Reforming Medicaid In Ohio:

A Framework for Using Consumer Choice and Competition to Spur Improved Outcomes

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Executive Summary

Ohio's spending on health care for low-income families, the disabled, and the elderly is enormously expensive. With 2003 direct spending of over $7.5 billion on the state's Medicaid program, and a combined budget of more than $10 billion, the program costs taxpayers almost $661 per year for every man, woman and child in the state ($2,644 per year for a family of four). Direct Medicaid costs are expected to increase by 66 percent over the next three years.

Ohio's Medicaid costs have risen faster than health costs in the private sector generally. Part of the reason is Ohio Medicaid pays for health care in ways that needlessly contribute to rising health care costs. The state currently pays for 13,000 empty nursing home beds. Another problem is Ohio has not taken advantage of cost-control techniques widely used in the private sector. As much as 75 percent of the expansion of Medicaid nationwide has been offset by a reduction in private insurance.

Traditional reform efforts are unlikely to achieve significant long-term savings—they simply won't change the rules of the game sufficiently to create better outcomes. Cutting pharmaceutical drug coverage, for example, could lead to higher costs by encouraging the use of more expensive or less effective traditional services. More promising approaches focus on changing the way Ohio pays for medical care. More specifically, the state should:

- ❖ Follow the lead of private insurers and choose hospitals based on the lowest price for a given level of quality;
- ❖ Pay for services rendered and outputs, not costs incurred or inputs;
- ❖ Enroll substantial numbers of beneficiaries with disabilities into managed care programs designed to meet their special needs; and
- ❖ Consider block granting Medicaid funds to innovative localities.

The creative use of federal waivers could increase quality and lower costs by:

- ❖ Giving Medicaid enrollees an opportunity to enroll in employer plans;
- ❖ Giving beneficiaries who do not qualify for a private-sector plan opportunities to enroll annually in a plan that provides a Medical Savings Account (MSA) option;
- ❖ Exploring a consumer driven grant system for nursing home care;
- ❖ Restructuring benefit levels and options for people with disabilities and low-income families.

Overall, the authors estimate savings of as much as 15 percent, or $1.5 billion per year in the near term and more than $100 billion in the long term.

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Reforming Medicaid In Ohio: A Framework for Using Consumer Choice and Competition to Spur Improved Outcomes

1. Introduction

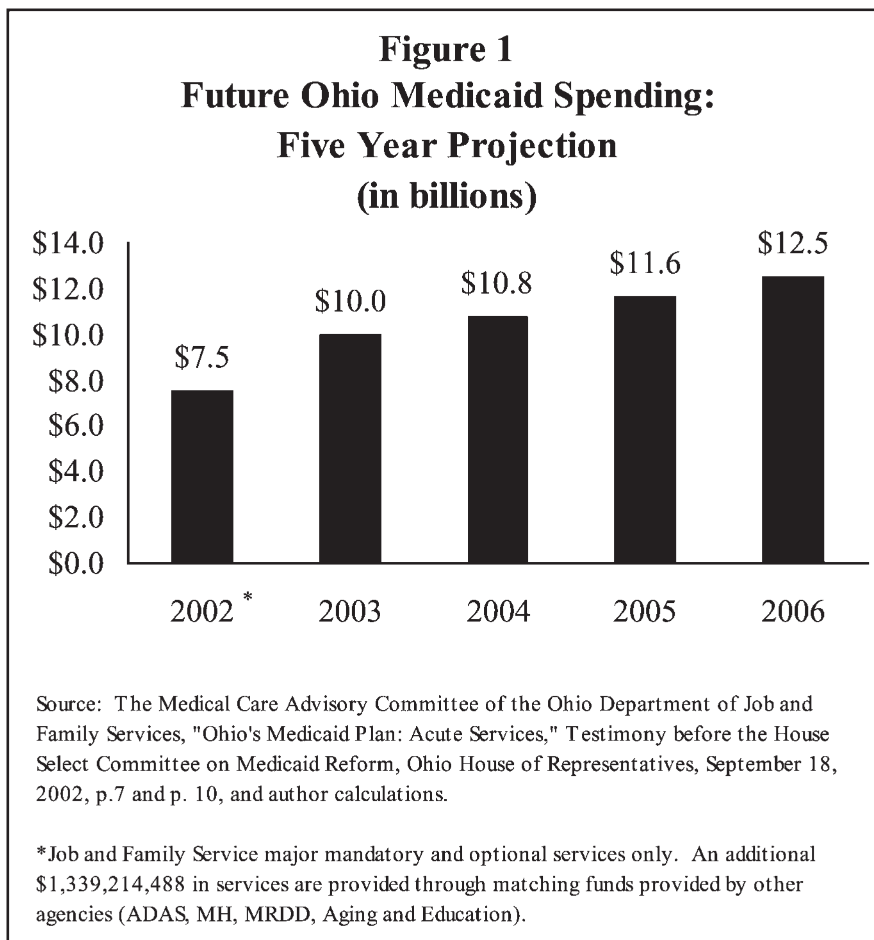
Ohio Medicaid is expensive. With a 2003 direct budget of more than $7.5 billion, the program costs taxpayers almost $661 per year for every man, woman and child in the state.[1] That equals $2,644 per year for a family of four. Indeed, it is likely that some people pay more in state and federal taxes to support Medicaid insurance for others than they pay in premiums to buy private insurance for themselves and their families.

Before considering the case for reform, let's first consider the spending path the state is traveling on and what taxpayers are getting in return for all of that spending.

A. Projected Costs

As high as Medicaid spending is today, in the future it is certain to be higher. Between 1982 and 2002, state spending on Medicaid grew at a compound annual rate of 8.7 percent per year. If that trend continues, Medicaid will double every eight and one-half years. Left unchecked, this program will eventually consume the entire state budget. Ohio Medicaid not only imposes an enormous burden on taxpayers, it is also crowding out spending on other valuable programs.

Moreover, in recent years, Ohio Medicaid has been growing even faster than the historical trend. Figure 1, for example, shows that if double-digit growth continues for five more years, the program will increase in size by 66 percent to $12.5 billion by 2006.[2]



Source: The Medical Care Advisory Committee of the Ohio Department of Job and Family Services, "Ohio's Medicaid Plan: Acute Services," Testimony before the House Select Committee on Medicaid Reform, Ohio House of Representatives, September 18, 2002, p.7 and p. 10, and author calculations.

*Job and Family Service major mandatory and optional services only. An additional $1,339,214,488 in services are provided through matching funds provided by other agencies (ADAS, MH, MRDD, Aging and Education).

How realistic is a forecast of growth in Medicaid health care cost on the order of 65 percent in four years? Let us look at the assumptions separately.

First, consider caseload trends. Ohio Medicaid caseload declined for a time after 1994 from a peak of approximately 1.3 million enrollees. It remained relatively flat at about 1.1 million people in 1998, 1999, and the beginning of fiscal year 2000. Since then, caseloads have increased sharply to 1.3 million in 2001 rising to about 1.5 million today (about 10 percent above expected levels).[3]

Second, consider health care costs. Realistically, health care costs are more difficult to predict. However, in the late 1980s when the economy last replicated current conditions of questionable or no economic growth combined with sharply rising health care costs, Medicaid and health care costs increased at double-digit rates for six to eight years. If that cycle repeats itself, at least four more years of significant health care inflation may be expected.

Health Affairs reports national health care spending for privately insured Americans rose by 10 percent in 2001, the first double-digit increase in a decade.[4] The Center for Studying Health System Change reports a 15 percent average increase from Spring 2001 to Spring 2002 in the rates for employer-sponsored health insurance, so it appears the nation is in its second year of double-digit inflation for health insurance rates.[5] Medicaid and other health expenses already account for about 20 percent of state spending nationally, and those costs rose 13 percent last year — "the largest increase in a decade," according to a National Governors Association report.[6]

What do these considerations mean to policymakers? They should be a warning of dangerous conditions ahead. Even with excellent on-going cost containment efforts, Medicaid caseloads and costs are going to grow substantially in the near future.[7] Just continuing existing services that were funded off budget will require at least an additional $150 million added to current spending levels, even if inflation is not addressed. Furthermore, there exists a real possibility that these projections will be too low. To obtain additional matching funds, agencies often attempt to match eligible current expenditures with federal Medicaid funds. However, what often occurs is federal matching funds are matched with new spending — resulting in a net increase in state expenditure. The existence of such pressures and the needs upon which they are based are all too real. Mental health, mental retardation, developmental disability, public health, juvenile justice, and child welfare populations could all receive additional federal funds by bringing eligible services under the Medicaid tent.

B. Medicaid's Impact on Economic Behavior

Although Medicaid was designed to assist people who need assistance through no fault of their own, the program creates perverse incentives as a consequence. For example:

- Because Medicaid benefits are conditional upon low-income, the program penalizes those who succeed; individuals can lose eligibility (and therefore health insurance coverage) for themselves and their families simply by getting a promotion or a raise at their place of work.
- Because Medicaid benefits are conditional on having few assets, the program encourages

people to spend rather than save their income.

- Because Medicaid is an alternative to private insurance, the program encourages people to drop coverage paid by themselves and their employers and turn to "free" insurance paid by taxpayers instead.

There has been very little research to document ways in which people have responded to these incentives. But what research there is confirms what common sense would predict: Medicaid beneficiaries have behaved in a rational manner. They have dropped private insurance coverage, saved less and consumed more.[8] Any attempted reform of state Medicaid plans needs to understand the perverse effects of the program already in place.

There is also empirical documentation of a "crowding out" effect of Medicaid on private health insurance. Nationwide, the percentage of children who can receive Medicaid increased by more than 50 percent between 1987 to 1992 and the number of women eligible for Medicaid if pregnant more than doubled. Thus, Medicaid coverage increased by more than 2.3 million. However, this increase was accompanied by a significant drop in private insurance, offsetting from 50 to 75 percent of the increase in Medicaid coverage. The vast majority of this reduction came from workers deciding to drop private coverage (particularly for dependents) rather than because their employers stopped insurance coverage.[9]

C. Medicaid's Impact on Health Behavior

A common argument for Medicaid is that by making health care virtually free at the point of consumption the program encourages preventive care that has the potential to reduce overall health care costs. Unfortunately, there is little evidence in support of this view.

