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**THE POLITICAL ECONOMY OF MEDICAID: EVIDENCE FROM  
FIVE REFORMING STATES**

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**The Political Economy of Medicaid Reform: Evidence from Five Reforming States**

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## I. Introduction

Of the big three U.S. entitlement programs—Medicaid, Medicare, and Social Security—Medicaid has been growing the most rapidly over the last few years. One of the Great Society programs introduced by President Lyndon Johnson in 1965, Medicaid is the major health care financing system for the poor, some elderly, and the disabled. It is based on a complicated funding model where states design their own programs within federal guidelines, eligibility requirements, and benefit packages, but the federal government provides large grants to augment state funds. In 2010, the most recent fiscal year for which we have data, annual Medicaid spending totaled nearly \$375 billion and accounted for more than 15 percent of U.S. health expenditures, and more than 51 million people received some Medicaid coverage.<sup>1</sup> In 2011, for which we still await final data, average monthly Medicaid enrollment is estimated to have exceeded 55 million, with 70 million people covered by the program for one or more months during the year.<sup>2</sup>

In this paper, we look at the recent growth in Medicaid spending and attempt to explain Medicaid reform successes and failures by focusing on five reform experiences. Careful case study analysis will advance our understanding of best practices in Medicaid reform. Even though many states have introduced reforms over the last 10 years, combined federal and state Medicaid expenditures have grown from 2.0 percent of gross domestic product (GDP) in 2000 to 2.7

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<sup>1</sup> U.S. Department of Health and Human Services, “Fiscal Year 2010 Budget in Brief: Medicaid,” HHS.gov, 2011, <http://dhhs.gov/asfr/ob/docbudget/2010budgetinbriefm.html>; The National Association of State Budget Offices, “State Expenditure Report,” NASBO.org, 2011, <http://nasbo.org/Publications/StateExpenditureReport/tabid/79/Default.aspx>.

<sup>2</sup> Kaiser Commission on Medicaid and the Uninsured, “Medicaid Enrollment: December 2010 Snapshot,” December 20, 2011, <http://www.kff.org/medicaid/enrollmentreports.cfm>; Kathleen Gifford et. al., *A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50-State Survey* (Washington, DC: Kaiser Commission on Medicaid and the Uninsured, 2011), <http://www.kff.org/medicaid/upload/8220.pdf>. CMS data came from CMS, *National Health Expenditure Projections 2010–2020* (Washington, DC: CMS, 2010), <https://www.cms.gov/NationalHealthExpendData/downloads/proj2010.pdf>.

percent of GDP in 2007. When we look past the rhetoric of cost savings and the so-called introduction of market principles into state Medicaid plans, the reality is that few reforms have succeeded at simultaneously (1) reducing costs, (2) maintaining or increasing access to health care, and (3) surviving the politics of reform. Some reforms that promise to reduce costs are dead ideas politically; others that are politically popular simply drive up costs. Successful reforms that provide a combination of cost reduction and maintained or increased access are hard to find, and as a result, the easier path has been to increase Medicaid expenditures over time.

While Medicaid defenders will point to rising health care costs as the primary determinant of rising Medicaid expenditures, Medicaid spending has significantly outpaced health care price increases. These increased expenditures have been the result of changing demographics, increased access and eligibility, service expansions, and waste. Some states have tried to reduce waste and fraud in their programs. Others, such as Arizona, have attempted to cap enrollment and to impose premiums on plan members.<sup>3</sup> But for each small state-level step toward controlling expenditures, there are other states expanding eligibility to uninsured childless adults, abandoning market-oriented systems, and pursuing more costly alternatives.

Finding ways to reduce costs to taxpayers—both state and federal—has become imperative since the 2008 financial crisis and with America’s increasing fiscal challenges. Fiscal policy at both the federal and state levels is on an unsustainable path, and reform in many of America’s major entitlement programs—particularly Medicaid—will soon shift from a question of, “Should we cut?” to a question of, “How much do we have to cut?”

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<sup>3</sup> Julie Nelson, “Impact of Health Reform’s ‘Maintenance of Effort’ Provisions on Arizona’s Health Care Programs,” *Health Care Reform: Finding Your Way* 1, no. 1 (2011), [http://www.azhha.org/member\\_and\\_media\\_resources/documents/FindingYourWayvol1no1.pdf](http://www.azhha.org/member_and_media_resources/documents/FindingYourWayvol1no1.pdf).

Ideally, Medicaid reform should be based on careful cost–benefit analysis of different program features and implementation of “best practices.” Rather than rely on the blunt instrument of across-the-board cuts, reformers should focus on reducing waste, targeting spending cuts at programs’ most ineffective aspects, and creating a framework with better long-term incentives. Targeted spending cuts that take a “scalpel” approach to reform can be more effective politically,<sup>4</sup> provide greater efficiency gains, and put states and the federal government on a more sustainable fiscal trajectory. But given the massive total expenditures on Medicaid and the rapid increase in costs to taxpayers in recent years, even targeted cuts and alterations to individual incentives will have to be significant in scale and scope to realize meaningful cost savings.

Fixing Medicaid and putting it on a saner budgetary trajectory involves reform at several levels. It involves federal reforms that simplify processes, eliminate redundancy, and grant states greater autonomy over eligibility requirements and access. It involves giving states the freedom to experiment with their programs in an environment where they are no longer beholden to simplistic federal matching grant formulas. It also involves sweeping changes to the incentive structure so that individuals—the poor, the elderly, and children—respond rationally to a pricing structure that makes sense for them and for taxpayers.

In this paper, we explore recent state-level Medicaid reforms and the effects of these reforms on individuals and on state budgets. The five states we selected explicitly reformed their Medicaid programs with an eye toward cost savings for taxpayers. Two of the states we look at—Rhode Island and Washington—are probably in the “too soon to tell” category when it comes to cost savings, but it is nonetheless useful to examine how they implemented their

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<sup>4</sup> David Folkenflik, “The Hatchet and Scalpel: A Debate Parable,” National Public Radio, October 16, 2008.

reforms. The other three states—Florida, Idaho, and Tennessee—all developed innovative programs to save money and ensure quality care. Other states can benefit from imitating the successes and avoiding the pitfalls that earlier reformers encountered.

## II. A Brief History of Medicaid

Title XIX of the Social Security Act authorized the establishment of Medicaid in 1965. The program provided health care coverage to the poor and their children, and complicated federal and state funding formulas supported enrollees. While the federal government plays a crucial role in supporting Medicaid programs across the states, each state administers its own program within federal guidelines. In addition to covering low-income individuals, the program also covers some elderly people, the disabled, and some uninsured working adults.

The Centers for Medicare and Medicaid Services (CMS) monitor the programs and evaluate reform proposals, waivers, and compliance. Since 1982, when Arizona decided to participate in Medicaid, all 50 states have had programs in place. Some have named their programs—Tennessee, for example, calls its program TennCare and Oklahoma’s is known as SoonerCare.

Medicaid coverage and enrollment have both grown tremendously since 1965. In the 1970s, Medicaid coverage was extended to elderly, low-income Medicare members needing additional coverage. In the 1980s, benefits were extended to all eligible pregnant women and illegal immigrants involved in emergency situations. In 1989, the Omnibus Budget and Reconciliation Act (OBRA) required all states to phase in coverage for children under 6 years of age growing up in families with incomes of less than 133 percent of the federal poverty line.

OBRA 1990 then required states to cover children under age 11 in any family with an income below the federal poverty line.

In 1995, the Republican-controlled Congress approved a transition to block-grant funding of Medicaid;<sup>5</sup> President Clinton vetoed the bill.<sup>6</sup> In 1997, as part of the Balanced Budget Act, Congress granted states \$4.8 billion per year to develop State Child Health Insurance Programs (SCHIPs). SCHIPs could stand on their own or be implemented through state Medicaid plans.<sup>7</sup> Today, every state has SCHIP, but Medicaid is still the primary program for children.

In October 2000, the Breast and Cervical Cancer Prevention Act was signed into law. The program extended Medicaid coverage to any uninsured woman—regardless of income—who suffers from breast or cervical cancer.<sup>8</sup> In 2001, the Bush administration announced the section 1115 waiver initiative, the Health Insurance Flexibility and Accountability (HIFA) initiative. HIFA granted states greater flexibility in Medicaid design so long as they did not compromise coverage. In 2005, the Deficit Reduction Act (DRA) allowed for more cost sharing and authorized higher copayments for nonemergency services provided in an emergency room. According to the Congressional Budget Office (CBO), the DRA would reduce Medicaid

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<sup>5</sup> A block grant is a fixed sum of money granted by the federal government to states or localities with the requirement that it be spent on a broad area of public policy. Block grants are often used to give flexibility to state or local governments while providing the federal government with budget certainty.

