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Reforming Medicaid in Texas

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EXECUTIVE SUMMARY

The nation's health care inflation rate — recently five times the rate of general inflation — has caused many to conclude that health care is unaffordable. Further compounding the problem, employers who provide health insurance to their employees — in order to remain competitive — are shifting more and more of the escalating health care costs to their employees. Consequently, increasing numbers of people are forgoing insurance. Texas has the highest rate of uninsured (28.4 percent) of any state, while Houston has the highest uninsured rate (31.8 percent) of any large city in the nation.

Some Texans receive health insurance through Medicaid, which is intended to be the safety net for the nation's poor. The program is operated by states under federal rules, and is jointly funded by the states and federal government. In recent years, Texas Medicaid spending has doubled, on the average, every six to seven years, an eightfold increase in less than 20 years.

At this explosive rate of unprecedented growth, the present $17 billion annual Texas Medicaid budget will exceed $136 billion annually — more than one-quarter of a trillion dollars ($272 billion) a biennium in less than 20 years. That amount is more than double the state's budget today.

Texas Medicaid spending multiplied despite continuing attempts to limit its growth. The easiest savings options have already been taken. According to a number of state finance experts, the possibility of Medicaid bankrupting every state within 20 years (or forcing significant change in government operations) is real.

Of more immediate concern to policymakers is Medicaid's impact on the upcoming Texas budget. The Texas Health and Human Services Commission (HHSC) has notified the Legislature that it will require an additional $8.4 billion throughout the current biennium to continue support of the state's Medicaid program. At that rate of increase, Medicaid spending will once again double quickly.

Medicaid must be changed. Texas can no longer afford to maintain a program whose soaring costs threaten not only all other programs (such as education), but also the overall stability of the state budget itself.

Successfully changing Medicaid will not be easy. However, policymakers can continue to provide a safety net for needy Texans that Texas taxpayers can afford, if two necessary conditions are met and five guiding strategies are followed.

Conditions Necessary for Medicaid Reform

1. Ensure Medicaid budgets, expenditures, and projections are accurate and complete.
2. Develop, use, and refine long-term models for predictable Medicaid spending cycles.

Guiding Strategies for Reforming Medicaid

1. Tailor Texas Medicaid to Texas priorities. Use federal waivers to target optional services to specific populations, such as eye care services for school-age recipients.
2. Develop and encourage use of less expensive alternatives for Medicaid recipients. Create premium assistance programs, integrate Medicaid and Medicare funding, expand consumer-directed services, enroll Medicaid recipients in private sector health plans, and encourage optional populations to purchase long-term insurance for extended care.
3. Introduce market-based forces into Medicaid. Establish a state-operated insurance and provider exchange (health mart) and allow Medicaid recipients to select private-sector plans.
4. Encourage individual responsibility and empower patients to control costs. Create Medicaid Benefit Accounts to allow recipients to control some or all of their health care dollars and establish co-payments.
5. Create and pilot test models for Medicaid overhaul. Use federal waivers to create test models for comprehensive, long-term reform.

Ultimately, the entire health care finance system needs to be reformed, especially its heavy reliance on third-party payers and excessive regulatory mandates. Although Texas, with more mandates than most states, certainly can improve the health care system, much of the needed reforms will have to come from the federal government at the urging of the states.

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OVERVIEW

Stress fractures are appearing throughout the structure of the nation's health care system, signaling an imminent crisis. The nation's health care inflation rate, recently five times the rate of general inflation, has caused many Americans to conclude that health care is unaffordable. Further compounding the problem, employers who provide health insurance to their employees, in order to remain competitive, are shifting more and more of the escalating health care costs to their employees. Consequently, increasing numbers of people are forgoing insurance. An estimated 45 million Americans are uninsured[1] and the number is growing rapidly. Texas has the highest rate of uninsured (28.4 percent) of any state, while Houston has the highest uninsured rate (31.8 percent) of any large city in the nation.[2]

Some Americans receive health insurance through Medicaid, a program intended to be the safety net for the nation's poor. It is operated by states under federal rules and is jointly funded by the states and the federal government. It has become a giant vacuum cleaner, sucking vast amounts of revenue out of state budgets. In less than 40 years, this program has grown so large that it consumes 21 percent of the average state budget.[3] Medicaid consumes one-third of the Tennessee budget and 28 percent of the Texas budget. During 2004, Medicaid replaced elementary and secondary education as the number one spending category in the average state budget, according to the National Governor's Association.[4]

Recently in Texas, Medicaid spending has averaged doubling every six to seven years, an eightfold increase in less than two decades. At this explosive rate of unprecedented growth, the present $17 billion annual Texas Medicaid budget will exceed $136 billion a year, or more than one-quarter of a trillion dollars ($272 billion) a biennium, in less than 20 years. While powerful special interest groups can be expected to contest this conclusion, two factors suggest such projections may, in fact, prove to be very conservative, unless significant structural changes are made to Medicaid.

> First, if it were not for decreased Medicaid caseloads due to welfare reform, the average historical doubling of Medicaid spending might be more on the order of every three or four years, as occurred in the late '80s and early '90s in Texas when Medicaid doubled and redoubled in less than eight years.
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> Second, Texas Medicaid spending multiplied despite continuing attempts to limit its growth. The easiest savings options have already been taken, yet the multiplication continues. According to a number of state finance experts, the possibility of Medicaid bankrupting every state within 20 years (or forcing significant change in government operations) is real.[5]

Of more immediate concern to policymakers is Medicaid's impact on the upcoming Texas budget. The Texas Health and Human Services Commission has notified the Legislature that it will require an additional $8.4 billion during the current biennium to

continue support of the state's Medicaid program.[6] At that rate of increase, Medicaid spending will quickly double once again.

Escalating Medicaid costs create a policy dilemma. On one hand, those who believe health care is a right view increasing numbers of uninsured as a clear mandate for increased government-provided health care. However, as Oregon and Tennessee have already demonstrated, attempts to provide even limited universal government health care are ultimately unaffordable.[7] On the other hand, others say that Texas needs to regain control of its budget by limiting or eliminating Medicaid services or eligibility, which can generate considerable personal disruption for needy Texans, not to mention political backlash if the issue is not addressed with great sensitivity and wisdom. A less intrusive alternative is to make the present system more efficient and effective — still challenging given Medicaid's 40-year history of cumulative regulations.

How have we arrived at this critical point without more advance warning? Why have Medicaid spending growth and the resulting pressure on states budgets been under-publicized?

- First, the media and special interest groups generally do not consider finite state revenues to be a limitation when discussing health care problems of the poor and uninsured. More government spending is viewed as part of a solution, not part of the problem.

- Second, since Medicaid has joint federal-state accountability, it is easier to point fingers after a problem is identified rather than to proactively notify policymakers of potential problems.

- Third, bureaucracies view growth of their programs as a positive, and, therefore, do not sound the alarm about their exponential growth.

- Fourth, because Medicaid is an entitlement and its growth often lags economic conditions, the program's largest spending occurs at a time when state revenue pressures are the greatest. There is a tendency to use quick fixes and to ignore the long-range implications of such temporary measures at such times. Furthermore, meaningful solutions to underlying structural issues are much more difficult to achieve politically without additional funding, which is not available under such conditions.

- Fifth, most legislators and policymakers are unaware of the actual size of Medicaid growth. While some public officials recognize the Medicaid growth problem, they have no "silver bullet" to solve it. Furthermore, traditional responses have failed spectacularly in their efforts to stop long-term spending growth, even after short-term "savings" from multiple applications of these traditional remedies. If policymakers publicize Medicaid growth, then the public may expect a solution at a time when these policymakers must confront powerful political players vested in maintaining the status quo. Simply put, at least in the short run, the political risk is greater than the potential political gain.

In the long run, unchecked Medicaid spending growth will wreck havoc with Texas' budget. The magnitude of the problem is such that it will severely limit the Legislature's ability to respond to other policy concerns, including the state's historic priority of education. Given that Medicaid is an entitlement, the cost of health care for eligible recipients must be paid by the state whether or not sufficient funds have been budgeted (or are even available) and regardless of whether other issues (such as education finance) are in serious need of attention and funding. Consequently, the Legislature's ability to develop a workable (even a phased) long-term solution to school finance likely will be eliminated or, at best, severely limited until Medicaid is fundamentally changed.

A CALL TO ACTION: MEDICAID MUST BE CHANGED

If the federal government does not take the lead, reformation must be undertaken at the state level. Texas can no longer afford to maintain a program with soaring costs that threatens not only all other programs, but the overall stability of the state budget itself.

Successfully changing Medicaid will not be easy. However, policymakers can continue to provide a safety net for needy Texans that Texas taxpayers can afford, if two necessary conditions are met and five guiding strategies are followed.

