

Governor's Medicaid reform plan needs work

The first thing I don't like about the changes in the state's Medicaid program proposed by Gov. Mark Sanford is the way I found out about it—reading a slanted article on the opinion page of *The Wall Street Journal*.



Publisher's Note

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An op/ed article by two advocates of “consumer driven” health care asserted that a central element of the plan being floated by “visionary governors” like Sanford is that the plans would “liberate” Medicaid enrollees to manage their own health care instead of “bureaucrats” doing so on their behalf.

Liberate? Bureaucrats? Visionary governors?

Right away, you smell the pungent scent of political spin. Doesn't it seem odd to use a totally inappropriate word like “liberate” to describe changes in a health care program?

This appears to be the latest “issue framing” word dreamed up by conservative spinners to put a happy face on a bitter pill. But this time, I'd say they made a poor choice of words. Two years ago the nation bought into a plan to “liberate” Iraq and that venture has proved far more costly and difficult than originally predicted.

Another liberation effort on the domestic policy side has also floundered—the drive to “liberate” Americans from their Social Security retirement benefits and throw them into the stormier seas of the stock market. This time around, people woke up and smelled the coffee, and the invasion of the benefit-snatchers was stopped on the steps of the Capitol.

A whisper, then a roar

My second source for information on the governor's plan was an article in *BusinessWeek* magazine. The governor, said *BusinessWeek*, “has quietly asked the federal government for permission to redesign Medicaid for the 800,000 low-income residents of his poor, largely rural state.”

Perhaps a bit too quietly, as it turns out, since a recent article in *The State* newspaper depicts a number of Democratic state legislators as crying foul and saying the governor should have consulted with the Legislature before submitting such a sweeping proposal for approval by the federal government.

Robby Kerr, director of the S.C. Department of Health and Human Services, maintains that input from the public and the General Assembly is expected and welcomed as a part of the evaluation process and that the General Assembly's budget powers give them substantial control over implementation of the plan.

In any event, the governor's proposal is a serious and sweeping initiative. It is imperative for the public, the media and policymakers to invest the time and attention needed to assess the impact of the “Medicaid waiver” application submitted by the state to the federal government in June.

Two Washington, D.C., think tanks recently published analysis of the proposal. Their general conclusion was that the plan would inevitably reduce benefits for Medicaid recipients. That is particularly troubling because 55% of all enrollees are low-income children.

Since 1997, the percentage of uninsured children in the state dropped from 26% to 11%, largely due to expansion of the Medicaid program.

This is, in fact, a great success story for South Carolina, since focusing on the health and education of poor children is probably the best way to lift people out of poverty and improve the general economic standing of our state. But on its face, the governor's Medicaid waiver program might significantly reduce or reverse the successes achieved on the health care front. Kerr insists, however, that the intention is not to change or limit the coverage provided to low-income children.

The free market isn't free

The governor's basic political philosophy is well known: If you just cut taxes to the bone and leave as much as possible to the free market, everything will work out better. That's why one cornerstone of his proposal is “Personal Health Accounts.”

BusinessWeek says the plan echoes

President Bush's “ownership society.” The article describes the choices offered to Medicaid enrollees as follows:

Medical network. The poor would use their entire accounts to join a network. Patients would still have modest deductibles and co-payments. A primary-care gatekeeper would coordinate treatment.

Private insurance. Beneficiaries would purchase a managed-care plan with conventional premiums, co-pays and deductibles. Insurance companies or HMO's could offer extras such as dental or vision coverage.

Self-directed care. Patients would use their accounts to buy limited insurance for hospital care and pay out-of-pocket costs for all other services. The state might still negotiate discount rates with Medicaid doctors.

The two aforementioned Washington think tanks have raised several questions about the plan. They assert that virtually all recipients would receive less coverage than they have now and that requiring recipients to cover co-pays or deductibles would lead them to avoid necessary care, making them sicker and increasing the risk of death or expensive hospitalizations stemming from a lack of preventive care.

They also say that the requirement of “budget neutrality” in the federal waiver program could put a cap on funding from the federal government that would further strap the South Carolina program over time.

Let the debate begin

One can't help but sympathize with the challenge faced by Kerr in riding herd over the state's Medicaid program. Under his tenure, the program has achieved some significant milestones in terms of staying solvent and holding down costs while extending coverage to more needy South Carolinians.

What is needed now is a wider debate about health care in South Carolina, not just Medicaid or Medicare or care for the uninsured, but the entire system, warts and all.

There are some good ideas in the governor's plan and some that are of dubious value. The best outcome of the proposal as drafted would be a spirited and thoughtful dialogue across the state about how we can both improve and fund health care for all our citizens.

Let the debate begin! 