



# POLICY BRIEF

## True Medicaid Reform, *Not* a Protection Racket

By Peter Ferrara

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# True Medicaid Reform, Not a Protection Racket

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## EXECUTIVE SUMMARY

Rapidly growing Medicaid costs are devouring state budgets. As a result, states are scrambling for short-term quick fixes to alleviate the budget pressure.

Some states have adopted a supplemental drug rebate program to raise some money. These programs require drug companies to pay a fee set by the state, in addition to the state fees already established in federal law, for their drugs to be available to the state's Medicaid patients. This amounts to a tax on innovation.

Many drug producers don't pay the supplemental rebates. As a result, this shortsighted state policy denies access to these necessary medications, and limits the full range of drug therapies for the poor, harming minorities and those suffering from mental illness in particular. It also leads to higher costs for the general public, as drug companies that do pay the rebates shift those costs onto the general insurance system. Moreover, these rebate programs are effectively a tax on new drug costs. As a result, they discourage investors from investing in

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the development of the miracle life-saving drugs that many of us may find ourselves needing at some point in the future.

Florida was one of the first states to adopt a supplemental rebate program. But it has also allowed the use of options that avoid the need for supplemental rebates from all manufacturers. The *Florida: A Healthy State* program was developed jointly by Pfizer and the state, in place of the supplemental rebates on Pfizer products. Pfizer finances teams of case managers for hospitals serving large Medicaid populations. The case managers focus in particular on patients with one of four serious chronic illnesses – asthma, diabetes, hypertension and heart disease.

The case managers seek to overcome language and cultural barriers, and old habits, to achieve several important health goals:

- n Help patients better understand doctors' instructions;
- n Help patients better understand what foods they need to avoid, and what foods they need to eat, and better follow those requirements;
- n Help patients learn and follow appropriate exercise programs; and
- n Help patients better understand their courses of treatment, and maintain those treatments.

These activities are expected to reduce unnecessary emergency room visits and keep a critical portion of the population healthy for a longer period. This will both reduce costs and improve the health of Medicaid

patients.

But even this program will not remotely begin to solve the problems of Medicaid. To do that, states need to focus on broader, more fundamental reform.

Welfare reform started with a federal waiver program for innovative state experiments. Section 1115 of the Social Security Act already provides a similar waiver authority for Medicaid. States should utilize that authority to begin innovative Medicaid reforms that will both reduce costs and improve services and health for Medicaid patients.

A promising reform alternative would transform Medicaid to operate like the Federal Employee Health Benefits program. Medicaid would provide a monthly stipend for each beneficiary to choose coverage from a wide range of private insurance alternatives, including highly innovative and beneficial Medical Savings Accounts.

Ultimately, Congress should adopt fundamental long-term reforms like those adopted for general cash welfare in 1996. The Federal government would provide a block grant to each state, providing funds to be used to serve the Medicaid population. The states would then each design their own programs, bearing additional costs beyond the amounts of the Federal block grants.

Rather than pursuing counterproductive Band-Aid approaches like supplemental rebates, states should focus on these broader reforms. Those reforms hold great potential for benefiting everyone – the federal govern-

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ment, states, Medicaid patients and taxpayers.

## Introduction

Medicaid has grown into a huge problem for the states. The program is now costing states \$100 billion per year out of their own revenue, and it is the most rapidly growing item in state budgets.

Legislators have often addressed this problem with short-term Band-Aids, like the supplemental drug rebate program discussed below. But quick fixes do not begin to solve the problem, and, more often than not, they create new problems of their own.

What is needed is comprehensive, fundamental reform of state Medicaid programs. Through Section 1115 waivers already included in federal law, states can get federal authorization for such fundamental reforms, without waiting for congressional action. Through such reforms, states can fundamentally reduce their costs while actually improving the program.

This paper will first discuss state supplemental rebate programs and their shortcomings. It then discusses an innovative alternative program that was adopted in Florida. But even Florida's program is not a comprehensive reform addressing the big picture.

