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Weidenbaum Center Forum
Medicaid Financing: Challenges for Missouri and the Nation

Panelist: The Future of Medicaid

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Good afternoon. I'm going to talk about Medicaid in Missouri. I had talked a few weeks ago in Kansas City about the Health Improvement Act from the state legislature and it was a more informal setting than this. But I was interrupted every ten seconds so I'm not going to talk for very long because I think you will want to talk about this program. I'm going to talk a little bit about overall legislative trends and then some specific trends in Missouri Medicaid.

I wanted to just mention first that the Center for Health Policy at Washington University has been around for a little over three years and for two years we have focused pretty hard on Medicaid. We have contracted with the Missouri Foundation for Health and have done some work specifically about different aspects of Medicaid. First, we have done a survey of physicians and dentists in Missouri to try to figure out who takes Medicaid and for those who don't, why? We then stratified the list by how many Medicaid patients providers take to try to determine the barriers to accepting Medicaid patients around the state. We did this in different pockets around the state. I have kept this in mind as I have looked at some of the legislative initiatives that have come up because it has been pretty instructive, and I'll just touch on that later.

The other thing, as I looked at the legislation this year, that helped me think about it is a study we are doing for the Missouri Foundation for Health around the 2005 changes to the Medicaid law and trying to figure out the people who no longer have Medicaid coverage because of that law. What's happening to their health care, and what's happening to their health? Then finally we've done some work this year around the legislative analysis. We are doing a survey in different

low-income housing developments around the state to try to figure out what's happened to people because of the Medicaid changes in 2005.

We have conducted interviews with individuals for this study and two things particularly have struck me. The first involves a man who we called to interview. He desperately wanted to do the interview but his teeth were hurting him so much that he couldn't talk. He said the reason his teeth were hurting him so much was because he couldn't go to the dentist because he no longer had dental coverage.

Another story comes from a woman who is a parent/teacher educator. She is very used to talking to women with small children. The educator was talking to a woman who said that her children were still covered, but she is not covered and has cervical cancer and can't go to the doctor. I try to keep those very small stories in mind as I look at Medicaid because it often becomes so dehumanized when we talk about public policy. I've been doing public policy my entire career but I still try to keep these other things in mind as I think about the much larger policy issues. I just wanted to bring that up. That's what's in my head as I look at a lot of this legislation.

In general, I think the overall legislative trends that we are seeing are certainly incentives for healthy behavior. That was in one of the iterations of the bill in Missouri but we have certainly seen it in other states, where if a person signs a contract and agrees to either stop smoking, take your medicine, or follow other protocols in order to get certain benefits from Medicaid. That's becoming sort of a trend. Often we see public programs being used as an experiment for the general population, so when you start to see these incentives for healthy behavior, we assume that they will be popping up in other areas as well. Also pooling has become a pretty significant idea, to try to have individuals pool together to try to help them purchase insurance. That we are seeing in Massachusetts and that was also in a piece of legislation in Missouri this year. Finally individual mandates, which go along with the pooling concepts in Massachusetts, make individuals

responsible for purchasing their insurance instead of systematic responsibility. All of these are showing up in Missouri legislation.

In 2005 we saw the second largest cut backs in benefits in the history of Medicaid are in Missouri. The largest was in Tennessee. That's certainly the trend that we are seeing. Missouri and Tennessee covered some of the highest rate poverty, up to 300% of poverty, so you could argue that they had gone maybe too far. But we have seen that very significant cutbacks in Missouri.

SB577 that George Oestreich talked about quite a bit, the Health Improvement Act, certainly increases individual responsibility. We've seen that as a pretty significant trend and I'll talk about that specific issue in a little while and also the future of Medicaid. Children's Health Insurance Program (CHIPs) is still very popular nationally. It's being re-authorized this year in Congress and up to \$900 million for Missouri over five years is what's on that table right now. The CHIPs match in Missouri is for every dollar that Missouri pays, the federal government pays \$2.72, so that's something to keep in mind. That's *Family's USA* brought that up last week. The most significant legislation at this point in Missouri probably is that Medicaid law. It was scheduled to sunset. That has been taken care of this year. George talked about the law in pretty much detail, but I just want to bring up a few of the biggest points that get to some of these trends and then talk about trends specifically.

