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Building on MaineCare's Success

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C O M M E N T A R Y

*Building on
MaineCare's
Success*

By Lisa Pohlmann and
Christine Hastedt

Since its enactment more than 40 years ago, the Medicaid program has remained true to its original mission—providing access to health care and improving health outcomes for low-income people throughout the nation.

Medicaid was originally designed to provide health coverage to low-income elders, people with disabilities, and families with children receiving cash welfare, but has evolved to assume responsibility for many more people who fall through the cracks of private insurance coverage as a result of the U.S. health care system. Indeed, the program has been likened to the “tail of the line” at the end of a fast moving children’s game of crack the whip, absorbing the changes in coverage created by other institutions and phenomena that lead the line (Mann and Westmoreland 2004).

Filling the growing gaps in health coverage has increased the costs of states’ Medicaid programs; however, the real culprit for state budgets is the ever-rising costs of health care generally. Indeed, Maine, like the nation, is experiencing a health care crisis, not a Medicaid crisis. This important fact is often overlooked as policymakers across the country struggle to manage the growing pressures on state budgets.

Even in the face of these pressures, some states are pursuing comprehensive health care reforms with the goal

of reaching universal coverage. These efforts (implemented in Massachusetts and proposed in California and Wisconsin) share common characteristics; in all instances they use their Medicaid programs as a foundation for expanding access to the uninsured. Additionally, they combine the concept of personal responsibility—through mandates on the purchase of coverage—with government subsidies to ensure affordability.

On the other hand, a few states have implemented Medicaid program modifications such as benefit restrictions and cost sharing for program enrollees in an effort to control costs. Several proposals in the last session of the Maine Legislature were modeled after these experiments—seeking to promote greater personal responsibility by threatening reduced benefits, introducing a “choice” of products, or imposing increased cost sharing for all enrollees or for those who engage in unhealthy behaviors. Most of these proposals were rejected because they were viewed as reducing health care access and affordability and as contradicting the original intent of the program. Meanwhile, the state has enacted measures that seek to reduce overall health care costs in Maine. We discuss the merits and dangers of this range of recently debated MaineCare proposals and conclude with recommendations for considering future reforms.

*FLORIDA AND WEST VIRGINIA:
RESTRICTING HEALTH
CARE ACCESS*

Florida has implemented an experimental Medicaid program that purports to add private market concepts such as consumer “choice” and health plan competition to the program. In two pilot locations, Florida Medicaid beneficiaries are no longer guaranteed a standard Medicaid package of services, but are

required to choose one that they think will most likely meet their needs from a group of private plans. The experience of this program to date has left enrollees, providers, and policymakers concerned and cautious.

A recent survey showed that more than one-quarter of the health care providers in the Florida pilot areas who participated in Medicaid prior to the pilot reform program were planning to pull out of the program (Alker and Hoadley 2007). About half of the doctors reported that it is now harder for them to provide medically necessary services to children because of limitations in the pilot program plans. The AIDS Healthcare Foundation has recently filed a federal lawsuit, alleging Florida’s Medicaid reforms have resulted in AIDS/HIV patients receiving inadequate access to medical care and prescription drugs (AHF 2007).

In addition, the Florida experiment has raised concerns about financial risk for the state. Already the pilot program is experiencing fiscal pressures that would take the state beyond the expenditure cap set by the federal government. At the request of the managed care companies that operate the pilot program, the Florida Legislature considered increasing HMO payments after only nine months, but the governor vetoed the proposed increase, finding it unjustified (Crist 2007).

West Virginia’s new Medicaid plan, which makes “personal responsibility” a requirement for obtaining coverage, is another example of a state Medicaid reform with negative consequences for program enrollees. The underlying assumption is that requiring beneficiaries to sign an agreement in order to receive certain health benefits will encourage them to seek preventive care rather than emergency room care and other costly services, thereby improving their health

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and saving the state money. Beneficiaries are required to sign a member responsibility contract in which they agree to take their medications, keep their appointments, and avoid unnecessary emergency room visits. Patients who do not comply have some benefits reduced or eliminated. About three-quarters of the affected beneficiaries are children who risk the loss of needed prescription drugs and hearing and vision services. Adults who do not fulfill the responsibilities of their agreement risk the loss of prescription drugs, diabetes care, and mental health services.