Studies suggest explicit attempts to encourage Medicaid beneficiaries to use preventative care are generally unsuccessful. For example, outreach programs in North Carolina found a statistically significant but very small impact on utilization.[10] Another study found providing Medicaid benefits for a year increased the probability of children receiving checkups by only 17 percent. The researchers concluded "factors other than insurance and income, such as the low educational attainment of low-income mothers, explain approximately 80 percent of the gap between low-income and other children in their well-child visits."[11] Research from the University of Washington found there was no evidence prenatal care pays for itself by reducing future health care costs.[12]

Additionally, there is no definitive evidence infant mortality rates have any relationship to Medicaid coverage. There is also no evidence becoming eligible for Medicaid has a significant impact on immunization rates.[13]

2. Reforming the Basic Medicaid System

States appear to have considerable flexibility in determining the number of people and the types of services that are covered by Medicaid. Nationwide, about 70 percent of all Medicaid spending is optional, covering either beneficiaries that do not have to be covered, or services that do not have to be covered, or both.[14] Since the average state currently spends 19.6 percent of its budget on Medicaid, almost 14 percent of Medicaid spending could be saved in an average state by eliminating optional people and optional services.[15] In Ohio, that number is closer to 15 percent.

Despite this apparent flexibility, Medicaid in other ways is incredibly rigid. For example, because Medicaid is an entitlement program, services must be provided to eligible enrollees regardless of whether funds have been appropriated, or are even available. To compound these difficulties, Medicaid caseload changes tend to parallel changes in the economy. This means mandated Medicaid spending goes up during economic downturns, when state fiscal conditions are at their worst — usually just after normal sources of available funds have been depleted. For example, according to one source, states are facing "the worst budget crises [they] have faced since World War II," and Medicaid funding problems are a major contributor to the gap.[16]

What can be done? Currently, 46 states face a combined budget gap of $37.2 billion. A major driver is Medicaid which grows at a rate two to three times higher than other major categories of state spending.[17] Moreover, this is occurring at a time when the number of people with private insurance is shrinking. Already, 37 states have cut a combined $12.6 billion from their Medicaid budget.[18] More cuts will follow. According to the Kaiser Commission on Medicaid and the uninsured:[19]

- Eighteen states plan to tighten Medicaid eligibility rules in fiscal year 2003, compared to eight in 2002;
- Fifteen states are cutting Medicaid services this fiscal year, compared to nine last year; and
- Forty states are reducing the amount they will pay for prescription drugs on implementing preferred drug plans.

Ohio may be able to make some progress by instituting similar changes. A more promising approach is to seek a federal waiver.

A. Reducing the Number of People Covered by Medicaid

Certain people must be covered by Medicaid under federal law. These are "mandatory" populations. Others are enrolled at the discretion of the state. These are "optional" populations. For example, formerly, states were required to make eligible for Medicaid all children under age 5 in families with incomes up to 133 percent of the federal poverty level and children ages 6 to 15 in families with incomes below 100 percent of the federal poverty level. But, as of September 2002, states are required to grant eligibility to all children living in poverty, regardless of their age.[20]

Unfortunately, it is very difficult to lower spending by reducing the number of people covered. The difficulty can be illustrated by considering what would happen if Ohio limited eligible

populations to minimum federal requirements. This change would mainly involve eliminating insurance coverage for children under State Children's Health Insurance Program (S-CHIP). Yet even that draconian measure would save only about $75 million per year in state dollars.

B. Reducing Services Covered by Medicaid

Another possible change is to eliminate optional services. Examples of acute care optional benefits include prescribed drugs, diagnostic screening, preventative and rehabilitative services, clinic services, dental care, dentures, physical therapy and related care, prosthetic devices, TB-related care, and primary care case management.[21]

More dollars can be saved under the approach of limiting optional benefits than by limiting optional people. For example, about $3 billion is spent on optional services in Ohio. Of this amount, the largest expenditure category is just over $1 billion for prescription drugs, followed by $398 million for private ICF-MR facilities.[22] Trying to eliminate these expenditures, however, may prove penny wise and pound foolish. For example, drug therapy is often a less expensive and more effective alternative to doctor therapy and hospital therapy. A study by Columbia University professor Frank Lichtenberg found that in the health care system an increase of 100 prescriptions is associated with about 1.48 fewer hospital admissions, 16.3 fewer hospital days and 3.36 fewer inpatient surgical procedures. Overall, a $1 increase in pharmaceutical expenditures is associated with a $3.65 reduction in hospital care expenditures.[23] Mental health and physical health services often substitute for each other. In one study, an employer who reduced spending on mental health saw more than offsetting cost increases in other health services.[24]

A stronger case can be made for eliminating lower priority (although still important) services. But in these cases, the savings would be relatively small. For example, eliminating podiatry, chiropractic, and physical therapy from the approved optional Medicaid funding list in Ohio would save less than $14 million state dollars per year.[25]

C. Federal Waiver Opportunities[26]

All of the previous options imply the adoption of a "one size fits all" approach to Medicaid. Cuts would be across-the-board, ignoring the unique health needs of individuals and subgroups of beneficiaries. These are not the only options. A window of opportunity has emerged that allows states to break from this regulatory straightjacket and tailor their Medicaid programs to their own priorities. Since August of 2001, states have had the opportunity to take control over their programs through waivers, also called HIFA waivers:

- To reduce some benefits in return for increases in other benefits;
- To reduce benefits in return for increases in the number of people eligible for those benefits; or
- To reduce benefits for some people in order to create a new set of benefits for other people.

The constraint is that the change must be budget neutral.[27]

Suppose a state wants to expand eligibility to a new population (and qualify for federal matching funds for its spending on that group) without increasing the total amount of state spending on health care. Under a federal waiver (called a HIFA waiver) the state can have access to three sources of funds in order to pay for its share of the costs for the newly eligible beneficiaries:

- Disproportionate Share Hospital (DSH) funds, which are federal and state funds available to hospitals treating a disproportionate share of Medicaid and charity care patients.
- Unspent State Children's Health Insurance Program (S-CHIP) funds.
- Savings from the reduction of Medicaid benefits for currently eligible populations or the reduction in eligible populations. Furthermore, the benefits created for the newly eligible group can be more limited than the benefits made available to the previously eligible group.

Opportunities and Risks of a HIFA Waiver.

These options are new and, compared to previous experience, quite radical. For the first time, the federal government has allowed a state to reduce benefits to current Medicaid enrollees in order to reallocate those funds to offer some coverage to working individuals who have no health care coverage in the workplace. Even more surprising, for the first time, the federal government has permitted a state to offer a benefit plan that does not include hospitalization and specialty care. Congress may or may not have understood what it was doing when it authorized HIFA waivers. But it did authorize them. And, the Bush Administration has been very aggressive in suggesting to states that creative alternatives will be entertained, and within constraints, are likely to be approved. (See the sidebar on "The Utah Experience.")

The Utah Experience:
Testing the Limits of Federal Waiver Opportunities

A revolutionary use of a waiver is illustrated by the Utah model. Utah uses unexpended federal matching funds for CHIP, reduces benefits for currently eligible Medicaid recipients, and expands eligibility to cover low-income working individuals who do not have coverage.

The Utah model meets the requirements for HIFA waivers of obtaining budget neutrality while expanding eligibility to new populations. Thus the change in mandated populations is balanced by changes in mandated benefits and unused federal funds. The state also uses fact-based evaluations to guide disease management and care coordination to ensure that the net effects of better care with fewer services achieve the desired outcomes. For example, by providing appropriate treatment during pregnancy, a number of low weight births can be prevented. Instead of sick babies, healthy babies would be the result. Fewer services would be provided so costs would be lower, yet outcomes would be better.

On the cost reduction side, Utah replicates the benefit package provided to Utah Public Employees Plan rather than the more generous Medicaid design.[1] State law also was changed so private insurers can offer employers plans with the same benefits as the plan public employees are enrolled In. This allows the state to buy Medicaid enrollees into employer plans — relying on the private market rather than expanding public programs and saving money for the state, because employer premium payments substitute for Medicaid spending. Under the Utah waiver, an enrollment fee and co-pays up to 11 percent of annual income are permitted.[2]

On the cost expansion side, Utah broadened eligibility under the waiver to cover two groups: (1) parents with children enrolled in Medicaid or CHIP whose family income is below 150 percent of poverty, and (2) childless adults with the same income level. The significance of the Utah waiver is monumental. By following Utah's example, other states can exercise greater control over their Medicaid costs. States can now make budget neutral changes in one year that reduce Medicaid expenditures in succeeding years.

HIFA waivers are not without risks. Specifically, there is an inherent danger of rising costs under HIFA waivers, because of the eligibility expansion. As the experience of Texas shows (see the sidebar on "The Texas Experience."), eligibility expansions can multiply other cost increases.

[1] This more limited benefit package is also the package made available under Utah's CHIP program.

[2] Enrollment under the Utah waiver will be restricted until program evaluations can be completed on: (1) the success of the plan in reducing health problems for the populations served; (2) the impact on the use of emergency rooms; and (3) the effect on "crowd out" (the extent to which public insurance is substituted for private insurance that was formerly purchased).

The Texas Experience:
A Lesson about Maximizing Federal Funds

In the late eighties, Texas (a very fiscally conservative state with eligibility levels similar to Ohio) faced many of the same problems that Ohio confronts today: Policymakers had to address a variety of economic woes, including expanding entitlement caseloads, budget shortfalls, and other needs that could not be addressed without major tax increases. Further, its position in the health care cost cycle was similar to today's. To address these issues a decision was made to maximize federal matching funds.

Two basic approaches were used: obtaining Medicaid matching funds for already-existing expenditures that were not being used for a Medicaid match and expanding Medicaid eligibility. The first did not cost additional direct state tax dollars, at least initially. The second did.

The first approach converted money that was already being spent on charity care for indigent patients (but with no federal match) into expenditures (which qualified for a federal match) through paper transactions. To accomplish this result, Texas counties sent funds to Austin on one day and the state returned the funds the next day. This one-day bookkeeping transaction converted (at least on paper) county spending into state spending — thus satisfying federal requirements and turning county spending on indigent care into state Medicaid spending under the Disproportionate Share Hospital funds (DSH is known as the Hospital Care Assurance Program in Ohio). This program, which qualifies for federal matching funds, was set up to compensate hospitals that treat a disproportionate number of Medicaid patients (for which they receive state payments that are below market rates) and uninsured patients (from whom they receive less than the amounts billed). The state also expanded Medicaid eligibility, primarily to pregnant women, infants, and children, thus qualifying for even more matching funds. But that decision also increased the demands for state matching dollars as well.

All in all, approximately a billion dollars a year were added to the DSH program alone; eligibility to pregnant women and infants under Medicaid was expanded; and other needy populations were selectively added to Medicaid.