It then discusses fundamental reforms that states should adopt through the Section 1115 waiver program. Finally, it will address longer-term reforms that the federal government should also adopt.

## The Supplemental Rebates Protection Racket

Medicaid is a joint federal/state program providing health care to low-income individuals and families. The

federal government establishes minimum requirements and ground rules for the program. Then each state enacts its own Medicaid program consistent with these requirements.

The federal government pays at least 50% of the costs for each state program. But the federal funding formula is skewed to favor low-income states with a higher proportion of federal funds. Consequently, the federal share of state Medicaid costs ranges as high as 83%.

As an outgrowth of pressures to reduce rapidly rising costs, federal law provides that if manufacturers of newer, "innovative" drugs want those drugs eligible for reimbursement under a state's Medicaid program, the manufacturer must pay the state a fee, like a kickback. That fee is equal to a minimum of 15.1% of the Average Manufacturer Price (AMP) for the drug, a price that approximates that average selling price from the manufacturer. However, rebates are typically higher based on a "best price" rule that requires manufacturers to pay the difference between the AMP and the lowest price the company charges its commercial customers, if this difference is greater than the minimum rebate. Manufacturers must also pay an additional rebate for price increases that exceed the consumer price index (CPI), making sure that price increases to the government never exceed inflation. As a result, the government is able to secure a net price for a medication that is at least as good as, if not better than, virtually any other price available in the private sector. However, a troubling element of this program is that states are not

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required to use the money from these fees in their Medicaid programs. They can, and often do, just put the money in the general fund, where it can be used for any general state program.

But these are not the supplemental rebates. The supplemental rebates are in addition to these kickbacks. Five states have adopted, and five more have authorized, requirements mandating that drug companies pay an additional fee set by the state if they want their drugs eligible for payment under the state's Medicaid program.

About a dozen states, however, have wisely rejected such policies. One reason for doing so is that such policies ultimately deny the poor dependent on Medicaid access to the full range of possible drug therapies. Some drug companies won't pay the supplemental rebates to register their drugs. Others will arrange to pay fees to register only some of their drugs. When Florida initially adopted a supplemental rebate program in 2001, more than 1,000 of the 1,827 brand-name drugs that had been approved for Medicaid were removed from the list.

This policy is particularly harmful to minorities. A far higher percentage of blacks and Hispanics are covered by Medicaid than whites, so minorities more heavily suffer the negative effect of this policy. In addition, they often respond to drugs differently than the majority white population. For example, diuretics work better in reducing high blood pressure among blacks than among whites, and anti-psychotic drugs work effectively for Asians at far smaller doses on average than for whites. It is most important, therefore, for minorities to have access to the broadest possible range of drug therapies,

so doctors can find and prescribe those that work best for them, rather than just prescribing the standard therapies that work for the broad majority.

Those suffering with mental illnesses will also be particularly harmed under such a program. That is because the response to drug treatments for mental illness is highly variable across the population, and doctors must search among many drugs for the one that is most effective for each patient. If the available drugs are limited, then many mental illness patients will not get the drug that is best for them.

Even where drug companies pay the supplemental fees to register their drugs, there are still problems. Cost shifting is common in health care, where a third party insurance company generally pays the bill. This leaves consumers and doctors indifferent about most rising costs. So if drug companies lose revenues in the Medicaid market, they can be expected to increase prices to recover the revenues in other markets. This will cause those without prescription drug coverage to pay more for their medications and contribute to already rapidly rising health insurance costs for the general public.

When insurance costs rise, another problem results. Some small businesses and individuals drop their coverage, or fail to buy it in the first place, because they can no longer afford it. As a result, the number of uninsured increases. This in turn will increase Medicaid costs when some of these uninsured become seriously

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ill.

Finally, where drug companies are unable to shift costs to others, and then face a reduction in revenues, another crucial problem arises. Some demagogues who have never produced a single drug that has saved or improved lives have waxed apoplectic about merely reasonable drug company profits. These people are a direct threat to the public health, and to your personal health. For most drug company profits end up being heavily invested back into the drug research that produces the miracle drugs that save and dramatically improve lives. Domestic R&D spending in fact totaled a whopping \$23.9 billion in 2001.<sup>1</sup> Those campaigning to reduce drug company revenues and profits are effectively campaigning to slash the nation's budget for research on such cutting-edge miracle drugs. If these people have their way, when you are older and contract a deadly illness or condition, the miracle drug that could have saved your life will in all likelihood not be there.