<sup>6</sup> The term “block grant” has negative political connotations dating back to President Clinton’s battle with the “Contract with America” Republicans in 1995. Democrats remember the period as one of intense political hostility, and the term “block grant” reminds them of the gridlock and rancor that ultimately resulted in federal government shutdowns. With this history in mind, even if block grants make sense, some policy makers are going to be put off by the term.

<sup>7</sup> The issue of whether child health insurance programs should be called SCHIPS or CHIPS illustrates the tremendous politicization of Medicaid discussions. Those inclined to emphasize the role of state financing still tend to refer to the program as SCHIP or S-CHIP; others prefer that the program just be called CHIP to reinforce the federal aspect.

<sup>8</sup> For more eligibility information, see CMS, “Breast and Cervical Cancer: Prevention and Treatment,” CMS.gov, [https://www.cms.gov/MedicaidSpecialCovCond/02\\_BreastandCervicalCancer\\_PreventionandTreatment.asp](https://www.cms.gov/MedicaidSpecialCovCond/02_BreastandCervicalCancer_PreventionandTreatment.asp).

spending by \$11 billion over 5 years and by \$43 billion over 10 years.<sup>9</sup> The predicted savings were relative to a CBO baseline and CBO projections are highly sensitive to the assumptions built into the forecast. If we take the CBO projections at face value, though, the expected spending cuts did not occur: Medicaid spending grew steadily between 2006 and 2010, rising from approximately \$325 billion in 2006 to \$375 billion in 2010.<sup>10</sup>

### III. A Survey of Five Recent State Medicaid Reforms

Over the last 10 years, all states have introduced Medicaid reforms. Some have expanded coverage. Others have revised enrollment caps and financing formulas. The Medicaid waiver process, which gives states the chance to test new or existing ways to deliver and pay for health care services in Medicaid and in Children’s Health Insurance Programs (CHIPs), was streamlined under the Bush administration and has encouraged more state-level experimentation. The DRA and the need for greater austerity have also driven Medicaid reforms. Since every state has attempted Medicaid reform in recent years, selecting states to focus on in this paper was difficult. We selected Florida, Idaho, Rhode Island, Tennessee, and Washington because, on paper, their reforms seemed to have the greatest chance of reducing costs for taxpayers. Here are brief descriptions of the five states’ major initiatives.

**Florida Medicaid reform of 2005:** In 2005, the state submitted a Medicaid reform waiver, which CMS approved. The reform rests on four key pillars: (1) risk-adjusted premiums, which are paid by the state’s Medicaid agency, to help reduce adverse selection problems and to

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<sup>9</sup> The Kaiser Commission on Medicaid and the Uninsured, “Deficit Reduction Act of 2005: Implications for Medicaid,” (Washington, DC: Kaiser Family Foundation, February 2006), <http://www.kff.org/medicaid/upload/7465.pdf>.

<sup>10</sup> The Kaiser Commission on Medicaid and the Uninsured, “Medicaid Spending Growth Over the Last Decade and the Great Recession, 2000–2009” (Washington, DC: Kaiser Family Foundation, February 2011), <http://www.kff.org/medicaid/upload/8152.pdf>.



encourage managed care partners to identify enrollees with chronic conditions; (2) enhanced benefits accounts to encourage healthy behaviors; (3) premium assistance for employer-sponsored insurance, which gives Medicaid enrollees the freedom to opt out of traditional benefit plans; and (4) establishment of a low-income pool, which provides a minimum safety net to the uninsured.

**Idaho Medicaid reform of 2006:** After the DRA, Idaho was one of the first states to reform Medicaid. Idaho's reforms tailored benefit packages to members' ages and health status. The reform created three different packages: (1) the Benchmark Basic, which provides coverage to low-income children and working-age adults with average health care needs; (2) the Enhanced Benchmark, which serves individuals with disabilities or special health needs; and (3) the Coordinated Benchmark, which provides supplemental coverage to people who are eligible for both Medicaid and Medicare. The reforms also introduced a cost-sharing system of tiered premiums within the Benchmark Basic plan, implemented copays for several services, introduced more online enrollment processes, and encouraged preventative care programs.

**Rhode Island Global Consumer Choice Compact of 2008:** In August 2008, Rhode Island received waiver approval for sweeping Medicaid reform. The reforms reduce the federal government's role in running the state's Medicaid program, and the state receives capped support levels in return. As part of the Rhode Island waiver, the federal government capped aggregate spending through 2013 at \$12,075 billion in exchange for greater program flexibility over delivery and payment of health care services in the state. The reform should produce approximately \$2.7 billion in savings over five years.<sup>11</sup> Core features of Rhode Island's reform

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<sup>11</sup> Jason Mercier, "States Need Medicaid Flexibility," WashingtonPolicy.org, February 16, 2011, <http://www.washingtonpolicy.org/blog/post/states-need-medicaid-flexibility>.

package include (1) competitive contracting, which ensures that Medicaid-related services are provided by the winning firms in a competitive bidding process, (2) performance-based contracting, which allows governments to acquire services via contracts with clearly defined objectives but with open-ended means to attaining or satisfying these objectives, (3) increased transparency, which helps taxpayers understand how funds are being allocated and encourages accountability, and (4) more streamlined processes, such as the implementation of new information technology systems to simplify eligibility determination, enrollment, and renewal procedures.

**TennCare II of 2002:** Tennessee's first attempt to enact Medicaid reform came in 1994 with the implementation of TennCare I. The reforms implemented managed care systems with the hope of reducing program costs. The managed care providers were responsible for negotiating payment rates and received a capped rate per Medicaid enrollee; plan savings would then cover the uninsured and uninsurable. The program had a huge surge in enrollment, and the cost savings were insufficient to offset the additional participants. TennCare II was, therefore, introduced in 2002. It tightened up program eligibility for the uninsured and uninsurable, implemented income thresholds, and required members to demonstrate ineligibility for standard insurance.

**Washington State's SB 5596 of 2011:** In May 2011, Washington unanimously passed and signed into law SB 5596. In exchange for a capped federal contribution, Washington's waiver grants the state the authority and autonomy to improve its health services program as it sees fit. The waiver gives Washington more freedom to control program costs, and the new plan authorizes the following: (1) capped per capita payments; (2) limited, reasonable, and enforceable cost sharing for patients using nonurgent health services; (3) innovative reimbursement methods that no longer reward patients for selecting more costly services; and (4)

broadened enrollment in employer-sponsored insurance by collaborating with some of the larger private employers to negotiate less costly rates for enrollees.

**Table 1: Summary Statistics for Five Reforming States and the United States**

	Florida	Idaho	Rhode Island	Tennessee	Washington	United States
Total Medicaid Enrollment (#), FY 2008	3,021,300	210,300	194,600	1,485,300	1,179,600	59,468,700
Medicaid Enrollment as a % of Total Pop.	16	14	18	24	18	20
Poverty Rate as a % of Total Pop.	19	17	17	21	15	20
Income Eligibility Limits for Low-Income Parents as a % of federal poverty line, Jan 2011	59	39	181	127	74	N/A
Medicaid Managed Care Expenditures as a % of Total Medicaid Expenditures, June 2009	66	84.1	62.1	62.1	86	71.7

Medicaid Spending Per Enrollee	\$4,574	\$5,685	\$8,208	\$4,687	\$4,998	\$5,342

*Source:* See The Kaiser Family Foundation, *State Health Facts*, <http://www.statehealthfacts.org/index.jsp>.

As the table above shows, the characteristics of coverage across the five states vary greatly. Florida and Tennessee, for example, have large programs with more than one million participants; Tennessee also stands out as a state with participation rates above the U.S. average. Idaho, Rhode Island, and Washington each have comparatively small Medicaid programs; yet, Rhode Island enriches our study because of its high spending per enrollee.

