Backgrounder

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State Health Reform: How States Can Control Costs and Expand Coverage

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Governors and state legislators too often hear from Washington health care consultants and advocacy groups, the "experts," that health care is simply expensive, that nothing can be done about it, and that the citizens of their states are passive victims of high and uncontrollable health care costs. They are also often told that the "right" solution is to wait for Congress to act on "national health reform"; or to obtain more money from the federal Treasury for Medicaid, which is administered at the state level; or to impose a new tax on private employers and workers in their states; or to extract new revenues from doctors and hospitals in the form of a "provider tax" either to offset rising health care costs or to pay for the cost of caring for, or covering, the uninsured.

What many health policy "experts" will not tell them is to take a clear-eyed look at their own state policies and programs. The problem is that many state legislators often do not understand the underlying policies crafted by their predecessors, so they do not know how to change them, or they fail to recognize the negative impact of their own invariably well-intentioned policies, which are often contributing factors in rising health care costs.

Legislative committees dealing with insurance are not the same as those dealing with Medicaid, which often means that health care is viewed in two vastly different environments. In fact, Medicaid may be the largest "insurer" in the state. Too often health policy experts fail to give state officials sound advice for harnessing market forces to control costs or expand cov-

Talking Points

- The rising cost of health care for states and their citizens is often assumed to be a problem solely in search of a federal solution. In reality, states influence costs as regulators, financiers, purchasers, and providers of health care.
- State legislators often do not understand the underlying policies crafted by their predecessors and they do not know how to change them, or they fail to recognize the negative impact of their own policies.
- To control costs, improve coverage, and restructure the financing and delivery of health care in their states, policymakers can create premium support in Medicaid, re-direct government funds from institutions to individuals, and reform health insurance markets.
- State officials should ignore those who insist that the only solution is to obtain more money from the federal government and instead focus new efforts on returning competition to their states' health insurance markets.

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erage. But state officials are not powerless at all. Just as states drive up health care costs, they can reverse current trends through sound reform.

False Assumptions

The rising cost of health care for the states and their citizens is often tacitly assumed to be a problem solely in search of a federal solution. In reality, state officials also drive up costs as regulators, financiers, purchasers, and providers of health care. State officials play critical roles in both the *supply* (the licensing of health care professionals, controlling the supply of medical facilities through "certificate of need" laws that determine the number of hospital beds in a certain area, and regulating health insurance markets) and *demand* (determining eligibility for public programs, setting reimbursement rates for doctors and hospitals, and mandating health benefits, procedures, and treatments). Because Medicaid is now the largest single budget expenditure in many states, "crowding out" funding for other state priorities, legislators and governors have little choice but to engage in serious, long-term reform of their Medicaid programs. With rising costs, they should also take a broader view of how state policies affect the cost of health care and how those policies can be changed.

It must also be acknowledged that change requires taking on special interests in the health care sector that are often even more powerful at the state level than at the national level. Challenges to the status quo are likely to meet resistance from well-entrenched alliances between advocacy groups and providers.

New and Better Policies

State policymakers can do a great deal to control costs, improve coverage, and restructure the financing and delivery of health care in their states. There are several avenues open to them:

1. **Create premium support**. State legislators can create, within current law, a premium support system for Medicaid and the State Children's Health Insurance Program (SCHIP) recipients, enabling them to enter or re-enter private insurance markets. Premium support is essentially a direct government payment to a private health plan of the recipient's choice.
2. **Re-direct government funds from institutions to individuals.** They can also re-direct existing government funding in order that the public dollars follow the person, and not the institutions. This would transform the system from a provider-based to a patient-centered system. Where this has been tried on a limited basis, such as the "cash and counseling" demonstration projects that provide long-term supportive services for the disabled and elderly, it has increased access to services, improved patient care, and increased patient satisfaction, all without any increase in the risk for fraud.
3. **Reform health insurance markets.** State policymakers, who have an enormous amount of authority over state health insurance markets, can restructure their health insurance markets, reduce excessive benefit mandates and regulation, and foster competition both within the state and across state lines with interstate health insurance plans.