The first necessary condition for controlling Medicaid spending is to ensure that Texas Medicaid budgets, expenditures, and projections are accurate and complete. Hundreds-of-millions or even billion-dollar Medicaid shortfalls have emerged far too often to be ignored. Agency and policy-making staff must be held accountable for consistently underestimating current or future Medicaid spending needs. The second necessary condition is to understand that Medicaid's spending cycle is both dynamic and nearly 40 years old. Medicaid patterns can be predicted. Long-term Medicaid models should be developed, used, and refined so that cyclic changes are neither unexpected nor ignored during tight revenue periods.

Guiding strategies to avoid a continual Medicaid budget crisis are recommended for a number of reasons. Primarily, they would enable policymakers to circumvent the perpetual argument of whether health care is a right and to instead begin developing solutions to make Medicaid affordable. Texas can no longer afford the classic delay tactic of arguing details and cost estimates in an effort to ensure that Medicaid is not substantively changed. Finally, guiding strategies would ensure that all participants, including taxpayers, are better able to understand the effects of changing strategies rather than the effects of changing arcane Medicaid rules.

Guiding strategies for reforming Medicaid include:

1. Tailor Texas Medicaid to Texas priorities,
2. Develop and encourage use of less expensive alternatives for Medicaid recipients,
3. Introduce market-based forces into Medicaid,
4. Encourage individual responsibility and empower patients to control costs, and

5. Create and pilot test models for Medicaid overhaul.

Ultimately, the entire health care finance system also needs to be reformed, especially its reliance on third-party payers and excessive regulatory mandates. Texas, with more mandates than most states, certainly can improve, but much of the needed reforms must come from the federal government at the urging of the states.

NATURE OF THE PROBLEM

The Looming Health Care Crisis

Disturbing reports pour in year after year heralding new rounds of medical inflation, increasing costs of health insurance premiums, rising numbers of Americans without insurance, emergency room overcrowding, and escalating Medicaid costs with their devastating impact on state budgets. Despite the alarming statistics, they are often ignored even as the health care system moves closer to crisis. A more detailed examination of these components of the health care crisis is provided in Attachment A.

At the heart of this crisis is the federal-state Medicaid program, an attempt by the government to respond to the health care needs of the poor. Unfortunately, as the Medicaid program has evolved, it has become outdated and regulation-encrusted, as much a problem as it is a solution.

A Costly Program

Without a doubt, Texas Medicaid is expensive. Texas Medicaid spending for fiscal year 2004 was an estimated $17.0 billion[8] of the state's $59.6 billion budget. Stated another way: Texas Medicaid currently consumes more than one-quarter (28.5 percent[9]) of the total Texas budget, costing taxpayers more than $750 annually for every man, woman, and child in the state.[10] Indeed, it is possible that some families pay more in state and federal taxes to support Medicaid for others than they pay in premiums to buy private insurance for their own families.

More Costly in the Future

As high as Medicaid spending is today, future spending is certain to be considerably higher. In the early days of the Texas Medicaid program, it took 20 years for it to become a $2 billion-a-year item in the state budget. However, over the next 17 years, Texas Medicaid grew to a $17 billion-a-year budget item. This spending increase occurred despite the fact that caseloads were relatively stable from 1994 to 2001.

At this historic rate of increase, in another 20 years, Texas Medicaid expenditures will be more than $135 billion a year (more than one-quarter of $1 trillion per biennium). This figure is more than twice as large as the total current state budget.

Staggering increases in Medicaid costs are not unique to Texas. Nationwide studies report Medicaid costs per enrollee have nearly doubled in the last five years — with projected spending increases rising even faster. Medicaid, unreformed, threatens to take every new state tax dollar.[11] According to a number of state finance experts, the doomsday scenario of Medicaid bankrupting every state within 20 years (or forcing significant change in government operations) is very realistic.[12]

Perhaps the most disturbing aspect of these Medicaid increases is that they have occurred despite dramatic attempts by many states (including Texas) to stem the tide of rising Medicaid costs. Thirty-seven states have cut a combined $12.6 billion from their Medicaid budgets.[13] Some states are tightening Medicaid eligibility rules to limit the number of people receiving services, and some are cutting services. Forty states are reducing the amount paid for prescription drugs by implementing preferred drug plans.[14] Even with such attempts to control Medicaid, costs have continued to spiral upward at an alarming rate.

The Reality of Projections for Medicaid's Future

An eightfold increase in Texas Medicaid spending in less than 20 years and increases of more than 50 percent during the past five years are established facts, but how likely is it that these increases will continue? An examination of the factors that influence Medicaid costs is needed to determine the likelihood of whether Texas will experience Medicaid increases of this magnitude in the future.

Medicaid's cost is driven by a number of factors, including caseload, types of patients served, and prices of services offered. Caseload affects the cost of Medicaid because the larger the number of individuals on Medicaid's rolls, the more a state will pay. While Texas Medicaid's annual caseload has fluctuated due to changes in economic conditions and policy decisions affecting eligibility, the long-term trend has resulted in 2.5 million individuals currently on the rolls.

The type of Medicaid client served also affects Medicaid costs. Medicaid's general adult population has been found to have poorer health than its low-income, privately insured counterpart population.[15] Consequently, their medical needs are an important influence on the cost of Medicaid. Moreover, about one-fifth of the Medicaid population is elderly and disabled, clients who clearly have greater medical needs than the general population. And while their numbers may be small, the aged, blind, and disabled populations accounted for 80 percent of increased national Medicaid expenditures in 2004, according to data from the Kaiser Family Foundation.[16]

The third cost factor is the price of medical services. Increasing prices for medical services drive up the cost of Medicaid; prescription drug prices, as well as costs for acute care in hospitals and long-term care in nursing homes, are particularly strong contributors to medical inflation, thereby increasing Medicaid costs.[17] New advances in medical technology can also increase costs for medical care. A more in-depth discussion of cost drivers is included as Attachment B.

HOW MEDICAID CONTRIBUTES TO ITS OWN PROBLEMS

The very manner in which Medicaid is structured contributes to the costly nature of the program, creating perverse incentives that discourage recipients from becoming financially self-sufficient and leaving Medicaid's rolls. Because Medicaid benefits are conditional upon low income, the program penalizes those who succeed; individuals can lose eligibility (and therefore health insurance coverage) for themselves and their families simply by getting a job-related promotion or raise. Additionally, Medicaid benefits are conditional upon having few assets, forcing recipients to consider spending rather than saving their income. Finally, because Medicaid is an alternative to private insurance, the program encourages people to drop employer-based coverage in favor of "free" insurance underwritten by taxpayers, a phenomenon referred to as "crowding out."

There has been very little research documenting ways in which people have responded to these incentives. However, existing research confirms what common sense would predict: Medicaid beneficiaries have behaved in a rational manner, given the program's parameters. They have dropped private insurance coverage, saved less, and consumed more.[18] Any attempted reform of state Medicaid plans needs to take into account the perverse effects of the program already in place. With such an understanding, better incentives can be developed.

There is also empirical documentation of a "crowding out" effect of Medicaid on private health insurance. Nationwide, the percentage of children who could receive Medicaid increased by more than 50 percent between 1987 and 1992; the number of pregnant women who became eligible for Medicaid more than doubled. Consequently, Medicaid rolls increased by more than 2.3 million. This increase, however, was accompanied by a significant drop in private insurance, offsetting 50 percent to 75 percent of the increase in Medicaid coverage. The vast majority of this reduction came when workers decided to drop private coverage (particularly for dependents), not when employers eliminated coverage.[19]

How Medicaid Contributes to Inflation

Not only is Medicaid adversely affected by inflation, Medicaid contributes to it, using a pricing system that divorces it from the marketplace. The costs for Medicaid services are determined not by market forces, but by bureaucrats speculating as to the future price of specific medical services. This speculative figure becomes the price providers are reimbursed for services given to Medicaid patients. If, as often happens, actual costs are higher than the set Medicaid price, then Medicaid expenditures will be artificially low. The problem, aside from misallocation of resources, is that someone must pay the difference, which leads to cost shifting.

Cost shifting occurs when one payer does not pay the full cost for medical services, either because the party is indigent and unable to pay or because the party is a Medicaid recipient for whom the government underpaid the provider. In either case, if health care

providers are to remain in business, the difference between their costs and the payments received must be covered; that difference is passed on to other payers. Cost shifting causes prices to increase for those who can pay, and medical care inflation results. That medical inflation then becomes a factor in the next cost-based Medicaid rate-setting process. Thus, cost shifting caused by Medicaid can fuel new structural inflation. As Medicaid continues to take more of the budget, the impact of such structural inflation will become larger and larger.

Furthermore, if the cost-based system sets artificially low reimbursement rates, actual costs are not being processed through the Medicaid rate-setting system in a timely manner. If prices are frozen or held artificially low, those costs must come through the system at a later date,[20] which means Medicaid inflation will last longer than general medical inflation. By paying less than medical services cost, Medicaid shifts costs (as discussed earlier) to other payers in the health care system.

It seems counterintuitive to think that delaying cost increases could be detrimental if the objective is to reduce state spending. However, the payment system for Medicaid is based on cost, and as long as costs (as opposed to quality or outcomes) are the basis for Medicaid payments, those costs must ultimately be passed through the system. To the extent that costs are not passed through, the state likely will lose lawsuits, quality suffers, and inflationary pressures are bottled up within the system. In Medicaid terms, the outcome of delaying cost increases is that inflation in Medicaid will last longer than inflation in the general economy.

