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Making Medicaid Work for the Most Vulnerable

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I am Tarren Bragdon and serve as the President and CEO of the Foundation for Government Accountability. The Foundation is a free-market think tank specializing in health and welfare policy solutions and is based in Naples, Florida. Thank you for the opportunity to testify on this critical issue.

Medicaid currently represents the single largest and fastest growing line item of state budgets.[1] Medicaid spending already represents one-fourth of the federal deficit and federal Medicaid spending is expected to more than double during the next decade.[2] This spending growth is nearly twice as fast as the expected growth in the economy.[3]

But more importantly, Medicaid is failing patients by keeping too many people poor and sick, and robbing them of the hope of a better life. States are currently debating whether or not to expand this broken Old Medicaid program, but that should not be the priority. The priority for states should be to make Medicaid finally work best for patients and taxpayers.

Some states are leading the way. Here are a few strategies that are working well for patients, providers, policymakers and taxpayers:

1. Empowering Medicaid patients with meaningful choices. States such as Florida, Kansas and Louisiana have empowered Medicaid patients to choose the health plans that work best for them. In Florida, for example, patients can choose from up to 13 different health plans offering 31 different and customized benefit packages.[4]

When given meaningful choices and adequate, objective information, Medicaid patients take more control over their health. In Florida's Reform Pilot and in Louisiana's Bayou Health, for example, independent choice counselors assist Medicaid patients in navigating the plan selection process, providing neutral comparisons based on patients' specific needs and concerns.[5-6]

As a result, between 70 percent and 80 percent of patients in Florida's Reform Pilot actively choose their health plan, compared to the 20 percent to 30 percent who let the state automatically

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[1] Brian Sigritz, "State expenditure report: Examining fiscal 2010-2012 state spending," National Association of State Budget Officers (2012), http://www.nasbo.org/sites/default/files/State%20Expenditure%20Report_1.pdf.
[2] Christina Hawley Anthony et al., "The budget and economic outlook: Fiscal year 2013 to 2023," Congressional Budget Office (2013), http://www.cbo.gov/sites/default/files/cbofiles/attachments/43907-BudgetOutlook.pdf.
[3] Ibid.
[4] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_YR_6_Final_Annual_Report_07-01-11_06-30-12.pdf.
[5] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_yr_6_Final_annual_report_07-01-11_06-30-12.pdf.
[6] Medical Vendor Administration, "Request for proposals: Enrollment broker for Louisiana Medicaid coordinated care networks, RFP # 305PUR-DHHRFP," Louisiana Department of Health and Hospitals (2011), http://new.dhh.louisiana.gov/assets/docs/Making_Medicaid_Better/RequestsforProposals/enrollbroker/EB_RFP_FINAL.pdf.

assign them to a plan.[7] In Louisiana, approximately 70 percent of new Medicaid patients actively choose their health plan.[8] Choice counseling programs ensure patients are empowered not only with the ability to choose, but with the knowledge necessary to choose wisely.

This active participation and plan selection illustrates that, when given the power to choose and the information necessary to make an educated decision, patients want to take more responsibility over their health future. In Kansas, for example, American Indians were allowed to opt out of the reforms that offered them a choice of multiple private plans and instead remain in traditional Old Medicaid. But since the reforms launched in January 2013, just 12 American Indians chose to opt out of the reforms and return to Old Medicaid.[9]

The competition among plans has resulted in those plans constantly striving to innovate, improve customer service and maximize the offered benefits and rewards. Costs for these reformed benefit packages have been substantially below spending for similar populations statewide.[10] Florida expects to save nearly $1 billion annually when the reforms are phased in statewide.[11] This example highlights how states are able to deliver more choices to Medicaid patients and still save precious taxpayer dollars.

These customized benefit packages are not only delivering greater choice, they are delivering better results as well. The plans offered in Florida's Reform Pilot outperformed the traditional Old Medicaid program on 22 of 33 widely-tracked health outcomes.[12] Better yet, 94 percent of the Reform Pilot's regularly-tracked health performance measures have improved since 2008.[13] Implementing a robust Medicaid marketplace, where patients choose the health plan that works best for them, has increased access to needed care, improved health outcomes, provided patients with greater satisfaction with the quality of the care and service they receive, and lowered costs for taxpayers.

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[7] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_yr_6_Final_annual_report_07-01-11_06-30-12.pdf.