West Virginia officials have provided no evidence that this plan will either lead to better health outcomes or save the state money in the short or long term (Solomon 2006). On the contrary, there is considerable evidence that low-income beneficiaries will lose access to services if they are required to pay for those services themselves, resulting in worse health outcomes (Gruber 2006; Newhouse 1993; Tamblin et al. 2001).

INCREASED COST SHARING: COSTS OUTWEIGH BENEFITS

To its credit, the Maine Legislature rejected several proposals that would have significantly increased cost sharing for MaineCare enrollees, heeding the preponderance of literature and experience that demonstrates its ineffectiveness. For example, an Urban Institute study shows that when premiums are set at three percent of income, only 35 percent of low-income people purchase health insurance coverage. When premiums are increased to five percent, the rate drops to 18 percent (Ku and Coughlin 2000).

Simply put, the only way that cost sharing reduces Medicaid program expenditures is through attrition when enrollees cannot afford their health services. In fact,

the Congressional Budget Office anticipated that 80 percent of the resulting savings from increased cost sharing in Medicaid authorized under the federal Deficit Reduction Act of 2005 would come *from diminished use of services by beneficiaries* (emphasis added) not, as is often mistakenly assumed, from the actual collection of co-pays (USCBO 2006).

Commercial insurance companies serving middle-income people increasingly are backing away from co-payments, recognizing that they may be “health penny wise and medical pound foolish” (Freudenheim 2007). *The Wall Street Journal* recently reported that higher co-pays might also not make long-term economic sense. Although they curb drug spending in the short run, studies show that higher co-pays discourage some people from taking essential medications (Fuhrmans 2007).

Policymakers should reject “quick fix” solutions like cost sharing and benefit limits that save little money and reduce access to needed care, resulting in higher costs throughout the health care system.

MAINE'S EFFORTS TO CONTROL HEALTH CARE COSTS

MaineCare costs will continue to reflect the overall health care costs in Maine; thus, controlling these costs should be the central policy measure taken (KFF 2007). Maine lawmakers took steps to control health care costs in the recent legislative session by charging the Advisory Council on Health Systems Development with conducting a comprehensive review and analysis of significant health care cost drivers in Maine. The council is further required to examine the administrative costs of health insurance plans and geographic variation in the cost and use of health care services and to identify specific potential reductions in

total health care spending. The council is required to make recommendations on an annual basis beginning in March 2008 (Maine State Legislature 2007).

In addition, as Saucier notes in his article, the Maine Department of Health and Human Services (DHHS) is piloting a project to provide care coordination and disease management services for high-cost MaineCare members with chronic conditions. A significant expansion of this effort was enacted as part of the governor's biennial budget. Since MaineCare serves a higher proportion of high-cost beneficiaries than state Medicaid programs as a whole, this relatively new initiative is a promising approach to some of the cost challenges MaineCare faces.

CONSIDERATIONS FOR THE FUTURE OF MAINECARE

In response to recent MaineCare debates and the questions raised in Paul Saucier's article, we suggest that policymakers consider the following as they deliberate the future of MaineCare.

We would argue that MaineCare lowers costs for everyone who purchases health care services. It plays a vital role in Maine's health care system, financing one in every four dollars spent on health care in the state in 2004 (USDHHS 2004). It helps to keep costs lower in the private insurance market by covering the people with the most costly needs and reducing the use of the most costly services. The breadth of benefits fills the void created by other insurance and is medically essential for children with disabilities, people in need of long-term care, and others with complex medical conditions. In MaineCare, the proportion of high-cost beneficiaries is 5.4 percent, significantly higher than the national average of 3.7 percent (Sommers and Cohen 2006). Providing coverage for

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them through MaineCare prevents those costs from being spread throughout the health care system.

This central feature of the MaineCare program is often lost in policy debates—namely that MaineCare costs have grown significantly in part because the program is filling gaps left in the services for our aging population and non-elderly adults with disabilities. In fact, although seniors and people with disabilities make up just over a quarter of MaineCare beneficiaries, they represent approximately 60 percent of MaineCare spending (Figure 1). MaineCare pays for approximately two-thirds of all nursing home costs in Maine (Richard Erb, Maine Health Care Association, personal communication). Although the higher cost of caring for seniors and people with disabilities is by no means unique to Maine, Maine has an older population than the nation as a whole, and therefore, the program is, and will continue to be, very critical.