State officials are not helpless, and they should not wait for Washington to improve public programs, revitalize health insurance markets, and expand coverage.

How States Drive Up Medicaid Spending

In the $350 billion Medicaid program, the nation's largest means-tested program (participation determined by income level), federal dollars follow state decisions. Within broad federal guidelines, states set Medicaid eligibility, adopt optional benefits, and determine reimbursement rates. Medicaid consists of "mandatory" populations and benefits, set by federal law, and "optional" populations and benefits, determined by state law. State decisions on optional spending account for 60 to 65 percent of the cost of Medicaid.[1]

Broad Flexibility. States already have a great deal of flexibility and freedom in setting Medicaid policy, such as determining:

- Income levels of eligibility for enrollment in the program beyond the minimum federal requirements;
- Application of an asset test for certain populations;

- Coverage extension to "medically needy" populations;
- Frequency of re-determining eligibility for enrollment;
- Liberalization of access by adopting "presumptive" eligibility (starting benefits immediately prior to a full determination process because the person appears to be eligible based on initial information) for certain persons or continuous eligibility for persons already enrolled;
- Adoption of the administrative flexibilities available to them under the Deficit Reduction Act of 2005 reforms on benefit packages and cost-sharing;
- Methods for setting reimbursement and rebates for prescription drugs;
- Which benefits, if any, are to be subject to prior authorization rules; and
- The number of home- and community-based waiver slots for elderly and disabled populations seeking alternatives to institutional facilities that will be offered.

States can also decide how to deliver health care coverage—through "fee-for-service," capitation contracts (flat fee per patient) with managed care organizations, or other types of managed care arrangements. Long-term care accounts for about one-third of Medicaid spending. States can determine the ratio of institutional care and community-based care. Medicaid spends about $100 billion on Medicare beneficiaries ("dual eligibles"). States can play a key role in the spread of Medicare Advantage Special Needs Plans. Better coordination for the high-risk, high-cost dual eligibles has the potential for improving health outcomes for the beneficiary and lower costs for both Medicare and Medicaid. It is clear that states can do a great deal, under existing law, to rationalize Medicaid spending and thus more effectively control costs.

Temptation of "Free" Money. Medicaid and Medicare (the large government program for senior and disabled citizens) were both created in 1965. Since its inception, Medicaid has operated as a federal–state partnership, with the states largely administering the program under federal law and regulation, and has been jointly financed as a federal–state "matching" program. This fundamental arrangement relies on both partners to share the cost, and therefore the risk, of caring for the poor and the indigent. Over the years, states have been encouraged by advocacy groups to expand Medicaid because for every dollar a state is willing to spend, it will receive at least a dollar from the federal government; and in a state with a higher match rate, even more. Not surprisingly, during the fiscal years (FY) 2007 and 2008 alone, an expansion of Medicaid benefits occurred in 24 states; eligibility for Medicaid coverage was expanded in 36 states, including so-called conservative states.[2]

Federal Money Machine. During the 1990s, Medicaid became a federal money machine used to help fuel "economic development" and even balance state budgets. The combination of Medicaid as a matching program and loopholes in federal law were often exploited in ways that allowed states to claim more federal taxpayers' dollars without proportionately increasing the state taxpayers' share of cost. Creative state officials discovered imaginative ways to artificially generate additional federal funds through "provider taxes" (i.e., new taxes on hospitals, nursing homes, and even physicians), the Dis-

1. Kaiser Commission on Medicaid and the Uninsured, "Medicaid 'Mandatory' and 'Optional' Eligibility and Benefits," July 2001, p. 12. See also, Kaiser Commission on Medicaid and the Uninsured, "Medicaid Enrollment and Spending by 'Mandatory' and 'Optional' Eligibility and Benefit Categories," June 2005, p. 11. In order to qualify for federal matching funds, states are required to cover certain mandatory populations and provide mandatory benefits. Federal matching funds are available to states to cover additional populations and provide additional benefits at their discretion. In the July 2001 paper, Kaiser estimated expenditures on optional populations and benefits to be 65 percent. In the later paper, that number was revised to 60 percent. Estimates may vary over time due to changes in eligibility groups and assumptions about benefits. Some consider all benefits to children mandatory due to the Early Periodic Screening Diagnosis and Treatment (EPSDT) provision. Other changes over time that can affect the percentage include the migration of prescription-drug benefits for "dual eligibles" from Medicaid to Medicare and growth in caseload.
2. Heather Jerbi, "Tracking State Health Reform Initiatives," *Contingencies,* (September/October 2008), pp. 20–26.