[8] Between January 2013 and May 2013, approximately 56,000 of the 82,000 newly eligible Bayou Health patients made pro-active choices about which health plan in which to enroll. See, e.g., Maximus, "New enrollment by Medicaid eligibility group and health plan," Louisiana Department of Health and Hospitals (2013), http://dhh.louisiana.gov/index.cfm/page/1391.

[9] Division of Health Care Finance, "Quarterly report to CMS regarding operation of 1115 waiver demonstration program: Quarter ending March 31, 2013," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/reports/KanCare_Quarterly_Report_QE_3_31_13.pdf.

[10] Tarren Bragdon, "Florida's Medicaid reform shows the way to improve health, increase satisfaction and control costs," Heritage Foundation (2011), http://www.medicaidcure.org/wp-content/uploads/2012/09/Medicaid-Cure-Floridas-Medicaid-Reform-Pilot.pdf.

[11] Ibid.

[12] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 7, 2nd quarter progress report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_Q2_yr_7_report_10-1-2012_12-31-2012_final.pdf.

[13] Ibid.

2. Integrating work with health outcomes. Kansas has created two unique employment-focused pilot programs that integrate work with health outcomes for individuals with developmental disabilities. The first pilot, which covers individuals receiving SSI who are on the waiting list to receive home and community-based services, provides assistance with obtaining employment and provides up to $1,500 per person per month in employment support services.[14] The second pilot focuses on youth and those who would likely meet the criteria for Social Security Disability but are not yet receiving it. These individuals receive employment assistance focused on jobs with employer-sponsored health coverage and receive wrap-around Medicaid services once enrolled in a work-related health plan.[15]

By integrating employment into Medicaid, KanCare can help these individuals gain opportunities to maintain and improve their skills, helping lead to long-term employment and productivity. Given the strong association between employment and better health, integrating employment services also helps to avoid the culture of poverty, poor health and social isolation stemming from lack of employment.[16]

3. Innovation through private plans. States have also been able to harness, through contracted private plans, innovations which improve quality and reduce costs. By allowing health plans to offer customized and extra benefit packages, states can provide patients with benefits not typically covered by the traditional Old Medicaid program, but which have profound effects on health outcomes. In 2012, plan providers in Florida's Reform Pilot offered 31 different benefit packages, with coverage for over-the-counter drugs, vision, preventive dental coverage, nutrition therapy and respite care included among the value-added extra benefits.[17] In Kansas, individuals can choose plans that offer additional dental benefits, smoking cessation programs, GED programs, Weight Watchers membership and Boys and Girls Clubs membership, among other benefits.[18] Customized and enhanced benefit packages ensure that health plans are able to compete on value by tailoring their benefits to best meet the needs and desires of their patients.

This customization is most evident for patients with very complicated health challenges. In Florida's Reform Pilot, for example, these patients are offered specialty plans tailored to their unique needs. This includes plans developed specifically for medically fragile children and plans customized to best manage HIV/AIDS.[19] Kansas offers programs that are specifically designed

[14] Division of Health Care Finance, "KanCare: Section 1115 demonstration waiver," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/download/KanCare_Section_1115_Demonstration_August_6_2012.pdf.
[15] Ibid.
[16] Ellie C. Hartman, "A literature review on the relationship between employment and health: How this relationship may influence managed long term care," Wisconsin Department of Health Services (2008), http://www.dhs.wisconsin.gov/wipathways/ResearchDocs/litrevw.pdf.
[17] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_yr_6_Final_Annual_Report_07-01-11_06-30-12.pdf.
[18] Division of Health Care Finance, "Medicaid for Kansas: Choosing a KanCare health plan," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/choosing_a_plan.htm.
[19] Ibid.

to help manage complicated conditions such as HIV/AIDS and schizophrenia.[20] Specialty plans ensure that patients with complicated health challenges can receive the unique care they deserve.

Private plan innovation is not just occurring in plan customization. Private plans are also innovating wellness programs. These wellness programs adopt incentive structures that reward Medicaid patients for healthy behavior. Patients in Florida's Reform Pilot plans can earn up to $125 per year for receiving certain preventive services, complying with maintenance and disease management programs, keeping appointments and engaging in other healthy behaviors.[21] Individuals may then use these rewards to purchase over-the-counter items at participating pharmacies.[22] In Kansas, patients can choose plans that offer cash incentives for healthy behaviors, such as getting vaccinations, regular checkups and the like.[23]

This kind of wellness program further encourages Medicaid patients to take control of their own health by offering financial incentives for engaging in healthy behaviors. Similar wellness rewards programs operate through contracted Medicaid managed care organizations in Arizona, Georgia, Illinois, Indiana, Kentucky, Louisiana, Massachusetts, Missouri, Mississippi, New Hampshire, Ohio, South Carolina, Texas, Washington and Wisconsin.

