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Don't Wait for Congress to 'Fix' Health Care *States can implement real health care solutions today*

By Matthew Glans*

Introduction

Medicaid is a controversial and troubled entitlement program providing health coverage to low-income adults, children, pregnant women, and people with disabilities. The quality of care received by Medicaid beneficiaries is below that received by people with no health insurance at all. Costs have soared along with waste and fraud.

Rather than reform Medicaid, the Patient Protection and Affordable Care Act (ACA, also known as Obamacare) offered large federal subsidies to states that would expand their Medicaid programs to provide coverage to individuals with incomes up to 133 percent of the federal poverty level.

To date, 31 states and the District of Columbia have expanded their programs to qualify for more federal aid.

It is time for the states to take up the interests of their own citizens—those in need as well as the taxpayers who foot the bills—who have been failed by the national government.

The cost of Medicaid is shared by states and the national government. While the national government promised to cover the immediate cost of the expansion of state programs, its share of funding will decline over time and may fall back to pre-expansion levels if Congress acts to repeal or “repeal and replace” Obamacare. Medicaid rolls have been expanding faster than

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predicted, and recent surveys show the costs for new enrollees are higher than for those covered by the existing program. This means new costs could be significant.

A federal provision called “Maintenance of Effort” requires states to fund a program at the initially agreed-upon level, regardless of the amount of federal funding received. This will leave state taxpayers on the hook for the new liabilities.

What should state legislators do? This *Policy Brief* offers the following guidance:

The failure of Congress so far to repeal and replace Obamacare presents the states with opportunities to develop their own programs offering aid to the poor and disabled in more cost-efficient and -effective ways.

- Part 1 provides some background on how Medicaid works, how Obamacare changed the program, and how the program is now unsustainable. Keeping the *status quo* is not an option.
- Part 2 documents how two states—Arkansas and Oregon—expanded their Medicaid programs and produced falling health care quality and rising costs. Expanding an already failing program is also not an option.
- Part 3 describes how states can apply to the Health and Human Services (HHS) Secretary for waivers to Medicaid and to Obamacare. HHS Secretary Tom Price has encouraged states to be bold and ambitious in their waiver requests, reversing the attitude and policy of his predecessor.
- Part 4 describes how two states—Florida and Rhode Island—used waivers during the Obama administration to dramatically improve their Medicaid programs by introducing competition and choice.
- Part 5 describes the “Medicaid Fix,” a proposal to have federal dollars earmarked for Medicaid go directly into health savings accounts created for the indigent.
- Part 6 describes other reforms states can initiate without waiting for Congress to repeal Obamacare or even for Secretary Price to act on their waiver requests. These reforms have been part of a market-based health care reform agenda for many years.

The failure of Congress so far to repeal and replace Obamacare presents the states with opportunities to develop their own programs offering aid to the poor and disabled in more cost-efficient and -effective ways. Already, several states have had success with this approach. It is time for the other states to take up the interests of their own citizens—those in need as well as the taxpayers who foot the bills—who have been failed by the national government.

1. Medicaid and the Affordable Care Act

Medicaid began as part of President Lyndon Johnson’s “Great Society” expansion of the welfare state. The Title XIX amendment in 1965 to the Social Security Act sought to create a safety net to ensure the poorest of the poor would not find themselves sick and with no access to medical care. While the program was meant in most cases to be temporary and used during periods of unemployment or other financial stress, Medicaid now serves as the primary long-term source of health insurance coverage for low-income populations.

Medicaid is primarily administered by the states, with matching funds from the national government. States are not required to participate in the Medicaid program, yet all have participated since 1982. Under federal laws and guidelines, each state establishes its own eligibility standards, the rate of payments to providers, and the types of services it will cover. This means benefits vary from state to state, and individuals may not qualify for the program in all states.

The portion of Medicaid funding provided by the national government, the Federal Medical Assistance Percentage (FMAP), varies from state to state as the result of a complicated formula involving per-capita income, a “multiplier” determined by state spending, and exceptions for certain

Unlike spending by the national government on items like defense, education, and transportation, Medicaid spending is not subject to the annual appropriations process.

services, certain populations, and certain administrative costs. Wealthier states generally receive a smaller FMAP than states with lower per-capita incomes. The maximum regular FMAP is 82 percent. FMAPs are adjusted on a three-year cycle. This allows funding to reflect changes in the economy, state spending, and other variables.

The Children’s Health Insurance Program (CHIP) program, signed into law in 1997, is a companion program to Medicaid. All states participate in this program as well.

The national government’s Centers for Medicare and Medicaid Services (CMS) monitors the state programs. The states must secure permission from the U.S. Department of Health and Human Services (HHS) to make any substantive changes to their programs. This is done through Section 1115 waivers.

Unlike spending by the national government on items like defense, education, and transportation, Medicaid spending is not subject to the annual appropriations process. Medicaid is an entitlement, and the amount spent on the program depends on the number of people who enroll in it, not on any congressional action.

As part of the Affordable Care Act (ACA), the national government encouraged states to expand their Medicaid programs by offering, at least initially, to cover the entire cost of expansion. The Obama administration also sought to make federal Medicaid payments under the *existing* program conditional on the expansion of eligibility to all individuals with incomes up to 133 percent of the federal poverty level. The Supreme Court ruled that arrangement unconstitutional, deciding states could not be required to expand their Medicaid programs in

order to continue receiving current levels of federal funding.¹ The subsidies for expansion remain, however, and the allure of federal dollars has proven difficult for most states to resist. As of this writing, 31 states and the District of Columbia have chosen to expand their Medicaid programs through ACA.

From its modest beginning in 1965, Medicare grew to 8 percent of states' budgets in 1985, 22 percent in 2005,² and 29 percent in 2016.³ In FY 2016, the program cost \$553 billion. The national government covered \$349 billion, or 63 percent, while the states covered \$204 billion, or 37 percent.⁴ This did not include CHIP.

Unless repealed, ACA will cause Medicaid spending to rise even more. According to the Kaiser Family Foundation, "Overall, the coverage provisions in the ACA are expected to increase gross federal costs by \$1.8 trillion over the 2015–2024 period. Medicaid and CHIP outlays are expected to increase by \$792 billion over the 2015 to 2024 period as a result of the ACA coverage provisions accounting for 43 percent of the total gross costs."⁵

2. Why Expanding Medicaid Is Not the Answer

Just as the original Medicaid program proved costly, Medicaid expansion promises to be costly and already is delivering sub-par service.

