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21st Century Health Care Options for the States

By Chris Jacobs

Across the country, state legislatures are considering whether or not to expand their existing Medicaid programs. Last year's Supreme Court ruling struck down the mandatory nature of Obamacare's expansion of Medicaid to all families with incomes up to approximately $30,000 a year. Chief Justice Roberts' June 2012 opinion stated that the health law as originally written engaged in "economic dragooning that leaves the states with no real option but to acquiesce in the Medicaid expansion."[1] The Court's opinion gave states a choice whether or not to expand their Medicaid programs to approximately 20 million new individuals,[2] a decision which states are weighing during their current legislative sessions.

The reasons why states should NOT participate in Obamacare's Medicaid expansion are well-documented[3]: Medicaid patients have worse health outcomes than patients with other forms of insurance, and in many cases worse health outcomes than the uninsured;[4] Medicaid beneficiaries often face difficulty finding doctors who will treat them;[5] and by increasing federal spending funded by massive tax increases, a Medicaid expansion will destroy jobs rather than create them.[6]

Less well known, however, are the innovative programs states have utilized over the past several years to modernize and enhance their health sectors, expanding coverage and improving quality of care while lowering costs. Rather than utilizing Obamacare's top-down, government-centric approach of putting more people into a broken Medicaid program, these policy solutions seek to transform Medicaid using market incentives to create a health system that works for patients.

Recently the Centers for Medicare and Medicaid Services (CMS) issued a bulletin providing clear evidence that the Obama administration views Medicaid expansion as an all-or-nothing proposition.[7] The Administration apparently hopes that pressure from hospitals and special interests will force state legislators to approve Obamacare's massive Medicaid expansion. However, as Chief Justice Roberts indicated in his opinion last June, states now have a real choice. Based on the examples presented below, states should choose innovative, market-driven solutions, rather than Obamacare's bureaucratic approach.

Rhode Island

States seeking to improve their health care system should closely examine Rhode Island's successful global compact waiver for its Medicaid program. The waiver, negotiated by then-Gov. Don Carcieri and approved by CMS in

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January 2009, attempts to reduce expenses by giving the state the flexibility to improve the quality of care. The Rhode Island waiver focuses on promoting home-and-community-based services as a more affordable (and more desirable) alternative to nursing homes, on improving access to primary care through managed care enrollment, and on other similar methods to provide quality care at better cost. In December 2011, the non-partisan Lewin Group released an analysis of the Rhode Island global compact waiver.[8] The Lewin report provides demonstrable examples of the waiver's policy success, saving money while simultaneously improving care:

- Shifting nursing home services into the community saved $35.7 million during the three-year study period
- More accurate rate setting in nursing homes saved an additional $15 million in Fiscal Year 2010 alone
- Better care management for adults with disabilities and special needs children saved between $4.5 and $11.9 million, and
- Enrollment in managed care significantly increased the access of adults with disabilities to physician services.

Lewin's conclusion:

> The GW [Global Waiver] initiatives and budget actions taken by Rhode Island **had a positive impact on controlling Medicaid expenditures**. The actions taken to re-balance the [Long Term Care] system appear to **have generated significant savings** according to our estimates. The mandatory enrollment of disabled members in care management program **reduced expenditures for this population while at the same time generally resulting in improved access to physician services**. Continuing the GW initiatives already undertaken by the state and implementing the additional initiatives included in the [Global Waiver] will result in significant savings for the Rhode Island Medicaid program in future years.[9]

All this progress comes despite the Obama administration's efforts, not because of them. Pages 14-15 of the Lewin report note that maintenance of effort mandates imposed in Obamacare and the "stimulus" prevented Rhode Island from imposing modest premiums on some beneficiaries, even though the approved waiver was supposed to give the state that flexibility.[10]

Despite the ways in which the Obama administration's bureaucratic requirements interfered with Rhode Island's ability to implement its global waiver fully, the state achieved measurable progress in reducing costs while improving care – providing a clear example that other states can emulate.

