



Health Care Reform and Medicaid

Covering the Uninsured

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By Robert Kaestner and Nicole Kazee

Editor's Note: This chapter served to provide background and context for the IGPA State Summit on Medicaid, held in Champaign in December 2010. More information from the Summit, including the State Summit Report on Medicaid, can be found at: <http://igpa.uillinois.edu/PE/state-summit>.

Covering the Uninsured

On March 23, 2010 President Obama signed H.R. 3590, the Patient Protection and Affordable Care Act (PPACA) into law. One of the primary purposes of the PPACA is to reduce the number of persons without health insurance. An important provision that would help accomplish this objective is the expansion of Medicaid, the public health care program for the poor, to all individuals with incomes up to 133 percent of the federal poverty level (FPL). In 2010, the FPL was \$14,403.90 for a single person and \$29,326.50 for a family of four. The PPACA also extends funding for the State Children's Health Insurance Program (SCHIP) through 2015. Medicaid and SCHIP are programs that provide generous health insurance benefits at an extremely low or no cost for recipients. Both programs are jointly administered and financed by the federal and state governments.

Prior to the PPACA, most states' Medicaid programs covered poor children and pregnant women, and adults who were enrolled in public, cash assistance programs (i.e., welfare). In addition, previous changes to Medicaid, which covered all children up to 133 percent of the federal poverty level, and the creation of SCHIP in 1997, ensured that most children in fami-

lies with incomes up to 200 percent of the federal poverty level were eligible for publicly-provided health insurance. Thus, the big change for Medicaid in the PPACA was the extension of Medicaid eligibility to adults with low incomes, particularly childless adults. Currently, approximately half of the states allow parents in low-income families to obtain Medicaid, but only five states offer full Medicaid benefits to childless adults. The new Medicaid eligibility rules will become effective in 2014.¹ Notably, Illinois has one of the most generous Medicaid/SCHIP programs in the country. Currently, Illinois provides virtually free health insurance through its Family Care program to adults with incomes up to 150 percent of the federal poverty level if they live with children under age 18. Parents with incomes up to 200 percent of the federal poverty line are eligible for subsidized insurance coverage. Among Midwestern states, only Minnesota and Wisconsin provide full Medicaid benefits to parents at similar or higher levels. Single adults are not eligible for publicly provided, or publicly subsidized, health insurance in Illinois. In addition, the All Kids program (Illinois' SCHIP program) provides free health insurance for children in families with incomes up to 200 percent of the federal poverty level, and subsidized health insurance coverage for all other children regardless of income.

Given the existing generosity of coverage in Illinois, the PPACA will have less impact on enrollment in Illinois than in most other states. States that currently have low eligibility levels to their Medicaid and SCHIP programs will see the biggest increases in enrollment. In the Midwest, this includes states such as Kansas and North Dakota, which the Urban Institute estimates could see

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¹ States have the option to adopt the changes in eligibility immediately, but will only receive federal financial assistance at current matching rates until 2014, at which point higher rates for newly eligible recipients will begin.

² These figures are consistent with those reported by researchers at the Urban Institute: John Holahan and Irene Headen. 2010. "Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133 percent FPL," The Urban Institute, Washington, D.C., Table 7.

³ In FY009 and FY2010, the federal percentage increased temporarily to 60 percent as a result of federal stimulus spending targeted at states.

⁴ The 20 percent figure is obtained by dividing the 10 percent state financial burden for newly enrolled by the usual 50 percent financial burden of those previously enrolled. For example, if the state spends \$100 providing insurance (health care benefits) the federal government pays approximately \$50 of that total. Now the federal government will pay \$90. So every new person will cost the state only \$10 instead of \$50, or 20 percent of the normal amount.

enrollment increases of as much as 56 and 61 percent, respectively. Nevertheless, the legislation is likely to significantly increase the number of persons covered by Medicaid in this state. There are approximately 3.2 million persons in Illinois with incomes below 133 percent of poverty. National estimates applied to Illinois suggest that approximately 650,000 of this group have private health insurance; 1.75 million of them are covered by Medicaid, SCHIP or Family Care, and 800,000 are uninsured. One estimate of the increase in Medicaid caused by the PPACA is 800,000, which would occur if all uninsured persons with incomes below 133 percent of federal poverty become covered by Medicaid. However, this figure may be too large because a substantial portion of uninsured people in Illinois are undocumented immigrants who are ineligible for Medicaid under the PPACA. The exact number is difficult to determine. According to the Pew Hispanic Center, approximately 1.8 million people in Illinois were foreign-born and 450,000 of these people are undocumented. If we assume that half of undocumented persons have incomes below 133 percent of federal poverty, then perhaps only 575,000 or so of the 800,000 uninsured persons with incomes below 133 percent of federal poverty will be eligible for the expanded Medicaid program created by the PPACA.