Among the most significant problems with Medicaid expansion is a lack of clear funding in the future.

Among the most significant problems with Medicaid expansion is a lack of clear funding in the future. The national government promised to cover 100 percent of the costs of newly eligible enrollees until 2017. The

matching rate will now begin to decline, falling to 95 percent in 2018 and reaching 90 percent in 2020. States will eventually have to find other ways to pay for the newly eligible population. Future funding of the expansion is subject to congressional approval. Proposals to repeal and replace ACA would end or phase out the subsidy, leaving states on the hook for the entire cost.

Medicaid has long used taxpayer dollars inefficiently, and the recent expansion under ACA has exacerbated the problem. According to a report issued by HHS, in 2015 the average Medicaid expansion enrollee cost \$6,366; HHS had predicted the average would be only \$4,281. HHS also

¹ [National Federation of Independent Business v. Sebelius](#), 567 U.S. 519 (2012).

² Israel Ortega and David Weinberger, "[Healthcare Reform – Could History Repeat Itself?](#)" *Commentary*, The Heritage Foundation, November 24, 2009.

³ National Association of State Budget Officers, "[State Expenditure Report: Examining Fiscal 2014–2016 State Spending](#)," 2016.

⁴ Kaiser Family Foundation, "[Federal and State Share of Medicaid Spending](#)," 2016.

⁵ Robin Rudowitz, "[A Look At CBO Projections For Medicaid and CHIP](#)," Kaiser Family Foundation, June 2014.

reported total federal and state Medicaid spending in fiscal year 2015 was 5 percent higher than its projections.⁶

Waste and abuse continue to plague Medicaid as well. A 2016 article in *The Wall Street Journal* highlights a government report that revealed a dramatic increase in improper Medicaid spending between 2013 and 2016.⁷ “The Medicaid failure rate matters because the 9.7% increase in total improper payments in 2015 across 121 programs run by 22 agencies—to \$136.7 billion—was driven almost entirely by this single program, according to the Government Accountability Office (GAO). The 11.5% increase for 2016 is likely an underestimate given that HHS’s goal last year was 6.7% and instead scored 9.8%, which amounts to \$29.1 billion,” *The Wall Street Journal* reported.

Medicaid expansion also may not improve business for its staunchest supporters, the hospitals receiving new patients and subsidies. A working paper released by the Congressional Budget Office (CBO) in September

“The open-ended federal subsidy discourages both states and the federal government from conducting effective program oversight.”

2016 analyzed profit margins for hospitals and made projections for the coming decade.⁸ It modeled the likely impact of various provisions of ACA in 2025 and compared those outcomes with hospitals’ profitability in 2009, prior to ACA’s passage. The authors concluded, “The hospitals we examined would have to increase the growth of total revenues or reduce the growth of total costs by an additional 0.2 percent to 0.5 percent per year to achieve the same level of average profitability in 2025 as they obtained in 2011.” In other words, Medicaid expansion will not make a notable difference in hospitals’ overall, already-stressed financial viability. Because the large increase in improper Medicaid payments occurred during the ACA Medicaid expansion, Brian Blase of the Mercatus Center at George Mason University argues expansion may be to blame. “Before the ACA,” he wrote, “Medicaid was already growing rapidly, and contained embedded problems that resulted in large amounts of low-value spending.”⁹ Among those problems, he noted, “The open-ended federal subsidy discourages both states and the federal government from conducting effective program oversight, leading to wasteful spending and state schemes to inappropriately obtain federal funding through Medicaid.”¹⁰

Oregon: Funding Low-Value Services

With the huge Medicaid spending increases, one might expect the program would be able to deliver better medical services than it does. Yet a 2013 study published in *The New England*

⁶ Office of the Actuary, Centers for Medicare & Medicaid Services, [2015 Actuarial Report on the Financial Outlook for Medicaid](#), Department of Health and Human Services, 2015.

⁷ “[ObamaCare’s ‘Improper’ Failure](#),” *The Wall Street Journal*, September 6, 2016.

⁸ Tamara Hayford, Lyle Nelson, and Alexia Diorio, “[Projecting Hospitals’ Profit Margins Under Several Illustrative Scenarios](#),” *Working Paper* 2016-04, Congressional Budget Office, September 2016.

⁹ Brian Blase, “[Evidence Is Mounting: The Affordable Care Act Has Worsened Medicaid’s Structural Problems](#),” Mercatus Center, 2016.

¹⁰ *Ibid.*

Journal of Medicine (NEJM) found Oregon’s Medicaid expansion program failed to achieve its primary goal: improving overall health.¹¹

In 2008, before ACA, Oregon expanded its Medicaid program to 30,000 people selected randomly from a waiting list of 90,000. The *NEJM* researchers analyzed health outcomes for more than 12,000 of the new enrollees.

The authors of a study of Oregon’s Medicaid expansion concluded recipients received between 20 and 40 cents’ worth of value for every dollar spent on Medicaid expansion.

On the positive side, the researchers found Medicaid enrollment raised the rates of diabetes detection and management, lowered rates of depression, and reduced financial strain.

On the negative side, the researchers found Medicaid expansion increased the

number of emergency room visits by 40 percent in the first 15 months. This is significant because ACA architects said one goal of the legislation was to encourage patients to take advantage of traditional preventive care instead of relying on emergency rooms.

In a follow-up study also published in *NEJM*, the authors found the cost of Medicaid continued to rise in Oregon, due in part to increased emergency room use. The authors concluded the value of Medicaid expansion for its recipients was quite low. The study estimated, “[The] benefit to recipients from Medicaid per dollar of government spending range from about \$.2 to \$.4.”¹²

Arkansas: Spikes in Costs and Fraud

Medicaid expansion builds on a failing model in which the national government dictates multiple aspects of the program, thereby losing the beneficial aspects of market competition. Arkansas’ expansion of Medicaid highlights the perils. That state originated the so-called private-option model many states used to expand their Medicaid programs. But the market benefits did not come.

