

Congressional Health Care Reform Education Project  
September 19, 2008

**Ed Howard** welcomed the attendees, thanked the Energy and Commerce Committee for its help in arranging for the accommodations and set the stage for the panel. He explained that this session on public programs was included in the syllabus because public programs are potential platforms for health reform. **Robin Rudowitz** of the Kaiser Family Foundation would briefly describe existing public health care programs and **Marilyn Moon** and **Lou Rossiter** discussed how public programs might be used in health reform.

Robin described the insurance status of Americans with 52 percent of Americans insured by private insurance, 14 percent from Medicare, 13 percent Medicaid/SCHIP, 1 percent the Military/Veterans Administration and 5 percent from private non-group insurance. Medicare provides universal coverage for 37 million elderly and 7 million disabled individuals under the age of 65. It is federally financed and administered. Medicaid is a means-tested program that provides health and long-term care for low income children and their parents, elderly and disabled. It is financed jointly by the federal government and state and administered by the states. SCHIP is financed jointly by states and the federal government, which, unlike for Medicaid, has its funding commitment capped.

The Veterans Health Administration and the Military Health system provide care to 13 million people. Unlike Medicare, Medicaid and SCHIP which purchase care using private delivery systems, the VA and military systems uses its own delivery systems to provide care.

Medicare is divided into Parts A, B, C and D. Part A pays for hospital inpatient services, skilled nursing facilities and Hospice and comprised 37 percent of the program's total benefit payment in 2008. Part B pays for Hospital Outpatient and physician services and accounted for 28 percent of the programs total benefit payment in 2008. Medicare Part C pays for private plans which provide services that Parts A and B provide. It comprises 21 percent of Medicare's total benefit payments. Outpatient prescription drugs account for 11 percent of total payments, and home health (which is paid for by both parts A and B) accounts for 4 percent.

Medicare's benefit package is less generous than typical large employer plans or FEHB; Medicare beneficiaries have relatively high out-of-pocket costs. As a result most Medicare beneficiaries have wraparound coverage of some type to help them pay for premiums cost sharing and deductibles. Sixteen percent of Medicare beneficiaries are dually eligible for Medicaid, 35 percent have employer sponsored supplemental insurance, 19 percent are in Medicare part C plans and 18 percent purchase their own supplemental insurance plans.

There are large variations in Medicare per capita expenditures—19 states spend up to \$3,000 per beneficiary while 7 states spend more than \$12,000 per person. The Congressional Budget Office is looking into why these variations exist. Most of

Medicare's projected growth is attributable to growth in health care costs.

States administer programs with federal funds and guidelines, and operate as 50 distinct state programs with variation in eligibility, benefits and provider payments. These programs provide health insurance coverage for 29 million children and 15 million adults in low-income families and 8 million low-income persons with disabilities. Nearly 9 million Medicare beneficiaries are dually eligible for Medicaid. It provides long-term care assistance to 1 million nursing home residents. It accounts for 16 percent of national spending on health services and it accounts for 7 percent of the federal budget.

Medicaid payments per child only cost \$1,617 for children. Cost per disabled enrollee by contrast cost \$13,524 per enroll and the elderly \$11, 839 per enrollee. Comparing the Medicare and Medicaid per enrollee costs, you see that states such as Texas and California who had high Medicare costs have low Medicaid costs. This is because Medicare is a national program with the same benefits across states. Medicare variation occurs because of differences in the way medicine is practiced. Medicaid differences occur because states provide different benefit levels and set their own payment rates for Medicaid providers.

But since childless adults without disabilities cannot qualify, Medicaid covers only 29 percent of poor childless adults and 46 percent are uninsured. Medicaid covers 64 percent of poor children. Twenty percent of poor kids are uninsured. Only eight states provide coverage for adults between 100-150 percent of poverty. All states provide coverage to kids under 185 percent of poverty.

During the Q & A , Ms. Rudowitz explained the countercyclical nature of the Medicaid program. Medicaid enrollment grows at the same time that states suffer declining revenues as unemployment rises. Last time this happened the federal budget provided states with a higher match to assist states. As a condition of that assistance, states were required to maintain their eligibility levels. The assistance may have helped they avert deeper cuts. All states did do things to control for costs, such as cut or freeze provider payments.

She clarified that the charts reflecting per capita Medicare and Medicaid expenditures did not include for administrative costs.

She also promised to provide data on race and ethnicity after the session.

### **Marilyn Moon**

Single-payer is unlikely to be considered as a health reform measure, Marilyn Moon said, but it is one way a Medicare-like program could be used to expand coverage. Another way is to consider Medicare as one of many options from which an individual could choose and id could be used as a default option. If someone didn't sign up for another health insurance plan, they could be auto enrolled into Medicare. (This is particularly useful where an individual mandate is used.) This would result in Medicare getting a

larger pool of beneficiaries. Finally, the program could be used for those with only low incomes.

Public programs have advantages as vehicles for reform. They have low administrative costs, existing infrastructure, and comparatively reasonable growth in spending. Medicare is well liked by the public; it is viewed as mainstream and has high patient satisfaction. Medicaid and SCHIP could supplement Medicare expansion by providing for populations with special needs.

Over time, Medicare's growth has been comparable, even slightly lower than, the growth in the private sector. Medicare has lessons to draw on. Moon believes it would be advantageous to consider a basic benefits package that would provide reasonable coverage for all and then allow some to supplement above that. Medicare has not done a good job enrolling low income beneficiaries into its special programs. The program would need to change its benefit package to be better than it is (Medicare's benefit package is not especially good.) However, if you make the program more generous for those under 65 to mimic what working insured folks get, you will create pressure to improve benefits for those over 65.

