Improve health care for Medicaid patients while controlling costs for taxpayers

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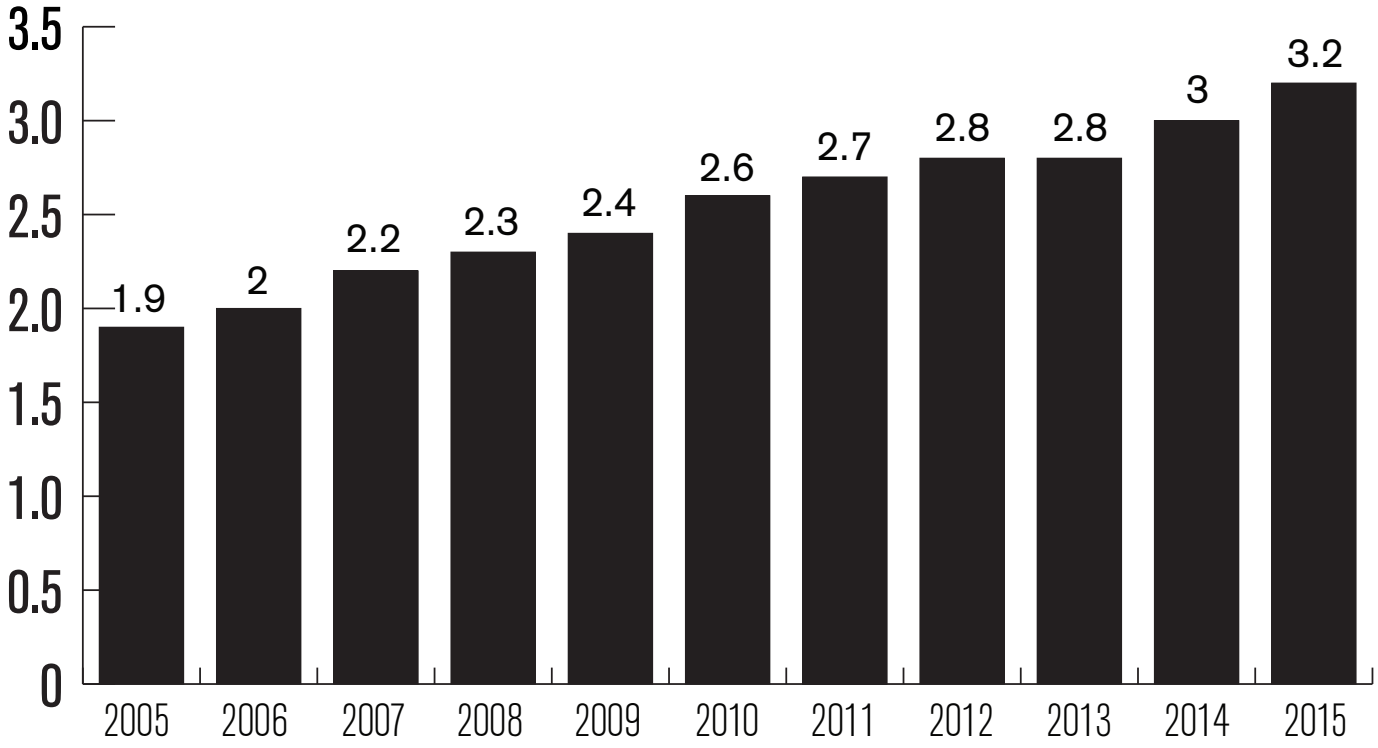
The problem: In fiscal year 2015, the Illinois Medicaid program will spend almost $13 billion in general and related funds, with about half coming from federal funds – $20 billion if all funds are counted.[1] Despite this spending, the program is increasingly failing to meet the medical needs of Illinois' most vulnerable population. The state's recent Medicaid expansion to cover primarily able-bodied adults – triggered by the Affordable Care Act – compounds the problem of rapidly increasing costs in this program. Worse, it threatens the state's long-term economic well-being and ability to deliver quality health coverage to those who need it most.

Our solution: Currently, Illinois' Medicaid program is administered as a federal-state partnership program in which enrollees receive full benefits with little to no cost for services. Instead, it should be transformed into a sliding-scale premium-assistance program that targets resources to those who need them most.

Why this works: The state must ensure that priority is given to those Medicaid patients with the greatest needs, while simultaneously using its Medicaid dollars in a more effective manner. A premium-assistance program would give Medicaid patients more control over meeting their own health-care needs and preferences.