Under Arkansas’ “premium assistance” model, which was enacted in 2013, an estimated 250,000 new enrollees were added to the state’s Medicaid rolls. Using the funds made available under ACA’s Medicaid expansion, these new enrollees received premium-support payments enabling them to purchase private insurance from the state’s Obamacare health insurance exchange. Despite the private-market veneer, Arkansas’ program maintained many of the most problematic aspects of the state’s failed Medicaid system and has led to increased costs.

¹¹ Katherine Baicker, Sarah Taubman, Heidi Allen, *et al.*, “[The Oregon Experiment — Effects of Medicaid on Clinical Outcomes](#),” *New England Journal of Medicine* **368** (May 2013): 1713–22.

¹² Amy N. Finkelstein, Sarah L. Taubman, Heidi L. Allen, Bill J. Wright, and Katherine Baicker, “[Effect of Medicaid Coverage on ED Use — Further Evidence from Oregon’s Experiment](#),” *New England Journal of Medicine* **375** (October 2016):1505–07.

As of May 2015, Medicaid in Arkansas covered 832,510 people, including the 250,000 new enrollees added under expansion, according to healthinsurance.org.¹³ A report by The Stephen Group in October 2015 found substantial waste and fraud in the state’s Medicaid expansion program.¹⁴ More than 42,891 individuals with out-of-state addresses were enrolled in the program—20,110 of them in the Private Option. In addition, 6,753 enrollees, including 3,210 Private Option recipients, had no record at all proving state residency.¹⁵ The Stephen Group also found the state’s Medicaid program enrolled 367 deceased individuals (128 of them Private Option recipients); 427 individuals enrolled in dual programs; and 1,198 incarcerated recipients who already receive health care in jail or prison.¹⁶

The right way to eliminate fraud and waste in Medicaid expansion is to end Medicaid expansion. However, to do so requires a difficult-to-get waiver of HHS’s Maintenance of Effort requirement. In an August 2015 report conducted for a task force of the Arkansas legislature, The Stephen Group found ending Medicaid expansion and reverting to traditional Medicaid, even if allowed, could cost the state \$438 million between 2017 and 2021.¹⁷ This finding reinforces the idea states should not expand Medicaid in the first place: When expansion programs fail and lose money, they can be costly even to roll back.

Medicaid expansion builds on a failing model in which the national government dictates multiple aspects of the program, thereby losing the beneficial aspects of market competition.

With the failure of the so-called private-option model, Arkansas is now attempting to become the first state to enact reforms significantly scaling back Medicaid expansion under ACA. The approved legislation launching the rollback effort requires the state to request a Section 1115 waiver from HHS to modify its expanded Medicaid program, known as Arkansas Works. The waiver seeks to drop Medicaid eligibility in the state from 138 percent of the federal poverty level (\$33,948 for a family of four) to 100 percent FPL (\$24,600 for a family of four).

In the waiver application, Arkansas officials say the 60,000 people losing coverage would use tax credits and cost-sharing reduction payments to buy individual plans on the state marketplace. The waiver also includes work requirements: Adults remaining on Medicaid would be required to work, participate in job training, be in school, or be actively looking for employment at least 80 hours a month to keep their insurance.

Arkansas is not the only state to consider rolling back its Medicaid expansion. Legislators in Ohio and Oregon are considering reforms similar to what was passed in Arkansas.

¹³ Louise Norris, [“Arkansas and the ACA’s Medicaid Expansion, Governor Pushing for New Modifications to Arkansas Works,”](#) March 29, 2017.

¹⁴ The Stephen Group, [Volume I, Findings Report](#), submitted to Arkansas Health Reform Task Force, October 1, 2015.

¹⁵ *Ibid.*, p. 176.

¹⁶ *Ibid.*

¹⁷ Arkansas Legislature, [“Arkansas Health Reform Legislative Task Force Final Report,”](#) December 15, 2016.

States that have not expanded their Medicaid should avoid doing so, but for states that have expanded Medicaid, Arkansas' reforms could be a good model for limiting the cost of expansion.¹⁸ Other states should take advantage of the waiver process (see below) while there is an administration in the White House willing to approve market-oriented Medicaid changes.

3. States Should Seek Waivers

Instead of expanding an expensive and failing program, states should apply to the Health and Human Services Secretary for Section 1115 waivers, giving them more flexibility managing their Medicaid programs, and for Section 1332 waivers easing the financial and regulatory burden of ACA. HHS Secretary Tom Price invited states to submit such waiver requests in a letter sent to governors on March 14, 2017.¹⁹

Section 1115 Waivers to Medicaid

Under Section 1115 of the Social Security Act, the HHS Secretary can approve experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid law. Section 1115 waivers cannot be used for widespread reforms like dramatically changing funding,

Through Section 1115 Medicaid waivers, states can adopt work requirements, deploy incentives for healthy behavior, offer more flexible benefits, and more.

but they still allow states to make significant changes to their Medicaid programs.

To get a Section 1115 waiver approved, a state must prove to the Secretary of HHS that its proposal meets the goals of the Medicaid program and federal

budget requirements. Section 1115 waivers generally are approved for a five-year period and then must be renewed.

Most Section 1115 waivers fall into one of three categories:

1. Coverage expansions.
2. Expansions of contraceptive and family planning coverage.
3. Implementation of the Affordable Care Act.

While Section 1115 waivers historically have been used to expand coverage, benefits, or both, states also can use them to make more consumer-friendly reforms to their Medicaid program. States can—and should—prepare and submit Section 1115 waivers to move their Medicaid

¹⁸ Matthew Glans, "[Why Arkansas' Medicaid Rollback Could Be a Model for Expansion States](#)," *Research & Commentary*, The Heartland Institute, May 19, 2017.

¹⁹ U.S. Department of Health and Human Services, [Letter from Secretary Thomas Price and Seema Verma](#), March 14, 2017.

programs in a more market-oriented direction. Some reform proposals states can submit to CMS and the HHS Secretary through 1115 waivers include:

- Requirements that able-bodied beneficiaries work, look for work, or prepare for work—requirements the Obama administration previously rejected, but were central tenets of the successful 1996 welfare reforms.
- More flexible benefit packages, allowing the enrollment of Medicaid beneficiaries in subsidized employer coverage without providing cumbersome “wrap-around” benefits.
- Payment enforcement mechanisms to encourage enrollees to pay cost sharing.

- Mechanisms that allow employers to financially assist employees who purchase individual health care coverage, in lieu of offering employer-sponsored group health care coverage.