In Ohio, for example, patients can earn up to $175 for preventive services and disease management. Pregnant mothers may earn up to $100 for completing regular prenatal visits and parents can earn another $100 for completing regular well-child visits. In South Carolina, parents can earn an extra $105 just for completing regular well-child visits.

But not all programs are innovating. Here are a few things that are not working:

1. Perverse funding formulas. Under the Patient Protection and Affordable Care Act, states that choose to expand Medicaid coverage will receive an enhanced matching rate for the new Medicaid population.[24] This population consists primarily of able-bodied adults without children and low-income parents.[25] The enhanced matching rate for the newly eligible population starts at 100 percent in 2014 and then gradually reduces to 90 percent by 2020.[26]

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[20] Division of Health Care Finance, "KanCare: More choices, better access, healthy patients," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/download/KanCare_ProPatient_ProTaxpayer.pdf.

[21] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/Fl_1115_yr_6_Final_annual_report_07-01-11_06-30-12.pdf.

[22] Ibid.

[23] Division of Health Care Finance, "Medicaid for Kansas: Choosing a KanCare health plan," Kansas Department of Health and Environment (2013), http://www.kancare.ks.gov/choosing_a_plan.htm.

[24] 42 U.S.C. § 1396d(y).

[25] Genevieve M. Kenney et al., "Opting into the Medicaid expansion under the ACA: Who are the uninsured adults who could gain health insurance coverage?" Urban Institute (2012), http://www.urban.org/UploadedPDF/412630-opting-in-medicaid.pdf.

[26] 42 U.S.C. § 1396d(y).

The matching rate for currently eligible individuals, on the other hand, ranges from 50 percent to 83 percent, with the federal government typically paying an average of 57 percent of Medicaid expenditures.[27] This means that states will receive less federal support to provide services to the most vulnerable; those patients currently eligible for Medicaid, including the elderly, individuals with disabilities and children. This perverse funding formula provides states with incentives to cut services and benefits for the most vulnerable, giving preferential treatment to adults without any disabilities or dependent children.

There are more than 511,000 individuals on waiting lists to receive home and community-based services through Medicaid.[28] Those on waiting lists include individuals with intellectual disabilities, developmental disabilities, traumatic brain and spinal cord injuries, physical disabilities, mental health conditions and HIV/AIDS.[29] The Medicaid expansion's perverse funding formula ensures these individuals will be kicked to the end of the line in order to provide coverage to able-bodied adults in the states that opt to expand.

2. A too expansive, broken program. When broken Old Medicaid programs become too expansive, states often delay payments to doctors, hospitals and other providers in order to make ends meet. For example, Illinois owed doctors, hospitals and other medical providers more than $2 billion for unpaid Medicaid services at the end of fiscal year 2012.[30] The average medical provider waited more than 5 months to receive reimbursement for their services, with some delays lasting eight months or more.[31-32] These reimbursement delays occurred despite federal law requiring states to pay 90 percent of Medicaid bills within 30 days and 99 percent within 90 days.[33]

Earlier this year in Maine, a coalition of 39 hospitals demanded $484 million for unpaid Medicaid bills dating back to 2009.[34] The hospitals went so far as to launch radio and newspaper advertisements to build public pressure on state policymakers to pay down the backlog of Medicaid bills. Of course, Maine expanded Medicaid eligibility to able-bodied adults without