Indiana

The Hoosier State's Healthy Indiana Plan (HIP), created in 2008, applied the principles of personal responsibility, consumer-driven health plans, and Health Savings Accounts in its expansion of coverage to low-income populations. Initiated as part of a Medicaid demonstration waiver, the program requires individuals to make contributions to a Personal Wellness and Responsibility (POWER) account. No beneficiary pays more than 5% of their income, and the state supplements individual contributions so that all participants will have $1,100 in their accounts to pay for routine expenses.

Healthy Indiana promotes personal responsibility in several ways. First, the required beneficiary contributions to the POWER account ensure that all participants have an incentive to take greater responsibility for their own health and health spending. Second, the program promotes preventive care by providing an additional $500 to fund important preventive screenings. Moreover, only those beneficiaries who participate in a series of annual screenings may

roll over unused POWER account funds from year to year. Third, Healthy Indiana assesses co-payments for non-urgent visits to the emergency room, attempting to reverse a trend of high ER usage by Medicaid beneficiaries prevalent nationwide.[11]

Overall, Healthy Indiana has achieved many of its policy goals. Despite the modest incomes of beneficiaries enrolled in the program – all of whom must have incomes below 200% of the federal poverty level, or about $31,000 for a couple in 2013 – nearly four in five contributed to their POWER account.[12] Nine in ten participants have at least one physician visit in their first year of enrollment, demonstrating that the HIP deductible does not hinder patients from obtaining needed care.[13] And an analysis by the consulting firm Milliman found that parents in Healthy Indiana "seek preventive care more frequently than comparable commercial populations."[14]

Healthy Indiana has not only proved successful – it's been popular as well. Only about one-quarter of participants ever enrolled in the program during its first two years left the program, "a retention rate much higher than the rate for adults in Indiana's regular Medicaid managed care program."[15] Approximately 70% of beneficiaries considered the required POWER account contributions just the right amount, and 94% of members report being satisfied or highly satisfied with their coverage.[16]

A 2011 policy brief by Mathematica Policy Research commented on the program's successes:

> HIP has successfully expanded coverage for the uninsured, while giving enrolled members an important financial stake in the cost of their health care and incentives for value-based decision making. Early implementation suggests that members value HIP benefits and that at least some low-income, uninsured adults are willing and able to contribute toward the cost of their care.[17]

Just as important, the program's increase in preventive care, and decrease in emergency room usage, have achieved measurable savings. Milliman reports that HIP exceeded its targets for budget neutrality, spending nearly $1 billion less than its original spending cap in its first five years.[18]

In the past five years, the market-based incentives of the Healthy Indiana Plan have yielded two-fold success in improving the population while containing overall spending. It remains to be seen whether CMS will approve an extension of HIP or will instead claim that Obamacare's bureaucratic mandates preclude the program's continuation. The week the law passed, then-Gov. Mitch Daniels publicly worried that Obamacare would force him to plan for HIP's termination.[19] State legislators seeking to avoid Obamacare's requirements and restrictions who are looking instead to market incentives as a way to control costs would be wise to examine the Healthy Indiana Plan approach.

Florida

Earlier this year, CMS granted approval to the state of Florida's two waivers to alter its Medicaid program. These waivers, which follow on the heels of a five-county pilot reform program begun in 2006, will roll out over the coming 18 months; both waivers should be fully implemented by October 2014.[20]

One of the two waivers would transform the Medicaid program for low-income beneficiaries. The waiver will allow all Medicaid recipients to enroll in managed care plans; each will have at least two, and as many as 10, Medicaid plans from which to choose.[21] The waiver allows managed care plans – which are based in one of 11 regions – to create customized benefit packages that meet the unique needs of their local populations. In applying for its waiver, Florida rightly noted that "each plan will face the competitive pressure of offering the most innovative package," which will allow

beneficiaries "to use their premium [dollars] to select benefit plans that best meet their needs."[22]

