POLICY BRIEFING

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Move Missouri's Medicaid Program Forward, Not Backward

By Patrick Ishmael

It was March 10, 2010, just days before the U.S. House of Representatives would give final approval to the Patient Protection and Affordable Care Act. With passage of his signature health care legislation on the horizon and on his mind, President Barack Obama arrived for a fundraiser and speech in downtown Saint Louis. Before a packed house at the Renaissance Grand Hotel, he hailed the Affordable Care Act (ACA) as an historic reform that would benefit both the middle class and the needy.

"Understand," he told the audience, "the wealthiest among us can already buy insurance, the best insurance there is. The least well off, they're covered under Medicaid. It's the middle class that's getting squeezed, and that's who we have to help — small businesses, self-employed, individuals who are out there struggling.

"Americans buying comparable coverage to what they have today in the individual market," the President continued, "they'd see their premiums drop 14 percent to 20 percent."[1] The President said that small businesses would benefit, as well. "And by now, we've incorporated every single serious idea across the political spectrum about how to contain rising costs in health care."

Of course, the country's experience since 2010 suggests that the President's promises, intoned four short years ago, have not borne themselves out. As the meat of the law rolled out in 2013, millions of Americans found out that they would lose their health insurance because of the ACA,[2] and tens of millions more could lose their plans in the years ahead because of the law.[3] Millions of Americans have already seen their insurance rates rise dramatically rather than fall.[4] By the Administration's own estimates, most small businesses will see higher, not lower, health care costs in the coming years.[5]

But his last claim, that supporters had "incorporated every single serious idea across the political spectrum," was perhaps the umbrella under which every other claim would find refuge. The ACA — all 2,000-plus pages of it — was purposefully heavy-handed because serious ideas across the political spectrum were not in fact part of the law, and where the law lacked in consensus, it made up for it in sheer force.

Nowhere was that hand heavier and force clearer than when it came to its Medicaid provisions.

As enacted, the ACA required states to expand their Medicaid programs to include adults with incomes of 133 percent of the federal poverty level or else lose all funding for their states' Medicaid programs

— a multi-billion dollar penalty that would have eviscerated many states' Medicaid plans. When the issue reached the United States Supreme Court in 2012, the majority opinion called the requirement an unconstitutional "gun to the head"[6] of the states and threw it out. Had the Court affirmed the provision's constitutionality, Missouri and other states would have had essentially no choice but to expand their Medicaid programs — and in so doing, expand and extend Medicaid's problems.

Supporters argue today that expanding Medicaid is a "good deal," but what sort of a "good deal" supposedly incorporating "every single serious idea" has to be forced on someone?

And Medicaid's failures are not new. Multiple studies have found that Medicaid patients are among the least well-served when it comes to positive health care outcomes: that the program that's supposed to keep them healthy, isn't. For some surgical procedures, having Medicaid could actually be worse than being uninsured,[7] and rather than reducing emergency room utilization, a gold standard study out of Oregon suggests the Medicaid program may actually *increase* wasteful ER visits.[8] That is in addition to the fact that Medicaid's reimbursement rates are so low that many doctors no longer take Medicaid patients — narrowing the program's provider network, decreasing access for the most vulnerable citizens, and sowing the seeds for terrible, needless tragedies.[9]

On their own, those health outcome problems are justification enough to demand reform without pre-conditions.

Then there is the cost to state taxpayers. The Kaiser Family Foundation (KFF) found that if Missouri had expanded Medicaid under the ACA, the state would spend more than $1 billion between 2013 and 2022 on just the newly eligible enrollees.[10] In addition, the state would spend another $1.6 billion over that period on currently eligible enrollees who would come into the program as a result of the government's enrollment push.[11] That works out to nearly $3 billion in new Medicaid expenses without a plan to pay for any of it — and in addition to the state's current Medicaid spending.

One-third of Missouri's budget already goes to the Medicaid program; neither the current health outcomes nor the present budget situation justify growing that share further.