It is important to understand how the term “managed care” is used in conjunction with Medicaid. “Managed care” usually refers to an arrangement in which a health maintenance organization (HMO)—a closed panel of physicians, hospitals, and other providers—provides a comprehensive set of contractually defined covered services for an enrolled population. The HMO is paid a per-member-per-month premium, known as a capitation payment, and the HMO accepts financial risk for the full cost of services provided. In Medicaid, managed care encompasses more varied approaches to delivering and financing care, including risk-based arrangements with HMOs and contracts with other health plans for a noncomprehensive set of services. The Kaiser Family Foundation’s Commission on Medicaid and the Uninsured (KCMU) and Health Management Associates (HMA) collected information from states regarding the three basic models of Medicaid managed care recognized under federal law and regulations. They are the following:

**Risk-based managed care organizations (MCOs) or health plans.** States contract with MCOs to provide a comprehensive benefits package to enrolled Medicaid beneficiaries, primarily on a

capitation basis (i.e., the state pays a per-member-per-month premium to the plan). Medicaid MCOs may be commercial HMOs that also serve people with employer-sponsored insurance, or they may be Medicaid-only plans with no commercially insured members. States develop their own Medicaid participation policies for MCOs, which usually include the following requirements: (1) adhere to specified protocols for enrollment and member support, (2) ensure adequate access to care, (3) achieve set benchmarks for quality and quality improvement, and (4) collect and submit data. Medicaid MCOs may be licensed by the state, or they may operate under a contract with the Medicaid agency regardless of licensure.

**Primary care case management (PCCM) programs.** PCCM programs are also considered a form of comprehensive Medicaid managed care. These state-administered programs build on the Medicaid fee-for-service system. States contract with primary care providers (PCPs) who agree to provide case-management services—including the location, coordination, and monitoring of primary health care services—to their assigned Medicaid enrollees assigned to them. States generally set specific requirements for PCPs, such as the ability to provide a set of primary care services, minimum hours of operation at each location, specific credentials or training, and responsibility for referrals to specialists. In addition to fee-for-service reimbursement for services delivered, PCPs are usually paid a nominal monthly case management fee. PCPs are usually physicians, physician group practices, or clinics (such as federally qualified health centers), but a state may also recognize nurse practitioners, nurse midwives, and physician assistants as PCPs. State Medicaid staff carry out (or sometimes contract out) the administrative functions related to PCCM, from network development and credentialing to quality monitoring and improvement, and the state usually (though not always) assumes full financial risk.

**Noncomprehensive prepaid health plans (PHPs).** States contract with PHPs on a risk basis to provide either comprehensive or noncomprehensive benefits to enrolled Medicaid beneficiaries. Federal regulations that govern Medicaid managed care refer to MCOs as a comprehensive type of PHP and identify two types of noncomprehensive PHPs. A prepaid inpatient health plan (PIHP) provides, arranges, or otherwise has responsibility for a defined set of services that includes inpatient hospital or institutional services, such as inpatient behavioral health care. A prepaid ambulatory health plan (PAHP) provides, arranges for, or otherwise has responsibility for outpatient care only. Common types of noncomprehensive PHPs provide only behavioral health services or only dental services, which, in many instances, are “carved out” of the MCOs’ benefit package. Like MCOs, noncomprehensive PHPs may be state-licensed or may operate under a contract with the Medicaid agency regardless of licensure.<sup>12</sup>

In the next section, we look more deeply at each of the five programs to see how successful seemingly sensible reforms turned out in practice. Successful reform can be understood as producing some combination of the following: (1) better care and coverage for enrollees, (2) reduced costs for state and federal taxpayers, and (3) political viability. To a large extent, number 3 is crucial in gauging success because the most sensible reforms from a cost standpoint are futile if they cannot survive a state’s politics. At the same time, not all politically viable reforms make sense economically.

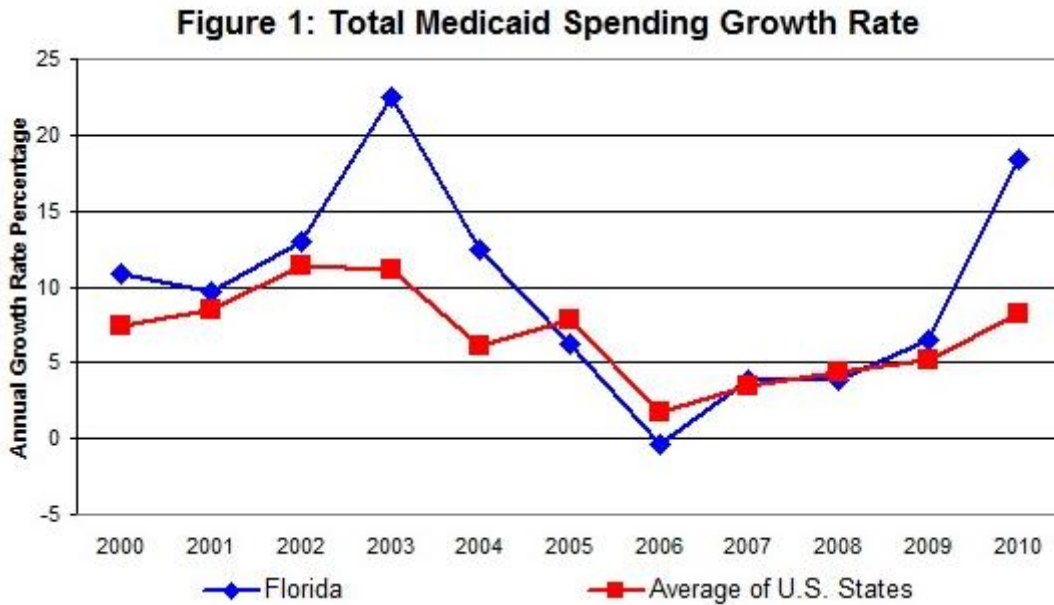
#### IV. The Political Economy of Reform

In this section, we examine the political and economic constraints politicians faced in each state and provide general assessments of the reform experience.

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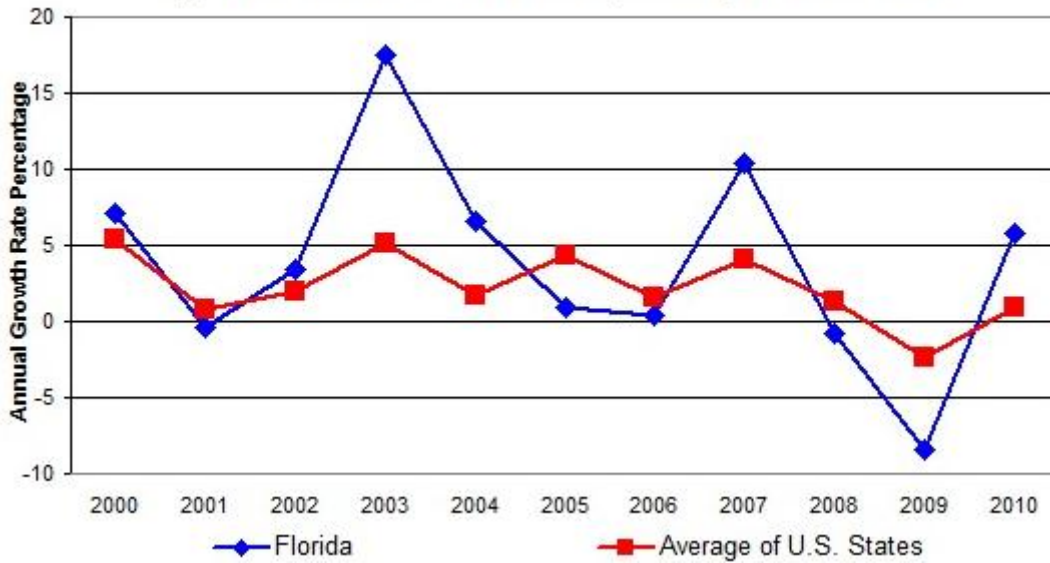
<sup>12</sup> Gifford et. al., *A Profile of Medicaid Managed Care Programs in 2010*.

A. Florida Medicaid Reform of 2005



In June 2005, Governor Jeb Bush signed an ambitious Medicaid reform bill for Florida. The bill initially established pilot programs in two Florida counties—Broward and Duval—and policy makers hoped the programs could be expanded statewide if pilot results were positive. In the years leading up to the pilot programs, Florida’s Medicaid spending growth rates were averaging more than 10 percent per year. As figure 1 above indicates, the growth rate of total spending declined—though a decline in average spending increases from 10 percent per year to 5 percent per year should not be misunderstood as a decline in growth rates overall. To a great extent, Florida’s spending changes have closely mirrored those of all U.S. states (which our red line, “Average of U.S. States,” captures).

**Figure 2: Total Per Enrollee Spending Growth Rate**



When we look at per enrollee spending over time in figure 2, the main takeaway is that Florida’s Medicaid program moves in fits and starts—spending is controlled for a year (e.g., 2006) and then skyrockets the next year (e.g., 2007).