States can—and should—prepare and submit Section 1115 waivers to move their Medicaid programs in a more market-oriented direction.

- Deployment of incentives for enrollees to engage in healthy behaviors, like attending primary care appointments, completing a health assessment, increasing physical activity, or quitting smoking.
- Time limits on coverage.
- Monthly income verification and eligibility renewals.
- Changes to what exchange recipients pay, benchmarks for setting payments, and rules concerning family size and income eligibility.

1332 Waivers to the Affordable Care Act

Section 1332 of ACA allows states to request waivers of several key provisions of that law. A waiver will not be approved by the HHS Secretary if it results in a reduction in the number of people covered by ACA or if it makes coverage more expensive or less comprehensive. States cannot, for example, waive ACA’s ban on excluding people with pre-existing conditions. The waiver also must not increase the federal deficit.

A governor can submit a Section 1332 waiver request to the HHS Secretary only after the waiver has been authorized by his or her state legislature. States must engage in a transparent public process when requesting a waiver, including publicizing requests on state websites, holding hearings, and collecting public comments.

Some reforms states can submit to the HHS Secretary through 1332 waivers include:

- End the individual mandate, which includes a penalty or fine for not buying health insurance.
- End the employer mandate, which requires all businesses with 50 or more full-time-equivalent employees provide health insurance.
- End the premium tax credit, a subsidy made available for certain households who purchase federally approved coverage in the state health insurance exchanges.

Through Section 1332 ACA waivers, states can end the individual and employer mandates, adopt health savings accounts, redefine essential health benefits, and more.

- Allow cost-sharing mechanisms like co-pays, premiums, or health savings accounts.
- Redefine which services are considered essential health benefits—benefits all plans must cover under ACA.

- End the requirement that insurance plans cap annual out-of-pocket spending.
- Change the rules regarding actuarial value, a measure of the percentage of expected health care costs a specific health plan will cover for the “standard” population.
- Change the rules governing what plans can be offered in the health insurance marketplaces.

4. Two Success Stories

Two states—Florida and Rhode Island—have used waivers to dramatically improve their Medicaid programs. They offer models for other states seeking to improve the quality of care received by the poor, reduce waste and corruption, and contain spending increases.

Florida: The Medicaid Cure

By providing existing Medicaid recipients with a range of premiums and plans from which to choose, a pilot program in Florida called the Medicaid Cure program dramatically improves health care competition and consumer choice.²⁰ While similar in some ways to Arkansas’ Medicaid reforms, the program applied only to existing Medicaid recipients, adding choice and flexibility to a flawed state program without expanding it.

In 2006, Gov. Jeb Bush established the Medicaid Cure in five large Florida counties. Under the pilot program, 290,000 Medicaid recipients were given a range of premiums and plans from

²⁰ Foundation for Government Accountability, “[Florida’s Medicaid Cure](#),” July 18, 2012.

which to choose. According to Tarren Bragdon, president and chief executive officer of the Foundation for Government Accountability, patients may choose among as many as 11 plans, depending on their county of residence. Each plan offers Medicaid's core benefits, but many offer additional services like adult hearing or dental benefits. The premiums are determined using the payment and cost history of the state's Medicaid patients.²¹

The key to the pilot program is the expanded choice and guidance it gives Medicaid recipients, helping them identify which plan is most suitable for their needs. Bragdon argues this power of choice is important:

Florida's "Medicaid Cure" provides existing Medicaid recipients with a range of premiums and plans from which to choose, dramatically improving health care competition and consumer choice.

Because patients can switch plans every year, plans compete to attract new enrollees and keep the ones they have. This means plans prioritize customer service, innovate, maintain access to specialists, and continuously improve to attract patients' business. If expectations and access to care are not met plans lose patients, and then lose revenue. It's the free market at work.²²

The Medicaid Cure also holds plans accountable. According to Bragdon:

Florida's Medicaid Cure funding structure aligns health with profit and holds plans accountable. Unlike old Medicaid fee-for-service, the Medicaid Cure provides plans with greater funding for enrolling sick patients and lets them make more money if patients' health improves. The Medicaid Cure ties a plan's fiscal performance to patient health, just like payment to a private sector business is tied to its results.²³

Patients also can earn benefits for having regular checkups and taking responsibility for their own health. Bragdon notes between 2006 and 2012, patients were offered more than \$31 million in healthy behavior incentives, and two of three patients used the rewards program.²⁴

In June 2013, CMS approved an amendment to Florida's Medicaid Reform waiver. The amendment allowed for extending managed care to nearly all Medicaid beneficiaries statewide. The new program, renamed the Managed Medical Assistance (MMA) program, enrolled more than 3 million recipients by December 31, 2014. According to a report to CMS from the Florida Agency for Health Care Administration, the program was successful in bringing down costs:

The MMA program transformed Florida Medicaid from a primarily fee-for-service payment system to a capitated, risk-adjusted, payment system. The MMA program facilitates enhanced fiscal predictability and has enabled the State to leverage the efficiencies of the managed care model to gain greater control over costs.

²¹ Tarren Bragdon, "[Florida's Pro-taxpayer Cure for Medicaid](#)," *Human Events*, June 29, 2012.

²² *Ibid.*

²³ *Ibid.*

²⁴ *Ibid.*

Consequently, the per-member per year cost to the State has decreased without reducing services to enrollees or quality of care.²⁵

Rhode Island: A Spending Cap

Rhode Island has been experimenting with a different way to fund Medicaid since January 2009 under an HHS waiver. The original waiver ran from 2009 to 2013; it was extended for a second five-year period to 2018. The waiver replaces the traditional federal matching grant with a capped grant. The capped grant limits the state's federal Medicaid matching funds to \$12.075 billion over a five-year period, roughly \$2.4 billion per year. In exchange for the cap,

According to a 2011 study, the Rhode Island Medicaid reforms were “highly effective” in controlling costs and improved access to appropriate care.

the state received flexibility in administering its Medicaid program and an incentive to keep costs down.

