to market to individuals than groups, prices can be prohibitive. Many of the items in the above "uninsured section" can help. The real solution is for the federal government to raise the amount of the health care tax deduction for self-employed to the same level as employers covering their employees—100%.

- Working Poor. Unlike the above two populations, the working poor share something with the traditional Medicaid eligibles: poverty. As such, they could be treated similarly as today's "medically needy" on a sliding income scale and included in "patients first" (especially if time limited) is a possibility. Again, small market reform would be better.
- Small Employers. The best thing small employers could do is to pick up the premiums as Medicaid recipients emerge into the workforce. Their present tax deduction would still apply. This would guarantee portability and continuity of care. As to the problem of securing affordable health care for their other employees, any government support must be done in a way that does not crowd out other private insurance, and must be, for a time, done in a limited and transitional way. By permitting access to Medicaid's rich benefit package, adverse selection by working poor and non-poor would guarantee "crowding out".
- Chronic and/or Severe Illness *(those with additional social service needs in addition to health needs.) These people are generally the fewest in number, highest in cost, and in most need of individualized and specialized services (both health and social.) They are often institutionalized in nursing homes or mental health facilities. In many cases there is no hope of recovery. They are, therefore, the most difficult populations to fit in a traditional insurance model. Although some states have used a separate managed care per capita payment to insurers, it may be better to use separate high risk pools to service their needs. If this proves unworkable, patients could be randomly assigned to all participating companies based upon their market penetration. For some specialized populations, a block grant/pass through that grandfathers the present funding mechanism may be the only solution. There is little consensus on what works best, so this may be an area for state experimentation—mandating only that a program exist that meets these people's needs.
- Uninsurable: The first determination must be if they are truly uninsurable. An uninsurable individual is someone who is turned down for private health insurance because they are currently very ill or undergoing costly treatment. Approximately 1-2 percent of the general population falls into this category. In some states, the laws are so lax that private companies have every incentive to dump persons on the states as uninsurable. (Tennessee has more uninsurables than the 27 states with uninsurable high risk pools combined. California has 1/5th as many as Tennessee with 6 times the population.) Case management, use of a broker, coordination with HIPAA, and small market reform all can help to ensure the population is truly uninsurable. For those truly uninsurable, the state would establish a high risk pool that would: 1) have premiums from 125% to 200% of the regular Medicaid calculated benefit, 2) have a lifetime limit ($500,000-1,000,000), and 3) have a waiting period (90 days-one year). The limits in parentheses above are extrapolated from the existing 27 state programs.
- Long Term Care*. Those who need chronic nursing home services should be treated like the chronic/severe category above. Those temporarily using LTC services could be in the "patients first" program. LTC reform is broader than merely Medicaid. The ultimate solution is to get people to purchase private LTC insurance. Then the present chronic population would slowly go away. This must be done before 2010 when the baby boom retires—or state LTC expenditures will quadruple by 2020.
- Blind and Disabled*: These are presently part of Medicaid's population. Given proper case management, some might be able to be placed in the high risk pool, some in "patients first" and some in the pass—through, like chronic long term care. It isn't possible to calculate the financial consequences until this is done. A broker could help direct to the proper program.
- Behavioral/Mental Health*: While only 0.1% of the Medicaid population, they constitute some of the highest costs. Usually Medicaid just passes federal funds to the state mental health bureau. Some would question if this population should be

part of Medicaid to begin with. Given that their health and social needs are so specialized, and the population is almost assuredly uninsurable, a block grant/ voucher/pass through, or even a separate federal program for funding, should be considered.

Element Number 6: Regulation

Traditional Regulation. In a defined benefits plan, regulation focuses on cost containment, reimbursement restraint and fraud and abuse. Among the best-known attempts have been certificate of need (CON), restrictions on beds, wage and price controls, prior authorization, rebates, formularies, and cost reports. All of these systems need not be employed with a defined contribution program. If individual plans did choose to employ these cost containment measures, the enrollees must be told about them before they chose the plan.

New Regulatory System. The focus would be on four major regulatory elements: 1) plan certification, 2) provider quality assurance, 3) patient satisfaction, information and appeal rights, and 4) fraud and abuse. The primary focus would be on providing quality benefits. The worry about lack of federal quality controls is overblown; states do much of this today. Insurance is a state regulated industry and "patient first" is primarily an insurance, not an entitlement, model. In addition, in a defined contribution approach, quality and patient satisfaction are crucial: they are the variables. To make informed choices, quality and patient satisfaction data would be part of the choice process. This regulatory plan reverses the incentives. In today's system, providers and regulatory bureaucrats are rewarded for keeping costs low, but in "patients first" they would be rewarded for keeping quality high.

IX. WHAT GOVERNORS AND STATE LEGISLATORS SHOULD DO IF CONGRESS FAILS TO ACT

Use the 1115 Waiver Process with the HIFA initiative. If Congress is unwilling or unable to reform the Medicaid program, then state officials should take the lead. They can accomplish on health care reform what Governor Tommy Thompson accomplished on welfare reform. State officials could apply to CMS for a section 1115 waiver to implement much of the reform program outlined here. The major difference would be that the Medicaid program would not be fully under the control of the state, and Congress wouldn't have enacted, or the President signed, the refundable tax credit for low income people. If CMS blocked innovative attempts to expand and improve health insurance coverage for low-income people, the very conflict itself would raise the profile of state officials and help them frame a new national health care debate on their own terms. Using the new HIFA initiative should help in this process.

For state officials, there are tremendous opportunities to help millions of Americans and improve the quality of America's health care financing and delivery systems. Fifty-six state and territorial programs could be turned into "laboratories of health reform," trying different variations for the five-year length of the Medicaid waiver. It would provide markets large enough to test and refine a real consumer choice approach. Of course, securing a federal tax credit for this purpose would be ideal. But the state could, under the waiver approach, use Medicaid funds the state presently gets from the federal government. And since a waiver necessitates CMS's approval only, political roadblocks in Congress would not stymie innovative state officials.

There are some restrictions on the use of the Medicaid waiver. But essentially a state can change all benefits in eligibility and reimbursement rules with a few exceptions. If CMS officials can overcome their institutional bias against consumer choice reforms that rely on private sector alternatives, and can be convinced of the value of the research project, and states ensure budget neutrality to the federal government, the Medicaid waiver could be granted. The consumer-based model, as opposed to the regulatory models that CMS has supported in places like Tennessee and elsewhere, is certainly worthy of serious research. And because it is a defined contribution program, budget neutrality can be assured.

Overcome Internal Opposition. As with welfare reform and other serious government reforms, the chief threat to the success of an innovative governor won't necessarily be the federal government, but rather his/her own state bureaucracy. The reason is obvious: If such an approach were successful, there would be little reason to keep the present state (or federal) Medicaid bureaucracy. Every faction in the state with a vested interest in keeping the welfare entitlement program will be out of a job. So, the problem for reform-minded governors is a problem of personnel management as well as project management. While every effort should be made to encourage the cooperation of the state

career civil service in developing and implementing such a reform program, the high stakes may require that the governor and his appointees take direct managerial control of the effort. Therefore, it might be prudent to establish an independent organization to administer this program, or alternatively, have the consumer choice program director and his team report directly to the governor.

X. CONCLUSION

Federal and state officials can put the patient first while dramatically improving the Medicaid program. They can rapidly reform the widely different 56 state and territorial Medicaid programs from a hindrance into a vibrant, superior system of consumer-based private health insurance plans.

Real reform would end CMS control and change the system from a 1960s—style "defined benefits" welfare entitlement to a defined contribution program, putting a premium on choice, competition, and consumer information. It would enable doctors and other providers to get more appropriate levels of reimbursement, while making government expenditures predictable and controlled. The focus would change from cost containment and intrusive regulation to quality assurance and patient satisfaction. It would also end the era of unfunded federal Medicaid mandates by returning the program to the states.

If federal and state officials pursue such a reform policy, they can improve patient care by making the plans portable. They can also help small employers obtain health insurance for their employees, and they can create a large and steady market for insurance companies without changing the way they market their insurance products.

Most importantly, federal and state policymakers can return Medicaid to the original vision of its architects. They can give Medicaid recipients the same continuity of high quality medical care that the vast majority of Americans get today through private health insurance arrangements. They can liberate an entire class of Americans from what is today a health care "ghetto." It is as simple as this: design the system by putting "patients first."

ENDNOTES

1 John K. Iglehart, "The American Health System—Medicaid", The New England Journal of Medicine, Feb. 4, 1999, pp.403-408. Wilbur Cohen was the architect of President Franklin Roosevelt's Social Security System in 1935-36. He subsequently served in a similar position for President Lyndon Johnson when Medicare and Medicaid were developed. He also was LBJ's last Secretary of Health Education and Welfare in 1968.