The main feature of Florida’s 2005 pilot program was a call for shifting enrollees in Broward and Duval counties to managed care networks. In theory, the managed care networks would help to control costs by matching enrollees with Medicaid service providers. In so doing, the managed care networks would act as a buffer against overuse and inappropriate use (e.g., relying on emergency care for basic medical treatments). The 2005 reforms also introduced benefit flexibility, incentives for healthy decisions, and premium assistance.

Within three years of the plan’s introduction and additional county phase-in, Broward County had 200,000 people enrolled in 16 different private plans; Duval County had 7 different private plans; and Clay, Nassau, and Baker counties each had two private providers.<sup>13</sup> As James

<sup>13</sup> James Frogue, “Florida Medicaid Under Siege,” *The Florida Times-Union*, February 6, 2008, [http://jacksonville.com/tu-online/stories/020608/opl\\_244036167.shtml](http://jacksonville.com/tu-online/stories/020608/opl_244036167.shtml).



Froge noted in a 2008 *Florida Times-Union* op-ed, the private plans had “a strong financial incentive to quickly get each new member in for a thorough check-up because they will be on the hook later for avoidable high-cost encounters.”<sup>14</sup>

In 2009, Paul Duncan of the University of Florida put together an independent evaluation of the Florida Medicaid reform pilot project and reached the following conclusion:

It appears that Medicaid reform in Florida resulted in lower per-member-per-month (PMPM) expenditures in comparison to preceding pre-Reform fiscal years, especially among Provider Service Networks (PSNs). However, it is not known whether the lower expenditures were achieved through more efficient provision of care or from reduced access and utilization of care.<sup>15</sup>

In follow-up work to his 2009 study, Duncan’s team found generally high enrollee satisfaction rates in survey data and further evidence of reduced expenditures in the counties employing Medicaid reform experiments.<sup>16</sup>

The results of Florida’s five-county pilot project have been described as “a decided success.”<sup>17</sup> But a highly publicized Georgetown University study from April 2011 claimed the Florida pilot program did not produce any significant results, limited access to prenatal care, and saved costs primarily through low provider reimbursement rates.<sup>18</sup>

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<sup>14</sup> Ibid.

<sup>15</sup> Jeffrey Harman, “An Analysis of Medicaid Expenditures Before and After Implementation of Florida’s Medicaid Reform Pilot Demonstration,” University of Florida Medicaid Reform Evaluation Team Issue Brief No. 6, July 2009, <http://mre.php.ufl.edu/publications/MRE%20Issue%20Brief%206%20-%20Fiscal%20Analyses.pdf>.

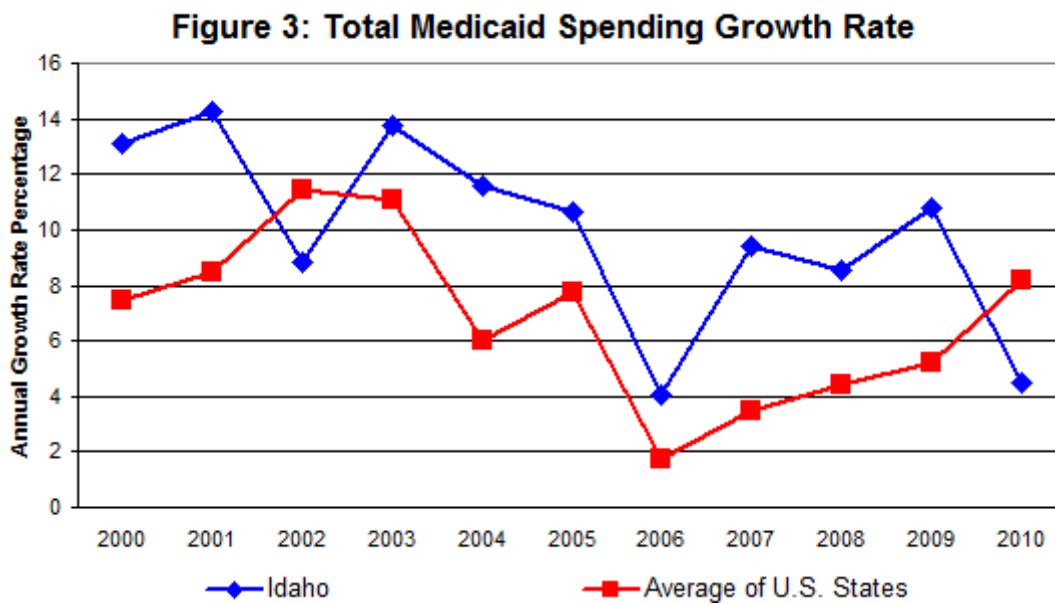
<sup>16</sup> Paul Duncan, *Evaluating Medicaid Reform in Florida: Evaluation Update* (Tallahassee: Florida Senate Health and Human Services Appropriations Committee, 2010), [http://mre.php.ufl.edu/talkspresentations/MRE%20Senate%20Health%20and%20Human%20Services%20Appropriations%20Committee%20Meeting\\_Paul%20Duncan\\_Final\\_02-10-2010.pdf](http://mre.php.ufl.edu/talkspresentations/MRE%20Senate%20Health%20and%20Human%20Services%20Appropriations%20Committee%20Meeting_Paul%20Duncan_Final_02-10-2010.pdf).

<sup>17</sup> Tarren Bragdon, *Florida’s Medicaid Reform Shows the Way to Improve Health, Increase Satisfaction, and Control Costs* (Washington, DC: Heritage Foundation, 2011), <http://www.floridafga.org/wp-content/uploads/Combined-Medicaid-Reform-Pilot-Nov-2011.pdf>. Bragdon estimates \$28.6 billion in savings for the United States as a whole if all 50 states embraced the Florida model.

<sup>18</sup> See Joan Alker and Jack Hoadley, *Understanding Florida Medicaid Today and the Impact of Federal Health Care Reform* (Washington, DC: Health Policy Institute at Georgetown University, 2011), [http://hpi.georgetown.edu/floridamedicaid/pdfs/Health\\_Reform\\_FL\\_2011.pdf](http://hpi.georgetown.edu/floridamedicaid/pdfs/Health_Reform_FL_2011.pdf). See also Alker and Hoadley, *As Legislators Wrestle to Define Next Generation of Florida Medicaid, Benefits of Reform Effort Are Far from Clear*

At the moment, Florida is awaiting federal approval for expansions to its pilot program. Many parties, such as researchers at Georgetown University’s Health Policy Institute,<sup>19</sup> are still opposed to expanding Florida’s program, but the Florida case has weak evidence of cost reductions, weak evidence of coverage reductions, and evidence of significant (but not insurmountable) political barriers to reform.

B. Idaho Medicaid Reform of 2006



Idaho signed into law the Medicaid Simplification Act of 2006 and then applied for a Medicaid waiver. Their waiver requested permission to benchmark the state’s benefit spending relative to that of other state plans and to tailor Medicaid coverage to different enrollee needs. The greater flexibility for different enrollee groups promised to reduce costs and to provide care more consistent with enrollee needs. In addition to benchmarking, the state’s reforms also called

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(Washington, DC: Health Policy Institute at Georgetown University, 2011), [http://hpi.georgetown.edu/floridamedicaid/pdfs/Medicaid\\_Reform\\_FL\\_2011.pdf](http://hpi.georgetown.edu/floridamedicaid/pdfs/Medicaid_Reform_FL_2011.pdf).

<sup>19</sup> Joan Alker, Jack Hoadley, and Jennifer Thompson, *Florida’s Experience with Medicaid Reform: What Has Been Learned in the First Two Years?* (Washington, DC: Health Policy Institute at Georgetown University, 2008), <http://hpi.georgetown.edu/floridamedicaid/pdfs/briefing7.pdf>.