proportionate Share Hospital (DSH) program (used to channel federal payments to hospitals for caring for the uninsured), and phantom "upper payment limits (UPL)." Using upper payment limits, states and providers, usually hospitals and nursing homes, worked together to generate additional funding from the federal government by charging in excess of the net amount the provider received for services. The UPL was calculated based on Medicare cost principles and the federal government paid its share based on those amounts. However, the provider returned a portion of such amounts to its state or local government.[3]

Missouri and Tennessee. A number of states jumped at the chance to receive more federal dollars in the 1990s only to create conditions that would force them to face more difficult budget decisions in the 2000s. Looking at two such states, Tennessee and Missouri, the ebb and flow of Medicaid funding can be observed. TennCare was originally conceived as a federal bailout for the state's budget crisis. The relief was short-lived. Without appropriate safeguards, enrollment ballooned, the health insurance markets were disrupted, over-regulation thwarted competition, costs soared, and the program was in a perpetual state of litigation and uncertainty.

Missouri implemented a waiver in 1998 to expand eligibility for children to 300 percent of the federal poverty level (FPL) ($63,600 for a family of four in 2008) to 100 percent FPL ($21,200 for a family of four in 2008) for parents and to 125 percent FPL ($26,500 for a family of four in 2008) for adults. Coupled with the economic slowdown, enrollment in Missouri's public programs soared and private coverage dropped. Prior to the waiver, Medicaid enrollment averaged 2.9 percent annually during 1993–1998.[4] In 1998–2001, enrollment averaged 11.4 percent annually.[5] There was also evidence of a decline in private coverage acceptance or enrollment, a typical consequence of public program expansion. Employer-sponsored health insurance for low-income adults dropped from 41.7 percent in 2000 to 30.0 percent in 2004.[6]

In FY 1997, before the waivers kicked in, Medicaid expenditures as a percentage of total expenditures in Missouri and Tennessee were generally in line with other states. Medicaid expenditures accounted for 20 percent of total expenditures in all states compared to 20.2 percent in Missouri and 23.7 percent in Tennessee.[7] By FY 2001, however, the percentage spent by Missouri on Medicaid had grown to 29.5 percent and to 31.4 percent by Tennessee compared to just 19.7 percent by all states.[8] From 2002 to 2005, Missouri and Tennessee were the only states spending more than 30 percent of their budgets on Medicaid in each of those years. As a percentage of total expenditures, Tennessee spent more on Medicaid than any other state and Missouri was second. Medicaid spending, as a percentage of total expenditures, for Missouri and Tennessee peaked in FY 2005 at 34.3 percent and 35.9 percent, respectively.[9]

Federal Crackdowns. As more money was pumped out of the Treasury, Members of Congress and executive branch officials alike awakened to the funding abuses and acted, over time, to close the various financing loopholes. The effects of those actions caught up with states during the Bush Administration. No longer able to rely on the cost-shifting arrangements, states, including Missouri

3. For a detailed explanation, see U.S. Government Accountability Office, *Medicaid: CMS Needs More Information on the Billions of Dollars Spent on Supplemental Payments*, GAO-08-614, May 2008, p. 10. Also see various reports of the GAO and the Office of the Inspector General in the U.S. Department of Health and Human Services. For a comprehensive list of reports, see Hearings, *H.R. 5613, Protecting the Medicaid Safety Net Act of 2008*, Subcommittee on Health, Committee on Energy and Commerce, U.S. House of Representatives, April 2, 2008.
4. John Holahan and Mindy Cohen, "Missouri Medicaid Spending Growth 2001–2005," Missouri Foundation for Health, 2006, p. 2.
5. *Ibid.*
6. *Ibid.*, p. 4.
7. National Association of State Budget Officers (NASBO), *1998 State Expenditure Report*, June 1999, Table 29.
8. *Ibid.*
9. *Ibid.*

