Robert Kaestner, PhD

Institute of Government and Public Affairs

University of Illinois

Health v. Health Care Policy

- **Health policy is different from health care policy**
  - Health policy is targeted at improving health
  - Health care policy also has a goal of improving health, but is mostly concerned with providing people with access to and the ability to pay for medical services
  - Use of medical services may not improve population health, but obviously reduces morbidity and repairs health when persons are adversely affected by disease

Publicly Provided Health Insurance

- **Most government spending on health, including in Illinois, is related to health care policy and dominated by the provision and subsidization of health insurance**
  - Medicaid costs $12 billion, approximately half of which is state contribution
  - State Group Health Insurance costs $2 billion
  - Spending on Mental Health and Developmentally Disabled is $1.5 billion
  - Governor has made expanding health insurance a priority: All Kids, Illinois Covered
- **Little government spending on public health**
  - Illinois Department of Public Health budget is approximately $400 million
  - 3 percent the size of Medicaid
- **Unfortunately there is a weak link between health insurance coverage and health**
  - RAND Health Insurance Experiment—free insurance has no health benefits
  - Studies of Medicaid eligibility expansions show little effect of expanding coverage on infant or child health
  - Studies of Medicare by Fisher, Skinner and Wennberg indicate significant amount of wasteful—not beneficial to health--spending

Fiscal Burden of Medicaid and Publicly Provided Insurance

- **Illinois State Budget in Brief (FY 2004)**
  "Medicaid liability has increased 41 percent since fiscal year 1999 and is expected to grow another $580 million in fiscal year 2004"

- **Illinois State Budget in Brief (FY 2005)**
  "… the costs of the Medicaid Program continue to grow at a rate in excess of state revenue growth. …basic Medicaid spending is projected to increase 7.8 percent in fiscal year 2005.

- **Illinois State Budget Summary (FY 2006)**
  "To break the cycle of structural imbalance, the state must aggressively pursue meaningful reform of its core fixed costs—especially pensions and debt service—as well as its primary health care costs—Medicaid and group health insurance.

- **Illinois State Budget in Brief (FY 2007)**
  "Health care services become more costly each year to provide both to the needy and disabled served by Medicaid as well as state employees."

- Medicaid accounts for nearly 25% of all income and sales tax revenues and almost 20% of all state revenue

Issues to Consider For the Redesign of Medicaid and Publicly Provided Health Insurance

- **High Rates of Utilization**
  - Medicaid and publicly provided insurance is generous, involving little consumer cost sharing (out-of-pocket spending)
  - Incomes of Medicaid recipients prevent implementing significant consumer cost sharing
  - Generous program with no cost sharing results in high rates of utilization relative to similar persons with private insurance (or uninsured)
  - Estimates in literature suggest between 10 and 30 percent of medical spending is inefficient (costs greater than benefits) because of insurance
  - My own estimates are in the range of 20 to 25 percent

Children's Use of Health Care Services by Health Insurance Status
Low-income Families, Use Relative to Similar Privately Insured Children

	Public Insurance (Medicaid/SCHIP)	Uninsured
Number Visits to Medical Professional Last 2 Weeks	26% Greater	51% Less
Number of Overnight Stays in Hospital Past 12 Months	18% Greater	27% Less
Number of Visits to ER Past 12 Months	23% Greater	No Difference
Saw A Specialist Past 12 Months	No Difference	No Difference
Had A Well Child Visit Past 12 Months	5% Greater	24% Less

Sample: NHIS 2005, Ages 0-15, Family Income <45,000
Controls: gender, age, race/ethnicity, health status, nativity, citizenship, family structure, family income and poverty ratio, mother's education, region

Reform:
Limit Utilization Using Supply Side Rationing

- **Traditional Supply Side Rationing: Low Reimbursement Rates**

  - traditional approach is to reduce (delay) provider payments
  - may significantly lower the quality of care
  - may create access problems although no evidence in national data

- **Increase use of mandatory managed care with capitated (full risk) reimbursement and narrow provider networks**

  - provider managed (rationed) care can reduce over utilization **WITHOUT** increasing patient financial risk or adversely affecting health

  - Prior to this year, little use of managed care in Illinois: only 9% of Medicaid recipients are in managed care

    Nationally, 58% of Medicaid recipients are in managed care
    Regionally, Illinois is a laggard: MI – 100%, WI – 54%, IN – 70%, MN – 69%

  - Adoption of Primary Care Case Management (PCCM) will be cost increasing; state estimates a savings of 0.05% (rounding error) from switching 100% of Medicaid recipients into managed care