Other features of the waiver likewise seek to reduce costs while improving the quality of beneficiary care. Managed care plans will be required to "establish a program to encourage and reward healthy behaviors," similar to the Healthy Indiana Plan incentives discussed above.[23] Florida also is seeking waiver flexibility from CMS to encourage beneficiaries to enroll in health coverage through their employer when available and require modest cost-sharing for certain populations.[24]

Coupled with another waiver for the state's long-term care program – one which seeks to place individuals in home and community-based services instead of nursing home facilities – the two waivers collectively will transform the Medicaid program in Florida. The waivers' focus on participant choice, competition among plans to enroll beneficiaries, and incentives to promote wellness and preventive care all hold the potential to provide a more personalized experience for Medicaid beneficiaries – and, just as important, a more effective and efficient one as well.

Even as Florida moves ahead on implementing its waivers, state legislators are offering state-based alternatives to Obamacare's costly Medicaid expansion. House Speaker Will Weatherford introduced legislation – the Florida Health Choices Plus bill – with Rep. Richard Corcoran, chairman of the House Health and Human Services Committee, to provide incentives for low-income individuals to obtain health insurance.[25] Under the proposal, individuals with incomes below the federal poverty line would receive $2,000, deposited into a CARE (Contribution Amount for Reasonable Expenses) account.[26] Beneficiaries would be required to deposit $25 per month, or $300 per year, into the account, and employers could contribute additional amounts as well. The money could be used to purchase affordable health coverage in the Florida Health Choices insurance clearinghouse, or used directly for health expenses.

Because more than two in three uninsured Americans lack coverage for periods of less than a year, Florida Health Choices Plus would provide bridge funding to the majority of citizens who suffer only short spells without health insurance.[27] It does so without providing incentives for individuals to drop private health insurance and enroll in a government program – a problem that has plagued past state coverage initiatives.[28] The proposal includes a personal responsibility component, coupled with incentives for beneficiaries to serve as wise consumers of health care. And it accomplishes these objectives without relying on Obamacare's massive new gusher of federal spending.

Texas

Although it has not yet come to fruition, state thought leaders have begun to consider how additional flexibility from Washington could result in better care for patients and a more predictable and stable Medicaid budget for states. The Texas Public Policy Foundation recently released a paper outlining its vision for a Medicaid block grant, and how Texas could use the flexibility under a block grant to revamp its existing Medicaid program.[29] The paper describes how the amount of a block grant might be set, along with the terms and conditions establishing a new compact between the federal government and states – giving states more flexibility, but also requiring accountability for outcomes in the process.

Texas envisions a block grant as providing a way to revamp its Medicaid program for both low-income and elderly beneficiaries. For lower-income applicants, the state could choose to subsidize private health insurance, with incentives linked to Health Savings Account (HSA) plans. Beneficiaries would fund the difference between the amount of the state-provided subsidy and the cost of the insurance plan, "provid[ing] strong incentives to the

enrolled population to purchase low premium, high value plans. Beneficiaries selecting coverage that costs less than their premium support entitlement would be allowed to deposit the difference in an HSA."[30]

With respect to long-term care for the elderly, the Texas paper envisions a series of reforms under a Medicaid block grant. Incremental reforms – including partial benefits for those who seek to remain in community settings, a competitive bidding process for nursing home care, and greater restrictions on asset transfers, to ensure benefits are targeted toward truly needy individuals – would eventually lead to a fundamental transformation of the long-term care benefit into a defined contribution model. Under this reform, "the state will provide a pre-determined level of financial support directly to those eligible by establishing and funding an account on each beneficiary's behalf" to be used for eligible care expenses – maximizing beneficiary choice and flexibility and encouraging the use of community-based service over institutional nursing homes.