The ACA doubled down on a broken health care status quo. That fact is especially clear in the law's treatment of, as the President described them, "individuals who are out there struggling" who are either stuck in the already broken Medicaid system or would be put into it. Instead of fixing what we have, we are spending what we do not.

Medicaid needs to be reformed, not expanded with debt-addled Washington spending. Free market ideas can take us in a better direction.

Free-Market Medicaid Reforms

The principles of free-market reforms to the Medicaid program[12] boil down to four basic elements:

- The empowerment of the individual;
- the improvement of services and access to our most vulnerable citizens;
- the curbing of waste, fraud and abuse in the health care system; and
- the leveraging of market forces to rein in the health care prices for all.

As Michael Tanner, of the Cato Institute, wrote in his survey of health care systems internationally:

> [T]he broad and growing trend is to move away from centralized government control and to introduce more market-oriented features. The answer then to America's health care problems lies not in heading down the road to national health care but

> in learning from the experiences of other countries, which demonstrate the failure of centralized command and control and the benefits of increasing consumer incentives and choice.[13]

No health care system is, or will be, perfect. Yet, as policymakers consider ways of making health care better and more accessible in this country, they would do well to explore reform proposals that concentrate power in as many people as possible — using the power of the market, of people freely negotiating for goods and services with one another — to improve health care access and cost.

The free market has worked in countless industries to make goods and services cheaper and more available. It can do the same for Medicaid. Here are some ideas that stand out.

Convert Medicaid into a Health Savings Account Program For Most Beneficiaries

This is probably the most ambitious reform that a state could enact, but the evidence-based justification for such a change is well-established.

In 2008, Oregon expanded its Medicaid program, but because the number of spots it had available to enrollees was limited, beneficiaries were chosen through a lottery. This left two groups of otherwise comparable people: one group that had Medicaid coverage and one that did not. As Michael Cannon, of the Cato Institute, put it, "The random assignment of subjects makes Oregon's the most reliable study—indeed the only reliable study—ever conducted on the effects of Medicaid."[14] So, what happened?

> Medicaid increased medical spending from $3,300 to $4,400 per person, but produced no discernible improvement in blood pressure, cholesterol, blood sugar levels, or risk of heart attacks after two years. Medicaid should have had an immediate impact on these measures, especially among the poor. Its failure to do so also casts doubt on any supposed long-term benefits from Medicaid and even ObamaCare's subsidies for higher-income households.

Although these Medicaid beneficiaries had health care through the Medicaid program, their health outcomes were no better than those who had no insurance — except that they were psychologically comforted by the fact that they would not go bankrupt because of a catastrophic medical event.

Therein lies a hint for what the biggest value of most health insurance is, whether private or public: as a bulwark against financial catastrophe. Catastrophic health care plans would not only be more responsive to what most beneficiaries need from Medicaid, but they would also be less expensive to the state.

What would a conversion of Medicaid from a health plan to a backstop look like?

Instituting the equivalent of government-held health savings accounts (HSAs) ranging from $3,000 to $5,000 (based on per-capita Medicaid funding levels) would be sufficient to sustain less expensive catastrophic insurance plans and empower individual beneficiaries to tailor any additional spending to their specific medical needs. For those who do not have medical needs beyond their insurance plan, saved or leftover HSA money could be rolled over year-to-year, meaning beneficiaries would not feel compelled to use or lose those health dollars unnecessarily. That does not just save the government money; it also puts downward pressure on health care prices propped up by needlessly rigid government expenditures.

For the vast majority[15] of the Medicaid population, a conversion to a Medicaid HSA/catastrophic plan system would be a significant step toward more tailored and efficient medical care.[16] For taxpayers? Lower costs would be a welcome change in these tight budgetary times.

Encourage Medicaid Enrollees to Leave the Program

Enrollment in a traditional Medicaid program brings with it all sorts of negative effects. Along with confirming the questionable health benefits of Medicaid, the Oregon study also found that program beneficiaries went to the emergency room 40 percent more than those who were not on Medicaid. In other words, being in a traditional Medicaid program is related to negative behaviors in other health care areas, such as wasteful emergency room use.