In addition to the currently uninsured, some residents with private insurance will switch to Medicaid because health insurance coverage through Medicaid is far cheaper and more generous than most private health insurance. Based on past research, it is expected that between 10 percent and 25 percent of low-income persons with private health insurance coverage will drop that coverage and switch to Medicaid. This substitution of Medicaid for private coverage has become known as "crowd out." Therefore, the number of persons switching from private health insurance to Medicaid will be between 65,000 and 162,500 persons.

Exacerbating a Structural Budget Problem

Overall, we estimate that somewhere between 640,000 and 962,500 additional persons in Illinois will be covered by Medicaid as a result of the PPACA.² This represents an increase over current enrollment in Medicaid of between 27 percent and 43 percent. Normally, Illinois is financially responsible for approximately half the cost of Medicaid and the federal government is responsible for the other half. (The federal government covers 65 percent of the costs of SCHIP in Illinois.³) However, the federal government will at least initially assume a much larger fraction of the cost for the people enrolled in Medicaid as a result of expanded eligibility rules in the PPACA. Thus, it is not expected that Illinois' financial responsibility for Medicaid will increase proportionally by the size of the expected enrollment increase. The PPACA requires the federal government to assume 100 percent of the cost of those newly eligible for Medicaid in 2014 and 2015. Between 2015 and 2020, the share of costs paid by the federal government will gradually decline to 90 percent. The federal government's share after 2010 is not yet known. Even if we assume that the federal government will continue to pay 90 percent of the cost of those enrolled as part of the PPACA, state Medicaid expenditures are expected to increase by 5 percent to 9 percent by 2020, which represents 20 percent of the full cost of the 27 percent to 43 percent increase in enrollment.⁴

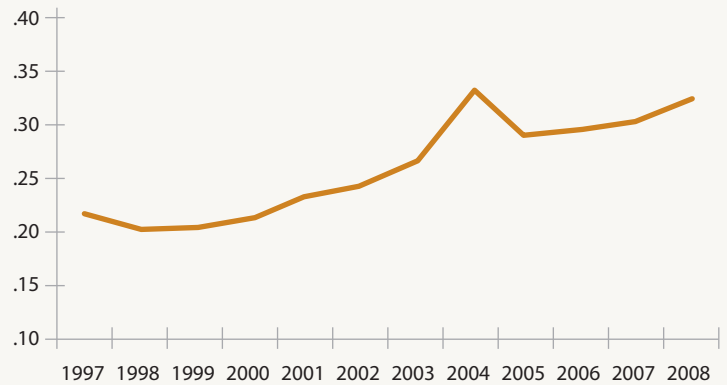
The actual increase in expenditures may be a bit lower than 5 percent to 9 percent because those newly enrolled in Medicaid are likely to be healthy and cost relatively little to insure. On the other hand, expenditures could be substantially greater because the more generous federal matching rate will not apply to Medicaid recipients who were eligible but not enrolled before reform. This group could be quite large. Estimates suggest that 25 percent of the uninsured are currently eligible for

Medicaid/SCHIP, and this group is likely to enroll in the coming years as states increase their efforts to publicize and encourage new enrollments and people try to meet the requirement of the PPACA that all persons have health insurance. In addition, as parents become eligible for Medicaid, they may drop private insurance coverage and switch the entire family to Medicaid (crowd out). The children in these families will have been eligible under the old Medicaid eligibility rules and the new federal matching rate will not apply to them. If we assume that 25 percent of the increase in Medicaid enrollment in response to the PPACA consists of those previously eligible, then the state's Medicaid expenditures may grow by between 10 percent and 20 percent by 2020. In addition, for those who only recently enrolled but were always eligible, the state's Medicaid expenditures would increase in 2014 and thereafter, as the state would not get any special funds from the federal government for this group.

