Approved: July 21, 2006
Date

MINUTES OF THE SENATE WAYS AND MEANS COMMITTEE

The meeting was called to order by Chairman Dwayne Umbarger at 10:40 A.M. on February 8, 2006, in Room 123-S of the Capitol.

All members were present.

Committee staff present:
Jill Wolters, Revisor of Statutes Office
Michael Corrigan, Revisor of Statutes Office
Alan Conroy, Director, Kansas Legislative Research Department
J. G. Scott, Kansas Legislative Research Department
Reagan Cussimanio, Kansas Legislative Research Department
Audrey Dunkel, Kansas Legislative Research Department
Susan Kannarr, Kansas Legislative Research Department
Judy Bromich, Chief of Staff
Mary Shaw, Committee Secretary

Conferees appearing before the committee:
Dr. Michael Bond, Adjunct Scholar, Kansas-based Flint Hills Center for Public Policy

Others attending:
See attached list.

Bill Introductions

Senator Barone moved, with a second by Senator Wysong, to introduce a bill concerning employment; relating to the mis-classification of employees (5rs2006). Motion carried on a voice vote.

Chairman Umbarger called the Committee's attention to discussion and possible final action on:

SB 475--Creating the state affordable airfare fund; moneys from the economic development initiatives fund; implementing a program to provide more flight options, more competition and affordable airfares

Senator McGinn moved, with a second by Senator Schodorf, to recommend **SB 475** favorable for passage. Committee questions and discussion followed. Senator McGinn withdrew her motion on **SB 475**, with agreement by Senator Schmidt, the second to the motion.

Senator Wysong moved a substitute motion, with a second by Senator Schmidt, to amend **SB 475** from $1.0 million to $1.67 million (25%) in funding from the catchment area and $5.0 million (75%) state funds. Motion carried on a voice vote.

In reference to the wording in the fiscal note on page 2, Senator Emler explained that legislative intent was not to harm any other Economic Development Initiatives Fund (EDIF) programs, agencies, or budget.

Senator Emler moved, with a second by Senator Schodorf, to amend **SB 475** to require a yearly report from REAP to the House Appropriations Committee and the Senate Ways and Means Committee beginning in 2008. Motion carried on a voice vote.

Senator McGinn moved, with a second by Senator Schodorf, to recommend **SB 475** favorable for passage as amended. Motion carried on a roll call vote.

The Chairman welcomed George Pearson, Flint Hills Public Policy Institute, who provided a biography of and introduced Dr. Michael Bond, Public Finance Economist, who presented an overview of the Kansas-Specific Proposal for Medicaid Reform (Attachment 1). A copy of the Flint Hills Center Studies Addressing

Unless specifically noted, the individual remarks recorded herein have not been transcribed verbatim. Individual remarks as reported herein have not been submitted to the individuals appearing before the committee for editing or corrections.

MINUTES OF THE Senate Ways and Means Committee at 10:40 A.M. on February 8, 2006, in Room 123-S of the Capitol.

Medicaid Fiscal Issues was distributed (Attachment 2).

Dr. Bond presented his briefing on the policy paper he wrote, Reforming Medicaid in Kansas: A Market-Based Approach (Attachment 3). The following items are addressed in Dr. Bond's written testimony:

- What is wrong with Medicaid?
- Reform Step 1 - Create an Insurance and Provider Exchange
- Reform Step 2 - All Plans Will be Prepaid
- Reform Step 3 - The Medicaid Health Credit Will be Actuarially Risk-Adjusted
- Reform Step 4 - Medicaid Will Reinsure Smaller Plans
- Reform Step 5 - All Beneficiaries Will Receive "Reverse" Health Savings Accounts
- Reform Step 6 - The Disabled and Elderly Will Enroll in Prepaid Plans
- Reform Step 7 - Allow Medicaid Beneficiaries to Buy into Private Plans
- Reform Step 8 - All Market-Distorting Practices and Policies are Discontinued
- What happens in real markets for health care?
- Summary and Conclusion

Chairman Umbarger thanked Dr. Bond for his presentation and apologized that the committee time was shortened and that he hoped that Dr. Bond could return for another briefing to the Committee.

The meeting adjourned at 12:00 p.m. The next meeting was scheduled for February 9, 2006.