Rhode Island requires able-bodied people with incomes above 150 percent of the poverty level to contribute toward

their own health coverage. The state helps pay all or part of the cost of employer-sponsored health insurance for Medicaid-eligible families who have access to these plans.²⁶

According to a 2011 study from The Lewin Group, the Rhode Island Medicaid reforms were “highly effective in controlling Medicaid costs” while improving “access to more appropriate services.”²⁷ A *Wall Street Journal* commentary summarized the findings this way:

The total savings from all of Rhode Island's reforms were more than \$55 million—a big deal in such a small state. According to an analysis by Gary Alexander, who ran the Medicaid program in Rhode Island when the federal waiver was granted and who now serves as the Secretary of Public Welfare in Pennsylvania, if these savings were extrapolated for all 50 states, they would exceed \$200 billion in lower Medicaid costs over the next decade.²⁸

The positive results occurred quickly. According to Alexander, over the first three years of the waiver the state saved approximately \$100 million and is one of the reasons why Rhode Island possessed a state budget surplus in state fiscal year 2010.²⁹ The state also reduced waiting times for long-term care services and provided additional home care and physical therapy services.³⁰

²⁵ Florida Agency for Health Care Administration, “[Florida Managed Medical Assistance Program 5-Year Waiver Extension Request](#),” October 21, 2016.

²⁶ Galen Institute, “[Rhode Island Global Consumer Choice Compact Medicaid Waiver: A National Model for Medicaid Reform](#),” December 2010.

²⁷ The Lewin Group, “[An Independent Evaluation of Rhode Island's Global Waiver](#),” December 6, 2011.

²⁸ “[Providential Design](#),” *The Wall Street Journal*, April 5, 2012.

²⁹ Gary Alexander, “[Medicaid Waivers and the Rhode Island Model](#),” April 1, 2011.

³⁰ *Ibid.*

5. The Medicaid Fix

Although the focus of this report is on what states can do in lieu of action by Congress, a radical market-based reform proposed by Justin Haskins, Michael Hamilton, and Sam Karnick of The Heartland Institute sheds light on what *real* Medicaid reform would look like, and perhaps it is a proposal state legislators can lobby their congressional delegations to take seriously.³¹ The authors of the reform call it “The Medicaid Fix.”

The Medicaid Fix would deposit \$7,000 a year into a health savings account (HSA) for each Medicaid-enrolled adult and child. The funds could be used only to pay for health care expenses. A family of four would receive \$28,000 a year with which to buy insurance and cover a family deductible.

Under the Medicaid Fix, every Medicaid-enrolled adult and child would have access to \$7,000 a year deposited into a health savings account. A family of four would have \$28,000 with which to buy insurance and cover a family deductible.

In 2015, approximately \$545 billion was allocated to Medicaid by national and state governments. Under the Medicaid Fix, about \$511 billion of that total would fund the accounts. Medicaid recipients could use the HSA deposit to purchase health insurance in the private market and to cover out-of-pocket health care costs, including prescriptions, co-pays, and deductibles. The funds also could be used to help a sick spouse, sibling, parent, or child.

The authors note the accounts would provide a safety net for families. “Enrollees who are relatively young and healthy soon would build personal safety nets worth tens of thousands of dollars,” the Heartland researchers noted. “This would not only be good for them, it would stabilize Medicaid, which has become an enormous and unpredictable burden on state budgets.”³²

While the new accounts will be more than sufficient for young and healthy patients, older and sicker patients will likely need additional assistance in the program’s earliest years. The Medicaid Fix allocates the \$34 billion saved by the plan to aid those older, sicker recipients.

The Medicaid Fix would dramatically reduce administrative costs, ensuring more of every dollar devoted to Medicaid actually goes to doctors and other health care providers. Because beneficiaries get to keep in their accounts any money not spent at the end of each year, they have an incentive to spend wisely. Experience with health savings accounts suggests they will make less use of low-value services and seek out lower-priced medical services.

³¹ Justin Haskins, Michael Hamilton, and S.T. Karnick, [“Personal Health Care Safety Net Medicaid Fix,”](#) The Heartland Institute, March 28, 2017.

³² *Ibid.*

6. Other State Reforms

States don't have to wait for Congress to repeal Obamacare or even for Secretary Price to act on their waiver requests to implement reforms that could improve access to health care by increasing supply and lowering prices. These reforms have been part of a market-based health care reform agenda for many years.³³ Here some items on such an agenda.

The first thing states can do is repeal existing state regulations that are obsolete or counterproductive.

Repeal Regulatory Barriers

The first thing states can do is repeal existing state regulations that are obsolete or counterproductive. The list is

long, suggesting there are many opportunities for state policy makers to show progress.

- *Repeal mandated benefits:* In the United States, there are 2,271 laws mandating insurers cover specific health providers, procedures, or benefits. These laws often are billed as being pro-consumer, but they mostly benefit the special-interest groups that lobby for them. Repealing these mandates would lower the cost of premiums and allow millions of people to get back into the private insurance marketplace.
- *Repeal guaranteed issue laws:* Guaranteed issue laws require insurance companies to provide insurance to anyone who seeks it. The 1996 Health Insurance Portability and Accountability Act (HIPAA) required insurers to offer guaranteed issue policies in the small group (2–50 insured persons) market. Some states also try to impose guaranteed issue on their individual markets, with disastrous effects. Guaranteed issue drives up the price of health insurance by creating an incentive for people to wait until they are sick before buying insurance. The results are soaring premiums and rising numbers of uninsured people.
- *Repeal community rating laws:* Community rating laws require insurers to charge similar rates to all members of a community typically without regard to age, lifestyle, health, or gender. Because an insurer cannot adjust its premiums to reflect the individual health risks of consumers, the healthy majority see their premiums rise. Like guaranteed issue, this results in an insured population with higher health care expenses than the average population, requiring higher insurance premiums. Once again, premiums increase because more healthy people choose to go without health insurance.
- *Repeal certificate of need laws:* Thirty-five states require health care providers to obtain certificates of need before expanding facilities or opening new centers. Extensive research demonstrates certificate of need laws reduce competition and result in higher prices.³⁴

³³ NCPA Health Care Task Force, *An Agenda for Solving America's Health Care Crisis* (Dallas, TX: National Center for Policy Analysis, 1990); Joseph Bast, Richard Rue, and Stuart Wesbury, [Why We Spend Too Much on Health Care](#) (Chicago, IL: The Heartland Institute, 1993).

³⁴ Matthew Glans, "[Certificate of Need Reform](#)," *Research & Commentary*, The Heartland Institute, November 13, 2014.

