



The University of Kansas

*Supporting Regional Economic Development through Analysis and Education*

# THE CENTER FOR **APPLIED ECONOMICS**

## REFORMING MEDICAID IN KANSAS A PLAN FOR IMPROVING QUALITY AND REDUCING COSTS

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## TABLE OF CONTENTS

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<b>Introduction .....</b>	<b>1</b>
Poor Access.....	1
Poor Quality.....	2
Fraud and Abuse.....	2
What’s Wrong With Medicaid? .....	2
Fixing The Problem .....	4
<b>What Should Kansas Do?.....</b>	<b>5</b>
Reform Step I: Create An Insurance And Provider Exchange.....	5
Reform Step II: Prepay All Plans .....	6
Reform Step III: Actuarially Risk Adjust The Medicaid Health Credit.....	7
Reform Step IV: Reinsure Smaller Plans .....	7
Reform V: Provide “Reverse” Health Savings Accounts To All Beneficiaries .....	11
Reform VI: Enroll Disabled And Elderly In Prepaid Plans .....	11
Reform VII: Allow Medicaid Beneficiaries To Buy Into Private Plans.....	13
Reform VIII: Discontinue Market-Distorting Practices And Policies.....	13
Can Markets Improve Quality And Reduce Costs Of Health Care? .....	13
<b>Appendix: Section 1115 Waivers For Medicaid Funding.....</b>	<b>16</b>
Background.....	16
Benefits to States of 1115 Waiver .....	16
The 1115 Process and Operational Attractiveness for States .....	16
<b>Endnotes .....</b>	<b>17</b>



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# INTRODUCTION

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Medicaid, the joint Federal/State program that was created to provide health care for the poor, celebrated its 40<sup>th</sup> birthday in 2006. There was no party for the program, however.<sup>1</sup> In Kansas and around the nation, Medicaid is growing at a long-term, unsustainable rate and threatens both state and federal budgets. It represented 2% of GDP in the year 2000 and is projected to rise to 9% by 2075!<sup>2</sup> This, combined with unfunded liabilities in Social Security and Medicare, will require a devastating doubling of Federal taxes and enormous increases in state funding. Indeed, the program is now larger than education in many state budgets.<sup>3</sup>

Over the last 17 years the Kansas program has increased at approximately 9.0% rate versus around 6.6% for medical inflation.<sup>4</sup> In 1990, Medicaid represented around 8.2% of the State budget. As of 2007, that total had increased to around 14.9%. Extrapolating these trends over 75 years shows Medicaid growing to over 200% of the state budget by 2082. Obviously this is unsustainable and represents a major challenge to policymakers. In addition, there is a strong probability that expanding Medicaid coverage under pending Federal legislation will make the fiscal problem far worse.

Kansas' Medicaid Program spends around 30% of its budget on health care for the poor, mostly mothers and children. The other 70% goes for the elderly and the disabled. Of the money spent on mothers and children around 22% is for hospital care, 8% for physician care, 5% for outpatient services, 7% for drugs, and 26% are insurance premiums paid to managed care plans that enroll the poor. The remaining 32% goes for other services and Medicare claw backs. Of the 70% spent on the elderly and disabled about 1/3rd goes for the elderly and 2/3rds for disabled individuals. For this group, 40% of funding is for nursing homes, 53% for home care and the remaining 7% is for institutional care facilities.<sup>5</sup> Medicaid thus serves as a needed program for those who would fall "between the cracks" in our health care system. This is grounded in the American tradition of helping the less fortunate. Unfortunately, a system that bankrupts

the State of Kansas and the Federal Government while providing low quality care serves no one's interests.

The enormous fiscal problems facing Medicaid often overshadow its other major flaw. That is, Medicaid has a well-deserved reputation as a low quality provider of health care. It has been argued that the Medicaid population is sicker than the general population which is probably true. What proponents do not understand is that Medicaid's low quality *makes* some of the beneficiaries sick. The program delivers episodic treatment, poor preventative care, and low quality services to many beneficiaries. According to a 2006 investigation, Medicaid produces some tragic health outcomes for America's most vulnerable populations. Medicaid is rife with quality issues including:<sup>6</sup>

## POOR ACCESS.

- 69.5% of physicians surveyed were willing to accept new Medicaid patients. Compare that to: 99.3% percent for privately insured, 95.9% for Medicare, and 92.8% for the uninsured. This holds for primary care physicians and specialists.
- More recent data show 21% reported accepting no new Medicaid patients in 2004–05 (latest data available), six times higher than for Medicare patients and five times higher than for privately insured patients. The most important reasons given by physicians for not accepting Medicaid patients are inadequate or delayed reimbursement and the growing burden of Medicaid administration and paperwork.
- There is much evidence of Medicaid's inability to provide access to primary care services. Medicaid beneficiaries use of emergency department services for non-urgent problems is a serious problem in many states. In 2004, the emergency department visit rate for Medicaid and SCHIP patients (80.3 visits per 100 persons) was higher than the rate for those in any other payer group, including those in Medicare (47.1 visits per 100 persons), without insurance (44.6

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visits per 100 persons), and with private insurance (20.3 visits per 100 persons).

- In addition, a greater portion of emergency department visits by Medicaid/SCHIP patients in 2005 were classified as non-urgent or semi-urgent (35.7 percent) than visits by self-pay patients (23.7 percent), according to data from the National Ambulatory Medical Care Survey. In other words, Medicaid enrollees often use emergency departments for primary care.

## POOR QUALITY.

- Medicaid patients with heart issues were less likely to receive evidence-based therapies and had worse outcomes (including increased mortality rates) than patients who had private insurance as the primary payer. These differences in care and outcomes persisted after adjusting for clinical characteristics (associated illness), socioeconomic factors (education and income), and the type of center where patients received treatment. In other words, the most important predictor of treatment and outcome in the investigation was whether the patient had Medicaid or private insurance.
- Medicaid beneficiaries face more difficulties scheduling adequate and timely follow-up care after initial treatment for an illness than those with private insurance.

## FRAUD AND ABUSE

Medicaid is also routinely abused by both providers and beneficiaries. This ranges from Medicaid “mills” to outright theft. There have been estimates that as much as 40% (over \$100 billion) in Medicaid spending involves fraud and abuse.<sup>7</sup> Low estimates place fraud and abuse at 10% with the higher figure being more relevant in urban areas. Examples of specific Medicaid fraud and abuse include drug diversion, durable medical equipment abuses, embezzlement, false claims, financial abuse, fraudulent prescriptions, home health care, negligent homicide, nursing home abuse, overpayments, patient abuse, and pharmaceutical manufacturer’s abuse.

