MEDICAID REFORM

A PRELIMINARY REPORT

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Medicaid is the nation's largest health care program, providing health and long term care services to 53 million low-income pregnant women, children, individuals with disabilities and seniors. It is a vital health care safety net and provides important services to those who can get care from no other source. Medicaid coverage has also played a critical role in reducing the number of the uninsured, currently estimated at 45 million nationwide.

Medicaid spending, however, has increased dramatically over the last five years driven by a 40 percent increase in caseload and a 4.5 percent per year increase in the health care price index, strengthening the impetus for reform. Comprehensive Medicaid reform must focus both on reforming Medicaid and on slowing both the number of low-income individuals and elderly becoming eligible for Medicaid. Medicaid will always have an important role as the health care safety net, but other forms of health care coverage must be strengthened to ensure Medicaid's financial sustainability. Enhancing the quality of care and containing costs are also critically important. Governors believe that Medicaid reform must be driven by good public policy and not by the federal budget process.

The Vision

The policies that are outlined in this paper do not represent comprehensive health care reform. However, the scope is wider than the existing Medicaid program as it focuses both on populations that may become Medicaid eligible, as well as some of the underlying cost drivers in the overall health care system. In this sense it can be viewed as Medicaid plus health care reform. The various policies that are recommended are linked by a number of themes that underline this reform package. First, there are a number of incentives and penalties for individuals to take more responsibility for their health care. Second, moving to a more flexible benefit package for non elderly, non disabled Medicaid populations as well as for individuals who gain access through the individual health care tax credit will reduce costs while increasing total access. Third, the creation of state purchasing pools, that would use the combined leverage of public programs (offering a common S-CHIP-type benefit package) and individuals using the health care tax credit should strengthen the ability of small purchasers to gain more competitive rates in the health care marketplace. Fourth, technology and other state innovations are focused on reducing the long-run costs. Fifth, there are a number of policies designed to reduce reliance on Medicaid coverage. Finally, the paper includes a number of potential short-run policy changes as well as long-run structural changes that will improve the US health care system.

Specific health care policies are organized around these five objectives:

1. Reforming Medicaid
2. Enhancing Quality and Reducing Costs in the Overall Health Care System
3. Strengthening Employer-Based and Other Forms of Private Health Care Coverage
4. Slowing the Growth of Medicaid Long-Term Care
5. State Contribution to the Medicare Drug Benefit

1. Reforming Medicaid

Medicaid now covers 53 million Americans and the program is expected to spend a total of $329 billion in combined state and federal funds in 2005. While the Medicaid program is extremely cost effective compared to private sector health care, the existing program structure is inflexible and the benefits are not necessarily consistent with the needs of the various populations. This

paper focuses on both short-run flexibilities that could help states realize incremental savings and a major restructuring that would be necessary to make the program sustainable over the long-run.

Long Term Restructuring

Although Medicaid is the largest health care program in the nation, generalizations about the program are difficult to make, because it operates so differently in each of the states and territories. In addition, Medicaid is even more complicated than 56 different programs, because within each state, Medicaid plays a number of very distinct roles while serving a number of very distinct populations.

Medicaid essentially has three major functions:

- It provides comprehensive primary and acute care coverage for everyone who is eligible for the program (low income children, parents, seniors, and people with disabilities);
- Some Medicaid beneficiaries also qualify for comprehensive long term care services, depending on their needs; and
- Medicaid also helps finance services for people with chronic and disabling conditions such as HIV/AIDS, severe mental illness, and MR/DD. Each of these populations relies on Medicaid for support that they cannot receive elsewhere, and Medicaid restructuring must consider their unique needs and circumstances.

Although Medicaid does serve these three major roles, it also serves other functions such as a source of funding for uncompensated care in hospitals, and as a supplement to Medicare for low-income beneficiaries for whom it pays cost sharing and wraps around for various services in addition to long-term care.

Medicaid is serving many roles in the health care system. All of these roles could be improved upon by a greater focus on wellness and health promotion as opposed to simply "sick-care" treatment. These goals can be achieved by relying more heavily on care management and coordination.