- *Repeal unnecessary licensing standards:* Restrictions on what nurse practitioners, dental therapists, and midwives are allowed to do, and whether they can operate without a medical doctor present, unnecessarily restrict the supply of medical services and consequently raise the price.³⁵
 - *End overregulation of dental service organizations:* First launched in the late 1990s, dental service organizations (DSOs) allow dentists to focus on patients by providing, on a contract basis, routine office operations such as accounting, insurance, scheduling, and purchasing equipment and supplies. State Dental Boards often oppose DSOs and try to over-regulate them.³⁶
 - *Change maintenance of certification (MOC) requirements:* While a certain degree of certification will always be necessary, physicians should not be required to pass through a quagmire of costly and expensive tests that may be unnecessary.³⁷ Oklahoma provides a model other states can follow: It forbids the requirement of MOC as a condition of licensure, reimbursement, employment, or admitting privileges at a hospital in the state.³⁸
- Physicians should not be required to pass through a quagmire of costly and expensive tests that may be unnecessary.
- *Allow interstate licensure reciprocity:* Reciprocity laws would allow a physician in one state to use his license in another state without needing to reapply. According to the Mercatus Center at George Mason University, reciprocity laws are “the easiest and least controversial ways for states to minimize restraints on physicians, yet a substantial number of states do not allow reciprocity.”³⁹

Direct Primary Care

A new proposal currently being considered in Michigan would integrate a direct primary care (DPC) program into the state’s expensive Medicaid system to help reduce costs and improve care. Under the pilot project, 2,400 Medicaid recipients would be enrolled in the state’s Direct Primary Care Services (DPCS).⁴⁰

³⁵ Michael Hamilton, Bette Grande, and John Davidson, “[The Case for Licensing Dental Therapists in North Dakota](#),” *Policy Brief*, The Heartland Institute, 2016.

³⁶ Matthew Glans, “[Missouri Should Avoid Overregulating Dental Service Organizations](#),” *Research & Commentary*, The Heartland Institute, June 21, 2017.

³⁷ *Ibid.*

³⁸ Michael Hamilton, “[More States Consider Outlawing Forced Maintenance of Certification](#),” June 7, 2016.

³⁹ Darcy N. Bryan, Jared Rhoads, and Robert Graboyes, “Occupational Regulation,” *Mercatus Center Healthcare Openness and Access Project*, December 1, 2016.

⁴⁰ Matthew Glans, “[Michigan Direct Primary Care Pilot Could Save Medicaid Millions](#),” *Research & Commentary*, The Heartland Institute, May 31, 2016.

Under a direct primary care program, patients pay a monthly membership fee, typically ranging from \$50 to \$80. As part of the membership, patients receive a more generous allocation of appointments than they would under most traditional health insurance plans, even allowing in some instances for same-day appointments or house calls.

According to the Docs4Patient Care Foundation, under a DPC model medical practice overhead can be reduced by as much as 40 percent.

The guarantee of a set monthly fee removes layers of regulation and bureaucracy created by the traditional insurance system and allows physicians to focus more time and attention on each patient. According to the Docs4Patient Care Foundation, under a DPC model

medical practice overhead can be reduced by as much as 40 percent.⁴¹

Routine tests and procedures are included in most DPC plans, and lower membership fees are often charged for programs that do not provide these additional services. Individuals enrolled in a DPC program often supplement that coverage with a wraparound catastrophic insurance policy for services not specific to primary care.

According to the Michigan pilot bill's sponsors, its success would be determined based on a reduction in the number and severity of non-primary-care claims.⁴² The hope is to eventually expand DPCS to all 2.4 million Medicaid enrollees in the state, which could generate potential savings to the state of \$3.4 billion. One in four Michiganders is currently enrolled in Medicaid.

In one 2012 study published in the *American Journal of Managed Care*, urgent and avoidable hospital admissions were found to be lower among DPC patients. The study concluded, "We believe that the [DPC] personalized preventive care model of smaller practices allows the physician to take a more proactive, rather than reactive approach. ... This increased physician interaction has resulted in lower hospital utilization and ultimately lower healthcare costs."⁴³

Specific steps states and the national government can take to help promote the movement to DPC-type arrangements between patients and physicians include the following:

- Congress can pass legislation specifying DPC is an acceptable form of payment under Medicaid and Medicare and fund pilot programs testing the concept.
- Congress can pass legislation, such as the Primary Care Enhancement Act (HR 365), that clarifies DPC arrangements are not health plans for the purposes of the tax code, and defines fees paid to primary care providers in periodic fee arrangements as qualified health expenses paid from HSAs.

⁴¹ Docs4Patient Care Foundation, "[The Physician's Prescription For Health Care Reform](#)," 2016.

⁴² Office of Senator Patrick Colbeck, "[Sen. Colbeck Proposes Direct Primary Care Services Medicaid Pilot](#)," May 2016.

⁴³ Andrea Klemes, Ralph E. Seligmann, Lawrence Allen, Michael A. Kubica, Kimberly Warth, and Bernard Kaminetsky, "[Personalized Preventive Care Leads To Significant Reductions in Hospital Utilization](#)," *American Journal of Managed Care* **18** (12): e453–60.

- States can pass legislation stating DPC is not a form of insurance.
- States can integrate DPC into their Medicaid systems with or without waivers from the national government to help reduce costs and improve care.
- States also can incorporate DPC programs into health benefits for state and local employees.

Expand Health Savings Accounts

Health savings accounts (HSAs) reduce utilization of low-value services and encourage price competition. States can help expand HSAs by adopting policies recommended by the Council for Affordable Health Insurance.⁴⁴

- Ensure the state’s definition of income conforms to the Internal Revenue Code for HSA purposes. Among the states that do not accept or follow the federal tax treatment for HSAs are Alabama, California, and New Jersey.⁴⁵

<p>Health savings accounts reduce utilization of low-value services and encourage price competition.</p>
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- Adopt laws exempting HSA high-deductible health plans from state-mandated benefit requirements. States with mandated benefits that conflict with HSAs include California, Illinois, Maine, Missouri, New York, and Ohio.
- Add an HSA option for persons who buy insurance through the state’s high-risk pool (12 states have done so already), for state and municipal employees (13 states have done so already), and for Medicaid (until the Obama administration shut it down, Indiana had a very successful Medicaid program that included HSAs).

