



The Trouble with Medicaid Managed Care

A renewed push for universal health insurance coverage is underway in Minnesota, and many believe expanding the state's existing Medicaid program is the answer. But the present Medicaid program, one of the most expensive (and expansive) in the nation, has serious problems and expanding it would only exacerbate those problems.

In the mid-1980s Minnesota began shifting Medicaid populations from traditional fee-for-service Medicaid to Medicaid managed care. Under fee-for-service, the government administered the health plan: The government fixed the price for medical services, and the government paid the provider's bill. Today, the state pays a private managed-care health plan a per-person fee, and the health plan, in turn, pays the doctor.

Moving away from government administered fee-for-service was a step in the right direction. Yet exclusive reliance on private managed-care plans has proven to perpetuate in varying degrees the same problems that beset traditional fee-for-service Medicaid, without realizing any of the benefits that managed care promised.

Two particularly troublesome fee-for-service traits have carried forward to managed care: For one, managed care requires little to no cost-sharing in the form of co-pays or deductibles and, two, managed care pays providers low, often below-cost reimbursement rates.

By providing generous first-dollar coverage that requires little to no cost-sharing, managed care perversely erodes the incentive for enrollees to take personal responsibility for their health care decisions. With scant out-of-pocket expenses, prudent use deteriorates, giving way to overuse, a connection long ago confirmed by the RAND Health Insurance Experiment.¹

Reining in overuse could result in significant savings. A study commissioned by the Minnesota Department of Human Services estimated \$26 million in emergency room overuse by Medicaid enrollees in 2003, which is about the annual cost to fund 11,000 children in MinnesotaCare.²

Unfortunately, the RAND Experiment also showed that sick people with low incomes who were subject to cost-sharing had worse health outcomes on *some* measures. Still, this finding does not suggest that Medicaid should be free of any and all cost-sharing; rather, it cautions states to apply cost-sharing judiciously.

Cost-sharing could be targeted to medical services not linked to worse health outcomes and that tend to be based on patient prefer-

ence versus medical need. Cost-sharing could also be structured so that enrollees are not forced to spend cash out of pocket. For instance, Oklahoma, South Carolina, Indiana and Idaho are implementing Medicaid reforms that publicly fund special enrollee-controlled medical spending accounts that can be used to pay for medical care.

Additionally, generous Medicaid coverage competes head-to-head with private insurance coverage for low-income customers, which can "crowd out" private coverage. One study estimates that public coverage crowds out private coverage by around 60 percent; meaning that for every ten people who enroll in Medicaid, six drop private coverage.³

If 60 percent of people enrolling in Medicaid already had private coverage, they obviously did not *need* Medicaid. By pulling people from private coverage, private payers' influence on the health care marketplace diminishes and the government's role grows.

By paying providers lower-than-market rates—often below the operational cost of procedures—reduced access, cost shifting, and incentives to deliver second-class care all become issues under Medicaid managed care.

In an American Academy of Pediatrics (AAP) survey of Minnesota pediatricians, 45.1 percent reported Medicaid payments do not cover overhead (47.2 percent reported they didn't know).⁴ The latest estimates from the Minnesota Hospital Association show that Medicaid underfunds hospitals by 9.3 percent below cost.⁵ Consequently, doctors sometimes try to avoid serving unprofitable Medicaid populations. Some outright refuse to accept them as patients, while others avoid them through less overt methods. For instance, older established doctors can refuse to accept any new patient; younger doctors can start or relocate clinics away from less mobile, lower-income populations; and medical school students can avoid practice areas, like pediatrics, with higher proportions of patients on Medicaid.

Too-low reimbursement rates also result in a perpetual cost-shifting game where health plans, providers and patients parry the costs of low reimbursement rates to someone else. Cost shifting is a zero-sum game. All resources devoted to the game are wasted, because they're expended to shift, rather than to create, value.

Costs often end up inequitably shifting to people least able to afford it. Residents of lower-income inner-city neighborhoods will find their nearest hospital charges them a higher rate than suburban hospitals because they treat more patients on Medicaid. Costs shifted in the form of higher insurance premiums make health care less

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affordable for people at the margins—poor but not poor enough to qualify for Medicaid. Further, higher premiums are essentially a hidden tax subsidizing Medicaid that operates much like a sales tax and, like any sales tax, it's regressive.