- Example of benefits of managing care: pharmacy management
  - price of anti-psychotic drugs increased 400% between 1993 and 2001 because of introduction of new drugs
  - Medicaid buys 90% of all anti-psychotic drugs
  - anti-psychotic drugs represent 12% of all Medicaid spending on drugs
  - studies have shown that new (costly) drugs resulted in no improvement in health
  - potential savings from **NOT** adopting new anti-psychotic drugs is approximately $100 million

Issues to Consider For the Redesign of Medicaid and Publicly Provided Health Insurance

- **Crowd Out**
  - High rates of private insurance coverage among low-income families
  - Extending public coverage to higher income groups may be very costly as risk of crowd out is great
  - Each newly insured child or family may come at the expense of covering one or more formally privately insured child or family
  - Estimates in literature indicate that one out of every two families enrolled come from private insurance

Health Insurance Coverage of Children by Income and Poverty Status
1996 Prior to SCHIP and Major Expansion to Higher Incomes

Family Income	Private	Public	Uninsured
$0-20,000	22	55	23
$20-30,000	65	13	21
$30-50,000	88	3	9
$50,000 or more	96	1	3
Family Poverty Status			
0-100 %	17	61	21
100-200%	69	12	19
200-300%	90	2	8
300-400%	88	5	7
400% or more	84	8	8

- **Expanding Medicaid and publicly provided insurance to higher income groups is very costly because of crowd out**
- **Medicaid is not an efficient vehicle for covering the working poor**
- **Expanding insurance to higher income groups threatens to erode the employer-provided market without being a feasible alternative**
- **Universal coverage is not a realistic goal of states—any plan that significantly decreases the proportion uninsured will prove too costly for state**

Issues to Consider For the Redesign of Medicaid and Publicly Provided Health Insurance

- **Publicly provided insurance has diverse population with different needs**
  - Illinois operates a traditional Medicaid program
  - All eligibility groups gets same benefits: healthy children, children with special needs, adults, disabled, seniors, near-poor, poor, etc.
  - Inefficient use of resources, as it doesn’t allow matching services to needs in most efficient manner

- **Obtain a Health Insurance Flexibility and Accountability (HIFA) waiver**
  - HIFA waiver provides flexibility to better match benefits with needs of recipients and can generate savings on a per capita basis
  - Eliminates one size fits all approach and allows different benefit packages for different groups
  - Allows spending to be concentrated on most important services
  - Can be used to control future costs and expand insurance coverage—budget neutral in initial year
  - Open ended in its possibilities

South Carolina Example

- Each Medicaid enrollee will be provided a Personal Health Account (PHA) to be administered by the State. Contributions to accounts will be risk adjusted according to age, gender, and eligibility category.
- Adult benefit package includes coverage for mandatory Medicaid services plus pharmacy and durable medical equipment
- Children's benefit package must include all mandatory and optional services including Early and Periodic Screening, Diagnostic and Treatment Services (EPSDT)
- Recipients enroll in approved plan and state pays plan premium and puts remaining money in PHA to be used for co-pays ($250-$400 out-of-pocket cap) and other medical expenses
- Marketing done only through state—no direct to consumer marketing
- Current PCCM plan is available—represents status quo choice
- Option-out programs: Use PHA to pay for group health insurance through an employer, or use PHA to purchase major medical plan and any other medical services they choose (only adults)

Summary

- Providing health insurance is only one way to improve and maintain health of the state's population
  - State short changes public health programs (obesity, smoking, exercise) that can be extremely cost effective
- Unfortunately, health insurance is only weakly linked to health because a significant amount of spending is on low-value medical care
  - For example, dramatic expansion of public insurance, which was originally motivated by plight of pregnant women and that has benefited black families disproportionately, has not altered the black/white infant mortality ratio in Illinois

Summary

- Current programs are inefficient
  - High rates of utilization suggesting significant waste (use where cost > benefit)
  - Costly expansions to income groups not in particular need of subsidy
  - No use of high-powered supply side incentives (risk-based managed care with narrow provider networks)
  - One size fits all approach

Recommendations

- Limit eligibility to ALL persons with incomes under 200 percent of poverty
- Obtain a waiver and radically redesign publicly provided health insurance programs to match needs with services more efficiently
- Make use of private managed care organizations and high-powered supply-side incentives
- Focus should be on providing insurance for major medical care and some cost-effective prevention (primary care) services—this allows expansion of coverage
- Increase spending on public health