[27] 42 U.S.C. § 1396d(b).
[28] Kaiser Commission on Medicaid and the Uninsured, "Waiting lists for Medicaid section 1915(c) home and community-based service (HCBS) waivers," Kaiser Family Foundation (2013), http://kff.org/medicaid/state-indicator/waiting-lists-for-hcbs-waivers-2010/.
[29] Ibid.
[30] John Sinsheimer, "General obligation bonds, Series A and B of April 2013," Illinois Governor's Office of Management and Budget (2013), http://www.state.il.us/budget/ILState02a-FIN.pdf.
[31] Mallory Meyer et al., "State of Illinois budget summary: Fiscal year 2012," Illinois Commission on Government Forecasting and Accountability (2011), http://cgfa.ilga.gov/Upload/FY2012BudgetSummary.pdf.
[32] Jennifer Levitz and Louise Radnofsky, "Delays in Medicaid pay vex hospitals," The Wall St. Journal (2013), http://online.wsj.com/article/SB10001424127887324442304578234020690323296.html.
[33] 42 C.F.R. § 447.45(d)
[34] Jennifer Levitz and Louise Radnofsky, "Delays in Medicaid pay vex hospitals," The Wall St. Journal (2013), http://online.wsj.com/article/SB10001424127887324442304578234020690323296.html.

children in 2002.[35] Its Medicaid expansion far exceeded projected costs, forcing the state to cap enrollment in the program at various times and lengthen payment cycles to cope.[36]

Likewise, Arizona expanded Medicaid eligibility to childless adults in 2000.[37] But the expansion cost four times what was expected, forcing policymakers there to cut other areas in order to maintain the expansion.[38] Indeed, Arizona had to eliminate Medicaid coverage for heart, liver, lung, pancreas and bone marrow transplants in 2010 in order to pay for the growing costs of its Medicaid expansion.[39]

These payment delays and service cuts – emblematic of an expansive, broken program – ensure that Medicaid patients will face greater difficulty in finding doctors willing to treat them, likely resulting in worse health outcomes.

3. Slow, inflexible federal waiver processes. For many states, the waiver process is a long, drawn-out and complex negotiation with CMS. States face burdensome reporting requirements, subjective deadlines and general uncertainty about whether and when CMS will approve requested reforms. Even if a state receives a federal waiver to implement its desired reforms, the waiver lasts just three to five years.[40] After that time, it must either seek an optional extension of the waiver or submit a new waiver request altogether if it wants to continue its reforms. Even reform ideas that have proven effective elsewhere must follow this slow, inflexible process and states have no guarantee that the federal government will grant them permission to implement these effective reforms.

4. New taxes on private plans. The Affordable Care Act imposes a new $8 billion tax on private health plans, starting in 2014. This tax gradually increases to more than $14 billion in 2018, then increases at the annual growth in premiums. Strangely, this new tax also applies to Medicaid plans in states that have reformed their programs with managed care. Because the Medicaid managed care rates are required by federal law to be actuarially sound, the cost of this new tax will be borne by state and federal taxpayers. This results in a situation where the federal government is taxing both itself and states, increasing Medicaid costs and shifting more costs to the states.

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[35] Alexis Gibson, "MaineCare for childless adults: Section 1115 demonstration," Centers for Medicare and Medicaid Services (2011), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/me/me-childless-adults-fs.pdf

[36] Jonathan Ingram, "Medicaid expansion: We already know how the story ends," Foundation for Government Accountability (2013), http://www.medicaidcure.org/wp-content/uploads/2013/03/Medicaid-Expansion-We-Already-Know-How-the-Story-Ends-Medicaid-Cure-Policy-Brief-31.pdf.

[37] Jennifer Vermeer, "Ballot proposition 204, Healthy Arizona: Publicity pamphlet fiscal impact summary, revised Aug. 17, 2000," Arizona Joint Legislative Budget Committee (2000), http://www.azleg.gov/jlbc/ballotprop204.pdf.

[38] Jonathan Ingram, "Medicaid expansion: We already know how the story ends," Foundation for Government Accountability (2013), http://www.medicaidcure.org/wp-content/uploads/2013/03/Medicaid-Expansion-We-Already-Know-How-the-Story-Ends-Medicaid-Cure-Policy-Brief-31.pdf.

[39] Kevin Sack, "Arizona Medicaid cuts seen as sign of the times," New York Times (2010), http://www.nytimes.com/2010/12/05/us/05transplant.html.

[40] Section 1115 waivers are generally approved for five-year periods, Section 1915(b) waivers are generally approved for five-year periods and Section 1915(c) waivers are generally approved for three-year periods.

Nearly one-fifth of this new tax on private plans is expected to be borne by Medicaid programs.[41] The tax is expected to increase Medicaid capitated rates by up to 2.5 percent for some states, with the national average falling somewhere between 1.5 percent and 1.6 percent.[42] This amounts to between approximately $37 billion and $42 billion in increased Medicaid costs during the next ten years, with much of that added burden falling on state governments.[43] Adding a new tax on Medicaid plans will only accelerate the mayhem Medicaid programs are already creating for state budgets.