The Sustainability of Medicaid

Components of the health care system act upon and reinforce one another, generating a downward, or — as some have described it — "death spiral." The death spiral operates as follows: Higher insurance premiums result in fewer people who can afford private employer-based insurance, therefore more people are without insurance. Having more people without insurance puts increased strain on public systems because, when sick or injured, the uninsured seek health care from government and private charity; demand for Medicaid, the Texas Children's Health Insurance Program (CHIP), and charity hospital care increases and emergency rooms become clogged with the uninsured and those on Medicaid. Hospitals must cover their costs from those who cannot pay or from inadequate Medicaid reimbursements by overcharging other patients, so insurance premiums go up. More individuals decide they cannot afford the higher premiums and drop their insurance; the number of uninsured rises and the demand for Medicaid increases. States must pay. Pressure accumulates, and the cycle continues its downward course and problems worsen. Like other states, Texas is caught in this potentially fatal downward cycle.[21]

The probability of a collapse of the health care system can be reduced, but only if changes are made. The Texas budget cannot continue to absorb increases of the magnitude previously described. Texas policymakers must recognize that Medicaid is not static; they must consider its dynamic nature and the resulting implications and act

accordingly. The message is clear: Traditional approaches of limiting eligibility, benefits, and provider payments have not stopped the increasing cost of Medicaid. Texas taxpayers cannot afford current trends and Medicaid must be fundamentally changed. The final section of this report provides more detailed suggestions for making such changes.

STRATEGIES FOR SOLUTIONS

This section provides a general discussion of strategies to reform Medicaid and specific recommendations to implement those strategies. While the merits and drawbacks of individual recommendations may be debated and specific recommendations adopted, rejected, or modified, the overall strategies are key to successful reform of Texas Medicaid.

STRATEGY #1: Tailor Texas Medicaid to Texas Priorities.

Over its 40-year lifespan, Medicaid has evolved into an expensive, heavily regulated, one-size-fits-all-states program. To receive federal matching funds, Texas has been forced to accept an inflexible patchwork of federal mandates and requirements regardless of whether or not they respond to Texas' health care concerns and priorities. Fortunately, the federal government recently introduced the Health Insurance Flexibility and Accountability (HIFA) waiver in an attempt to allow states to free themselves from Medicaid's federally regulated straightjacket and experiment with tailored Medicaid solutions. For states willing to take the challenge, the waiver creates an opportunity to creatively and radically restructure their Medicaid programs. For instance, Utah used the waiver to expand Medicaid coverage to a larger group of uninsured by cutting back on services provided to existing recipients (see "The Utah Experience").

HIFA waivers allow the states to:

- Reduce some benefits in return for increases in other benefits;
- Reduce benefits in return for increases in the number of people eligible for those benefits; or
- Reduce benefits for some people in order to create a new set of benefits for other people.

The constraint is that the change must be budget neutral. If carefully designed, though, the waiver can introduce a greater measure of state control and improve effectiveness of the program.

The Utah Experience: Testing the Limits of Federal Waiver Opportunities[1]

The Utah model demonstrates the revolutionary use of a waiver: Using unexpended federal matching funds for CHIP, reducing benefits for currently eligible Medicaid recipients, and expanding eligibility to cover low-income working individuals without coverage.

The Utah model meets the requirements for HIFA waivers by obtaining budget neutrality while expanding eligibility to new populations. The change in mandated populations is balanced by changes in mandated benefits and unused federal funds.

The state also uses fact-based evaluations to guide disease management and care coordination, ensuring the net effects of better care with fewer services achieve the desired outcomes. For example, by providing appropriate treatment during pregnancy, a number of low-weight births can be prevented; instead of sick babies, healthy babies would be the result. Fewer services would be provided so costs would be lower, yet outcomes would be better.

On the cost-reduction side, Utah replicates the benefits package provided through theUtah Public Employees Plan rather than the more generous Medicaid design.[2] State law was changed so private insurers could offer employers plans with the same benefits as the plans in which public employees are enrolled. As a result, this allows the state to buy Medicaid enrollees into employer plans, relying on the private market rather than expanding public programs. This saves money for the state because employer premium payments substitute for Medicaid spending. Under the Utah waiver, an enrollment fee and co-pays up to 11 percent of annual income are permitted. [3]

On the cost-expansion side, Utah broadened eligibility under the waiver to cover two groups: (1) parents with children enrolled in Medicaid or CHIP whose family income is below 150 percent of poverty, and (2) childless adults with the same income level. The significance of the Utah waiver is monumental. By following Utah's example, other states can exercise greater control over Medicaid costs, making budget-neutral changes in one year that reduce Medicaid expenditures in succeeding years.

HIFA waivers are not without risks. Specifically, there is an inherent danger of rising costs under HIFA waivers because of the eligibility expansion. Eligibility expansions can multiply other cost increases.

[1] The Buckeye Institute and National Center for Policy Analysis, *Reforming Medicaid in Ohio: A Framework for Using Consumer Choice and Competition to Spur Improved Outcomes*, March 2003.
[2] This more limited benefit package is also the package made available under Utah's CHIP program.
[3] Enrollment under the Utah waiver will be restricted until program evaluations can be completed on: (1) the success of the plan in reducing health problems for the population served; (2) the impact on the use of emergency rooms; and (3) the effects of "crowd out" (the extent to which public insurance is substituted for private insurance that was formerly purchased).

Tailoring through Federal Waiver Opportunities

A strong case can be made for Texas to tailor optional Medicaid services to specific groups of beneficiaries. For example, Texas might decide that eye care services are essential for school-age Medicaid recipients (due to the correlation between good eyesight and school performance) but that they are not critical for some other Medicaid populations. (In fact, most private or employer-based insurance policies do not provide policyholders the wide range of services available to Medicaid recipients. As a result, taxpayers generally have lower benefits in their own health insurance plans than those provided to Medicaid enrollees at taxpayer expense.)

Another potential example of tailoring: Texas might decide that providing certain services, such as those designed to prevent or identify early stages of diseases to a group heretofore ineligible for Medicaid, might reduce overall health care costs in the future. Often, non-Medicaid, uninsured persons delay seeking health care until their illness is so advanced that more expensive care is necessary. The cost of such treatment is either paid by the taxpayer as charity care or is passed on to paying patients through increased costs. Tailoring optional Medicaid services to specific population groups can exert a positive influence on Medicaid and other health care costs. To pay for this potentially cost-effective expansion, non-critical benefits would necessarily be reduced for current Medicaid recipients.

To What Extent Medicaid Can Be Restructured

Nationwide, about 70 percent of all Medicaid spending is optional, covering either beneficiaries who do not have to be covered or services that do not have to be provided, or both.[22] In Texas, these optional beneficiary populations primarily involve infants, pregnant women, and those in nursing homes with incomes up to 220 percent of the poverty level. Any attempt to reduce these optional populations would require revisiting earlier Texas legislative decisions.

The other alternative — reducing optional services — presents a different set of challenges. Examples of optional services include prescription drugs, diagnostic screening, prevention and rehabilitation services, clinic services, dental care, dentures, eye care services, physical therapy, and prosthetic devices. Some of these optional services can be eliminated, and may have to be reduced or eliminated if Texas is to have any hope for budget certainty and control of the burgeoning Medicaid program.

The largest optional service expenditure in Texas, as in many states, is prescription drugs. A review of this category may illustrate some of the difficulties in attempting to eliminate such optional services. For example, a study by Columbia University professor Frank Lichtenberg discovered that an increase of 100 prescriptions is correlated with about 1.48 fewer hospital admissions and 3.36 fewer inpatient surgical procedures.[23] Overall, a $1 increase in pharmaceutical expenditures is associated with a $3.65 reduction in hospital care expenditures. In another study, an employer who reduced spending on mental health

witnessed a greater increase in other health services.[24] Clearly, eliminating optional services needs to be approached with caution as well.

The Current "One-Expensive-Size-Fits-All" Approach

The expansion of Medicaid to include such a large national percentage (70 percent) of non-mandated or optional populations and services is the result of adding, over time, both new population groups in need of some type of assistance (but perhaps not the full array of Medicaid services), as well as adding new, across-the-board services that, while valuable, may not be essential to all those eligible for Medicaid. Historically, when an unmet need is identified there has been a tendency to apply Medicaid as the solution — one of the most expensive and possibly least efficient of all available health care options.

Recommendation:

Develop HIFA Waivers for Texas. Texas should seek HIFA waivers to shift its Medicaid program away from providing low-priority, high-marginal-cost services toward providing high-priority, lower-marginal-cost services. A series of waivers should be sought as long as Medicaid costs increase at near double-digit rates or higher. The Legislature and governor would determine the services and the populations eligible under the HIFA waiver.