2 http://www.cbo.gov/showdoc.cfm?index=1821&sequence=0&from=7#t5. This estimate assumes that the federal government will retain the historical 57% of total Medicaid spending

3 This is due to the very complex issue of the Federal Medical Assistance Percentage- or FMAP and its fiscal repercussions on individual states.

4 Carrie J. Gavora, "Medicare Minus Choice", Heritage Foundation Backgrounder, No. 1218, September 1,1998, pp4-5

5 http://www.cbo.gov/showdoc.cfm?index=1821&sequence=0&from=7#t5.

6 http://www.hcfa.gov/pubforms/actuary/ormedmed/default4.htm

7 Iglehart, "The American Health Care System", pp. 403-408

8 "Program Spending Second Largest Expense for 2000 State Budgets, NGA Says", BNA Health Care Policy, Jan. 10,2000, p. 84

9 Rep. Jim McCrery, op. cit.

10 John Holahan, Joshua Wiener and Susan Wallin, "Health Policy for the Low-Income Population: Major Findings from the Assessing the New Federalism Case Studies", The Urban Institute, Occasional Paper Number 18, Nov.1998, pp 29-30

11 Before the enactment of the Balanced Budget Act of 1997, state officials had to seek waivers from HCFA to contract with managed care companies and enroll Medicaid recipients on a voluntary basis. With the BBA, states could, under certain specified conditions, enroll Medicaid patients in managed care plans without a HCFA waiver.

12 Robert Pear, "Clinton to Chide States for Failing to Cover Children", New York Times, Aug.8, 1999, p.1

13 Ibid.

14 Dan Balz and David Broder, "Clinton Optimistic on Budget Accord", The Washington Post, Aug.9, 1999, p. A3

15 www.hcfa.gov/medicare/ormedmed.htm op.cit.

16 Ibid.

17 http://www.hcfa.gov/pubforms/actuary/ormedmed/default4.htm

18 www.hcfa.gov/medicaid/map0597.htm Growth Rates by Total Computable of Medical Assistance

19 www.hcfa.gov/medicaid/map0597.htm Medicaid Recipients by Maintenance Assistance Status and by state

20 Ibid.

21 Holahan, Wiener and Wallin, "Health Policy for Low-Income Population", pp.48-49

22 Personal telephone interview Mike Hogan, researcher, The American Health Care Association, Sept. 15,1999

23 Ibid.

24 Ibid.

25 Congressional Research Service, "Long Term Care for the Elderly", Publication IB95039, Nov.2, 1998, p. CRS2

26 Ibid.

27 Ibid.

28 www.hcfa.gov/medicare/ormedmed op.cit.

29 Ibid.

30 www.hcfa.gov/stats/hstats96/stathili.htm. HCFA Statistics: Highlights

31 Ibid.

32 Personal telephone interview with Mary Hogan, Director, Data & Systems Group, Center for Medicaid and State Operations, HCFA, Dec 15,1999

33 www.hcfa.gov/pace/pacegen.htm. The Pace Program

34 Steven Moses, "LTC Choice", Center for Long-Term Care Financing. Bellevue, Washington. Sept. 1, 1998, p. 17

35 Holahan, Wiener and Wallin,"Health Policy for Low-Income Population", pp 49-50

36 www.hcfa.gov/stats/nhe-oact/tables/chart.htm. Medicaid Charts

37 www.hcfa.gov/medicaid/2082-5.htm. Medicaid Vendor Payments by Type of Service

38 www.hcfa.gov/medicaid/2082-4.htm. Medicaid Recipients by type of Service

39 Jane Marie Mulvey and Barbara Stucki, "Who will pay for the Baby Boomers' Long-Term Care Needs?" American Council of Life Insurance", April, 1998, p. 1

40 http://www.heritage.org/library/lecture/hl658.html. Robert E. Moffit, Richard Teske, and Stephen Moses, "How to Cope with the Coming Crisis in Long-Term Care" (Heritage Lecture #658. Released April 27, 2000. Delivered December 7, 1999)

41 Under the Boren Amendment, the several states were required to reimburse doctors and hospitals at rates that were "reasonable and adequate". Naturally, one of the consequences of the language of the law was a series of lawsuits by doctors and hospitals against the states on reimbursement. This, of course, also contributed to the costs of the Medicaid program.

42 www.hcfa.gov/medicaid/2082-3.

43 Iglehart, "The American Health Care System", pp.403-408

44 Carrie J. Gavora, "Medicare Minus Choice", Heritage Foundation Backgrounder, No. 1218, Sept.1, 1998, pp.4-5

45 Irene Fraser, Elizabeth Chait and Cindy Brach, "Promoting Choice: Lessons from Managed Medicaid," Health Affairs, September/October 1998, pp. 165-174

ABOUT THE AUTHOR

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

American Legislative Exchange Council

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News *Release*

AMERICAN LEGISLATIVE EXCHANGE COUNCIL

FOR IMMEDIATE RELEASE
Wednesday, October 26, 2005

FOR MORE INFORMATION CONTACT:
Stella Harrison Melley (202) 431-6461

MEDIA ADVISORY

U.S. Senate to Hold Medicaid Hearing in Charleston, South Carolina

ALEC Member Representative Tracy Edge to Testify

WHAT: **Hearing: "Medicaid: Creative Improvements from the Field"**
U.S. Senate Committee on Homeland Security and Governmental Affairs
Subcommittee on Federal Financial Management, Government Information, and International Security

WHO: **ALEC member State Representative Tracy Edge (SC)**, Chairman, South Carolina House Ways & Means Subcommittee on Health, Human Services, and Medicaid; South Carolina Governor Mark Sanford; and South Carolina Board of Medical Examiners Member Donald Tice, among others.

WHEN: **Friday, October 28, 2005, 10:00 a.m.**

WHERE: **College of Charleston's Wachovia Auditorium** (ground floor of the School of Business and Economics), **5 Liberty Street, Charleston, SC.**

COLUMBIA – South Carolina Representative **Tracy Edge**, a member of the American Legislative Exchange Council, will testify at a U.S. Senate hearing entitled "Medicaid: Creative Improvements from the Field." The hearing will take place on Friday, October 28, at 10:00 a.m. in the College of Charleston's Wachovia Auditorium at 5 Liberty Street.

Edge will testify in support of South Carolina Governor Mark Sanford's Medicaid waiver proposal. Other witnesses include **Governor Sanford**, South Carolina Board of Medical Examiners Member **Donald Tice**, South Carolina Policy Council President **Ed McMullen**, and Harvard Business School Professor **Regina Herzlinger**.

The hearing will be led by **U.S. Senator Tom Coburn** (R-Okla.), who is chairman of the Senate Federal Financial Management, Government Information, and International Security Subcommittee of the Senate Committee on Homeland Security and Government Affairs.

For more information or to schedule an interview with ALEC member Representative Tracy Edge (SC), or ALEC's Heath & Human Services Task Force Director Christie Raniszewski Herrera, please contact Stella H. Melley at (202) 431-6461.

Media is invited to attend the event, and RSVPs are encouraged by e-mailing sharrison@alec.org or by calling (202) 431-6461.

# # #

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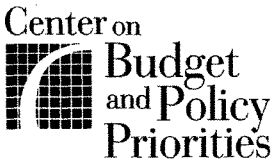

820 First Street NE, Suite 510
Washington, DC 20002

Tel: 202-408-1080
Fax: 202-408-1056

center@cbpp.org
www.cbpp.org

TESTIMONY OF JUDITH SOLOMON
SENIOR FELLOW, CENTER ON BUDGET AND POLICY PRIORITIES

U.S. SENATE COMMITTEE ON HOMELAND SECURITY
AND GOVERNMENTAL AFFAIRS
SUBCOMMITTEE ON FEDERAL FINANCIAL MANAGEMENT,
GOVERNMENT INFORMATION AND INTERNATIONAL SECURITY

Charleston, South Carolina
October 28, 2005

My name is Judith Solomon. I am a Senior Fellow at the Center on Budget and Policy Priorities. The Center is a non-profit policy institute in Washington that specializes in fiscal policy and in programs and policies affecting low- and moderate-income families. The Center does not hold (and never has received) a grant or contract from any federal agency.

I would like to thank the Chairman and the Ranking Member, Senator Carper, for giving me the opportunity to testify today and raise our significant concerns about the South Carolina Medicaid waiver proposal.

The Medicaid program is extremely important to South Carolina. It covers over 40 percent of all children in the state as well as 30 percent of all seniors, and it pays for half of all births. Medicaid provides important support for hospitals, nursing homes, and other health care providers in South Carolina. Except for some children and pregnant women, Medicaid beneficiaries in the state all have income at or below the poverty line. Medicaid provides a lifeline for low-income and vulnerable seniors, children, and people with disabilities.

While it is true that the cost of providing coverage to Medicaid beneficiaries is rising, the cost of providing health care to everyone is going up. Solutions to contain the costs of South Carolina's Medicaid program must be grounded on hard evidence to ensure that changes do not harm the hundreds of thousands of South Carolina residents who rely on Medicaid for essential health care services.

