

The Illinois Budget Policy **TOOLBOX**



Tools to Address Spending

Options for Health Care Policy

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The state of Illinois spends roughly \$6.7 billion on health care, nearly all of which is accounted for by the Medicaid program: \$5.8 billion is on medical assistance and \$875 million is for long-term care. Comparatively tiny amounts are spent on public health and other initiatives.¹

For the medical assistance program, the Affordable Care Act (ACA) will lead to increases in state spending in the immediate term. Specifically, efforts to enroll the uninsured in health plans will increase Medicaid enrollment and private enrollment via the health insurance exchange (known in Illinois as the Get Covered Illinois Health Marketplace). Newly eligible Medicaid enrollees will cost the state virtually nothing for several years. However, enrollees who were previously eligible but not enrolled, perhaps because they had private insurance, will cost the state the usual 50 percent of total expenditures.

Notably, Medicaid is a state-federal partnership program with significant federal oversight that leaves relatively few options available to the state to craft and implement creative solutions to reduce spending (such as altering benefits and cost sharing for different eligibility groups). In this jointly administered

program, each dollar the state spends is matched by a dollar of federal contribution (at the current Federal Medical Assistance Percentage or FMAP for Illinois). This federal subsidy has long been recognized as a source of weakened incentives to improve the efficiency of the program at the state level.

Background

To put state spending levels in a national perspective, total spending per enrollee in Illinois, including both state and federal dollars, was \$5,277. The national average was \$5,563 in 2010. While per enrollee Medicaid spending in Illinois is higher than the national average for children (\$2,630 versus \$2,359), adults (\$3,717 versus \$3,025) and the disabled (\$17,955 versus \$16,240), Illinois makes up that difference by spending considerably less on the aged (\$10,734 versus \$12,958). This latter point is due to Illinois' lowest-in-the-nation Medicaid reimbursement rate for nursing home care.

Policy options

In 2012, the state enacted the Save Medicaid Access and Resources Together (SMART) Act, which includes a series of changes to Medicaid. It lowers provider payments, increases user fees, increases fraud fighting efforts, expands risk-based managed care, tightens eligibility levels, and eliminates optional services (notably mental health treatment and pharmaceutical

¹These figures do not include federal matching dollars.

assistance to older adults and the disabled). Collectively the efforts aim to save \$1.6 billion annually. However, the savings estimated for 2013 are reduced to \$1.1 billion due to a variety of operational delays, and many of the projected savings are unlikely to be realized in practice.

Through 2016, the federal government fully pays for the cost associated with newly eligible individuals as a direct result of the ACA (adults under 138 percent of the federal poverty level). The federal government matching rate will decline to 90 percent by 2020. Of the 1.1 to 1.2 million uninsured citizens in Illinois, the state anticipates that roughly a half-million will enroll in Medicaid by 2017. Two-thirds of those will be the “newly eligible” adults (approximately 340,000), and one-third will be the currently eligible who are not yet enrolled (approximately 160,000). For the currently eligible group, the federal government pays half of the cost. Thus, all else constant, state spending on medical assistance will be \$600 million higher per year once the enrollment adjustment has taken place.

Medicaid “care coordination” is the state’s desired silver bullet to limit medical assistance spending among traditional Medicaid enrollees. The goal is to facilitate communication between diverse sets of providers in different settings in order to harmonize treatment services for patients. A key part of the approach is to involve care coordinators (who are often not physicians) to play the role of managing the delivery of services by communicating directly with both providers and patients. The idea is not without merit, at least on paper. Spending for Medicaid enrollees is highly skewed because the sickest 3 percent of enrollees account for half the spending in the program. By contrast, the healthiest 72 percent of Medicaid enrollees account for 10 percent of spending.² As a result, isolating that relatively small number of extremely expensive patients through care coordination efforts has the potential for meaningful savings.