Specific HIFA waivers, which have been suggested by various analysts, are for the use of premium financial assistance to experiment with the eventual implementation of a benefit phase-out rate for Medicaid. Maine is currently experimenting with a form of this type of waiver, and the results of the Maine waiver should prove very useful in such an undertaking (see sidebar on "Maine's Proposed Experiment with Expanded Coverage"). A second federal waiver to consider might be to permit integration of Medicaid and Medicare funding for individuals who are eligible for both programs. Such integration would allow for greater coordination and efficiency. A third waiver possibility would be to seek federal approval to expand consumer-directed services beyond personal-assistance services to include transportation, assistance technology, and modification of home and vehicle. Yet another option is being explored by South Carolina, which has developed a waiver to allow it to integrate consumer-driven and market-based principles. *(The South Carolina waiver is described in detail in Attachment C.)*

A major advantage of HIFA waivers is that they can be used as intermediate steps toward reform. HIFA waivers should include a strong evaluation component as each phase is completed so that the state will be able to implement successful features and eliminate those found unsuccessful. In addition, HIFA waivers should include market incentives to improve quality and reduce costs.

STRATEGY #2: Develop and Encourage Use of Less Expensive Alternatives for Medicaid Recipients.

As discussed earlier, Medicaid benefits are far more extensive than the benefits provided in many private insurance policies. This is unfair and unwise. It is unfair because some taxpayers are forced to provide health benefits for others more generous than they can afford for their own families. It is unwise because the Medicaid population is insulated from many of the cost-controlling, quality-improving innovations that are a part of many private sector insurance plans. The Medicaid program is structured so that its recipients have little incentive to consume health services wisely. There are no incentives to use preventive measures or engage in healthy lifestyle practices. Furthermore, because Medicaid recipients pay no premiums, co-pays, or deductibles, there is no mechanism to discourage unnecessary visits to physicians or the use of medical services that may be only marginally useful or even cost-ineffective.

Recommendations:

- *Encourage and assist Medicaid recipients to switch to private sector plans.* One way to reduce reliance on the more expensive and less cost-conscious Medicaid program would be to allow and encourage Medicaid enrollees to switch to private sector plans, including employer plans as well as individually owned insurance plans. To qualify to accept Medicaid enrollees, a health plan would have to offer specific benefits as determined by the state. The plan should also incorporate a Medicaid version of a health benefit account that rewards individuals for their efforts to control costs (see sidebar on "Medicaid Benefit Accounts"). The government would subsidize the premiums and insurance companies would compete to sell their policies, thus bringing the benefits of marketplace competition to the process, which would likely reduce cost and increase innovation. For example, by moving to private market catastrophic coverage along with cost-effective prevention and disease management programs, the state could provide incentives for personal responsibility. Done properly, such a system could significantly lower present cost trends.

  Although the private sector plans may appear less generous than the Medicaid program, they would allow enrollees access to a greater range of providers and facilities than is currently the case with Medicaid in many areas. Furthermore, access to a health benefits account would give recipients greater control over decisions about their health care.

- *Encourage optional populations to purchase long-term insurance to cover cost of nursing home stays.* A second way to encourage use of less-expensive alternatives to Medicaid is to modify the single most costly aspect of the Medicaid program. Currently, about 20 percent of the Medicaid population is elderly or disabled. While their numbers may be small, they account for an incredible 80 percent of increased national Medicaid expenditures in 2004, according to data from the Kaiser Family Foundation.[25] In Texas, the aged, blinded, and disabled category

accounts for 20 percent of the Medicaid caseload but 62 percent of the cost. The aged category represents 11 percent of the total caseload but 36 percent of the total costs. The elderly are generally covered under Medicare except for (1) extended nursing home care for those meeting income requirements, which is paid for by Medicaid, and (2) those dually eligible for services from both programs. It is significant to note that long-term nursing care has the highest income eligibility level of any Texas Medicaid activity — 220 percent of the Federal Poverty Level (FPL), even though mandatory Medicaid eligibility for this program is only 74 percent of poverty.

One promising strategy to contain the enormous costs of long-term institutional care is to lower the income eligibility level closer to the mandatory level and to encourage optional populations to purchase long-term insurance, which would cover the cost of nursing home stays should the need arise. Long-term insurance could also provide other community-based services for the elderly. As an incentive to purchase long-term care, the federal government could offer tax credits for states to provide the individual greater control over provider choice and fewer bureaucratic regulations with which to comply.

Maine's Proposed Experiment with Expanded Coverage

Concerned with the rising number of uninsured, Maine has designed a program to subsidize the purchase of health insurance by small businesses and individuals. The state proposes assisting small businesses with their share of the insurance premium costs, beginning Jan. 1, 2005, and offering similar financial assistance to individuals effective April 1, 2005.

Currently, Maine businesses providing health insurance to employees are required to cover a minimum of 60 percent of the cost of the premium. There are no requirements for businesses to make a contribution for family health coverage. The state's expectation is that, with financial assistance, more small businesses will be able to offer insurance coverage to employees, decreasing the number of uninsured employees in Maine.

Because a portion of the cost of the premium must be shouldered by the individual, Maine also proposes offering financial assistance to individuals — up to 80 percent of their share of the premium cost for a non-Medicaid eligible person or a family, depending on household income. Nearly 75 percent of those receiving assistance
through the program will be eligible for discounts of between 20 percent and 40 percent of a typical $300 premium for individuals and a $930 premium for a family. Preventive services will be covered 100 percent.

Even with these subsidized discounts offered on a sliding scale, some uninsured individuals may consider the cost too high. However, by increasing the opportunity and the ability to secure insurance, Maine expects to reduce the ranks of its uninsured. While the program is not mandatory, Maine anticipates that by 2009, most of its 140,000 uninsured will have obtained insurance coverage.

STRATEGY #3: Introduce Market-Based Forces to Medicaid

The Medicaid system is structured in such a way that it is isolated from the forces of the marketplace. There is little competition to offer better services at lower prices. Additionally, the government estimates and sets the prices for reimbursing providers for services rendered. If the price is set below the provider's cost, the remainder is passed on to other patients who can pay. If the price is set above market value, then the government has paid more than it should.

Recommendation:

Create a State Insurance and Provider Exchange. The introduction of a state-operated Insurance and Provider Exchange (IPE) or health mart (see sidebar "Making Health Marts Work") would put the marketplace to work to reduce costs and encourage innovation. Rather than remain in the state Medicaid plan, the beneficiaries could choose among alternative private sector plans. This would make it easier for those leaving public assistance to keep medical coverage since they or their employer could simply substitute private premium payments in place of the state subsidy. Other advantages of this plan are reasonably priced coverage for the poor and near poor, insurance portability and continuity, and easy-to-understand insurance information from the IPE. The role of the state would be to set the ground rules, determine what minimum benefits private insurers would have to offer, encourage insurers to participate, and provide information to prospective enrollees in an understandable format (a blueprint for constructing an IPE is provided in Attachment D).

An IPE or health mart could also be used to significantly reduce Medicaid nursing home costs. Texas' method of paying for long-term care indirectly pays for beds only, not patients; as a result, taxpayers are subsidizing empty Medicaid beds. Those who qualify for Medicaid-supported nursing coverage could be provided nursing home grants to purchase nursing home "insurance" from insurance carriers soliciting business with the IPE. These insurers would not be insurers in a traditional sense because they would be soliciting business from a group they know will incur nursing home expenses. Rather, these carriers would negotiate with nursing homes and other elder care organizations for varying packages of nursing home services. Providers of services to the elderly would compete vigorously for this business, producing competitive pricing and increased quality of coverage.

Such a proposal could eliminate statutory rate setting. Rates should be determined by the market, rather than legislation, as much as possible. Qualifying individuals would purchase nursing home services from providers competing on both price and quality. It would also stop the practice of paying for empty beds. Nursing homes would no longer have an incentive to operate with excess capacity since they would be paid for services provided. Consequently, they would be more profitable by reducing unneeded capacity. In the current system, providers have incentives to maintain empty beds. This reform would dramatically reduce that overhead and, in the process, allow nursing homes to provide services at lower costs.

Medicaid Benefit Accounts[1]

Medical Savings Accounts (MSAs) were the pilot program and more restrictive precursor to today's Health Savings Accounts (HSAs). Yet, the idea behind MSAs and HSAs is the same. HSAs couple tax-free savings accounts with a high deductible health plan to offer account holders greater control over their own health care dollars and health care decisions. At the same time, HSAs provide individuals with greater incentives make wise health care decisions and eliminate waste and inefficiency with the promise of building greater savings.

By lifting the restrictions that impeded the growth of MSAs, HSAs have grown more popular in the private health insurance market and with employers providing coverage for their employees. The success of HSAs is not unprecedented, however, as South Africa has seen great success through the use of a flexible MSA policy for about a decade.[2]

Implementation of a flexible account for Medicaid beneficiaries, called a Medicaid Benefit Account (MBA), may hold similar opportunities for success in reforming Medicaid. Health plans that offer these accounts should have low or zero deductibles where it is appropriate to encourage patients to obtain the medical service. But they should have substantial cost-sharing for services for which patients can exercise considerable discretion.