While the good news is that the large increase in Medicaid enrollment expected as a result of the PPACA will cost the state much less than it normally would to expand Medicaid by this amount, any increase in state Medicaid expenditures represents a significant sum. The state's share of Medicaid spending is approaching \$8 billion, and a 5 percent to 9 percent increase as a result of the PPACA implies an increase of between \$400 million and \$720 million. If the state's expenditures increase by the higher amount noted above because of new enrollment from those always eligible for Medicaid, then the state's Medicaid expenditures may increase by between \$800 million and \$1.4 billion.

An increase in Medicaid spending will only worsen the structural imbalance between Medicaid expenditures and available state financial resources. As Figure 1 shows, Medicaid expenditures have been taking an increasing share of state revenue over the

Figure 1
Medicaid as a Share of Income and Sales Tax Revenue



Source: Authors' calculation based on Fiscal Futures Project data

past decade. In 1997, spending on Medicaid accounted for 20 percent, or one out of every five dollars, of state income and sales tax revenue combined. By 2008, this figure was more than 30 percent, or nearly one out of every three dollars. The PPACA would add at least two more percentage points to this figure, bringing it closer to 35 percent of combined income and sales tax revenue. Medicaid's increasing claim on state resources is a concern in good fiscal times, let alone during a period of extreme fiscal distress. Adding another \$400 million to \$1.4 billion to state obligations, as the PPACA does, is non-trivial. Increasingly, because of the growing burden of Medicaid, which will only become worse as a result of health care reform, there is a smaller proportion of the budget available to fund other state priorities such as K-12 and higher education, maintaining and improving transportation infrastructure, and providing pensions to public servants.

We can expect that the difficulty in finding any additional state funds for Medicaid expansions will be universal. According to the Center on State Budget and Policy Priorities, all but three states faced budget shortfalls in 2010, including all Midwestern states except for North Dakota. In addition, Iowa, Kansas, Michigan, Minnesota, Missouri, Ohio, and Wisconsin are all projected to face shortfalls in FY2012 (although none nearly as large as Illinois, where the

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gap is projected to be over half of the total budget for FY2011).

Reconciling the Tension: How Can Illinois Slow Growth of Medicaid Expenditures?

The options to reduce, or slow the growth of, Medicaid spending are limited.

Medicaid expenditures depend upon the number of people enrolled, the quantity of health care services used by those enrolled, and the prices paid for the services used.

Therefore, to reduce expenditures the state must adjust one of these variables.

Reducing the number of people enrolled in Medicaid is not a viable option for the state. The PPACA includes a “maintenance of effort” clause that requires states to continue their current Medicaid and SCHIP eligibility levels in order to receive *any* federal dollars for their programs. This clause is intended to prevent states from reducing eligibility for, and enrollment in, Medicaid, which is partly state funded, and pushing low-income residents into the federally mandated and federally subsidized insurance exchanges. The “maintenance of effort” clause is particularly problematic for Illinois and other states that have expanded eligibility beyond the federally mandated level. Federal law mandates that Medicaid cover children up to 133 percent and allows states to cover children up to 200 percent of poverty through the SCHIP program. Illinois is at both of these thresholds.

Illinois also covers parents in families with incomes up to 200 percent of poverty. These eligibility categories cannot be changed without putting at risk federal matching for Medicaid/SCHIP. However, Illinois could eliminate state funding for children in families with incomes above 200 percent of federal poverty who are currently eligible for state-funded, subsidized insurance regardless of income. The rationale for this state program is unclear post health care reform because the federal government will now provide subsidies to the families targeted

by the expanded All Kids program. Unfortunately, the number of higher-income children in the program is not large: a report from the Illinois Auditor General concluded that 94,525 children were enrolled in the state-only funded portion of All Kids for a total cost of approximately \$70 million in 2009. Thus, discontinuing this part of the All Kids program would not save the state much money.

An alternative way to reduce the state’s Medicaid expenditures is to limit the use of services by those enrolled. Indeed, reducing the quantity of health care services used by people in order to save money is the holy grail of health care reform not just in Illinois, but across the United States. There was, and continues to be, much debate and controversy over whether the PPACA will lower, or slow the growth of, health care costs by eliminating the use of inefficient health care. Some, such as researchers affiliated with the Dartmouth Atlas of Health Care, argue that eliminating inefficient care is straightforward and requires a revision of how doctors are paid to deliver care. Others see the problem as more complex and point to the fact that large, self-interested organizations, such as employers who self-insure and health care insurers, have not been able to eliminate waste and reduce health care costs substantially below the growth in costs of Medicaid and Medicare.