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SENATE WAYS AND MEANS
GUEST LIST

Date February 8, 2006

NAME	REPRESENTING
Jeff Arpin	Budget
Julia Thomas	DOB
Roger Werholtz	KDOC
Dennis Williams	KDOC
Charles Simmons	KDOC
Roger Haden	KDOC
Kim Lynch	KFMC
Genny Nicholas	Children's mercy
Taira Green	Children's Mercy Hospital
Kraig Knowlton	DofA
Ken Otte	DofA
Stuart Little	Little Government Relations
Tom Bruno	EDS
Judy Shaw	Kearney & Associates
Shelley Duncan	Youthville
Tessa [illegible] Goupil	TILRC
[illegible] Fred Miller	Tessa
Kevin Siek	TILRC
Sharon Joseph	KS ADAPT
Modesto Hernandez	TILRC
Eric Van Allen	SRS-HCP
[illegible]	KSAG
Andy Schlapp	Sedgwick County

SENATE WAYS AND MEANS
GUEST LIST

Date Feb. 8, 2006

NAME	REPRESENTING
Bernie Koch	Wichita Metro Chamber of Commerce
Mary Ellen Conlee	United Way of the Plains
Luke Thompson	DHPF

Michael Bond, Ph.D.
Senior Fellow in Health Care Policy

Michael Bond, Ph.D., is an adjunct scholar for the Kansas-based Flint Hills Center for Public Policy, the Senior Fellow in Health Care Policy at The Buckeye Institute, a Professor of Finance at Cleveland State University and an adjunct lecturer at the Weatherhead School of Management at Case Western Reserve University. He has taught health care finance along with numerous other courses. He is an active consultant and has worked with over 150 law firms and companies on numerous issues. His work on Medical Savings Accounts (MSAs) and health-care policy reform has received national attention and appeared in a wide range of professional and popular publications, including *Health Care Financial Management*, *Public Personnel Management*, *Compensation and Benefits Review*, *Benefits Quarterly*, and *Business Horizons*. Along with over 70 articles and presentations, he is the author of the nation's first practical guide to establishing MSAs (published by The Buckeye Institute in 1997). He also co-authored a guide to reforming Medicaid using a market based plan (published by the Buckeye Institute in 2003). This resulted in the establishment of a Medicaid Commission in Ohio that adopted many of the proposals in their final report. The State of Florida recently proposed Medicaid reforms based on his "Insurance & Provider Exchange Model." Bond earned his Ph.D., M.A. and B.A. in economics from Case Western Reserve University and serves as an advisor on Medicaid to South Carolina Governor Mark Sanford.

Senate Ways and Means
2-8-06
Attachment 1

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FOR PUBLIC POLICY

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P.O. BOX 782317 • WICHITA, KANSAS • 67278-2317

Flint Hills Center Studies Addressing Medicaid Fiscal Issues:

- *Staying the Course* by Matthew Hisrich – Hisrich discusses many of the cost savings recommended in the 2003 Senate President's Task Force Report on Medicaid Reform that have yet to be adopted.
- *Controlling Medicaid Long Term Care Costs* by Stephen Moses – Moses recommends tightening eligibility so that a program for the poor does not evolve into a universal welfare program.
- *First Things First* by Matthew Hisrich – Hisrich presents the financial challenges of financing home-based care.
- *Backgrounder on Kansas Medicaid* by Matthew Hisrich – Hisrich looks at ways to improve the quality of care and at the same time reduce the cost imposed on Medicaid.
- *Kansas Estate Recovery Primer* by Roger Van Etten and Brian Vazquez – This report addresses the challenge of capturing the millions of dollars of reimbursements that Medicaid is entitled to.

All studies are available online at www.flinthills.org. Hard copies are available upon request by contacting the Flint Hills Center at inquiries@flinthills.org or (316) 634-0218.

Senate Ways and Means
2-8-06
Attachment 2

FLINT HILLS CENTER
FOR PUBLIC POLICY

POLICY PAPER

Volume 3, Issue 3 February 2, 2006

REFORMING MEDICAID IN KANSAS: A MARKET-BASED APPROACH

BY DR. MICHAEL BOND

Medicaid faces serious challenges in Kansas and across the U.S. The joint Federal/State program suffers from unsustainable budget growth that threatens the fiscal solvency of both the states and the Federal Government.[1] In addition, the level of satisfaction among Medicaid's beneficiaries is troublingly low.[2] A plan that is unable to deliver a satisfactory level of service and is actively driving the nation into bankruptcy is a plan that needs to be reformed.