There is a trade off between choice and complexity, she said. Part D has a lot of choice but is very complicated for seniors. Also, enrollment is significantly affected by whether a voluntary program is opt-out or opt-in. Part D is opt-in, meaning you have to affirmatively choose to sign up. Part B is opt-out. It is voluntary, but you must opt-out if you don't want it. This is one factor in the higher enrollment numbers in part B.

Moon then reviewed the issues for Medicare as option. One must consider risk selection and pricing. If you make Medicare the default option you bring a lot more people into the pool. If you make a high risk pool (just poor or very sick), the program would look very expensive. If you allow people to voluntarily enroll, you must consider risk adjustment for sicker beneficiaries. It can be hard to do, as it is in Part D. If you use Medicare as a reform vehicle you would have to address payment issues. At the moment, providers are not happy with existing payment. They might balk if the program became an even larger share of their business. One must also consider some tradeoffs in flexibility if you use Medicare as a reform avenue because it does not have the flexibility that smaller plans have to make exceptions case-by-case. You also have to consider some of the geographic challenges the program has, for example, provider payment, cost of living differences, and the way medicine is practiced.

**Lou Rossiter**

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While a federal level discussion may be underway, states are proceeding. Three states have already enacted comprehensive reform, three have enacted universal coverage for children and 18 have enacted incremental reforms. Several federal proposals would give states assistance for state reform efforts.

Medicaid's state-federal structure is a strength on which we could build reforms. But how do you help states stabilize their finances during down times?

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Medicaid is the dominant payer. Children's hospitals receive 90 percent of their funding from Medicaid. Hospitals view it as important for pediatric care. Medicaid is the dominant payer to nursing homes and to an increasing degree, home health organizations. It has very low, administratively established reimbursement rates. The rule of thumb among payers is that the highest payments in descending order come from private payers, Medicare and then Medicaid. Low reimbursement keep program costs down but physicians are unhappy. There is always the risk that physicians will not see Medicaid patients.

Some policy options to decrease overall federal health spending includes: improving price setting, developing better information, improving health care delivery, promoting consumerism and competition, limiting health outlays.

Specific options for Medicaid include, some of which can be found in greater detail in the book Restoring Fiscal Sanity, include change state incentives, change how care is delivered change the behavior of individual beneficiaries, and reduce program demand.

Some of the ways state incentives can be changed include block granting Medicaid to make it more like SCHIP. One could also impose per capita caps on spending so that you decrease variation in the amount states spend on enrollees. Another way to reform Medicaid would be to have Medicare and Medicaid "swap" responsibility. For example, Medicaid could take responsibility for universal coverage while Medicare could take responsibility for long term care. The program could also use more capitation programs like those used by managed care. Also changes in chronic care. Medicare chronic care demos yielded disappointing results, but better disease management has yielded good results for Medicaid.

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Medicaid can also use policy to change the individual behavior of enrollees. Vouchers should be given for the purchase of private insurance. Some states are experimenting with financial incentives for health promotion.

Factors that will determine whether comprehensive reform occurs include the outcome of the presidential election, the growing severe financial crises, and the politics of wealth transfer to cover the uninsured. The South and West face the largest challenges insuring residents which would require not only wealth transfer from higher to lower income individuals but also regional wealth transfer.

During the Q&A session, Diane Rowland was asked about variation in state spending between Medicare and Medicaid. She explained that Medicare has a standard benefit, so differences are largely attributable to the way medicine is practiced, the number of teaching hospitals and supply of doctors in the state. Medicaid variation among states

reflects variation in the scope of benefits and very different eligibility requirements from state to state. High Medicaid-spending states tend to have a lot of elderly. Medicaid variation also reflects provider payment. Some states reimburse at lower rates to control costs.

Ms. Rowland also noted that Medicaid provides a broader set of benefits than Medicare because it provides long term care and specific benefits for the disabled. Also children are entitled to Early, Periodic, Screening, Diagnoses and Treatment, which can include services not covered under the state plan.

In response to a question about the possibility of states “swapping” long-term care responsibilities to the federal government in exchange for assuming broader coverage for the under-65 population, Ms. Rowland noted that states vary in their long-term care policies, for both income eligibility levels and generosity of benefit. In order to make the swap work for the losers (mostly southern states with low numbers of elderly but high levels of low income poor) you would have to invest a lot of new federal money.

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On the issue of using Medicare to cover the near-elderly.

Ms. Moon observed that there is no reason why you can’t take what works for Medicare and avoid what doesn’t work. The Medicare benefits package may not be worth duplicating for groups other than the near elderly, but it may have administrative and other infrastructure capacities that make sense to use.

Asked how to control costs, Mr. Rossiter said that the problem is that some people are overinsured while some don’t have any insurance at all. We need to incentivize people to have insurance, but only appropriate insurance. Ms. Moon said that one way or another we will pay for it, either publicly or having individuals bear the costs alone. And cutting costs alone won’t get there; we will have to consider higher taxes. She also observed that public programs have some efficiency advantages when it comes to administrative costs. Medicare signs up everyone, which cuts marketing costs that private plans incur. Ms. Rowland noted HAS are not bringing down costs overall, just shifting the costs from premiums to deductibles.

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