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spotlight

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Health Care's New Prescription

The Power To Heal Through Consumer-Driven Medicaid

KEY FACTS: • **Medicaid's ineffective utilization of its unpredictable budget is a parasitic disease to taxpayers and beneficiaries. The state now faces a budget overrun of more than $248 million.**

• **Over 1.8 million North Carolinians receive Medicaid benefits, while taxpayers contribute over $14 billion annually to the entitlement program.**

• **Consumer-driven Medicaid reform emphasizes principles of choice, competition, and fiscal responsibility for beneficiaries and providers.**

• **Under a consumer-driven model, Medicaid patients would be able to choose benefits and services that best fit their medical needs from multiple health plans with defined block grants. Patients could also either engage in cost-sharing or benefit from healthy incentives.**

• **Multiple Managed Care Organizations (MCOs) compete to offer the best services to Medicaid beneficiaries while remaining fiscally afloat.**

• **Comprehensive and coordinated care between mental and physical health providers has the potential to produce positive health outcomes for patients and achieve cost-effectiveness via preventative health measures.**

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In the economic sphere an act, a habit, an institution, a law produces not only one effect, but a series of effects. Of these effects, the first alone is immediate; it appears simultaneously with its cause; it is seen. The other effects emerge only subsequently; they are not seen; we are fortunate if we foresee them[1] *-Frederic Bastiat, 19th century free-market political economist.*

Medicaid Masquerade

We currently live amid a Medicaid masquerade, where many unintended consequences of this government entitlement program go unnoticed or are simply ignored.

North Carolinians see that over 1.8 million of their fellow state residents receive Medicaid benefits, and approximately 67% of this population receives care through Community Care of North Carolina (CCNC), the questionable "gold standard" of Medicaid managed care organizations (MCOs).[2, 3]

But North Carolinians do not recognize that large sums of their taxpayer dollars ($14 billion annually to be precise)[4] are not satisfying the entitlement program's insatiable appetite. North Carolina citizens now face the burden of a $248 million overrun, recently announced by the state's Department of Health and Human Services. The increase of $135 million in the anticipated shortfall dates back to Governor Perdue's 2012 Administration where there was a miscalculation of total federal funding.[5]

Diagnosis and Prescription

Medicaid's ineffective utilization of its unpredictable budget is a parasitic disease to taxpayers and beneficiaries. Fortunately, a prescription pill for a cure exists, if only it will be swallowed. It is known as consumer-driven Medicaid reform.

Consumer-driven Medicaid emphasizes principles of choice, competition, and fiscal responsibility for beneficiaries and providers. Patients may choose from a broad menu of services and products that best meet their health needs. At the same time, competition arises among insurers and providers as they offer a variety of medical services. Insurers and providers also embrace the principle of choice, since they can offer to consumers whichever enhanced services and benefits they wish. Consumer-driven Medicaid turns upside down Medicaid's uniform list of "defined benefits."

Patients gain access to quality care with "defined contributions," or block grants distributed by a fixed state fund. When money is placed in the hands of a patient, it is more likely to be spent wisely, especially when patients must pay for certain health services out-of-pocket. This encourages fiscal responsibility.

Fiscal responsibility must also be encouraged by Managed Care Organizations (MCOs), since Medicaid benefits are often offered through these entities. Managed Care Organizations (MCOs) impose limits. Services that are provided by contracted medical providers to patients are limited. Payment is also limited, or capitated, as primary care physicians are reimbursed on a per-member, per-month (PMPM) basis. This means that, no matter how many times a Medicaid patient sees a physician in one month, that physician receives the same fixed amount of payment.[6]

One may cringe at the thought of "limited health care." However, these limited services focus on preventative health measures. If properly run, MCOs allow their contracted networks of providers to offer quality preventative health services to patients, yielding positive health outcomes and cost-effectiveness.

Let's take a look at how certain states have capitalized on consumer-driven Medicaid via multiple health organizations.

Pill #1: Indiana's Healthy Indiana Plan[7]

Indiana's Healthy Indiana Plan (HIP) was initiated in 2008 under Republican Governor Mitch Daniels following the successful addition of a consumer-driven health plan to the benefit options of Indiana's state employees in 2006. The first year this benefit was introduced, only 4 percent of state workers enrolled. Six years later in 2012, 94 percent had chosen that option.

Essentially, HIP operates a state-run Health Savings Account (HSA), or a block grant designated for discretionary use by recipients in need. Eligible citizens who qualify for HIP must be between ages 19-64 with household income between 22-200% of the Federal Poverty Level (FPL). While North Carolina should not expand its medical assistance eligibility to 200% of the FPL like Indiana, the effort to encourage choice and responsibility through health savings accounts should be emulated.