In sum, while there have been isolated examples of care being effectively managed and costs significantly reduced, there is little evidence that on a large scale, any system of care has been able to limit the growth in the cost of health care. For example, health care spending grew at an annual rate of 4.6 percent between 2000 and 2008 in Great Britain, which has a centralized, government-run system of health care, and the average annual rate of growth of health care spending in all OECD countries was 4.2 percent between 2000 and 2008. Health care spending in the

U.S. has been growing at an annual rate of 3.4 percent during the same period. In light of these figures, it is difficult to argue that growth in health care spending can be significantly affected by the way we pay physicians. While there are some countries (e.g., Germany and Switzerland) that organize the delivery of care differently where growth of health care spending has been substantially lower than that observed in the U.S, there are other countries (e.g., Spain, Netherlands and the United Kingdom) with similar systems in which health care spending has grown faster than the U.S.

However, Illinois' Medicaid program has had some reported success managing the use of care by enrollees. In 2006, the state implemented a medical home program (Illinois Health Connect) and a disease management program (Your Healthcare Plus) for Medicaid enrollees. Illinois Health Connect links Medicaid enrollees with physicians so that the individual has a regular medical home and a physician to manage his or her care effectively. Physicians are paid a small monthly fee of between \$2 and \$4 per enrollee and physicians are required to meet particular standards of care (e.g., 24/7 access). Your Healthcare Plus is a disease management program focused on Medicaid enrollees with chronic illness and it is operated by McKesson Health Solutions. Both programs have been reported to have generated savings, approximately \$500 million over two years (2008-2009), although it is difficult to assess the veracity of these reports because they have not undergone public scrutiny.

Recently, Illinois signed a contract with providers to move up to 37,000 adults with disabilities into a risk-based, Medicaid managed-care program that will likely save approximately 5 percent of the cost of caring for these individuals. The program is called the Integrated Care Program because it requires that providers use a network of primary care providers that

coordinate care, emphasizing prevention and disease management. The state pays a fixed fee to providers, who are responsible for all the cost of the care these individuals receive. The state set a price that was approximately 95 percent of the average cost of caring for the individuals in the program. The 5 percent savings is in line with previous studies of the effect of risk-based managed care on the costs of care. Applied to all Medicaid recipients, this implies a savings of \$400 million per year. The takeaway point from this discussion is that a risk-based Medicaid managed care plan can effectively manage care and save significantly more money than the state's current primary care case management system, even assuming that the Illinois Health Connect and Your Healthcare Plus programs generated the savings reported.

Another way for states to limit the quantity of health care services used by Medicaid beneficiaries is to simply reduce the number of covered benefits. States historically have been required to cover particular services in their Medicaid programs, such as hospital care and basic physician services, while they have had flexibility to add other benefits like prescriptions drugs and vision care. Illinois currently covers most of these optional benefits (such as dental care, family case management, and prescription drugs) in its Medicaid and All Kids programs. According to the Kaiser Family Foundation, 20 states—including Illinois—implemented cuts to some of these benefits in FY2010 by either eliminating or restricting access and 14 have scheduled cuts for FY2011. This is one of the first strategies pursued by states that are looking to cut Medicaid costs in times of fiscal strain.

The PPACA reduces some of this flexibility for changing benefits by requiring that most newly eligible beneficiaries and some groups of previously eligible beneficiaries receive what are known as "benchmark" benefits. This refers to a package of



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benefits that covers all essential services and is roughly equivalent to private insurance coverage. Federal standards for a benchmark package have not yet been established.

Another way to reduce Medicaid expenditures is to reduce payments to providers. However, this option is unlikely to be available in either the near term or long term. According to the Illinois State Comptroller, the state began the current fiscal year with \$4.7 billion in unpaid bills, with outstanding bills to health care providers comprising most of that amount. Indeed, for several years the state has balanced the budget partly by failing to pay health care providers in a timely manner. Thus, in the near term, which given the current fiscal crisis may be several years, lowering or further delaying payments to health care providers is not a viable option.

