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Indiana Lawmakers Set State Up for Health Care Reform Failure
By Steven Keltner PA-C

In a June 11, 2006 article found online at *Indiana Economic Digest*, Vi Simpson D-Ellettsville was quoted as saying that she and other Senate Democrats are planning to propose a "hybrid of plans adopted in Massachusetts, and other states" in order to fix Indiana's healthcare crisis. The only problem is that the Massachusetts plan will not only fail the Bay State, but anyone who looks to it as a panacea for heath care.

It is important to understand the true motive of Massachusetts Bill 4850. It was not passed to solve their healthcare crisis, but was passed with all its flaws to avoid losing Federal funding. In July, the state was facing a Federal deadline to show that it was making some effort to cover more uninsured citizens. Failure to show progress would have resulted in losing $385 million in federal funding for the Massachusetts' Medicaid program. By passing the bill, the state managed to keep Federal dollars flowing.

Fixing Medicaid is a tricky proposition. Even well-educated, well-informed people find discussions on the subject confusing and mind numbing. Because of this it's no wonder members of our General Assembly would prefer to adopt some other states plan. But this is not possible in when dealing with Medicaid.

In February of 2006, President Bush signed a bill giving individual states flexibility in the Medicare decision process. States now have the ability to decide who can qualify for Medicaid, what services they should receive, and how much recipients should co-pay. As Daniel C. Vock points out in his August 3, 2006 Stateline.org story "The result is that no state's Medicaid program is exactly like another's, leading health policy experts to say Medicaid isn't one program, but 51 (one for each state and the District of Columbia)." Because our state is unique in many ways, a tailored healthcare reform will be necessary. The entire infrastructure must be completely reorganized to spread Federal and State Medicaid dollars over a greater population.

Many may rush to judgment and declare that we need to cut spending. This would be a huge mistake. Medicaid's financial structure is a type of matching system. According the 2004 Lewin Group report submitted to a subcommittee on Medicaid and Human Services, "In Indiana, cutting one State dollar from Medicaid causes Medicaid spending to decline by approximately three dollars." For example, "in fiscal year 2003 Indiana Medicaid expenditures totaled $3.8 billion in combined Federal and State funding. Indiana was responsible for about 1.4 billion." This was the amount needed to cover 800,000 residents. How then can we continue to cover the current 850,000 recipients and add provided coverage for another 600,000 to 800,000 uninsured Hoosiers. We could raise taxes, or we could think outside the proverbial box.

One thing everyone must realize is insurance is expensive, but healthcare is not. The proof is found in the rapid proliferation of walk up clinics across the county. The services are excellent and provided at a fraction of the cost of the same services provided in over crowded Emergency Departments. Yet they serve much the same patient population, that of uninsured patients who have no primary healthcare provider.

Further, there is a great difference between the cost of health care and the price of health care. With fall approaching, healthcare providers will be administering rapid strep test in large numbers

looking for the presence of strep throat. The provider's cost for this is about $5 per single use test. If the test is done in the Emergency Room the price billed to your insurance can be almost $100. Prescriptions that cost pharmacies 62 cents to dispense are sold for a price of over $12. This type of inflationary pricing is not the exception, but more and more it is the rule, and it is the result of insurance companies.

In essence, we need to shift our mind set from giving everyone universal insurance to giving everyone universal access to high quality, cost effective healthcare.

Establishing a large-scale system of small clinics can help alleviate the access crisis. Staffing could be augmented through mid-level practioners, as is the practice in many existing walk up clinics. This would allow physicians more time to focus on the most difficult cases referred by the midlevel practioners. In many cases, the services provided by mid-level practioners are discounted 15% compared to physician's services, another obvious cost savings to the Medicaid program.

These clinics could partner with Indiana companies like Eli Lilly and Cook Pharmaceutical Solutions to buy medicines and supplies directly and avoid the high costs put on the products by third parties. These companies have repeatedly shown they are dedicated to Indiana and its communities. It is doubtful they would scoff at such a mutually beneficial proposition.

Medicaid recipients must undergo a benefit and status reassessment. Like many working Hoosiers, my family's health plan gets more expensive and less inclusive every year, and I have no choice but to accept higher deductibles, higher co-pays, and less drug coverage. People receiving free healthcare or greatly reduced pricing will also have to be satisfied. In the same 2004 Lewin Group report mentioned earlier, they observed that disabled participants accounted for only 12% of all enrollees, yet they accounted for 40% of expenditures. That's 40% of the $3.8 billion spent in Indiana in fiscal year 2003. Disability is an area that is rife with abuse that I see first hand in the Emergency Department with great frequency, and it is the starting point for Medicaid reform.

Finally, Medicaid recipients will be forced to cope with the personal choices they make. Smokers will have higher co-pays, but will have an opportunity to get smoking cessation help. Mother's of newborns will be strongly encouraged to reap the health benefits of breast feeding for the first six months, or they will face higher co-pays. People must be held accountable for their own health and lifestyle choices. But, they need access to providers to give them proper guidance.

Amy Goldstein of the *Washington Post* wrote in her June 12, 2006 article that West Virginia will require Medicaid "patients to sign a 'member agreement,' promising they will keep doctors' appointments, take prescribed medicine and not overuse hospital emergency rooms." Refusal to do so will mean limited care. Further, the article pointed out the need to "instill self-reliance in low-income people who had depended on government help." Attaining such self-reliance will not be popular, but it is necessary.

According to an August 23 article in the *Indianapolis Star*, Andrea Neal observed, "Nationally welfare cases have dropped an average of 58 percent from August 1996 when President Clinton passed the Personal Responsibility and Work Opportunity Reconciliation Act. In Indiana, the caseload fell only 6.3 percent." Change is hard but most of us have had no choice. My healthcare reform will ensure high quality, effective, efficient, safe, timely, patient centered and equitable healthcare. It will take time getting accustomed to such a drastic change. But it will be a change for the better.

For more on Steve's ideas visit www.votekeltner.com

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