Firstline Midwest

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As costs continue to rise, states seek new ways of saving on health care

by Tim Anderson

Hoping to contain costs further, and having already largely exhausted quick-fix strategies, several Midwestern states have decided to take a longer-term approach to Medicaid.

Thirty-five years ago, health care spending made up 5 percent of the nation's gross domestic product. It now consumes more than 15 percent.

As legislators know all too well, a significant portion of this historical rise in health care spending has been taken on by states.

The costs for states come in a variety of ways. In recent years, for example, they have expanded health coverage for low-income children and had to absorb higher insurance costs for state employees.

But the single greatest cost driver has been Medicaid. The state-federal partnership has grown into the nation's largest health insurance program, providing coverage to more than 52 million low-income, disabled and elderly Americans.

This growth in enrollment, combined with increases in overall U.S. health care costs, is reflected in state budgets. According to the National Association of State Budget Officers, Medicaid now accounts for the single largest share of total state spending, 21.9 percent. Two decades ago, it made up 10.8 percent of the state budget pie.

Higher year-to-year costs in the program appear unavoidable, because it operates within a U.S. health care system where expenses are rising and because federal requirements restrict what states can do. Reining in Medicaid spending growth, though, has become a top legislative priority. Left unchanged, many policymakers say, the program's costs will outpace revenue growth at unsustainable levels.

According to the Kaiser Commission on Medicaid and the Uninsured, every U.S. state enacted at least one cost-containment strategy in fiscal year 2004 and planned to do so in 2005. The most common action has been cutting or freezing payments to health care providers and implementing pharmacy cost controls. Some states also have cut Medicaid benefits and eligibility and enacted new co-payment requirements.

Hoping to contain costs further, and having already largely exhausted quick-fix strategies, several Midwestern states have decided to take a longer-term approach to Medicaid. As a result, measures that focus on disease management, long-term-care reform and a greater utilization of managed care are increasingly being considered by state lawmakers.

Next month:

Focus on higher ed

State initiatives target affordability, accessibility issues in higher education.

The Midwestern Office of The Council of State Governments supports several groups of state officials, including the Midwestern Governors Association and the Midwestern Legislative Conference, an association of all legislators in the region's 11 states. The Canadian provinces of Manitoba, Ontario and Saskatchewan are affiliate members of the MLC.

Measures in Midwest focus on better managing care, costs

In many ways, negotiations this summer in the MINNESOTA Legislature over its health and human services budget reflected discussions occurring in state capitols around the region.

For a final agreement to be reached, contentious and highly publicized issues related to eligibility, benefits and costs in the state's public health care programs had to resolved. For example, one proposal would have eliminated coverage for more than 20,000 childless, low-income adults in the MinnesotaCare program. Ultimately, lawmakers rejected this plan and also repealed a $5,000 benefits cap that had been placed on some program recipients.

The negotiated agreement seeks to save money by raising premiums in MinnesotaCare and implementing new co-payments for non-preventative and non-emergency visits to emergency rooms. Lawmakers also strengthened verification-of-eligibility procedures for those enrolling in MinnesotaCare and the state's Medicaid program. In addition, more resources will be put into investigating cases of fraud and abuse by health care providers.

But as in other Midwestern states this year, Minnesota lawmakers did not just focus on short-term issues. The final budget bill also includes some longer-term strategies to contain expenses in Medicaid and other health care programs.

For instance, a new "evidence-based" decision-making process has been established in Minnesota for the care of Medicaid patients.

The goal of the plan is to eliminate spending on services that are ineffective, unnecessary or inappropriate.

A state medical director and health policy committee will more closely review how doctors are caring for Medicaid patients. Ultimately, the state may elect not to cover certain services. In other cases, prior authorization for procedures could be required. Doctors also could be rated based on how closely they are following the state's evidence-based guidelines.

Another new strategy calls for more intensive medical management of high-cost Medicaid enrollees (for example, those with more than one chronic medical condition).

The plan's objective is to provide thorough outreach and support to those at highest risk of hospitalization. Through better management of these enrollees' health conditions, the state hopes to reduce its acute care costs. According to the Minnesota Department of Human Services, similar initiatives in the private sector have netted savings of "$3 for each dollar invested."

The Minnesota legislation also addresses concerns about the increasing cost of long-term care. To encourage the purchase of private insurance, and prevent the use of Medicaid for long-term-care services, the state wants to develop new incentives for Minnesota residents. Individuals who buy long-term-care insurance in the private sector, and then later exhaust it, could qualify for Medicaid with a higher asset limit. In addition, the state's recovery of medical costs from these individuals' estates would be limited.

Implementation of Minnesota's long-term-care partnership program requires changes in federal law. Under a current federal waiver program, four states — including INDIANA — have been authorized to administer these partnership programs.

OHIO is another Midwestern state that has incorporated new cost-saving strategies into its latest budget.

