

Medicaid HMOs, Hospitals Delighted With House Vote

Governor Rendell's plan to close an over \$1 billion deficit in the state's share of the Medicaid Program was mercilessly kicked in the teeth last week in a vote on the state House floor. The unanimous vote against the Governor's proposal came much to the delight of the seven HMOs that cover Medicaid recipients and the state's hospitals. Both stood to lose money under the Governor's plan.

On the other hand, the vote, taken as a public gesture to show that there was virtually no support for the Governor's plan, also removes some pressure from the Governor's office and places it with the General Assembly.

"Now the Governor can put the pressure from coming up with a fiscal solution on legislative leaders," one long-time health care lobbyist said. "In effect, his message will be 'if you don't want to make the cuts, then come up with the money from other sources.'"

Given the vote last week, the sources are almost certainly not going to be hospitals and the Medicaid HMOs. Both clearly have strong political support in the House, and both have strong fiscal arguments for maintaining reimbursement levels at the current rates, or even increasing them. Under the Governor's plan, for instance, the HMOs were going to see their reimbursement rates per enrollee, after a reduction in enrollee benefits, increase a net of only two percent. The plans argue that they need a much higher reimbursement increase to continue to offer the same level of services, and to continue to save the state money.

A recently released study by an independent research group, The Lewin Group, backs them up. The study shows that the Medicaid HMOs, operating under Pennsylvania's HealthChoices Program, have saved the state a whopping \$2.7 billion over the last five years alone. HealthChoices began in the mid-1980s as a way to save state money over fee-for-service plans, and offer better preventative care.

The Lewin report also says that the HealthChoices has performed "exceedingly well and should serve as a national model."

"The Report demonstrates that managed care approaches are having a favorable impact on care for thousands of medical assistance beneficiaries, and that this has benefited taxpayers in the process," said Karen Ignagni, President and CEO of America's Health Insurance Plans. "We should look to the plans in Pennsylvania as a model of innovation in Medicaid managed care, and identify the programs that are working there that can be identified elsewhere."

Governors From Both Parties Push Medicaid Overhaul Plan

A coalition of the nation's Governors unveiled their bipartisan proposals to reform Medicaid for the first time on Capitol Hill Wednesday (June 15) but met skepticism from both sides of the aisle, foreshadowing political schisms over how to fix the nation's health-care safety net.

Despite governors' insistence to talk policy and not budget savings, Republicans on the U.S. Senate Finance Committee pressed for details of how the plan would achieve the \$10 billion in Medicaid cuts over five years to which Congress is now committed. Democrats, meanwhile, expressed worries that the plan would deprive the nation's most impoverished citizens of basic health care.

The appearance before Congress by Govs. Mark Warner (D) of Virginia and Mike Huckabee (R) of Arkansas, the chairman and vice chairman of the National Governors Association, kicked off a pivotal stage in which the states, the Bush administration and Congress will try to meld ideas for reining in the explosive growth in costs in Medicaid, the state-federal program that covers 53 million low-income and disabled Americans.

The governors released a 14-page proposal that disclosed new details of their strategy to overhaul the \$330 billion program, which now consumes an average 22 percent of state budgets. The plan, hammered out by an 11-governor task force and subject to approval by all 50 of the nation's governors at an NGA conference in July, seeks to stem the steep run-up in Medicaid costs without lopping people from the program's rolls.

The difficulties of negotiating a solution to Medicaid's woes quickly showed up in the clash between the governors' bipartisan approach and rifts on display in Congress, where Democrats have boycotted a commission to study Medicaid and deficit-conscious Republican leaders have pushed through a commitment to trim Medicaid by at least \$10 billion over five years.

"We may be the only bipartisan game in town," Warner told reporters before the hearing. Warner and Huckabee, who also testified before the House Committee on Energy and Commerce, hammered repeatedly on two major themes: that states are bearing the brunt of the rising cost of Medicaid and that the NGA proposal should be given significant weight because it represents a bipartisan consensus among the nations' governors.

Since earlier this year, when President Bush proposed the first cuts in entitlement programs since 1997, governors have been adamant that the debate over Medicaid reform should be driven by policy, not budget numbers.

In addition to taking their proposals to Congress, the governors also said they plan to forward them to a nascent commission headed by U.S. Department of Health and Human Services Secretary Michael Leavitt that is looking for short- and long-term Medicaid savings. Leavitt's commission is slated to tackle long-term Medicaid reforms in the fall.

Specifically, the governors' proposals call for a handful of preliminary fixes for Medicaid, including:

Giving states broad discretion to establish premiums, deductibles and co-payments for all Medicaid services and populations. Governors propose a safety valve to ensure that beneficiaries pay no more than 5 percent of their total family income.