Along with ensuring that Medicaid better serves our vulnerable, it is important to get as many people out of it as possible, as soon as possible. For instance, if a Medicaid patient complies with the rules of his or her Medicaid HSA and does not use emergency room services unnecessarily, the beneficiary could take some percentage of this leftover HSA money when leaving the program. This could be in the form of either an HSA or some reduced amount in cash. Instead of being effectively penalized for, say, taking a better-paying job, enrollees would be encouraged to exit Medicaid without negatively affecting their income.

Medicaid beneficiaries would be rewarded by taking responsibility for healthy and fiscally prudent behaviors. That is better for everyone.

Widen Medicaid Care Networks to Put Downward Pressure on Health Care Prices

There also would be benefits beyond just the government if a state implemented a Medicaid HSA reform. By converting hundreds of thousands of Medicaid enrollees into paying consumers with properly aligned personal financial incentives, a state like Missouri would be able inject a huge number of freshly minted, cost-conscious customers into the marketplace who could bid down the prices for all sorts of health products and services. Instead of facing narrow care networks, Medicaid patients could take their money practically anywhere because the services would no longer be connected to government reimbursements; instead, they would be tied to the cash in the enrollees' accounts. Regulatory reforms relating to the availability of care, which I will touch on shortly, would also support this end of augmenting health care access to Missourians in need.

Encourage Price Transparency

One of the few positive reforms that the ACA instituted was the special attention it paid to revealing the prices hospitals charge to patients for common medical procedures. Last year, the U.S. Department of Health and Human Services examined the prices of some typical treatments and found they were all over the board.[17]

> For example, average inpatient charges for services a hospital may provide in connection with a joint replacement range from a low of $5,300 at a hospital in Ada, Okla., to a high of $223,000 at a hospital in Monterey Park, Calif.
>
> Even within the same geographic area, hospital charges for similar services can vary significantly. For example, average inpatient hospital charges for services that may be provided to treat heart failure range from a low of $21,000 to a high of $46,000 in Denver, Colo., and from a low of $9,000 to a high of $51,000 in Jackson, Miss.

State laws requiring price transparency from hospitals vary wildly across the United States.[18] Missouri hospitals and health care providers are required only "to provide charge data to the [Missouri] Department of Health and Senior Services." Other states, such as New Hampshire and Massachusetts, have more robust transparency requirements meant to make price shopping easier, allowing users to easily compare the costs for common medical procedures at different hospitals.

But generally speaking, states have done a poor

job of ensuring that patients are able to compare the prices of medical procedures quickly and conveniently,[19] though that may change as consumers become more cost-conscious and tech savvy.[20] Whether such transparency reforms were implemented with private plans or Medicaid HSAs in mind, the effect would be mutually beneficial; more price information is good for consumers, whatever their type.

Pursue Regulatory Reforms

More can be done in other areas as well. In practice, Certificate of Need (CON) rules restrict the number of hospital beds that can be offered in a single community. This protects incumbent hospitals but harms price-conscious patients who would benefit from having more care options. Relaxing CON laws would promote competition for these patients.

Similarly, scope of practice (SOP) laws restrict who can provide certain medical services to the public. While there are legitimate public health considerations in some SOP restrictions, some prohibitions, particularly regarding what advanced practice nurses and pharmacists can do without a doctor's participation, are more about protecting powerful incumbent medical professions than protecting patients. Deliberate, well-researched reforms that expand care options[21] are overdue regarding SOP.

Finally, health insurance approved for sale in other states should be approved for sale in Missouri. As with hospitals and medical professionals, robust competition in health insurance should lead to better prices, services, and access for consumers.

Rather than interfere with the market, policymakers should ensure that patients — whether they hold a private insurance plan or a Medicaid HSA — have as many choices in their hospitals, medical professionals, and insurance plans as possible. Let the market work.

Takeaway

This brief is intended to contribute to the conversation about Medicaid reform, not end the conversation. Moreover, not every proposal in this document can be immediately enacted through an act of a state legislature alone; after all, the federal government will have to sign off on many of these reforms before they can take effect, considering its substantial role in the Medicaid program.