How did a well-meaning government attempt to provide quality health care for the poor end up as an actuarially bankrupt plan that delivers poor quality care? While the problems facing Medicaid are indeed complex, in one way the problem is actually quite simple: there is no real marketplace for the vast majority of health care in the United States. Any economic product and/or service where buyers have no incentive to economize and sellers have no incentive to be efficient will face ever-escalating costs. This is the fundamental problem of Medicaid and, for that matter, Medicare and much of the private medical sector. Failure to design a program with proper incentives to be cost efficient is doomed to fail

## WHAT’S WRONG WITH MEDICAID?

How does Medicaid work? Medicaid is responsible for providing medical services and care to three major groups: acute care for the poor and near-poor, the disabled population, and long-term care recipients. Some of these individuals would not be able to obtain coverage in the traditional health market because of their low incomes and/or the chronic nature of their health needs.

The fundamental problem of Medicaid is a flawed program design. Medicaid does not rely on a market in the traditional sense of buyers and sellers acting in their own interest in a decentralized marketplace. Instead, it is an “administered pricing” system where various schemes are used to determine reimbursements. This system ranges from cost-based reimbursement for nursing homes to prospective payments for acute care. We believe this is the Achilles Heel of the current program. Any efforts to fix Medicaid need to address this payment system.

All administered pricing schemes are fundamentally flawed due to the “information problem.” Centralized systems and price determination often appear attractive. In reality, they suffer from this basic problem. In order to know where resources should be directed, the central planners and price-setters need to know both what goods and services people want and how they can be most cheaply produced. But this knowledge is held in the minds of individual consumers, businesses and providers, not in the filing cabinets or computers of a government-planning agency such as Medicaid. The only practical way for consumers and providers to relay

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this knowledge to each other is through a decentralized system of market-determined prices.<sup>8</sup>

Medicaid administrators and their consultants can never know the “correct” price for a bypass in Lawrence or an appendectomy in Wichita. Only a decentralized market with buyers and sellers can determine accurate prices. Since the rates set by Medicaid are almost all certainly “wrong,” the impact on the health care system is to produce surpluses, shortages, and inefficiency.

Payments to physicians are also an administered price scheme called Resource Based Relative Value Scale (or some variant of this method).<sup>9</sup> Developed by researchers at the Harvard School of Public Health, the Resource Based Relative Value Scale is based on a point system involving how much physical and mental effort goes into providing a particular physician service. In addition to an absurd belief that this can actually be measured, the Resource Based Relative Value Scale also ignores how much demand exists for various services. This scheme is nothing more than a variant of the more than century-old discredited “Labor Value Theory.”

It is important to remember what happens when the price is not “correct”: If the price is set too high there will be surpluses and excess capacity—charged to taxpayers. If the price is set too low there will be shortages and a lack of capacity. Both Medicaid and Medicare use administered pricing schemes that do not rely on market prices. These programs represent a large share of the health care market, rendering the entire system inefficient. This problem is exacerbated by private payers copying the governments pricing schemes or, at best, using them as a starting point in price negotiations.

In Medicaid, payments are often set below the going rate that would exist in a real market. The result is outright shortages of services to beneficiaries. With assorted services like health care, the “shortage” often arises in the form of low quality. These include failure to treat illnesses properly as well as long waiting times for receiving services.<sup>10</sup> Another outcome of reimbursements being set too low is cost-shifting to those paying for health care outside the government controlled programs. According to the Lewin Group, low public reimbursements correlated about -0.75 with private payment ratios. This

indicates that Medicaid’s “low cost” actually is a driver of medical inflation in the private sector. Medicaid reform that pays actual market rates will produce benefits through reduced private sector cost-shifting.<sup>11</sup>

Medicaid also has higher effective overhead than private insurance including substantial compliance costs placed on providers in terms of time and overhead needed to meet the paperwork burden imposed by Medicaid. Medicaid imposes significant costs in unnecessary utilization and reduced quality. Since a large portion of Medicaid is fee for service, with very little or no cost sharing, this results in a significant increase in the demand for health care services. In addition, the excess burden of the income taxes used to finance all or part of Medicaid may be over 20%. This burden results in economic costs as real as any physician or hospital payment associated with the program.<sup>12</sup> All of these and other costs of the Medicaid design produce effective overhead as much as two-thirds higher than private insurance.<sup>13</sup> Policies that encourage dropping of private coverage and enrollment in Medicaid/SCHIP are very expensive when real overhead costs are taken apart.

To control rising costs Medicaid plans have been attempting to enroll beneficiaries in managed care plans. The supposed advantage of managed care is that it is prepaid, so the provider has an incentive to eliminate unnecessary care. There are substantive problems with this type of health plan. While Federal law requires that beneficiaries be given at least two choices in managed care plans, often there is little effective choice for beneficiaries with plans having the same doctors and hospitals. Plans “choices” are usually determined by selective contracting. That means government administrators decide who gets the business. The process becomes intensely political.

The selected plans know that the real “customer” is the government, not the beneficiaries. And often what the “real customer” wants is to spend very little on care. The result is too little quality. Many Medicaid plans mandate a broad package of benefits. On paper, they are often more generous than private health plans. Medicaid then determines a per-beneficiary “premium” that the plan will receive. These payments are established administratively.

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As would be expected, it can become a balancing tool for states when budgets are tight, as happened in the early part of this decade in numerous states. Medicaid cuts reimbursements to managed care providers but usually does not change the required package of services.<sup>14</sup> The resulting outcome, at best, is rationing of care despite administrative attempts to maintain quality. In the worst case, the plans simply leave the market.<sup>15</sup>

The current Medicaid system is an inherently inefficient program because it relies on administered prices as opposed to a decentralized marketplace. No government has ever been able to effectively set prices, and health care is no exception. The result of this system is provider inefficiency, explicit and implicit shortages of health care, and higher medical inflation. Without reform, the system will continue to increase budgetary pressure on Kansas.

## FIXING THE PROBLEM

The solution to quality and cost problems in government-run plans like Medicaid and Medicare, as well as the private sector, involves “opening the markets and leveling the playing field.” States should create “insurance and provider exchanges” for the provision of services to beneficiaries. Indeed, the creation of these exchanges is effectively mandated in the most recent health reform bill. Unlike the current price control system, those eligible for Medicaid will receive risk-adjusted credits to purchase services from competing plans. This will turn Medicaid into a real market where buyers are acting in their own interests and providers compete to enroll beneficiaries. This will produce gains in efficiency that will make the programs sustainable in federal and state budgets and, just as important, improve the quality of health care that beneficiaries receive.

While this model may seem worlds away from Kansas’s current Medicaid program, it is actually a reform within reach. The State of Florida received approval from the federal government to begin converting their Medicaid plan to the exchange model. While in its early stage, these reforms are working well. It is time for Kansas to look to bold reforms for Medicaid along these market-based lines.