The results were immediate and dramatic. It had taken about twenty years, from 1968 to 1988, for total Medicaid spending in Texas to reach two billion dollars a year. Yet it reached seven billion dollars — a three and one-half times increase — in just five more years. And it doubled to ten billion dollars over the next ten years.

Today's circumstances are very similar. Ohio could easily replicate that experience — if it does not learn from the Texas example.

In Ohio, a HIFA waiver alone (without any efforts to control costs) could be unwise. But if a HIFA waiver were coupled with market incentives to improve quality and reduce costs, and other appropriate cost-control activities, a strong argument to use them can be made. Furthermore, by phasing in parts of the HIFA waiver and limiting eligibility expansions until an evaluation of the outcome of each phase is completed, unanticipated financial risks to the state can also be limited.[28]

3. A Specific HIFA Waiver Proposal

Ohio should seek a HIFA waiver. The extent of services to be covered and the eligibility expansion under the HIFA waiver should be determined by the General Assembly, or if no determination is made this coming session, by the Governor.[29] In the meantime, we make the following recommendations.[30]

A HIFA waiver should not be considered an "all or nothing" policy option. On the contrary, obtaining the waivers necessary to fundamentally change the way Medicaid operates will require a series of HIFA waivers, each with its own goals and objectives. Thus, the State of Ohio can benefit from intermediate steps toward reform without having the entire program in place.

A. Medicaid Benefit Changes

Medicaid has a very rich benefit package. Consistently, Medicaid benefits exceed most private insurance benefits in most states. As a result, taxpayers generally have lower benefits in their own health insurance plans than those provided to Medicaid enrollees at taxpayer expense.

This is unfair and unwise. It is unfair because taxpayers should not be forced to provide health benefits to others more generous than they can afford to purchase for themselves and their families. It is unwise because the Medicaid population is largely insulated from many of the cost-controlling, quality-improving innovations that are available to private sector plans in Ohio and throughout the nation.

We propose to allow Medicaid enrollees to enroll in private sector plans, including employer plans and individually owned insurance plans. To qualify to accept Medicaid enrollees, a health plan would have to offer benefits similar to the plans currently offered to Ohio private-sector employees. In addition, the state should authorize a new type of plan that incorporates a health care savings account.

Although the private sector plans may appear less generous on paper than the current Medicaid program, they would allow enrollees access to a greater range of providers and facilities than is currently the case in many localities. Put differently, this proposal would allow Medicaid enrollees to participate in the same kinds of health plans other Ohioans are participating in.

B. Eligibility Changes

In expanding eligibility, the dilemma is whether to address the most urgent need or the largest need.[31] If the choice is to address the most urgent need, then expanding eligibility to certain persons with disabilities (for example, persons with developmental disabilities, who are currently not eligible) would be appropriate. If the choice is to address the largest need, then focusing on the largest uninsured group, the near poor, would be the appropriate decision.[32] These groups have different needs and requirements. Waivers should be developed with those needs in mind. An obvious first step towards covering the large group of needy would be to expand Medicaid eligibility to parents of children with Medicaid or S-CHIP. After evaluations to determine the full effects of

expanding Medicaid eligibility, including crowd-out effects, additional phased expansions could be undertaken.

As noted above, the benefits provided to a new group of eligibles under a federal waiver do not have to be identical to the benefits provided to the currently eligible. Nor does the state subsidy have to be the same. One option is to follow Utah's example and provide only primary care to the newly eligible population. Another option is to allow the new eligibles access to an insurance exchange (see below) but subsidize the insurance on a sliding scale basis. This could be done along the lines of a negative income tax, where additional income leads to a somewhat smaller premium subsidy.

In order to discourage crowding out of private coverage, a waiting period could be imposed between the time when individuals lose private coverage and when they are eligible for Medicaid rolls. In a more extreme manner, individuals could be denied Medicaid coverage if private insurance is available from their employer. Since there are often Medicaid payments to individuals who actually have private health insurance, workmen's compensation and/or liability insurance, the state should vigorously attempt to recover these funds from the appropriate carriers.

C. Marked-Based Cost Control

In order to take full advantage of cost-controlling, quality-improving innovations in the private sector, Medicaid enrollees need access to health plans that compete for customers in the marketplace. One opportunity is to give Medicaid beneficiaries the option to enroll in employer plans (for which they qualify) at Medicaid's expense. Provided the plan satisfies the benefit requirements described above, Medicaid should be willing to pay the standard employee contribution or 50 percent of the premium — whichever is less.

Those beneficiaries who do not qualify for employer plans should be able to participate in a state-operated insurance exchange, or health mart, giving them the ability to directly enroll in individually-owned health insurance plans. (See the sidebar on "Making Health Marts Work".) The carriers participating in the insurance exchange would offer a host of competing health plans. Participants could purchase an HMO type plan, a preferred provider plan or a plan combining significant patient cost-sharing with a Medicaid Benefit Account (see below).[33]

The insurance exchange would have the following features. The role of the state would be organizing the exchange, soliciting information from health plans, and making information available to the beneficiaries. This would make the plan similar to the federal government employee health insurance system.[34] Health plans would be required to accept enrollees at risk-adjusted premiums based on age and sex. Those failing to make a plan choice would automatically be enrolled in the "no frills" plan with limited choices (probably a closed panel HMO). The exchange could be contracted privately with Medicaid overhead reductions financing the operation. Health plans offered through the exchange would be exempt from state small-group market reforms and laws mandating health benefits. This could significantly lower the cost of coverage.

The introduction of an insurance exchange would put the marketplace to work to reduce costs and encourage innovation. Rather than remain in the state plan, beneficiaries could choose among alternative private-sector plans. This would also make it easier for those leaving public assistance to keep medical coverage since they or their employer could simply substitute private premium payments in place of the state subsidy. Other advantages of this plan are reasonably priced coverage for the poor and near poor, facilitation of plan continuity (so that the poor can keep their coverage when they leave public assistance), an entry point for Medicaid beneficiaries into the private insurance system and easy to understand information regarding cost, coverage and plan features.[35]

The State would move from being a health insurer to a health financier. Its role would be to set the ground rules, determine what minimum benefits private insurers would have to offer, solicit insurers to join, collect information about plan benefits and costs, and provide the information to prospective enrollees through the state insurance exchange.

Making Health Marts Work

Under the Federal Employees Health Benefit Plan (FEHBP), federal employees and their employer, the federal government, pay community-rated premiums to enroll in competing, private sector health plans. Although there is competition in this system, the competitors are not allowed to charge premiums that reflect an individual's expected health care costs. Because of the community-rating requirement, healthy people are overcharged and unhealthy people are undercharged relative to the costs they are likely to generate.

As a result, health plans have strong incentives to underprovide to the sick and overprovide to the healthy.[1] Risk-adjusted premiums can ameliorate this problem somewhat. However, risk-adjustment cannot eliminate the problem and under some circumstances can make it worse.[2]

In designing a health mart or insurance exchange for Medicaid, we must be careful not to repeat these mistakes. In particular, we need FEHBP-type competition in which the competitors have good incentives rather than bad ones. How can that be done?

Under the FEHBP system, federal employees join health plans for a period of 12 months; once a year, they reselect their health plan during an "open season." A better structure is to have long-term enrollment — lasting, say, three to five years. Under this arrangement, enrollees would also be able to have long-term relationships with physicians and health care facilities because they would have long-term relationships with the health plans that contract with those physicians and facilities.

During the contract period, enrollees could switch health plans. However, a switch of plans would require consent of both the new and the old plans and would almost always necessitate a lump sum payment from one plan to the other. For example, if a sick and high-cost enrollee switched from Plan A to Plan B, A would have to compensate B for the extra expected costs B would subsequently incur over and above the annual premium B would receive on the patient's behalf. If a healthy and low-cost enrollee switched from Plan A to Plan B, B would have to compensate A for the difference between the premiums it was collecting and the health care costs it likely would have incurred.

Under this system, health plans could not dump their sick enrollees on other plans without compensating the other plans for their expected losses. Nor could health plans lure healthy enrollees from another plan without compensating the other plan for its lost profit. In such a system, health plans would have an incentive to compete for the sick instead of actively trying to avoid them.

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[1] John C. Goodman and Gerald L. Musgrave, "A Primer on Managed Competition," *NCPA Policy Report No. 183*, April 19, 1994, National Center for Policy Analysis.

[2] John C. Goodman, Mark Pauly and Phil K. Porter, "The Economics of Managed Competition," unpublished. Available from the National Center for Policy Analysis, 12655 N. Central Expressway, Suite 720, Dallas, Texas 75243.

D. Patient Power Cost Control

When patients have first-dollar coverage for health care services, they have no incentive to avoid waste or ensure that they get a dollar's worth of value for each dollar they spend. To the contrary, if the out-of-pocket costs are zero, patients have an incentive to utilize health care services until their value approaches zero, at the margin. Similarly, doctors treating patients with first-dollar insurance coverage have an incentive to provide services as long as those services offer any positive medical benefit (or probability of benefit), even if the value of the benefit is well below its cost.

Managed care arose to try and counteract these perverse incentives. But all too often managed care consists of an impersonal bureaucracy putting the goal of cutting costs ahead of patient welfare. So as an alternative, many employers across the country are empowering employees instead — by giving them the opportunity to manage some of their own health care dollars and experience the costs and benefits of prudent consumer behavior in the medical marketplace.[36]

Ohio Medicaid needs to follow this example. Accordingly, beneficiaries should have access to plans with patient cost-sharing and a health care saving account called a Medicaid Benefit Account (MBA), from which to pay the patient's share of the bills.

Since these accounts would be wholly or partly funded with taxpayer dollars, they should probably be restricted to the payment of medical bills and insurance premiums. This means that beneficiaries who consume health care wisely and see their MBA balances grow through time would not be able to withdraw these balances for non-health care spending. However, they would be able to use the funds for medical services not covered by their health plan. And in the future, they would be able to use unspent balances to pay insurance premiums and buy medical care directly after they have left the Medicaid rolls. (See the sidebar on Medicaid Benefit Accounts.)

Medicaid Benefit Accounts

The idea behind a health care savings account is that individuals should be able to control some of their own health care dollars and profit from efforts they make to control costs and eliminate waste and inefficiency.