- For low-income, but relatively healthy individuals who rely on Medicaid as a health insurance product, Medicaid should be transformed into a more mainstreamed, S-CHIP type program that could be coordinated with state and federal tax credits.
- For individuals with disabilities who have no other recourse than to rely on Medicaid, reforms should encourage more consumer choice and benefit packages that improve the quality of their care where possible, but not jeopardize their stability of care.
- A new national dialogue is needed to confront the issues of an aging population and the potential sources of funding for end-of-life care. The easiest solution may be to incorporate long-term care services into Medicare, but an alternative approach could be to link long-term care funding to Social Security, or broader pension reforms or other changes to solidify the link between personal responsibility and end-of-life care.

What is clear is that Medicaid can no longer be the financing mechanism for the nation's long-term care costs and other costs for the dual eligibles. Approximately six million Americans are dually eligible for full Medicare and Medicaid benefits, and another one million receive financial assistance to cover out-of-pocket costs, such as co-payments and deductibles. These individuals represent a small portion of Medicaid's 53 million person caseload, and despite the fact that they are fully insured by Medicare, they still consume 42 percent of all Medicaid expenditures.

Compared to other Medicare beneficiaries, dual eligibles are sicker, poorer, more likely to have chronic health conditions, and at higher risk for institutional care.

The details of this restructuring, however, are beyond the scope of this paper. The nation's Governors will continue to work on this issue and will be providing further detail.

Short-Run Flexibilities

A. Prescription Drug Improvements – States and the federal government have long suspected that Medicaid overpays for prescription drugs. The President's budget proposes to set federal ceilings on the prices that states pay for prescription drugs. The proposal would change the current system, whereby states purchase drugs based on the Average Wholesale Price (AWP). States have long been concerned that manufacturers have been inflating this number and that Medicaid has therefore been overpaying for drugs for many years. The President's proposal would establish a new price target for states, the Average Sales Price (ASP) that would be defined by law, subject to Federal audit, and lower than AWP. States would be allowed to reimburse pharmacies no more than ASP plus six percent (to account for dispensing fees and other costs) for all generic and brand name drugs.

Governors believe that the burden of reducing Medicaid expenditures for prescription drugs will require a multi-prong approach and should include savings proposals that affect both drug manufacturers and retail pharmacists, as well as increase state utilization management tools that decrease inappropriate prescribing and utilization. It is critical that states maintain and enhance their ability to negotiate the best possible prices with the industry.

There may be benefits of using ASP or other calculations as a reference price, because increased transparency of drug costs can serve to decrease total costs, especially if there is more flexibility with respect to dispensing fees (they should not be tied to a percentage of the cost of the drug dispensed, for example.)

This proposal should be modified in several ways:

- *Increasing the minimum rebates that states collect on brand name and generic prescription drugs to ensure lower total costs that would not solely impact pharmacists nor create disincentives to provide generic drugs where appropriate. Medicaid's "Best Price" provision should not be eliminated in exchange for this;*
- *Requiring that "authorized generics" be included in the Medicaid rebate calculations. An authorized generic is a brand product in different packaging that some manufacturers distribute through a subsidiary or third party at the same time that a true generic is launched by a generic manufacturer. This product is essentially a brand product at a cheaper price, but it violates the Hatch-Waxman 180 day exclusivity protection for generic manufacturers, and because CMS does not include these products in the Medicaid rebate calculations, it results in hundreds of millions of dollars in lost revenue for state Medicaid programs.;*
- *Forcing discounts on the front end of drug purchases rather than waiting an average of six months (not including dispute time) to receive rebates;*
- *Using closed formularies to drive beneficiary utilization and decrease costs similar to those that will be used by Medicare Part D plans;*
- *Giving states additional tools such as tiered co-pay structures to encourage greater utilization of generic drugs;*

- *Enacting stronger sanctions (including criminal penalties) for companies and individuals that fail to accurately report ASP (or whatever new methodology is adopted);*
- *Allowing states to join multi-state purchasing pools and to combine Medicaid with other state-funded health care programs to improve leverage; and*
- *Allowing managed care organizations to access Medicaid rebates directly for the Medicaid populations that they serve.*

B. Asset Policy –
Asset Transfers. There is concern that many individuals are utilizing Medicaid estate planners in order to shelter assets and therefore qualify for Medicaid funded long term care services. Examples of such estate planning approaches include:

- Sheltering assets in trusts, annuities and other financial instruments that are then deemed as "not available to the Medicaid beneficiary;"
- Converting "countable assets" under the law into "exempt assets"; and
- Transferring assets through joint bank accounts or other means to close relatives.