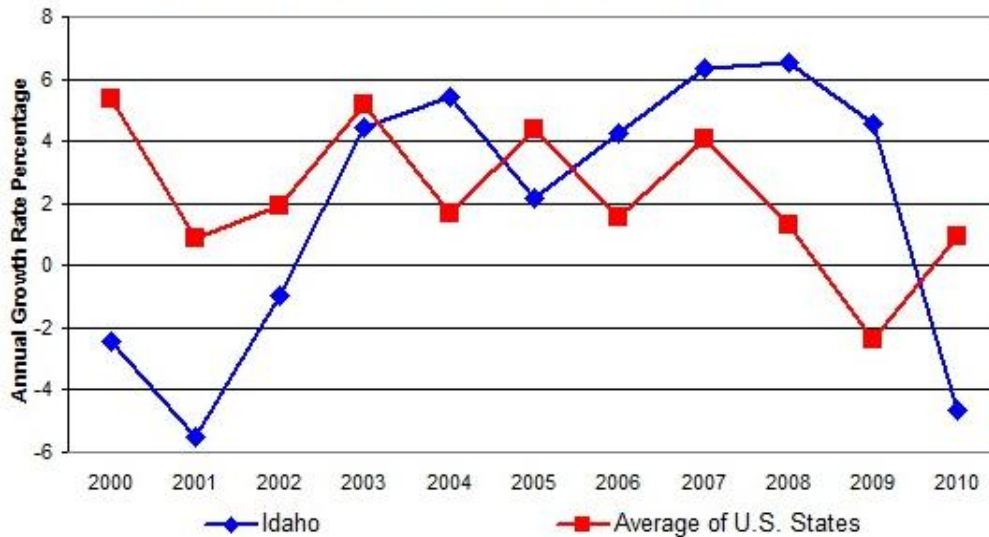
for healthy choice initiatives, premium sharing, consolidated purchasing of prescription drugs and medical supplies at lower prices, and other cost reductions.<sup>20</sup>

As figure 3 above indicates, Idaho's spending habits were similar to Florida's prior to 2006, averaging increases of more than 10 percent per year in total Medicaid expenditures. After their 2006 reforms, the growth rate of these states' total expenditures declined somewhat. When we look at per-enrollee spending in figure 4 below, Idaho's spending increased significantly following the 2006 Simplification Act and there were no significant per-enrollee program cuts until 2010. Idaho's inability to constrain spending following the 2006 reforms occurred largely because its segmented approach to enrollees (i.e., matching care with need) reduced the risk pool and had significant adverse selection effects. By segmenting people into separate risk categories, the high risk pool became underfunded, and an excessive number of risky enrollees were wrongly placed in safer pools. In addition, total Medicaid enrollment increased substantially from 2007 to 2011.

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<sup>20</sup> Center on Disabilities and Human Development (CDHD), *Issue Brief: Federal Approval of Idaho Medicaid Reform* (Moscow, ID: CDHD, 2006), <http://www.idahocdh.org/Portals/44/docs/federal-approval-of-idaho-medicaid-reform.pdf>.

**Figure 4: Total Per Enrollee Spending Growth Rate**



At the time of reform, Idaho was one of the first states to be granted permission to treat different Medicaid enrollees differently and its program was described as “groundbreaking” and “radical.”<sup>21</sup> The 2006 reforms were generally popular at the time, and Idaho’s governor, Dick Kempthorne, encountered minimal opposition.<sup>22</sup>

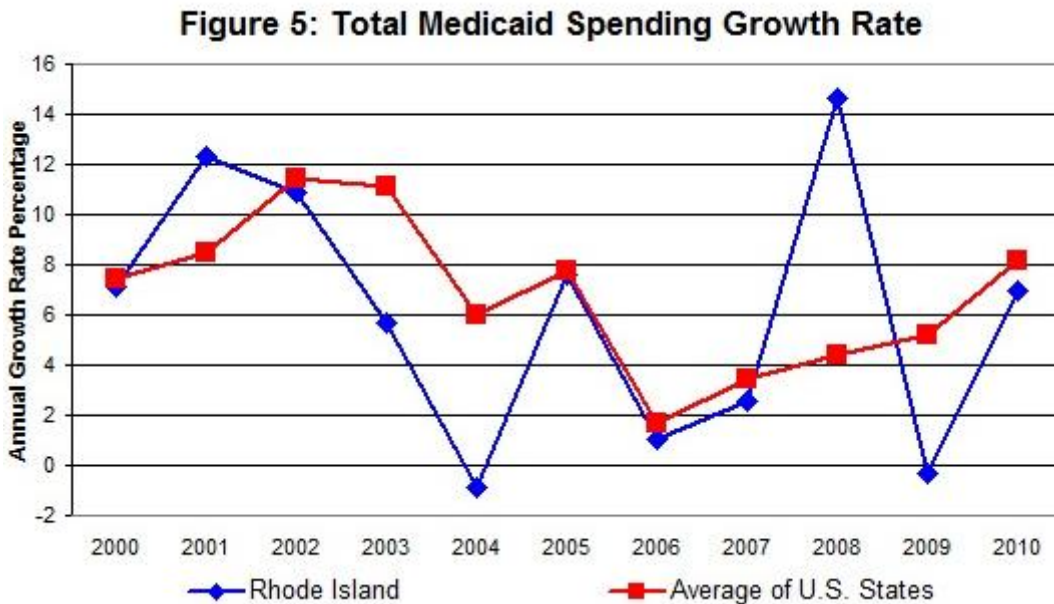
The smooth reform process enjoyed in Idaho came, in part, from Kempthorne’s willingness to hold town hall meetings and public forums to discuss the reform proposal. In discussions with Idaho residents and in much of his political rhetoric, Kempthorne combined discussions of cost savings with discussions of state control versus federal control: Idaho’s reforms were not going to leave anyone without coverage; they were going to reduce costs; and they promised to return more power and control to the state, which knows its own issues better than the federal government does. Kempthorne’s message helped him “sell” the bill, and the Idaho model has been recommended to other states with low populations.

<sup>21</sup> “Idaho Becomes First State with Approved Medicaid Reform Plan,” SeniorJournal.com, May 26, 2006, <http://seniorjournal.com/NEWS/Medicaid/6-05-26-IdahoBecomesFirst.htm>.

<sup>22</sup> National Association of Social Workers, “Lawmakers So Far Like Medicaid Plan...” *The Gatekeeper*, December 2005 (reprint from *Idaho Statesman*, October 30, 2005), <http://www.naswidaho.org/newsletter/The%20Gatekeeper%2011-05.pdf>.

More recently, Idaho lawmakers have been in talks with Rhode Island reformers. They have been that told Rhode Island’s reform experiment, which we will learn more about in the next subsection, could serve as a model for future reform.<sup>23</sup>

C. Rhode Island Global Consumer Choice Compact of 2008



According to many analysts, the Consumer Choice Compact of 2008 is, to date, the most radical Medicaid reform bill in the United States.<sup>24</sup> Near the end of George W. Bush’s second term, Rhode Island’s block-grant request was converted into a capped allotment program and approved.<sup>25</sup> The program sets spending for five years and gives state leaders flexibility to introduce market principles to Rhode Island’s Medicaid program. The Rhode Island plan encourages the state to control costs through an incentive system: When the state spends less

<sup>23</sup> Dustin Hurst, “Idaho Lawmakers Examine Local Control Reform Package for Medicaid,” IdahoReporter.com, January 13, 2011, <http://www.idahoreporter.com/2011/idaho-lawmakers-examine-local-control-reform-package-for-medicaid/>.

<sup>24</sup> *Rhode Island Medicaid Reform: Global Consumer Choice Compact Waiver* (Alexandra, VA: Galen Institute, 2010), <http://www.galen.org/fileuploads/RIMedicaidReform.pdf>.

<sup>25</sup> This capped allotment preserves the traditional federal Medicaid funding mechanism of the federal medical assistance percentage (FMAP), a formula designed such that the federal government pays a larger portion of Medicaid costs in states with lower per capita income and less in states with a higher per capita income, but, in similar fashion to a block grant, placed a cap on aggregate spending.

than the capped amount, it gets to keep a fraction of the federal money. While the Rhode Island experience may be too new to evaluate, figure 5 shows that total expenditures since 2008 have been somewhat constrained, and the state has enjoyed below-average growth rates in Medicaid spending. The graph above also helps us understand why Rhode Island sought radical reform in 2008: Medicaid growth in 2008 was more than 14 percent! Rapid spending, coupled with declining state revenues following the financial crisis, probably triggered reform momentum.