and Tennessee, were required to deposit more of their own taxpayers' dollars into Medicaid to continue spending at the same rate. The current governors of Missouri and Tennessee, one Republican and one Democrat, were stuck with difficult and painful decisions left to them by the actions of their predecessors in the 1990s. These states subsequently made some of the most difficult decisions of all to include reductions in eligibility in order to restore their programs to more fiscally sustainable levels. According to projections for FY 2007, Medicaid spending for the two states has dipped below 30 percent. Maine and Pennsylvania have since replaced them as the highest-spending Medicaid states as a percentage of all state expenditures.[10]

Medicaid Increases Private Costs. In California's inconclusive health care debate last year, Republican Governor Arnold Schwarzenegger described the "hidden tax" in health care caused by the cost of uncompensated indigent care and how providers shift costs from low Medi-Cal reimbursement rates to private payers, and thus working families (Medi-Cal is California's name for its state Medicaid program.). It is estimated that 17 percent of premiums paid by insured individuals in California are attributed to this "hidden tax."[11]

In New York, the dynamics are different: Excessive reimbursement drives up costs. New York uses high inpatient hospital reimbursement rates to subsidize outpatient clinics. Hospital beds in New York have massive debt attached to them, which must be repaid through higher rates, thus driving up costs for everyone. New York State Health Commissioner Richard F. Daines, M.D., told the State General Assembly last February that "[f]rom this data we know that New York ranks well above average of avoidable hospitalizations. And we know that there are huge disparities in the numbers of avoidable hospital admissions across the state. The state's own reimbursement system has perpetuated this problem by overpaying for the delivery of acute care and high-tech interventions and underpaying for the provision of basic preventive and primary care. So we shouldn't be surprised that we have more inpatient care and less outpatient care."[12]

To its credit, New York now appears to be taking the threat caused by overspending seriously and has taken steps to reduce Medicaid inpatient hospital payments and combat Medicaid fraud.

According to the New York State Department of Health's "Report on Implementation of the Report of the Commission on Health Care Facilities in the Twenty-First Century," the state is undergoing "a historic transformation of the New York State health care delivery system. Approximately *one-fourth* of all hospitals in the State have been reconfigured; some have closed, others have merged, and still others have eliminated excess beds and redundant services."[13] When fully implemented by 2011, "it is expected that 21 hospitals and nursing homes will have been closed and more than 6,200 beds eliminated."[14] New York estimates the changes will save $106 million annually.

New York has also begun seriously combating Medicaid fraud. According to the 2007 Annual Report of the New York State Medicaid Fraud Control Unit, increased investment in states has yielded dividends: "The Unit obtained orders and settlements of Medicaid restitution totaling $112.5 million (in 2007), 90% higher than the $59.4 million achieved in 2006."[15]

10. *Ibid*.
11. Office of the Governor, Governor's Health Care Proposal, "Governor Schwarzenegger Tackles California's Broken Health Care System, Proposes Comprehensive Plan to Help All Californians," January 8, 2007, p. 3.
12. Commissioner Richard F. Daines, M.D., "New York State Department of Health's 2008–2009 Budget," testimony before the Finance Committee, New York State Senate, and the Ways and Means Committee, New York State Assembly, February 6, 2008.
13. New York State Department of Health Services, "Report on Implementation of the Report of the Commission on Health Care Facilities in the Twenty-First Century," Summer 2008, p. 1, at *http://www.nyhealth.gov/facilities/commission/docs/implementation_of_the_report_of_the_commission.pdf* (September 15, 2008). Emphasis in original.
14. *Ibid*., p. 26.

