

Louisiana State Medical Society's ACCESS to BETTER CARE plan

Introduction

Like many states, Louisiana is facing a crisis in the Management of its Medicaid program designed to assist the impoverished individuals who are aged, blind or disabled or members of families with dependent children. This fiscally-based crisis comes at a time when the federal government's contribution to Medicaid programs is being significantly curtailed through the reduction of Medicaid disproportionate share payments to Louisiana's hospital. In Louisiana, a budget deficit of an estimated \$740 million in Fiscal Year 1996 is projected by the state. Because these funds were also used to help boost the state's match, the net effect of this reduction is expected to reach more than \$2 billion. This situation requires the state to 1) reduce Medicaid expenditures, 2) find additional state revenues to fund Medicaid services, *or* 3) restructure the entire Medicaid system.

In facing this crisis, the State of Louisiana, through its Department of Health and Hospitals, is currently drafting a plan to shift the Medicaid program into a statewide managed care program. It is the state's intent to seek a waiver of Section 1115 of the Social Security Act which allows the state to develop a specific demonstration project to test new delivery and reimbursement alternatives to the traditional Medicaid program. By seeking a Section 1115 Waiver - rather than a 1915(h) Waiver - the state also hopes to expand the Medicaid program to include some of the state's uninsured population (approximately 1 million people, or 25% of the state's population) and underinsured population (estimated at approximately 350,000 people).

Medicaid Managed Care

A number of states have already received such a waiver and several others have applications pending. Because states have moved increasingly in recent years to try managed care as an approach to contain Medicaid expenditures, the federal government has had time to evaluate such programs. In a recent report, the U.S. General Accounting Office noted that managed care has had significant quality and access problems. It found that some Medicaid managed care plans:

- Used incentive payments to physicians that rewarded them for limiting services to Medicaid program beneficiaries;
- lacked adequate quality assurance programs;
- did not gather and analyze utilization data to detect potential under serving of program beneficiaries;
- did not follow up and correct care quality problems;
- did not provide timely and federally mandated Early Periodic Screening, Diagnostic, and Treatment (EPI,;DT) services for children; and
- contracted with physicians whose performance was substandard or unprofessional-'

It should also be noted that managed care will not, necessarily be a panacea for Medicaid's ills. As a recent study notes: "...while efficiencies and savings can be achieved in the current Medicaid program with reform efforts such as managed care, these savings are not likely to be great. The Medicaid program enrolls beneficiaries with unusually difficult health and social problems and currently pays doctors and hospitals at much, lower rates than that paid by private insurance plans or Medicare. -Future savings are likely to be modest ... "2

The LSMS is concerned that the Department of Health and Hospitals has taken the managed care approach as the only path available to address this important issue. Like DHH, the LSMS would like to see an end to a "two-tiered system" of health care. However, the plan espoused by DHH could very well be a continuance of a two-tiered system, since it is this approach that disrupts the very essence of the American system of health care delivery: the doctor-patient relationship and the freedom of every patient to choose or maintain a relationship with his or her own physicians. In addition, the Society fears the potentially harmful and chaotic results of a narrowly focused, fast-track approach to resolving this dilemma. We have the benefit of very useful lessons learned during the national debate on health system reform.

And the one message from the public that resounded clearly throughout the health system reform debate was- "slow down and take the time to do it right."

Government = Increased Costs, Reduced Access

As noted by the American Legislative Exchange Council in its 1993 report "Keeping the Promise: Making Health Care Accessible and Affordable for All Americans," government's expanded role in Medicaid is directly responsible for increasing costs and decreasing access to care.³ This is exemplified by three outcomes of government intervention.

First, current methods of directly reimbursing providers for any and all health care services automatically disassociates the recipient from any fiscal responsibility. In turn, this leads recipients to view health care as a free service and encourages excessive demand and utilization of health care services regardless of need or cost. Under this system, beneficiaries are not required to take any financial responsibility for their decisions.

Second, government's attempt to control prices, by reimbursing doctors and hospitals only a portion of actual costs, has forced health care providers to recover unreimbursed balances from patients with private insurance. The practice of cost shifting has contributed considerably to the cost of health care,

some estimating that this' accounts for 25% of all health care expenditures. Worse yet, some physicians elect not to @ Medicaid patients because of public reimbursement policies or administrative hassles associated with dealing with government run medicine. Consequently, many Medicaid patients either use hospital emergency rooms to receive medical attention, or delay seeking treatment until an illness became severe. In both cases, the cost to taxpayers is increased.

