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Florida and South Carolina: Two Serious Efforts to Improve Medicaid

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States are not waiting for Congress to reform Medicaid. Many are taking it upon themselves, using existing options, to improve and bring stability to their Medicaid programs. Two states have taken the lead in this effort: Florida and South Carolina are pursuing federal waivers so that they can bring the principles of choice, individual control, and competition into Medicaid. Their experiences have the potential to bring much needed change and innovation into the Medicaid program.

Learning from the successful state-based approach to welfare reform, Congress should encourage states' efforts to reform Medicaid and provide broader flexibility to states that seek to experiment with innovative changes. More importantly, other states should recognize the promising common features of Florida's and South Carolina's proposals and use them as a basis for reform of their own Medicaid programs.

The Case for Change. In Florida, the Medicaid program covers 2 million people. The cost of the program has grown 13 percent per year, on average, over the past six years. Twenty-four percent of the state's budget will fund the Medicaid program in 2005. By 2015, Medicaid will consume nearly 60 percent of the state's budget.

In South Carolina, almost 20 percent of the population is on Medicaid, including 40 percent of children and 30 percent of seniors. About half of all births in the state are paid for by Medicaid. Medicaid expenditures are growing in every enrollee category. Nineteen percent of the state's budget will fund Medicaid in 2005. By 2010, Medicaid is expected to consume 24 percent of the state's budget.

These trends are unsustainable. To hold down costs, states have traditionally used techniques like cutting provider reimbursements, limiting access to prescription drugs, scaling back benefit packages, and cutting eligibility.

The existing federal waiver process gives states the opportunity to move beyond that sort of tinkering and test new policy concepts. Many states have already received waivers for limited experiments. Florida and South Carolina are now taking the next step: incorporating proven free market strategies to stabilize and improve their Medicaid programs over the long term.

The Principles for Change. In the Florida and South Carolina reform plans, three basic principles form a common basis:

- *Competition*. The current Medicaid program relies on price controls that are completely isolated from competitive market forces. The states' proposals aim to inject a dose of competition into Medicaid by encouraging private plans and networks to compete for Medicaid enrollees. To

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attract enrollees, these plans will have to design benefits packages that appeal to enrollees.

- *Choice.* Today, enrollees depend on a Medicaid bureaucracy that micro-manages and imposes arbitrary limitations that directly impact and limit enrollees' access to care. Under the states' innovative proposals, enrollees would select from a variety of packages that are aimed at their individual health care needs. With the proper informational tools and funding, enrollees will be able to choose the plans that are best for them.
- *Stability.* One of the biggest problems facing state Medicaid programs is the unsustainability of their current growth rates. A contributing factor to this problem is the lack of predictability in expenditures. In a traditional fee-for-service system, the state pays for Medicaid services after services are performed. In contrast, the Florida and South Carolina plans will provide annual Medicaid contributions to individuals, and so the states will face more predictable expenditures.

Similar features can be found in the Federal Employee Health Benefit Plan (FEHBP). Federal workers receive a defined contribution from the government and are able to select from a menu of competing private plans. Besides maintaining high satisfaction among participants, the FEHBP has proven to be far superior to other government programs, such as Medicare, the Veterans Administration's health system, and Medicaid, in adapting to medical advancements and innovations. Moreover, even with an aging population, the FEHBP defined-contribution structure has outperformed private employer based coverage in keeping down cost increases.

Key Steps for Change. While the two states' proposals differ in some ways, they also share several similar features. These features are intended to spur competition, give Medicaid enrollees choice, and bring fiscal stability to the programs. Specifically, both plans are designed to:

- *Establish a fair and equitable financing system.* Historically, Medicaid has paid for services on a fee-for-service basis. This means providers are paid after the service is delivered. Fee-for-service exposes the program to fraud and abuse and does little to promote good care management. Fee-for-service programs may be efficient administrative payers, but they fall short in focusing on whether enrollees are getting the care that is best for them.