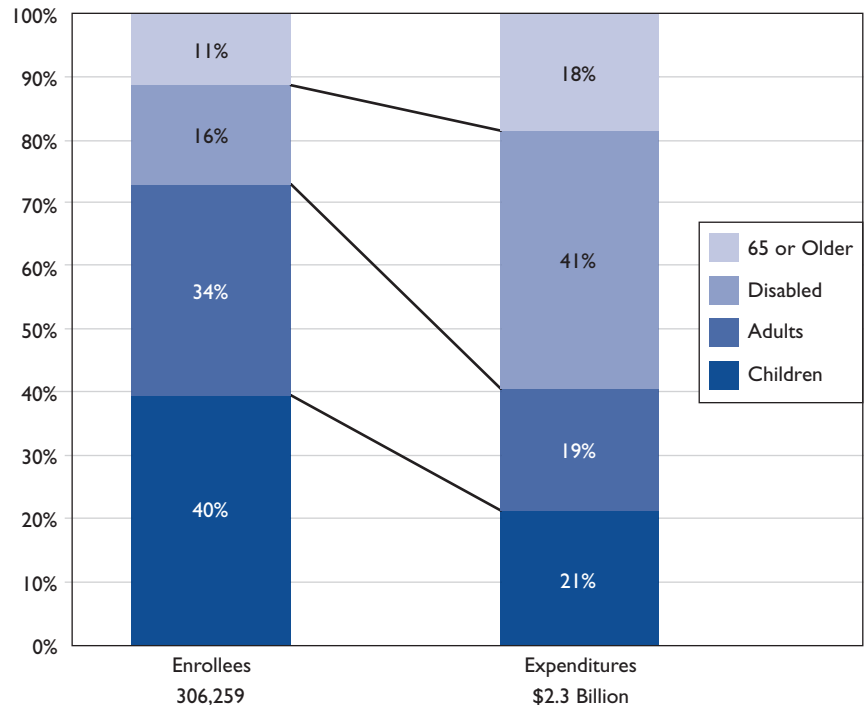
In addition, when MaineCare pays for the care of those who were previously uninsured, it benefits the entire health care system by reducing the bad debt and charity care borne by hospitals and passed on to private payers. Too often, when a person delays care for financial reasons, their condition worsens and they resort to care at a hospital emergency room, which they cannot afford. The cost of that care is then shifted to providers, insurers and ultimately all payers in the health care system through increased premiums (Families USA 2005). In Maine the average employer-sponsored individual premium of \$4,756 in 2005 included \$275 for the cost of health care for the uninsured (Families USA 2005: 4). We argue that this cost would have been even higher were it not for the MaineCare program.

Options for cost containment need not reduce eligibility or benefits. Financing schemes that limit accessibility and affordability for program enrollees are shortsighted and contrary to the original mission of the MaineCare program. By seeking ways to improve efficiencies, such as uniformity of eligibility and simplified enrollment processes, the program can be simplified, administrative burdens can be lessened, and access to care can be increased.

The federal match makes MaineCare a smart investment. Currently, the federal government pays 63 percent of Maine's

Medicaid costs. This two-to-one match has brought millions of dollars into the state to help our residents with health coverage. Maine gets greater value for its investment and covers proportionately more uninsured residents at a lower cost than any other New England state. Maine spent \$597 per state resident in its MaineCare program in 2005, compared to the New England average of \$613 (computed from Kaiser Family Foundation, State Health Facts). The difference in state expenditures is due in large part to the difference in the federal matching rates for each state.

FIGURE 1: MaineCare Enrollees and Costs, 2004



Source: Kaiser Commission on the Uninsured and Urban Institute estimates, based on data from the Centers for Medicare and Medicaid Services Medicaid Statistical Information System (MSIS) (KFF 2006).

C O M M E N T A R Y

Freudenheim, Milt. 2007. "Scant Drug Benefits Called Costly to Employers." *New York Times* (June 27). <http://www.nytimes.com/2007/06/27/business/27copy.html?ex=1340596800&en=7661a71793e756ae&ei=5090&partner=rssuserland&emc=rss> [Accessed August 17, 2007]

Fuhrmans, Vanessa. 2007. "New Tack on Copays: Cutting Them." *Wall Street Journal* (May 8).