What would happen under broad based market reforms in Kansas? We can surmise that competition and innovation would bend down the long-run growth rate of the Kansas Medicaid Plan. Given that productivity growth has accelerated from essentially zero to around 2% in the service sector since 1995 (Alan Greenspan’s “New Economy”) efficiency gains in the health sector should result from the creation of a real marketplace. If the Medicaid Reform could produce just half the productivity gain of the private service sector, Medicaid would be half as large as currently projected in the year 2082!

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## WHAT SHOULD KANSAS DO?

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### REFORM STEP I: CREATE AN INSURANCE AND PROVIDER EXCHANGE

Kansas Medicaid should establish an Insurance & Provider Exchange. The Insurance & Provider Exchange is nothing more than a state-run market where Medicaid beneficiaries will purchase their health care. Think of it as Orbitz for health insurance and other medical services. Providers can offer packages of services to the enrollees at the Insurance & Provider Exchange. The role of the state will change from being the buyer of the health care to facilitating a real marketplace in Medicaid. Kansas Medicaid will provide beneficiaries with funds to buy their own health care. It will mandate minimum required benefits and services from providers. Kansas Medicaid will require complete transparency on the part of providers with regard to the services that they offer to enrollees. It will assist beneficiaries in selecting health products that best meet their needs by establishing a counseling program but the actual choice will be made by the enrollees. Beneficiaries will receive a Medicaid Health Credit from Kansas Medicaid to buy the coverage they want at the Insurance & Provider Exchange from competing providers. This may be an HMO, a network plan, health savings account type product or some hybrid product.

Health exchanges are rare but have existed for some time. Two of the best known are the Federal Employee Health Benefits Plan and the University of California with good quality and cost results.<sup>16</sup> These are both related to employment by the federal government or the University of California system but they allow employees a wide range of choices in their health plans.

The Insurance & Provider Exchange would serve other functions as well. It would be a central shopping place for health insurance for those in Medicaid. It would be accessible online or via toll-free telephone for convenience shopping. It would present the products being offered in an easy-to-understand format. The format would also allow for easy comparison among product costs and coverage items. It would act like a “human

resources” department for this group of buyers, and it would have significant economies of scale.

It is important to understand that Insurance & Provider Exchange is a “market maker,” not a regulatory agency. It would have the power to prevent carriers from selling in the mart if they fail to meet minimum capitalization, benefit, and quality criteria. But it would not allow any special consideration for any particular carrier marketing its product to potential customers. Competing carriers and provider plans will be listed at the mart, with individual beneficiaries able to choose among these plans. Instead of one-size-fits-all, with the choices being made for them, the individual will select among different benefit packages. Giving enrollees a choice will allow them to select the plan that best fits their needs. This should increase the quality of care in three ways. First, the Insurance & Provider Exchange will allow for easy comparison of plan benefits so that the “customer” (the Medicaid beneficiary) can enroll in a package that gives him the coverage with the best match to various health issues he faces.

The importance of this cannot be overstated. Not only will the Insurance & Provider Exchange allow for complete transparency in benefit packages, but it will also employ counselors to help enrollees select the best plan for their needs. Second, if they feel they are not being treated properly, they are not trapped in a plan. Rather, they can easily enroll in a competing plan. This significant increase in competition will induce providers to offer better care or face the loss of customers. (Isn't that how other industries work?) Finally, in order to keep existing enrollees and increase their profits, the competing plans will have powerful bottom-line incentives to innovate. This acceleration in the rate of innovation will initially be reflected in higher plan profits. Ultimately, competition among the providers will be reflected in a slowing of the rate of medical inflation. It is this productivity gain that, as in other industries, will make healthcare finance sustainable within individual and employer budgets. These efficiencies will occur slowly over time,

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but the compounding effects will be enormous after a few decades.

Another role the Insurance & Provider Exchange could play involves helping health plans to “braid” services to enrollees. This concept is being used on a limited basis in some Medicaid plans in New Mexico, among other places. The idea is that some health issues and problems have multiple sources of treatments and/or funding. The Insurance & Provider Exchange could assist private plans in working with these private/public entities that deal with a host of medical problems. To the extent that additional resources are available to beneficiaries that, on the margin, are free and/or low cost, the total premium for coverage could be lowered.

The new federal health laws enacted in 2010 effectively mandates states to create “exchanges” for the private small group and individual markets. The infrastructure for this could be easily used for the Insurance & Provider Exchange. Indeed, from below, there may be advantages to the exchange serving both private and Medicaid individuals/families. But it is crucial that any waiver request allow the exchange to operate without “modified community rating.” Under the recent health bill, premiums are limited to a 3 to 1 band, meaning that the highest premium cannot be more than three times the lowest premium. This band is far too narrow and will give the healthy a huge incentive not to enroll while making insurance for the sick an outstanding deal.<sup>17</sup> Premium payments to health plans selling to Medicaid beneficiaries should be fully risk-adjusted based on the individual’s health status. Beneficiaries will not actually see the Medicaid Health Credit. It will simply be allocated to the plan that the enrollee chooses.

## REFORM STEP II: PREPAY ALL PLANS

One of the major problems facing Medicaid is the large scale use of fee-for-service delivery systems. Essentially, the beneficiaries find a doctor or emergency room or get admitted to a hospital for services. Kansas Medicaid then pays the provider a fee. This system has three major flaws.

First, there is no effective way to limit usage with arbitrary administrative edicts. Health care is complicated and no agency can effectively design a rationing system to control usage in a useful manner. Since the Medicaid beneficiary pays little or nothing out of pocket, they certainly have no incentive to economize on using unneeded care. And providers have an incentive to deliver services that are not appropriate.

Second, the “prices” that are paid to providers are not determined by supply and demand but are set administratively through government rulemaking. They are, in effect, price controls. If the rates are set too high, there will be too much health care delivered (a surplus). If they are set too low, there will be too little care provided (a shortage). In services like health care, where quality is important, these shortages can take the form of lower actual quality (5 minute office visits), long waiting periods, and actual inability to get services at all. Further, rates set below market prices cause fewer providers to deliver services and suppress the competition needed to lead to innovative medical practices.

Finally, fee for services often produces episodic health care utilization. Problems are (may be) treated after they’ve developed instead of being prevented in the first place.