A sound proposal for reducing Medicaid costs would be tailored to the different populations served by the program as well as the characteristics of the state's health care delivery system. Rhetoric regarding consumer choice and empowerment is not enough to justify untested models of

providing care such as the personal health accounts proposed for South Carolina. In evaluating proposals to apply models such as health savings accounts to Medicaid, the fact that the vast majority of Medicaid beneficiaries have incomes below the poverty line must be taken into account. They simply do not have resources available to pay for health care out of their own resources. A substantial body of research demonstrates that even modest cost-sharing significantly increases the likelihood that low-income children and adults will not receive effective medical care and that making low-income Medicaid beneficiaries incur increased cost-sharing can endanger their health.

The South Carolina proposal is based on a series of faulty assumptions about Medicaid — that it costs more than private insurance, that it encourages people to use more health services than they need, and that Medicaid is administratively inefficient — that are demonstrably incorrect. While the state apparently believes that it can save money by replacing a public health insurance program with private programs, the evidence suggests that the state's proposal would increase the costs of providing health care to covered beneficiaries rather than reduce those costs. The waiver proposal does not include the beneficiaries or services that represent the lion's share of Medicaid expenditures, focusing instead on those whose care is already relatively inexpensive. Moreover, methods of risk adjustment used to determine rates for managed care programs cannot be used to predict the amount of money an individual will need to pay for health care costs.

Summary of the South Carolina Proposal

Under the South Carolina proposal, each Medicaid beneficiary would receive a capped personal health account to use to purchase health coverage. The state would deposit funds in an individual's account each quarter.[1] The amount of the deposits would depend on the individual's age, sex, eligibility category, and (in some cases) health status.

Individuals could use their personal health accounts in one of four ways:

- ***Self-directed care***: For individuals who choose this option, an amount would be deducted from their personal account to cover inpatient hospital care and "related" services; these individuals would purchase all other necessary health care services directly from providers at Medicaid fee-for-service rates with the funds remaining in their personal account. When the funds in the account were exhausted, these individuals would have to purchase any other needed health care services with their own money.

- ***Private insurance***: Individuals who choose this option would use the funds in their personal accounts to purchase coverage from private managed care organizations or other insurance companies and from pharmacy or dental plans. Any remaining funds in the personal accounts could be used for co-payments and deductibles, as well as for health care services not covered by the plan.

- ***Medical home networks***: Under this option, individuals would use their entire personal accounts to join medical home networks, which are groups of health care providers that would be organized to serve the state's Medicaid beneficiaries. Each beneficiary would be assigned to a primary care provider, who would be responsible for authorizing any needed services that the

[1] Balances in the account at the end of a quarter would roll over to the next quarter within a benefit year. According to the original waiver proposal, a portion of unexpended funds *may* be allowed to roll over to the following year.

primary care provider could not supply. Like the private insurers in the option above, the medical home networks would be allowed to provide a more limited package of benefits than is currently offered by the state's Medicaid program.

- ***Group health insurance:*** Individuals who have access to group health insurance through an employer could use their personal health accounts to help pay for the employee share of the premium. Individuals and families who choose this option would be subject to cost-sharing charges and benefit limits of the private plan, so children would not receive all the services guaranteed by the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program. Under EPSDT, children receive regular preventive health care and all necessary follow-up diagnostic and treatment services without any limitations, including services that may not otherwise be covered by a state's Medicaid program for adults.

Research Shows that Medicaid is an Efficient and Effective Program that is Less Costly than Private Coverage.

Medicaid provides comparable services at less cost than private insurance. A recent 13-state study contradicts the notion that Medicaid beneficiaries use more health care than they need, finding instead that adult Medicaid beneficiaries use about the same level of health care services as adults with private insurance.[2] A study of mothers in low-income families found similar results.[3] Among children, Medicaid has been found to provide better access to preventive services for children than private health insurance does; this is a desirable outcome that likely reflects the success of Medicaid in facilitating preventive services for children.[4]

Moreover, Medicaid is not costlier than private health insurance. A recent study by Urban Institute researchers for the Kaiser Family Foundation found that Medicaid's cost per beneficiary is lower than that of private insurance.[5] A separate study by Urban Institute researchers finds that Medicaid's per-beneficiary costs have been rising more slowly than those of private insurance in recent years.[6]

Most Beneficiaries Included in the South Carolina Waiver Proposal are Children and Parents Who Account for Only a Third of Medicaid Expenditures.

In South Carolina, 79 percent of Medicaid beneficiaries are children, parents with income below 50 percent of the poverty line, and pregnant women. The cost of providing Medicaid to these

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[2] Teresa Coughlin, Sharon Long and Yu-Chu Shen, "Assessing Access to Care Under Medicaid: Evidence for the Nation and Thirteen States," *Health Affairs*, 24(4):1073-1083, July/August 2005.

[3] Sharon K. Long, Teresa Coughlin and Jennifer King, "How Well Does Medicaid Work in Improving Access to Care?" *Health Services Research*, 40(1): 39-58, February 2005.

[4] Lisa Dubay and Genevieve M. Kenney, "Health Care Access and Use Among Low-income Children: Who Fares Best?" *Health Affairs* 20(1): 112-21, January/February 2001.

[5] Jack Hadley and John Holahan, "Is Health Care Spending Higher under Medicaid or Private Insurance?" *Inquiry*, 40 (2003/2004): 323-42.

[6] John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs* web exclusive, January 26, 2005

beneficiaries, who represent the vast majority of individuals in the program, constitutes just over one-third of the Medicaid program's cost.

Not surprisingly, the cost of providing long-term care services and other Medicaid services to seniors and people with disabilities who are eligible for Medicare and Medicaid — often called "duals" — accounts for about 40 percent of Medicaid spending in South Carolina. However, these individuals are not covered by the waiver proposal, and no changes would be made in how their care is managed or delivered. Overall, the waiver proposal would only encompass about 40 percent of what the state spends on Medicaid.

Given that the proposal mainly focuses on care provided to children and non-disabled adults, it is hard to see how the proposal would save money. The most recent national data on Medicaid expenditures from 2002 shows that the per person cost of Medicaid in South Carolina is just over $1,700 per year for both children and non-disabled adults under the age of 65. Even though the cost of providing Medicaid coverage to children and adults has increased somewhat during the last three years, Medicaid coverage still costs considerably less than care in the private market, where this year's average annual premium for employer coverage for an individual is just over $4,000 with family coverage costing almost $11,000 per year.[7]

Providing Medicaid beneficiaries covered by the waiver with "medical homes" may save some money and could increase quality and improve health outcomes. However, no waiver is needed to accomplish this, and in fact the state is already working on the laudable goal of increasing the number of medical homes for beneficiaries.

The South Carolina Waiver Would Substantially Increase the Administrative Costs of the State's Medicaid Program.

The latest draft of the waiver proposal notes that the new program is intended to limit unnecessary administrative costs, stating that nationally "over twenty cents of each healthcare dollar is spent on administration." Yet administrative costs for the Medicaid program average only 6.9 percent of total program costs. South Carolina does a particularly good job of keeping its administrative costs down. The state recently reported that its administrative costs were only 4.6 percent of total program costs,[8] well below the national average, and in 2004 the state's Medicaid expenditures grew substantially more slowly than the national average (5.8 percent versus 9.3 percent).

According to the most recent draft of the waiver proposal, the state would contract with:

- A vendor to develop and manage electronic cards for the personal health accounts;
- An enrollment broker to provide information and support to beneficiaries about their various choices;
- Managed care plans;
- Administrative service organizations to oversee the medical home networks;
- A dental benefits manager; and

[7] "Employer Health Survey: 2005 Summary of Findings," (Menlo Park, CA: Kaiser Family Foundation and Health Research and Education Trust).

[8] Medicaid and SCHIP Budget Estimates, Forms CMS-37 and CMS-21B, May 2005 submission.

- A transportation broker.

Every one of these new entities would have its own administrative structure. In addition, the state would have to provide funds to start up and administer the new option to allow beneficiaries to use their personal health account to contribute toward the cost of employer-sponsored insurance. A recent review of similar programs in five states found that they only achieved savings if enrollment was high enough so that savings covered start-up and administrative costs. However, in most states enrollment was not high. Enrollment in the five programs that were examined ranged from 73 in Utah to 10,564 in Oregon.[9] To date, South Carolina has presented no information regarding its estimates of the numbers of families in Medicaid with access to employer sponsored coverage, so it is impossible to know whether the enrollment would offset the new costs.

A proposal to allow ten states to establish Health Opportunity Accounts for some Medicaid beneficiaries is included in the House Energy and Commerce Committee's reconciliation legislation. The proposal has some similarities to the personal health accounts proposed by South Carolina. The Congressional Budget Office has found that allowing these accounts would actually add to both state and federal Medicaid costs.[10]

With all the new costs that South Carolina would incur to implement its proposal, the historically low administrative costs of the South Carolina Medicaid program actually could increase substantially, taking away resources needed to provide health care services to beneficiaries and putting further pressure on already low provider payment rates.