Supplemental rebate programs that reduce drug company revenues are just contributing to this result. They are effectively a tax on new drug cures and drug therapy innovation. Of course, any time you tax something you get less of it. So supplemental rebates are just another element that will discourage investors from putting funds into the development of life-saving drugs that any of us may find ourselves needing at some point in the future. Development of new drugs, especially the most advanced and innovative, is highly risky. Many lead to potentially miracle cures, but many others end up as dead ends after considerable expenditures. Then,

there is a long lead time before FDA approval and market education and acceptance take hold. Unless there is the prospect of a high reward for development of new drugs, especially the cutting edge innovative and miracle cures, no one is going to put up the money to develop them. That is just going to harm you and me and the general public. The crusade to effectively tax away drug company profits fairly earned in the marketplace is consequently misguided, counterproductive and harmful to patients.

## **An Alternative Approach**

One of the first states to adopt supplemental rebates was Florida. However, that state has also adopted an innovative new program as an alternative to supplemental rebates. Many low-income patients do not understand the medical resources that are available under Medicaid. Consequently, they do not regularly visit doctors for treatment for serious chronic conditions. When they do see a doctor, they do not understand the treatment programs they are supposed to follow. So they do not adequately maintain prescribed courses of care.

As a result, Medicaid patients end up using emergency rooms far more often, many times for avoidable emergencies. In these situations, they don't access appropriate care until it becomes a medical emergency. In the top volume Medicaid hospital in Florida, 90% of admissions for treat-

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ment of diabetes symptoms are through the emergency room rather than doctor referrals. For those with heart failure, the number is 89%, and for those with hypertension, 60%. Overall, Medicaid patients with serious chronic illnesses are more than twice as likely as non-Medicaid patients with the same illness to be admitted to a hospital emergency room because of an acute emergency.

To counter this problem, Pfizer developed the *Florida: A Healthy State* program in conjunction with the state of Florida. The program was first implemented in Jackson Memorial Hospital in Miami, the hospital with the most heavy concentration of Medicaid patients in the state.

Pfizer financed a team of 19 case managers at the hospital, who provide special services one on one to approximately 4,000 selected Medicaid patients to help them manage one of four serious, chronic illnesses – asthma, hypertension, diabetes or heart failure. The case managers will help educate the patients about the nature of their illnesses and the proper course of treatment, in coordination with their doctors. They will seek to overcome language and cultural barriers and old habits to get the patients to avoid foods that are dangerous, given their condition, and to concentrate on healthy foods and cooking methods. Too many Medicaid patients with diabetes don't understand the full extent of sweets they are supposed to avoid. Too many Medicaid patients with heart disease or hypertension don't understand which foods will worsen their condition.

The case managers will also educate the patients

about exercise programs that are appropriate for them and that will help improve their condition. They will also make sure that the patients understand their prescribed courses of treatment and maintain that treatment, including taking prescribed medications. Too many Medicaid patients fail to consistently take the prescribed medications that will prevent their asthma or hypertension from deteriorating into something worse.

The program will ultimately be expanded to as many as 10 hospitals with heavy Medicaid populations throughout the state. More than 50,000 Medicaid patients are expected to be served by the program over the next two years. The program will significantly reduce Medicaid costs by reducing the need for expensive care in emergency rooms and other settings, and keeping the potentially costliest portion of the population healthier for longer periods.

Pfizer will supplement this program with another health education component. Working with federally qualified community health centers that serve many of the state's Medicaid patients, Pfizer is helping to develop and deliver health education materials and programs specifically tailored to the literacy levels and cultural backgrounds of the state's Medicaid population. This program will seek to overcome language and cultural barriers that keep many Medicaid patients from understanding doctors' instructions and carrying out basic requirements like diabetics avoiding sweets or hypertension patients taking blood pressure medicine. The program will include special classes and home visits for patients most in need of help.