Among the proposals approved by lawmakers is an elimination of the fee-for-service model for Medicaid families and children. These families will instead be placed into a managed care program. While there will be some up-front costs involved in the transition, the state expects to save money both during and after the current biennium.

The budget bill also revamps Ohio's estate recovery process, making it easier for the state to recover more assets from a deceased Medicaid recipient. Other provisions encourage

greater use of generic prescription drugs among Medicaid enrollees and strengthen state oversight of providers.

Several new long-term-care initiatives have been established as well, many of which encourage the use of home and community-based services instead of nursing homes. Changes include making assisted living a Medicaid option and creating a long-term-care resource center that makes the elderly and disabled more aware of their health care options.

Another part of the Ohio legislation seeks a more coordinated approach to Medicaid spending and services. One idea, for example, is to place administration of the entire program under a newly created, cabinet-level agency.

A like-minded approach is now being taken in KANSAS as the result of legislation passed earlier this year. Lawmakers agreed to create a Kansas Health Authority — made up of gubernatorial and legislative appointments — that will oversee Medicaid and various other state health care programs and services.

Handing over control to a single authority should lead to immediate savings because of administrative efficiencies and stronger purchasing power in the health care market, policymakers believe. The authority, which will include health care experts, also is expected to serve as a tool for the state to develop future strategies that cut costs and improve the delivery of care.

IOWA, meanwhile, is beginning to pilot several innovative ideas in Medicaid as the result of a waiver it recently received from the federal government.

The state-federal agreement will allow the state to cover between 20,000 and 40,000 more Iowans in the Medicaid program. New rules and ideas — greater individual responsibility, improved disease and case management, an enhanced use of preventative care, etc. — will be used to deliver care to this expanded population. Through this pilot initiative, policymakers will test various approaches that they believe can save the state money.

Upon enrollment, members in this expanded Medicaid population will receive a medical evaluation and personal health care plan, which will include incentives (lower premiums and co-pays) for positive life-style choices such as smoking cessation and weight control. A self-assessment of members' compliance with the plan will then be tracked by the state.

The pilot initiative also encourages the use of preventative care. Enrollees will need to have a primary care physician and, in many instances, be required to use a nursing hot line before accessing emergency room care.

In addition, Iowa eventually plans to offer health savings accounts to this expanded Medicaid population. Enrollees will be entitled to a credit of up to $1,000 toward any Medicaid-covered service, and they can pocket any unused money. The state's hope is that these accounts encourage enrollees to practice healthy life-styles and avoid costly medical treatment.

Numerous other ideas to change Medicaid in a way that controls future costs are being considered in the Midwest.

A proposal in MICHIGAN would impose new premiums and insurance co-payments on some Medicaid recipients. Discounts or waivers would be provided to recipients who exercise regularly, show up for scheduled medical appointments and don't smoke.

Like Minnesota, lawmakers in Michigan are examining ways to ease the burden that long-term-care costs are having on the state's Medicaid budget. Under one legislative proposal, the state would allow Michigan residents to open tax-deductible, long-term-care savings accounts. Contributions of $5,000 per person, or $10,000 per couple, would be permitted.

Account holders could use the savings to buy long-term-care health insurance or pay for the long-term-care costs incurred by them or a close relative.

Tim Anderson is publications manager for the CSG Midwestern Office.

*Health costs as a share of total state expenditures**

State	1997	1999	2001	2003
Illinois	30.0%	29.9%	31.8%	35.3%
Indiana	21.9%	25.5%	27.1%	28.4%
Iowa	17.5%	19.1%	19.4%	20.3%
Kansas	23.2%	21.8%	28.2%	27.4%
Michigan	26.5%	27.0%	27.8%	29.0%
Minnesota	22.6%	22.0%	31.5%	30.2%
Nebraska	22.3%	24.2%	30.6%	31.6%
North Dakota	23.6%	25.8%	28.8%	30.4%
Ohio	23.1%	23.1%	24.8%	28.4%
South Dakota	23.9%	26.7%	26.8%	27.0%
Wisconsin	18.2%	18.1%	15.9%	16.9%
50-state total	26.5%	*27.1%*	29.9%	*31.5%*

** Medicaid accounts for the bulk of state spending on health care. Other expenditures come from support for employee health benefits, correctional services, teaching hospitals, health insurance programs for children and other populations, direct public health care, and facility- and community-based services.*

Source: Milbank Memorial Fund

Source Guide

For further information on state health care costs:

Center for Studying Health System Change
www.hschange.org

Health Affairs magazine
www.healthaffairs.org

Health Management Associates
www.healthmanagement.com

The Kaiser Commission on Medicaid and the Uninsured
www.kff.org/about/kcmu.cfm

Milbank Memorial Fund
www.milbank.org

National Academy for State Health Policy
www.nashp.org

National Association of State Budget Officers
www.nasbo.org

National Governors Association
www.nga.org

Ohio Commission to Reform Medicaid
www.ohiomedicaidreform.com

U.S. Centers for Medicare and Medicaid Services
www.cms.hhs.gov

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