Policymakers in Kansas should take the following steps to improve the Medicaid program:

- Create a health mart (an Insurance and Provider Exchange) where providers offer prepaid services to beneficiaries.
- Establish actuarially adjusted credits for beneficiaries to purchase care they need from competing providers.
- Offer "reverse health savings accounts" for beneficiaries to pay them for engaging in behavior that leads to better health outcomes.
- Eliminate counter-productive and anti-market schemes such as Certificate of Need Laws and formularies.

Undertaking reform of such a complicated issue is, of course, a major effort on the part of Kansas. State policymakers can be comforted that such reforms are being implemented right now elsewhere.[3]

I. WHAT'S WRONG WITH MEDICAID?

As mentioned in an earlier publication by The Flint Hills Center, the fundamental problem facing Medicaid is the lack of a real marketplace.[4] In a traditional market, buyers acting in their own interest purchase goods and services with transparent prices. Sellers/providers seek to maximize their profit/incomes by offering goods and services that consumers want to buy. They also add to their bottom line by delivering those goods and services more efficiently over time and by improving the quality of their existing product. This market approach, while by no means perfect, works better than the command-control approach that has evolved.

Medicaid (and much of health care) lacks such a marketplace. There is little or no transparency in the cost of medical services. Consumers do not pay any significant portion of the cost of their care and therefore have little incentive to economize. Since they bear little or none of the cost of care they are less likely to lead healthy lifestyles that can significantly reduce medical needs.

Bureaucratic decree, rather than natural supply and demand, determines prices. Providers often have no incentive to control unnecessary utilization and/or treat health problems in a cost-effective manner. In fact, tort litigation and other pressures create an

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Attachment 3

incentive for providers to allow and/or encourage over utilization. There is little incentive to innovate in the delivery of health care. Finally, since beneficiaries are not really consumers in the traditional sense they lack the empowerment to receive quality care.

Looking to additional price controls and government regulations in Medicaid will simply make the problem worse. To fix the problem, policymakers must create a real marketplace. This requires making enrollees the buyer of the medical services they need and allowing competing providers to sell them those services. Beneficiaries need to have incentives to follow a regimen of health behavior and providers need profit/income incentives to continually innovate in the delivery of services.

II. REFORM STEP 1: CREATE AN INSURANCE AND PROVIDER EXCHANGE

Kansas Medicaid (KM) should establish an Insurance & Provider Exchange (IPE). The IPE is nothing more than a state-run mart where Medicaid beneficiaries will purchase their health care.

Providers will offer packages of services to the enrollees at the IPE. The role of the state will change from being the buyer of the health care to facilitating a real marketplace in Medicaid. KM will provide beneficiaries with funds to buy their own health care. They will mandate minimum required benefits and services from providers.

KM will require complete transparency on the part of providers with regard to the services that they offer to enrollees. KM will assist beneficiaries in selecting health products that best meet their needs but the actual choice will be made by the enrollees. KM will give beneficiaries a Medicaid Health Credit (MHC) to buy the coverage they want at the IPE from competing providers.

III. REFORM STEP 2: ALL PLANS WILL BE PREPAID

One of the major problems facing Medicaid is the large scale use of fee-for-service (FFS) delivery systems. Essentially, the beneficiaries find a doctor or emergency room or are admitted to a hospital for services. KM then pays the provider a fee.

This system has three major flaws. First, efforts to limit usage with arbitrary bureaucratic edicts yield highly unsatisfactory results. Health care is very complicated and no bureaucracy can effectively design a rationing system to control usage in a manner that contains costs while preventing negative health outcomes. On the demand side, the beneficiary pays little or nothing out of pocket and therefore has little incentive to economize on using unneeded care. On the supply side, providers are left with an incentive to deliver services that are not appropriate given that payments follow services rather than outcomes.

Second, these payments paid to providers are not only far removed from outcomes, but they are also equally far removed from true prices based on the interaction of supply and demand. Instead, “prices” are set bureaucratically through government schemes. They are, in effect, price controls. If the rates are set too high there will be too much health care delivered (a surplus). If they are set too low there will be too little care provided (a shortage). In services like health care where quality is important these shortages can take the form of lower actual quality (5 minute office visits), long waiting periods and actual inability to get services at all. Further, rates set below market cause fewer providers to deliver services and promote the competition needed to lead to innovative medical practices.