Pfizer and the state will also jointly finance a study conducted by the School of Public Health at the University of South Florida to determine whether these information and education efforts have any impact on health outcomes and costs.

Finally, Pfizer will donate prescription drug products at no charge to Medicaid patients receiving care at 67 community health centers throughout the state.

This is a far superior approach to saving state Medicaid funds than supplemental rebate programs, which lead to access restrictions and all the other problems discussed above. It has none of the negative effects of that rebate system. Yet, it would probably save the state at least as much through increased efficiency and improved health care outcomes resulting from the improved health education and knowledge. At the same time, patients gain the most, through markedly improved health.

But this innovative program does not even begin to address the much broader, fundamental problems of Medicaid. States need to focus on addressing these problems, through the more fundamental and comprehensive reforms discussed below.

## **Fundamental Medicaid Reform**

Welfare reform began with a law passed in 1988 that enabled the federal government to grant states waivers to try different welfare reform ideas and experiments. Based on this authority, Gov. Tommy Thompson (R) of Wisconsin and others began adopting increasingly comprehensive work requirements for welfare. Those ef-

forts proved shockingly successful with the welfare rolls consistently reduced by more than half. That led to the federal welfare reform legislation of 1996, which spread the reforms nationwide.

Similar waiver authority for the Medicaid program already exists under current law. Section 1115 of the Social Security Act, as amended, provides for Medicaid Research and Demonstration Waivers to be issued by the Federal Health Care Financing Administration (HCFA). These waivers allow broad flexibility for states to try new and innovative Medicaid reforms.<sup>2</sup>

A promising model that the states should examine for Medicaid reform is the Federal Employee Health Benefits Program. That system allows federal employees to choose from a broad range of private health plans. The federal employer contributes a fixed amount towards the purchase of these plans for each employee. Workers who choose the more expensive plans must contribute more money out of their own pockets.

Similarly, a state Medicaid system would offer beneficiaries the choice of a broad range of private health insurance plans, including traditional third-party payer insurance, preferred provider networks, managed care and the more innovative Medical Savings Accounts, discussed further below. The state can pay enough for each beneficiary to pay for the lower-cost plans. Those who want to choose the more expensive plans would have to pay the difference themselves.

The system would generate a fierce competition among plans to keep costs down. They would more aggressively seek to root out waste and strive to devise

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new and innovative means of maximizing efficiency and reducing costs. The full imagination of the private market would consequently be employed towards this goal, under the spur of competition.

Medicaid patients would then tend to choose the less-expensive plans, and those that don't would be paying for the difference themselves anyway. The incentives and competition would make those plans less costly over time. States are consequently likely to save considerable sums over the long run. At the same time, service and care for Medicaid patients would quite likely improve under such a system of competitive choice.

Medical Savings Accounts (MSAs) are a particularly promising option that can be included in this new system. MSAs provide complete third-party coverage over some higher than usual deductible, perhaps \$1,500 to \$3,000 per year. But they also include a store of cash that can be used to pay for expenses below the deductible. That cash comes from the savings in buying insurance with a substantially higher deductible, which is much less costly than insurance with low deductibles. Cash that is not used in one year can be carried over to the next year. After just one healthy low-cost year enough cash will generally accumulate in an MSA to cover all expenses below the deductible. Any unused cash at the end of a year can also be withdrawn in whole or in part and used for any purpose, as a bonus for staying healthy and keeping costs down.

These MSAs provide powerful incentives to patients to keep costs down, because they share in the savings. This gives medical care providers more incen-

tives to reduce costs as well. Experience with MSAs shows that these incentives do work to reduce costs substantially.<sup>3</sup>

MSAs also allow patients broad choice in how to use the cash available for expenses below the deductible. That cash can be used for checkups and other preventive care. This is particularly important for low-income Medicaid patients who would otherwise find paying for such checkups and care quite burdensome. Medicaid patients can also use the cash to pay for the care of their choice for whatever illnesses they may have. They could choose particular doctors or other providers they prefer, or even types of alternative medicine they think would be effective. So MSAs are a good means for enhancing patient choice as well as controlling costs.