States are leading the way, implementing innovative solutions to the persistent problems Old Medicaid has created. But federal rules and regulations often hinder state leaders who want to make their Medicaid safety nets more responsive to patients, more accountable to policymakers and more affordable to taxpayers. Additional flexibility from the federal government should give each individual state the opportunity to build a Medicaid safety net to best serve patients and taxpayers.

A few recommendations to provide states with additional flexibility include:

1. Reject the one-size-fits-all expansion. Expanding Medicaid eligibility diverts scarce Medicaid resources away from the truly vulnerable in order to fund coverage for able-bodied adults. Prioritizing able-bodied adults above the elderly, individuals with disabilities and low-income children will only exacerbate the many problems present in Old Medicaid.

The various fiscal and health promises made by expansion supporters have already been broken in the states that have previously expanded eligibility to this group of people. They are likely to be broken in the states that opt into the Affordable Care Act's Medicaid expansion.[44] Medicaid expansion, including its perverse funding formula, should be rejected and states should regain their control over eligibility levels based on the needs, culture and values of their own state population.

2. Remove perverse funding dynamics. Under current law, states that implement innovative reforms see the majority of their savings go to the federal government, not to the states themselves. Under current Medicaid matching rates, states can expect to see only 17 percent to 50 percent of the savings their innovative reforms achieved. This creates a disincentive for states to make meaningful changes, as the lion's share of savings will accrue to the federal government.

The federal government could reduce this perverse funding dynamic by granting states flexibility and incentives to better share those savings. Doing so would promote innovation and provide

[41] John D. Meerschaert et al., "PPACA health insurer fee estimated impact on state Medicaid programs and Medicaid health plans," Milliman (2012), http://publications.milliman.com/publications/health-published/pdfs/ppaca-health-insurer-fee.pdf.
[42] Ibid.
[43] Ibid.
[44] Jonathan Ingram, "Medicaid expansion: We already know how the story ends," Foundation for Government Accountability (2013), http://www.medicaidcure.org/wp-content/uploads/2013/03/Medicaid-Expansion-We-Already-Know-How-the-Story-Ends-Medicaid-Cure-Policy-Brief-31.pdf.

states with a greater financial incentive to implement bold solutions. Although this recommendation would appear to increase federal spending, in practice it would reduce federal spending as states would have strong incentives to innovate and generate savings with Medicaid reform, something lacking today.

3. Allow proven waivers to be seamlessly incorporated into state plan amendments. The waiver process is often accompanied by uncertainty about whether and when the federal government will approve requested reforms. Because waivers have a limited duration, this uncertainty persists even for reforms that have proven effective and popular. Currently, states are operating under 378 different active waivers and have another 27 waivers pending with the Centers for Medicare and Medicaid Services.[45]

Congress could embrace an accountable, common sense approach to Medicaid oversight by granting states the flexibility to turn previously-approved waivers into permanent state plan amendments once the waivers have been proven effective. Doing so alleviates the stress and uncertainty states now face as their waivers approach scheduled expiration dates. This also ensures patients' care and taxpayer savings do not face interruptions resulting from lengthy renegotiations with CMS. Further, states should be able to incorporate a reform proven effective in other states into their own state plans without enduring the burdensome waiver process and scrutiny the reform already received elsewhere.

This would allow states to avoid months- or years-long delays for waiver approval. Reforms accomplished through state plan amendments can expect approval within 180 days. And rather than needing approval again after just a few years, a state plan amendment becomes a permanent part of a state's Medicaid program unless changed by a future state plan amendment.

4. Provide greater flexibility on mandatory and optional services. Customized benefit packages provide patients with the greatest value and competition among plans has proven effective at reducing costs for taxpayers. In Florida, Medicaid patients can choose from up to 31 different, customized benefit packages.[46] The state allows health plan providers to offer customized benefit packages as long as the benefit packages are actuarially equivalent to the state plan and still provide key benefits at a level sufficient to meet patient needs.[47]

But states and health plan providers are hamstrung by federal rules dictating how much they can customize benefits. Federal rules require coverage for inpatient hospital services, outpatient hospital services, early and periodic screening, diagnostic and treatment services, nursing facility