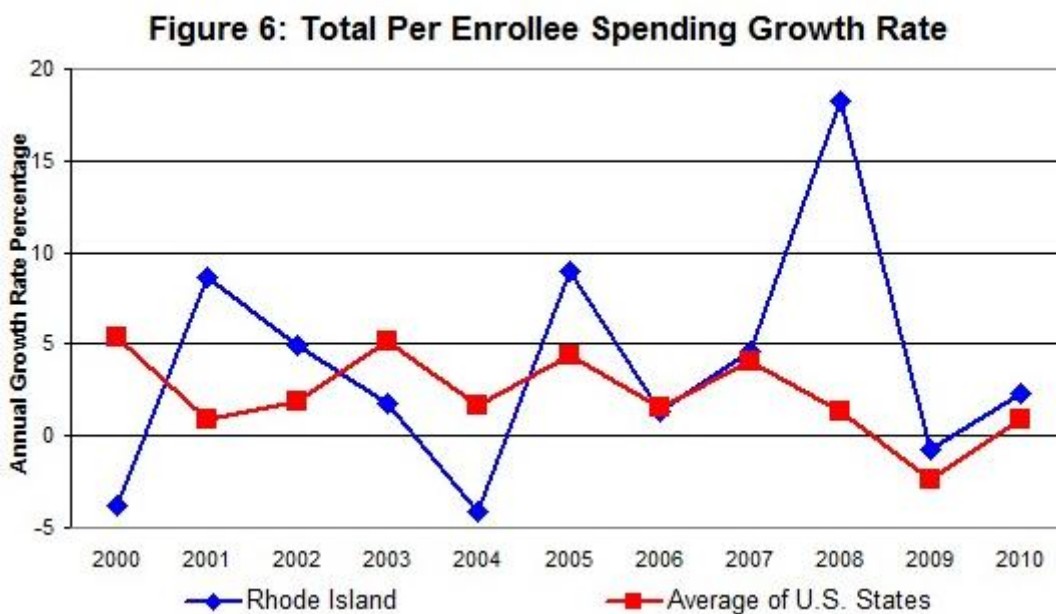


Figure 6 above indicates that Rhode Island’s per-enrollee expenditure rates are slightly higher than the increases experienced across the United States, but the gap pales in comparison to the 2008 gap and the gaps in earlier years.

The story of Rhode Island’s reform is one of both compromise and determination. State lawmakers were forced to compromise, particularly on the issue of block-grant funding. While Rhode Island’s program is basically a block-grant program in that allotments are capped and the

state enjoys a relatively high level of freedom to innovate, federal leaders involved in the state's Medicaid waiver and CMS officials gave Rhode Island most of the reforms it wanted.

Rhode Island's new approach, which took full effect in 2009, has eliminated many federal mandates. The exemptions relate to the following three areas:

**Program Redesign and Innovation:** "In order to implement any reforms in these programmatic areas, the State requires the ability to make changes quickly without the prior approval of the federal government."<sup>26</sup> Rather than waiting 3–12 months, state initiatives for changes in eligibility or services receive an expedited 45-day review.

**Flexibility in Eligible Populations:** "The State has committed to maintaining the mandatory Medicaid populations. The State does reserve its authority to impose new or revise existing cost-sharing requirements to mandatory populations. If expenditures exceed budgeted amounts, the State seeks the ability to revise eligibility for optional populations. Any efforts in this area will be conducted in an open public process and will require the approval of the State General Assembly. Decisions to revise optional eligibility groups will not require the prior approval of the federal government, as long as the state meets its financial maintenance of effort commitment."<sup>27</sup>

**Flexibility in Services:** "If . . . the State finds that expenditures are exceeding the Medicaid budgeted amount, the state reserves the right to revise the benefits available under the Program. Again, the State is committed to maintaining the mandatory benefits. If the State decides to remove certain benefits, the State will undertake a public process. Any decisions to revise the benefit package will not be subject to prior approval from the Federal Government, as long as the state meets its financial maintenance of effort commitment."<sup>28</sup>

In addition to getting breaks from several federal mandates, Rhode Island's new approach introduces incentives for healthy behavior. In its first two years, the program has helped Rhode Island cut Medicaid spending from \$3.8 billion to \$2.7 billion, and the global waiver alone saved more than \$100 million in its first year.<sup>29</sup> Rhode Island's early success led some to describe it as

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<sup>26</sup> *Rhode Island Global Consumer Compact Waiver* (2008), <http://www.ohhs.ri.gov/global/documents/pdf/TheRIGlobalConsumerCompactGlobalWaiverFinal082808.pdf>.

<sup>27</sup> *Ibid.*

<sup>28</sup> *Ibid.*

<sup>29</sup> John Graham, "In the Nick of Time: Rhode Island's Medicaid Waiver Shows How States Can Save Their Budgets from Obamacare's Assault," *Health Policy Prescriptions* 9, no. 1 (San Francisco: Pacific Research Institute, 2011), <http://www.pacificresearch.org/publications/in-the-nick-of-time-rhode-islands-medicaid-waiver-shows-how-states-can-save-their-budgets-from-obamacares-assault>. See also Benjamin Domenech, "The Rhode Island Medicaid

a model for other states, and Washington State's more recent Medicaid reforms clearly imitated Rhode Island's.

Governor Donald Carcieri ignited Rhode Island's Medicaid reforms. Since Medicaid was one of the state's largest budget items, controlling Rhode Island's structural deficits involved reforming the way Medicaid spending was allocated. Carcieri leveraged his reform ideas by pointing out the state's weak, unsustainable fiscal path. After spelling out why Medicaid reform was crucial to the state's long-term solvency, he asked Gary Alexander, the secretary of Rhode Island's Office of Health and Human Services, to manage the reforms.

Carcieri also won people over by making a compelling rhetorical case. His proposals were not going to deny people care, but rather target care at things different groups really needed. For example, when asked if people were going to have coverage completely denied, Alexander replied, "If there is an elderly population that needs podiatry, we want to be able to offer it to them rather than to the entire population."<sup>30</sup> Statements like this were transparent and to the point: care and coverage were now going to become more targeted, but the targeting was going to be focused on what made sense for different groups and different medical conditions.

Liberal Democrats in Rhode Island were skeptical of the reform, but many went along with the Carcieri and Alexander plan because of its popular support. With political momentum on their side, Carcieri and Alexander were able to get a large coalition on board with reform. Once the pair secured broad support, the major challenge for state legislators was not one

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Experience," *Reform + Medicaid*, March 19, 2011, <http://reformmedicaid.org/2011/03/the-rhode-island-medicaid-experience/>.

<sup>30</sup> John Buntin, "Ending Medicaid As We Know It," *Governing the States and Localities*, June 2011, <http://www.governing.com/topics/finance/ending-medicaid-as-we-know-it.html>.

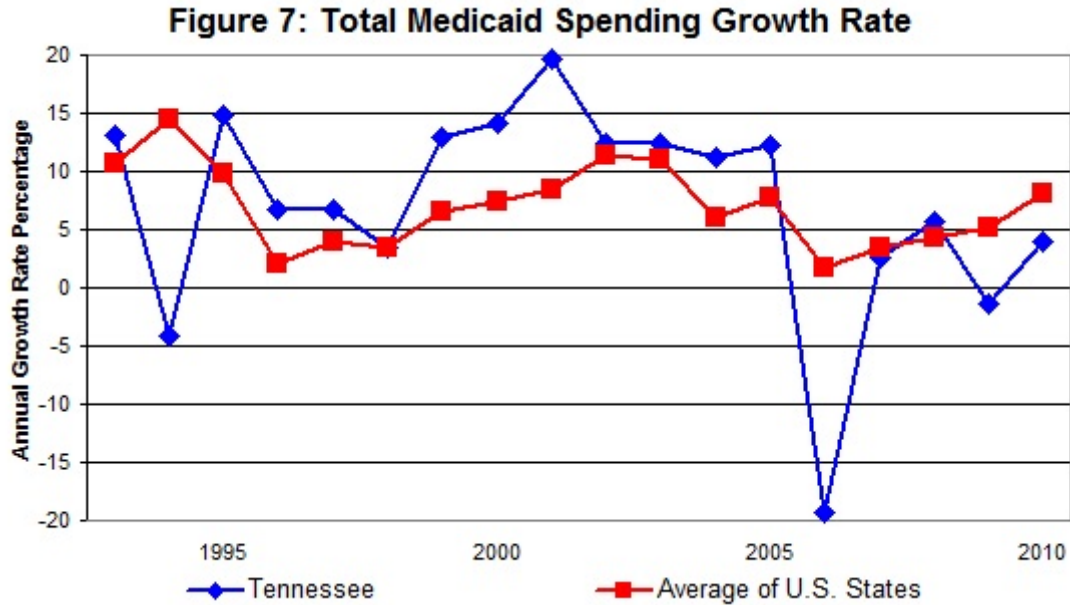


involving Republicans versus Democrats, but Rhode Island versus the federal agencies handling the state's waiver.

The federal agencies proved to be the biggest obstacle to reform in Rhode Island, which is not surprising considering that the state submitted section 1115 waivers. The bureaucratic process asked Rhode Island's leadership for a lot of information, and the CMS repeatedly rejected elements of the proposal that did not comply with federal law. Frustrated, impatient, and with key stakeholders on his side, Carcieri responded to the CMS with a take it or leave it offer: The state would accept a block-grant approach as long as it could keep 20 percent of the cost savings. The CMS found Carcieri's radical proposal to be inconsistent with federal law but gave him some flexibility: Rhode Island's many waivers were consolidated into one global waiver, and the CMS then allowed Rhode Island's funding to be capped over a five-year period.