Finally, FFS often produces episodic health care where problems are (maybe) treated instead of being prevented. Prepaid plans benefit financially from patients having better health and have an incentive to provide preventative care that reduces major health problems in the future. Further, they have an incentive to cost effectively manage existing conditions because their profits/incomes will be higher. It makes much more sense to get a pregnant beneficiary proper prenatal care then it does to spend a fortune on treating a low birth-weight baby. Since the plans can generate a higher income/profit by reducing costs, they have a strong incentive to

innovate. Competition between the plans then forces prices down to their marginal cost. The result will be a slowdown in the rate of medical inflation that Medicaid faces. This innovation will put the plan(s) on a more sustainable fiscal basis.

IV. REFORM STEP 3: THE MEDICAID HEALTH CREDIT WILL BE ACTUARIALLY RISK-ADJUSTED

Insurance companies are in the business of managing risk. Better drivers pay lower insurance premiums. Teenagers as a group are not better drivers and pay higher premiums. Younger people live longer and pay lower life insurance costs. Women live longer than men and pay lower life insurance rates. And in a properly-designed health insurance market sicker beneficiaries would pay more than healthier beneficiaries.

Due to quirks in history there effectively has not been a real market for health insurance. First, many traditional carriers practiced community rating where equalized rates encouraged sicker people to enroll and healthier people to drop out of the insurance pool. Second, tax laws encouraged the purchase of health care through employers. Employer-based insurance is, therefore, just a reallocation of employee compensation to health insurance instead of wages to minimize income taxes.

The above proposed Medicaid reform involves beneficiaries buying prepaid plans from competing providers. Existing Medicaid "managed care" plans are generally set up through selective contracting. Theoretically there may be choices for beneficiaries, but as a practical matter they tend to wind up in one plan over time.

The payment to the plan from Medicaid is an administered price (price control) and is not risk adjusted for each enrollee. While the enrollment in the plans is guaranteed, the failure to risk-adjust payments encourages "cherry picking" by prepaid plans. With the advent of easy to use software it is a relatively simple task to risk-adjust the MHC. While risk adjustment is not perfect, it significantly reduces the incentive to enroll only healthy beneficiaries.[5]

In addition to risk-adjusted Medical Health Credits (MHCs) there should also be a requirement of an actuarial payment from one provider to another if a chronically-ill enrollee switches plans. First, this will further minimize a plans desire to avoid signing up ill beneficiaries. Second, it will encourage the provider that the beneficiary is currently enrolled with to offer quality care focused on disease management. The combination of risk adjustment and a transfer actuarial payment will give plans a strong incentive to compete vigorously for all beneficiary business.

V. REFORM STEP 4: MEDICAID WILL REINSURE SMALLER PLANS

A central tenet in reforming Medicaid is creating a competitive marketplace where beneficiaries can obtain their health care. Monopolies and oligopolies are bad for consumers in any industry – health care is certainly no exception.

In order to make reform work in Kansas it is imperative that choices exist for enrollees. It is also necessary for these providers to be prepaid to control utilization and give incentives for cost reducing, quality promoting innovations. But the benefits of prepaid plans also raise a potential problem in terms of smaller providers who may wish to enter the marketplace.

For a provider to have a reasonable idea of what health costs will be in a current year requires a significantly large pool of coverages (say 5,000 lives). Larger prepaid plans will have an incentive to offer coverage to Medicaid beneficiaries if the enrollees' buying power is risk-adjusted and there is flexibility on the benefits package.

While many of these organizations are indeed effective and innovative, history shows that start-up entrepreneurs often develop revolutionary new methods and products. The problem is that a prepaid practice of, say, ten innovative doctors that enroll 1,000 beneficiaries could be wiped out if they are unlucky enough to sign up a few very high-cost patients. Thus, good ideas that could reduce Medicaid costs and improve its quality may never

make it to the marketplace. This problem, of course, is particularly acute in rural areas like Kansas.

The solution to this problem involves KM "reinsuring" smaller practices if they run into high costs. Actuarially, the risk to a prepaid plan becomes greater given a smaller number of enrollees. KM could use a sliding scale framework with very small plans having a much smaller effective stop-loss limit than medium-size providers. Large prepaid groups would not receive reinsurance. To maintain the incentive for providers to control unneeded utilization there would need to be some financial risk once the reinsurance begins. As with the reinsurance itself, this should be set up on a sliding scale with smaller groups being required to cover a smaller proportion of expenses in the reinsurance range.