Expand High-risk Pools

High-risk pools offer affordable health insurance to people with pre-existing conditions who otherwise could not find affordable health insurance in the private marketplace.⁴⁶ They offer a safety net narrowly targeted to those who need public assistance. By removing from the insurance pool people with very high known health care costs, high-risk pools help stabilize the rest of the marketplace and lower premiums for healthy people.

⁴⁴ Council for Affordable Health Insurance, *HSA State Implementation Report*, 2007.

⁴⁵ [HSA for America](#), “States Following Federal HSA Tax Treatment,” 2007.

⁴⁶ Matthew Glans, “[State High-Risk Pools for Health Insurance](#),” *Research & Commentary*, The Heartland Institute, May 25, 2017.

Embracing high-risk pools and encouraging them to thrive would allow states to abandon guaranteed issue and provide health insurance to a vulnerable population while helping to keep health insurance prices down. During the debate over how to repeal and replace Obamacare, House Republican leaders proposed a national \$15 billion high-risk pool, an idea with considerable merit.

Encourage Price Transparency

Most health care consumers, insulated from price considerations by private insurance, Medicaid, or Medicare, simply do not care about prices.

Over-reliance on third-party payers for health care has resulted in a system in which health care providers have little incentive to advertise or even share prices for their services. Most health care consumers, insulated from price considerations by private insurance,

Medicaid, or Medicare, simply do not care about prices: They pay the same copay regardless of the services they choose and are not penalized for ineffective choices.⁴⁷

A July 2016 “report card” on state price transparency laws produced by the Health Care Incentives Improvement Institute and Altarum Institute said: “State laws mandating health care price transparency for consumers can help fix the mystery surrounding health care prices, unbolting the door between consumers and the information they need to shop for and buy high-quality, affordable health care.”⁴⁸ The report card found “too many states still fall far short of requiring and implementing thorough, useable transparency resources. Dozens of states have laws that refer to price transparency, but provide little to help consumers shop for and choose care, and offer little potential to move the health care delivery system toward quality and affordability.”⁴⁹

In 2016, the Missouri legislature considered a health care bill that would require the state Department of Health and Senior Services to create an online web portal where hospitals and health care providers would share service costs for 100 common health care procedures. This is one way to empower consumers and create real competition in the health care market.

Ultimately, the only way to restore price transparency to health care is to reduce reliance on third-party payers. Without increased consumer demand for prices, hospitals and other providers have no incentive to post prices or even discover them for internal purposes.

⁴⁷ Alex M. Azar II, *et al.*, “[Transparency in Health Care: What Consumers Need to Know](#),” speech delivered at The Heritage Foundation, October 3, 2006.

⁴⁸ Francois deBrantes and Suzanne Delbanco, [Report Card on State Price Transparency Laws](#), Health Care Incentives Improvement Institute, July 2016.

⁴⁹ *Ibid.*

Expand Access to Prescription Drugs

Prescription drugs are an essential component of the modern medical system, extending life, reducing suffering, and making surgery less necessary. New technologies for discovering and testing drugs promise to make them an ever-growing part of the health care system, leading to concerns over their cost. Drug treatments tailored to an individual's genetic makeup are especially promising.

Prescription drugs are an essential component of the modern medical system, extending life, reducing suffering, and making surgery less necessary.

Thoughtful policymakers can make prescription drugs more affordable by encouraging price transparency, speeding the approval of generic drugs and new drugs by the Food and Drug Administration (FDA), and preserving the market-based provisions of Medicare Part D.

A promising way to reform FDA regulation of new drugs is “Free to Choose Medicine,” a dual-track system whereby patients and their doctors can choose either to wait for FDA-approved drugs or use drugs that have passed Phase I safety trials but still are undergoing clinical trials for effectiveness.⁵⁰ Patients choosing early access to new drugs agree to post information about side effects to a publicly accessible Tradeoff Evaluation Database.

The Goldwater Institute has developed a similar but more limited model it calls “Right To Try.” The program allows access to experimental drugs by terminal patients who have exhausted other available treatments.⁵¹ Participating patients must provide informed consent, limiting legal exposure for the drug's manufacturer.

Policymakers who wish to expand access to prescription drugs should:

- Support policies that increase price transparency, such as creating state websites that report the price of prescription drugs sold by different drug stores and the availability of generic alternatives.
- Support efforts underway at FDA to speed up the approval of generics and new drugs and the Free to Choose Medicine plan allowing drugs to reach patients without going through FDA's time-consuming and largely obsolete series of efficacy trials.
- Oppose efforts to restrict access to new drugs by imposing restrictive formularies on public programs. While tough decisions must sometimes be made, the prevailing policy ought to be to respect the decisions of doctors and favor newer drugs.
- Continue to oppose efforts to legalize the importation of drugs from other countries. The

⁵⁰ Bartley J. Madden, FreetoChooseMedicine.com.

⁵¹ Christina Corieri, “[Everyone Deserves the Right to Try: Empowering the Terminally Ill to Take Control of Their Treatment](#),” Goldwater Institute, 2014.

public health hazards created by allowing drugs from countries outside the highly secure U.S. drug supply chain are simply too high to merit relaxing the current ban.

Remove Barriers to Entrepreneurship

Entrepreneurs and innovators are developing new ways to deliver health care that are more convenient, higher quality, and less costly than currently available services. Unfortunately, public policies often stand in their way. Entrepreneurship in health care, as in other markets, requires that consumers are free to choose and producers are free to compete with one another.

Entrepreneurs and innovators are developing new ways to deliver health care that are more convenient, higher quality, and less costly.