In the United States, a federal government pilot program allows certain individuals access to a tax-free Medical Savings Account (MSA), which is associated with a high deductible insurance plan. Individuals use their MSA funds to pay costs below the deductible and rely on third-party insurance to pay costs above that amount.[1] In South Africa, a flexible MSA policy is more common. In a typical plan, the deductible is zero for hospital services (on the theory that patients exercise very little discretion in that setting) but is $1,100 or $1,200 for outpatient care (on the theory that patients exercise a lot of discretion in that setting). A zero deductible may also apply for drugs for certain chronic conditions (on the theory that if the patient skimps on the drug, total health costs may increase as a result).[2]

For Ohio Medicaid beneficiaries, we recommend a flexible account, called a Medicaid Benefit Account (MBA). Health plans that offer these accounts should have low or zero deductibles where it is appropriate to encourage patients to obtain the medical service. But they should have substantial costsharing for services for which patients exercise considerable discretion.

Patients would benefit from not spending all of their MBA money by being able to spend the funds on other valuable goods and services. For example, remaining funds in this account could be used for dental, eye care, and other noncovered medical expenses. In addition, unused funds would be available for future medical insurance and health expenses, for tuition costs, as well as for housing, transportation, or other acceptable expenditures needed to remove themselves from public expenditures.

Giving individuals and families funds to meet their most pressing needs will reduce waste and encourage self-reliance. (These accounts should not be subject to asset testing.) Such states as Michigan and Massachusetts have "consumer-directed" models of providing Medicaid services. They have found that beneficiary satisfaction is higher than when administered by the state and costs are often lower. For example, in Michigan two party checks are used to pay attendants for elderly, disabled and medical care. The requirement that the patient (or guardian) co-sign the paycheck of the personal care attendant ensures that the latter works for the patient rather than the government and creates incentives for goods services. It also tends to reduce costs.[3]

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[1] John C. Goodman, "MSAs for Everyone, Part I," National Center for Policy Analysis, *Brief Analysis, No. 318*, March 31, 2000; Greg Scandlen, "MSAs for Everyone, Part II," National Center for Policy Analysis, *Brief Analysis, No. 319* March 31, 2000; John C. Goodman, "MSAs for Everyone, Part III," National Center for Policy Analysis, *Brief Analysis, No. 356* April 19, 2001.

[2] Shaun Matisonn, "Medical Savings Accounts and Prescription Drugs: Evidence from South Africa," National Center for Policy Analysis, *NCPA Policy Report No. 254*, August 2002.

[3] The Michigan Home Care Program uses two-party checks to discourage fraud. When paying for personal care assistance in the home these checks must be signed by both the caregiver and the care recipient. See The Robert Wood Johnson Foundation, "Grant Results Report: Studies of Cash Disability Allowances for Long-Term Care," September 1998.

E. Institutional Cost Control

For those enrolled in private sector plans, the cost control methods utilized will be those that survive the market test. However, for those who remain in Medicaid, more could be done to ensure that taxpayers are getting their money's worth. The first and largest cost reduction opportunity is to move Ohio Medicaid to evidence-based, disease management and care coordination.[37] One goal would be to make sure that services provided are needed and appropriate.[38] Where treatment protocols do not exist, government should foster their development in conjunction with academic institutions and practitioners. Doctors still would retain the right to make treatment decisions for their patients, but when they choose to prescribe treatments other than those in the protocols, they would know they have a higher burden of justification. Protection from liability, or at least limited liability, could be the reward for following protocols.

A second goal is to eliminate errors. Some of the more costly problems include: drug misuses, overuse of antibiotics, preventable hospital-acquired infections, and under-diagnosis and mistreatment of chronic conditions.[39] Medical errors are dangerous and costly. Elimination of errors in diagnosis and care provides better treatment at lower cost. Everyone is a winner.

A third goal is to create evaluation and payment systems with incentives to lower cost and achieve desired outcomes. Specifically, Ohio should establish a timetable to phase in the treatment protocols described above. In this way, Ohio would only pay for what it deems worthwhile.[40] Significant savings could be obtained in such areas as mental health, substance abuse, or certain durable medical equipment.[41]

F. Complying with HIPAA

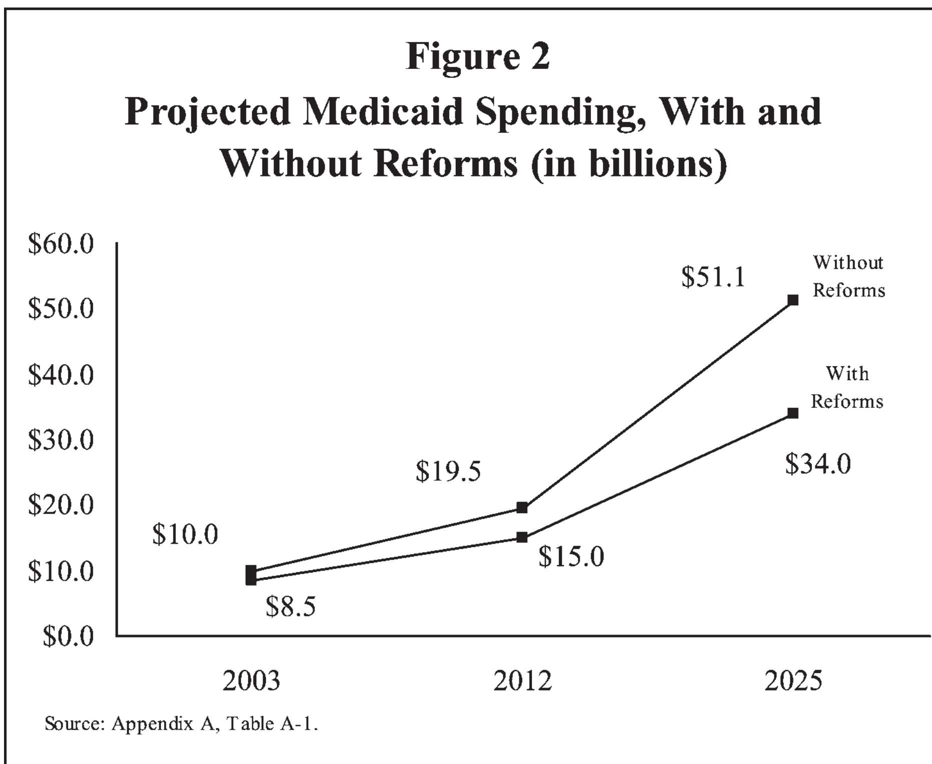
Ohio should seek a partnership with the federal government in developing Health Insurance Portability and Accountability Act of 1966 (HIPPA) standardized systems. Under this statute, states are required to simplify and standardize administrative procedures. If implemented properly, this mandate provides an opportunity to reduce providers' administrative costs. A typical doctor's office usually has many sets of large books, each giving an insurer's administrative codes for a set of diagnostic codes.[42] If the administrative codes were standardized, only one set of books would be required. Time and money could be saved.

Developing codes that are acceptable to various providers and insurers will take time. But the state that takes the lead will have two advantages. First, it will obtain savings before other states. Second, since its providers and insurers will have developed the codes, Ohio's providers should have little difficulty implementing them.

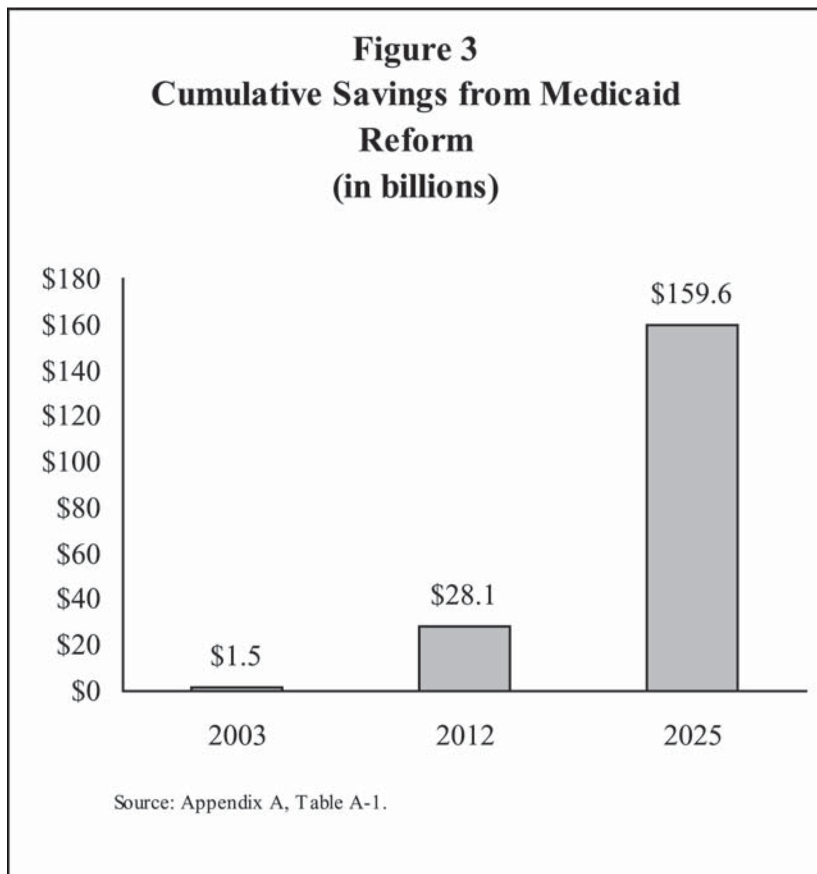
We recommend Ohio participate only on the condition that any additional costs of participation be borne by the federal government. There are two reasons for this. First, state administrative costs in Ohio are already so low that the Department does not have sufficient funds currently available to pay for the additional costs of participation. Second, the federal government will pay more attention to cost implications to the states if it has to pay development costs to set up the new system.

G. Expected Benefits from the HIFA Waiver

The HIFA waiver recommendation is based on the twin principles of free markets and personal responsibility.[43] A number of significant benefits can result from this approach:



- First, moving to a market based system can provide greater freedom and efficiency than the present system allows.
- Second, individual recipients and providers can be given incentives to improve quality and lower costs, which benefits those recipients and providers, as well as taxpayers.



- Third, the effects of these improvements and resulting savings can continue to accrue over time.
- Fourth, Ohio Medicaid can begin to be controlled from the state rather than from Washington, which is important because people in Ohio will always know better what is best for Ohio than people in Washington.
- Finally, some draconian cost increases can be reduced or avoided during a period when available revenue is limited.

These waivers would be applied for as part of a series. The first waiver would restructure benefits, using the successful model of Utah. The second waiver would establish the Health Marts and introduce the

concept of the Health Benefit Account. The third waiver would move the Medicaid program to an outcome-based system for payments to providers.

How much can Ohio expect to save (in terms of dollars and cents) from implementing the HIFA waiver and other reforms suggested in this report? With the caution that projecting health care costs is an activity fraught with error, we have made some tentative projections discussed at length in Appendix A and reflected in Figures 2 and 3.