The High Price of Inaction. There is a price to inaction, as well as a cost for bad policy. Once again, California provides an excellent case study. Three years ago, the Public Policy Institute of California published a paper, "Medi-Cal Expenditures: Historical Growth and Long Term Forecasts," outlining the challenge of the state's Medicaid spending. The researchers, not surprisingly, found that, "the most expensive 2 percent of enrollees were responsible for more than 40 percent of all fee-for-service Medi-Cal benefit expenditures. The bottom 75 percent of enrollees accounted for less than 6 percent of all costs. This means that even if costs were cut in half for all fee-for-service enrollees in the lowest 75 percent of cases, the total savings would be less than 3 percent."[16] The researchers concluded that California needs to focus reforms on disabled and elderly enrollees, which are the highest cost cases: "[A]ny serious strategies to contain costs for Medi-Cal need to address costs for the high-end enrollees, costs driven by long-term care for the elderly, a broad array of expenses for disabled enrollees, and expensive hospital stays for other enrollees."[17]

But when the federal government tied special Medicaid funding under a hospital financing reform waiver to adopting benchmarks to expand managed care for the expensive Medicaid populations, the California General Assembly forfeited those funds and future savings rather than adopt any meaningful reform. Today, California faces a $16 billion budget deficit and Medi-Cal providers face 10 percent cuts in reimbursement in this year's budget. Providers in turn have sued the state to prevent the implementation of these cuts, alleging that such action threatens access to health care for California's Medicaid recipients.

More Taxes. State decisions are often influenced by Medicaid financing arrangements as well as by the delivery of health care itself. States received a total of $12 billion in various provider taxes in 2007 through Medicaid. Hospitals in New York alone paid $2 billion in provider taxes. Hospitals and other providers often willingly agree to such arrangements as they are generally passed along with rate increases. Such "taxes" more accurately resemble slot machine tokens that are played with the expectation of a return. The result: The state share of the cost is passed to the provider, the provider is made whole, and the unwary federal taxpayer foots the bill. Federal rules say that such provider taxes are to be "broad-based," uniform, and do not constitute a "hold harmless" arrangement. In other words, the tax must be applied equally and the tax cannot be repaid. The underlying assumption of these three requirements is that it should be politically difficult to tax the provider, who in turn, must pass the tax on to the patient. Fundamentally, a provider tax would mean taxing people who are elderly, disabled, sick, or perhaps all three. These federal rules are supposed to be safeguards for the taxpayers, but states continue to try to stretch the limits of their power to extract more federal taxpayer dollars.

Some state policymakers view provider taxes, like taxes on employers, as a politically attractive source of revenue. But the reliance on provider taxes may disrupt the service system itself. Because nursing homes can be a source of provider taxes, yet home- and community-based providers cannot, nursing homes may have an advantage in competing for government funding in times of tight budgets.

Such provider taxes may be politically easier to sell to the public when carefully crafted to shift the cost to federal taxpayers. But such financing should be rejected as unstable. The federal government can be expected to close such loopholes, and it eventually does when discovered. The government has closed loopholes both through statutory and regulatory oversight. In 2005, Georgia shifted to managed care in part because of a loophole in federal law on how provider taxes are applied to managed care plans. Through the Deficit Reduction Act of 2005,

15. New York State Medicaid Fraud Control Unit, *2007 Annual Report*, p. 7.
16. Thomas MaCurdy, Raymond Chan, Rodney Chun, Hans Johnson, and Margaret O'Brien-Strain, "Medi-Cal Expenditures: Historical Growth and Long Term Forecasts," Public Policy Institute of California, June 2005, p. vi, at *http://www.ppic.org/main/publication.asp?i=619* (September 7, 2008).
17. *Ibid.*, p. 45.

Congress struck back and subsequently stopped the spread of arrangements in which managed care plans were taxed by states that had the potential to shift costs to the federal taxpayers.[18] Illinois has enacted different versions of provider taxes on hospitals over the past few years. But the hospitals in Illinois have faced disruption in payments as changes were made in the complex provider-tax arrangements under federal scrutiny through the state plan amendment review process.