Prepaid plans benefit financially from patients having better health and have an incentive to provide preventative care that reduces major health problems in the future. Further, they have an incentive to cost effectively manage existing conditions because their profits/incomes will be higher. It makes much more sense to get a pregnant beneficiary proper prenatal care than it does to spend a fortune on treating a low birth weight baby. In addition, many individuals with high health costs suffer from a multitude of health problems. They are likely to derive better care and lower costs from an integrated health plan where differing specialists can work together to deal with the patient’s issues.<sup>18</sup>

It is important to recognize that the payment of physicians, hospitals and other medical providers on a fee-for-service basis will not completely disappear. Some of the health plans selling to Medicaid beneficiaries will compensate providers on a fee-for-service basis. What

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will change is the state Medicaid plan directly paying doctors and hospitals under fee-for-service. Instead, they will pay a premium to the health plan in question. At that point, the plan has agreed to provide a benefits package to enrollees for an agreed period (probably one year). If the medical usage and plan payments to doctors and other providers exceeds the premium then the plan loses money. But the state is not at risk. This gives network plans that compensate doctors on a fee-for-service basis an incentive to conduct utilization reviews and to not compensate medical professionals for unneeded services.

### REFORM STEP III: ACTUARILY RISK-ADJUST THE MEDICAID HEALTH CREDIT

Insurance companies are in the business of managing risk. Better drivers pay lower insurance premiums. Teenagers as a group are not better drivers and pay higher premiums. Younger people live longer and pay lower life insurance costs. Women live longer than men and pay lower life insurance rates. And, in a properly designed health insurance market, sicker beneficiaries would pay more than healthier beneficiaries. Due to quirks in policy-making there has not been a real market for health insurance. Many traditional carriers practiced community rating where equalized rates encouraged sicker people to enroll and healthier people to drop out of the insurance pool. Second, tax laws encourage the purchase of health care through employers. Employer-based insurance is, therefore, just a reallocation of employee compensation to health insurance instead of wages, in order to minimize income taxes.

The proposed Medicaid reform involves beneficiaries buying prepaid plans from competing providers. Existing Medicaid “managed care” plans are generally set up through selective contracting. Theoretically, there may be choices for beneficiaries, but as a practical matter they tend to wind up in one plan over time.<sup>19</sup> The payment to the plan from Medicaid is an administered price (price control) and is not risk-adjusted for each enrollee. While the enrollment in the plans is guaranteed, the failure to risk-adjust payments encourages “cherry picking” by prepaid plans. With the advent of easy to use software it is a relatively simple task to risk-adjust the Medicaid

Health Credit. While risk-adjustment is not perfect, it significantly reduces the incentive to enroll only healthy beneficiaries.

In the past risk-adjustment was not widely practiced and not particularly effective. Indeed, the difficulty in doing it was one of the reasons for actuarially unsound community rating. Risk-adjustment is now much more effective and economical to implement. A perfect example of this is Medicare Advantage which is the new Medicare Part C managed care plan. Medicare Part C was very ineffective primary because the payment schedules were based entirely on demographics such as age, sex, employment status, Medicaid and disability eligibility and institutional status. Medicare has implemented a new risk-adjustment system called the CMS Hierarchical Condition Category.

Switching Medicare reimbursement of private plans to follow the CMS Hierarchical Condition Category system has had very desirable effects. Indeed, private firms under Medicare Advantage are able to market directly to those with chronic illnesses under what are called Special Needs Plans. So instead of attempting to cherry pick healthy enrollees the market is now functioning to provide care to the chronically ill since they receive a significantly higher payment from Medicare. This accomplishes two things. First, it makes the sick desirable customers. Second, it will accelerate medical innovation in dealing with higher cost patients. Why? Because the plans are prepaid and finding ways to keep enrollees healthier will flow to the provider’s bottom line.<sup>20</sup>

In addition to risk-adjusted Medicaid Health Credits, there should also be a requirement of an actuarial payment from one provider to another if a chronically ill enrollee switches plans. First, this will further minimize a plans desire to avoid signing up ill beneficiaries. Second, it will encourage the provider that they are currently enrolled with to offer quality care focused on disease management. The combination of risk-adjustment and a transfer actuarial payment will give plans a strong incentive to compete vigorously for all beneficiary business.

## REFORM STEP IV: REINSURE SMALLER PLANS

A central tenant in reforming Medicaid is creating a competitive marketplace where beneficiaries can obtain their health care. Monopolies and oligopolies are bad

for consumers in any industry, including health care. In order to make reform work in Kansas it is imperative that choices exist for enrollees. It is also necessary for these providers to be prepaid to control utilization and give incentives for cost reducing, quality promoting

### THE MECHANICS OF RISK-ADJUSTMENT

To better understand the mechanics of risk-adjustment it is useful to examine the methodology being used in Florida’s Medicaid reform demonstration.<sup>21</sup> Risk-adjustment is a process to predict health care expenses based on chronic diagnoses. It distributes premium payments across health plans based on the health risk of the members enrolled in each health plan. It does not set premium rates but rather allocates premiums. The purpose of risk-adjustment is to prevent “cherry picking” and encourage “specialty” plans to develop that treat chronic, high-cost patients. Traditional methods for adjustment included examining age/gender, prior cost and doing health risk. These all have major issues. A better method is Health Based Risk-Adjustment.

Health Based Risk-Adjustment uses historical diagnosis codes and/or pharmaceutical utilization available on individual’s claims records as basis for risk assessment. Certain conditions (heart disease, asthma, diabetes, etc.) and use of particular pharmaceuticals have strong link to future health care cost. Statistical models are then used to correlate historical diagnoses/ pharmaceutical utilization to likelihood of future health care cost. Each individuals is assigned a “risk score” which, in turn, determines the premium paid by Medicaid based on recipient’s predicted need.

The actual methodology for risk-adjustment in Florida is the Chronic Illness and Disability Payment System. It was developed by a team at the University of California, San Diego. The Chronic Illness and Disability Payment System uses a limited set of diagnosis data indicative of chronic conditions to assign risk-adjustment factors by individually classified major diagnosis categories. The Chronic Illness and Disability Payment System also offers a pharmacy-based version of the model. The methodology is available for different types of Medicaid beneficiaries.

The easiest Chronic Illness and Disability Payment System methodology is based on pharmacy data. The data is easy to obtain but less predictive than diagnostic approaches. To develop individual risk scores Kansas Medicaid would pull diagnoses and/or pharmaceutical utilization from claim and encounter systems.