As with the private sector, providers need to have flexibility in designing their product. The current Medicaid system has a federally required benefits package with states having the ability to expand the minimum required services providers must cover. Generally, states have operated with a "one-size-fits-all" mentality on the mandated benefits package. This makes no sense given the diverse population that Medicaid covers. Providers must be able to market to specific groups as in the private sector. This specialization and division of labor will increase efficiency and lower medical inflation.

Just as important, it will improve the quality of care for beneficiaries. Since payments for beneficiaries will be risk-adjusted, plans will have an incentive to enroll both healthier and sicker beneficiaries. Practices specializing in the treatment of those afflicted with AIDS could develop alongside those who provide OB/GYN services. As in the private sector, plans may implement an overall benefit limitation.

VI. REFORM STEP 5: ALL BENEFICIARIES WILL RECEIVE "REVERSE" HEALTH SAVINGS ACCOUNTS

Incentives matter. The failure to recognize this is one of the major problems of Medicaid and, indeed, all of health care. The proposed reform plan will get the incentives right and produce cost-effective, higher-quality care for the poor.

Some have suggested that a better alternative to the supply-side control of prepaid plans is demand-side control of health care usage through significant cost-sharing. Indeed, the widely heralded Rand Health Insurance study showed significantly less usage of health care when those enrolled had higher levels of cost-sharing. Anyone familiar with the basic laws of economics could predict the result. The law of demand had its impact.

Health Savings Accounts (HSAs) are another tool touted as a solution to the problem of using health care demand and inflation. How do they work?

Suppose families have a health plan with 100 percent coverage with an average premium cost of $10,000 per year. Under an HSA plan they or their employer increase the deductible on the plan from zero (in this example) to say, $4,000. Since the firm or insurance carrier has less cost risk the premium on the plan will drop. How much is an actuarial issue. Health expenditures tend to be highly skewed in any given year. One rule of thumb is the 80/20 assumption where 20 percent of individuals incur 80 percent of all costs in a year. In other words, a small number of sick people run up most of the expenses annually.

The effect of these skewed expenditures on increasing the deductible to $4,000 is that "premium" would not decline by an equal amount. The actual reduction depends on several factors but assume it is $2,800 so that the new premium is $7,200. Proponents argue that the high deductible will cause enrollees to use health care more carefully, and even most critics agree this will happen below the deductible.

Given the $4,000 deductible the plan allows for a deposit of $2,800 to each HSA. Families with expenditures of less than $2,800 have unused funds and obviously benefit from the HSA. Those with expenses above $2,800 now have to pay out-of-pocket up to the deductible of $4,000. They are financially worse off.

Proponents argue this is not a major issue in the private sector for two reasons. First, the out of pocket risk is not particularly large in most cases. Second, it is not the same individuals who are sick every year. The National Bureau of Economic Research examined a large set of medical expenditures and found, as expected, that 10 percent of those covered generated 80 percent of spending in a year. But over a 35-year work life, 55 percent of employees ran up 80 percent of the medical expenses. In other words, there is declining persistency in spending over time. This has the effect of leaving the vast majority of those using HSAs with unused balances if they are enrolled in the plans over a long period of time.[6]

But these can be significant issues in Medicaid. First, from above, there is likely to be an increase in out-of-pocket risk to beneficiaries. This is obviously a much greater burden for the poor than for wealthier enrollees. Further, the Rand Study showed some unfavorable health outcomes for low-income groups when they were subjected to cost-sharing. Second, people move on and off of Medicaid over time. This does not allow for the declining persistency that occurs in the private sector and makes it less likely that a high percentage of beneficiaries will have unused HSA balances. As such, a private sector type HSA may not be advisable.[7]

A better way to generate the incentives that HSAs can produce is by "reversing" the accounts. KM should give every Medicaid beneficiary a reverse HSA (RHSA). The accounts will have a zero balance initially. KM would then add dollars to the account when beneficiaries use health care in an effective and responsible manner.

Medicaid in many states, for example, suffers from a significant problem of enrollees using hospital ER's for non-life threatening illnesses. KM could pay beneficiaries a portion of the savings from getting coverages to use a physician for their primary care. Large savings could result by paying pregnant women to obtain proper prenatal care and avoiding low birth-weight babies. The same is true of obtaining a full panel of immunizations for children and for diabetes spots and blood pressure checks for adults.