The healthy behaviors were in the bill that did not pass. I still think because it was such a major part of the bill that we will see that in some way come up again – health-care home certainly, health improvement plans, premium offset, long-term care partnerships and raising provider reimbursement. I just want to touch on the provider reimbursement because Missouri is probably the second to third lowest state in the nation in it's Medicaid reimbursement and so it would probably go a long way if they put the provider reimbursement in there. It's not mandated, but, as I

understand it, they will raise the fees. To not necessarily get it up to Medicare but to start to, but that's pretty significant.

Now I will just briefly touch on some of the trends that we are seeing in the Medicaid program. One is a continued movement towards managed care, and managed care certainly in the 1990s got a lot of publicity. It got a lot of attention, a lot of analysis. Now it doesn't get as much overt attention, but it's still very significant as a way of thinking about continuing to reform Medicaid. By 2011, in the Medicaid legislation in Missouri, all enrollees must be in some kind of health-improvement plan. This can be a care coordination plan, which is a risk-bearing entity. It can be an administrative service organization or it can be a coordinated fee for service plan. The aging, blind or disabled are not mandated to be in managed care at this point. Nationally, 56 percent of Medicaid enrollees are in a managed care plan. This is mostly children and their parents. All states except Arkansas or Wyoming have some kind of Medicaid managed care in their state. The goals of this are usually to provide a health-care home, to provide accountability, to provide improved outcomes and to get some cost savings.

I would say in Missouri and probably nationwide, and this has been written about several times, it is difficult to think about really capturing a lot of cost savings if you are just using the parent and child population. I'll just give you a little bit of data on this. The average monthly cost for a child on Medicaid in Missouri is \$199. The average cost for a non-disabled parent or adult is \$200. That's \$400 total. The average monthly cost for an elderly person is \$1,200, and for a disabled person is \$1,300. So \$2,500 a month for the elderly and disabled, and \$400 a month for parents and kids. I just wanted to provide that information.

Another trend that we are seeing is expanding coverage for children. There are 41 states that cover 200% of poverty or above for kids. The federal poverty level for a family of three is \$16,600. We are talking about a \$33,000 family of three and 41 states are covering 200% or

above. Missouri is still at 300% of poverty for CHIPS, although there is some cost sharing involved in that. There seems to be much less interest in covering parents. The median CHIPS eligibility threshold for parents is 65 percent of the federal poverty level.

I don't want to get too political but you think about that mother that I mentioned earlier who has cervical cancer and can't go to the doctor. She's probably above 65 percent of poverty and she can't get health care even though her kids can. That's what I keep in mind when I start to look at these different legislative packages.

The last two that I will mention is the individual responsibility trend. The incentives for health behavior require an individual to engage in healthy practices in order to get some benefits. We see that in West Virginia and in Florida. They have passed legislation that says you have to sign a contract that says I will engage in healthy behaviors. I will write a plan that shows you that I will quit smoking, I will take my diabetes medicine in order to get certain benefits. Sometimes it's dental care, sometimes vitamins, and other benefits. That is certainly becoming a trend. It's a pilot program in West Virginia and it's just beginning in Florida. It was in one of the versions of the Health Improvement Act in Missouri but has been taken out.

I would say the individual responsibility trend probably goes farther than talking about personal incentives. When we look at some of the other programs that George talked about, things like the premium offset program where if you are an employee in a company Medicaid will now offer you some subsidy to purchase insurance with your employer. We are sort of saying in order to get a little closer to covering everybody we are putting the onus on the individual to try to purchase the insurance but we will give you a subsidy.

The long-term care partnership is sort of the same type of thing. Medicaid is being used as a subsidizer to help people purchase long-term care insurance and again it's putting responsibility on the individual. In the 1990s, for example, we were talking about employer mandates, we were

talking about pay for play, we were talking about the CHIPS program when it was beginning. We were saying that the government or employers are responsible for increasing, either incrementally or systematically, access to health care. Now we have shifted very much more to the individual both in the Medicaid program and in programs overall. I think that's pretty significant. I think it's really significant that we are using the Medicaid program, the public program for low-income people, to try to help all different kinds of people who maybe don't hit the Medicaid threshold but try to help them try to purchase insurance on their own. We are having them go into the individual market and have them purchase insurance, and I think that's a tremendous trend. This has a lot of implications.

When we talk about individual responsibility, it shifts the way we think about health care and health-care reform. Now we think of health care as a privilege and people when they talk about personal health care often talk about it as a right. Now we have begun to talk about it as the responsibility. When we look at Massachusetts, in particular, you see that it is now a responsibility of an individual to purchase insurance. It is almost another one of the things they have to do, just like you have to purchase auto insurance. I think it is a slight shift but it is very significant in the way that we now think about health care and what it means. Thank you.

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