Long-Term Care Costs. In long-term care, Medicaid dominates the market and exerts tremendous influence over both supply and demand in virtually every state in the union. According to a January 2008 report for the Department of Health and Human Services prepared by researchers at Mathematica Policy Research, Inc., "Medicaid is the largest insurer for long-term care services in the United States, covering over 60 percent of long-term care users and accounting for 45 percent of nursing home expenditures in 2002."[19]

Any state that continues to invest Medicaid dollars disproportionately in institutions rather than home- and community-based options is driving up costs for taxpayers. Mathematica analyzed spending for 1.3 million Medicaid enrollees using community-based long-term care and 1 million enrollees using institution-based long-term care in 2002 and found that total Medicaid expenditures per Medicaid enrollee who used only community-based long-term care was $24,966—compared to $38,844 for an enrollee who used only institutional care.[20]

How States Distort the Health Care Markets

State and local governments frequently play leading roles on the supply side of health care as providers themselves. Even in the face of numerous and serious violations of health quality standards that resulted in several deaths, the state of California and Los Angeles County (aided by federal matching dollars) bailed out the dysfunctional Martin Luther King Hospital, a county facility, for years before it was finally closed last year. Government facilities may receive preferential treatment in terms of higher reimbursement rates. Contracts may require health plans to include government entities within their networks, whether or not that inclusion makes sense from an economic point of view. States also exempt Medicaid from the legal or regulatory requirements that they often apply to the private sector.

Certificate of Need. As regulators enforcing "certificate of need" (CON) laws, state health planning entities often decide whether private medical facilities can be opened or closed.

The recent high-profile closing of Muhlenberg Regional Medical Center in Plainfield, New Jersey, reflects state and local political decisions and market distortions, not federal law or regulation. After 131 years of providing care, the state of New Jersey approved the 355-bed facility's closure this summer. State law "provides for the issuance of a certificate of need only where the action proposed in the application for such certificate is necessary to provide required health care in the area to be served, can be economically accomplished and maintained, will not have an adverse economic or financial impact on the delivery of health services in the region or statewide, and will contribute to the orderly development of adequate and effective health care services."[21]

The Muhlenberg Medical Center's closure provides a number of interesting insights into government financing as well as the implementation of CON. In its analysis, the state agency staff recognized that Muhlenberg was not a "financially sus-

18. The Deficit Reduction Act of 2005, Public Law 109–171, Section 6051, "Managed Care Organization Provider Tax Reform."
19. Audra T. Wenzlow, Robert Schmitz, and Kathy Shepperson, Mathematica Policy Research, Inc., "A Profile of Medicaid Institutional and Community-Based Long-Term Care Service Use and Expenditures Amount of the Aged and Disabled Using MAX 2002: Final Report." Prepared for the Office of the Assistant Secretary for Planning and Evaluation, Contract #HHS-100-97-0013, January 18, 2008, p. 1.
20. *Ibid.*, p. 23.
21. Letter from State Commissioner Heather Howard to John P. McGee, Solaris Health System, July 29, 2008, approving Solaris's certificate of need application for the discontinuance of Muhlenberg Regional Medical Center, p. 2.

tainable hospital."[22] The staff cited several factors contributing to the decision to close the hospital. For example, the hospital was running annual operating losses because of charity care and low government payments. In 2007, over 71 percent of admissions were dependent on government payment (Medicare, Medicaid, and Charity Care) or were without insurance, compared to the state average of 59 percent."[23]

Meanwhile, as the staff report noted, the hospital was nonetheless the beneficiary of tens of millions of dollars of private investment for the purpose of increasing its revenue and expanding its patient base.[24] Yet, on the basis of 2007 data, the Muhlenberg emergency department contributed only 18.2 percent of hospital admissions, indicating that the emergency room was serving primarily as a unit for "non-acute diagnostic and treatment services."[25]

Curiously, the staff report also noted that, despite the CON law to establish a "rational" number of hospital beds, there was already an oversupply of licensed acute care beds in the surrounding areas, and the hospital had only a 38 percent occupancy rate of licensed beds. [26] In fact, according to the State Health Planning Board, there were already eight hospitals within 13 miles of Muhlenberg, as well as a federally qualified health center. In a normal market, as opposed to a centrally planned allocation of hospital beds by a government panel, that sort of "oversupply" would have been highly unlikely. Investors are normally rational.