- We project initial savings of about fifteen percent of Medicaid spending, or $1.5 billion.
- In ten years, the cumulative savings (versus no reform) will grow to $28 billion.
- By 2025, the cumulative savings will grow to $159 billion.

4. Reforming Medicaid for People with Disabilities

A large portion of people with disabilities access Medicaid benefits by qualifying for Federal Supplemental Security Income (SSI). This program has a history of being riddled with fraud and abuse.[44] It is not difficult to understand why. Since coverage is related to medical conditions that may be fairly easy to fabricate or exaggerate, there is a strong incentive for individuals or parents to fraudulently represent their true medical conditions. Unlike the poor and near poor, whose income and assets can be documented, this group of recipients is much more likely to attempt to "game" the system to obtain coverage.

The ability of most SSI recipients to obtain Medicaid coverage is a state decision and not a federal mandate. While most states have opted to provide coverage for SSI recipients, the fact that this is a state decision makes it easy to significantly tighten eligibility (although the politics of doing so will certainly be more challenging).

A. Tailoring Benefit Packages

Given varying degrees of disabilities, the benefits package should be related to the level of the medical problem and the income of the recipient. This could be accomplished by restricting the benefits package to only those health costs relating to the disability, depending on the severity of the health problem, and providing sliding scale premium support with less support for those with higher incomes.

B. Contracting Out

In rural areas, one method for efficiently providing needed health care to this group is a managed care plan operated in each county. Providers in each area could bid to offer specific medical services. For example, disparate providers could provide services for mental illness, physical disability, substance abuse and so-forth. The comparative advantage of these various providers would serve to reduce costs and possibly increase the quality of service.[45] In urban areas, the state could take advantage of competition among health plans, perhaps in the manner of the insurance exchange described above.

C. Encouraging Cost-Effective Alternatives

Cost savings could be realized in some cases with home health care services instead of a medical center, due to reduced overhead. However, a very efficient screening process for eligibility will be needed. For example, an individual with disabilities might resist applying for coverage if it implies residence in a nursing home but may opt to do so if eligible for home health care. When less costly services are also more attractive they can have the effect of increasing demand.

5. Reforming Long-Term Care

Institutional care in nursing homes and intermediate care facilities for the mentally retarded currently accounts for 39 percent of all Medicaid spending in Ohio. Here is a prime opportunity for cost containment. Ohio long-term care costs are a billion dollars higher today than a decade ago, even though the number of patients is smaller. There is ample reason to believe these costs can be curtailed. Ohio already spends about $2.5 billion annually on nursing home care. And absent reform, annual spending will jump another $400 million by next year, bringing the amount spent per patient per year to about $55,600.[46] Among the symptoms of wasteful spending:

- Ohio's method of paying for long-term care pays for beds, not patients; as a result, taxpayers are subsidizing nearly 13,000 empty Medicaid beds.
- Ohio's method of paying for long-term care rewards institutional care over less expensive community care.
- Under Ohio's methods of determining who is eligible for long-term care, a new category of lawyers has emerged to provide Miller trusts to help beneficiaries satisfy the asset test and avoid (apparent) legislative intent.[47]
- Ohio's method of reimbursing long term care based on costs encourages nursing home sales, by allowing each new buyer to depreciate property that has already been depreciated by the previous buyer; the resulting churning of facilities erodes needed stability and threatens quality of care.
- Ohio's method of reimbursement even rewards bankruptcy; by allowing bankrupt owners to continue operations until a new buyer is found, Ohio allows the sellers to get rid of their debts and rewards the buyers by giving them a higher (reimbursable) cost basis.

In addition to this list of concerns, long-term care probably generates the most dissatisfaction of any major Medicaid expenditure category. Although one in three adults over 55 are likely to use long-term care, few want to utilize it, and concerns about quality of care are consistently expressed.

What follows are some suggested reforms.

Table 1

Ohio's Aged, Blind and Disabled Population at a Glance (2001)	
Enrolled ABD population	815,630
Average **Monthly** Cost per Member	$1,255
Average **Annual** Cost per Member	$15,057
Total **Monthly** ABD Cost	$1,023,307,112
Total **Annual** ABD Cost	$12,280,885,345

Source: Ohio Department of Jobs and Family Services

A. A Market-Based Approach

The idea of using competitive forces to control costs in the Medicaid Covered Families and Children program (CFC) described in the previous section could be extended to coverage for the elderly. One way to do this would be to provide those who qualify for Medicaid supported nursing coverage nursing home grants (NHGs) to purchase nursing home "insurance" from carriers soliciting business at the Medicaid Insurance Exchange. These would not be insurers in a traditional sense because they would be soliciting business from a group they know will incur nursing home expenses. Rather, these carriers would function as HMO type organizations who would negotiate with nursing homes and other elder care organizations for varying packages of nursing home services. Elderly service providers would compete vigorously for this business producing competitive pricing and increased quality of coverage.

The State Medicaid Program, as with the CFC Proposal, would operate the insurance exchange and mandate minimum standards for nursing home services. The establishment of the exchange and the development of NHGs would accomplish some of the aged population goals set up in the proposal presented in earlier sections. First, it would eliminate statutory rate setting. Rates should be determined by the market, rather than legislation, as much as possible. Qualifying individuals would purchase nursing home services from providers competing on both price and quality. Second, it would stop the practice of paying for empty beds (see also Section D below). Nursing homes would no longer have an incentive to operate with excess capacity since they would be paid by services provided. They would be more profitable by reducing unneeded capacity. In the current system, providers have incentives to add additional empty beds. This reform would dramatically reduce that overhead and, in the process, allow nursing homes to provide services at lower costs.

Third, it would eliminate other wasteful practices. Bankrupt facilities would no longer be bailed out because the state would no longer pay owners to continue operating them until new buyers are found. Bankrupt homes would seek protection from creditors through normal legal channels while continuing to provide services to patients. If it is unable to continue, the home would be shut down and insurance exchange firms will make new arrangements for their Medicaid customers. Allowing inefficient, poor quality homes to leave the market can only produce a more efficient, lower cost, higher quality system of providers. Reimbursement for depreciation and other costs would be eliminated and the incentives for homes to operate properly would be dramatically increased.

Fourth, the insurance exchange firms would solicit bids from low-cost community care and home health-care facilities. This would accomplish two things. First, it would serve as a source of competition for institutional care facilities and force price competition. Second, it would allow insurance exchange firms to lower their overall price to buyers since community and home health care providers often cost less. Finally, the introduction of competitive forces would increase quality of care and essentially allow for payment of outcomes. This would occur because insurance exchange firms would use quality of care when attempting to attract Medicaid buyers. They would almost certainly attempt to market the quality of their nursing home providers through various quality measures and statistics (bed sores, patient satisfaction, and so forth). Nursing homes would have a strong financial incentive to improve the quality of their care or risk not being solicited by insurance firms.

The state Medicaid program would undertake the operation of the insurance exchange, set minimum nursing home and elderly care standards and assist recipients in purchasing services by providing easy to understand information on the products being offered. In addition, the Medicaid program would retain the role of determining eligibility for nursing home coverage. Special care should be taken to ensure eligibility is restricted to those in need.

The Medicaid program would also establish the amount of the NHGs through their actuaries. This could be set annually at the lowest rate from the nursing home “insurers” for a specific geographic region such as a county or adjacent counties. Recipients would be free to purchase a broader package of services or a more costly nursing home from exchange providers in excess of the NHG with their or their families’ own funds.

A Note on the Disabled and Mentally Ill.

An alternative approach to reforming Medicaid is probably desirable for coverage of disabled and/or mentally ill individuals. Since coverage is related to medical conditions that may be fairly easy to make up or exaggerate there is a strong incentive for individuals (or the parents of a child) to engage in fraudulent presentation of their true medical condition. Unlike poor and near poor coverees, whose income and assets can be documented, this group of benefit recipients is much more likely to attempt to “game” the plan to obtain coverage. A grants system might backfire especially if unused funds were available for other purposes as outlined in the MBA proposal.

Additional resources should be made available to the appropriate state screening bureau (or create one if not currently available) to judge whether individuals are truly disabled. Savings from removing those on the rolls that are unqualified would serve as the funding source. In addition, given varying degrees of disabilities, the benefits package should be related to the level of the medical problem and the ability of the applicant to work. This could be accomplished by a sliding scale of benefits and premium costs depending on the severity of the health problem.

Because of the good possibility of gaming, a system of grants to this group is unwise. The best method for efficiently providing needed health care to this group is a managed care plan operated in each county. In order to deal with the possibility of adverse selection it is probably advisable to have only one managed care plan per county so as to remove “cherry picking” (adverse selection) of less disabled individuals by providers. The resulting higher costs from this “monopoly” could be partially or fully offset by allowing bidders in each county to “carve out” and offer a portion of the medical services. Separate providers could be allowed for mental illness, physical disability, substance abuse and so-forth. The comparative advantage of these various providers would serve to reduce costs and possibly increase the quality of service. Other states have had at least moderate cost benefits from carve outs.

Cost savings could be utilized in some cases with home health care services instead of a medical center due to reduced overhead. However, from above, a very efficient screening process for eligibility will be needed. For example, a disabled individual might resist applying for coverage if it implies residence in a nursing home but may opt to do so if eligible for home health care. This would have the effect of increasing costs since they were obviously able to get along without the

services anyway. To avoid the establishment of another monitoring bureaucracy the state Medicaid Program could contract with existing firms who document the truthfulness of submitted claims for such programs as Workmen's Compensation.

B. Statutory Rate Setting

Even if a broad-based market reform approach is not adopted, reform in long-term care is crucial if Ohioans want to avoid needless Medicaid spending. Statutory rate setting is one area where reform can be achieved through the state legislature. There are enough cost-increasing rigidities built into federal regulation of Medicaid without a state piling on more. Existing rate setting procedures are largely mandated by statute. This should change. Such statutes are too inflexible. They limit policymakers' ability to develop effective health care policy and cost taxpayers needlessly. Rates should be determined by the market, rather than legislation, as much as possible.

C. Empty Nursing Home Beds

A second step would be to stop subsidizing empty beds by including the cost of unused beds in the basis for setting rates. As a result of rewarding owners for keeping unused beds, occupancy has declined from 93 percent in 1994 to 87 percent in 1999. Ohio is paying for 13,000 empty nursing home beds and has enough beds to last until 2020 at current rates of utilization. The state did not mandate those beds be created and consequently should not be forced to pay for them.