In HIP, patients receive an upfront contribution of $1,100 from the state in a POWER (Personal Wellness and Responsibility) account, may choose one of three commercial plans, and must contribute a monthly sum to the account, based on a sliding-scale, that cannot exceed more than 5% of their total income. Leftover amounts also roll over to renewed POWER accounts, just like in any HSA.

Table 1: POWER Account Contribution Charts

FPL	Income	%	Lowest Annual Contribution	Highest Annual Contribution	Less CHIP Premiums	Lowest Monthly Contribution	Highest Monthly Contribution
Single Adult, No Children							
0-100%	$0-$10,210	2%	$0	$204	N/A	$0	$17
100-125%	$10,211- $12,763	3%	$306	$383		$26	$32
125-150%	$12,764- $15,315	4%	$511	$613		$43	$51
150-175%	$15,316- $17,868	5%	$766	$893		$64	$74
175-200%	$17,869- $20,420	5%	$893	$1,021		$74	$85
Family of 2: 1 Adult, 1 Child							
0-100%	$0-$13,690	2%	$0	$274	$0	$0	$23
100-125%	$13,691- $17,113	3%	$411	$513	$0	$34	$43
125-150%	$17,114- $20,535	4%	$685	$821	$0	$57	$68
150-175%	$20,536- $23,958	4.5%	$924	$1,078	$264	$55	$68
175-200%	$23,959- $27,380	4.5%	$1,078	$1,232	$396	$57	$70

HIP offers benefits covering $500 dollars in preventative services and provides an Enhanced Services Plan (ESP) for those with pre-existing conditions and intensive medical needs. Indiana also tears down the isolated silos of mental and physical health providers and emphasizes coordinated care among these providers, as mental health and substance abuse services are offered through HIP.

Overall, the POWER account induces conscientious discretion among beneficiaries because health care costs become transparent. Participants are exposed to the full cost of health care services and forced to decide if the care is appropriate.[8] And beneficiaries report high satisfaction: of the 98,000 HIP enrollees, 94% are pleased with the system and 99% will consider re-enrollment.

HIP forces patients to have "skin in the game." If one fails to make a timely payment, his coverage terminates. Also, if a patient does not renew HIP's annual contract, he or she cannot apply for enrollment for another year and faces a penalty of a 25% deduction from the POWER account.

Table 2: Savings by State from Florida's Medicaid Cure (2009 data)								
State	**Total Spending on SSI Individuals**	**Spending per Person on SSI Individuals**	**Annual Savings if at Medicaid Cure Spending**	**Total Spending on TANF Individuals**	**Spending per Person on TANF Individuals**	**Annual Savings if at Medicaid Cure Spending**	**Total Possible Savings**	**Savings as % of Related Medicaid Spending**
North Carolina	*$2,784,010,413*	*$16,996*	*$1,353,586,487*	*$3,100,204,510*	*$2,467*	*$1,309,073,210*	*$2,662,659,697*	*48%*
South Carolina	$1,104,031,062	$13,728	$401,734,832	$1,350,522,411	$2,083	$426,437,895	$828,172,727	38%
Virginia	$1,585,211,332	$17,298	$784,933,683	$1,844,978,758	$2,764	$893,623,384	$1,678,557,067	53%
Tennessee	$2,071,900,665	$12,341	$605,820,934	$2,683,537,751	$2,779	$1,307,085,710	$1,912,906,644	46%
Georgia	$1,965,517,644	$10,859	$384,846,809	$2,794,792,027	$2,230	$1,008,131,032	$1,392,977,841	35%

Other enforcement initiatives prohibit patient "crowd-out." This happens when patients who become financially eligible for medical assistance drop their private coverage. As a result, these enrollees squeeze out those who truly cannot afford health insurance.[9] In Indiana, people financially eligible for HIP cannot apply if they have access to employer-sponsored insurance.

Pill #2: Florida's Medicaid Cure[10]

Further south, the Sunshine State is seeking to expand its five-county Medicaid pilot program, Medicaid Cure, statewide. Like HIP, this consumer-driven model focuses on the concept of choice among insurers, providers, and patients.