Analysis of pros and cons

Other states have enacted care coordination programs, but a careful analysis by the U.S. Congressional Budget Office of more than 30 disease management and care coordination programs found that the programs were as likely to increase costs as they were

²Pollack, Harold. (December 7, 2013). Republicans have Medicaid’s cost problem completely wrong. *The Washington Post*. Available at: <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/12/07/republicans-have-medicaids-cost-problem-completely-wrong/>

to decrease them, and on balance the programs had no effect on spending.³ This rather disheartening result shows that savings resulting from state reliance on care coordination efforts are likely to be minimal. Moreover, anyone familiar with the application process to become a “care coordination entity” for the state will know that the financial projections are nothing short of guesstimates and wishful thinking. The broader literature on the efficacy of Medicaid managed care to generate savings in the program is similarly downcast. A 2012 report of the Robert Wood Johnson Foundation states:⁴

The peer-reviewed literature finds little savings on the national level, but some success by particular states, in controlling costs through Medicaid managed care. The successful states appear to be those with relatively high provider reimbursement rates in their fee-for-service program. The cost savings are due primarily to reductions in provider reimbursement rates rather than managed care techniques, though reductions in emergency room utilization and inpatient hospital care also contribute (page 22).

Illinois is not a high fee-for-service reimbursement state—indeed, nationally it is one of the lowest reimbursement states. Thus, even movement into more aggressive, risk-based managed care will not necessarily achieve meaningful savings. Nevertheless, Illinois is not alone in its pursuit of managed care in Medicaid,⁵ perhaps because there are few easy answers.

Distributional effects

Traditional “demand-side” insurance tools—that is, enrollee copayments and other cost-sharing mechanisms—are off the table, because charging traditional Medicaid enrollees for services is generally illegal. Thus, much of the debate centers around “supply-side” efforts, such as reimbursement rates and

³Nelson, Lyle. (January, 2012). Lessons from Medicare’s demonstration projects on disease management, care coordination, and value-based payment. Congressional Budget Office. Available at <http://www.cbo.gov/sites/default/files/cbofiles/attachments/01-18-12-MedicareDemoBrief.pdf>

⁴Sparer, Michael. (September, 2012). *Medicaid managed care: Costs, access, and quality of care*. Robert Wood Johnson Foundation. Available at: <http://www.rwjf.org/content/dam/farm/reports/reports/2012/rwjf401106>

⁵Sommers, Benjamin, Gordon, Sarah, Somers, Stephen, Ingram, Carolyn, and Epstein, Arnold. (December 30, 2013). Medicaid on the eve of expansion: A survey of state Medicaid officials about the ACA. *Health Affairs Blog*. Available at <http://healthaffairs.org/blog/2013/12/30/medicaid-on-the-eve-of-expansion-a-survey-of-state-medicaid-officials-about-the-aca/>

care coordination. From an equity perspective, supply-side controls are less transparent from the enrollee's vantage point. When low reimbursement rates make physicians less likely to care for Medicaid patients, the reasons for the difficulty obtaining an appointment are not obvious to the individual. Demand-side controls are not without their flaws, and, for example, the most obvious one is that very low-income individuals may not be able to afford copayments. However, they at least have the virtue of being transparent.

As noted earlier, Illinois already has the nation's lowest reimbursement rate for skilled nursing facility care for aged Medicaid enrollees. Hence the state has little ability to wring further savings from the long-term care component of health care spending.

Conclusion

Medicaid dominates Illinois' health care spending budget, and the state has already made substantial cuts to optional services in Medicaid in 2012. The state is looking towards aggressively pushing "care coordination" to the Medicaid program in the near term, but skepticism about the potential for cost savings is warranted. It is possible that meaningful reform of the Medicaid program needs to be initiated at the federal level. •

Further Reading

Pauly, Mark V. and Grannemann, Thomas W. (2009). *Reform Medicaid first: Laying the foundation for national health care reform*. Washington, DC: AEI Press.

Sommers, Benjamin, Gordon, Sarah, Somers, Stephen, Ingram, Carolyn, and Epstein, Arnold. (December 30, 2013). Medicaid on the eve of expansion: A survey of state Medicaid officials about the ACA. *Health Affairs Blog*. Available at <http://healthaffairs.org/blog/2013/12/30/medicaid-on-the-eve-of-expansion-a-survey-of-state-medicaid-officials-about-the-aca/>

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