Third, program attempts to control Medicaid expenditures by restricting access to prescription drugs have actually led to increased costs. Some states have attempted to "play doctor" by determining which medications are paid for by Medicaid and which are not. Drugs on restricted state formularies are often chosen not on the basis of quality but costs. As a result,

Many patients are denied timely treatment, or in *some* cases, denied complete access to certain drugs. Without proper medication therapy, medical costs are ultimately increased. Some estimates show increased government spending as high as 29% for physician services and 39% for mental hospital care to compensate for problems generated by this policy.

The LSMS Alternative: Privatize Medicaid

To preserve choice and eventually eliminate a two-tiered system, the LSMS proposes that the State of Louisiana consider a voucher approach to privatizing the Medicaid program. Such an approach, we believe, would increase the patient's freedom to choose his or her doctor, decrease public outlays, reduce overall health care costs by eliminating cost-shifting, increase access to quality care, and empower the needy to make decisions about their health care needs. This is not a new concept. Governments at all levels have been doing this for years, tapping into the efficiencies and expertise available in the private sector.

Access to Better Care, the LSMS Medicaid reform plan, would accomplish these results by providing a publicly financed voucher to eligible Medicaid recipients. This voucher, limited to the categorically needy and AFDC-eligible recipients, would be used to purchase a private health insurance plan. The array of health coverage options available to Medicaid beneficiaries could include traditional indemnity-based insurance, managed care plans such as HMOs or PPOS, or a benefit-payment schedule. Coupled with these plans should be a medical savings account designed to reward recipients for prudent use of the health delivery system.

It is widely agreed by those in the private and public sectors that to ultimately control costs and the abuses of health care there must be behavioral change. The most lasting and rapid changes in

behavior come about when there is self-motivation to do so. The Medical Savings Account (MSA) is a concept that introduces motivation or incentives into the process of wisely utilizing health care resources.

The Louisiana State Medical Society is probably one of the earliest supporters of Medical Savings Accounts. In December 1979, the LSMS unveiled its "Consumer Health Investment Plan," generally referred to as CHIP. The concept was developed by F. Michael Smith, M.D., a pediatrician from Thibodaux, LA. It was Dr. Smith's opinion that a private sector approach that empowered patients to make sensible choices in health care was preferable to government-imposed solutions to rising health care costs.

The financial soundness of the MSA approach is becoming increasingly clear. For example Dominion Resources, a utility holding company in Virginia with over 12,000 employees, began their present program in 1989. Since that time health care spending has increased by less than 1% per year. Quaker Oats, with 20,000 employees, started their program in 1983. From its inception to 1992, Quaker's costs grew at an annual rate of 6.3% which is well below the national average. Forbes, Inc., with a more recent program saw their 1993 premiums for health insurance drop by 20%. Golden Rule Insurance Company, in the first year of their MSA program, saw health costs, which were 40% lower than they otherwise would have been.

Historically, both employees and employers have saved money using these types of accounts. The Rand Corporation found that people spent 30% less with no adverse effects on their health when they are spending their own money.

The basic concept of the MSA is supported by the American Medical Association. At its 1994 Annual Meeting the AMA adopted a recommendation from its Council on Medical Services that pilot demonstrations of the MSA concept be tested for the Medicaid population through government contributions of catastrophic insurance premiums and MSA funds. It has also been suggested that the MSA is the single most popular idea in Washington with 24 different proposals with 23 cosponsors including a bill introduced by Louisiana Senator John Breaux. At the state level, seven states have enacted MSAS, and three states have resolutions calling on Congress to enact MSAS. It is estimated that up to 25 states are expected to introduce legislation next year.

It should be emphasized that *Access to Better Care* breaks with recent tradition in regard to our Medicaid population. In recent years this group has had their health care managed, directed and in many cases provided by the state of Louisiana. This third party control of the process has functionally removed these individuals from controlling their own "health-care destiny". They became less familiar with the overall system since they were effectively removed from the entire decision making process. Such an approach fosters increasing dependence of these individuals on the state and does little to increase feelings of self-reliance and dignity. This third party control over the provision of health care was then "justified" by what we feel is a potentially pernicious assumption that these individuals cannot make the decisions they must make to secure their own health care service.