Policymakers should remove regulations that stifle innovation with red tape and price controls that do not allow reimbursement for new services. Examples of innovations that state regulations often currently block or discourage include:

- *Retail health clinics:* Retail health clinics located in shopping malls or big-box retail outlets are increasingly popular because of their convenience, minimal waiting, low prices, and high quality of care. They typically are staffed by a nurse practitioner (NP) with a master's degree in nursing who focuses on diagnosing and treating relatively common and minor illnesses. These clinics can be hindered by legislation restricting the number of NPs a physician can supervise or limiting the scope of practice for NPs, or by preventing NPs from staffing clinics inside pharmacies.⁵²
- *Specialty hospitals:* Specialty hospitals, typically owned at least in part by the doctors who practice in them, focus on a few areas of care, enabling them to increase efficiency and provide higher levels of care than general hospitals do.⁵³ Unfortunately, the Affordable Care Act prevents new physician-owned specialty hospitals from being established.
- *Telemedicine:* The internet and the spread of high-speed broadband services hold enormous potential for improving the quality and lowering the cost of health care. Patients can contact their doctors by email and get quick answers to questions, schedule meetings, and exchange test results. Doctors can monitor their patients' conditions remotely, store and access medical records more quickly, and minimize the amount of time spent on paperwork.⁵⁴ Telemedicine can be held back by state laws requiring doctors be licensed in the state where the patient resides or is treated. Licensure reciprocity, discussed earlier, is one way to remove that obstacle. Another obstacle is that Medicare and Medicaid may not reimburse doctors for time spent responding to emails or talking to patients by phone.

⁵² Charlotte LoBuono, "[Cost Comparison Web Sites Enhance Choice for Prescription Drug Buyers](#)," *Health Care News*, November 2006.

⁵³ Sean Parnell, "[Specialty Hospitals Offer Savings, Improved Care in Future](#)," *Health Care News*, January 2005.

⁵⁴ Heather Kleba, "[A Health Link Hits Home](#)," *Governing*, March 2007.

- *Health care sharing ministries:* Health care sharing ministries (HCSMs) are faith-based alternatives to conventional health insurance. Members pay monthly “shares” of approximately \$200 per individual or \$500 per family.⁵⁵ As medical needs arise, members pay a portion of their expenses and forward their bills to their HCSM. The HCSM reimburses members for most of their expenses, with the “share” money contributed by other members. HCSMs are discouraged when states attempt to regulate them like insurance companies.

Reduce Malpractice Litigation Expenses

Malpractice insurance, litigation, and defensive medicine add to the unnecessarily high cost of health care in the United States. Some of this expense is caused by over-reliance on third-party payers, which makes it difficult for patients to hold providers accountable for their mistakes without resorting to lawsuits.

Malpractice insurance, litigation, and defensive medicine add to the unnecessarily high cost of health care in the United States.

The experience in Texas since 2003 provides a model for state-level reform of malpractice litigation. In 2003, legislation was passed containing the following provisions (this summary is by Roger Stark, M.D.⁵⁶):

- Juries should hear more evidence about who may really be at fault.
- Only those who cause harm should pay, and then only to the extent of their own fault.
- Damages should be limited to the amount the injured patient paid or incurred or what someone, like an insurance company, paid or incurred on their behalf, thereby eliminating “phantom damages.”
- A medical report written by a physician in the same or similar field as the physician being sued should be submitted within 120 days of the filing of a lawsuit, clearly identifying the appropriate standard of care, how the standard of care was violated, and the damages that resulted from the violation of the standard of care.
- Non-economic damages should be capped at \$250,000 for any and all doctors sued with an additional cap of \$250,000 for each of up to two medical care institutions.

⁵⁵ Scott E. Daniels, [Health Care Sharing Ministries: An Uncommon Bond](#) (Washington, DC: Charlotte Lozier Institute, 2015).

⁵⁶ Roger Stark, [“The Cost of Medical Malpractice Lawsuits in Washington State— Lessons from Texas Reform,”](#) Washington Policy Center, April 2016.

- Other procedural and substantive devices used to tilt the scales of justice, such as forum shopping, should be eliminated.

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As the length of this section of the paper suggests, there are many things states can do to encourage innovation, efficiency, and higher quality health care without waiting for the national government to pass laws or even grant waivers.

Conclusion

There are many things states can do to encourage innovation, efficiency, and higher quality health care without waiting for the national government to pass laws or even grant waivers.

Medicaid is an expensive program that provides very poor quality care. The Affordable Care Act has made a bad situation worse, causing spending to rise at an unsustainable rate while increasing health insurance premiums in the rest of the market on average by 25 percent, pricing millions of people out of the

market.⁵⁷ Heartland Institute Research Fellow Benjamin Domenech noted, “I would rather have a smaller program that met its promise to America’s poor and the truly sick rather than a larger one that offered a false promise of access.”⁵⁸

Instead of expanding a flawed model that is unnecessarily costly, delivers subpar health care, and shifts more power to the national government, state lawmakers should focus on some of the many reform options described in this paper. States waiting for Congress to pass health care reform need wait no longer. Instead of being *reactive* to what’s happening in Washington, DC, state lawmakers should be *proactive*, applying for waivers from HHS to allow for more control over their Medicaid programs and adopting a state reform agenda.

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⁵⁷ Nick Clements, “[Obamacare Premiums Increase 25%: Is The ‘Death Spiral’ Here?](#)” Forbes.com, October 25, 2016.

⁵⁸ Benjamin Domenech, “[How the Oregon Study is Rocking Liberal Assumptions,](#)” *Health Care News*, The Heartland Institute, May 2, 2013.

About the Author

Matthew Glans joined the staff of The Heartland Institute in November 2007 as legislative specialist for insurance and finance. In 2012, Glans was named senior policy analyst. His responsibilities include interacting with elected officials and staff on a variety of issues; tracking new legislation; and drafting responses to emerging issues via talking points, news releases, and op-ed pieces, with the goal of educating legislators and informing them about free-market ideas.

Glans is a member of the American Legislative Exchange Council's Commerce, Insurance and Economic Development Task Force. His work has appeared in many publications, including the *Chicago Tribune*, *Milwaukee Journal-Sentinel*, *Los Angeles Times*, *USA Today*, and *St. Louis Post Dispatch*. He is the co-author of The Heartland Institute's "[Ten Principles of Property and Casualty Insurance Regulation](#)" booklet, a [Policy Brief on credit scoring in Washington State](#), and the chapter on health care reform in *The Patriot's Toolbox, Fourth Edition*.

Glans earned a master's degree in political studies from the University of Illinois at Springfield and a Bachelor of Arts degree in political science from Bradley University. Before coming to Heartland, Glans worked for the Illinois Department of Healthcare and Family Services in its legislative affairs office in Springfield.

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The Heartland Institute is a national nonprofit research and education organization. Founded in Chicago, Illinois in 1984, Heartland's mission is to discover, develop, and promote free-market solutions to social and economic problems. Its activities are tax-exempt under Section 501(c)(3) of the Internal Revenue Code.

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