#### Risk Score Example From Florida Medicaid

**Table A**  
Sample Individual Risk Score Development

Component Category	Weight
Demographic: Female age 25 to 44	0.50
Diagnostic: Hypertension	0.40
Diagnostic: Diabetes	2.40
Risk Score (Sum of Weights)	3.30

Table A depicts a hypothetical enrollee—a female age 25-44 with hypertension and diabetes. If she were of average health for an enrollee her score would be 1.0. Because of her two health conditions she is much more likely to have health expenses, thus her score of 3.30. Her score is then averaged with other enrollees signing up for a particular health plan as shown in Table B below:

**Table B**  
ABC Health Plan

Plan Members	Risk Score
Jo Smith	3.30
Betty Jones	0.43
Doug Brown	0.66
Charlie Williams	0.37
Brad Wilson	0.45
Case Mix Score (Average)	1.042

The average of the five individual risk scores in Table B is 1.042. Thus, this plan’s pool of hypothetical enrollees is 4.2% riskier than the entire Medicaid population, because one member (Jo Smith) is so much riskier than average (the other members are less risky than average, since an average risk score equals 1.0). The premium paid to this plan would be 4.2% above Medicaid’s average premium payment as shown in Table C on the following page:

innovations. But the benefits of prepaid plans also raise a potential problem in terms of smaller providers who may wish to enter the marketplace.

For a provider to have a reasonable idea of what health costs will be in a current year requires a significantly large pool of coverees (say 5,000). Larger prepaid plans will have an incentive to offer coverage to Medicaid beneficiaries if the enrollees buying power is risk-adjusted and there is flexibility on the benefits package. While many of these organizations are indeed effective and innovative, history shows that revolutionary new methods and products are often developed by start-up entrepreneurs. The problem is that a prepaid practice of, say, ten innovative doctors that enroll 1,000 beneficiaries could be wiped out if they are unlucky enough to sign up a few very high-cost patients. Thus, good ideas that could reduce Medicaid costs and improve its quality may never make it to the marketplace. This problem, of course, is particularly acute in a rural state like Kansas.

The solution to this problem involves Kansas Medicaid “reinsuring” smaller practices if they run into high costs. Actuarially, the risk to a prepaid plan becomes greater given a smaller number of enrollees. Kansas Medicaid could use a sliding scale framework with very small plans having a much smaller effective stop-loss limit than medium size providers. Large prepaid groups would not receive reinsurance. To maintain the incentive for providers to control unneeded utilization there would need to be some financial risk once the reinsurance begins. As with the reinsurance itself, this should be set up on a slid-

ing scale with smaller groups being required to cover a smaller proportion of expenses in the reinsurance range.

As an example, suppose a small health plan accepts patients at the Insurance & Provider Exchange. It enrolls 1,000 individuals. From above, each of these enrollees is risk rated to determine the premium Kansas Medicaid will pay the plan for each member. Suppose that averages \$2,000 per enrollee. Kansas Medicaid then pays this plan a total premium of \$2,000,000 (\$2,000 x 1,000 enrollees). It turns out, after the fact, that the plans total costs are \$2,500,000. Kansas Medicaid might “reinsure” 90% of the plans loss of \$500,000. The plan is still “At Risk” but the loss is now low enough to encourage the development of small plans.

Providers need to have flexibility in designing their product. The current Medicaid system has federally required minimum benefits package with states having the ability to expand the services that must be covered by providers. Generally, states have operated with a one-size-fits-all mentality on the mandated benefits package. This makes no sense, given the diverse population that Medicaid covers. Providers should be allowed to market to specific groups, as is the practice in the private sector. While the plans would have different benefits they would be required to be actuarially equivalent, that is, each plan would have the same dollar value. This specialization and division of labor will increase efficiency and lower medical inflation. Just as important, it will improve the quality of care for beneficiaries. Since payments for beneficiaries will be risk-adjusted, plans will have an incentive to enroll healthier and sicker beneficiaries.

## THE MECHANICS OF RISK-ADJUSTMENT *(continued)*

**Table C**  
**Rate Methodology Comparison**

Item/Member	Not Risk Weighted	Risk Weighted
Total Medicaid Payment	\$500	\$521 (\$500 x 1.042)
Average Medicaid Payment	\$100	\$104.20 (\$100 x 1.042)
Brad Wilson	\$100	\$45 (\$100 x 0.45)
Charlie Williams	\$100	\$37 (\$100 x 0.37)
Doug Brown	\$100	\$66 (\$100 x 0.66)
Betty Jones	\$100	\$43 (\$100 x 0.43)
Jo Smith	\$100	\$330 (\$100 x 3.30) 22

The point of the risk-adjustment approach is that sicker individuals cost more to treat. Health plans need to be compensated for enrolling those individuals. Without risk-adjustment, health insurers have a huge incentive to “cherry pick” enrollees.

## THE MECHANICS OF ACTUARILY EQUIVALENT CUSTOMIZED BENEFITS PACKAGES

The goal of Customized Benefit Packages is to increase access to care, promote innovation and efficiency and customize benefit packages to meet the needs of specific Medicaid group. Health plans will propose one benefit package for each target population they want to serve. Each plan must offer a minimum benefits package. The base premium will be based on the minimum benefits package. Any customized plans must be actuarially equivalent to the minimum package. Certain services must be provided at least to minimum coverage level. Other services must be provided at least to meet benefit sufficiency standard. The remaining services must be offered, but the amount, scope and duration are flexible. Reform plans can enhance any service above current minimum level and can add services not currently covered under the minimum. For example, Florida has the following breakdown:

Services required to meet at least the current minimum benefits package limits:

- Emergency care
- Maternity care and other services to pregnant women
- EPSDT and other services to children
- Hospital inpatient care
- Non-emergency transportation
- Outpatient mental health services
- Physician and physician extender services

Services required and tested for benefit sufficiency:

- Hospital outpatient services
- Durable medical equipment
- Home health care
- Prescription drugs

Services required to be offered, but amount, scope and duration are flexible

- Chiropractic care

- Adult dental services
- Adult vision services
- Adult hearing services
- Physical and respiratory therapy
- Podiatrist care

Florida Medicaid provides a standardized benefit template that plans must use to convey proposed benefit packages. This allows for comparability among plans and is like that offered by employer-sponsored plans. The completed form, once approved by Florida Medicaid, forms the basis of the contractual agreement between Florida Medicaid and plans on the benefit package. It is crucial that the plans have actuarial equivalence. This includes examining how the value of proposed benefits compare to historical Medicaid for the average member of the population and ensuring that overall level of benefits is appropriate. The plan must be sufficient to meet medical needs.

To provide for benefit sufficiency, Florida Medicaid develops a pre-set standard for each service subject to sufficiency testing, such as meeting the needs of 95% of adults in the target population. This is accomplished by continuance tables and claim probability distributions constructed from the target population's historical service utilization.

Table D provides an example. Table E illustrates sufficiency results. Table F illustrates equivalency results.

### Premium Development

- Actuarial equivalence says that the value to the average member is equivalent to historical Medicaid benefits, not that the cost of the plan is the same.
- Actual plan cost for an average member of the group, and the premium received, is expected to be lower than average historic costs.

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Practices specializing in the treatment of those afflicted with AIDS could develop along side those who provide OB/GYN services. As in the private sector, plans may implement an overall benefit limitation.