Of course, the snapshot of Muhlenberg revealed in the State Health Planning Board report reflects the culmination of years of planning decisions by state and local authorities. The story, interestingly, does not end with the closure of Muhlenberg. Literally days after the last patient left Muhlenberg, it was reported that the company that applied for the closure of the hospital was back working the system: "Solaris Health System is looking to expand JFK Medical Center in Edison…."[27]

A state's "certificate of need" regime can provide a lucrative avenue for lawyers and consultants who can spend a great deal of time, effort, and money on behalf of their clients arguing for or against the construction or expansion of a "competing" medical facility before a state planning agency, adding to health care's administrative costs in the process. But it can also have a negative impact on market competition in the state and thus undermine efforts to control health care costs.

In a joint 2004 report on the lack of competition in the health care sector of the economy, *Improving Health Care: A Dose of Competition,* the U.S. Federal Trade Commission and the U.S. Department of Justice called on state officials to take several steps to reduce barriers to market competition, including a reconsideration of CON laws. The joint agency report held that such laws are not effective in containing health care costs and can pose "anticompetitive risks" that outweigh their benefits.[28]

Benefit Mandates. The 1990s witnessed significant increases in state-mandated benefits for group and individual health insurance policies. According to the Council for Affordable Health Insurance, there are 1,961 state mandates nationwide, and depending on the nature and scope of those mandates, they can significantly increase health care costs. State officials are beginning to examine them. At least 30 states require a cost assessment before they are imposed, and at least 10 states have enacted laws that allow "mandate-lite" insurance policies to ease the financial burdens on individuals and families.[29]

22. State Health Planning Board, "Certificate of Need, Department Staff Project Summary, Analysis and Recommendations, Closure of Muhlenberg Regional Medical Center," FR #080303-20-01, 2008, p. 1.
23. *Ibid.*
24. *Ibid.*, p. 2.
25. *Ibid.*, p. 5.
26. *Ibid.*, p. 6.
27. Continuous News Desk, "Solaris Looking to Expand JFK Medical Center," *The Star-Ledger,* August 9, 2008.
28. See the U.S. Federal Trade Commission and the U.S. Department of Justice, *Improving Health Care: A Dose of Competition* (Washington, D.C., 2004).

States differ radically in their health insurance markets and widely in their laws and regulations. A key objective for state policymakers is to take a clear-eyed look at how much competition is present in their respective health care markets and what they can do to increase it. Market discipline, driven by consumer choice, is necessary not only to control costs, but also to secure value for patients.

In a study for the Wisconsin Policy Research Institute, health care economist Linda Gorman argues that due to lack of competition dating back to rating setting actions in the 1980s and other government policies related to benefits and payments, "[t]he Milwaukee (Wisconsin) health care market is plagued with unusually high costs."[30] Gorman points out that a "Mercer/Foster Higgins survey placed Milwaukee's costs at 55 percent above other Midwest metro areas."[31] Such costs are passed on to taxpayers, employers, and employees.

What State Legislators Must Do to Control Costs

As the cost of health insurance continues to rise and threaten coverage even among the middle class and the number of non-insured remains at unacceptably high levels, many state officials clearly are determined to address the health care needs of their citizens, and rightly so. But they should not assume that many of the nation's health policy so-called experts are correct in either their analyses of, or their prescriptions for, these problems. To control health care costs or expand quality care, Medicaid is not the best option. State officials can do better.[32] In fact, state officials should look at reforms both within and outside the Medicaid program:

1. **Adopt a system of premium support for Medicaid recipients**. Within Medicaid, states can move their healthy members covered by Medicaid and SCHIP back into the private health insurance market through premium assistance, providing direct funding to the insurance options chosen by the recipients.[33] This policy will help reverse the "crowd out" effect of the public program expansions that have been displacing private health insurance coverage, draining private insurance pools of younger and healthier members, and driving up the costs for the working families that remain.

   Within Medicaid, states can also adopt appropriate cost-sharing in Medicaid and SCHIP to help prevent over-use and to share the cost of public programs.