Patients would benefit from not spending all of their benefit account money by being able to spend the funds on other valuable goods and services. For example, remaining funds in this account could be used for dental needs, eye care, and other medical expenses. In addition, unused funds would be available for future medical insurance and health expenses, for tuition costs, as well as for housing, transportation, or other acceptable expenditures needed to remove themselves from public assistance.

Giving individuals and families funds to meet their most pressing needs will reduce waste and encourage self-reliance. These accounts should not be subject to asset testing. Such states as Michigan and Massachusetts have "consumer-directed" models of providing Medicaid services. They have found beneficiary satisfaction is higher than when administered by the state and costs are often lower. For example, in Michigan, two-party checks are used to pay attendants for elderly, disabled, and medical care. The requirement that the patient (or guardian) co-sign the paycheck of the personal care attendant ensures that the latter works for the patient rather than for the government and creates incentives for good service. It also tends to reduce costs.

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[1] The Buckeye Institute and National Center for Policy Analysis, Reforming Medicaid in Ohio: A Framework for Using Consumer Choice and Competition to Spur Improved Outcomes, March 2003.

[2] Shaun Matisonn, "Medical Savings Accounts and Prescription Drugs: Evidence from South Africa," National Center for Policy Analysis, NCPA Policy Report No. 254, August 2002.

STRATEGY #4: Encourage Individual Responsibility and Empower Patients to Control Costs.

When insurers provide first-dollar coverage for health care services, patients have no incentive to avoid waste or ensure that they get a dollar's worth of value for each dollar they spend. If the out-of-pocket costs are zero, patients have an incentive to utilize health care services until their value approaches zero, at the margin. Similarly, doctors treating patients with first-dollar insurance coverage have an incentive to provide services as long as those services offer any positive medical benefit (or probability of benefit), even if the value of the benefit is well below the cost. A more effective approach would be to give patients the opportunity to manage some of their own health care dollars and experience the cost and benefits of prudent consumer behavior in the medical marketplace.[26]

Recommendations:

- *Implement Medical Benefit Accounts for Medicaid Recipients.* Texas Medicaid needs to involve its recipients in efforts to use health care dollars wisely. Beneficiaries should have access to plans with patient cost-sharing and a health care benefits account called a Medicaid Benefit Account (MBA), from which the patient's share of the bill would be paid (see sidebar on "Medicaid Benefit Accounts").

  Since these accounts would be wholly or partially funded with taxpayer dollars, they probably should be restricted to the payment of medical bills and insurance premiums. This means that beneficiaries who consume health care wisely and see their MBA balances grow through time would not be able to withdraw these balances for non-health care spending. However, they would be able to use the funds for medical services not covered by their health plan. Unspent balances would be carried over into the recipient's account for the next year. Recipients would be able to use these unspent balances to pay insurance premiums and buy medical care directly even after they have left Medicaid rolls.

- *Allow disabled Medicaid recipients greater control in determining how Medicaid funds will be spent for their care.* Some states currently are experimenting with providing grants to disabled recipients to allow them to decide which eligible services they will purchase for their care. Placing recipients in control of their treatment is expected to provide incentives for wise consumption of heath care resources and to increase patient satisfaction.

Making Health Marts Work[1]

Under the Federal Employees Health Benefits Plan (FEHBP), federal employees and their employer, the federal government, pay community-rated premiums to enroll in competing, private sector health plans. Although there is competition in this system, the competitors are not allowed to change premiums that reflect an individual's expected health care costs. Because of the community-rating requirements, healthy people are overcharged and unhealthy people are undercharged relative to the costs they are likely to generate.

As a result, health plans have strong incentives to under-provide to the sick and over-provide to the healthy.[2] Risk-adjustment premiums can ameliorate this problem somewhat. However, risk-adjustment cannot eliminate the problem and under some circumstances can make it worse.[3]

In designing a health mart or insurance exchange for Medicaid, we must be careful not to repeat these mistakes. In particular, we need FEHBP-type competition in which the competitors have good incentives rather than bad ones. How can that be done?

Under the FEBHP system, federal employees join health plans for a period of 12 months; once a year, they reselect their health plan during an "open season." A better structure is to have long-term enrollment — lasting, say, three to five years. Under this arrangement, enrollees would be able to have long-term relationships with physicians and health care facilities because they would have long-term relationships with the health plan that contracts with those physicians and facilities.

During the contract period, enrollees could switch health plans. However, a switch of plans would require consent of both the new and old plans and would almost always necessitate a lump sum payment from one plan to the other. For example, if a sick, high-cost enrollee switched from Plan A to Plan B, A would have to compensate B for the extra expected costs B would subsequently incur over and above the annual premium B would receive on the patient's behalf. If a healthy and low-cost enrollee switches from Plan A to Plan B, B would have to compensate A for the difference between the premiums it was collecting and the health care costs it likely would have incurred.

Under this system, health plans could not dump their sick enrollees on other plans without compensating the other plans for their expected losses. Nor could health plans lure healthy enrollees from another plan without compensating the other plan for its lost profit. In such a system, health plans would have an incentive to compete for the sick instead of actively trying to avoid them.

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[1] The Buckeye Institute and National Center for Policy Analysis, Reforming Medicaid in Ohio: A Framework for Using Consumer Choice and Competition to Spur Improved Outcomes, March 2003.

[2] John C. Goodman and Gerald L. Musgrave, "A Primer on Managed Competition," NCPA Policy Report No. 183, National Center for Policy Analysis, April 19, 1994.

[3] John C. Goodman, Mark Pauly, and Phil K. Porter, "The Economics of Managed Competition," unpublished, available from the National Center for Policy Analysis, 12655 N. Central Expressway, Suite 720, Dallas, Texas 75243.

STRATEGY #5: Create and Pilot Test Models for Medicaid Overhaul.

Few informed taxpayers dispute the need for a major overhaul of the Medicaid system. The magnitude of the long-term implications for the states if Medicaid goes unreformed is similar to the magnitude of implications for the federal government were Medicare and Social Security to continue on as is. One of the major difficulties in reforming Medicaid, however, lies in the fact that it is approaching 40 years old. During this time, bureaucratic rules have been piled upon bureaucratic requirements to make it a rigid, regulation-encrusted, antiquated, very expensive, and relatively inefficient program. It is like a worn-out, artery-clogged heart on which numerous surgeries have already been performed. A new heart is needed, but corrective surgery cannot occur until an appropriate replacement is found. Similarly, problems with the existing Medicaid system are too great to correct with "another bypass." However, it is extremely dangerous to perform surgery on the existing Medicaid system until its replacement has been tested and determined to be effective. Fortunately, there is a way to do so.

Recommendation:

Design and implement CHIP models to serve as pilot tests for reforming Medicaid. In addition to HIFA waivers, Texas should take its CHIP program and design a market-based, consumer-driven, cost-effective, and cost-stable system that encourages personal responsibility. After implementation and evaluation, Texas will have the evidence and models showing how to make the major changes necessary. The outcomes from the rural Texas CHIP program have already demonstrated the value and effectiveness of injecting a care coordination/disease management component into CHIP.[27] Other features, such as the use of co-pays to encourage responsible utilization, should be designed and tested as well. **Texas requires CHIP participants to share in the cost of certain services through the use of copayments. The 78th Legislature established a tiered premium sharing plan according to family income, but following the Governor's directive, the Health and Human Services Commission has temporarily suspended collection of all CHIP premiums.** Proven and successful CHIP models should then be used to overhaul the Medicaid system.

CONCLUSION

There is an alternative to the Medicaid system. However, it will take wisdom, vision and, above all, courage on the part of legislators and decision-makers to refashion a system that is no longer operating in the best interests of the taxpayer or the Medicaid recipient.

Reformation of Texas' Medicaid system requires a clear understanding of the consequences of inaction and failure — not just for taxpayers forced to pick up the tab, but also for other state programs desperately in need of the funds being diverted to cover Medicaid cost increases. Overhauling the system will require diplomacy and determination in dealing with entrenched interest groups. It will require dedication on the part of staff to remain accountable for the quality and accuracy of information used to make such decisions and for implementation of new and creative solutions. It will be difficult, but it can be done.
Other states are in the process of accepting the challenge, and Texas should be at the forefront, leading the charge. The stakes are high, but Texas' innovative ability, independence, and resources are great.

State policymakers can continue to provide a safety net for needy Texans that Texas taxpayers can afford, if two necessary conditions are met and five guiding strategies are followed.

Conditions Necessary for Medicaid Reform

1. Ensure Medicaid budgets, expenditures, and projections are accurate and complete.
2. Develop, use, and refine long-term models for predictable Medicaid spending cycles.