Unfortunately, a block grant requires approval from Congress – and neither the Democrat Senate nor President Obama currently appear inclined to grant states the degree of flexibility the Texas paper envisions. But Rhode Island's Global Waiver, approved in the final days of the George W. Bush administration, shows that the administration does have the authority to grant global waivers to other states seeking the same control over their Medicaid programs.

Nevertheless, the ideas offered in the paper present a vision where both flexibility and market incentives can provide better quality coverage to residents while providing budgetary stability to federal and state governments alike.

Learning from other states

Other examples of states taking action on their Medicaid programs:

North Carolina: States first need to be armed with solid information about how the Medicaid program is working. They need to know who is being helped or harmed and how much is being lost to waste and inefficiency in this ossified, rule-driven program. In North Carolina, state auditor Beth Wood recently found that the state's Medicaid program endured $1.4 billion in cost overruns each year, including $375 million in state dollars. As a result, North Carolina has decided not to expand its Medicaid program. Before considering any action, others states should commission objective, independent audits of their Medicaid programs to understand the program and the problems that need fixing.

New York also was able to gain more control over how Medicaid subsidy money is spent in exchange for a global cap on a substantial fraction of its Medicaid expenditures.

West Virginia offers alternative benefit packages that create incentives for beneficiaries to take responsibility for their own health and health care. Kentucky and Idaho are among other states with similar programs. Patients receive additional benefits if they select a medical home, adhere to health improvement programs, keep and arrive on time for appointments, use the hospital emergency room for emergencies only, and comply with prescribed medications.

Utah fought for and received a waiver that allowed the states to scale back Medicaid's excessively large benefit package to stretch the money to cover more citizens.

These are a few examples of the creative programs that states could develop if they weren't forced to jump through Washington's Mother-May-I Medicaid hoops to get approval to make even minor changes to their Medicaid programs.

Lessons and Themes

While each state's Medicaid program is unique, the examples discussed above each contain common themes that should guide policy-makers seeking to transform their state health systems – and avoid the pitfalls of Obamacare's massive, bureaucratic expansion:

- ***Customized Beneficiary Services***: Providing beneficiaries with a choice of coverage options can provide plans an incentive to tailor their benefit packages to best meet individuals' needs. Similar incentives promoting competition in the Medicare Part D prescription drug benefit helped keep that program's cost more than 40% below original estimates.[31]

- ***Coordinated and Preventive Care***: Several of the reform programs focus on providing individualized, coordinated services to beneficiaries – an improvement to the top-down, uncoordinated care model of old. In many cases, preventive care interventions for Medicaid recipients suffering from chronic conditions can ultimately save money.

- ***Personal Responsibility***: Cost-sharing can be an appropriate incentive, to encourage beneficiaries to take ownership of their health, and discourage costly practices, such as emergency room trips for routine care. The fact that more than two-thirds of Healthy Indiana Plan participants consider their cost-sharing levels appropriate proves that even families of modest means are both willing and able to provide some financial contribution to their cost of care.

- ***Home and Community-Based Services***: Several of the reform programs attempt to continue and accelerate the trend of providing long-term care in patients' homes, rather than in more cumbersome and costly nursing home settings.

- ***No New Federal Funds***: Most importantly, each of the reform projects discussed above neither seek nor require the massive new spending levels contemplated by an Obamacare expansion. In many cases, the programs above were implemented successfully **despite** Washington's interference, not **because** of it.

Conclusion

Functioning in their traditional role as laboratories of democracy, states have provided better solutions for policy-makers seeking to reform their Medicaid programs. These solutions have expanded coverage, and improved the quality of care, even while reducing costs to taxpayers. As the Obama administration denies states true flexibility when it comes to Obamacare's costly Medicaid expansion, states have demonstrated that they can convert a modicum of leeway from Washington into maximum improvements for their citizens – and savings for taxpayers.

The analysis above shows that Chief Justice Roberts was right: states do have a choice when it comes to their Medicaid programs. They can – and should – choose the options that will reform and revitalize their programs, rather than the massive and costly expansion of the Medicaid monolith included in Obamacare.