Funds in the account could be used to purchase additional medical care or rolled over for future purchases. They could also be used to pay for medical care when the beneficiary leaves Medicaid. The RHSA would be a money saver for KM with credits to account being a fraction of the expected actuarial savings from discouraging "bad" behavior and encouraging "good" behavior.

This type of HSA does not expose beneficiaries to out-of-pocket costs and is not dependent on a long enrollment period for effectiveness. In addition, since funds may be rolled over and taken out of the accounts at a later time they will produce a "reverse" working capital effect for Medicaid. The State of Florida's reform plan has this account as part of its design.

VII: REFORM STEP 6: THE DISABLED AND ELDERLY WILL ENROLL IN PREPAID PLANS

As with the acute care population, Medicaid beneficiaries who are disabled and/or elderly will enroll in prepaid plans. They, too, will receive risk adjusted MHCs. The purpose of the prepaid plan, as above, is to limit unnecessary usage and create incentives for innovations in the delivery of care. This population is a minority in state Medicaid plans but accounts for majority of expenditures. As such, it is crucial that providers to these populations deliver quality care in a cost-effective manner. In addition, this group of enrollees will also receive RHSAs to encourage appropriate medical behavior that results in cost savings.

A central tenet of the proposed reform in this area involves changing the bottom line of providers. Many institutions that deliver services to Medicaid receive payment using a cost-based methodology. This, of course, is just another administered pricing scheme. And, like other price control schemes, it encourages inefficiency and low quality. The development of the MHC will make beneficiaries a sought-after "customer" and competition between providers will lower medical inflation.

Nursing homes and other institutions that provide services to Medicaid should become prepaid in nature. There are two ways this can happen. One is for the provider to list their services at the IPE. The other is for managed care companies to negotiate with these institutions the same way they negotiate with physicians and hospitals. The marketplace will determine which mechanism is most effective. Prepaid plans would have an incentive to develop innovative methods to deliver needed care in a cost-effective manner.

The RHSA can encourage behavior that lowers costs. For example, the mentally disabled sometimes stop taking medications that allow them to function in a reasonably normal manner and avoid very expensive institutionalizations. Documented care visits and usage of effective prescriptions could be rewarded by deposits to the RHSA. As well, offering RHSA funds to loved ones could allow parents and other family members to care for the mentally and physically disabled in a non-institutional setting.

Here the RHSA would essentially function as a "cash and counseling" program. These limited experiments around the country have proven very popular with the disabled. Beneficiaries who are eligible for Medicaid coverage of nursing home care could instead receive RHSA funds if they are able to obtain services in a less-costly environment. This would allow some to stay at home as opposed to assisted living facilities. Here, too, the ability of family members to receive payment from the RHSA could significantly reduce Medicaid's nursing home costs.

It is, of course, possible that allowing payments to family members could create an "out of the woodwork" effect. That is, individuals currently not enrolled in Medicaid may sign up for the plan to access these dollars. It is crucial that estate recovery efforts be highly effective to minimize this occurrence. There are estimates that as many as 90 percent of those enrolled in Medicaid coverage for nursing homes have done some type of asset planning to qualify for their coverage. Further look-back periods and recovery programs for those seeking Medicaid nursing home coverage would produce larger potential losses in estates to family members and reduce the incentive to game the RHSA.[8]

VIII: REFORM STEP 7: ALLOW MEDICAID BENEFICIARIES TO BUY INTO PRIVATE PLANS

Medicaid enrollees would be free to use their MHCs to join existing employer-provided plans. Given that a significant number of new Medicaid enrollees in the last 15 years dropped family coverage, this could be a low-cost way of offering coverage to these groups. Since many of them are above the poverty level, KM could offer grants to them on a sliding scale, with high amounts for near-poverty and lower amounts for incomes near the arbitrary established poverty level.

Related to this, another possible reform is to allow individuals and small businesses to purchase private health plans from the IPE. This would generate four potential benefits.

First, it could reduce Medicaid enrollments by moving some beneficiaries back into private-sector coverage. Second, it will induce more firms to offer health insurance by lowering the insurance overhead cost that exists in this market. Third, it will also reduce insurance costs by creating a larger pool of buyers with more purchasing power and reduced annual claims uncertainty. Finally, private providers seeking to sell to private firms/individuals could be required to sell in the Medicaid market as well. This will increase the number of firms competing for Medicaid beneficiary dollars.