Access to Better Care achieves several important social functions in addition to improving the quality and affordability of health care. It helps the Medicaid recipient begin the process of more clearly understanding health care and the advantages and disadvantages of different health care systems. Equally important, it reorients the role of government from a self-perpetuating, ever growing, complex cradle-to-the-grave provider of assistance to a government that helps its citizens be more intelligent consumers with meaningful input into the programs of which they are participants-

Access to Better Care would create savings by purchasing private insurance for less than states currently spend per Medicaid recipient and by streamlining the Medicaid bureaucracy. The average Medicaid payment per recipient in the United States in 1993 was \$3,042.4 In Louisiana, according to a recent legislative fiscal report, the average Medicaid payment per recipient in 1993 was \$3,275, ranking the state second among 16 Southern states,!. This figure excludes administrative costs, disproportionate share payments, and other adjustments. This amount is higher than the cost of an average health insurance plan. Therefore, states *could* save money by using vouchers to purchase individual policies. Indeed, the state of Louisiana currently engages in this practice to some extent when it purchases Medicare coverage for Medicare-Medicaid dually-eligible beneficiaries. In addition, a fixed annual amount in the form of a voucher would make it easier for states to accurately budget for Medicaid expenditures, while the elimination of claims processing, with a one-time payment, would significantly reduce the size of the state's Medicaid bureaucracy. Privatizing Medicaid would strengthen the private health insurance market, and, thereby, provide additional tax revenues.

Access to Better Care would eliminate cost shifting. Since reimbursement for procedures and treatments would be through the private insurance system, providers would be much more likely to see Medicaid patients, and the current two-tiered health care system would be eliminated. By eliminating cost-shifting, health care costs for everyone would be reduced. In addition, providers are already used

to dealing with private insurance entities and are familiar with their administrative requirements. There would then be no need for a fiscal intermediary to handle claims and payment, which would reduce office administrative costs of providers and increase the attractiveness of the Medicaid patient by reducing the hassle factor associated with government programs.

Access to Better Care would empower the needy to make decisions and create a system based on choice. *Access to Better Care* would empower recipients to make important decisions regarding their own health care needs, moving them away from dependency and closer to self-sufficiency. The voucher system would also encourage recipients to make informed decisions regarding costs. The plan could tie these decisions to incentives, such as usable credits for unused benefits that lead recipients to make cost effective choices. Finally, *Access to Better Care* would allow individuals to choose the kind of health care coverage they desire and to choose their own doctors.

The following section provides a more detailed description and synopsis of the LSMS conceptual plan to privatize Medicaid, a program we believe would provide an innovative solution to controlling costs while improving the quality of care,

REFERENCES

1. "Medicaid Prenatal Care: States Improve Access and Enhance Services, but Face New Challenges," U.S. General Accounting Office, May 1994.
2. "Medicaid Beneficiaries and Health Reform," Robert J. Blendon, et al, Health Affairs, Spring 1993, p. 143.
3. "Keeping the Promise: **Making** Health Care Accessible and Affordable for All Americans," Molly N4. Hering, Samuel Brunelli, Eds., American Legislative Exchange Council, January 1993.
4. "Medicaid Total Recipients, Expenditures and Average Cost Per Recipient: Fiscal Year 1993," Health Care Financing Administration, Division of Medicaid Statistics, as published in "Reforming the Health Care System: State Profiles 1994" by the American Association of Retired Persons Public Policy Institute.
5. "Comparative Data Report on Medicaid," David W Hood, Louisiana Legislative Fiscal Office, Nov. 13, 1994.

ACCESS TO BETTER CARE
*A Conceptual Plan to Privatize the Louisiana Medicaid Program
and Assure Patients' Basic Freedom of Choice*

Plan Summary

Purpose

The Purpose of the program is to privatize the Louisiana Medicaid program through the use of publicly-financed vouchers and thereby create a program that would decrease state expenditures, streamline the state's Medicaid program, improve access to quality health care, and provide health care to a greater number of needy families.

Eligibility Requirements

The following persons would be eligible for coverage under *Access to Better Care*.

1. Any person who is an AFDC recipient;
2. Any person whose income is equal to or less than 100% (or other appropriate percentage) of the Federal poverty level and who is not covered under an employer-provided health care plan.
3. Those persons whose incomes are equal to or greater than 100% of the Federal poverty level, but not more than ?% (or other appropriate percentage) shall be required to pay 10% of the reimbursable premium amount determined by the Louisiana Secretary of the Department of Health and hospitals.