D. Wasteful Reimbursement Practices

A third step would be to eliminate other wasteful practices. Stop bailing out facilities in bankruptcy by paying owners to continue operating them until new buyers are found. The state should intervene in bankruptcy only long enough to get acceptable new operators in place. Then it should force the old operators to pay for the costs of transition or prevent them from future involvement in long-term care if they cannot do so. If depreciation of property is allowed for purposes of rate setting, it should be allowed only once, instead of being repeated each time a new owner purchases unneeded beds.

E. Asset Test Enforcement

A fourth step would be to make sure asset tests for Medicaid long-term care eligibility work as intended by the General Assembly. Although currently legal, establishing Miller trusts to circumvent asset tests for Medicaid long-term care eligibility is an apparent abuse of legislative intent and is driving up costs. If Miller trusts are not what the General Assembly intended, the law should be changed. If existing trusts are what were intended, that should be clarified as well, by excluding trusts that reduce current income and setting clear income eligibility standards.

F. Community Care

A fifth step would be to give preference to community care (in a home or small facility) rather than institutional care. At a minimum, Ohio should eliminate the current bias towards institutional care. Where comparable services are more cost effective in the community, services should be provided there.

To appreciate the opportunities for reducing costs, consider that Oregon, Washington, and Wisconsin expanded home and community based care to help control rapidly increasing expenditures for institutional care. These states were able to provide services to more people with the available budget. Home and community based services helped control the growth in overall long-term care spending. For example, between 1982 and 1992 the combined number of beds in Oregon, Washington, and Wisconsin declined by 1.3 percent during a period when total nursing facility beds in the U.S. increased by 20.5 percent.[48]

G. Outcome-Based Payments

A sixth improvement would be to pay for outcomes, (i.e., quality of care and consumer satisfaction) instead of inputs, (i.e. beds, staff, etc.). To get results, a payment system should only pay for what is desired. Quality and satisfaction is what recipients and their families want. An index of indicators of quality of care should be constructed and used to distribute total funds. Three factors could be averaged to create the index. One third could be based on resolved complaints; one third could be based on customer satisfaction surveys of patients or their guardians; and one third could be based on such performance measures as changes in pressure sores (adjusted for acuity level of population), use of restraints, odors, food, etc.[49] The facility that was 50 percent better on this index than another facility would and should get a 50 percent larger share of payments (per patient, adjusted for acuity). Nothing will improve quality quicker than paying for quality instead of paying for inputs. Payment should never be made for inputs if a satisfactory outcome or proxy for an outcome exists.

Note that this recommendation is consistent with a recent report by the National Academy of Sciences, which recommended that all federal health programs pay providers based on objective assessments of quality for the treatment of 15 health conditions.[50]

6. Fraud, Waste, and Abuse

Fifteen years ago, opportunities for reducing fraud nationwide appeared to be much larger. But in the intervening years, activity in this area has been minimal. Efforts to eliminate fraud, waste, and abuse should be constantly reviewed to make sure they are up-to-date and cost-effective.

A. Fraud

Medicaid is especially vulnerable to fraud. It is a large program with a rapidly growing budget. It generates more than $1 billion in medical claims per year, nationwide. The General Accounting Office estimates that fraud and abuse may be a high as 10 percent of Medicaid spending.[51]

State Medicaid agencies have claims data and other medical information that could be used to identify fraud abuse, overuse and unnecessary care but rarely take advantage of this opportunity. Most abuse is identified through tips or other unreliable means. The numerous jurisdictions having responsibility in a fraud case confounds detecting and prosecuting fraud.

In addition to the little chance of being caught, the penalties for fraud have been traditionally light. Perpetrators are often plea-bargained or are subject to pretrial diversion where their court records are sealed if they abide by a court approved probation for a short period of time. Financial penalties tend to be very light even for providers who have billed into the millions. Over half of cases have had restitution of $5,000 or less, which the providers can easily pay. In instances where restitution is set at higher amounts only a small percentage of funds are usually recovered.

Further, those convicted of fraud are usually able to become involved in medical delivery in the same or somewhat different capacity. There apparently is little follow up to make sure these individuals are barred from participating in the health care system. A major problem is these individuals/groups relocate and become providers in new, unsuspecting states. Establishment of a state Medicaid provider information exchange would be useful.[52] The *que tam* provisions of current law that allow private citizens to obtain up to triple damages for any proven fraud, may also be of use.

It is helpful to review what is legally required to prosecute and convict a perpetrator. First, the activity has to be clearly illegal. Second, it has to be persistent. Third, it has to have significant impact. Aside from worker compensation-type fraud, very little recipient fraud exists. The difficulty of overcoming all three hurdles may explain why there are so few convictions. For example, in Texas, recipient fraud has exceeded 1 percent of claims only once. Provider fraud may be more prevalent, but tends to be committed by very transient, small groups moving from area to area and state to state, before routine audits identify them.

B. Abuse

With respect to fraud, there are clear legal standards to be met. The same is not true of abuse. All too frequently, “abuse” is defined as what someone finds offensive. For example, putting

stainless steel caps on the baby teeth of a child is abuse to some. But according to the Medicaid rules, it is not.

Medicaid rules are very complex and can be less than clear. (Remember the same kind of bureaucracy that develops income tax forms develops Medicaid rules and regulations.) One result is many providers are unsure about what exactly is required of them. The ensuing confusion and attendant publicity give rise to a popular conception that abuse is pervasive in Medicaid. However, Medicaid provider abuse is rarely proven, and should not be expected to generate significant savings.

C. Waste

The potential for reducing Medicaid costs through controlling waste is real and significant. Medical errors are more prevalent than anyone would like to admit, and the threat of tort liability makes it dangerous to be entirely candid when an error occurs. Some believe the reduction of errors may be the greatest opportunity for reducing health care costs.[53] As noted above, evidence-based evaluation systems should be developed, starting with those procedures that generate the most spending. Done properly, disease management and care coordination provide a simple way to reduce costs and improve quality of care that is acceptable to providers and patients alike. Major savings could be realized.

Also, as in the case of fraud detection, the introduction of MBAs would give Medicaid patients an economic incentive to detect and reduce some of the waste that occurs.

7. Administrative Savings

Another opportunity for saving is reduction of administrative costs. Any additional administrative spending should be cost justified individually. A number of possibilities are worth review.

A. Standardizing Insurance Codes

As discussed previously, standardization of insurance codes can generate significant savings, perhaps as much as 10 percent of existing costs. Given the current low level of administrative cost in Ohio, in certain areas, additional spending could result in better outcomes at lower cost.

B. Paying for Outcomes

Evidence-based evaluation systems focusing on outcomes could improve quality of care and then could be used to build payment systems based on desired outcomes, a fundamental shift from current Medicaid practice.

C. Making Medicaid the Payer of Last Resort

A third area where additional administrative spending is likely to prove beneficial involves setting up procedures to ensure Medicaid is indeed the payer of last resort. Systems or procedures should be developed to identify non-custodial parents with family incomes above allowable limits that do not provide insurance for their children when Medicaid is providing that insurance. Likewise, other private payment options for Medicaid recipients should be identified and utilized, whenever analysis suggests they will be cost effective. Public insurance such as Medicaid should always be a payer of last resort. Medicaid should only pay after workers compensation and liability insurance payments have been collected and efforts should be made to enforce this provision.

This is not an exhaustive list of possible ways to reduce the burden on taxpayers from Medicaid. Such a list is extensive and the Department is actively pursuing a number of other savings opportunities. Those efforts should be supported. Also, the State of Ohio's task will become much easier to the extent private insurers assume much of the responsibility for controlling costs. Buying beneficiaries into employer plans and enrolling them directly into private plans through the insurance exchange should help significantly in this regard.

8. Conclusion

There is an alternative to uncontrolled Medicaid growth. It is neither simple nor easy. The alternative is unsettling in many ways. It may require expanded eligibility for certain populations. It will require standing up to powerful interest groups. It will require a dedicated staff to make it work properly. The alternative will not stop Medicaid budget growth, but it can lower the rate of that growth. It will provide Ohio policymakers with significantly greater control over costs and health outcomes. It will introduce some of the efficiency of the marketplace into Ohio's health care programs. And patients and providers will be able to make more of their own decisions with less interference than presently.

Out-of-control increases in Medicaid costs are not inevitable. But if reforms are not made soon, the question in a few years will be: Why didn't Ohio policymakers take control of our destiny when the opportunity was there?

Appendix A
Estimated Cost Savings from Medicaid Reforms

Estimating cost savings from our suggested reforms is quite subjective since no previous attempt to dramatically reform Medicaid into a market-based system was possible until HIFA. Thus, the estimates for savings must be interpreted in the right context: They provide a general sense of the scope of potential savings that might be achieved using reasonable actuarial assumptions. Moreover, the estimates below assume that coverage is not significantly expanded. If Ohio expands coverage, we would expect the potential savings to be lower.

We estimate savings in the form of reduced spending on four population groups for whom reforms should influence behavior and expenditures. These include poverty level covered families, "near poor" covered families, those with disabilities and the elderly. Reductions in the cost of providing this coverage are based on assumed one-time changes and conservatively assume no long run change in behavior from the reforms. We recognize that it may take time for savings to materialize. On the other hand, our estimates may be too conservative. Thus, we presume gains in the current year from reforms.

A. Poverty Level and Near Poor Covered Families

Fiscal Year 2002 expenditures for hospitals, drugs, and physicians total approximately 20 percent of the recommended 2003 direct Medicaid appropriation of $7.5 billion, or approximately $1.5 billion for the Covered Families and Children (CFC) population of approximately 1 million people.[54] The introduction of Medicaid Benefits Accounts and the Medicaid Insurance Exchange should reduce utilization and insurance overhead substantially. The General Accounting Office estimates switching to Medicaid managed care plans provided reductions in the range of 5 to 15 percent.[55] Actuaries working with Medical Savings Account plans (MSAs) report first year reductions in utilization from fee-for-service plans in the range of 15 to 20 percent.[56] It seems reasonable that switching to MBAs would produce a similar reduction in expenditures. In addition, MBAs will be much cheaper to administer since they could essentially be done with a low cost debit card. The American Academy of Actuaries assumed a 13 percentage point reduction in insurance overhead by switching to MSAs.[57]

Insurer overhead should be additionally reduced by competition through the Medicaid insurance exchange, although quantifying this is difficult. In addition, a much smaller state Medicaid overhead will be needed with the grants program. If we assume reductions in utilization from switching to managed care, provider networks and MBAs, as well as lower state and provider overhead, a one-time reduction of 15 percent in the costs for these services could be accomplished. We assume no savings on the $400 million in existing expenditures on HMOs in order to be conservative. This produces savings of approximately $160 million.