The law concerning the tax treatment of MSAs is highly confused, but this is not really a barrier to their use. The MSA plan can be structured to provide traditional tax-free reimbursement for medical services, with cash bonuses for keeping expenses down. Any such bonuses not spent on health care would always be taxable under any system in any event.

MSAs can be a useful addition to other Medicaid reform plans as well. One approach popular among many policymakers is to contract out coverage for Medicaid patients to private managed-care companies. These companies can then reduce costs by clamping down on unnecessary care and waste, or overly expensive care. But such managed-care operations have come under heavy criticism for reducing patient choice.

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This criticism can be met by allowing Medicaid patients in such systems to choose MSAs instead of managed-care coverage if they prefer. This would give patients a chance to avoid managed-care if they feel it is too limiting. That choice would also provide a check on the managed care operations, keeping them from being too oppressive lest they start hemorrhaging patients to the MSA option. The MSA option can consequently make these managed-care reform plans much more palatable to the general public.

These are the sorts of reforms that would truly and comprehensively address the Medicaid problem in the states. States should focus on these broader reforms, rather than counterproductive Band-Aid approaches like supplemental rebates.

## Long-Term Federal Reform

Ultimately, the federal government must adopt Medicaid reform as well. These reforms should follow the model of the 1996 welfare reform act which thoroughly modernized the old Aid to Families with Dependent Children (AFDC) program. That act replaced the old program with a system of federal block grants to each state.

Under the new system, the federal government provides a set block grant to each state to be used to meet the cash welfare needs of those who would be served by the old program. The states then each develop and implement their own programs to address the needs of the population. Each state itself must cover its own costs above the amount of the block grant. So states have

strong incentives to develop the most efficient and least costly programs, and avoid waste and unnecessary spending. Federal and state policies also led the states to utilize work programs and incentives to reduce unnecessary costs, which the incentives of the block grants would likely do anyway. The end result of such reform is that the welfare rolls have been reduced by over 50% across the country, as compared to the old AFDC program.

Congress should similarly adopt a system of block grants for Medicaid. The federal government would set the block grant amount it is going to give to each state each year to be used for the Medicaid program. The state would then be free to design its Medicaid program as it desires, within broad parameters. Federal safeguards can be included to protect vulnerable populations. The costs of each state's program above the amount of the federal block grant would then be borne by each state.

With such reform, states could integrate their Medicaid programs into the work oriented reforms that replaced the old AFDC program. States would also be free to adopt the best systems that reduce unnecessary costs. They would be free as well to tailor the system to best meet the needs of the varying populations of each state. At the same time, federal costs would be limited to the block grant amounts, and runaway Medicaid spending could be avoided.

Such reform in the end would consequently benefit everyone – the federal government, the states, Medicaid patients and taxpayers.

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March 14, 1995.

## Conclusion

Supplemental rebate programs are counterproductive and will not even begin to solve the problems states face with their Medicaid programs. The innovative program adopted by Florida instead is a much better alternative. But even this program will not significantly address the big picture.

States need to focus instead on broader, fundamental reforms. The Section 1115 waiver already provides broad federal authority for states to adopt innovative and sweeping reforms. If states use that authority wisely, they can reform their Medicaid programs to benefit everyone – the federal government, states, Medicaid patients and taxpayers.

## Footnotes

<sup>1</sup> Merrill Mathews, Jr. “Patent Protection for Me, But Not for You,” Institute for Policy Innovation, June 14, 2002.

<sup>2</sup> Richard Teske, “How States Can Use Federal Waivers to Help the Poor and Test Health Reforms,” The Heritage Foundation, Washington D.C., *Backgrounder* No. 1337, November 2, 1999.

<sup>3</sup> Peter Ferrara, “More Than a Theory: Medical Savings Accounts at Work,” *Cato Policy Analysis* No. 220,

# Notes

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