Under current law, when an individual applying for Medicaid has transferred assets within the three year "look-back" period, the amount of those transfers are used to calculate a period of ineligibility for Medicaid. This period of ineligibility is determined by dividing the total amount of the assets transferred by the average monthly cost of nursing home care in a given service area. For example, if an asset worth $40,000 is transferred during the look-back period and the average costs of nursing home care is $5,000 per month, then the individual would be subject to an eight-month waiting period to receive Medicaid eligibility. This period of ineligibility, however, begins on the date of the actual transfer of the asset, and by the time the person actually applies for Medicaid, that period has often expired.

The President's budget proposes to change the rules regarding penalties for individuals who transfer assets in order to become eligible for Medicaid long term care. The proposal would begin that penalty period on the date that the individual enters the nursing home or becomes eligible for Medicaid, whichever is later.

This approach should be encouraged and a number of other similar approaches should be explored around assets transfers to prevent estate planners from simply moving to alternate schemes. Other approaches to address inappropriate transfers could include:

- *Increasing the look-back period from three years to five years (or longer);*
- *Limiting the amount and types of funds that can be sheltered in an annuity, trust or promissory note*

In all cases, these changes should be federal requirements, although there should be ability to "opt-out" of the federal guidelines if the state can prove that existing policies would meet the intent of the law. Furthermore, there should be some resource threshold, e.g., $50,000 and indexed in future years, below which assets transfers would be exempted, as well as policies in place to protect individuals with dementia or others at risk of being exploited.

While this approach should provide some savings by preventing inappropriate transfers, state officials will need many more tools in order to fully address the growing long-term care crisis in

the Medicaid program. Many of these other approaches are addressed in the long-term care section below.

Reverse Mortgages. This is another tool that could help prevent individuals with considerable assets from depending upon Medicaid. According to the U.S. Census Bureau, 81 percent of seniors own their homes and 73 percent own them free and clear. This represents $1.9 trillion in untapped home equity that is currently exempted from Medicaid's eligibility calculations. According to the National Council on Aging, 48 percent of America's 13.2 million households age 62 and older could get $72,128 on average from reverse mortgages, and "in total, an estimated $953 billion could be available from reverse mortgages for immediate long term care needs and to promote aging in place."

This proposal would create an incentive and a new allowance for individuals to pursue reverse mortgages in order to pay for long-term care services (in addition to private long term care insurance, which is currently allowed). Any person who obtained a reverse mortgage under this proposal would be able to shelter $50,000 (or some other appropriate amount that would be indexed to inflation) in equity from their house without incurring penalties. Other incentives to encourage reverse mortgages should be contemplated. Broader use of reverse mortgages would be both an effective way to reserve Medicaid funding for those who have truly exhausted all of their other means, and a way to provide more consumer-directed options for seniors to choose from in developing their own long-term plan of care. The number of individuals currently on Medicaid who own their own homes is relatively small and this proposal would not likely affect them, so immediate savings would be limited. However, the major impact of this proposal would come from restraining the future growth of the program and in fostering a greater sense of personal responsibility with respect to end of life financial planning.

Other similar approaches could include requiring some form of family contribution to the costs of long-term care. Similar methods of "deeming" family income are utilized by states in their child support systems and might not be difficult to implement for Medicaid. In any case, provisions should be made to allow individuals to pass along some portion of their assets/resources to family members without incurring penalties. This would allow the balancing of both the needs of an ownership society with the responsibility of family to provide for the care of their loved ones.

C. Cost Sharing – Current law prohibits co-payments for some populations; for some services like family planning and emergency care; restricts co-pays, where allowed, to a maximum of $3; and ultimately treats cost sharing as unenforceable if the beneficiary cannot or will not pay. These rules, which have not been updated since 1982, prevent Medicaid from utilizing market forces and personal responsibility to improve health care delivery.

A new vision for cost-sharing should make Medicaid look more like S-CHIP, where states have broad discretion to establish any form of premium, deductible, or co-pay for all populations, for all services, and could make them enforceable. As in S-CHIP, financial protections to ensure that beneficiaries would not be required to pay more than 5% of total family income (no matter how many family members are in Medicaid) are a critical balance to this proposal. For higher-income households (for example, those above 150 % FPL) a 7.5% cap could be applied, as under the current HIFA waivers.