Lowering Medicaid's drug costs, in part by increasing the rebates that states collect on brand-name and prescription drugs and by making the drug-pricing processes more transparent. The Bush administration supports efforts to decrease drug costs, but governors are concerned President Bush's plan would place the burden solely on pharmacies, instead of requiring drug companies to reduce costs.

Closing loopholes that let elderly people intentionally transfer their assets to family members or place wealth in trusts or annuities so they can qualify for taxpayer-funded care through Medicaid. The governors also propose providing incentives for "reverse mortgages" so older people can tap into real-estate equity to pay for their own long-term care. Closing the loopholes has the support of the Bush administration.

Sweeping Medicaid Changes Proposed in South Carolina

Struggling to control Medicaid's growth, South Carolina officials are proposing a sweeping change in the way health care is delivered to the state's poor and disabled.

Under a plan now awaiting federal approval, most of the state's nearly 850,000 Medicaid recipients would be given personal health accounts to buy public or private health coverage and would be required to pay higher co-pays for medications, doctor visits or hospital stays.

Recipients would get a debit card to pay those co-pays or other health bills not provided by the coverage they choose.

The amount of money the state would put into these debit accounts hasn't been determined, but the amount would be similar to what people spend on private-sector health care. It also would be based on the recipient's age, gender and health status.

The purpose of the plan is to bring market principles to Medicaid by treating recipients as consumers, giving them a broad choice of health plan options for which they would pay through the debit accounts. The state believes traditional Medicaid drives up costs because there is a disconnection between the recipients and the cost of care they receive.

"We believe change is vital to the long-term fiscal health of Medicaid and the physical health of the program's beneficiaries," the state Department of Health and Human Services, which runs Medicaid in the state, said in its proposal to federal regulators.

The agency submitted its proposal to the federal Centers for Medicare and Medicaid Services last week. Typically, such proposals are followed by months of back-and-forth between state and federal agencies, so it's uncertain when the federal government might give its approval.

But with concern mounting about Medicaid's rising costs and with the massive budget deficit, federal officials have been more willing recently to listen to state reform ideas.

Robby Kerr, the state's health and human services director, said federal officials gave the plan a "favorable initial impression" but added "we're at the beginning of a very long process."

"There are more regulations in Medicaid than there are in the tax code," Kerr said. "We're

asking them to waive a lot of their regulations. If there's a lengthy review process, that's why."

State and federal Medicaid spending in the Palmetto State totaled \$4.2 billion last year, up 50 percent from 2000. Prompted by Gov. Mark Sanford and his desire to find a long-term solution to Medicaid's rising costs, the agency has been working on the plan for more than a year.

The proposal would require recipients to choose from a range of coverage options, some from the state, others from private insurers. These plans would include cheaper plans with limited services to comprehensive HMO coverage.

Recipients would pay for coverage with the money in their personal health accounts. Anything left would be placed on their debit cards, which they would use to pay for other health services, especially in plans that offer more limited coverage.

The debit accounts would also be used for co-pays, which would range from \$5 for a generic drug or a doctor visit to \$100 for a hospital stay.

Bryan Kost, a Health and Human Services Department spokesman, said that the sickest and most costly recipients would be directed into plans that help enrollees coordinate health care and, as a result, help save them money. Five percent of Medicaid beneficiaries account for half of the program's expenses.

Sanford pushed the debit-card concept in a paper he wrote for the Centers for Medicare and Medicaid Services. He said the plan would prompt consumers to spend more carefully.

"You're empowering Medicaid recipients to become more cost-conscious consumers," Chris Drummond, a spokesman for the governor, said Thursday. "Hopefully, this will provide both better quality of service and help rein in some of the cost that we've seen."

The concept is worrisome to advocates for the poor, such as Sue Berkowitz, director of the South Carolina Appleseed Legal Justice Center, who also serves on a panel that advises the state about Medicaid.

If a parent has to spend money from the card treating a child's broken arm, Berkowitz wants to be sure the parent won't be without money to handle a severe ear infection a few months later.

PROPOSED MEDICAID CHANGES

Proposed changes in the state's Medicaid program would provide debit cards to participants to pay deductibles at hospitals, doctors' offices or pharmacies. The following co-payments have been proposed under each type of policy.

Major medical only:

Inpatient hospital procedure, \$100

Outpatient surgery, \$25

Medical home network plan:

Inpatient hospital procedure, \$100

Outpatient hospital, \$25

Outpatient surgery, \$25

Emergency room, \$25 for emergencies, \$50 for non-emergencies.

Doctor's visit, \$5

Pharmacy, \$5 for generic, \$10 brand name

Other proposed changes, which must be approved by the federal Medicaid program, include:

- Ending freedom of choice that Medicaid recipients now have for their care.
- Eliminating retroactive eligibility.
- Allowing care providers to bill recipients for unpaid deductibles and co-payments.
- Forcing people with high medical use into managed care.
- Treating all pregnant women as adults regardless of age.