States must take the lead in insisting that Washington provide more flexibility over Medicaid spending so they can expand access to care without burdening taxpayers with

significant new costs or burdening their citizens with a program that can be worse than being uninsured.

States can show that Medicaid can have a more efficient and effective service delivery system that enhances quality of care and outcomes. Expanding Medicaid without a guarantee of flexibility would be a major missed opportunity for the states. If states join together, they have more leverage to demand true flexibility than if they try to gain leverage one by one.

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NOTES

[1] *NFIB v. Sebelius*, June 28, 2012, http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf, p. 52.
[2] Prior to the Supreme Court ruling, the Congressional Budget Office estimated that Obamacare would expand coverage to 17 million individuals through Medicaid by 2022, while the Office of the Actuary at CMS estimated the Medicaid expansion would cover 25.9 million individuals by 2020. See CBO, "Estimates for Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision," July 24, 2012, http://cbo.gov/sites/default/files/cbofiles/attachments/43472-07-24-2012-CoverageEstimates.pdf, Table 1, p. 19, and Office of the Actuary, Centers for Medicare and Medicaid Services, "2011 Actuarial Report on the Financial Outlook for Medicaid," March 16, 2012, http://www.cms.gov/Research-Statistics-Data-and-Systems/Research/ActuarialStudies/Downloads/MedicaidReport2011.pdf, p. 30.
[3] Grace-Marie Turner and Avik Roy, "Twelve Reasons States Should Not Expand Medicaid," Galen Institute, March 15, 2013, http://www.galen.org/topics/tennessee-should-block-medicaid-expansion/.
[4] Scott Gottlieb, "Medicaid Is Worse than No Coverage at All," The *Wall Street Journal* March 10, 2011, http://online.wsj.com/article/SB10001424052748704758904576188280858303612.html.
[5] See, for instance, Joanna Bisgaier and Karin Rhodes, "Auditing Access to Specialty Care for Children with Public Insurance," *New England Journal of Medicine* June 16, 2011, http://www.nejm.org/doi/full/10.1056/NEJMsa1013285.
[6] Chris Conover, "Will Medicaid Expansion Create Jobs?," *Forbes*, February 25, 2013, http://www.forbes.com/sites/chrisconover/2013/02/25/will-medicaid-expansion-create-jobs/.
[7] CMS Bulletin, "Medicaid and the Affordable Care Act: Premium Assistance," March 29, 2013, http://medicaid.gov/Federal-Policy-Guidance/Downloads/FAQ-03-29-13-Premium-Assistance.pdf.
[8] Lewin Group, "An Independent Evaluation of Rhode Island's Global Waiver," December 6, 2011, http://www.ohhs.ri.gov/documents/documents11/Lewin_report_12_6_11.pdf.
[9] Ibid., p. 40.
[10] Specifically, the report notes that the maintenance of effort requirements included in the "stimulus" (P.L. 111-5) and Obamacare (P.L. 111-148) "had a profound impact on the flexibility Rhode Island anticipated…The Special Terms and Conditions for the global waiver authorized Rhode Island to charge premiums of up to 5 percent…however, CMS prohibited Rhode Island from using this authority," citing the maintenance of effort requirements. Ibid., pp. 11-12.
[11] See, for instance, a 2010 Centers for Disease Control research brief finding Medicaid beneficiaries were nearly twice three times as likely as those with private insurance to visit the ER multiple times in one year. Tamrya Caroll Garcia, Amy Bernstein, and Mary Ann Bush, "Emergency Department Visitors and Visits: Who Used the Emergency Room in 2007?" National Center for Health Statistics Data Brief No. 38, May 2010, http://www.cdc.gov/nchs/data/databriefs/db38.pdf.
[12] Timothy Lake, Vivian Byrd, and Seema Verma, "Healthy Indiana Plan: Lessons for Reform," Mathematica Policy Research Issue Brief, January 2011, http://mathematica-mpr.com/publications/pdfs/health/healthyindianaplan_ib1.pdf.
[13] Indiana Family and Social Services Administration, Healthy Indiana Plan 1115 Waiver Extension Application, February 13, 2013, http://www.in.gov/fssa/hip/files/HIP_WaiverforPosting.pdf, p. 18.
[14] Cited in Ibid.
[15] "Healthy Indiana Plan: Lessons for Reform."
[16] Healthy Indiana Plan 1115 Waiver Extension Application, pp. 19, 6.
[17] "Healthy Indiana Plan: Lessons for Reform."
[18] Milliman letter to Indiana Family and Social Services Administration regarding budget neutrality of Medicaid Section 1115 waiver, January 30, 2013, http://www.in.gov/fssa/hip/files/041115_Budget_Neutrality_Waiver_Renewal.pdf.