States would have broad latitude to waive these types of cost-sharing for any populations or services that it determines would be negatively impacted by such policies. The purpose of increased cost sharing is not to restrict access to necessary medical care, but to allow individuals

to contribute to the costs of their own health care as much as possible. These new policies would be monitored and evaluated heavily and if the evidence shows that increased cost-sharing harms appropriate access, the policies should be revised.

D. Benefits Package Flexibility – The Medicaid program is viewed as the health care program for the poor, but it neither serves all poor people, nor are all of the beneficiaries below the federal poverty level. Medicaid's populations are very diverse, ranging from relatively healthy families and children to the frail elderly, to individuals with serious physical and developmental disabilities. The types of services and supports needed by these populations are quite different, yet the Medicaid benefits package remains "one-size-fits-all."

Many states have found that the flexibility built into the SCHIP program allows for greater efficiencies without compromising quality of care. Extension of this flexibility to services for appropriate Medicaid populations would allow states to provide more targeted services while managing the program in a way that prevents sweeping cuts in the future.

Medicaid reform should include the ability to offer a different level of benefits, using S-CHIP as a model, to certain Medicaid beneficiaries, such as those for whom Medicaid serves as a traditional health insurance program. This discussion extends beyond the traditional distinction between "mandatory" and "optional" populations, which are arbitrary distinctions when it comes to the need for health care services. This would include an improved ability to set benefit limits and cost sharing amounts, do employer buy-in programs, eliminate retroactive eligibility periods, and establish different benefit packages for different populations or in different parts of the state. Medicaid can be improved by focusing more on improving health outcomes rather than adhering to a sometimes-arbitrary list of benefits mandates (that are often the result of effective lobbying by provider interest groups).

Many relatively healthy kids and families are technically mandatory, and many of the optional populations, such as the Medically Needy, are among the frailest in the program. Reform must therefore acknowledge that there are people served by Medicaid that need a comprehensive package of benefits. For more medically fragile populations, changes in the benefit package should be made to encourage more chronic care management and other services that can improve health outcomes and reduce costs.

E. Comprehensive Waiver Reforms – Waiving various portions of the federal Medicaid statute has become the norm, rather than the exception for states. HHS officials routinely describe that they consider thousands of state waivers every year. Yet, despite all this action, states must still jump through significant hoops in order to make relatively minor changes to their Medicaid programs, and often, major changes are simply outside the scope of the current waiver authority. *Reforms are needed to increase the ease with which states get current waivers, expand the ability to seek new types of changes, and change the federal statute to eliminate the need for many waivers altogether.*

The most commonly waived portions of the Medicaid statute are those requiring that beneficiaries have "freedom of choice" of provider, and that services be comparable, statewide, and consistent with respect to amount, duration, and scope.

- *The federal statute should change to reflect these commonly waived and antiquated provisions by allowing states to innovate in these areas through the state plan amendment process.*

- *Similarly, 1915(b), 1915(c) and PACE waivers should be administered through the state plan process, not waivers. It is critical in this scenario that these waivers retain the basic protections of the waiver, such as the ability to control costs and utilization common to the 1915(c) waivers. The state plan amendment process should include check boxes for typical waived items so that States could continue to target these services on the issues of comparability, statewideness, and amount, duration, and scope. States would realize cost savings because services would be implemented sooner and States would reduce administrative costs associated with waiver development, cost effectiveness/budget neutrality, reporting, and the waiver amendment/renewal process.*
- *In addition, streamlining the waiver process for all states that choose to pursue larger reforms and innovative programs would be a helpful improvement.*
- *Allowing states to easily receive approval to try an approach already tested successfully in other states would be one improvement.*
- *Automatically converting a waiver to a state plan after the first renewal would be another, as would a consistent 5 year approval/renewal period.*
- *Many promising innovations in Medicare/Medicaid integration or care coordination are never implemented because of outdated notions of siloed budget neutrality requirements. The requirement for budget neutrality should be waivable at state option and the statute should also allow for states to consider savings to the Medicare and other federal programs when considering the impact of Medicaid changes.*
- *States that wish to make substantial improvements to their Medicaid programs may find that some portions of the statute are not waivable at all. States should be allowed to apply for "superwaivers" that envision much broader changes than can be achieved under the current 1115 waiver structure. Such waivers should allow states to develop effective programs that meet the unique needs of their citizens.*