Guiding Strategies for Reforming Medicaid

1. *Tailor Texas Medicaid to Texas priorities.* Use federal waivers to target optional services to specific populations, such as eye care services for school-age recipients.
2. *Develop and encourage use of less expensive alternatives for Medicaid recipients.* Create premium assistance programs, integrate Medicaid and Medicare funding, expand consumer-directed services, enroll Medicaid recipients in private sector health plans, and encourage optional populations to purchase long-term insurance for extended care.
3. *Introduce market-based forces into Medicaid.* Establish a state-operated insurance and provider exchange (health mart) and allow Medicaid recipients to select private sector plans.
4. *Encourage individual responsibility and empower patients to control costs.* Create Medicaid Benefit Accounts to allow recipients to control some or all of their health care dollars and establish co-payments.
5. *Create and pilot test models for Medicaid overhaul.* Use federal waivers to create test models for comprehensive, long-term reform.

ATTACHMENT A:
Components of the Health Care Crisis

The health care crisis consists of several major components including medical care inflation, rising costs of health insurance premiums, rising numbers of Americans without insurance, emergency room overcrowding, and Medicaid's devastating impact on state budgets.

Medical Care Inflation

Medical care costs have risen dramatically in recent years, outpacing growth in the economy by 3 percent to 8 percent every year of the new millennium (see Figure 1 for a comparison of growth in medical costs and growth in the Gross Domestic Product, or GDP). Unfortunately, insurance premiums are based on medical costs plus projected inflation plus adjustments for risk, so health insurance premiums are rising even faster than medical inflation.

Figure 1:
Per Capita Growth in Health Care Spending and GDP Percentage Increase
(Source: Health System Change, Data Bulletin #27, June 2004)

Year	*Health Care Spending*	*GDP*
1997	3.3	5.0
1998	5.3	4.1
1999	7.1	4.8
2000	7.8	4.8
2001	10.0	1.8
2002	9.5	2.7
2003	7.4	3.8

Increasing Cost of Health Insurance Premiums

Most Americans, historically about three out of five, receive their medical insurance through their employers. In 2003, 60.4 percent of all Americans — including both workers and their dependents — were covered by employer-based insurance.[28] Only 52.4 percent of Texans receive such coverage. The status of employer-based insurance is critical because those individuals not covered by employer-based insurance must either secure government-sponsored coverage, primarily through Medicaid, or join the swelling ranks of the uninsured.

Unfortunately, the insurance situation is deteriorating. Fewer Americans are receiving employer-based insurance as time goes on. A recent U.S. Bureau of Labor Statistics study of employees (excluding dependents who were included in earlier figures) noted a

"dramatic" decline in the percentage of private sector workers receiving employer-sponsored insurance coverage, down from 63 percent in 1992-93 to 45 percent in March 2003. Texas' employment-based insurance percentages for workers and their dependents also have been dropping at an average rate exceeding 1 percent a year from 57.1 percent in 1999 to 52.4 percent in 2003.[29] A straight-line projection of this average suggests that employer-based insurance in Texas could drop below 50 percent as early as 2005. If these trends continue, Texas would be the first state to have less than half of its population covered through employer-sponsored health insurance since the current system was established during World War II.

Declining participation in employer-based insurance is due primarily to the increasing cost of insurance premiums.

Employer-based health care premiums have experienced double-digit increases for the last four years, rising a staggering 59 percent since 2000. Premium increases were higher than general inflation in all but one of the last 10 years (1996).[30] Not surprisingly, this increase has taken its toll on employer-based insurance. Since employers and employees share premium costs, it is understandable that both employers and employees are dropping their insurance participation. Fewer companies are offering insurance and fewer individuals are opting to obtain insurance even if their employer offers it.

Nationwide, 5 million fewer jobs provided health insurance in 2004 than in 2001,[31] and the bulk of the drop-offs occurred at smaller firms.[32] Fortunately, the worst of the premium inflation may be abating. The figures for 2004 reveal that it is the first year since 1996 that premium increases slowed compared to the previous year. Nevertheless, premiums continue to increase and the problem remains serious.

While the reasons for declining private health insurance in Texas are similar, Texas does face some unique challenges. Most businesses in Texas are small, and as such, face both higher rates and higher inflation in premium increases than their larger competitors. Texas demographics also add to the pressure. Texas has a large and increasing proportion of younger workers and Latinos, and both demographic groups are less likely to purchase insurance than the general population. Both groups are more likely than other groups to feel that insurance is not personally affordable, and thus may feel that the benefits are not worth the expense. These factors suggest that Texas employer-based insurance is likely to continue to decline in the future.

The problem of increasing premium costs contributes to another problem — the rising number of uninsured. When premiums increase, as has occurred recently, more and more individuals and businesses are unable to afford insurance. Consequently, the number of uninsured increases.

Rising Numbers of Americans Without Insurance

Currently, in 2003, 43.6 million Americans, more than the combined population of the 24 states with the smallest populations, lack health insurance.[33] Texas already has the highest uninsured rate (28.4 percent) of any state in the nation. Harris County (Houston) has the highest uninsured rate (31.8 percent) of any county in the state, and working-class areas in Harris County are estimated to have uninsured rates two-and-a-half times (estimated up to 85 percent)[34] higher than the overall county rate.[35] By merely doing nothing, Texas and Harris County are at risk of becoming ground zero for the beginning of a downward spiral, which some experts refer to as the "death spiral," of the present health care system, a self-perpetuating, reinforcing phenomenon described elsewhere in this report.

The uninsured as a general rule do not have a primary care physician to consult about non-emergency treatment. Instead they tend to seek medical attention for their medical needs in the emergency room. The formerly uninsured who move on to Medicaid often continue this pattern even after they have Medicaid. Not surprising, as the number of uninsured and Medicaid recipients rises, the pressure on ER facilities mounts, creating yet another health care problem.

Emergency Room Overcrowding

Emergency room overcrowding is becoming an increasingly serious situation. Emergency room visits in the Austin area alone rose 43 percent among uninsured adults and children on Medicaid between 1999 and 2003.[36] Nearly one-half of those adult ER visits and two-thirds to three-fourths of ER visits by children were not true emergencies and could have been handled outside of the costly emergency room setting.[37] Although not all of the inappropriate utilization of the ERs is by the uninsured and Medicaid population, the majority is. The situation in Harris County is already stark. ERs there are on drive-by status 30 percent of the time.[38] (Drive-by status is when ambulances are diverted to other hospitals because of emergency room overcrowding.) Emergency room overcrowding endangers the lives of the uninsured and insured alike.

Medicaid's Devastating Impact on State Budgets. In an attempt to respond to the health care difficulties faced by the nation's poor, Congress created Medicaid in 1965. Today, Medicaid is in a crisis, similar to that of two other federal programs, Social Security and Medicare. Unlike those programs, however, Medicaid is also wreaking havoc on state budgets. It is a program in which the federal government provides funds for certain categories of medical services to those defined as eligible. States may access these federal funds provided they use state matching funds and agree to serve all eligible persons (regardless of whether they have budgeted or even have available the required state match).

In spite of recent signs of an improving economy, 23 states experienced Medicaid shortfalls[39] in fiscal year 2003, as did 18 states in 2004, with a total shortfall of almost $7 billion in 2004.[40] In attempts to cover these shortfalls, from 2002 to 2004 50 states reduced or froze provider payments, 50 took action to control drug costs,[41] 34 reduced or

restricted eligibility, and 35 reduced Medicaid benefits as a means to bring spending in this entitlement program under control. Even with those actions, Medicaid is on track to replace elementary and secondary education as the largest spending category by states by 2005.[42] In 2003, state Medicaid spending nationwide grew at 10 times the rate of overall state fund spending (6.0 vs. 0.6 percent).[43] In 2004, the nationwide state Medicaid expansion rate (4.6 percent) was still larger than overall budget growth (2.8 percent)[44] even though there was a massive infusion of new federal funds that year. As Medicaid spending increases, state funding for education, highways, the environment, parklands, agriculture, and every other program funded by the state is seriously jeopardized.[45] The pervasive impact of Medicaid is illuminated by the fact that every state currently is planning at least one new cost-containment action for its Medicaid program in fiscal year 2005.[46]

Fraud, Waste and Abuse

Fraud, waste, and abuse are also components of the health care crisis. Efforts to control and eliminate fraud, waste and abuse are always a priority. Total recoupments by the Texas HHSC Office of Inspector General currently exceed $390 million. Cost avoidance and savings exceed $237 million.47 However, increasing the amount recouped from current amounts will be difficult.

ATTACHMENT B:
Medicaid Cost Drivers

Medicaid has a number of obvious cost drivers, including patients served, caseload, premium increases in private insurance, and specific services provided.

Type of Patients Served

Medicaid's general adult population has been found to have poorer health than its low-income, privately insured counterpart. Consequently, the general Medicaid adult population's needs are an important influence on the cost of Medicaid. Moreover, about one-fifth of the Medicaid population is elderly and disabled, individuals who clearly have greater medical needs. While their numbers may be small, the elderly and disabled populations accounted for an incredible 80 percent of increased national Medicaid expenditures in 2004, according to data from the Kaiser Family Foundation.