## REFORM V: PROVIDE “REVERSE” HEALTH SAVINGS ACCOUNTS TO ALL BENEFICIARIES

Incentives matter. The failure to recognize this is one of the major contributors to rising costs in Medicaid and, indeed, all of health care. The proposed reform plan will implement the right incentives which, in turn, will produce more cost-effective, higher quality care for the poor. One way to give beneficiaries proper incentives is for Kansas Medicaid to give every Medicaid beneficiary a Reverse Health Savings Account. The accounts will have a zero balance initially. Kansas Medicaid would then add dollars to the account when beneficiaries use health care in an effective and responsible manner. Medicaid in many states, for example, suffers from a significant problem of enrollees using hospital emergency rooms for non-life threatening illnesses. Kansas Medicaid could pay beneficiaries a portion of the savings from getting coverees to use a physician for their primary care. Large amounts of money could be saved by paying pregnant women to obtain proper prenatal care and avoiding low birth weight babies. The same is true of obtaining a full panel of immunizations for children and for diabetes spots and blood pressure checks for adults.

Funds in the account could be used to purchase additional medical care or rolled over for future purchases. They could also be used to pay for medical care when the beneficiary leaves Medicaid. The Reverse Health Savings Account would be set up to be a money saver for Kansas Medicaid with credits to the account being a fraction of the expected actuarial savings from discouraging “bad” behavior and encouraging “good” behavior. This is crucial given that unhealthy behavior is one driver of high health spending.<sup>24</sup> In addition, since funds may be rolled over and taken out of the accounts at a later time they will produce a “reverse” working capital effect for Medicaid. The State of Florida’s reform plan has this account as part of its design.

## REFORM VI: ENROLL DISABLED AND ELDERLY IN PREPAID PLANS

As with the acute care population, Medicaid beneficiaries who are disabled and/or elderly will enroll in prepaid plans. They, too, will receive risk-adjusted Medicaid Health Credits. The purpose of the prepaid plan is to limit unnecessary usage and create incentives for innovations in the delivery of care. This population is a minority in state Medicaid plans, but accounts for a majority of expenditures. As such, it is crucial that providers to these populations deliver quality care in a cost effective manner. In addition, this group of enrollees will also receive Reverse Health Savings Accounts to encourage appropriate medical behavior that results in cost savings.

A central tenant of the proposed reform in this area involves addressing the bottom line of providers. Many institutions that deliver services to Medicaid are paid using a cost-based methodology. This, of course, is just another administered-pricing scheme. And, like other price control schemes, it encourages inefficiency and low quality. The development of the Medicaid Health Credit will make beneficiaries a sought after “customer” and competition between providers will lower medical inflation.

Nursing homes and other institutions that provide services to Medicaid should become prepaid in nature. There are two ways this can happen. One is for the provider to list their services at the Insurance & Provider Exchange. The other is for managed care companies to negotiate with these institutions the same way they negotiate with physicians and hospitals. The marketplace will determine which mechanism is most effective. Prepaid plans would have an incentive to develop innovative methods to deliver needed care in a cost effective manner.

The Reverse Health Savings Account could be used to encourage behavior that lowers costs. For example, the mentally disabled sometimes stop taking medications that allow them to function in a reasonably normal manner and avoid very expensive institutionalizations. Documented care visits and usage of effective prescriptions could be rewarded by deposits to the Reverse

**THE MECHANICS OF ACTUARILY EQUIVALENT  
CUSTOMIZED BENEFITS PACKAGES** *(continued)*

**Table D**

**Example of a Proposed Benefit Plan**

Target Medicaid Group: Children and Families

Target Region: Duval County, Florida

**Mandatory Services**

<b>Service</b>	<b>Limits</b>
Hospital Inpatient	\$3 co-pay per admission. 45 days per year.
Hospital Outpatient	\$3 co-pay per visit. \$1,500 per year.
Emergency Services	No co-pay. No limit.
Physician Services	\$2 co-pay per visit. No limit.
Advanced Registered Nurse Practitioner Services	\$2 co-pay per visit. No limit.
Early and Periodic Screening, Diagnosis, and Treatment	No co-pay. No limit.
Family Planning	No co-pay. No limit.
Home Health Care	\$2 co-pay per visit. 60 visits per lifetime.
Lab and X-ray	\$1 co-pay per day. No limit.
Transportation	\$1 co-pay per one way trip.
Federally Qualified Health Center/Rural Health Clinics	\$3 co-pay per visit. No limit.

**Optional Services**

<b>Service</b>	<b>Limits</b>
Adult Health Screening	\$3 co-pay per visit. No limit.
Dental Services	5% co-insurance. \$2 co-pay of per visit.
Durable Medical Equipment	No co-pay. No limit.
Hearing Services	No co-pay. No limit.
Hospice	No co-pay. No limit.
Outpatient Therapy	3.5 hours per week.
Behavioral Health	\$2 co-pay per visit.
Prescription Drugs (modified Preferred Drug List)	\$1.50 co-pay per script. \$750 per year limit.
Vision Services	\$2 co-pay per visit.
Other Outpatient Services	No change.
Adult Health Screening	\$3 co-pay per visit. No limit.

**New Services Not Covered Under Historical Medicaid**

Network-run group weight reduction/maintenance program

Smoking cessation program

Adult vision

**Table E**

**Sufficiency Results of Example Proposed Benefit Plan**

Target Group's Expected Use of Key Services Based on Historic Utilization

<b>Service</b>	<b>Limits</b>	<b>Benefit Limit Use per Eligible Expected to Exceed</b>
Hospital Outpatient	\$3 co-pay per visit. \$1,500 per year.	Share over limit: <1% Avg. amount over limit: \$82
Durable Medical Equipment	No co-pay. No limit.	Share over limit: n/a Avg. amount over limit: \$39
Home Health Care	\$2 co-pay per visit. 60 visits per lifetime.	Share over limit: <1% Avg. amount over limit: 0.6 visits
Prescription Drugs	\$1.50 co-pay per script. \$750 per year limit.	Share over limit: 3% Avg. amount over limit: \$146

Note: In terms of sufficiency, less than 1% of enrollees would exceed the limits established for hospital outpatient services and home health care. Around 3% would exceed the limits for prescription drugs. This is below the 5% limit established so the plan meets sufficiency requirements.

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Health Savings Account. Offering Reverse Health Savings Account funds to loved ones could allow parents and other family members to care for the mentally and physically disabled in a non-institutional setting. Here the Reverse Health Savings Account would essentially function as a “cash and counseling” program. These limited experiments around the country have proven very popular with the disabled.