The introduction of market-based reforms should produce savings from reduced utilization and overhead expenses for the near poor group of beneficiaries. The introduction of a sliding scale for the Medicaid premium subsidies provided to this group will produce further savings by limiting the

amount the State will spend on coverage and reducing the incentive to drop private insurance. Based on total increases in national enrollment from Medicaid expanded eligibility in the 1987 to 1996 period, and extrapolated to Ohio, we estimate approximately 200,000 "near poor" beneficiaries, or 20 percent of the CFC group. If we extrapolate this from the total cost of approximately $1.5 billion for hospitals, drugs, physicians, and HMOs we obtain a cost of approximately $300 million. This figure declines to approximately $260 million given the 15 percent reduction from above (that is, approximately 80 percent of the $300 million in this group will experience a savings of 15 percent, with the remaining 20 percent in HMOs experiencing no change in spending).

Since the proportion of beneficiaries is likely to be higher the nearer the income to the poverty level, we assume an average coverage of 33 percent above poverty (as opposed to an average of 50 percent). Using a linear sliding scale on costs (ranging from a 100 percent Medicaid grant at poverty to a 0 percent grant at an income of 133 percent of poverty) we presume average grant payments equal to two-thirds of full coverage. This ignores the fact that the availability of the Medicaid buy-in to private firms at reduced rates will induce some firms in the small group market to offer coverage or offer it at a reduced rate to encourage employees to obtain coverage there. The total reduction from the sliding grant program would be approximately $90 million. Total savings for Covered Families and Children: Approximately $250 Million in SFY 2003, or 16 percent.

B. People with Disabilities and Elderly Beneficiaries

Expenditures in 2003 for Nursing, ICFs, and other services for the disabled and elderly population (about 400,000) total approximately $6 billion. We have documented that "carving out" various aspects of disability coverage and expanding home health care services produces some cost savings. The state of Oregon was able to save approximately 17 percent with expanded home health and community based services while Wisconsin was able to reduce costs by approximately 16 percent.[58] Colorado, Iowa, Washington, and Massachusetts were all able to significantly lower disability expenditures with "carve out" programs, although the net savings were much lower because of reinvestment in expanded alternative disability services.[59] The net savings in Colorado was approximately 13 percent. Given these findings, it is reasonable to presume implementation of these types of reform could produce savings in the range of 14-15 percent. Total savings for Aged, Blind and Disabled: Approximately $850 Million in SFY 2002.

Thus, it is possible to produce estimated year 2003 savings of approximately $1.1 billion. If this is extrapolated to total Ohio Medicaid Spending (Medicaid plus other agencies) of approximately $10 billion the dollar savings are around $1.5 billion. Estimated savings in out years are obtained by extrapolating reduced baseline figures from above assuming 2 percent general inflation and growth in Medicaid spending per covered individual at an assumed rate of general medical inflation of 5 percent (medical inflation has been 3 percent above the general inflation rate for the last 20 years).[60] We believe it is reasonable to assume long run private-sector inflation for Medicaid given the market reforms we have suggested. In addition, an adjustment for Ohio's aging population of 1.5 percent assuming implemented reforms gives total reform Medicaid spending growth of 6.5 percent

annually. If there are no reforms, we forecast actual baseline plus Ohio's historical Medicaid growth above inflation of 5.7 percent to get the following projection for a total rate of 7.7 percent. (See table A-1.)

Table A-1
Estimate of Future Medicaid Spending
(in $ billions)

	2003	2012	2025
Current trends-no changes	**10.0**	**19.5**	**51.1**
Spending with suggested reforms	**8.5**	**15.0**	**34.0**
Cumulative Savings	**1.5**	**28.1**	**159.6**

Source: Calculations by Michael T. Bond.

The Ohio portion of Medicaid (not including other agencies) is currently around 17 percent of the General Revenue Fund. Given no Medicaid reforms and the state budget growing at a historical rate of 4 percent above CPI (a relationship that has held over the last 20 years), Medicaid will be around 24 percent of GRF by 2025. If Ohio spending grows at 2 percent above inflation, Medicaid will be around 36 percent of the budget without reforms. With reforms and assumed savings, Medicaid will be approximately 16 percent of 2025 state spending given spending at 4 percent above inflation. If state spending grows at 2 percent above inflation Medicaid will be approximately 25 percent of budget that year. If state spending grows at its historical rate of 4 percent above inflation the Medicaid plan after reform becomes sustainable in that it remains essentially the same percentage of the budget.

End Notes

[1] When combined with other programs spending to provide health insurance to low-income individuals and families totals nearly $10 billion. For a detailed list of Ohio Medicaid spending, see The Medical Care Advisory Committee of the Ohio Department of Job and Family Services, "Ohio's Medicaid Plan: Acute Services," testimony before the House Select Committee on Medicaid Reform, Ohio House of Representatives, September 18, 2002.

[2] Can other projections be made? Certainly. Recent testimony at hearings of an Ohio House Subcommittee on Medicaid included projections of rising health care costs until 2025, with assumptions based on census changes and continuation of current medical costs. See John R. Corlett, Federation for Community Planning, Testimony before the House Select Committee on Medicaid Reform, Ohio House of Representatives, October 16, 2002. That projection estimated a range of Medicaid spending from $20 to $40 billion by 2025, if no new cost containment occurs. As sobering as such estimates may be, they generally prove to be low because of at least two factors that cannot be predicted well in advance. The largest of these factors is medical cost, which is cyclical and heavily influenced by technology — a factor that is not susceptible to long run forecasting. Second is entitlement growth, which is heavily dependent on economic cycles and changes in eligibility, which are also not easily susceptible to long run forecasting.

[3] Caseload changes reflect changing economic conditions and usually lag the economy. Since existing caseloads already exceed projections, the relevant questions are "How much increase will occur?" and "When will it stop?" The ODJFS's existing projections were based on stable caseload populations that had existed for some time when the Department developed its budget. The Department did an exceptional job to project as well as it did. The error was predicting when conditions would improve - which is the most difficult of all economic projections. (For reference, compare the magnitude of other states' Medicaid shortfalls.) Until the economy improves significantly, continued double-digit caseload growth can be expected. Unless other changes are made, the caseload will stabilize only after the economy improves and stabilizes. Until then it seems reasonable to expect at least one more year of current economic conditions, remembering that Medicaid caseload will lag economic changes.

[4] Bradley C. Strunk, Paul B. Ginsburg and Jon R. Gabel, "Tracking Health Care Costs: Growth Accelerates Again In 2001," *Health Affairs* (Web Exclusive) Vol. 21, No. 6 (November/December 2002).

[5] Bradley C. Strunk, Paul B. Ginsburg and Jon R. Gabel, "Tracking Health Care Costs: Hospital Spending Spurs Double-Digit Increase in 2001," Center for Studying Health System Change, *Data Bulletin No. 22*, September 2002.

[6] *The Fiscal Survey of States*, National Governors Association and National Association of State Budget Officers, November 2002.

[7] Although Ohio Medicaid inflation rates have risen rapidly, they currently are between 6 and 7 percent. Nevertheless, it is a distinct possibility that low double-digit Medicaid cost projections could prove to be very conservative. The history of previous cycles provides a strong argument in favor of expecting double-digit spending increases to continue for at least four more years. The Department is moving to contain health care costs, but inflation is difficult to control under prospective Medicaid rate setting, once general health care spending has begun to inflate the existing spending base rapidly.

[8] The expansion of benefits allows for a controlled experiment on the impact of Medicaid on beneficiary behavior. The major work in this area is from the National Bureau of Economic Research (NBER). NBER researchers related the expanded generosity of Medicaid plans to the household wealth of recipients. They found that Medicaid lowered wealth holdings of eligible groups by $1,996 to $2,259 in 1993. They also found the existence of asset tests, not surprisingly, more than doubled the wealth reduction from expanded Medicaid eligibility. NBER also found the expanded generosity and eligibility for Medicaid increased the consumption of this group by 5.2 percent. See, Jonathan Gruber and Aaron Yelowitz., "Public Health Insurance and Private Savings," National Bureau of Economic Research, *NBER Working Paper No. #6041*, May 1997.

[9] See David M. Cutler and Jonathan Gruber, "Does Public Insurance Crowd Out Private Insurance," National Bureau of Economic Research, *NBER Working Paper No. #5082*, April 1995.

[10] Janet Currie and Jonathan Gruber, "Health Insurance Eligibility, Utilization of Medical Care, and Child Health," National Bureau of Economic Research, *NBER Working Paper No. w5052*, March 1995.

[11] "Learning From SCHIP and Learning From SCHIP II," Agency for Health Care Policy Research, June 1998.

[12] Laura-Mae Baldwin et al., "The Effect of Expanding Medicaid Prenatal Services on Birth Outcomes," *American Journal of Public Health*, Vol. 88, No. 11 (November 1998), pp. 1623-1629.

[13] See Janet Currie, Jonathan Gruber, "Saving Babies: The Efficacy and Cost of Recent Expansions of Medicaid Eligibility for Pregnant Women," National Bureau of Economic Research, *NBER Working Paper Series #4644*, February 1994.

[14] *HIFA: Will it Solve the Problem of the Uninsured*, National Health Law Program, HIFA Talking Points, February 28, 2002.

[15] *The Fiscal Survey of States*, National Governors Association and National Association of State Budget Officers, November 2002.

[16] Robert Pear, "States are Facing Big Fiscal Crises, Governors Report," *The New York Times*, November 26, 2002.

[17] "Preliminary State Budget and Tax Actions Report 2002," National Conference of State Legislatures, October 11, 2002.

[18] American Health Line, November 26, 2002.

[19] Vernon Smith, et al., "Medicaid Spending Growth: Results from a 2002 Survey," Kaiser Commission on Medicaid and the Uninsured, *Report #4064*, September 2002.

[20] In general, optional populations include children in families with income above federal minimums, adults with children with income above Section 1931 minimums (see below), people with disabilities and elderly with income above Supplemental Security Income (SSI) levels receiving home and community based services, certain workers with disabilities whose incomes are above SSI levels, elderly nursing home residents with income above SSI levels, pregnant women with incomes above 133 percent of poverty, and the medically needy. Two recent federal changes have expanded the options available to states for covering low-income parents under Medicaid. First, the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) created a new category of Medicaid eligibility in Section 1931 of the Social Security Act by requiring states to grant such eligibility to those adults and children who would have been entitled to AFDC under the income and resource standards in effect on July 16, 1996. Additionally, Section 1931 gives states the option to use less restrictive income and resource standards in determining eligibility, allowing states to make families that meet the categorical requirement under the old AFDC program eligible for Medicaid at the higher incomes. Income eligibility to receive SSI is defined as a) working and having an income less than $1,085 per month per person or $1,587 per month per couple or b) not working and having an income less than $520 per month per person or $771 per month per couple, provided other eligibility criteria are met. Medically Needy programs provide services to those persons whose income levels are greater than eligibility levels under TANF or one of the Medical Assistance Only (MAO) program for children and pregnant women but is not enough to cover their medical expenses. The coverage limits of service to Medically Needy persons are the same as for Medicaid.