Not incidentally, the hidden tax inherent in higher premiums hides the true cost of Medicaid and avoids the state budgeting process, which undercuts transparency and accountability within the Medicaid program.

Most troubling, low reimbursement rates can lead to second-class care. No doctor would ever admit to treating Medicaid patients differently than private-pay patients, but any other businessperson instinctively treats more profitable customers better. It's hard to prove that some doctors deliver second-class care, but the perception exists. Thirty-eight percent of adult Medicaid enrollees surveyed in 2003 believed providers treated them unfairly due to their enrollment in Medicaid.⁶

If managed care lived up to its promise—to lower costs and improve health by actively coordinating medically appropriate care—then some of the shortcomings just outlined might be forgiven. Unfortunately, managed care has not delivered.

The Urban Institute has conducted a number of studies assessing Medicaid managed care. One nationwide study concluded that managed care's expected cost savings "did not materialize, and managed care did not translate into dramatically slower growth in program costs per beneficiary."⁷ Two studies of rural Minnesota also suggest switching to managed care did not result in savings. The studies compared differences in the use of medical services for people in managed care after switching from fee-for-service Medicaid and uncovered no difference in emergency room or inpatient hospital use, two places prone to overuse and ripe for cost-cutting supervision from managed care.⁸

Moreover, if managed care were effectively containing costs, one would not expect per-person costs in MinnesotaCare—a Medicaid managed care program for children and families who don't qualify for traditional Medicaid—to have climbed 289 percent since 1998 compared to 212 percent for private insurance premiums.

As for quality, most research reveals that managed-care plans deliver quality no better and no worse than non-managed-care health plans. The two Urban Institute studies of rural Minnesota compared factors related to quality in managed care to fee-for-service Medicaid and found little difference in the location of where care is obtained, unmet health needs, reports of fair or poor health care experiences, or number of doctor visits.

In a free market, health plans compete on many levels, including price, service, quality, and benefit packages, as well as the plan design. All this competition should lead to lower prices, richer benefit packages, wider provider access, and higher quality service—in short, enhanced value. But most of this value-enhancing competition is absent within Medicaid managed care because the state defines the product. Thus, managed care plans generally have the same co-pays, premiums, benefits package and health maintenance organization plan design. Enrollees are left to choose a plan based almost entirely on the plan's provider network and subjective perceptions of quality.

Private health plans are constantly evolving and innovating to meet customer needs. Why restrict Medicaid enrollees to a single, almost immutable plan type? For people with incomes above the federal poverty guideline who are more able to share costs and are more capable of navigating the health care marketplace, other plan types might be more fitting.

One way to inject competition would be to provide Medicaid enrollees with the means to shop for their own private-market policies with direct subsidies or tax credits. Medicaid enrollees could then shop among plans with a defined state contribution that they or their employers would supplement to meet the full premium.

More shopping, choice, and competition would deliver more value to the Medicaid program, just as it has for Medicare's new prescription drug benefit. Since heavily subsidized private prescription drug plans became available under Medicare Part D, they have consistently offered more benefits at lower prices than ever expected.

On top of enhanced value, subsidizing private health plans offers a number of additional advantages:

- By purchasing the same health plans available to anyone in the private market, Medicaid enrollees would be covered by the same reimbursement rates and eliminate the access, cost-shifting, and quality problems caused by too-low reimbursement.
- Children who qualified for Medicaid when their parents did not could use the subsidy to join their parents' private policy, unifying families into one plan that's easier to navigate with the same network of providers.
- A private-market Medicaid policy would be more portable at the time enrollees lost or gained eligibility and thus would provide a more continuous and stable source of insurance. Instead of having to leave the plan altogether upon losing Medicaid eligibility, the enrollee or the enrollee's employer could take over payments.
- Employers, employees and Medicaid would find it much easier to share in the costs.

It bears repeating that Medicaid's motivating purpose—to assist people without health insurance—remains sound. Yet we could do better, much better, if only we would implement reforms that introduce competitive market forces to enhance the value of the health care services funded by Medicaid. ♦

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