[19] Mitch Daniels, "We Good Europeans," The *Wall Street Journal* March 26, 2010, http://online.wsj.com/article/SB10001424052748704094104575144362968408640.html.
[20] Frequently Asked Questions on Statewide Medicaid Managed Care Program, Florida Agency for Health Care Administration, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/FAQ_MC-SMMC_general.pdf.
[21] Ibid.
[22] Florida Agency for Health care Administration, Section 1115 waiver submission to the Centers for Medicare and Medicaid Services, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/fl/fl-medicaid-reform-pa.pdf.
[23] Ibid., p. 16.
[24] A summary of the specific federal authorities Florida seeks to waive can be found on the state Agency for Health Care Administration website, http://ahca.myflorida.com/medicaid/statewide_mc/pdf/Summary_of_Federal_Authorities_01232013.pdf.
[25] "Florida Health Choices PLUS+: Creating a Stronger Marketplace for Better Health, More Choices, and Expanded Coverage," Floriday House Majority Office, April 2013, http://myfloridahouse.gov/Handlers/LeagisDocumentRetriever.ashx?Leaf=housecontent/HouseMajorityOffice/Lists/Other%20Items/Attachments/6/Florida_Heath_Choices_Plus.pdf&Area=House.
[26] Available online at http://myfloridahouse.gov/Sections/Documents/loaddoc.aspx?PublicationType=Committees&CommitteeId=2738&Session=2013&DocumentType=Proposed%20Committee%20Bills%20%28PCBs%29&FileName=PCB%20SPPACA%2013-03.pdf.
[27] Congressional Budget Office, "How Many People Lack Health Insurance and for How Long?" May 2003, http://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/42xx/doc4210/05-12-uninsured.pdf, Table 4, p. 11. For a further discussion of the cohorts comprising the uninsured, see Chris Jacobs, "Deconstructing the Uninsured," Republican Study Committee Policy Brief, August 26, 2008, http://rsc.scalise.house.gov/uploadedfiles/pb_082608_uninsured%20analysis.pdf.
[28] See for instance Jonathan Gruber and Kosali Simon, "Crowd-Out Ten Years Later: Have Recent Public Insurance Expansions Crowded Out Private Insurance?" *Journal of Health Economics*, February 2008, http://economics.mit.edu/files/6422. The study found that about three in five individuals enrolled in government health programs dropped their private coverage to do so.
[29] James Capretta, Michael Delly, Arlene Wohlgemuth, and John Davidson, "Save Texas Medicaid: A Proposal for Fundamental Reform," Texas Public Policy Foundation, March 2013, http://www.texaspolicy.com/sites/default/files/documents/2013-03-RR05-MedicaidBlockGrants-Final.pdf.
[30] Ibid., p. 10.
[31] Robert Moffit, "Medicare Drugs: Why Congress Should Reject Government Price Fixing," The Heritage Foundation Issue Brief 3880, March 18, 2013, http://www.heritage.org/research/reports/2013/03/medicare-drugs-why-congress-should-reject-government-price-fixing.