Medicaid is typically viewed as a program for indigents while Medicare is typically viewed as a program for senior citizens. However, Medicaid's greatest expenditures and largest increases in expenditures have been for those individuals ages 65 and older. In Texas, even though the aged, blind, and disabled category accounts for only 20 percent of the Medicaid caseload, it accounts for 62 percent of the cost. The aged category alone represents 11 percent of the total caseload, but 36 percent of the total costs of Texas Medicaid. The elderly generally are covered under Medicare except for (1) extended nursing home care, which is paid for by Medicaid, and (2) those dually eligible for services from both programs.[48] It is noteworthy that such a costly program has the highest income eligibility levels (220 percent of poverty) of any Texas Medicaid activity, even though mandatory Medicaid eligibility is only 74 percent of poverty.[49] However, as Toni Harp, Connecticut state senator and Health Committee Chair of the National Conference of State Legislators, notes, "If we didn't have Medicaid, the middle class would be responsible for taking care of their parents in nursing homes. That's why the program has support … in both parties." Nevertheless, such analysis explains much about the nature of the problem.

Caseload

Another cost driver is caseload. Simply stated, the more individuals on the Medicaid rolls, the more the state will be paying for the program. The change in the size of the Medicaid caseload in any given year depends primarily on two factors: economic conditions and policy changes. Since Medicaid is intended to be a safety net, caseload tends to shrink during prosperous times and expand during poor or uncertain economic times. Unfortunately, most caseload growth occurs at times when state revenue streams are reduced or strained due to those same economic conditions.

Policy decisions, especially those expanding or restricting eligibility also influence the size of the Medicaid caseload. The figure below illustrates annual changes in the Medicaid caseload over the last seven years in both the United States and Texas. The

direction of change is relatively similar for both suggesting underlying economic conditions at work. However, in those instances in which the degree of change is disproportionate between the federal and state figures, it is likely that policy changes in Texas are the cause. Further study would help Texas policymakers determine how policy changes in eligibility have impacted caseloads and in turn Medicaid costs.

Figure 2:
Medicaid Caseload Increases in Percentages

Year	*United States*	*Texas*
1998	-2.3	-6.5
1999	2.1	-2.6
2000	3.7	0
2001	8.3	3.3
2002	8.5	12.3
2003	8.8	18.6
2004	5.5*	2.3**

Sources: Kaiser Commission on Medicaid and the Uninsured; HHSC, *Texas Pink Book*, 2004.
* Projected actual by Kaiser (original projection: 2.1).
** Estimated by author based on available and incomplete data.

Inflation

Increasing prices for medical services drives up the cost of Medicaid. Prescription drug prices as well as costs for acute care in hospitals and long-term care in nursing homes are particularly strong contributions to medical inflation, in turn causing Medicaid costs to rise. New advances in medical technology can also increase costs for medical care.

When Texas Medicaid costs do not track inflation, it is in large part because Medicaid's prospective pricing system is not responding appropriately to market forces. In a cost-based system, prices for reimbursing providers are set in advance, based on existing costs, then adding likely inflation. If the market performs differently than expected (for example, if actual costs are higher than the set price), then Medicaid expenditures will be artificially low. The problem, aside from misallocation of resources, is that someone must pay the difference, which leads to the next driver: cost shifting.

Cost shifting

Cost shifting occurs when patients do not pay fully the cost for their medical services, either because they are indigent and unable to pay, or because they are Medicaid recipients for whom the government underpays the provider. In either case, if providers are to remain in business, the difference between costs and payments received must be covered. As a result, it is passed on to other payers. Cost shifting causes prices to increase for purchasers of health care who have private insurance, and medical care inflation

results. That inflation then becomes a factor in the next cost-based Medicaid rate setting process. Thus, cost shifting caused by Medicaid can fuel new structural inflation. As Medicaid continues to grow, the impact of such structural inflation will become larger and larger.

ATTACHMENT C:
South Carolina Medicaid Reform Proposal

Bringing Medicaid into a Consumer-Directed, Market-Based Environment
The intent and challenge is to bring the benefits of marketplace incentives to a publicly funded program like Medicaid. South Carolina intends to create a new Medicaid coverage plan that integrates personal health accounts (PHAs), personal health incentives, and true options for consumer choice. They hope to create the environment in which providers and insurers are freed from unnecessary bureaucratic requirements and compete for the consumer's dollar. In this concept, three general categories of care are addressed: acute or general medical care, community care for the disabled and frail elderly, and institutional long-term care.

Acute Medical Care Coverage Plan

1. Medicaid will offer a traditional fee-for-service plan to beneficiaries. It will cover major medical items and physician visits only. Non-life threatening services will require co-pays. Drugs for life-threatening conditions are covered, as are immunizations and other medical items deemed to be absolutely necessary.

2. The fee-for-service plan will be accompanied by a personal health account. This will be used to pay for co-pays in the fee-for-service plan and to purchase other types of coverage such as eye care, drugs, dental, or insurance plans for such items. It will be accessed through a debit card with medical and insurance payment encoding.

3. Alternatively, the actuarial value of the fee-for-service plan plus the PHA may be used to purchase private sector networks and/or managed care plans marketed to Medicaid beneficiaries through an Insurance & Provider Exchange (IPE), a state-operated mart.

4. Unused PHA funds will roll over for beneficiaries who are renewed by the state. Beneficiaries exiting Medicaid may roll a portion of the PHA into a private sector health savings account (HSA).

Community Care Plan for Disabled and Frail Elderly

1. All beneficiaries will receive a PHA related to the severity of their disability/condition. The severity is determined by caseworker ratings. The PHA amount is a percentage (say 90 percent) of what the state currently spends on this type of disability.

2. The disabled may purchase retail items they need with their PHA debit card. Medical services such as home health care may be purchased from providers bidding at the IPE.

3. Beneficiaries may use PHA funds to hire relatives to perform services in addition to private providers. Family members must register with the IPE to receive payment.

4. Unused PHA funds may be rolled over annually, assuming continued eligibility. If a beneficiary leaves Medicaid with unused funds in a PHA, those funds may be rolled over into a private sector HSA.

Institutional Long-Term Care Plan

1. The state will determine the eligible number of nursing home beds covered by Medicaid, then solicit bids at the IPE. Medicaid will continue to accept beds, beginning with the lowest bid and moving to higher bid amounts, until the eligible number of beds is reached. All cost-based reimbursement will be eliminated.

2. Beds would be allocated to accepted bidders as vacancies occur to avoid the disruptions of moving patients. Beds would be bid three years at a time; annual reimbursements would be adjusted based on a quality index.

South Carolina Medicaid Choice represents a bold concept for integrating consumer-directed and market-based principles into a government program previously shielded from such forces — a groundbreaking opportunity to remove the disconnect between Medicaid beneficiaries and those delivering and paying for their care. These reforms will begin the difficult task of requiring Medicaid beneficiaries to recognize the financial consequences of their health care decisions.

South Carolina's courage in asking for wholesale changes in Medicaid should lead other states to begin submitting innovative waiver requests to the Centers for Medicare and Medicaid Services division of the Department of Health and Human Services. [50]

A VISION FOR TOTAL HEALTH CARE REFORM

The reform of Medicaid is simply part of what is needed in the overall health care system. Medicare is still largely a government price-control system with the same type of perverse results as Medicaid; even the private sector is far from a free-market system. Due to the exemption of employer-provided health benefits from taxation, most Americans who have health insurance receive it through their employer. Little or no choice of plan is permitted and little incentive is given to economize and make wise health-spending decisions. "Buying at the company store" prevents competition and market forces from driving innovations that improve health outcomes and slow medical inflation.

The first step in the reformation process is that the tax exemption on health insurance income be replaced by a per person/family-refundable tax voucher to be used to purchase private insurance. This credit would be redeemable by Medicaid and CHIP beneficiaries as well. The large company private sector population would use the credit and their own funds to purchase health insurance at employer-created "insurance exchanges" where

providers compete on the basis of cost and quality. Small firm employees and the self-employed could use the credit to buy at private exchanges or at Medicaid IPEs. Finally, Medicare beneficiaries would receive a defined contribution amount to purchase their insurance from a Medicare-operated IPE.

The aforementioned reforms would make great progress toward turning the entire health care system into a dynamic free market, yielding greatly improved health and financial outcomes.

ATTACHMENT D:
Creation of an Insurance and Provider Exchange:
A Far-Reaching Market Proposal

Texas could also seek to implement a much broader reform package involving the creation of a private marketplace for all Medicaid beneficiaries and providers. Since the fundamental problem facing Medicaid is the lack of a real marketplace, the solution is straightforward: Create one!

Medicaid needs to create a decentralized market where buyers and sellers purchase and sell health care. This would require the use of Section 1115, Health Insurance Flexibility and Accountability waivers and other federal waivers to dramatically alter the existing Medicaid program. Medicaid could be transformed into a modern, efficient health care plan with state financing and block grants from the federal government.

While this type of HIFA waiver presumes that efficiencies gained from waiver approvals are used to expand coverage for beneficiaries, health and human service officials have indicated they are willing to look at dramatic program restructurings under HIFA, unrelated to expanding coverage.