The political economy lessons from Rhode Island are clear: get state legislators on board with reform; shift the relevant debate from one between legislators within the state to one between the state and federal agencies; and push for the most radical reforms possible.

D. TennCare II of 2002

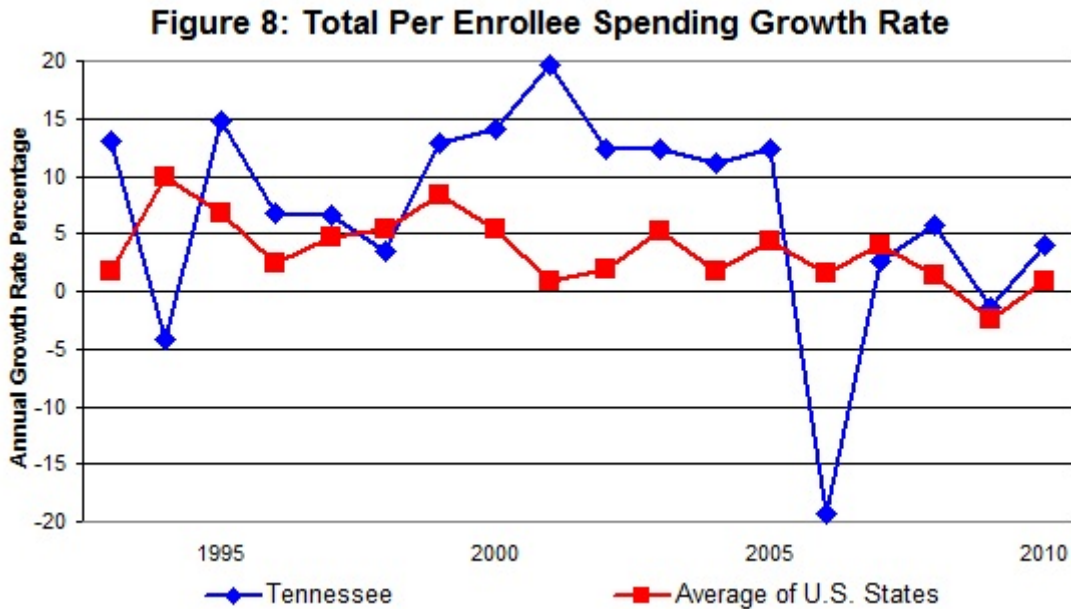


TennCare’s history dates back to June 1993, when Tennessee Governor Ned McWherter and the Tennessee Department of Health applied for a Medicaid waiver. The waiver was to take effect on January 1, 1994, and its main objective was to shift Tennessee’s Medicaid program from public provision to managed care organizations. McWherter sought rapid approval because he was concerned about pushback from the Tennessee Medical Association.<sup>31</sup> The savings resulting from a shift to managed care would then be used to expand coverage to the uninsurable and to non-poor uninsured groups.

Figure 7 above shows that TennCare significantly decreased Medicaid expenditures in 1994. Following 1994, though, TennCare grew steadily and rates of spending growth exceeded average state rates for all 50 states. The massive drop in 2004–2005 represents the tightening up of eligibility requirements, which came after 10 years of excessive spending. Figure 8 below tells

<sup>31</sup> Mark Ross Daniels, *Medicaid Reform and the American States* (Westport, CT: Greenwood Publishing Group, 1998).

a similar story: TennCare was a bloated Medicaid approach that delivered little in the way of cost controls and created significant uncertainty for enrollees.



On paper, though, TennCare seemed like a good idea: Tennessee’s reforms promised cost savings, and they were viewed at the time as a radical new approach to Medicaid. It was the rapid implementation of TennCare, however, that led to a great deal of confusion about care and weakened McWherter’s overall base. People were suddenly being told their traditional means of health care were being shifted, and many new policies were not in place soon enough to help them get questions answered. In addition, the Tennessee Medical Association took a strong position against the reforms by focusing on the low capitation rates being guaranteed under the new reforms. (Again, capitation rates are the rates Medicaid programs promise to pay authorized MCOs for providing health care to qualified patients.)

By 2000, academics and state leaders viewed TennCare as a failure. By shifting any cost savings to uninsured groups, the system faced constant demand-side pressure and never reduced

costs for taxpayers. The low capitation rates, which for a long time were the lowest in the country, reflected the state's failure to appropriately price risk: in essence, an adverse selection problem confronted TennCare in that eligibility was expanded to more and more groups without concomitant increases in capitation rates. Just as the Tennessee Medical Association warned, TennCare's poor pricing ultimately led to major increases in total expenditures.<sup>32</sup> By late 2000, Blue Cross/Blue Shield of Tennessee—the state's largest managed care provider for TennCare members—announced its intent to withdraw, which left half of all TennCare members in need of a new provider. The state negotiated with Blue Cross to ensure that patients in East Tennessee remained enrolled in Blue Cross, and they promised Blue Cross risk protection for MCO-related costs above \$33 million per year.<sup>33</sup>

With costs continuing to rise, Tennessee Governor Phil Bredesen introduced several reforms to TennCare in 2004. The reforms called for reducing eligibility levels and resulted in a 25 percent decline in TennCare enrollment—mainly the uninsured adults and uninsurable people who were originally promised benefits in the 1994 reform. Bredesen also introduced other benefit cuts, including caps on annual physician visits and lab work caps, which the CMS approved in 2005.<sup>34</sup>

Since 2005, TennCare remains a controversial subject in Tennessee. Despite Bredesen's reforms, TennCare has some of the highest participation rates for Medicaid programs in the United States. The state desperately needs greater reform along the lines of market principles and cost sharing, but the failed 1994 experiment significantly weakened reform opportunities.

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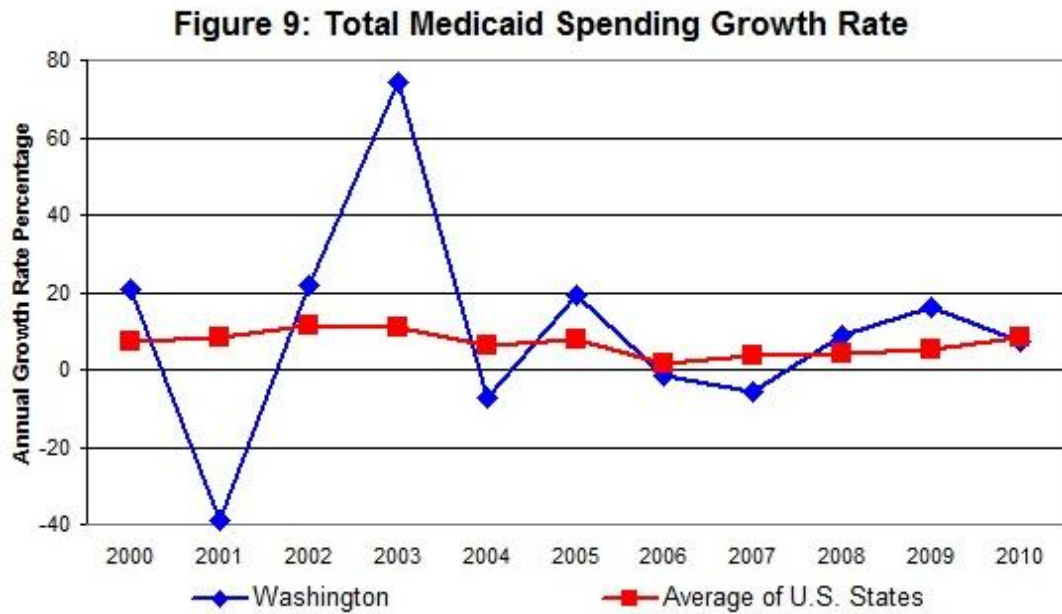
<sup>32</sup> Adam Zaretsky, "Revamping Medicaid: A Five-Year Check-up on Tennessee's Experiment," *Regional Economist*, Federal Reserve Bank of Saint Louis, 1999, <http://www.stlouisfed.org/publications/re/articles/?id=1751>.

<sup>33</sup> Patrick Poole, "Reforming an Ambitious State Health Care System," Heartland Institute Policy Document, July 1, 2000, <http://heartland.org/policy-documents/reforming-ambitious-state-health-care-system>.