The State of Arizona has operated its Medicaid program, the Arizona Health Care Cost Containment System (AHCCCS), through a Section 1115 waiver, since the inception of Arizona's participation in Medicaid in 1982. There are many lessons to be learned to reduce costs from Arizona's experience. All Medicaid eligible persons are enrolled into managed care plans that AHCCCS contracts with using competitive bidding to maximize market forces. Market forces drive quality while holding down costs. Several states have demonstrated success with this model, and others should look to it to contain costs.

F. Judicial Reforms – The right of states to locally manage the optional Medicaid categories is clearly defined in both policy and law, and the federal government should remove legal barriers that impede this fundamental management tool. To that end, Congress and HHS should authorize states to rightfully make basic operating decisions about optional categories of the program.

Federal judicial actions have sometimes become a means by which the judicial branch makes decisions about Medicaid programs that should be left in the hands of state elected officials and competent program managers. If the management of the Medicaid program is being handled in a manner that is consistent with legislative and congressional intent, the court system should not become involved.

These court actions sometimes conflict with the policy positions of state and local officials and go beyond addressing the specific problem that was the basis of the initial lawsuit. These court actions fit into two broad categories:

- Consent decree cases
- Court decisions based on a specific case that have an adverse affect on the state Medicaid program as a whole

These court decisions can remain in place for decades and institutionalize the policies of elected officials who have long since left office. For example: Arkansas cannot make any change in fees paid to physicians without going back to court to remain in compliance with a consent decree entered into between the state and the Arkansas Medical Society in 1993. These court actions also create an environment where state time and resources that could be spent on the greater good of the whole program go toward reducing the impact of the specific court decision.

Federal reforms are needed to constrain the broad ability of judicial decrees in Medicaid cases that clearly impede state innovation and reform. In a time of shrinking resources and growing demand it is not realistic to ask states to manage these complex programs with court decrees overriding sound management decisions.

These court decisions and the subsequent legal actions that follow, increase administrative costs and divert valuable resources that could be far better spent on services to clients.

G. Commonwealths and Territories – The federal Medicaid partnership with U.S. commonwealths and territories has become increasingly unbalanced over a period of years, to the extent that some of the jurisdictions are financing over 80 percent of their Medicaid costs, and many of the Medicaid expansions such as transitional medical assistance are not available. The imbalance affects quality of care issues and creates increased financial stress. Medicaid reform needs to include a review of the current relationship and the development of a pathway that moves to a rebalancing of this partnership.

2. Enhancing Quality and Controlling Costs in the Overall Health Care System

America's current health care system is ripe for improvement and states are ready to take the lead in helping drive change. States are small enough to tailor solutions unique to their cultures, institutions and health care markets, but large enough to experiment with systemwide reform. States can also partner effectively with health care providers, insurers, and purchasers to lead large scale pilot projects.

We must increase the efficiency, productivity, and quality of our entire health care system, which will increase the opportunities for reasonable coverage expansions. Like welfare reform a decade ago, states can play a lead role in driving this transformation through demonstration projects in partnership with the private sector.

Accordingly, Congress should establish a National Health Care Innovations Program to support the implementation of 10 to 15 state-led large-scale demonstrations in health care reform over a 3-to-5-year period. Using information technology to control costs and raise quality would be a core objective of these demonstrations. States would serve as the lead entity for these demonstrations, but they would have to partner with the private sector. Some of these would be for statewide provider networks while others would be for networks in major metropolitan areas. They would focus on:

- deploying information and communications technology, including interoperable electronic health records (EHRs) accessible to all participating providers and patients, to improve services;
- improving quality of care, including disease prevention and management, through establishment of evidence-based practices, measuring outcomes, and pay-for-performance programs;
- using innovative strategies to cover many of the Americans who currently lack health benefits;
- empowering consumer choice through price transparency, quality reporting, and financial incentives; or
- reducing malpractice incidents and improving adjudication of malpractice claims.