2. **Make public dollars follow the person, not the institution.** States can adopt consumer choice in their Medicaid long-term care programs and allow the "money to follow the person" rather than be controlled by institutions. Consumer direction has proven to increase quality and lower total costs. Moving the Medicaid dollars in the "right" direction will relieve the mounting pressures of cost shifting on families obtaining coverage in the private sector.[34]

3. **Make health insurance plans compete.** State officials can help lower the cost of private health insurance by allowing real consumer-directed competition among health plans, enabling indi-

29. Council for Affordable Health Insurance, *Health Insurance Mandates in the States 2008*, at *http://www.cahi.org/cahi_contents/resources/pdf/healthinsurancemandates2008.pdf* (September 7, 2008).
30. Linda Gorman, "Why Milwaukee Care Costs are High: What to Do About It," Wisconsin Policy Research Institute, May 9, 2008, p. 1.
31. *Ibid.*
32. For a checklist of sound health reform options, see Robert E. Moffit, "State Health Reform: Six Key Tests," Heritage Foundation *WebMemo* No. 1900, April 23, 2008, at *http://www.heritage.org/research/healthcare/wm1900.cfm*.
33. For a detailed discussion of how this can be done within current law, see Dennis G. Smith, "State Health Reform: Converting Medicaid Dollars into Premium Assistance," Heritage Foundation *Backgrounder* No 2169, September 16, 2008, at *http://www.heritage.org/Research/HealthCare/bg2169.cfm*
34. For a more detailed description of how this can be implemented, see Christopher J. Meyer, "State Health Care Reform: Retargeting Medicaid Hospital Payments to Expand Health Insurance Coverage," Heritage Foundation *Backgrounder* No. 2177, August 29, 2008, at *http://www.heritage.org/research/healthcare/bg2177.cfm*.

viduals and families to choose what is best for them, not government officials or the companies that dominate the existing health insurance markets—and by ending preferences for government monopolies where they still exist.

Another variation on this idea is for state legislators to restructure the state health insurance market itself, repealing existing health insurance laws and regulations, including the excessive benefit mandates that govern many health insurance markets, and replacing the existing legal regime with a statewide health insurance exchange, which would be confined to handling premium collection and related paperwork processing for individuals and small businesses in a broadly competitive market. This would allow individuals and families to buy the health insurance coverage of their choice, take advantage of the existing tax preferences for group insurance (provided through the "exchange") under federal law, and create ownership of health policies and portability of health insurance, just as there is portability of other types of insurance.[35] Through an employer-based defined contribution, such a mechanism would enhance the transparency of employment-based financing and allow individuals and small businesses access to the best features of group insurance, while permitting them to take advantage of the best features of competing health plans and benefit choice.

Beyond restructuring the market, state legislators could create a more sophisticated way of handling the persistent problem of adverse selection in a pluralistic system—the tendency of older and sicker enrollees to congregate in a few plans—by designing a risk-adjustment mechanism for the private health insurance markets without adding any additional financial burdens to the taxpayers.[36]

Conclusion

It is popular to think that states can do nothing about the cost of health care, that they are simply small rafts carried by the winds, currents, and tides. But it is the individual drops of rain that swell streams and rivers. Policymakers have already seen the dangers of "free" money demonstrated in Missouri and Tennessee. As long as Medicaid is a matching program, the federal government will eventually insist that the states pay their share. As such, states eventually face painful decisions to restore order to their budgets. But even getting the Medicaid budget in order does not repair the damage to the private insurance market on which most American families rely. In fact, some of the Medicaid remedies, such as benefit and eligibility expansions, can disrupt the private market even further, causing a "crowd out" of existing private coverage.

Governors and state legislators should ignore those who insist that the only solution is to obtain more money from the federal government and instead focus new efforts on returning competition to their states' health insurance markets.

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35. For a description of the purpose and function of a state health insurance exchange, see Robert E. Moffit, "The Rationale for a Statewide Health Insurance Exchange," Heritage Foundation *WebMemo* No. 1230, October 5, 2006, at *http://www.heritage.org/research/healthcare/wm1230.cfm*.
36. See Edmund F. Haislmaier, "State Health Reform: How Pooling Arrangements Can Increase Small-Business Coverage," Heritage Foundation *WebMemo* No. 1563, July 23, 2007, at *http://www.heritage.org/research/healthcare/wm1563.cfm*.