IX: REFORM VIII: ALL MARKET-DISTORTING PRACTICES AND POLICIES ARE DISCONTINUED

Consistent with basic principles of economics, all market-distorting activities and schemes should be eliminated. These include formularies, Certificate of Need (CON) laws, and state-mandated health benefits above the Medicaid requirements. Providers of medical services would directly negotiate with drug companies for discounts. Elimination of CON laws would allow for easy entrance into the long-term care market in response to market price signals and would reduce costs by promoting more competition among providers.

X: WHAT HAPPENS IN REAL MARKETS FOR HEALTH CARE?

Would the creation of a real marketplace really help Medicaid's beneficiaries and improve Medicaid's fiscal situation? Or is the purchase of health care simply too sophisticated for most people to deal with, especially the poor? Fortunately, we have some evidence on this issue. The Rand Research Corporation conducted a huge study of the impact of financial incentives on the use of medical services between 1974 and 1982. The study included a large group of families and individuals nationwide and included a wide range of family incomes, from as high as $100,000 (in today's dollars) down to the poverty level.

While we are simplifying the actual study here, the basic component consisted of some participants receiving "free" health care while others had to pay a deductible of up to $1,000 (around $4,000 in today's dollars). The conclusion of Rand Researchers:

- "The more families had to pay 'out of pocket,' the fewer medical services they used."
- "The percentage reduction in expenditure caused by cost sharing did not differ strikingly by income group…."

As economic theory predicts, the more something costs, the less of it people will use. Note that the study's low-income participants changed their behavior along with the middle- and upper-income participants.

It is important to note that there were some adverse health outcomes among the low-income participants when they were required to pay some of the cost rather than receiving the services free of charge. For instance, when blood pressure screenings were provided at no cost to the patient, mortality rates declined by about 10 percent. In addition, participants who entered the study with serious symptoms were less likely to leave them untreated when treatment cost was not a factor.

Recall, however, that most of the medical delivery system in this period (1974-82) was a standard fee-for-service plan. Now, the adverse health outcomes cited above could easily be dealt with by HMOs and provider networks which recognize the health and financial value of certain types of preventive care. Indeed, competition among providers for beneficiary dollars would likely raise the quality of care to the poor.

Broad market-based reforms are virtually non-existent in Medicaid. In the past, those in Washington would have looked unfavorably on significant reforms. While attempts have been made to utilize HMOs, these continue to suffer from administered pricing schemes where reimbursements to providers are set too low, causing providers to drop out of the system. Now, however, a new, more receptive attitude in Washington opens up the possibility of dramatically changing the system. Nonetheless, thus far no broad-based reforms have been undertaken at the federal level.

There are, however, several small market-based programs that have shown great success.[9] One of these is the "Cash and Counseling" approach tried in a few states. Florida, for example, operates a program where beneficiaries who are eligible for home- and community-based services receive a monthly budget instead. They may use this to hire caregivers or purchase services. Surveys of participants indicate that 96 percent were "very satisfied" with the service they received, and 97 percent would recommend the program. These are astonishing satisfaction levels!

A similar program in Arkansas called Independent Choices showed a similarly high degree of customer satisfaction, with 93 percent of the participants recommending the program to others. New Jersey has a related program called Personal Preferences. An amazing 99 percent of beneficiaries reported "satisfying" relationships with their caregivers, and 97 percent would recommend the program to others. Does anyone believe that Medicaid's more traditional programs produce these types of outcomes? While such programs are relatively new and limited in scope, we believe the success of "Cash and Counseling" shows that the idea of allowing

beneficiaries to buy their care in the market can work.

While the private sector suffers from many of the same problems as the public sector, we can see how a real market in medical care would operate. Most people did not have prescription drug coverage until the 1980s and 90s. They paid out-of-pocket. The result was a 34 percent increase in drug costs between 1960 and 1980 vs. a 236 percent increase in the general cost of medical care. After drug coverage became much more commonplace, prescription drug costs rose 336 percent vs. 281 percent for general health care from 1980 through 2002.

In cash medical markets such as for cosmetic care, the results are startlingly different. Along with continuing advances in quality, innovations, and comfort, the discipline of the market controls costs. Medical inflation between 1992 and 2001 was three times as high as that of cosmetic care, and these types of services rose in cost at a lower rate than general inflation.

