States' Changes Reshape Medicaid

New Restrictions Aim to Save Money

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After winning greater freedom from federal Medicaid rules, states are moving aggressively to transform the nation's largest public health insurance program, adding fees, restricting benefits and creating incentives for patients to take responsibility for their health.

The changes are just beginning in several states that are being watched closely by governors nationwide. Those changes are reshaping Medicaid, which covers 55 million poor and disabled Americans, so that the program more closely resembles private insurance, rather than a social welfare system run with a strong, central government hand.

Starting July 1, West Virginia will phase in a redesigned form of Medicaid that requires patients to sign a "member agreement," promising that they will keep doctors' appointments, take prescribed medicine and not overuse hospital emergency rooms. Patients who refuse to sign or to follow the rules will be eligible for less care.

Kentucky is dividing its Medicaid patients into four categories, depending on their health and their age, with different benefits for each group. Most adults will face higher co-payments for medical services and new limits on prescription drugs. But patients who sign up for a "disease management" program eventually will be able to earn credits toward extra "get-healthy benefits," such as eyeglasses or classes to quit smoking.

Florida, meanwhile, will privatize part of its Medicaid system in September, directing patients in Jacksonville and Broward County to pick from 19 health plans, each offering different services. In a departure from how states have reimbursed doctors or health plans, Florida health officials will rate the health of every Medicaid patient in the two communities and pay for only as much care as officials predict they should need.

"We've got a whole new dialogue about how health care should be delivered and financed," said Diane Rowland, executive director of the Kaiser Commission on Medicaid and the Uninsured, a nonpartisan policy group.

The emerging shape of Medicaid represents a victory for governors of both political parties and for fiscal conservatives, who argued for years that states deserved more control over the program so it would place less strain on their budgets. Some patients advocates, however, warn that the vulnerable patients Medicaid was designed to help will be less certain to get the health care they need.

Since its creation in the 1960s, Medicaid has been a shared responsibility of the federal government and the states. States shoulder more than 40 percent of the cost, which totals $338 billion this year, and have always had certain freedom to decide how many benefits to cover. But the federal government has determined many of the program's basic contours.

Last December, Congress granted states broad flexibility to alter benefits, charge patients more and expand the role of private insurers as part of a law that will cut federal Medicaid spending by $43 billion in the next decade. Even before the law, the Bush administration was sympathetic to states that wanted greater say over how their programs are designed.

The law, called the Deficit Reduction Act, and the administration's policies have eliminated a hallmark of the program: Until now, every Medicaid patient within a state has qualified for the same benefits.

Medicaid's new direction borrows ideas from the overhaul of the welfare system a decade ago. That transformation also decentralized a major piece of the social safety net, limited government assistance, expanded the private sector's role and tried to instill self-reliance in low-income people who had depended on government help.

The Bush administration is encouraging states to embrace the altered view of Medicaid. "We are trying to be as supportive as we can," said Mark B. McClellan, administrator of the federal Centers for Medicare and Medicaid Services. His agency has been coaching states on the changes they can make -- and swiftly approving states' revisions. When West Virginia's Medicaid commissioner, Nancy V. Atkins, sent the federal agency the proposal for the state's redesigned program on April 26, she was startled that it was approved one week later.

Other states are not far behind the leading edge. South Carolina's governor has been pushing for changes that would include health savings accounts and rewards for being a good patient. Oklahoma's legislature has just passed a bill that would allow the state to pay health plans a defined amount depending on a patient's health. And a recent Missouri law calls for the current Medicaid system there to be abolished in 2008; its replacement is being designed.

State health officials say such changes make sense, particularly because Medicaid has expanded in many states in recent years from a program that covered only the very poor and dispossessed into one that includes a growing share of children -- and sometimes parents -- in working-class families.

The most basic force behind the changes, though, is that Medicaid costs continue to increase more rapidly than state revenues. Ray Scheppach, executive director of the National Governors Association, said the states' new strategies are a trade-off, imposing "additional co-pays and small reductions in benefits" to avoid eventually "pushing hundreds of thousands of women and children off the rolls." Medicaid directors say they do not expect large savings in the next few years but hope to curb costs in the long run.

They are emphasizing preventive care and predict that patients will think twice about how much care to seek if they have to pay a fraction of the bill. And by specifying different benefits for different groups of patients, "we are trying to take advantage of a tool that's really been available in the private sector," said David Rogers, Medicaid administrator for Idaho, which -- like Kentucky -- is starting next month to divide patients into "health-needs categories."

Like Florida, several states are trying to steer Medicaid patients into private-sector health insurance. Arkansas, for example, has just received federal permission to use Medicaid money to subsidize small companies with low-wage workers if they begin to offer employee health benefits.

The focus on private-sector insurance and self-reliance is favored by conservative groups, such as the Heritage Foundation and the Center for Health Transformation, which was founded three years ago by former House speaker Newt Gingrich (R-Ga.). "If you look particularly at the states like Florida that are emphasizing more individual responsibility," Gingrich said, "they are moving in exactly the right direction."

On the other hand, Ron Pollack, executive director of Families USA, a consumer health lobby, said, "Low-income individuals are increasingly going to be put at far greater risk of not receiving critically important services that they used to receive."

Joan Phillips, a West Virginia pediatrician, said she worries that, with the member agreements, children could be denied certain medical services if "the parent is not motivated or is dysfunctional." And Phillips said doctors who report to the state that a patient is not following the rules will face an ethical bind, knowing the patient will lose benefits as a result.

In Florida, Lori Parham, a state lobbyist for the AARP, worries about Medicaid patients who are healthy when they join a health plan but later get cancer, say, or have a heart attack, requiring more expensive treatment than their plan has been paid to provide. "The question becomes, will the care be available?" she said.

Alan Levine, secretary of Florida's Agency for Health Care Administration, said the revised Medicaid will give patients more "emotional buy-in" by increasing their choices and incentive to take care of themselves, while eventually saving the state money. "We are doing it for the right reasons," Levine said. "I just hope it works."