However, states still should act to set up the appropriate legal triggers for their reforms and should not wait until the federal government gives states the explicit go ahead, whether through a waiver or change in the law. After all, as Supreme Court Justice Louis Brandeis once noted:

> *To stay experimentation in things social and economic is a grave responsibility. Denial of the right to experiment may be fraught with serious consequences to the Nation. It is one of the happy incidents of the federal system that a single courageous State may, if its citizens choose, serve as a laboratory; and try novel social and economic experiments without risk to the rest of the country.*[22]

With health care on the front of the public consciousness, now is a golden opportunity to enact bold and positive change in the Medicaid program that empowers people, not bureaucrats, to make themselves and their families better off. It is time to move Medicaid forward, not backward. It is time for these serious ideas.

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NOTES:

[1] The White House. "Remarks by the President at a Fundraising Dinner for Senator Claire McCaskill." View online here: http://1.usa.gov/1lvCTcM (accessed March 3, 2014).

[2] Associated Press. "Policy notifications and current status, by state." Yahoo! News. View online here: http://yhoo.it/19Ll8wH (accessed March 3, 2014).

[3] Fox News. "Almost 80 million with employer health care plans could have coverage canceled, experts predict." FoxNews.com. View online here: http://fxn.ws/IRnrqs (accessed March 3, 2014). McClatchy. "McClatchy DC." Analysis: Tens of millions could be forced out of health insurance they had. View online here: http://bit.ly/1dVJ1Dx (accessed March 3, 2014).

[4] Roy, Avik. "49-State Analysis: Obamacare To Increase Individual-Market Premiums By Average Of 41%." *Forbes*. View online here: http://onforb.es/1hyhWfo (accessed March 3, 2014).

[5] "We are estimating that 65 percent of the small firms are expected to experience increases in their premium rates while the remaining 35 percent are anticipated to have rate reductions," CMS' Office of the Actuary wrote in a new report. Harrison, J.D. "Obama administration: Health law's new rules will increase costs for most small businesses." *Washington Post*. View online here: http://wapo.st/NtYR1n (accessed March 3, 2014).

[6] "Nat. Fedn. of Indep. Business v. Sebelius, 132 S. Ct. 2566 - Supreme Court 2012." Google Scholar. View online here: https://bitly.com/1kQJMT9 (accessed March 3, 2014).

[7] Ishmael, Patrick. "Medicaid Expansion Under Obamacare Is Wrong For Missouri." Show-Me Institute. View online here: http://bit.ly/1fDuewT (accessed March 3, 2014).

[8] Ishmael, Patrick. "Oregon Study: Medicaid Expansion Increases Emergency Room Use." Show-Me Daily. View online here: http://bit.ly/1i1boDk (accessed March 3, 2014).

[9] Cannon, Michael. "Should Ohio Expand Medicaid?" Cato Institute. View online here: http://bit.ly/1g6fBmu (accessed March 3, 2014).

[10] It is useful at this point to note what the state expansion burdens are and how those burdens are allocated over time. As the National Conference of State Legislatures (NCSL) explains, "Full federal financing (100 percent Federal Medical Assistance Percentages) will be available for those newly eligible for Medicaid for three years (2014 to 2016). The Federal Medical Assistance Percentage falls to 95 percent in 2017, 94 percent in 2018, 93 percent in 2019, and 90 percent in 2020 and beyond; states pick up the balance." "Medicaid and the Affordable Care Act." NCSL. View online here: http://bit.ly/1eXKnle (accessed March 5, 2014). This makes the KFF calculations (which begin in 2013) look even worse budgetarily, as the state costs for the "newly eligible" of the Medicaid expansion do not really begin until 2017 anyway; in other words, the lion's share of KFF's billion dollar-plus cost prediction happens over about six years, not 10, with the lower match rate and much higher expenses continuing beyond the 2020 horizon. And all of this assumes, of course, that the federal government will not draw down its contribution and place a greater share of the expansion burden on the states as federal budgets tighten in the years ahead.