South Carolina Does Not Have Enough Managed Care Plans or Medical Home Networks to Enroll Beneficiaries in All Parts of the State.

The South Carolina proposal is being touted as providing new choices for beneficiaries. It is claimed that new managed care plans will compete for enrollees. These assertions are made even though South Carolina lacks sufficient private insurers to handle the many Medicaid beneficiaries who would be directed into the private insurance or medical home network options. Looking at the state as a whole, *only 6.1 percent* of all South Carolina residents were enrolled in health maintenance organizations in 2004.[11] For Medicaid, South Carolina ranks 47th in the nation in managed care participation:

- Only 8.4 percent of South Carolina Medicaid beneficiaries are currently enrolled in Medicaid managed care plans.[12]

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[9] Joan Alker, "Premium Assistance Programs: How Are they Financed and Do States Save Money?" (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, October 2005).

[10] See Edwin Park and Judith Solomon, "Health Opportunity Accounts for Low-Income Medicaid Beneficiaries: A Risky Approach," (Washington, DC: Center on Budget and Policy Priorities, October 2005).

[11] Managed Care Penetration by State and Region, 2004 from InterStudy Competitive Edge: Managed Care Industry Report Fall 2004 at *http://www.mcareol.com/factshts/factstat.htm.*

[12] Centers for Medicare and Medicaid Services, "Medicaid Managed Care Penetration Rates as of December 31, 2004," available at http://www.cms.hhs.gov/medicaid/managedcare/mmcpr04.pdf.

- There are only two Medicaid managed care plans in the state, and these plans currently cover just 28 of the state's 46 counties.[13]

- Adults with disabilities and children with special health care needs are not currently enrolled in managed care at all in South Carolina.

- South Carolina has only just begun to develop medical home networks.

Given the very low rate of managed care participation in South Carolina, the state's health care delivery system is not likely to be able to meet the needs of the many Medicaid beneficiaries who would choose (or be required to enroll in) private insurance or medical home networks.

In recognition of this problem, the South Carolina waiver proposal relies on the hypothesis that during the waiver period, "market forces will result in development of a number of as yet un-designed health plans to be offered to members." This rosy scenario — that a sufficient number of new private health plans will somehow arise to compete for Medicaid customers in an extremely short timeframe in a state with extremely low managed care participation — is not justified by the current marketplace for health care in the state.

Risk Adjustment Cannot Predict an Individual's Need for Health Care Services.

A fundamental question regarding South Carolina's proposal is whether the state would deposit sufficient funds in each beneficiary's personal health account to enable the beneficiary to purchase necessary health care services. The state says it would determine the amount of funding for each account through a process known as "risk adjustment." An individual's need for health care is inherently unpredictable, however, and no system of risk adjustment has ever been developed that can accurately predict what a specific individual will need for health care from one year to the next.

Under the South Carolina proposal, the state would begin by assigning each Medicaid beneficiary a "rate category" based on his or her age, sex, eligibility category, and (in some instances) health status. For each rate category, the state then would determine the *average* amount that Medicaid spent on beneficiaries in that category in a base year. That average amount, adjusted upward to reflect the increase in health care costs since the base year, would be deposited in the personal health account of each person in the rate category.

This process is similar to the way that states set per capita payments for their Medicaid managed care programs. Risk adjustment works relatively well in the managed care context because each plan enrolls a mix of individuals: while some individuals will cost the company more than the amount that it receives from the state to cover them, other individuals will cost the company less than that amount. Thus, if the plan receives a flat payment per person that represents average costs over all of its enrollees, the plan will come out behind on some people and ahead on others — and be able to cover its costs overall.

[13] According to the original waiver proposal, expansion of managed care into three additional counties is awaiting approval.

But using risk adjustment for personal health accounts, as South Carolina proposes, is very different. Since each account covers *only a single individual,* account funds *cannot* be shifted from people with relatively low health costs to people who turn out to have relatively high health costs. As a result, *some people will likely use up the money in their accounts and be unable to afford health care services that they need,* while at the same time, other people may have leftover funds in their account that they do not need. Because managed care plans can vary the benefit packages they offer as well as the premium an individual needs to join, even those choosing to enroll in a health plan may not have enough money to purchase the care they need.

South Carolina claims it will take individuals' health status into account when assigning them to rate categories. Yet this often will not be possible: many individuals will not have been on Medicaid long enough for the state to obtain a history of their usage of health care services.[14] Even when the state can determine an individual's health care needs, the accounts still will be insufficient for people whose costs are above average for those in their rate category. Furthermore, over the course of a year, some people who have used relatively few health care services in the past will become ill with chronic diseases such as cancer, heart disease, or diabetes; as a result, their health accounts will be too small to pay for the health care they now need.

Conclusion

The South Carolina proposal rests on giving new choices to beneficiaries, but what kinds of choices do Medicaid beneficiaries really want? While it does not appear that beneficiaries in South Carolina have been asked, a recent analysis of survey data helps answer the question. These survey results showed that having a choice of *providers* matters more to people than having a choice of *health plans.*[15] Efforts to increase the number of individuals with medical homes, efforts to increase provider participation, and better coordinate care to those with chronic conditions would increase consumer satisfaction and would likely decrease any unnecessary use of the emergency room and other services that may be occurring. The current proposal goes well beyond what is likely to improve quality and contain the costs of the program.

Thank you again for the opportunity to testify. I would be happy to answer any questions you may have.

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[14] One large study found that 35 percent of beneficiaries were enrolled for a year or less. Pamela Farley Short and others, "Churn, Churn, Churn: How Instability of Health Insurance Shapes America's Uninsured Problem," (New York, NY: The Commonwealth Fund, 2003)

[15] Jeanne M. Lambrew, "'Choice' in Health Care: What Do People Really Want?," (New York, NY: The Commonwealth Fund: September 2005).

Prepared Statement

Of

Dr. Donald Tice

Member
South Carolina Board of Medical Examiners

United States Senate

Committee on Homeland Security and Government Affairs
Subcommittee on Federal Financial Management, Government Information,
and International Security

October 28, 2005

"Medicaid: Creative Improvements from the Field"

Inquiries concerning four major fields of questions have been asked.

1. Address personal experience with the current Medicaid system.
2. How does the current system compromise quality of care, patient dignity, and the sanctity of the provider/patient relationship?
3. What effect does Medicaid reimbursement rates have on incentives for doctors, including specialists?
4. Address how the current system encourages patients to make costly visits to the emergency room for every health issue rather than the continuity of care from a personal physician.

Prior to answering these questions I visited and read the State of South Carolina web sites for Medicaid. I was impressed with the research that has identified many of the problems with the current system. What needs to be reiterated is that the vast majority of the recipients are children under the age of 18. This particular group is least able to select a program that would be right for them. If the children are dependents of low-income families, these families typically have low education levels or are illiterate partially or completely. As such, education as to how the program works is a major issue to be addressed. These people have no interest in saving the State mon! ey. They are concerned only that their needs are met. They are much less informed about their benefits than patients with commercial or other government insurance.

I. PERSONAL EXPERIENCE

PHYSICIAN PAYMENT. From a personal experience, I can say Medicaid is a prompt payer of claims. Virtually never is a physician requested to provide additional information to support his or her claim for services. Medicaid rightly holds the authority to audit records at any time and hold the physician accountable.

COMMUNICATIONS AND SUPPORT. Medicaid recently updated its Medicaid Provider Manual. This manual is clear and concise for users. Regretfully, my staff has great difficulty reaching a Medicaid representative at any time when an unusual situation arises. Voice messages left are often never returned. When a call is returned, the representative has refused to be put on hold while my staff member is called to the phone which implies the Medicaid representative considers his/her time and position much more valuable than my staff member's time or need. This is a most unfortunate condition and discourages field staff from calling t! heir representative for assistance. No designated customer service unit is provided that is accountable for claims resolution. Consequently, providers will write-off charges rather than try to invest an inordinate amount of time getting an issue resolved. The State benefits but the provider has just another reason why he or she does not want to take more Medicaid recipients into their practice.

RECIPIENT EDUCATIONAL AND INFORMATIONAL COMMUNICATIONS. Recently, Medicaid introduced the Select Health program. Parents were required to read informational materials notifying them their children were placed under the care of a physician unknown to them. A lot of parents never received materials because they were identified from a database that did not have current addresses. Parents were asked to make an affirmative decision to disenroll in the program if they did not want to go to this new physician. The burden of informing, educating, and trying to correct a parent's misunderstanding of their benefits fell upon the provider's staff. Medicaid officially met its burden of information and education but did parents a disservice by enrolling them in a program without an affirmative choice being made.