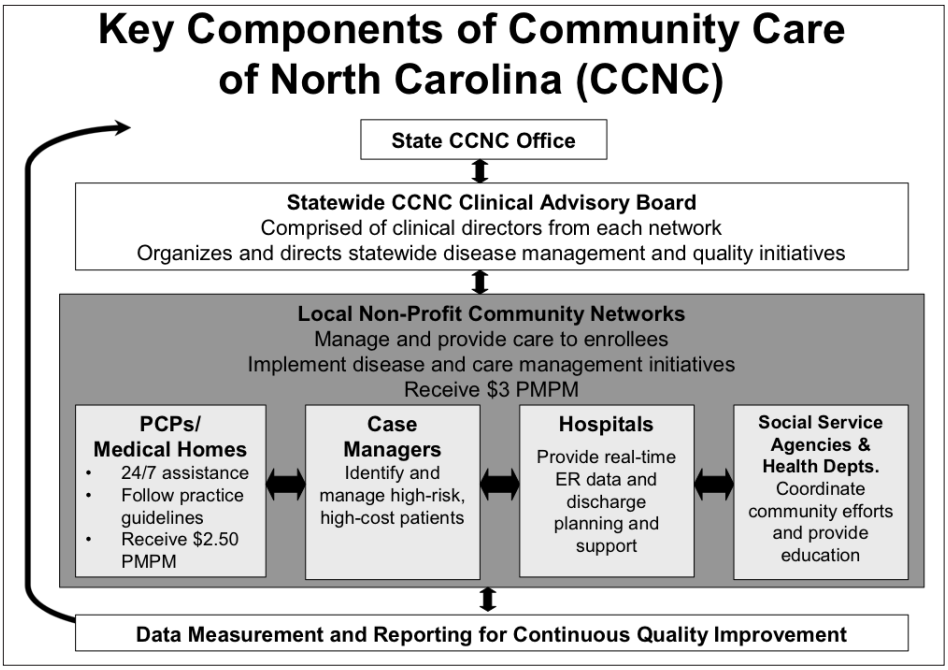
The pilot program was implemented in 2005 under Republican Governor Jeb Bush and provides a valuable model for the rest of the country to study. Currently, over 317,000 Medicaid recipients participate in this comprehensive program – more individuals than the state Medicaid program in approximately one-third of states.[11]

Medicaid Cure operates through the state paying a fixed monthly amount to 13 different private health plans with up to 31 customized benefit packages. Medicaid beneficiaries may "vote with their feet," choosing a plan and enhanced benefits that best meet their needs.[12]

At the same time, Medicaid Cure's network providers have the ability to offer benefits based on patient demand within geographical areas and demographic populations. Medicaid Cure even allows medical providers to develop their own provider networks, known as Provider Service Networks (PSNs). Like all Medicaid Cure provider networks, PSNs are financially responsible, risk-based managed care organizations (MCOs) that are either provider-owned or provider-run.[13]

Medicaid Cure produces positive health outcomes for its enrollees via cost-effective measures that do not neglect patient needs. Like Indiana's HIP program, Medicaid Cure utilizes risk-adjustment, where enrollees receive care based on their health status. These "base rates" are also reevaluated annually, and plans receive a one time "kick payment" if a child is born to a mother on Medicaid, or for certain transplants.[14]

Table 3: Reform Pilot Outcomes on Improving Health of Medicaid Patients					
	HEDIS Measures by Year				
	Non-Reform Counties		Reform Pilot Counties		MedicaidManaged Care
	2008	2010	2008	2010	National Mean
Diabetes Management	57.5%	61.2%	59.1%	64.1%	59.5%
Mental Health	38.8%	35.4%	28.1%	41.7%	41.8%
Preventative - Children	64.1%	63.7%	62.4%	62.3%	66.9%
Preventative - Adults	56.6%	58.8%	48.2%	64.9%	63.0%



If North Carolina were to implement a program simulating Medicaid Cure, total projected savings range from $1 billion to $2.6 billion. This would equate to between 18-48% savings on related Medicaid spending.[15]

The National Committee for Quality Assurance's Health Effectiveness Data and Information Set (HEDIS) is known as the most universal measure of health plan enrollee outcomes.[16] Table 3 portrays Medicaid Cure's success on multiple health measures. Reform-pilot counties outperformed non-reform pilot counties and national HMOs in many health measures, with significant results in the four categories of diabetes, mental health, preventative child, and preventative adult measures.

North Carolina Medicaid Monopoly: Dressing the Wound

State Average Medicaid Spending Per Enrollee FY 2009	
North Carolina	$6,098
Virginia	$5,870
South Carolina	$5,181
Tennessee	$4,742
Georgia	$3,979

North Carolina's current and only Medicaid MCO, Community Care of North Carolina (CCNC), operates as a medical home model designed to offer preventative health services to the Medicaid population to control chronic illnesses and reduce unnecessary and costly ER visits. Each patient is assigned to a medical home, or a "primary care physician," where individual medical needs are assessed.[17]

Many praise CCNC as an ideal framework, but having just one statewide MCO providing Medicaid services simply does not work. Proponents boast that North Carolina now has the slowest-growing Medicaid spending in the country at 3.5%.[18] However, costs per enrollee continue to increase rapidly. North Carolina's costs per enrollee significantly surpass its southeastern neighbors.[19] This is because CCNC neither carries the weight of accountability nor follows spending limits. This is a big problem.

Until North Carolina instills consumer-driven Medicaid principles in its ongoing Medicaid reform, the system cannot be fixed.

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