Each demonstration project would be selected through competition and encouraged to demonstrate multiple innovations. All projects would need to emphasize the goal of increasing cost-effectiveness and, to the extent possible, improving health care quality.

For a more comprehensive discussion on this issue, see the NGA white paper on health care reform demonstration programs.

The financing of any of these solutions should not come at the expense of Medicaid funding.

3. Strengthening Employer-Based and Other Forms of Private Health Care Coverage

Between 2001 and 2003, the proportion of Americans under the age of 65 covered by employer-sponsored health care dropped from 67 percent to 63 percent. While some of this reduction could be cyclical due to the economic downturn, many argue that the increase is more structural, as the U.S. economy is becoming more service and small business oriented and more competitive in the ever more global marketplace. Several policies could assist in reducing the number of individuals losing health care coverage. The financing of any of these solutions should not come at the expense of Medicaid funding.

A. Individual Health Care Tax Credit – A refundable tax credit could be developed that would be available to all low-income individuals below some income threshold, e.g., $3,000 for a family of four with incomes below $25,000, which is phased-out at income levels of $60,000. This credit would be a premium subsidy that could be paid directly to a health care plan by the U.S. Department of the Treasury. Unlike the trade assistance program that targets unemployed workers, eligible workers that could receive tax credits could have their employers deduct payments from wages and send them directly to the U.S. Treasury who would combine those funds with the tax credit, confirm eligibility, and forward the payment directly to the health plans.

To increase the use of the tax credit, the federal government could also mandate presumptive eligibility so that individuals would have to opt out as opposed to opting into the system. It is critical that this subsidy be set at the appropriate level. If it is too low, there will be few individuals who could use it; and if it is too high, then it would be an incentive for businesses to stop providing employer-paid health care. It is also critical that the level have the appropriate relationship with any credit for small employers. The credit would be available for all individuals who meet the income criteria and are not participating in an employer-paid or public program. Individuals who qualify for both Medicaid and the tax credit would be able to choose between the

two. States should also be allowed to enhance the tax credit. One option would be to allow states to use disproportionate share funds for the enhancement.

Because this is a refundable tax credit it is reflected in the federal budget as an outlay as opposed to a reduction in revenues. This opens up the potential option for the states to apply for a waiver that would allow the funds to come directly to the states based on a plan that would maximize health care access. For example, the Michigan Third Share program, which has equal amounts paid by employers, employee, and government, could utilize these funds for the government share. Such a waiver option would allow individual states to tailor the funds to their unique labor force and health care marketplace. Such a tax credit also equalizes tax treatment of all individuals with regard to health care. This tax credit can also be designed to allow individuals to buy into the S-CHIP benefit or to otherwise require that the credit only be viable when used to purchase some basic, threshold benefit, as defined by the state. It is difficult to determine how many individuals would use a tax credit of this nature.

B. Employer Tax Credit – A new employer tax credit would be developed for small firms, i.e., up to 100 workers. The employer tax credit would be about $200 per individual or the amount necessary to make the federal contribution necessary to enact this policy the same as that necessary to enact the individual tax credit. The policy rationale is to equalize the tax treatment between the individual tax credit and the employer-based tax credit. Unlike the Administration's proposal, it would not be restricted to employer contributions to Health Savings Accounts. The employer tax credit would be restricted to only workers below a given wage rate. The amount of the credit, the targeting, and the relationship to the individual tax credit are key in order to support the employer-based system, as opposed to providing incentives for employers to reduce coverage. Also, the state should be able to designate the minimum benefit package to be eligible for the tax credit. This credit would be reflected as a reduction in revenues to the federal government.

C. State Purchasing Pools – The federal government would make grants to states to create state purchasing pools. In the past, states have experimented with purchasing pools, but most have failed because they were never large enough to avoid risk-selection and ended up becoming high risk pools that were subsidized. Specifically, there was a financial incentive for healthy individuals to obtain their insurance outside the pool. Currently, the Federal Employees Health Benefit Program (FEHBP) and the small firm purchasing alliance in California (now called Pac Advantage) are existing purchasing pools. Permitting states to develop an SCHIP benefit package for their non-disabled, non-elderly Medicaid population, and including the same benefit package for the individual health care tax credit, should allow them to create a large enough pool (mostly in metropolitan areas) to negotiate effective rates.