Providers for the disabled (including government providers) would offer various packages for this diverse group ranging from comprehensive coverage for the mentally ill to low cost “carve outs” such as alcohol rehab services for the otherwise healthy. These providers would also be paid with grants that are risk-adjusted. They have shown success in dealing with this problem population and have developed innovative programs such as “braided funding” where multiple sources of coverage are linked together.<sup>25</sup> The beneficiaries would be evaluated by Medicaid to determine the severity of their disability, and a grant would be awarded based on that determination. Medicaid would create quality indices that would be available to inform beneficiaries when they’re choosing their providers.<sup>26</sup>

An important part of this reform would involve allowing beneficiaries to pay family members for providing services.<sup>27</sup> Because of the emotional bond involved, allowing this option can produce significant increases in the quality of care at far less cost than in an institutional setting. Beneficiaries who are eligible for Medicaid coverage of nursing home care could instead receive Reverse Health Savings Account funds if they are able to obtain services in a less costly environment. This would allow some to stay at home as opposed to assisted living facilities. Here, too, the ability of family members to receive payment from the Reverse Health Savings Account could significantly reduce Medicaid’s nursing home costs.

It is, of course, possible that allowing payments to family members could create an “out of the woodwork” effect. That is, individuals currently not enrolled in Medicaid may sign up for the plan to access these dollars. It is crucial that estate recovery efforts be highly effective to minimize this occurrence. It has been estimated that as high as 90% of those enrolled in Medicaid coverage for

nursing homes have done some type of asset planning to qualify for their coverage. Further “look-back periods” and recovery programs for those seeking Medicaid nursing home coverage would produce larger potential losses in estates to family members and reduce the incentive to game the Reverse Health Savings Account.

## REFORM VII: ALLOW MEDICAID BENEFICIARIES TO BUY INTO PRIVATE PLANS

Medicaid enrollees would be free to use their Medicaid Health Credits to join existing employer provided plans. Given that a significant number of new Medicaid enrollees in the last 15 years dropped family coverage, this could be a low-cost way of offering coverage to these groups. Since many of them are above the poverty level, Kansas Medicaid could offer grants to them on a sliding scale, with high amounts for near poverty and lower amounts for incomes near the arbitrarily established poverty level.

Related to this, another possible reform is to allow individuals and small business to purchase private health plans at a state initiated health mart.<sup>28</sup> This would generate several potential benefits. First, it could reduce Medicaid enrollments by moving some beneficiaries back into private sector coverage. Second, it will induce more firms to offer health insurance by lowering the insurance overhead cost that exists in this market. Third, it will reduce insurance costs by creating a larger pool of buyers with more purchasing power and reduced annual claims uncertainty.<sup>29</sup>

## REFORM VIII: DISCONTINUE MARKET-DISTORTING PRACTICES AND POLICIES

Consistent with well functioning markets, all market-distorting activities and schemes should be eliminated. These also include Certificate of Need laws, and state-mandated health benefits above the Medicaid requirements. Providers of medical services would directly negotiate with drug companies for discounts. Elimination of Certificate of Need laws would allow for easy entrance into the long-term care market in

response to market price signals and would reduce costs by promoting more competition among providers.

## CAN MARKETS IMPROVE QUALITY AND REDUCE COSTS OF HEALTH CARE?

Would the free enterprise system really help Medicaid’s beneficiaries and improve Medicaid’s fiscal situation? Or is the purchase of health care simply too sophisticated for most people to deal with, especially the poor? Fortunately, we have some answers to these questions based upon experience.

It is true that broad market-based reforms are virtually non-existent in Medicaid. In the past, federal administrators have looked unfavorably on significant, market-based reforms. While attempts have been made to utilize HMOs, these continue to suffer from administered pricing schemes where reimbursements to providers are set too low, causing providers to drop out of the system. Now, however, a new, more receptive attitude in Washington may permit dramatic changes in the system.

While the private sector suffers from many of the same problems as the public sector, we can see how a true market in medical care would operate. Most people did not have prescription drug coverage until the 1980s and 1990s. They paid out of pocket. The result was a 34% increase in drug costs between 1960 and 1980 contrasted

with a 236% increase in the general cost of medical care. After drug coverage became much more commonplace, prescription drug costs rose 336 %vs. 281% for general health care from 1980 through 2002.

In cash medical markets, such as cosmetic care, the results are what would be expected. Along with continuing advances in quality, innovations, and comfort, the discipline of the market serves to control costs. Cosmetic care rose at a lower rate than general inflation between 1992 and 2001, while general medical inflation was three times greater. Eye care costs—where there is not nearly as much third-party payment—increased 33% between 1990 and 2002, while general medical costs increased at 75%. This occurred during a period when there were dramatic advances in technology and services such as LASIK. In addition, the cost of other types of medical services, such as podiatry and chiropractic care (which are often not insured), rose at only 43% between 1990 and 2002 (versus the general medical inflation of 75%).

What would happen under broad based market reforms in Kansas? We can surmise that competition and innovation would bend down the long-run growth rate of the Kansas Medicaid Plan. Given that productivity growth has accelerated from essentially zero to around 2% in the service sector since 1995 (Alan Greenspan’s “New Economy”) efficiency gains in the health sector should result from the creation of a real marketplace. If the Medicaid Reform could produce just half the

### THE MECHANICS OF ACTUARILY EQUIVALENT CUSTOMIZED BENEFITS PACKAGES *(continued)*

**Table F**  
**Equivalence Results of Example Proposed Benefit Plan**

Target Group’s Expected Use of Key Services Based on Historic Utilization

<b>Service</b>	<b>Minimum Acceptable Amount</b>	<b>Example Plan</b>
Value of Hospital Care	\$81.36	\$81.36
Value of Physician Care	\$55.55	\$55.72
Value of Pharmacy	\$22.50	\$21.06
Value of Other Benefits	\$22.43	\$22.45
Value of Additional Benefits	n/a	\$3.00
Value of Total Covered Benefits	\$181.84	\$183.59
Actuarial Equivalence Ratio: 101.0%		

Note: The plan provides average benefits of \$183.59 versus the minimum acceptable amount of \$181.84. Thus, the value of the average benefit exceeds the value of the minimum package and the plan is actuarially equivalent.<sup>23</sup>

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productivity gain of the private service sector, Medicaid would be half as large as currently projected in the year 2085!

## RESULTS OF FLORIDA'S MARKET BASED MEDICAID REFORM

How is market based Medicaid reform working in Florida? So far most results are positive:

- More Competition In Plans
- More Competition In Benefits Packages
- More Enrollee Involvement In Plan Selection
- Large Scale Use Of “Reversed” Health Savings Accounts
- Enrollees Are Generally Satisfied With Their Reform Plans
- The Reform Is Budget Neutral
- The Reform Appears To Have Reduced Costs
- The Reform Appears To Have Improved Medical Outcomes
- The Opt Out Program Has Remained Very Small And Far Below Expectations

From above, the reform has gone through three full years with mostly positive outcomes.<sup>30</sup> This should give Kansas policy makers confidence that instituting a market based Medicaid reform program will generally improve both health outcomes and the fiscal situation of the State's Medicaid program.