Medicaid enrollment surges 68 percent over past 10 years in Illinois

Medicaid enrollment (in millions of people), fiscal years 2005-2015



Source: Illinois Department of Healthcare and Family Services

The problem

Low reimbursement rates and payment delays: About half of Illinois' Medicaid patients are enrolled in "fee for service" arrangements, in which doctors and hospitals are reimbursed for services they provide at a specified rate.[2] Even though someone has a Medicaid card, they often have to find a doctor who is willing to accept new Medicaid patients. If they are able to find one, they often have to wait – for months, in some cases – to obtain an appointment.

There are a variety of reasons why many physicians are not accepting new Medicaid patients. The slow payment process and low reimbursements are two of the leading reasons. In Illinois, Medicaid pays about 54 percent of what the federal Medicare program pays for similar services.[3] Only six states have lower fees than Illinois.[4] These fees generally do not even cover the actual costs incurred by medical providers to fulfill these services.[5] These payment problems make it difficult for doctors to take on additional Medicaid patients. As such, it is not uncommon for doctors' offices to put a cap on how many Medicaid patients they will accept, and for people to be turned away or wait weeks or months for an appointment.

Limited access and worse outcomes: These factors have created an environment in which Medicaid enrollees have medical coverage but limited access to care. Children on Medicaid, for example, are six times more likely than privately insured patients to be denied an appointment to see a specialist.[6] If and when Medicaid patients receive care, they frequently suffer worse outcomes than both privately insured and uninsured patients.[7] The ability to access care can have a significant impact on early diagnosis, as well as on patients' health-care outcomes.

Illinois' Medicaid program is wrought with waste and fraud: A 2013 state audit found between 15 to 20 percent of Medicaid cases to be overdue for eligibility redetermination, with an estimated 12 percent ineligible (due to inadequate verification or redetermination) enrolled in the program. Not only were many cases overdue for eligibility reverification, but in some cases, the reverification process had not been conducted in several years.[8] In the state's most recent report from the auditor general, there were 4,933 deceased individuals remaining on the state's rolls more than 60 days after their deaths.[9] As the state shifts its Medicaid population into managed care, the state will be paying for all enrollees – eligible or ineligible – so long as they remain on Illinois' Medicaid rolls. Lax redetermination not only perpetuates waste and fraud in the program, it diverts precious funds away from the neediest patients, squeezes out spending in other priority areas and violates the trust of taxpayers who foot the bill for the program.

Medicaid expansion puts the able-bodied before the vulnerable: As part of the Affordable Care Act, states were able to choose to expand Medicaid eligibility to

residents earning up to 138 percent of the federal poverty level, or $16,105 per year for a single person. The expansion population is primarily made up of able-bodied, working-age adults and is covered primarily by federal dollars.[10] Rather than allow individuals with incomes between 100 to 138 percent of poverty level to receive federal tax-credit subsidies for the purchase of private coverage on the federal health-insurance exchange, they are automatically thrown into the Medicaid program.

Illinois chose to expand its Medicaid program under the Affordable Care Act in 2013. While the state pays roughly half of the costs for the original Medicaid population, with the federal government picking up the other half, the tab for the expansion population is picked up almost entirely by the federal government. As a result, if the state sought to rein in Medicaid spending, it would need to cut about $2 in Medicaid spending on the traditional Medicaid population to save $1 of state spending. But because the federal government is picking up most of the tab for the expansion population, state would need to cut up to $10 in Medicaid spending on the expansion population to save $1 in state spending. In other words, services for the most vulnerable Medicaid populations will be first in line for budget cuts.[11] Childless, able-bodied adults will be last.

The Medicaid expansion essentially puts the state's neediest and most vulnerable in line for services behind able-bodied adults.

Our solution

• **Premium assistance:** Premium-assistance models – through which Medicaid recipients pay a share of the plan premium and contribute to their health savings account – provide recipients with a defined contribution toward the purchase of private health insurance. Using the funds in this personal medical savings account, individuals can select the insurance that best fits their needs and preferences. If Medicaid patients paid a share of health-insurance premium costs and copays based on income, this approach – which would curb overutilization – has the potential to save more than $1 billion per year.[12] The state's total annual liability for this portion of the program from general funds is about $7 billion.[13]

• **Workers gain more control over their own health care:** After paying for the insurance premium, Medicaid patients could use remaining funds in the account for health-care expenses such as doctor-visit copays, prescription drugs and hospital stays. The poorest enrollees would receive full subsidies based on the average insurance premium and deductible cost by age in Illinois, but the subsidies would gradually phase out for those who can afford to pay a portion of their health-care cost.[14]

• **Eligibility verification:** The state should reinstate a private vendor to verify Medicaid eligibility and weed out fraud. Additional and continuous front-end and point-of-service verification should also be considered.