To avoid adverse risk, states should be allowed to mandate that both populations be part of the purchasing pool. States will need the discretions to design their purchasing pools. This will include health plan qualifications, underwriting, rating rules, and enrollment rules. The pool could be the mechanism for Medicaid women and children, SCHIP, state employees, COBRA options, and the tax credit as well as any private firm, particularly small business that purchases health care in the state. This could have the added benefit of stabilizing the individual and small group market. Such a large pool could also maximize consumer choice. The President's budget includes this proposal.

D. Catastrophic Care/Reinsurance Model to Address Unsustainable "Legacy Costs" – Numerous employers in the U.S. have been consistent, reliable partners with their employees on

health insurance coverage, yet their ability to continue providing this coverage to retirees ("legacy costs"), current employees, and their families--amidst rising national health care costs--is becoming a distinct competitive disadvantage. Catastrophic care, chronic diseases, and serious illnesses contribute significantly to the overall cost of health care and should be addressed. While more attention and resources must be focused on wellness and disease management programs as well as best practices to ensure quality care, some bold options that offer uniquely American solutions for our American legacy cost challenges are needed. The following are two concepts to consider—one that is employer pools and another that is insurance pools. A hybrid could also be considered.

One option is to create a reinsurance pool whereby employers and other payers would be reimbursed by the federal government for part of the cost of catastrophic medical bills of their employees. To be involved in this program, employers could be required to provide health care coverage equivalent to a benchmark plan to all of their employees and/or provide preventive and disease management programs to better manage care and improve quality and care.

Another option to explore more fully is a national "Healthy Mae," as Senator Frist refers to it. The senator believes that a "Healthy Mae" model, fashioned after Fannie Mae, would help insurers more broadly share risk, reduce administrative costs, and create a vibrant secondary market for health insurance just as the U.S. has done for home mortgages. Potentially a publicly-chartered private insurer, "Healthy Mae" could help create a big secondary market for health insurance and would reduce the financial burden on employers when their workers' medical bills rise above a certain threshold. "Healthy Mae" would be designed to give buyers access to a more stable insurance market—which presumably would feature lower rates that could keep more people covered.

4. Slowing the Growth of Medicaid Long-Term Care

Medicaid has quietly over the years become the nation's largest payer of long-term care services, funding approximately 50 percent of all long-term care spending and nearly two-thirds of all nursing home residents. With the anticipated demographic changes, the potential liability for future long-term care costs can only grow. While Medicaid reforms over the past twenty years have focused on improving the long-term care benefit (eliminating the institutional bias, encouraging consumer-directed care, etc), new efforts need to focus on how to encourage personal responsibility and discourage the reliance on Medicaid financed long-term care. Ultimately, a new national dialogue is needed to confront the issues of an aging population and the potential sources of funding for end-of-life care.

The following two policies could help slow the growth of elderly enrollment in Medicaid.

A. Tax Credits and Deductions for Long-Term Care Insurance – Currently, about 28 states provide deductions or tax credits for long-term care insurance. The federal government currently allows tax deductions for the purchase of insurance, but only if the premium amounts exceed 7.5 percent of an individual's adjusted gross income. Only 11 percent of the population age 65 and older and 8 percent of those between ages 55 and 64 have a long-term care policy in effect.

The potential impact of deductions and tax credits is very different, since they impact quite different income groups. The deduction is more effective in stimulating the purchase of long-term care insurance since it is more valuable to younger, higher-income individuals in higher tax brackets. Because these individuals may allow policies to lapse and because they are less likely to

enroll in Medicaid, they do not provide the maximum possible relief to Medicaid per lost dollar in federal tax revenues. On the other hand, tax credits can be better targeted to lower-income individuals who have a higher probability of becoming Medicaid eligible. This will lead to more relief in Medicaid spending. A December 31, 2001 report by ABT Associates indicated that Medicaid saves $1.16 and $2.67 respectively in 2025 and 2050 for every dollar lost due to federal tax credits. Tax deductions do not break even. A combination of a significant tax credits, e.g., $2,000, and a small deduction, e.g., $200, might be the most effective in lowering Medicaid costs. States, through their capacity as regulators of insurance, set minimum standards and other guidelines for any such policy that could be obtained through the tax credit.