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# APPENDIX

## SECTION 1115 WAIVERS FOR MEDICAID FUNDING

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### BACKGROUND

Section 1115 of the Social Security Act permits the Secretary of Health and Human Services to waive certain portions of the federal Medicaid Act for a five-year demonstration project, if the demonstration is budget neutral to the federal government. Budget neutrality can simply be defined as the costs of Medicaid will not be higher to the Federal government than under the existing program. Recall, the Federal government contributes at least 50% of the cost of Medicaid (higher amounts for poorer states). When the budget neutrality test is met, the Secretary of Health and Human Services, through the Health Care Financing Administration, can grant a state's request to alter Medicaid. Usually the 1115 waiver is used to expand coverage to an otherwise uninsured group; to address disparities in health coverage among a state's population. But as Florida has shown it can also be used to change the nature of the program for existing enrollees.

### BENEFITS TO STATES OF 1115 WAIVER

- It is the only way a state can offer a “tailored” package of benefits, instead of the full Medicaid benefits, to a targeted expansion population. Examples of these targeted populations include HIV-positive individuals (to get them started on drug regimens before they become symptomatic and disabled) and to middle-income women of childbearing age (to allow them access to family planning benefits and avoid unwanted pregnancies).
- States can cap enrollment or create a time-limited program, unlike a regular Medicaid eligibility group. The 1115 waiver allows a state to avoid an open-ended entitlement, which is much more politically acceptable to governors and state legislatures.
- Financing and Budget Neutrality

The Centers for Medicare and Medicaid Services cannot approve a 1115 waiver proposal that would result in a higher level of spending than otherwise would have been the case under the State's Medicaid program. In order to do this, a comparison must be made between what the federal government would spend upon approval of the 1115 waiver against what the Health care Financing Administration would spend assuming the status quo: “with waiver costs” vs. “without waiver costs.” The state must make expenditure projections, and all assumptions and methodologies are negotiated with the Health care Financing Administration during the waiver review process. The budget neutrality requirement is for the five year period; there can be deficits in some years, if they are offset by savings in other years.

### THE 1115 PROCESS AND OPERATIONAL ATTRACTIVENESS FOR STATES

Unlike other waivers, there is no prescribed format for a 1115 application. States should include detailed information about the proposed program design, project administration and management, evaluation plan, supporting budget/cost information, and compelling policy reasons for proposing the coverage expansion. Generally speaking, the process could take as long as two years from design to implementation.<sup>31</sup> Since the waiver involves changing Federal law and regulations it is essentially negotiated line by line. As such, states need to have access to individuals experienced in such negotiations.

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## ENDNOTES

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- 1 See “Radical Surgery for Medicaid?”, Business Week, August 8, 2005.
- 2 Source: Congressional Budget Office
- 3 See [www.statecoverage.net/pdf/stateofstates2006.pdf](http://www.statecoverage.net/pdf/stateofstates2006.pdf)
- 4 Source: CPI for Medical Care, Bureau of Labor Statistics
- 5 [statehealthfacts.org](http://statehealthfacts.org)
- 6 See, for example, Calvin, J., “Medicaid Patients Less Likely Than Those With Private Insurance To Receive Recommended Cardiac Care,” *Annals of Internal Medicine*, November 21st, 2006.
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- 8 Hayek, F. A. 1945. “The Use of Knowledge in Society.” *American Economic Review* 35 (September): 519-30. Reprinted in Hayek, 1948a, pp. 77-91.
- 9 See W. Hsaio, et al, “Results, Potential Effects and Implementation Issues of the Resource-Based Relative Value Scale,” *Journal of the American Medical Association* 260, no. 16 (October 28, 1988): 2429-38.
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- 12 See, for example, Feldstein, M., “Tax Avoidance and the Deadweight Loss of the Income Tax,” NBER Working Papers 5055, National Bureau of Economic Research, 1999.
- 13 See Patricia Danzon, “Hidden Overhead Costs: Is Canada’s System Really Less Expensive?”, *Health Affairs*, Spring 1992, pp. 21-43
- 14 Bailit, M., Burgess, L., and Roddy, T., “State Budget Cuts and Medicaid Managed Care: Case Studies of Four States,” *National Academy of State Health Policy*, June 2004.
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- 17 See See “Focus on Health Reform: Summary of New Health Reform Law”, Kaiser Family Foundation, <http://www.kff.org/healthreform/upload/8061.pdf>
- 18 See Thorpe, K., and Howard, D., “The Rise In Spending Among Medicare Beneficiaries: The Role Of Chronic Disease Prevalence And Changes In Treatment Intensity “, *Health Affairs* 25 (2006): w378-w388; b
- 19 By law Medicaid Managed Care must offer two plans in a given area. As a practical matter there may be no real competition for several reasons including the same providers being in both plans and geographic location making enrollment in a competing plan impractical.
- 20 See Verdier, J., “Medicare Advantage Rate Setting and Risk Adjustment,” *Mathematica Policy Research*, October 2006.
- 21 Taken from: “Florida’s Medicaid Reform Risk Adjustment & Benefit Design”, Technical Advisory Panel January 13, 2006, Florida Agency for Health Care Administration.
- 22 Ibid.
- 23 Ibid.
- 24 See, for example, Thorpe, et. al, *The Impact Of Obesity On Rising Medical Spending*, *Health Affairs*, 10.1377/hlthaff.w4.480
- 25 See [www.valueoptions.com/news/releases/release09292006.htm](http://www.valueoptions.com/news/releases/release09292006.htm)
- 26 Gustofson, D., et. al., “The Quality Assessment Index (QAI) For Measuring Nursing Home Quality,” *Health Services Research*, v. 25, April 1990, pp. 97-127.
- 27 See Simon-Rusinowitz, L., Mohoney, K., and Benjamin, A., “Payments to Families Who Provide Care: An Option That Should Be Available,” *Generations*, 22:3, pp. 69-75, Fall 1998.
- 28 After being developed with State funding this “mart” would be operated by private carriers and health plans.
- 29 See Bond, M., “Dealing With Kansas’ Uninsured,” *Flint Hills Center*, Vol. 4, no. 2, March 2007.
- 30 See Bond, M., “Reforming Medicaid in Florida”, *JMI Backgrounder #65*, March 2010.
- 31 See “Section 1115 Waivers For Medicaid Funding”, *ACNM*, 44, June 2001.







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