Eight Steps to the Development of a Real Market in Medicaid

1. *Texas would create an insurance and provider exchange.*
   Medicaid would create an Insurance and Provider Exchange (IPE) where beneficiaries would purchase acute care, long-term care, and care for the disabled. The IPE is nothing more than a Health Mart where competing providers would offer various groups of services. In one sense it would be a much more complicated version of the Public Utility Commission's Apples to Apples comparison where providers would vigorously compete for business from eligible Medicaid beneficiaries.

2. *Medicaid would establish the rules of the game.*
   Texas Medicaid would establish minimum benefit levels and quality requirements consistent with Medicaid law and waivers obtained from Washington. It could assist eligible beneficiaries in selecting plans that best suit their needs through direct assistance and requirements that providers clearly lay out benefits. Given the type of population that Medicaid covers, such issues as helping to promote linguistic competence and health literacy among beneficiaries would be important responsibilities of Texas Medicaid. The IPE would establish conflict resolution methods.

3. *Medicaid would solicit annual provider service.*
   Texas Health and Human Services Commission would annually solicit sealed bids from various providers for the different Medicaid populations by county and/or contiguous counties or by a geographic area determined by Medicaid. HHSC would also solicit bids for various levels of coverage ranging from the minimum allowed

under law and waiver to more generous levels of coverage. This would help determine what amount of coverage can be "afforded" given budget constraints.

It is crucial to the effectiveness of this reform that choices be available to Medicaid beneficiaries. Obviously any monopoly situation increases costs and reduces quality of services. The greater the consumer choice, the greater the competition — and the possibility for provider innovation. Over time, innovation will slow the rate of medical inflation while increasing the quality of services to beneficiaries.

Medicaid's low service quality is well documented. During the 1999-2002 period, the percentage of practices open to all new Medicaid patients declined by 23 percent while spending nationwide rose by 36 percent. In California, researchers acting as patients suffering from a broken arm called 50 orthopedic doctors asking for treatment. When they indicated they had Medicaid coverage, 94 percent refused to treat them.[51]

In many states, Medicaid operates a system that appears to offer generous and broad benefits with easy access, while in reality, the system often low-balls payments to providers with resulting low quality, long waiting periods, and cost shifting to the private sector. Reimbursement rates are often 30 percent to 50 percent below what Medicare pays.[52]

4. *Medicaid would select the lowest-cost services consistent with their budget.*
   In each geographic region where bids are solicited, Texas Medicaid would select the lowest cost package consistent with the programs budget. For example: Four providers have submitted sealed bids for four different levels of acute-care coverage, ranging from primary care and hospitalization to dental and eye care. Medicaid would select the low-cost bid for each coverage level that could be financed under current state and federal funding. Each service would have an undisclosed "reserve price" (above which Medicaid would not pay) determined through consultation with private actuarial firms. If funds are short due to tight budgets or increasing required coverage (such as in a recession), the budget would be balanced by selecting a less generous benefits package or by reducing eligibility. The current price control process of paying providers below-market rates to balance the budget would be ended.

5. *Medicaid would become a financier for the poor.*
   Medicaid would award credits to eligible beneficiaries equal to the low-cost bid in their geographic area. Funds would never actually be in the hands of beneficiaries; they would be paid directly by Texas Medicaid to providers. Vigorous competition among providers would produce quality health care at reasonable costs. A provider submitting a price above the low bid for the area could easily lose thousands of "customers"; thus, Medicaid's buying power and competition among providers would serve as a powerful market force in controlling medical inflation along the lines of the Federal Employee Health Benefits Plan. Providers would also have a strong incentive to improve the quality of care. Otherwise they would face the loss of enrollees.

After the auction is conducted, "losing" bidders would have the option of lowering their proposal to within a certain percentage of the low-cost bid and beneficiaries would be able to purchase more "expensive" plans with their own resources. NOTE: A not-so-pleasant part of the current Medicaid problem is that a significant number of beneficiaries have assets and income that could be used to purchase medical services, particularly in the long-term care market.[53]

6. *The state would make direct payments to providers for disabled and long-term care.* Nursing homes and providers of services to the disabled could be paid directly with grants determined by the annual low-cost bid in their areas for packages of services requested by Medicaid. Nursing homes would no longer be reimbursed on a cost basis; instead, they would be paid for services or outcomes. This methodology would give providers an incentive to increase quality and control costs. As an incentive to keep costs low, Medicaid could also solicit home care service bids for eligible beneficiaries, as opposed to expensive nursing home care. Providers for the disabled (including government providers) would offer various packages for this diverse group ranging from comprehensive coverage for the mentally ill to low-cost "carve outs" such as alcohol rehabilitation services for the otherwise healthy. [54]

   As suggested earlier, credits should be made available to aged and/or disabled beneficiaries for "cash and counseling" services. As outlined above, providers would bid for these lower-cost services so the services provided would be based on the low-cost bid. Individuals and/or their families would have access to the funds for purchase of needed services. To maximize the number of current nursing home and Intermittent Care Facility beneficiaries being cared for at home, these cash and counseling grants could be used to pay family members for services provided.

   Paying family members to provide services has several potential benefits. First, loved ones may be willing to provide services at a lower rate than outsiders due to their relationship to the beneficiary. In addition, there is some evidence that family members providing services are likely to be more diligent than paid outsiders.[55] The ability to hire family members also should expand the available pool of personal care workers.[56] There is certainly precedent for allowing family compensation. The Veterans Administration Housebound Aide and Attendance Allowance Program provides cash to veterans for personal services, including services performed by family members.

   There are currently 200,000 veterans in this program.[57] Surveys of "cash and counseling" programs in Arkansas, New York, New Jersey, and Florida showed that between 86 percent and 93 percent of beneficiaries considering this type of coverage indicated that the ability to hire a family member contributed to their interest. In particular, families with developmentally disabled children overwhelmingly supported the idea of hiring a relative, primarily due to the trust factor.[58]

   In order to encourage both privately managed care plans and providers to offer services to Medicaid beneficiaries, Texas Medicaid would act as "re-insurer" to these

private plans in the acute care market.[59] Because a significant number of Medicaid beneficiaries sign up for coverage when they become ill (often by seeking treatment at an emergency room[60]), a traditional insurance market would suffer from significant "adverse selection." It would be difficult to induce private carriers to participate in this market. To manage this "guaranteed issue" problem, Medicaid could reimburse these private carriers and HMOs an arbitrary percentage above a certain amount of claims or average beneficiary costs. As an example, Medicaid might pay 80 percent of costs beyond $5,000 per covered individual. It is important that this group of providers be required to maintain some financial risk so as to create incentives to provide care at the lowest possible cost. An additional incentive for providers to offer services to Medicaid would be a subsidy system in which providers who enroll a "high cost" beneficiary receive a mandatory payment from the original provider. These two plan designs should effectively eliminate "cherry picking" and, along with the freedom to set rates annually, should produce a great deal of private sector interest in enrolling beneficiaries. Competition would produce low-cost provision of services along with higher quality of care.

This proposal is structured similarly to the Federal Employee Health Benefits Plan in which federal government workers have many choices in their providers. The FEHB plan produces high levels of satisfaction with slower growth in costs than other less competitive options.[61] In addition, the FEHB program (which gives a basic amount for employees to spend but allows them to purchase more expensive plans with their own money like the above Medicaid IPE) has been remarkably stable with no serious adverse selection problem.[62]

7. *Medicaid enrollees would be free to join employer-provided plans.*
Medicaid enrollees would have the option to use their grants to enroll in existing employer- provided plans. The grant amount would be the lower of the low bids from the IPE or the cost of joining the private employer plan. Given that a significant number of new Medicaid enrollees during the past 15 years have dropped family coverage, this feature could be a low-cost way of offering coverage to these groups.[63] Since many of these recipients are above the poverty level, Medicaid could offer grants to them on a sliding scale with higher amounts for near-poverty and lower amounts for incomes near the arbitrary federal poverty level. Eligible Medicaid beneficiaries failing to make a plan selection would automatically be enrolled with the low-cost provider for their category in their region. In order to further reduce costs, business firms in the small group market could be allowed to purchase their health insurance at the IPE. These firms could then take advantage of the economies of scale and pooling of risk that the IPE offers.

This provision should increase the number of private firms offering insurance and further reduce Medicaid's costs. Note that this proposal is different from some earlier ideas that proposed to build new services from a foundation of Medicaid, not the market.

8. *All market distorting practices could be eliminated.*
   Consistent with a free market, all market-distorting activities and schemes could be eliminated. These include formularies and state-mandated health benefits beyond Medicaid requirements. Providers of medical services could directly negotiate with drug companies for discounts.

   These suggested reforms are dramatic and would be immediately discounted by many as unrealistic and undoable. Surely, no state would seek so dramatic a change in their Medicaid plan. In fact, South Carolina has already submitted a concept letter to the Center for Medicare and Medicaid Services asking for broad waivers to fundamentally reform its Medicaid plan.

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