Issuance of Proof of Eligibility

Once the Louisiana Department of Health and Hospitals determines that a person(s) meets the eligibility requirements set forth above, the Department will issue that person(s) a proof of eligibility certificate. TMs certificate entities the person to coverage under any health insurance policy or plan offered in accordance with this program, in the amount of the premium indicated on the certificate and for a policy or contract period of one year. The voucher could also be supplemented by the individual to purchase a more costly or comprehensive plan if desired

Certification of Insurers

Insurance entities desiring to participate in *Access to Better Care* must first be certified by the State Department of Insurance that they meet various minimum requirements, including financial stability and capability of providing the benefits outlined.

Offering of Policies and Contracts

Once coverage is issued to the individual, policyholder, or contract holder, the insurer will submit the proof of eligibility certificate and a request for premium payment to the Louisiana Department of Health and Hospitals. In order to achieve a wide choice of plans, patients should have a choice of physicians and three different types of health plans:

- I. A traditional insurance plan
2. An HMO or PPO
3. A benefit payment schedule plan.

After a specified period of time, if a beneficiary has not exercised his or her choice option, he or she will be enrolled in a plan through a fair and equitable assignment process developed by the Department of Health and Hospitals.

High Risk Pool

Medicaid recipients who have been rejected previously by two or more insurers due to high risk conditions should be placed into the state high-risk pool. The difference between the value of the voucher and the high-risk pool premium would be paid by the state Medicaid program.

Standards Applicable to the Policies and Contracts

The health insurance or health care policies and contracts for which insurers are eligible must be provided in accordance with the following conditions:

1. The insuring entity must provide at least one policy that does not exceed the reimbursable premium amount indicated on the proof of eligibility certificate.
2. The policies and contracts are not subject to any previous state mandatory benefits.
3. Each policy and contract must include the following:
 - A) all of the federal Medicaid mandates;
 - B) in-patient care coverage for mental health, mental retardation, and substance abuse;
 - C) prescription drugs;
 - D) pre-natal coverage;
 - E) lifestyle incentives with Preventive education.
4. Plans would be required to provide perspective enrollees/patients with information regarding:
 - A) coverage provisions and exclusions;
 - B) prior authorization or other review requirements;
 - C) financial arrangements that would limit the services offered, restrict referral options, and establish incentives not to deliver certain services;
 - D) plan limitations and the impact of any limitations upon an enrollee; and
 - E) enrollee satisfaction statistics.

5. An insurer cannot impose any waiting period for benefits, or otherwise reduce or restrict benefits, for any claim that is the result of a high-risk condition.
6. If the insured locates any item or service listed on a billing statement, when such items or services were not received by or rendered to the person, the insurer must credit to the insured, in accordance with the program established by the Secretary of the Department of Health and hospitals, a portion of the savings identified. The insurance company would be allowed to collect the full amount of the overpayment from the health care provider.

Medical Savings Accounts

The state should consider creating a system in which the Medicaid recipient is issued a voucher for an actuarially determined amount of insurance. The Medicaid recipient would then be free, depending on the size of the family, unique insurance needs (such as a needs for mental health coverage, OB-GYN services, etc.) to choose among certified plans offered to Medicaid recipients. Importantly, this choice should be coupled with a Medical Savings Account (MSA).

Under our proposal, standards would be established to purchase an insurance policy and open a Medical Savings Account for each Medicaid recipient rather than simply paying their medical claims. The funds would be provided to each Medicaid recipient in the form of a state health care credit. This proposal allows individuals to choose their own insurance policy utilizing a specified state voucher and keep any savings in a medical savings account. These savings may result from the purchase of a less costly policy, savings from not using all of the deductible, savings from keeping the amount of annual claims less than the premium, savings from finding billing errors, savings from making effective use of preventive care, etc. The focus of the account is to empower the consumer to take more personal control and responsibility for management of health care dollars.

The accrued savings in the A4SA would not be issued to the beneficiary in the form of cash, but would be available for payment of approved medical services during the span of their coverage. To access these funds, the beneficiary could be issued a "debit card" to be used by the provider to generate a payment request from the savings account. When the recipient goes off Medicaid, funds in the MSA could be used for certain specified purposes determined by the Legislature and provided to the designated entity in the form of a payment guaranty.