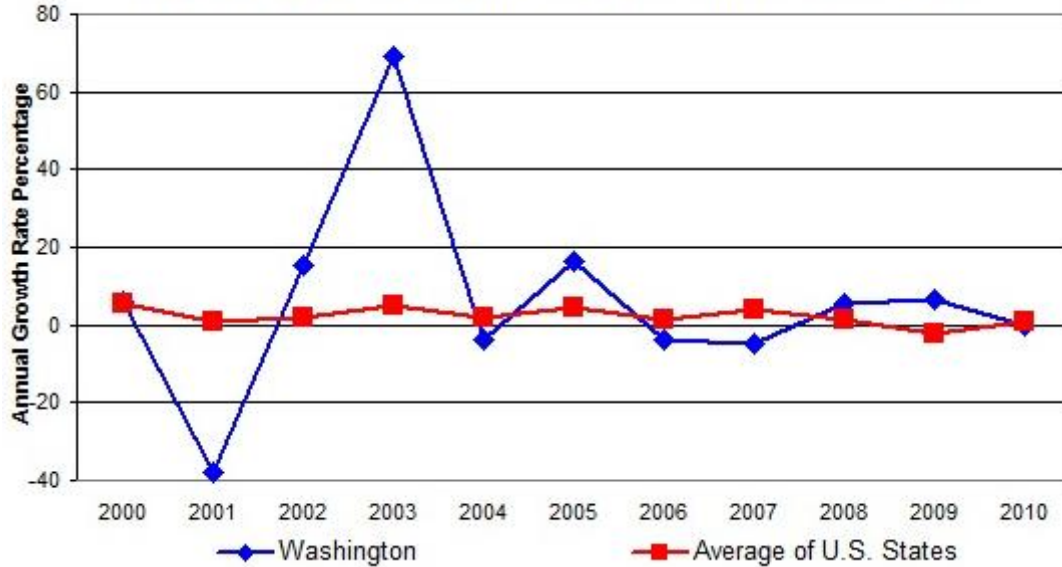
<sup>34</sup> AP and WATE, "Bredesen Scraps TennCare," WATE News (Knoxville, TN), November 10, 2004, <http://www.wate.com/Global/story.asp?s=2547662>.

Unlike Rhode Island, where there was buy-in from key stakeholders, the TennCare experience illustrates the problems of trying to plow ahead with reform in opposition to key interest groups. McWherter’s executive team tried to ram TennCare through without the Tennessee Medical Association’s support. Not getting the association’s buy-in and rushing reform left TennCare open to attack. TennCare’s problems were further complicated by the program’s inability to control costs. But from a political economy standpoint, the program was dead on arrival because of McWherter’s early decisions.

E. Washington State’s SB 5596 of 2011



**Figure 10: Total Per Enrollee Spending Growth Rate**



In May 2011, Washington State Governor Chris Gregoire signed into law Senate Bill 5596. The state’s senate and assembly unanimously supported the bill, which calls for a major overhaul of Washington’s Medicaid program. Shortly after it was signed into law, the *Wall Street Journal* described the bill as the most radical Medicaid reform proposal to date.<sup>35</sup> As figures 9 and 10 indicate, Washington’s Medicaid program had been hampered by drastic expansion in 2003 and 2004. While the program’s spending increases were not nearly as large after 2003–2004, they were still often above national averages and required attention. Gregoire and state leaders undertook radical action, and time will tell if their approach will prove effective.

SB 5596 provides for reforms similar to Rhode Island’s. The bill authorized a Medicaid waiver, which calls for greater flexibility and a block-grant-like approach to funding Washington Medicaid (though politicians in Washington are very careful not to call their reforms block grants.) In addition to shifting the state’s Medicaid funding approach, SB 5596 calls for the

<sup>35</sup> Nansen Malin, “Liberal Washington State Tries to Kiss Medicaid Goodbye,” *Wall Street Journal*, June 4, 2011, <http://online.wsj.com/article/SB10001424052702303657404576363812467438234.html>.

introduction of more market principles into Medicaid, encourages cost sharing and sensible premiums, and provides subsidies for enrollees who secure insurance coverage through their employers.

Like the Rhode Island experiment, Washington’s reforms were driven largely by necessity: Governor Gregoire, a liberal Democrat, claimed the state was in crisis and said Medicaid reform was a crucial part of any major fiscal reform. In January 2011, she reiterated the need for reform in statements like the following:

Our state’s fiscal crisis has grown since we originally asked for this waiver . . . Our options are limited, and we can no longer afford to support the safety net we once did. Options will need to be looked at to see if there is a way to additionally supplement this waiver.<sup>36</sup>

In addition to grounding her arguments for Medicaid reform in terms of the overall fiscal landscape, Governor Gregoire also provided transparent benchmarks when it came to future spending levels:

My goal is to limit the overall increase in health care costs to 4 percent each year. We have shown this goal is within reach and the cost of health care is not beyond our control. By making better use of our resources and helping families and employers control costs, we are helping taxpayers and businesses save money and helping patients improve their health.<sup>37</sup>

In contrast to TennCare, where reform goals were fairly open-ended, Gregoire provided analysts with a clear benchmark—4 percent health care expenditure growth per year—against which to judge the program’s success. Only time will tell how well Washington performs relative to its benchmarks, but the general tenor of the reforms and the block-grant style, which caps expenditures and encourages innovation, are causes for optimism.

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<sup>36</sup> Washington State Department of Social and Health Services, “Washington State Medicaid Receives Federal Approval of National Health Care Reform ‘Bridge Waiver,’” news release, January 4, 2011, <http://www.dshs.wa.gov/mediareleases/2011/pr11002.shtml>.

<sup>37</sup> Washington Governor’s Office, “Governor Gregoire Enacts Health Care Reforms,” news release, May 11, 2011, <http://www.governor.wa.gov/news/news-view.asp?pressRelease=1706&newsType=1>.

Unlike Tennessee’s program, which was six months in the making, Washington spent six years building consensus and figuring out the best reforms. Gregoire developed a commission tasked with recommending Medicaid reforms “for Washingtonians by Washingtonians.”<sup>38</sup> After many years of careful study, the commission submitted recommendations for fairly radical reform. By taking her time and by working to overcome the concerns of interest groups and the opposition, she succeeded in getting a fairly radical-looking reform bill passed.

## V. Conclusion

The need for significant Medicaid reform has become more pressing since the 2008 financial crisis. The federal government currently provides little hope for reform and is, in fact, headed in the opposite direction when it comes to controlling costs and encouraging maximum state-level autonomy. Over the last decade, however, states have been introducing new Medicaid reforms. Some of the new programs, particularly those being implemented in Rhode Island and Washington, could potentially reduce costs to taxpayers while still guaranteeing Medicaid enrollees coverage and access. Other reform efforts, by contrast, have had limited success.

This paper has attempted to advance an understanding of the political economy of reform. If cost-saving reforms are necessary for financial reasons, and if reforms do not compromise well-being, what blocks their passage? As we saw in our case studies, politics can kill the best of ideas. Reforms in Tennessee and Florida, for example, were fairly radical in their scale and scope. But they did not succeed nearly as well as reforms in Rhode Island and Washington because stakeholders were less engaged and reforms were rushed. A key takeaway from this analysis is the following: Reformers must work to bring key interest groups—even the groups

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<sup>38</sup> Ibid.



opposed to reform—into the reform discussions. In so doing, the skeptics are able to provide input and to grasp the seriousness of the fiscal problems.

Another takeaway from the Rhode Island and Washington experiences is that politicians should not let politically loaded terms get in the way of good policy. Rhode Island and Washington have, in a fundamental sense, implemented block-grant reforms. Yet, political leaders in the two states do not make a big deal about the radical nature of their reforms, nor do they even want their reforms to be called block grants because of the term's negative political connotations. Reformers who consider what their words and actions mean to people who disagree with them are more likely to succeed.

Tennessee's reforms are an example of bad messaging: Governor McWherter plowed ahead with reforms and took an in-your-face approach to the opposition. Rather than engage them, he used his "political capital" (to borrow a phrase from George W. Bush) to ram legislation through the political process. As a result, his reforms lacked the necessary buy-in for long-term success. Rhode Island and Washington leaders, by contrast, didn't fixate on ideological purity. They let go of the term "block grant" and implemented quasi-block-grant reforms. In states like Rhode Island and Washington, leaders' actions have spoken louder than words.

Despite the uncertainty created by the Affordable Care Act, many other states are embarking upon their own experiments with radical Medicaid reform. New York and Utah, for example, are both attempting radical reforms that would shift their Medicaid participants from current plans to privately run managed care plans. There are many lessons to learn from a careful study of other reform experiments. By incorporating lessons from other states into their own

reforms, state policy makers should be able to save themselves time, build greater consensus, and, most importantly, deliver more effective Medicaid services to participants at a lower cost to taxpayers.