The Treasury should also develop some mechanism so that individuals can receive the credit when they pay the premium to avoid the long delay between payment and reimbursement via annual tax submissions. Tax credits are particularly effective to the federal government as well as states due to the potential Medicaid savings. Because this credit focuses on the very expensive population in long-term care, potential Medicaid savings are significant. The federal government may also want to mandate that all firms who provide 401(k) and other pensions provide an option to convert a portion of an annuity into long-term care insurance. This tax credit would be reflected as a revenue reduction in the federal budget. As of 1998, there were $9.5 trillion in qualified retirement plans, some portion of which could ultimately be used for long term care financing.

B. Long Term Care Partnerships – Four states (California, Connecticut, Indiana, and New York) have been operating promising partnerships between Medicaid and the long-term care insurance industry. Although their approaches differ, the basic concept is that individuals who purchase private insurance and exhaust its coverage would be allowed to access Medicaid and still protect some of their assets. There are two basic approaches that the four states utilize—the dollar-for-dollar model and the total asset protection model. In the dollar-for-dollar model, beneficiaries are able to keep personal assets equal to the benefits paid by the private policy. In the total asset model, all assets are protected after a threshold for years of coverage has been crossed, typically three or four years. In both cases, Medicaid becomes the payer when the partnership policy benefits are exhausted. States are projected to realize savings because Medicaid becomes the payer of last resort, not the first.

Federal law prohibits the expansion of these partnerships beyond those four states, but 17 states have passed enabling legislation allowing them to begin such a program should the federal prohibition be repealed, and several others are currently exploring that option. While long-term care partnerships do not promise a silver bullet for Medicaid's long-term care crisis, they can be a key part of the solution, and therefore all states should be allowed to participate.

In addition to tax treatment and other incentives for the purchase of long term care insurance, there are ways to improve the delivery of long term care services for individuals who remain covered by Medicaid. Those include both increasing the focus on home and community-based alternatives to institutional care as well as strengthening the chronic care management components of both Medicare and Medicaid.

C. Improving Access to Home and Community-Based Care. The long-term care policies advocated by NGA should also include reforms to the Medicaid program that produce better health outcomes for beneficiaries and result in greater efficiencies for both the federal government and states. Such reforms should give states more tools to encourage home and community-based care and could include the elimination of the requirement for a waiver for

home and community based care as discussed in the section on waiver reforms and in the current NGA policy on Long Term Care (HHS-28).

D. Improving Chronic Care Management. The long-term care policies advocated for by the Governors should include reforms that encourage better care for the chronically ill populations in Medicaid. Although this is a small population, they demand a large portion of the available resources. States should be rewarded for program improvements that produce savings for both Medicaid and Medicare, particularly through improved chronic care management, by sharing savings evenly with states in the form of enhanced FMAP on a year-to-year basis. States should have the authority to provide financial incentives for care management methods that save money and improve outcomes outside of the targeted case management benefit.

5. State Contribution to the Medicare Drug Benefit

The Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA) was designed to deliver a federal pharmacy benefit to Medicare beneficiaries. It was also designed to ease state Medicaid programs of their responsibility for providing pharmacy benefits to those eligible for both the Medicare and Medicaid programs—the dual eligibles.

While Medicare beneficiaries have some guarantees that on January 1, 2006, the Medicare program will begin providing them with a drug benefit, states do not have the same guarantee that their fiscal burden will be lifted. In some states, contrary to clear congressional intent, the Phased-Down State Contribution (clawback) provision will actually cause states to spend more in Medicaid in fact, a handful of states are projecting that they will never see any financial relief in prescription drug costs from the MMA than they would have in the absence of the law. In addition to their monthly clawback payments, states will also face increased costs from the administrative burdens of the new law. While state Medicaid programs operate with administrative costs far below those of private insurers, states have been forced to trim their program overhead even further in order to protect scarce resources for the care that their beneficiaries need. Tracking, calculating, and reporting clawback payments, as well as the other duties that resulted from the MMA, present substantial new administrative tasks [as well as potential costs] for Medicaid programs.

Integrating Medicaid's coverage with the drug coverage provided by the separate prescription drug providers will be a difficult undertaking for states. The clawback provisions should not be a further financial burden on states as they work to focus on the coordination of care that is central to the spirit of the Medicare Modernization Act.