Examples of designated usages may include: education tuition, long-term care expenses, or first-time purchase of a home.

Since Medicaid recipients would now be insured at a level comparable to the rest of the population, the problems of access and cost shifting would be largely reduced. Insurance companies would be free to pursue other cost savings measures as they now do in the private sector. However, Medicaid recipients would have considerably greater incentives to make prudent consumption decisions; and would profit more directly from those decisions like those in the current private sector.

There are many advantages to the MSA approach. Among those advantages are:

it is an incentive for both the patient and the health care provider to balance cost and efficacy of care,

the patient plays a central role in the physician/patient relationship instead of a third party,

an incentive for patients to become more informed about health care alternatives and for health care providers to make information available, patient choice in the benefits available,

funds are available to continue coverage when unemployed or changing jobs since funds go with the insured,
insurance companies would perform the role for which they were primarily intended-to provide coverage against unforeseen and/or catastrophic loss, funds not spent would be available for other medically related expenditures not normally covered under a basic insurance plan.

DHH would establish a mechanism for administering the MSAS, including investigating the feasibility of private financial institutions serving as repositories and administrators of the accounts.

Reimbursement of Insurers

Within 30 days after receipt of a valid proof of eligibility certificate and request for premium payment from an approved insurer, the Department of Health and Hospitals will issue payment to the insurer in the amount of the premium indicated on the certificate.

Rule Making Authority

Within 90 days of adoption of an act authorizing the formation of this program, the Secretary of the Department of Health and Hospitals shall promulgate rules in accordance with @s program that provide for the fair, reasonable and equitable administration of the program, including the provisions relative to procedures for determining eligibility under the program, issuance of proof of eligibility certificates/vouchers by the Department of Health and Hospitals, annual determinations of the reimbursable premium amount, and procedures for the reimbursement of insurers that issue policies and contracts to eligible persons. Rules adopted should also include a schedule for the implementation of the program on an incremental basis, if necessary.

Duties of the Secretary

The duties of the Secretary of the Department of Health and Hospitals as they relate to this program include:

1. Administer and implement the program;
2. Monitor the operation of the program;
3. Disseminate to insurers and to the public information concerning the program and the persons eligible to receive benefits under the program;
4. Implement a system to provide information and guidance to all persons eligible under the program relative to the program's procedures and the selection of the most appropriate benefits under a health insurance or health care policy or contract;
5. Implement a program whereby insureds who locate any item or service listed on a billing statement which was not received by or rendered to the person shall receive credit for a portion of the savings identified.
6. Study and evaluate the Operation of the program and annually submit these findings, to the legislature.

7. Determine annually the Premium amount that is to be reimbursed by the Department of Health and Hospitals for both individual and family coverage,

Creation of Fund, Funding & and Uses

Under *Access to Better Care*, a special "Medicaid Access Trust Fund" would be created in the state treasury. The fund shall consist of all of the following:

- 1 - Federal payments received as a result of any waiver of requirements granted by the U.S. Secretary of Health and Human Services under the Health Care Programs, other than the nursing facility care programs and the intermediate care facility programs for the mentally retarded, established under Title XIX of the "Social Security Act."
2. State funding in an annual amount equal to the funding appropriate for expenditure in the fiscal year in which @ program is enacted for purposes of the Louisiana Medicaid program, other than the nursing facility care programs and the intermediate care facility programs for the mentally retarded. This money shall increase in proportion to any increase in the Federal payments received by plan as noted above.
3. All other money appropriated to the fund, interest earned on investments or deposits, grants and gifts made to the fund for reimbursing insurers for the provision of health insurance or health care policies and contracts to residents of this state who are eligible for benefits under this program.

Interest accrued from the Medicaid Access Trust Fund and the MSAs could be used to pay the additional premium costs for enrolling high risk individuals in the state High Risk Pool.

Prohibition against 'Dumping'

An employer cannot fail to extend coverage to or continue coverage of an employee or his dependents under any health care coverage provided by the employer solely to render the employee or dependent eligible to receive benefits provided under this program.

Employer Buy-In

Employers who hire current Medicaid voucher recipients would be permitted to provide health care coverage for the employee by buying into the remaining term of the Medicaid recipient's health plan. The amount of the plan would be prorated for the number of months remaining in the current year of coverage. The money from the employer buy-in would go directly to the Medicaid Access Fund.