II. IMPACT ON CARE AND PATIENT PHYSICIAN RELATIONSHIPS

NO REIMBURSEMENT FOR PHYSICIAN OFFICE SERVICES. The current Medicaid system sometimes interferes with decisions affecting the quality of care given recipients. Specifically, private offices are not even reimbursed the cost of their supplies in many cases. When patients need immunizations they are referred to the Public Health Department because providers are not reimbursed for these services. This fragments the care for patients and often these patients are non-compliant with medical direction. Another primary example where medical care is interfered with is when medications need to be injected or infused. Often administration of products in the office setting could be done at a far reduced cost over that of a hospital setting. Both Medicare and Medicaid could realize tremendous savings if private offices were allowed to treat more aggressively and not have to hospitalize patients who could be treated in an outpatient setting. Many articles have been published and much research has shown considerable savings when this concept is utilized. Unfortunately, this concept has fallen on deaf ears for some time and has cost both systems untold millions of dollars.

DENIED ABILITY TO PERFORM SERVICES. Physical therapy modalities cannot be offered in a private office because they are not reimbursed, specifically interferential, iontophoresis and hot/cold packs. A very common complaint of the general population much less the adult Medicaid population is back and joint problems. These services cannot be addressed in a private office because they are not reimbursed. The patient has to be sent to a much higher expense physical therapy setting or be referred to the hospital. Considerable cost savings could be realized if the care was moved out of the hospital to the private physician office. Continuity of care would be greatly improved and better health care could be provided at a much reduced cost. Private out-patient offices are not and cannot be operated like the more expensive hospital based offices or ER fast tracks with their much higher administrative costs. If they were, they could not survive.

PATIENT DIGNITY IMPACTED WITH INEQUITIES IN COVERAGE. Patient dignity and the sanctity of the provider/patient relationship is undermined when patients over 65 with Medicare/Medicaid coverage have suffered a loss of health care services when Medicaid cost-shifted the financial burden of the 20% co-insurance to the physician providers by denying payment when Medicaid is the second payer. Providers

in mass are no longer taking Medicaid as a secondary payer thereby making the patient responsible for a greater financial burden than they may be able to afford. Now these seniors are embarrassed to inform the provider they are financially strapped. In fact, these Medicare/Medicaid seniors avoid healthcare services while the under age 65 Medicaid only patients have practically unlimited access to healthcare. This group more assuredly has fewer chronic illnesses than the seniors. Physician owned office overheads run a minimum 50% to 70%. If almost 50% of their profit margin is removed, they cannot afford to operate with Medicaid on that basis.

III. LACK OF PARTICIPATION INCENTIVES FOR PRACTIONERS
LOW REIMBURSEMENT. Other than public service commitment on the part of providers, there are few incentives for physicians and specialists to participate with Medicaid. Medicaid reimbursement is lower than other health insurances, commercial or government (other than Tricare). Therefore, fewer providers accept Medicaid recipients or limit the number of Medicaid recipients they will see. Currently, Medicaid pays approximately 75% of the office visit charge that is paid by Medicare and other insurance companies. Private offices work on a 50% to 70% overhead. If half or better of their profit margin is taken away, they cannot afford! to take a large number of Medicaid recipients.

LACK OF ENROLLED MENTAL HEALTH PRACTIONERS. Specialty care of psychiatric and mental health services is a real problem in the Myrtle Beach area. The one place patients can be referred requires the patient to be off most if not all of their psychotropic medications before they can be seen for major depression or anxiety related problems. In many instances it is not possible to remove the patients from their treatments. Reimbursement rates for these services need to be revisited. This may attract a greater number of mental healthcare specialists to this area.

PHARMACEUTICALS ARE EXPENSIVE. Prescribing options have to be limited due to cost. Many of the adult Medicaid patients have chronic medical problems inherent with culture, race and poor diet. It is many times more challenging and time consuming for the practitioner to limit and choose the four medicine options presently authorized. Distributions of the specific formularies have helped but it does impact quality of care. Besides the distribution of a specific formulary, establishment of a central pharmacy that could fill medications at one site and for three months has saved many insurance companies money. Beyond that, I have no ! specific recommendations.

FRAUD AND ABUSE. Fraud and abuse are major problems with the current system. Many patients are working in service industries or construction work for unreported wages. They are making very good livelihoods and they have Medicaid coverage for themselves and their families. People who work and report their earnings and who come into contact with these individuals on a regular basis are aware of this, including the physician's office staff. There is currently no good way to report these people and if a report is made, nothing happens.

IV. POLICIES IMPACTING PROGRAM COSTS

INCONSISTENCY IN APPLICATION OF A CO-PAY. Medicaid cost shifted the $2.00 co-pay to adults. This is good because patients have some vested responsibility to their health care. This co-pay is only for the office however. There is a disincentive for them to go to any outpatient private office for care when they can go to the emergency room and not have to pay any out of pocket costs. The number one diagnosis in hospital or hospital based clinic setting is otitis media. There is no reason a patient needs to be seen in the hospital for a diagnosis of this type. Emergency room visits should require higher co-pays. Also, Medicaid could cost shift a coinsurance responsibility to the patient to cover the higher cost of the service charged by the hospital. Private insurances often make the patient more financially liable when ER services are performed for non-emergency care.

LIMITATIONS ON USE OF EMERGENCY ROOMS NEEDED. Patients have no incentive to conserve the frequency of their ambulatory visits. They are currently given twelve ambulatory visits per benefit year. When these visits are exhausted the patient merely goes to the emergency room for treatment where they have no set limits. Again, I believe the patient should be more financially responsible when they present to the ER for non-emergency reasons. Additionally, Medicaid recipients use the ER because the ER is available twenty-four hours a day, seven days a week. The Medicaid recipient is not constrained by normal office hours and can witho! ut any responsibility for planning be seen by a physician. People with private insurance don't have this option due to cost to them personally. Even if the Medicaid recipient is given a medical savings account, unless care is refused when the funds run out or they have to pay a larger portion out of their own pocket, the will continue to go to the ER where they know care cannot be refused them. When Medicaid made adults responsible for the $2.00 co-pay it did not apply to ER visits.

GREATER PATIENT RESPONSIBILITY – HEALTHCARE SAVINGS ACCOUNT. Possibly a health care savings account might benefit the system and put the recipients more in charge of their own health care. Caution should be exercised in that education of Medicaid recipients has historically been difficult at best. We are dealing with a subset of people that make many poor or uninformed decisions as a routine. Changes in their habits of both life choices, a desire to cooperate with the system and their choices for medical treatment must be accomplished. Education will be key. This responsibility cannot be borne by the outpatient offices. Changes in the inequity of the system toward its providers must be addressed. Everyone has to feel that they can make a difference by being able to help the State curb the abuses that are so obvious. Trust and cooperation has to be restored between the State system and its providers.

Respectfully submitted,

Donald W. Tice, D. O.

Medicaid: Creative Improvements from the Field

Senate Homeland Security and Government Affairs
Subcommittee on Federal Financial Management, Government Information, and International Security
College of Charleston, Charleston, South Carolina
October 28, 2005

"Consumer-Driven Medicaid"

Professor Regina E. Herzlinger
Nancy R. McPherson, Chair
Harvard Business School

The Medicaid program provides a much needed health insurance safety net for 52 million of our nation's poor and medically needy[1]; but its price tag threatens the financial stability of states—growing 9.5% in 2004 alone[2], far in excess of revenues. In South Carolina, for example, in 2004, Medicaid consumed 19% of the General Fund, or $4 billion.[3]

Fiscally responsible state Governors and Legislatures who decline to raise taxes and, instead, attempt to control these costs, face three choices: cut Medicaid expenses through reductions in enrollment, benefits, and provider reimbursement; cut other state expenditures, such as those for education roads; or try a new approach. Tennessee's Governor, for example, proposed to cut 300,000 recipients;[4] but South Carolina's Governor, Mark Sanford, opted for the third path. His plan gives Medicaid enrollees a choice: every recipient would obtain catastrophic and preventive coverage and a personal health account (PHA). Enrollees can use their PHA funds to pay for a consumer-driven option of a traditional Medicaid hospital insurance and any doctor they chose; a managed

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care policy and its deductibles and copayment; a network group of local physicians; or, if employed, to pay their share of employer-provided insurance.[5]

Because South Carolina's plan is likely to become a national model if adopted, it has drawn the attention of Washington, DC-based policy analysts who question the concept of choice in Medicaid and the consumer-driven option.[6] In this testimony, I will respond to both criticisms.

Choice of Health Insurance Policies

A wide choice of goods and services is the hallmark of most developed economies. Choice not only fulfills consumers' needs for products with different qualities but also creates that competition which is the key to productivity.

Most Americans want a choice of health insurance plans[7], but South Carolina's Medicaid recipients currently have virtually no choice: no physician networks organized to treat those with special needs—for example, those with AIDS or sickle cell disease; treatment limited to those physicians who take on Medicaid enrollees; and little managed care.