[45] Centers for Medicare and Medicaid Services, "Medicaid waivers: Dynamic list," U.S. Department of Health and Human Services (2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/dynamic-list/WA-508.xml.
[46] Florida Agency for Health Care Administration, "Florida Medicaid reform: Year 6 annual report," Florida Agency for Health Care Administration (2012), http://ahca.myflorida.com/medicaid/medicaid_reform/pdf/FL_1115_YR_6_Final_Annual_Report_07-01-11_06-30-12.pdf.
[47] Florida Agency for Health Care Administration, "Florida Medicaid reform: Application for 1115 research and demonstration waiver," Florida Agency for Health Care Administration (2005), http://ahca.myflorida.com/medicaid/medicaid_reform/waiver/pdfs/medicaid_reform_waiver_final_101905.pdf.

services, home health services, laboratory and x-ray services, family planning services, nurse midwife services, certified pediatric and family nurse practitioner services, freestanding birth center services, transportation to medical care and tobacco cessation services.[48] States may only choose which additional services to offer and set the scope and range of those services.

With added flexibility from the federal government, states could offer more customized benefit packages to vary these minimum benefits, so long as the benefit packages meet specified actuarial standards. One potential avenue for this customization would be to grant states much more flexibility for benchmark Medicaid coverage.

States currently have the option to design benefit packages for certain populations that vary from traditional Old Medicaid.[49] However, the flexibility provided in designing these benefit packages, known as "benchmark coverage" or "benchmark-equivalent coverage," is limited in nature. The benefit packages must be equivalent to the standard Blue Cross/Blue Shield health plan offered to federal employees, the health plan offered to state employees or the largest commercial, non-Medicaid health maintenance organization plan offered in the state.[50] Benchmark-equivalent coverage must also provide specified mandatory services.[51] Current law also requires states to "wrap around" benchmark coverage with additional benefits not typically covered by private insurance, such as transportation services to and from medical visits.[52] The Affordable Care Act further requires such benchmark-equivalent coverage include all essential health benefits.

Given adequate flexibility, states could restructure their covered benefits to provide truly patient-centered customized benefit packages. And if plans meet a target actuarial value, states should be free to allow plans to be offered that vary covered services and benefits, including those that are federally mandated, as well as the amount, duration and scope of those services. States would evaluate each proposed customized benefit plan in order to ensure plans meet the target actuarial value.

This will create greater competition within the Medicaid marketplace, lowering the cost to taxpayers and improving quality. Patients will be able to prioritize benefits according to their personal needs and circumstances and select the plans that will provide them with the greatest value. For example, a patient may wish to select a plan that does not offer transportation services, but instead select a plan that offers a better dental benefit package. They deserve that choice.

5. Create an off-ramp for Medicaid. Currently, federal restrictions on marketing private insurance plans to individuals transitioning off of Medicaid impose an undue burden on those leaving Medicaid. These restrictions further worsen the gaps in coverage for individuals leaving

[48] Centers for Medicare and Medicaid Services, "Medicaid benefits," U.S. Department of Health and Human Services (2013), http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Benefits/Medicaid-Benefits.html.
[49] 42 C.F.R. § 440.300 et seq.
[50] 42 C.F.R. § 440.330.
[51] 42 C.F.R. § 440.335.
[52] 42 C.F.R. § 440.390.

Medicaid. As Florida's Reform Pilot has proven, Medicaid patients can and do make informed choices about their health coverage when given access to appropriate information. Denying them such information while they are transitioning off of Medicaid hinders their ability to make educated choices, taking away their power to make meaningful decisions over their health futures.

Other federal rules and regulations restrict states from using Medicaid funding in innovative ways to move individuals off of Medicaid and into private coverage. With greater flexibility in this area, states would be able to take proactive steps to create an off-ramp for Medicaid, helping ensure that Medicaid patients are not trapped in government dependency and a culture of poverty, but rather help them move from poverty into long-term employment and productivity.

Conclusion

Despite Medicaid's fiscal challenges to state budgets and the federal budget, there are proven strategies that are working today for both Medicaid patients and taxpayers. However, the current funding structure, new taxes, a slow federal process, and perverse incentives inherent in Medicaid expansion threaten Medicaid services to the most vulnerable. It doesn't have to be that way. With reasonable flexibility, targeted incentives, streamlined administration, and a smooth off-ramp, the Medicaid safety net can work better today for patients and providers and be sustainable for taxpayers into the future.