Lowering payments is also not a good option given the fact that Medicaid payments in Illinois are already comparatively very low. Data from the Kaiser Family Foundation indicate that Illinois pays physicians treating Medicaid patients approximately 60 percent of what the federal government pays the same physician for treating Medicare patients. This is below the average of 72 percent for all states. Moreover, between 2003 and 2005, Medicaid physician fees in Illinois increased by 11.2 percent, while general health care spending in the U.S. increased by nearly 40 percent. The PPACA addresses the problem of low fees in Medicaid by requiring states to raise payments to primary care providers to the rate that the federal government pays for Medicare enrollees. While the federal government will pay the cost of this increase in 2013 and 2014, in subsequent years the state will have to bear the cost of this burden. This means that Illinois will have to raise its payments to primary care providers by approximately 40 percent. If we assume that primary care accounts for

20 percent of total Medicaid spending, which is not unreasonable, this will add another \$640 million to state Medicaid expenditures.

As the PPACA makes clear by its mandate to raise fees to primary care providers, difficulty finding timely and specialty health care because of low payments and provider reluctance to participate is a widely recognized problem that affects the Illinois Medicaid program, as well as many other states' programs. Therefore, lowering payments further is not a practical



Robert Kaestner is a Professor in the University of Illinois at Chicago's Department of Economics and a member of the Institute of Government and Public Affairs. He is also a Research Associate for the National Bureau of Economic Research. Professor Kaestner is an expert in health and labor economics and has conducted research on the effects of Medicaid and private health insurance on infant and child health and whether or not expansions in Medicaid crowded out private health insurance. Professor Kaestner received his undergraduate degree in Political Science and History from State University of New York at Binghamton in 1980 and his master's degree in Economics from the same university. In 1988, he received his PhD in Economics from City University of New York.

method because they may not be able to go much lower without risk of worsening access to quality and timely health care for those enrolled in Medicaid.

Summary

The Patient Protection and Affordable Care Act (PPACA) will have a major impact on the Medicaid program in Illinois. We estimate that the state may find itself with an additional \$2 billion (in current dollars) annual Medicaid liability by 2020 because of increased enrollment, higher payments to providers and greater administrative costs. More conservative estimates suggest an increased annual liability of \$750 mil-



Nicole Kazee is an assistant professor in IGPA and the Department of Political Science at the University of Illinois at Chicago. Kazee earned her PhD from Yale University in May 2009 and joined IGPA in August 2009. Kazee (pronounced Kuh-ZEE) researches American politics and policymaking, focusing currently on state and national health reform, as well as the anti-tax movement and its effect on state policy choices. She engages in both social science and applied policy research and writing. Kazee's research has been supported by full-year fellowships from the Brookings Institution, the Miller Center of Public Affairs, and PEO International. Kazee was also a fellow at Demos in New York.

lion, or nearly 10 percent more than current expenditures. Any increase in state Medicaid expenditures will worsen the structural imbalance that exists between growth in state Medicaid expenditures and growth in state income and revenue. The result of this worsening imbalance is an increasing crowding out of other state expenditures.

There are few good solutions to the budgetary problem. There is little room to decrease eligibility and enrollment in Medicaid/SCHIP beyond the small savings that can be obtained by phasing out subsidies for health insurance for families with incomes above 200 percent of poverty, as these families will soon be eligible for federal subsidies. There is virtually no room to lower prices paid to providers, as the state's rate is already relatively low and Illinois is a notoriously late payer of bills. One possibility to reconcile the tension between fiscal responsibility and caring for poor residents is greater use of Medicaid managed care that is completely risk-based and where providers have a financial incentive to reduce unnecessary use of services that drive up costs. The recent implementation of the Integrated Care Program for disabled adults demonstrates that even with low provider reimbursement that limits firm revenue, health care organizations believe they can make a profit by more effectively managing care. Accordingly, the state found willing bidders and providers to accept 95 percent of what the state pays for 37,000 enrollees with disabilities and high medical expenditures. The only way these firms will turn a profit is by more effectively managing care and reducing unnecessary and costly care. These firms obviously believe they can do this. As a result, the state saves approximately 5 percent on each enrollee. If this experience could be replicated for the entire Medicaid/SCHIP population, the state could save \$400 million annually. It would be a start.



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