Although the Governor's plan will give enrollees this kind of choice, some critics view it as wasteful. Because Medicaid's costs are already lower than those of private plans[8], they ask "What is the point of the transformation?"

But Medicaid's "low costs" come at participants' expense. "Low costs" are achieved primarily by paying service providers only 65% of what they receive for treating the state's employees.[9] As a result, 30% of all physicians refuse to accept any new Medicaid enrollees and enrollees experienced much more difficulty in scheduling

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visits for follow-up care than those with other types of insurance.[10] Medicaid recipients have more unmet needs than similar adults with private insurance.[11]

A majority of the U.S. public attributes Medicaid's growing costs to poor management.[12] For example, drugs represent the fastest growing component of Medicaid costs (35.4% growth 2000-2003)[13], in part because Medicaid pays off the "sticker price," which is substantially higher than acquisition costs.[14] Opening the market to managed care insurers and consumer-driven plans may well alter this situation through the pharmaceutical benefit managers, PBMs, employed by managed care plans, and tiered-payment pharmaceutical benefits plans. In a Medicaid context, these plans might charge zero for a generic drug and a $3 co-pay for a branded one. In the private sector, PBMs and tiered policies have caused generic drugs to represent over 50% of all prescriptions and have become the fastest growing component of the pharmaceutical sector.[15] Managed care can more readily achieve the benefits of the "pay-for-performance" movement too. For example, some plans achieved significant improvement in asthma care and diabetic testing.[16]

Critics also note that the planned allowance, based on the *average* cost of a person is a risk category, may not be adequate for the health care needs of the very sick in that category (and they may be excessively generous for those who are less sick than the average). In the consumer-driven Swiss system, this issue is managed by retroactive risk-adjustment of insurers: those who received unduly low payments because they enrolled the sick are compensated by funds removed from those who received unduly high reimbursement. A similar system could be devised in the state.[17]

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Last, critics of the Governor's plan contend that choice cannot materialize in a South Carolina market characterized by low managed care presence. But when Georgia requested bids for Medicaid managed care, ten firms responded.[18] Similarly, Ohio's conference for potential Medicaid managed care vendors drew nine new managed care firms, including well-established Goliaths such as Aetna, United Health and Anthem.[19]

Consumer-Driven Plans

Those who worry about giving Medicaid participants choice are especially concerned about the consumer-driven option. They contend that Medicaid enrollees are too poorly educated and lack access to sources of information like the Internet.[20]

These critics may well believe that Medicaid recipients will overwhelmingly choose the consumer-driven options; but when consumer-driven plans are offered along with other health insurance choices, they are not necessarily the most popular. A 2005 Kaiser family survey found that when enrollees were offered other insurance plans, only about 7% - 15% chose consumer-driven ones.[21] Industry experts estimate the percentages at 3% - 16% for HSAs[22] and 25% for HRAs, consumer-driven options usually offered by employers.[23] In Switzerland, which has had a century-old consumer-driven system, low-income people typically choose health care plans that offered the lowest deductible (see table below).

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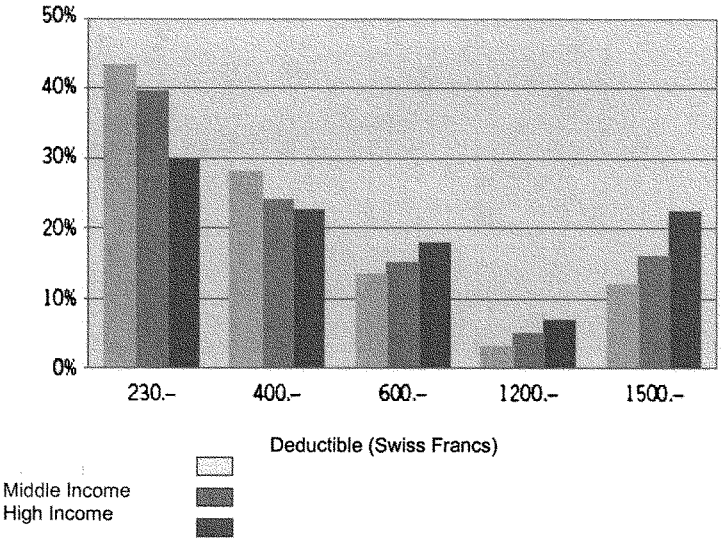
Choice of Insurance Policies by Income Categories



Insurance Policies Prices: high-deductible (230.- CHF), low-deductible (1500.- CHF).

Source: Bundesamt für Statistik (BFS), Schweizerische Gesundheitsbefragung 2002, Neuchâtel, Switzerland, 2003.

Nevertheless, can those who are not well-educated use consumer-driven plans to advantage?

The experiences of the disabled who opted for government-based "Cash and Counseling" programs indicate that they derived greatly enhanced satisfaction, while controlling costs, although many of the participants were intellectually impaired.[24] (Although the disabled and elderly represent only 25% of Medicaid's enrollees, they account for 69% of its costs, so their experiences with consumer-driven plans are of considerable importance[25]). Cash and counseling typically features a monthly allowance, based on the consumer's needs, that can be used to hire assistants, including family

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workers, and to purchase other resources. Enrollees must develop spending plans with the assistance of counselors.

Participants substantially increased their satisfaction and unmet needs and controlled costs.[26] In Arkansas, they reduced caregiver neglect by 58% and attained slightly better health outcomes, while costs for long-term care and hospitalization decreased.[27] As one program participant noted: "I'm . . . not . . . under anyone's thumb."[28] (Cash and Counseling enrollees were primarily non-elderly.[29] In interviews, African-Americans and Hispanics expressed much more interest in the program than Caucasians presumably because of their strong family and community networks.[30])

As for the private sector's consumer-driven experiences with lower-income populations, Assurant, a leading provider of individual and small group health insurance, found that only 20% of Health Saving Account (HSA—a consumer-driven plan) purchasers had incomes of less than $40,000 and net worths of less than $25,000.[31] Although it is not yet possible to analyze outcomes by income, the experience of Whole Foods, a supermarket chain, are instructive: as of 2004, its employees, primarily blue-collar, have saved $14 million in health account savings and turnover plummeted; costs increased by only 3.3%.[32]

The overall accomplishments of the consumer-driven plans are notable. They not only dramatically controlled cost increases but also improved the health status of those with chronic diseases. Definity Health, a provider of consumer-driven insurance policies, demonstrated a reduction in flare-ups among its diabetic and asthmatic enrollees, due to increased testing and drug utilization, while McKinsey found that consumer-driven

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enrollees were more likely to "very carefully follow treatment regimens for chronic conditions."[33]

These plans appeared to have transformed how some enrollees approach their health care. By enabling participants to trade off current expenditures against long-term health status and savings, consumers' behavior changed from I do it because "my health plan covers it" to I do it because "if I catch an issue early, I will save money in the long-run."[34] Thus, 75% of the enrollees in one consumer-driven group complied with the regimen for their chronic medications as opposed to 63% those enrolled in other insurance plans with virtually no deductible.[35]

Consumer-driven enrollees used the insurers' information resources substantially. Although their sources are sometimes depicted as high-tech and Internet-based, much of this kind of support comes from the phone and face-to-face interactions. Large insurers are now enabling price transparency.[36]

Consumer-driven plans increase enrollee satisfaction with both insurers and providers. A September, 2005 Blue Cross Blue Shield survey found that enrollee satisfaction levels exceeded those achieved by non-consumer-driven plans[37] and Swiss patients ranked its consumer-driven hospital care much higher than those in Germany, the U.K. and the U.S.[38]

Summary

Medicaid enrollees are currently treated like second-class citizens. Some providers choose either not to see them or to treat them only after considerable delay, because of the program's poor payment, and enrollees have little access to the managed care and no access to the consumer-driven plans available to the rest of the population.

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Governor Mark Sanford's plan for the transformation of South Carolina's Medicaid program will give its enrollees the same choices and access to care as the rest of us, and promises to control costs along the way.

Let's make it happen.

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Prepared Statement

Of

Ed McMullen
President
South Carolina Policy Council
Education Foundation

United States Senate
Committee on Homeland Security and Government Affairs
Subcommittee on Federal Financial Management, Government Information, and International Security

The College of Charleston
Wachovia Auditorium

October 28, 2005

Mr. Chairman:

Thank you for the opportunity to speak to you today. My name is Ed McMullen, and I am president of the South Carolina Policy Council, a non-profit, non-partisan public policy research organization. I am here to present an overview of the innovative solutions that are being proposed to improve Medicaid in our state.

There is no question that Medicaid must be reformed. It already consumes 20 percent of the state budget – that is up 10 percent from 1995. By the year 2015, Medicaid costs are projected to consume 30 percent of the state budget. That is a growth rate that cannot be sustained.

