



# The Council for Affordable Health Insurance's ISSUES & ANSWERS

Solutions for Today's Health Policy Challenges

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## *Medicaid Reform: Ten Options for the States*

State Medicaid budgets are strained to the breaking point. The Bush administration has proposed giving states more flexibility to reform their Medicaid programs, including expanding the role of private health insurance. Is there a way for states to make greater use of private insurance, reduce costs, *and* ensure the quality and availability of health care services for the poor, which have been declining under the Medicaid program? Following are some basic suggestions for reform.

**1. Allow Medicaid enrollees to choose among private sector plans.** While the Medicaid population is diverse, many beneficiaries use it primarily as an insurance policy. The state could provide a defined contribution so those who choose the option could purchase private health insurance. Medicare offers seniors something similar, though the Medicare program is constrained by low levels of federal funding and overregulation. Medicaid is so rich that in most states low-income workers could get good coverage and save the state money.

**2. Create a carve-out of the high-risk pool.** Critics of private sector options are concerned that health insurance companies would deny coverage to Medicaid beneficiaries or exclude many of the services covered under the current Medicaid program. The simple way to address this concern is to allow Medicaid participants who so choose to buy into the state's high-risk pool (HRP), which provides comprehensive coverage to people who have been denied health insurance because of preexisting conditions.

A carve-out of the high-risk pool would assure that Medicaid funds were not commingled with funds of those using the HRP because they had been denied health coverage. In essence, the state would use the medical network and mechanisms set up for the hard-to-insure and allow Medicaid beneficiaries to use their defined Medicaid contributions to buy into the HRP.

But aren't some high-risk pools full, with waiting lines, while others charge high premiums? Yes, but that is because budgetary constraints force some states to limit the number of people in the HRP. Medicaid participants

would bring their own funding to the pool and, since most would be standard risks, would pay standard rates.

**3. Allow a Medicaid MSA.** The problem with the Medicaid program, as with most health insurance, is that patients have little reason to be prudent shoppers in the health care marketplace.

A Medicaid MSA program would provide a high-deductible policy and put the premium savings in a tax-free account for Medicaid participants. Patients would pay for routine and preventive care from their MSA, turning to the policy only in case of an unforeseen, catastrophic medical event. Key to the success of this plan would be allowing beneficiaries to have access to the unspent MSA balance at some point.

**4. Establish a cash-and-counseling option.** Three states — Arkansas, New Jersey and Florida — have been granted Section 1115 waivers for a demonstration project that provides disabled Medicaid beneficiaries with a cash allowance used to buy the services they need. The program is quite popular with the patients. While this program is budget neutral, other states could adopt a similar approach, looking for ways to give beneficiaries control of their Medicaid funds.

**5. Combine Medicaid with the EITC.** Millions of low-income working Americans participate in the federal Earned Income Tax Credit (EITC) program, which provides cash to those who qualify. A defined contribution grant from the state Medicaid program could be added to the EITC grant, with the stipulation that recipients use the money to purchase health insurance. Thus, if the beneficiary wanted to spend more on health insurance than the amount of the Medicaid contribution, he or she could rely on the EITC funds.

**6. Turn to the state employee health plan.** A state could allow Medicaid recipients to join the health insurance plan that covers state employees or teachers. Medicaid would provide the health plan with a defined contribution to cover the cost of adding each additional person.

**7. Carve out the prescription drug plan.** State spending on prescription drugs for Medicaid recipients is rising. One way to contain these costs would be to turn the prescription drug benefit over to the private sector. For example, Nevada is using a private sector company to cover low-income seniors who do not qualify for Medicaid prescription drug coverage. Utilization costs are running about \$43 per person per month, plus an administrative fee for the insurer, with a \$5,000 per-person annual cap. States spending significantly more than the Nevada plan should consider adopting it for their Medicaid beneficiaries.

**8. Allow front-loaded policies.** Most health insurance policies are back-loaded, meaning that they expose policyholders to up-front deductibles and copayments to discourage overutilization but pay virtually all costs above a specified out-of-pocket limit. The reason for this approach is to protect the assets of policyholders.

However, low-income working families have very few assets to protect and may lack the \$500 or \$1,000 cash to meet the deductible. Why not allow these families to move into a front-loaded policy that keeps the deductible relatively low and proportionate to their income but provides up to, say, \$25,000 or \$50,000 total coverage in a year? Such an approach would exclude the most costly medical services, yet it could provide states with a very affordable option. The state could pay the catastrophic costs of especially needy families from a separate program.

Of course, limiting out-of-pocket expense would increase utilization. So it would be best to combine this program with some type of MSA plan.

**9. Implement a “Simple Care” model.** Some doctors, tired of dealing with health insurance (including federal and state programs), have gone to a cash-only basis, called “Simple Care.” Patients pay cash up front and the doctor provides the care. Could that approach work for Medicaid? Suppose the state gave Medicaid beneficiaries a debit card similar to that most states give the needy for food purchases. The new card would give the Medicaid beneficiary a set amount of money with which to pay for prescription drugs and other health care needs. If the beneficiary went to a pharmacy or physician participating in the program, he or she would pay a discounted price and the provider would receive immediate payment. Money would roll over from month to month and year to year. Knowing the sum in their accounts, and knowing they would have to pay additional costs themselves, patients would tend to be more prudent health care shoppers.

**10. Adopt the Asheville Project.** The city of Asheville, N.C., has cut its health care costs by being proactive toward chronic illnesses — diabetes, hypertension, asthma and high cholesterol. According to a *Washington Post* story: “In a highly unusual arrangement, pharmacists are paid to counsel patients, offering advice on diet, exercise, stress reduction and medications. With the monthly sessions, pharmacists help patients stay on track and act as a bridge to physicians.”

The city employee who runs the plan says he is getting a 4-to-1 return on his investment. “Although drug costs rose, total health care spending on diabetics fell from \$7,042 per patient in 1996 to about \$4,000 apiece each year since the program began, in 1997,” according to the story.

These four chronic medical conditions are prevalent among lower-income workers. States that adopt a similar approach for their Medicaid beneficiaries with chronic conditions might also see their costs decrease.

**Conclusion.** State and federal legislators and health policy experts should view the preceding 10 options as catalysts to discussions about Medicaid reform. These options or some variation of them could move millions of low-income Americans off the faltering government-run Medicaid program and into the private sector, giving them more choices, more dignity and better health care. Isn’t that the kind of “helping hand” the country should be offering?

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