Gruber, Jonathan. 2006. "The Role of Consumer Copayments for Health Care: Lessons from the RAND Health Insurance Experiment and Beyond." Report Prepared for the Kaiser Family Foundation, October. Menlo Park, CA. <http://www.kff.org/insurance/upload/7566.pdf> [Accessed August 16, 2007]

The Kaiser Family Foundation (KFF) 2006. "State Medicaid Fact Sheets (Maine and U.S.)." The Kaiser Commission on Medicaid and the Uninsured, Washington, DC. <http://www.kff.org/mfs/medicaid.jsp?r1=ME&r2=US&x=7&y=4> [Accessed August 17, 2007]

The Kaiser Family Foundation (KFF). 2007. From the Journals: Interview with Richard Kronick and David Rousseau, Kaiser Family Foundation Broadcast Studio, February 23, 2007. Transcript of audio interview. KFF, Menlo Park, CA. http://www.kaisernetwork.org/health_cast/uploaded_files/022307_kff_interview_healthaffairs_transcript2.pdf [Accessed August 17, 2007]

Ku, Leighton and Teresa A. Coughlin. 2000. "Sliding Scale Premium Health Insurance Programs: Four States' Experiences." *Inquiry* 36(4): 471-480. <http://www.urban.org/url.cfm?ID=1000270> [Accessed August 17, 2007]

Maine State Legislature. 2007. Public Law, Chapter 441. LD 1849—An Act to Protect Consumers from Rising Health Care Costs. Office of Legislative Information, Augusta. <http://www.mainelegislature.org/legis/bills/billtexts/LD184901.asp> [Accessed August 21, 2007]

Mann, Cindy and Tim Westmoreland. 2004. "Attending to Medicaid." *The Journal of Law, Medicine & Ethics* 32(3): 416-425.

Newhouse, Joseph P. 1993. *Free for All? Lessons from the RAND Health Insurance Experiment*. Harvard University Press, Cambridge.

Solomon, Judith. 2006. "West Virginia's Medicaid Changes Unlikely to Reduce State Costs or Improve Beneficiaries' Health." Center on Budget and Policy Priorities, Washington, DC. <http://www.cbpp.org/5-31-06health.pdf> [Accessed August 16, 2007]

Sommers, Anna and Mindy Cohen. 2006. "Medicaid's High Cost Enrollees: How Much Do They Drive Program Spending?" Issue Paper, Kaiser Commission on Medicaid and the Uninsured. The Henry J. Kaiser Family Foundation, Washington, DC. <http://www.kff.org/medicaid/upload/7490.pdf> [Accessed August 17, 2007]

Tamblyn, Robin, Rejean Laprise, James A. Hanley, Michael Abrahamowicz, Susan Scott, Nancy Mayo, Jerry Hurley, Roland Grad, Eric Latimer, Robert Perreault, Peter McLeod, Allen Huang, Pierre Larochelle, and Louise Mallet. 2001. "Adverse Events Associated with Prescription Drug Cost-Sharing Among Poor and Elderly Persons." *Journal of the American Medical Association* 285:421-429.

Toner, Robin and Janet Elder. 2007. "Most Support U.S. Guarantee of Health Care." *New York Times* (March 2). <http://www.nytimes.com/2007/03/02/washington/02poll.html?ex=1330491600&en=c983307f74f976cb&ei=5088&partner=rssnyt&emc=rss> [Accessed August 17, 2007]

U.S. Congressional Budget Office (USCBO). 2006. Additional Information on CBO's Estimate for the Medicaid Provisions in the Conference Agreement for S. 1932, the Deficit Reduction Act of 2005. U.S. CBO, Washington, DC. <http://www.cbo.gov/ftpdocs/70xx/doc7030/s1932updat.pdf> [Accessed August 17, 2007]

U.S. Department of Health and Human Services (USDHHS). 2004. "National Health Expenditure Data: Personal Health Care Expenditures 1998-2004, All Payers." USDHHS, Centers for Medicare and Medicaid Services, Washington, DC. <http://www.cms.hhs.gov/NationalHealthExpendData/downloads/nhestatespecific2004.pdf> [Accessed August 21, 2007]