  Florida and South Carolina aim to fix this outdated system by providing each enrollee with a defined contribution. With defined contributions, the states will be able to adequately finance enrollees' health care based on need, while making the budget more predictable. Both states have developed processes to determine that the size of defined contribution based on several criteria, including health status. A disabled enrollee, for example, may receive a larger contribution than a healthy child. In this way, the defined contributions will better reflect individual differences in service utilization and need.

  Under both states' proposals, the enrollee will use the defined contribution from the state to select and purchase the plan that best serves his or her needs. If an enrollee is later diagnosed with an illness, the plan would have to provide for the necessary care, just as with other health insurance plans, and the state could adjust enrollee allotment accordingly. Florida also divides the premium, for administrative purposes, into comprehensive and catastrophic care components to further tailor the contribution. With this approach, enrollees would receive funding commensurate with their needs and plans would face the proper incentives to take on enrollees with chronic conditions because they will be compensated accordingly.
- *Enhance and improve coverage options.* Medicaid is notorious for promising more than it can deliver. While, on paper, Medicaid services seem to be very generous, the reality is far different. All too often, Medicaid enrollees face direct rationing of access to care and services imposed on them by the Medicaid bureaucracy.

  In both Florida and South Carolina, enrollees would select from a menu of competing state-approved options, such as managed care plans, preferred provider organizations, and provider-based networks. Alternatively, an enrollee could choose to use his or her defined contribution to

participate in coverage obtained through the workplace. South Carolina also plans to allow certain enrollees, qualified by the state, to choose a self-directed option that would be similar to a Health Savings Account arrangement.

Both proposals aim to give participating plans the flexibility to design benefit packages that are tailored to meet individual Medicaid enrollees' needs. Participating plans must meet the states' standards in a variety of areas, including actuarial equivalence. However, the specific combination of services in a benefits package would be left up to the plan. For instance, a plan wanting to focus on children's care could create a benefits package that focuses on prevention, including immunizations and regular check ups. A plan may want to focus on the needs of enrollees with HIV; access to innovative drug therapies may be an important feature of that benefits package. Instead of facing a one-size-fits-all model with layers of blanket restrictions, enrollees would be able to choose the benefits packages that best suit their individual needs.

- *Educate and engage enrollees.* There is little care management in today's Medicaid program. Medicaid's combination of post-service payment and one-size-fits-all benefits does not encourage individualized care management.

  Florida and South Carolina aim to make their Medicaid programs more attentive to individual enrollees' comprehensive needs. To accomplish this, both states will rely on enrollee education. Under both proposals, enrollees would meet with counselors to help them assess their needs and select the plan that is best suited for them. After an enrollee chooses a plan, that plan has a strong incentive to engage the enrollee in his or her health care. For example, a plan that caters to diabetic enrollees could save money by monitoring the enrollee's compliance with routine health maintenance and may even provide assistance by, for example, scheduling meetings with dieticians.

  Both proposals would also create incentives to encourage enrollees to focus on their health. In South Carolina, enrollees could use any excess of their defined contributions to purchase additional services. In Florida, the state will create accounts for enrollees, who could earn contributions to those accounts for good health practices, such as participating in a smoking cessation program. As in South Carolina, these funds could be used to purchase additional services. By engaging the enrollee at every level, these plans create a greater incentive for the enrollee to be a more active participant in his or her overall care and health.

Conclusion. As policymakers concluded during the welfare reform revolution, state experimentation is critical to fostering much-needed structural change. The status quo in Medicaid is simply unsustainable for the states and the federal government. By focusing on the principles of competition, choice, and fiscal stability, Florida and South Carolina aim to change the course of the program for the better.

Congress should provide broader flexibility to states while still ensuring that clear benchmarks and performance measure are met. States, in turn, should build on the concepts in the Florida and South Carolina proposals and work to integrate market-based ideas into the Medicaid program.

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