Eye care costs and services where there is not nearly as much third party payment rose at 33 percent between 1990 and 2002, while general medical costs increased at 75 percent. This is in a period when there were dramatic advances in technology and services such as LASIK. In addition, the cost of other types of medical services such as podiatry and chiropractic care (which are often not insured) rose at 43 percent between 1990 and 2002.[10]

XI: SUMMARY AND CONCLUSION

Kansas Medicaid is in serious trouble. It produces a quality of health care that is increasingly unsatisfactory and its long-run fiscal situation is unsustainable. Its problems exist because of the lack of a real marketplace for medical services for beneficiaries. Price controls are inherently inefficient. Any plan for reform needs to address this fundamental flaw. If changes are not made the fiscal state of the plan will only worsen. The State of Kansas faces the unappealing situation of huge cuts in other government spending and tax increases that would wreak havoc on its economy. No reform would inevitably mean even worse health care for enrollees down the road.

Kansas should move now to reform its troubled plan. It needs to create a real marketplace where buyers act in their own interest and providers have an incentive to deliver quality care in a cost-effective manner. This involves creating a mart (an Insurance and Provider Exchange) where beneficiaries buy services from competing prepaid providers with risk-adjusted credits (Medicaid Health Credits) provided by Medicaid. Providers would be allowed to tailor plans for Medicaid's diverse population and Medicaid would reinsure smaller plans to promote competition in both urban and rural areas. All beneficiaries would also receive accounts (Reverse Health Savings Accounts) where they would essentially be paid for engaging in healthy and/or low cost behavior. The resulting outcome will be lower cost inflation in the future combined with better care for beneficiaries.

ABOUT THE AUTHOR

Michael Bond, Ph.D., is a an adjunct scholar with The Flint Hills Center for Public Policy, a fellow at the National Center for Policy Analysis and a professor in the Department of Finance at Cleveland State University.

NOTES

[1] For more information on the budget crisis facing Medicaid, see the "Medicaid Handbook" section of The Flint Hills Center's website. This report builds on two other reports recently completed by Dr. Bond on the subject of Medicaid reform for The Flint Hills Center. For these and to access the Medicaid Handbook, please visit: http://www.flinthills.org/.

[2] "Satisfaction with Own Health Insurance Remarkably Stable," press release (Rochester, NY: Harris Interactive, 29 March 2004). According to the Harris poll, "There are now only modest differences in the levels of dissatisfaction with employer-provided, privately purchased insurance and Medicare programs. However, Medicaid beneficiaries are more likely to be dissatisfied, with 36% of them rating Medicaid D, E or F, 27% not recommending Medicaid to healthy friends and family and 33% not recommending it to those who have serious or chronic illnesses." Available at: http://www.harrisinteractive.com/news/allnewsbydate.asp?NewsID=781.

[3] Dr. Bond recently completed a review of other state actions. See Michael Bond, "Reforming Medicaid in Kansas: What are Other States Doing?," The Flint Hills Center, 16 January 2006.

[4] Michael Bond, "What's Wrong With Medicaid in Kansas?," The Flint Hills Center, 26 December 2006.

[5] See eBenX (http://www.ebenx.com/) and DxCG (http://www.dxcg.com/) for two firms that have developed software for risk-adjustment.

[6] See Matthew J. Eichner, Mark B. McClellan and David A. Wise, "Insurance or Self-Insurance?: Variation, Persistence, and Individual Health Accounts," NBER Working Paper 5640 (Cambridge, MA: The National Bureau of Economic Research, June 1996). Available at: http://www.nber.org/papers/W5640.

[7] For an alternative view on this point, see Devon Herrick, "The Future Of Health Care For Kansans," The Flint Hills Center, 14 February 2005.

[8] For more information on the Estate Recovery program in Kansas, see Roger A. Van Etten and Brian M. Vazquez, "Kansas Estate Recovery Primer," The Flint Hills Center, 22 September 2005.

[9] For more detailed information on this subject, see Bond, "Reforming Medicaid in Kansas: What are Other States Doing?," The Flint Hills Center.

[10] See Michael Bond, "Reforming Florida's Medicaid Program with Consumer Choice and Competition," The James Madison Institute Backgrounder, number 43 (Tallahassee, FL: The James Madison Institute, February 2005). Available at: http://www.jamesmadison.org/article.php/331.html?PHPSESSID=68d249d5c06d5e56fdd4009259ec8580.

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Flint Hills Center for Public Policy

P.O. Box 782317
Wichita, KS 67278-2317
(316) 634-0218
inquiries@flinthills.org
www.flinthills.org

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