[11] Generally speaking, the cost breakdown of traditional Medicaid is 60 percent to the federal government and 40 percent to the state, not 90/10 as with the expansion. Because the match rates for the currently eligible will not change, the cost for each of these new enrollees is significantly higher. Ishmael, Patrick. "Assessing a Very Costly Medicaid Expansion." Show-Me Institute. View online here: http://bit.ly/1pY9Hfk (accessed March 3, 2014). This phenomenon is commonly known as the "woodwork effect" of the Medicaid expansion — individuals who were eligible for Medicaid all along "come out of the woodwork" to use benefits they were not previously using. Health Affairs defined the problem similarly: "Woodwork Effect: New enrollment among previously eligible individuals … also may have major budget implications for states, since they will have to pay a larger share of costs for this group." Sommers, Benjamin, Sarah Gordon, Stephen Somers, Carolyn Ingram, and Arnold Epstein. "Health Affairs Blog Medicaid On The Eve Of Expansion A Survey Of State Medicaid Officials About The ACA Comments." Health Affairs. View online here: http://bit.ly/1l2gf8Q (accessed March 5, 2014). See also: Ishmael, Patrick. "Bad Data, Bad Tech and No Expansion Lead to Fall in Missouri Medicaid Enrollment." *Forbes*. View online here: http://onforb.es/1h6XbUk (accessed March 10, 2014).

[12] Another worthy recitation of reforms and principles can be found in another Show-Me Institute paper. See: Arduin, Laffer & Moore Econometrics. "The Prognosis for National Health Insurance: A Missouri Perspective." Show-Me Institute. View online here: http://bit.ly/1c3g2Cc (accessed March 3, 2014).

[13] Tanner, Michael. "The Grass Is Not Always Greener: A Look at National Health Care Systems Around the World." Cato Institute. View online here: http://bit.ly/1fDu74i (accessed March 3, 2014).

[14] Cannon, Michael. "Why Expand Care With No Proven Benefits?." *New York Times*. View online here: http://nyti.ms/NP0xTx (accessed March 3, 2014).

[15] To be clear, a program like this would probably not work for the long-term care population because their medical needs are present, not prospective.

[16] Cannon would probably disagree about the value of the catastrophic plan provision. "The notion that Medicaid should provide only catastrophic coverage likewise misses the point," he wrote in his *New York Times* piece. "Congress should have to produce evidence of benefit before it forces taxpayers to fund any such program. Yet there's no reliable evidence that government-provided catastrophic coverage would improve enrollees' health, either." I do not disagree that Congress or a legislature should justify such a program on sound science. I do, however, believe there is sufficient evidence that not only would there be health benefits to high-risk beneficiaries and social benefits to averting bankruptcies stemming from the medical debts of low-income individuals, but when paired with other reform elements, HSA funding of catastrophic health insurance plans would incrementally and substantially move us toward a far leaner welfare state.

[17] "Administration offers consumers an unprecedented look at hospital charges." HHS. View online here: http://1.usa.gov/1hEcczA (accessed March 4, 2014).

[18] NCSL. "Transparency and Disclosure of Health Costs and Provider Payments: State Actions." State Actions Related to Transparency and Disclosure of Health and Hospital Charges. View online here: http://bit.ly/1ePaE5a (accessed March 4, 2014).

[19] HCI3. "Metrics for Transformation - Transparency." Transparency. View online here: http://bit.ly/1byXi6H (accessed March 4, 2014).

[20] HCI3. "Model State Health Care Price and Quality Transparency Legislation." Health Care Incentives Improvement Institute, Inc. (HCI3).View online here: http://bit.ly/1hEfx1C (accessed March 4, 2014).

[21] "From The Jaws Of Defeat: Volunteer Health Services Act Veto Overridden" Show-Me Daily. View online here: http://www.showmedaily.org/2013/09/from-the-jaws-of-defeat-volunteer-health-services-act-veto-overridden.html (accessed March 5, 2014).

[22] "New State Ice Co. v. Liebmann, 285 US 262 - Supreme Court 1932." Google Scholar. View online here: https://bitly.com/1g656je (accessed March 3, 2014).

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