In addition, the federal government will likely change the way it sends dollars to states. One plan proposes block grants instead of matching funds for states. Such a system would provide greater stability for states, and take away the perverse incentive for them to "spend more tax dollars to get more tax dollars." Our state would ultimately benefit from the change, because the current matching formula is based on a system that compares our state's per capita income to the US average, and that means as our economy grows, our matching funds will decrease. Already, South Carolina's federal matching ratio for Fiscal Year 2006 is 3.5 percentage points lower than it was in Fiscal Year 2004.

In the long run, economic growth will shrink Medicaid rolls, but not in time to stem the massive growth in the program.

Fortunately, there is progress toward reform in our state. The new waiver proposed by Governor Sanford is an innovative, market-based plan to provide quality health care to patients that is affordable to taxpayers.

You have heard about that plan today to provide Personal Health Accounts, or PHA's, for Medicaid patients. PHA's would offer greater access to quality care, allow patients to choose their doctors, decrease the number of emergency room visits through preventative care and empower special needs populations with more choices.

Special needs populations especially need choices because they often have less flexibility in their health care. For example, South Carolina ranks fourth in the nation for prevalence of diagnosed diabetes. Under the PHA proposal, those patients could choose the managed care option and select providers who offer the type of specialized care they need. This approach will encourage managed care organizations to offer packages that are tailored to these patients. In addition, both consumers and providers are offered incentives to choose and offer quality health care. Examples include bonus payments to outstanding providers, and financial incentives for healthy patient behavior.

There are some incorrect assumptions about the PHA's, particularly regarding children. Some claim this plan would drastically cut services to children. That is absolutely untrue. In fact, a PHA plan would offer children much-needed preventative and primary care as opposed to the drastic emergency room care that Medicaid patients often choose today. For example, parents of special needs children could choose a primary care management option. The provider would approve and monitor all care for a small monthly fee,

providing patients with focused care coordination and expert advice based on personal case knowledge. That type of approach has brought about improved care and a decrease in hospital time for non-intensive care for these children.

We know that Health Savings Accounts work in the private sector, resulting in decreased premiums and lower out-of-pocket expenditures. There is also research on other plans that provide more choices to those on government assistance. In states such as Arkansas, Florida and New Jersey, participation among elderly and disabled populations show high rates of satisfaction – as high as 90 percent. Clearly, these consumers are receiving high quality care, and they also believe it is an improvement over their previous plans.
It is important that this plan have the support of the private sector. Fortunately, companies in South Carolina -- including one managed care company that currently serves 60,000 Medicaid patients – indicate they are eager to participate in the proposed plan.

Health care companies support the plan. Consumers indicate their preference for more choices, not just in other states but here in South Carolina, where the managed care program for Medicaid receives high marks from patients. And physicians have long argued for the need for comprehensive primary care, which this plan will allow. So who opposes the PHA plan? Frankly, the self described "advocates" who argued against welfare reform in our state. Those who fought that change in the 90's made some of the same arguments, including that the children would suffer. Those dire predictions have simply not come true. A 2001 study for the South Carolina Department of Social Services found that of those who left welfare because they were earning money through new or better jobs, 75% were still employed a year later. Only 10 percent of all those leaving welfare believed their children suffered after leaving the program. A subsequent study in 2003 found that 65 percent of all who had left the welfare rolls were working 40 hours a week or more, and only 5 percent of them felt that leaving welfare created such a hardship that they were forced to put their children in someone else's care.

In spite of the doom-and-gloom scenarios, welfare reform is a success in our state. Furthermore, the Department of Social Services has become more efficient. And as the Post and Courier reported, "South Carolina has been among the national leaders in cutting welfare rolls, earning 'high performance' federal bonuses in the process."
We have to create that kind of positive change in South Carolina's Medicaid program. Neither patients nor taxpayers can afford the cost of the status quo.

Medicaid patients deserve high quality care, and they should be able to choose it themselves. They should not have to rely on overwhelmed emergency rooms that cannot possibly serve them as well as their own doctor could. Medicaid patients are every bit as capable as other consumers when it comes to making informed decisions for themselves and their families. They must be given the opportunity to do that. The proposed waiver plan is patient-centered, and it is based on successful approaches to health care. It is also cost effective, but most importantly, it is a step toward higher quality health care for those who are often denied the best available services. Such innovation deserves a chance in South Carolina.

ISSUE PAPER
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E D U C A T I O N F O U N D A T I O N

Fall 2005

Patient-Centered Medicaid Reform in South Carolina: The Healthy Choice

By Neil Mellen

INTRODUCTION

Medicaid is the Social Security program providing health care for those with low or limited incomes and special needs. Initially designed in the 1960s, it has seen only limited change in the last four decades. It delivers an essential service for the needy, but the nature of its structure is obsolete and inefficient. Medicaid consumes 20 percent of the South Carolina state budget. That is up from 10 percent in 1995, and projections for 2015 are at 30 percent of state expenditures. This is an unsustainable growth rate which threatens all state programs. A new Medicaid waiver which restructures certain portions of the delivery system has been submitted, and it would create a client-centered atmosphere with an emphasis on choices and preventive care. Both beneficiaries and tax-payers deserve this change. This waiver will allow for an improvement in the way Medicaid delivers health care. The reforms will prevent the inevitable cuts in Medicaid and other key government services that are otherwise inevitable.

UNSUSTAINABLE GROWTH

Medicaid is growing so fast that it will account for 50 percent of the state budget in 2035. Per capita the federal government spends 14 percent more on Medicaid in South Carolina than the national average.[i] As costs rise the state allocates more and more money which results in greater federal contributions. However in South Carolina the increases are providing diminishing returns. The Federal Medical Assistance Percentage (FMAP) which dictates the ratio of matching is based on a system that compares a state's per capita income to the US average.[ii] This means that as the state grows economically it

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receives a correspondingly lower FMAP to finance Medicaid. The South Carolina FY 2006 federal matching ratio is 3.5 percentage points lower than the rate for FY 2004. As Medicaid consumes an ever-greater portion of the state budget South Carolina is actually receiving proportionally less federal assistance to help pay for it.

All state programs are threatened by Medicaid's unsustainable growth.[iii] Systemic changes are necessary in order to save health care for needy citizens, as well as to preserve the entire range of state services, like education, public safety, and others, that our citizen depends on.

PLAN OVERVIEW

The South Carolina section 1115 waivers integrate four diverse programs, allowing the clients to employ their Personal Health Account (PHA) through one of four options: 1) the Managed Care Organization (MCO); 2) the Medical Home Network (MHN – presently termed primary care case management); 3) an employer group health plan insurance buy-out; or 4) total self-direction through a major medical plan. This range of options represents a deep structural change to South Carolina's Medicaid program. While the scope and integration of options is new, it is based on proven strategies and demonstrated results. South Carolina's Medicaid system will be refocused to the patient's desires and needs. No longer will those most in need be forced to settle for unresponsive and inadequate health care but rather they will be able to seek out the delivery systems which best match their needs.

Policy experts have been sounding the call to step away from a defined-benefits structure for years[iv]. Improving health care quality for South Carolinians using Medicaid can only be accomplished through a break from the 1960s styled regulatory model. Adoption of a client-driven structure will end the one-size fits all approach. The Healthy Choices wavier uses the mechanism of choice to encourage primary and preventive care over inappropriate and first stop emergency room visits. This creates proactive patients, a continuity of care, and appropriate reimbursement for providers. Medicaid will no longer be seen as a disincentive to employment, nor as a long term middle class health care haven. Higher levels of care will be expected, and then chosen, as beneficiaries develop into careful shoppers.[v]

1115 WAIVER – THE RIGHT TOOL

Section 1115 waivers are the tools which allow for broad changes in state Medicaid programs. They were placed into federal statutes to allow for research and demonstrative programs. This type of waiver

was the mechanism employed for the integration of managed care for many states during the 1990s. Through the 2001 Health Insurance Flexibility and Accountability (HIFA) waiver initiative even greater flexibility was provided for.[vi] States were encouraged to improve upon traditionally defined eligibility, benefits, and cost-sharing in ways that matched their specific needs. This means tailoring programs rather than relying on a centralized nation-wide plan. The South Carolina proposal uses this avenue to integrate the best aspects of four methods to provide South Carolina's Medicaid beneficiaries with the best possible care.