[21] Examples of long-term care optional benefits include Intermediate Care Facilities — Mental Retardation (ICF-MR), inpatient and nursing facilities for individuals over age 65 in an institution for mental disease, home health care, case management, respiratory care for ventilator-dependent individuals, personal care, private duty nursing, hospice, Programs of All-Inclusive Care for the Elderly (PACE) and home and community based services. However, under Early Periodic Screening Diagnosis and Treatment (EPSDT) rules, all of these optional services must be provided to children when shown to be needed based on a screening. See Kaiser Commission on Medicaid and the Uninsured, June 2001.

See "Medicaid 'Mandatory' and 'Optional' Eligibility and Benefits," Kaiser Commission on Medicaid and the Uninsured, *Policy Brief #2256*, July 2001. Also see John Holahan, "Restructuring Medicaid Financing: Implications for the NGA Proposal," Kaiser Commission on Medicaid and the Uninsured, *Policy Brief #2257*, June 2001.

[22] The Medical Care Advisory Committee of the Ohio Department of Job and Family Services, "Ohio's Medicaid Plan: Acute Services," testimony before the House Select Committee on Medicaid Reform, Ohio House of Representatives, September 18, 2002.

[23] Frank Lichtenberg, "Pharmaceutical Innovation, Mortality Reduction and Economic Growth," National Bureau of Economic Research, *NBER Working Paper W6569*, May 1998.

[24] *Mental Health: A Report of the Surgeon General* (Rockville, MD: U.S. Department of Health and Human Services, 1999).

[25] The Medical Care Advisory Committee of the Ohio Department of Job and Family Services, "Ohio's Medicaid Plan: Acute Services," testimony before the House Select Committee on Medicaid Reform, Ohio House of Representatives, September 18, 2002.

[26] In August 2001, under authority granted by Congress, the Centers for Medicare and Medicaid Services (CMS), formerly known as the Health Care Financing Administration (HCFA), announced the Health Insurance Flexibility and Accountability (HIFA) Demonstration Initiative.

[27] Budget neutrality requires that, according to the assumptions and definitions used in the HIFA waiver request, the projected costs equal the projected savings over the life of the demonstration project.

[28] The Utah model limits enrollment until program evaluations can be completed to determine the effect of the waiver on a number of factors such as emergency room use.

[29] Determining the tradeoffs between expanded eligibility and service limitations is a function of elected officials, (unless they properly delegate the determination to others).

[30] The eligibility and service modifications would be subject to adjustment by the Ohio Department of Job and Family Services to achieve budget neutrality. Existing services for persons who are provided services under optional Medicaid coverage, as well as those who would be added under the HIFA waiver, would receive benefits that would be sufficiently limited in scope compared to existing services to offset the additional costs due to additional persons becoming eligible. Department analysis would identify the precise level and scope of these adjustments.

[31] In either case, the state should phase in one group, evaluate the outcome, and, if successful, proceed to the next group.

[32] Currently 52 percent of the uninsured in Ohio have an income under 150 percent of the federal poverty level.

[33] Related to this is that smaller firms could purchase coverage through the state operated pool. This has been the case in Arizona. See *Arizona Medicaid: Competition Among Managed Care Plans Lowers Program Costs,* General Accounting Office, October 1995.

[34]The Federal Employees Health Benefits Program (FEHBP) has four main features: (1) federal employees in most places can choose among eight to 12 competing health insurance plans, including Blue Cross and a number of HMOs; (2) the government contributes a fixed amount that can be as much as 75 percent of each employee's premium; (3) the extra cost of more expensive plans must be paid by the employee with after tax dollars, and (4) the plans are forced to community rate, charging the same premium for every enrollee. Public employee health benefit options in the state of Minnesota are similarly organized, as is the California Public Employees' Retirement System (CalPERS).

[35] This is crucial for favorable health outcomes given some evidence that "poor" families had substandard results when given high deductible coverage. See B. Lyke, "Medical Savings Accounts: Background Issues," Congressional Research Service, May 6, 1996.

[36] See Ronald E. Bachman, "Giving Patients More Control," National Center for Policy Analysis, *Brief Analysis No. 399*, June 17, 2002; and Greg Scandlen, "Defined Contribution Health Insurance," National Center for Policy Analysis, *Policy Backgrounder No. 154*, October 26, 2002.

[37] An example of the possible magnitude is shown by a study in Employee Benefit News (08/02) that estimates that the cost of poor quality health care services is $1,350 per employee. If even a fraction of that figure can be saved per Medicaid recipient, hundreds of millions or billions of dollars in taxes can be saved. See Craig Gunsauley, "Estimate: 30% of Health Spending is Wasted," *Employee Benefit News*, Vol. 16, No. 10, August 1, 2002.

[38] "In health care markets, geography is destiny," concluded a 1996 report from Dartmouth Medical School's Center for the Evaluation Clinical sciences. For example 1.4 percent of elderly women in Rapid City, South Dakota received breast-conserving surgery from breast cancer. In Elyria, Ohio, 48 percent did. An elderly patient with back pain in Fort Meyers, Florida, was four times as likely to undergo surgery as a man or woman living in Manhattan. And a man with an enlarged prostate in Newark, New Jersey was twice as likely to get apart of his gland surgically removed as if he lived in New Haven, Connecticut. Tonsillectomies provide another example, particularly over time. In the 1950's, children of insured workers had a 50-50 chance of having their tonsils removed, despite an exhaustive review of the medical literature up to that time finding no evidence that a tonsillectomy accomplished its purposes. Today, tonsillectomy is still the surgical procedure most likely to be performed inappropriately. But now, only one in four is unneeded. An 1980 article calculated that the United States could have saved $4.2 billion in 1975 dollars if the rate at which seven common surgical procedures were performed more closely resembled the low-usage parts of Maine and Vermont rather than the high usage rate. John E. Wennberg et al., "Dartmouth Atlas of Health Care," Center for Evaluative Clincial Sciences, Dartmouth Medical School, 1996.

[39] One hospital study showed treatment caused complications in one out of five patients, and about 7 percent of the complications were fatal. As many as eight out of ten medical practices have never been scientifically validated. See Elihu Schimmel, "The Hazards of Hospitalization," *Annals of Internal Medicine*, Vol. 60 (January 1964), pp. 100-110.

[40] The National Academy of Sciences recommends all federal health programs begin paying for quality care rather than paying for services rendered. Initially, the effort would focus on the treatment of 15 health conditions, including diabetes, depression, osteoporosis, asthma, heart disease and stroke. See Janet M. Corrigan, Jill Eden and Barbara M. Smith (Eds.), *Leadership by Example*: *Coordinating Government Roles in Improving Health Care Quality* (National Academies Press:, D.C., 2002).

[41] Moving in the direction of provider networks, as the Department is already doing, can also facilitate care coordination in areas that may currently be underserved.

[42] Insurers generally accept the diagnostic codes developed by the federal government. However, each insurer tends to use a different set of administrative codes.

[43] It should be recognized that utilizing a HIFA waiver does not preclude the use of other cost-cutting opportunities.

[44] *Supplemental Security Income: Action Needed On Long-Standing Problems Affecting Program Integrity*, September 14, 1998, GAO/HEHS- 98 -158

[45] See *Medicaid Managed Care: Four States Experiences with Mental Health Carve Out Programs*, General Accounting Office, September 1999.

[46] Under current law, nursing home spending will increase automatically by 9.6 percent in fiscal year 2002 and 7.5 percent in fiscal year 2003, adding $400 million to Medicaid spending.

[47] Miller trusts are set up to allow individuals who have too much income to be eligible for Medicaid to receive care by putting their income into a trust that limits their income to allowable levels, providing other requirements are met. If state legislators want this loophole, they should clarify their intent.

[48] See *Medicaid Long-Term Care: Successful State Efforts to Expand Home Services While Limiting Costs*, General Accounting Office, August 1994.

[49] All payment systems are subject to manipulation, but using these three factors would make manipulation of all the components more expensive than improving quality. At the same time the administrative burden would not have to be too large.

[50] Janet M. Corrigan, Jill Eden and Barbara M. Smith (Eds.), *Leadership by Example: Coordinating Government Roles in Improving Health Care Quality*, (National Academies Press: Washington, D.C., 2002).

[51] Leslie G. Aronovitz, *Medicaid Fraud and Abuse: Stronger Action Needed to Remove Excluded Providers from Federal Health Programs*, United States General Accounting Office,GAO/HEHS-97-63, March 1997.

[52] See Sarah F. Jaggar, *Medicare and Medicaid: Opportunities to Save Program Dollars by Reducing Fraud and Abuse*, United States General Accounting Office, GAO/T-HEHS-95-110, March 22, 1995.

[53] Michael L. Millenson, *Demanding Medical Excellence: Doctors and Accountability in the Information Age* (University of Chicago Press: Chicago: Chicago, IL., 1997).

[54] Office of Ohio Health Plans "Spending Summary, Executive Budget for FY 2002 and 2003" Ohio Department of Job and Family Services, and Office of Ohio Health Plans, "Ohio Medicaid Report," Office of Ohio Health Plans, April 2002.

[55]James R. Cantwell, "Reforming Medicaid," National Center for Policy Analysis, *Policy Report No. 197*, August 1995.

[56] Mark Litow, *Examining Medical Savings Accounts with Guaranteed Issue, Community Rating and Risk Pools*, Milliman & Robertson, December 1994.

[57] Edwin C. Hustead, et al. (Medical Savings Account Work Group, American Academy of Actuaries), "Medical Savings Accounts: Cost Implications and Design Issues," American Academy of Actuaries, *Public Policy Monograph*, May 1995.

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[59] *Medicaid Managed Care: Four States Experiences with Mental Health Carveout Programs*, U. S. General Accounting Office, GAO/HEHS-99-118, September 1999.

[60] For an explanation medical inflation compared to consumer items, see *Medical Care Inflation Continues to Rise*, Bureau of Labor Statistics, U.S. Department of Labor, May 29, 2001.

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