• **Roll back the expansion:** The Medicaid expansion was passed with the promise that, if the federal government did not fulfill its promise to pay, the state could opt out of the expansion. Should the federal government reduce the state's reimbursement rate below 90 percent, the expansion should be rolled back.

Why this works

These solutions would:

• Give the most vulnerable Illinoisans the freedom to choose health plans that meet their needs based on price, range of options and quality.

• Offer actual access to health care, not just meaningless coverage.

• Ensure that precious resources are not misdirected. Every dollar in waste, fraud and abuse is a dollar not being spent on patient care.

• Provide protection for the state's taxpayers and the state's most vulnerable patients should federal Medicaid reimbursement levels change.

Endnotes

[1] While there is no single Medicaid appropriation in the Illinois state budget and the program operates from multiple agencies (primarily from Department of Healthcare and Family Services), the medical assistance spending by the Department of Healthcare and Family Services provides a good approximation of total Medicaid spending in the state. This totals approximately $20 billion for fiscal year 2015. Medicaid spending from general and related funds is about $13 billion. See Illinois Department of Healthcare and Family Services, "Presentation to House Human Services Appropriations Committee," April 10, 2014, pp. 8, 12 at illinois.gov/hfs/SiteCollectionDocuments/Budget2015HouseApprop.pdf

[2] Venteicher, Wes, "Illinois Medicaid shifts 1.4 million to managed care," Chicago Tribune, Jan. 2, 2015 at chicagotribune.com/news/ct-medicaid-managed-care-20150102-story.html

[3] Lopez Bauman, Naomi, "Why Medicaid coverage does not equal care," Illinois Policy Institute, July 2014 at illinoispolicy.org/reports/why-medicaid-coverage-does-not-equal-care/

[4] The Henry J. Kaiser Foundation, "Medicaid to Medicare Fee Index for 2012," at kff.org/medicaid/state-indicator/medicaid-to-medicare-fee-index/

[5] Lopez Bauman, Naomi, "Why Medicaid coverage does not equal care," Illinois Policy Institute, July 2014 at illinoispolicy.org/reports/why-medicaid-coverage-does-not-equal-care/

[6] Joanna Bisgaier, M.S.W., and Karin V. Rhodes, M.D., "Auditing Access to Specialty Care for Children with Public Insurance," New England Journal of Medicine, June 16, 2011, at nejm.org/doi/full/10.1056/NEJMsa1013285

[7] Roy, Avik, "The Medicaid Mess: How Obamacare makes it worse," Manhattan Institute for Public Policy Issues 2012, no. 8, March 2012 at manhattan-institute.org/html/ir_8.htm

[8] KPMG and Illinois Auditor General, "Single Audit Report for The Year Ended June 30, 2012," pp. 73-76 at auditor.illinois.gov/Audit-Reports/Performance-Special-Multi/Statewide-Single-Audit/FY12-Single-Audit-Full.pdf

[9] Sickich performed as special assistant auditors for the Auditor General, State of Illinois, "State of Illinois Department of Healthcare and Family Services Financial Audit for the Year Ended June 30, 2014," p. 40 at auditor.illinois.gov/Audit-Reports/Compliance-Agency-List/DHFS/FY14-DHFS-Fin-Full.pdf

[10] Lopez Bauman, Naomi, "Why Rauner should rollback Illinois' Medicaid expansion ASAP," Illinois Policy Institute, Jan. 6, 2015, at illinoispolicy.org/why-rauner-should-roll-back-illinois-medicaid-expansion-asap/

[11] Ingram, Jonathan, "Who is on the ObamaCare Chopping Block," Foundation for Government Accountability, July 17, 2014, at thefga.org/2014/07/whos-on-the-obamacare-chopping-block/

[12] There is a wide variety of options for cost-sharing and adding copays to Medicaid participation. For example, the monthly cost of Medicaid coverage for an expansion enrollee is $882 per person per month. If these enrollees were required to contribute an average of 20 percent of that cost, $1 billion would be saved (500,000 expansion enrollees x $882 x 12 months x .20 = $1,058,400,000).

[13] Illinois Department of Healthcare and Family Services, "Presentation to House Human Services Appropriations Committee," April 10, 2014, p. 21 at illinois.gov/hfs/SiteCollectionDocuments/Budget2015HouseApprop.pdf

[14] Ingram, Jonathan, "Medicaid Solutions: Florida's Medicaid Cure for Illinois' Ailing Program," Illinois Policy Institute Research Report, March 6, 2013, at illinoispolicy.org/reports/medicaid-solutions-floridas-medicaid-cure-for-illinois-ailing-program/