ACCOUNT BASED PLANS

The Personal Health Account incorporates certain aspects of the Health Savings Account (HSA) model to the Medicaid system. HSAs are an emerging health care approach that increases choice and benefits for enrollees in the private sector. Individuals are given money and allowed significant leeway in how it is used. At a time when health care costs across the industry continue to rise HSA premiums have actually decreased.[vii] Individuals using this type of consumer-driven health care plan have "consistently had lower out-of-pocket expenditures than in enrollees in Preferred Provider Organization (PPO) contracts."[viii]

The influence of the HSA model means Medicaid beneficiaries would receive funds into their PHA which they employ through a debit card. This amount would be determined by factors including the age, sex, and physical condition of the recipient. This is the same method used by actuaries in the private sector. The cards will be strictly controlled and may only be employed for the purchase of approved health services. The money could be used to: 1) pay premiums for an employer provided health plan; 2) buy hospital insurance through Medicaid and choose any doctor with the remaining funds; 3) pay co-payments and deductibles in a managed care insurance program; 4) join a medical home network. In the first three options the beneficiary will have the opportunity to roll over the account balance towards next year's spending or purchase additional care and equipment approved by Medicaid. On the other hand if the beneficiaries seek more care they will pay out of pocket. This ability to make choices and apply funds from an account towards qualified medical expenses is how HSAs have dramatically improved health care in the private sector, and how PHAs will reshape Medicaid in South Carolina.

As South Carolina's Medicaid system moves away from a defined-benefits program each beneficiary emerges as an individual client. Doctors will now longer work primarily through the Medicaid apparatus as a third partier financier, but rather develop individual relations with clients who seek the care best suited to their needs.

CHILDREN PROVIDED FOR

In a state where 47 percent of all new born deliveries are Medicaid births the care of children is a primary concern.[ix] Criticisms of the plan are littered with misconceptions. It has been asserted that the South Carolina plan would result in drastic cuts for services to children. That is not true. The plan is still evolving, and the working model for Early Periodic Screening Diagnostic and Treatment program is the South Carolina State Health Plan for state employees. This means preventive care, rather than the current system where numerous beneficiaries use hospital emergency rooms as a default primary site of service. This change fits in with the proactive patient-centered approach that beneficiaries deserve.

Even those children who are pregnant or have dependent children of their own are still categorized as children. No major changes in the quantity of care for children are involved. The only shift is a clarification of their existing status of young adults (18 and 19 year olds) that prevents them from receiving child "well visit" benefits. They will still be entitled to an annual eye exam, though non-emergency dental visits will be financed through the personal health account balance.[x]

Parents of children with Special Health Care Needs (SHCN) may decide to select the primary care management option. In this choice there is a primary care provider who approves and monitors all care for a small monthly fee, serving as a sort of gatekeeper and advisor. This would provide SHCN children with the enhanced care coordination and case management they need in a manner more effective than the present fee-for-service model.[xi] The comprehensive primary care approach has been associated with improved care and a corresponding decrease in length of stay for non-intensive care hospitalizations for these children.[xii]

SPECIAL POPULATIONS WELL-SERVED

Greater flexibility will mean an increase in responsiveness, something lacking in the present structure. Populations of beneficiaries such as individuals with diabetes are an excellent example. South Carolina

ranks 4th in the nation for prevalence of diagnosed diabetes.[xiii] Beneficiaries with diabetes who chose the MCO option would be able to select those providers who offer special programs, or care most suited to the patients' diabetic needs. This will prompt managed care organizations into further refining attractive suites or packages that meet these consumers' demands. Furthermore the state's rating and incentive plan will identify those group and individual providers who provide preventive and specialty programs, including diabetes care, consistent with national guidelines. These providers will be eligible for bonus payments to reward outstanding performance. The current format provides no motivation for doctors and nurses to administer even the most basic screening or diagnostic testing outside the limited range of current Medicaid reimbursement. Perhaps most importantly, the shift from a defined-benefits program to a consumer-centered system of choice will begin to address the long-term problem of soaring diabetes rates by stressing preventive care.

CLIENTS EMPOWERED THROUGH CHOICE

It has been suggested that beneficiaries will be overwhelmed by choice, and make poor or uninformed decisions. Research tells us that there is in fact a preference by clients for control.[xiv] This includes younger individuals with disabilities, as well as older populations when they have the ability to exercise choice through family members or friends.[xv] The change in funding model itself seems to promote a shift in delivery methods, and the consumer driven programs are "creating pressure to include person-centered planning, personalized housing, independent care management and other supports" among providers.[xvi] Not only are clients capable of choice, but this drives providers to offer more. The specifics of the South Carolina plan match well with the direction that existing private providers envision for the "collaboration" and "teamwork" necessary in real reform[xvii].

The fundamentals of consumer-driven programs have been termed "cash and counseling" by some, and there is a documented history of success. Variations of this program include systems in Arkansas, Florida, and New Jersey among elderly and disabled populations. Feedback from participants in these programs sounds far-removed from anything one might expect to hear about traditional regulatory-modeled assistance. Kevin Mahoney, PhD., serves as the director of the National Program for Cash and Counseling Demonstration and Evaluation. In testimony before a Congressional subcommittee he cited the fact that 96 percent of Arkansas clients, and 97 percent of New Jersey clients claim that they would recommend the programs.[xviii] In Arkansas 82 percent of clients felt the system had improved their lives,

and 65 percent qualified it as a "great deal" of improvement. While the specific mechanisms of cash and counseling vary from the wide rage of options provided by Healthy Choices, the underlying system of consumer-driven care provides for generalizable results which consistently point to quality care and consumer satisfaction.

NON-URGENT EMERGENCY ROOM VISITS

The waiver integrates proven strategies to reduce non-urgent emergency room visits. This means more appropriate care for beneficiaries and lower costs for tax-payers.

Individuals who lack a relationship with a regular doctor or primary care provider are more likely to use the emergency room for non-urgent needs[xix]. The absence of such a relationship is the most dominant predictor of non-urgent use. Continuity of care is also associated with decreased rates of emergency room utilization, and this has been demonstrated among both traditional and Medicaid populations.[xx] Counseling for the parents of Medicaid children who are receiving non-urgent emergency room treatment leads to lower utilization rates as well.[xxi] Developing doctor-patient relationships, providing a continuity of care, and using counselors to assist in decision making are all parts of the South Carolina waiver.

Just as importantly these strategies will also address the lack of follow up care that is inherent in non-emergency visits to emergency departments.[xxii] The waiver is a comprehensive solution to a systemic problem faced by beneficiaries and providers. The reduction of such nonurgent emergency usage was a major theme of the report issued by the Governor's Health Care Task Force.[xxiii] South Carolina Doctors on that panel made their concerns clear when they sited this phenomenon as both a cause and symptom of the lack of preventive care among needy populations. The proposed Medicaid waiver answers their call for reform in the delivery system, the promotion of individual responsibility, and greater access for all South Carolinians to quality healthcare.

THE MARKET WILL RESPOND

Under this program the beneficiaries will exercise choice within a market structure. Health care providers will respond in ways that attract clients through quality care. The Wall Street Journal pointed out how the market was even able to respond to the inefficient Fee For Service model of the defined-

benefits program.[xxiv] Since the 1990s health care providers have created managed care and disease management plans in order to combat the failures they attributed to a lack of management and oversight in Medicaid. As the health care industry responds to meet new demands this form of pure HMO may someday only exist within a Medicaid supported context.[xxv] It represents a creative attempt to work within an inefficient system. We can and should provide our low income citizens with a better option. Leaders in the South Carolina health care industry have already expressed their enthusiasms for patient choice as outlined in the waivers. They have publicly voiced commitment to develop new options for private sector implementation.[xxvi]

INTEGRATION OF APPROACHES

The value of the South Carolina plan is in its choices. In addition to the less-structured avenue there is an option for participation in a managed care or preferred provider organization. Initial data affirm the argument that MCOs and consumer-directed care are compatible.[xxvii] This is a system where clients can work within the framework of their choice. The use of enrollment counselors during the initial client selection and evaluation process, as well as the counselors' role as an ongoing point of contact for enrollees, helps beneficiaries make educated decisions. Such guidance is consistently identified as an important catalyst for making consumer-oriented programs successful.

CONCLUSION

The explosive and undirected growth of the present defined-benefits structures threatens to diminish resources for critical government programs like education and sfatey. Everyone, Medicaid beneficiary or otherwise, will lose out if no changes are made. The status quo is simply not an option. Placing hope in greater federal funding is naive and such increases would actually cost South Carolinians more due to the changing matching structure. Providing South Carolinians in need with the best possible health care can be accomplished within the context of 1115 waivers which develop a range of participant-driven options. This means a systematic shift in how Medicaid operates. Individual beneficiaries become the focus, and they are treated as empowered clients rather than members of a homogenous recipient pool. This is a proven approach which promotes greater care and results in overwhelming client satisfaction. As the Wall Street Journal explained, "with this waiver, the government will fulfill its duty of providing needy citizens with the same choices that other South Carolinians have the ability to pay for."[xxviii] The state's Medicaid beneficiaries deserve nothing less.

About the South Carolina Policy Council and the author:

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Neil Mellen is the Research Director of the South Carolina Policy Council. He is a graduate of the Virginia Military Institute and a former English teacher. Mr. Mellen served as a Peace Corps Volunteer in Micronesia where he created rural libraries, as well as being on the Board of Directors of the Asor Community Hospital.

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