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WHAT'S WRONG WITH MEDICAID IN KANSAS?

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INTRODUCTION

Medicaid, the joint federal and state program created to provide health care for the poor, just had its 40th birthday. Unfortunately, there is no party on tap. In Kansas and around the nation, the plan is growing at unsustainable rates and threatens both state and federal budgets.

In fact, Medicaid is now the largest health plan in the country. It represented 2 percent of the Gross Domestic Product in the year 2000 and is projected to rise to 9 percent by 2075.¹ Combined with unfunded liabilities in Social Security and Medicare, this will require a devastating doubling of federal taxes as well as enormous increases in state funding.

Indeed, the program is now larger than education in many state budgets. From 1991 to 2001, the average annual growth in Medicaid spending in Kansas was 12 percent, exceeding the national average.² By comparison, the roughly 6 percent rate for medical inflation no longer looks so high.³ Spending per Medicaid enrollee in Kansas currently ranks at 15th highest in the nation.⁴ Indeed, the program has grown at over \$200 million a year in recent years and now represents 15 percent of the Kansas state budget.⁵

Unfortunately, the enormous fiscal problems

facing Medicaid often overshadow another major concern. The reality is that Medicaid has a well deserved reputation as a low-quality provider of health care. The program produces episodic treatment, poor preventative care, and has proven incapable of delivering services of sufficient quality to beneficiaries.

The truth is that Medicaid too often produces tragic health outcomes for America's most vulnerable populations. Both providers and beneficiaries routinely abuse the program. This ranges from Medicaid "mills" to outright theft. There have been estimates that as much as 40 percent (over \$100 billion) in Medicaid spending involves fraud and abuse.⁶

How did a well-meaning government attempt to provide quality health care for the poor end up as an actuarially bankrupt plan that delivers poor quality care? While the difficulties facing Medicaid are indeed complex, in one way the problem of ever-rising program costs can actually be summed up quite simply: Americans, regardless of their incomes, want the best healthcare that someone else's money can buy.

WHAT IS MEDICAID?

How does Medicaid work? Medicaid is responsible for providing medical services



and care to three major groups: acute care for the poor and near-poor, care for the disabled population, and long-term care. These are groups that would not be able to obtain coverage in the traditional health market because of their low incomes and/or the chronic nature of their health needs.

Medicaid is thus a needed program for those who would fall “between the cracks” in our health care system. The idea is in the greatest American tradition of helping the less fortunate. Unfortunately, a system that bankrupts the State of Kansas and the Federal Government while providing low-quality care serves no one’s interests. It is vital that we restructure Medicaid so as to rest on a sound fiscal basis.

MEDICAID’S BUILT-IN DESIGN FLAWS

The fundamental problem of Medicaid comes down to its flawed program design. Any economic product and/or service where buyers have no incentive to economize and sellers have no incentive to be efficient will face ever-escalating costs. Medicaid is no exception, and if policymakers do not address the program’s basic structural flaws, it is doomed to failure.

The Medicaid program can be divided up into three organizational components: 1. the eligibility structure, or how Medicaid identifies and defines the conditions to qualify for benefits; 2. the benefits structure, or the medical coverage Medicaid will and will not provide to beneficiaries; and 3. the reimbursement system, or the amount Medicaid will dispense to doctors, pharmacies and long-term care homes for providing health care to beneficiaries.

ELIGIBILITY STRUCTURE

In Kansas, Medicaid eligibility is determined by using a formula involving the federal poverty level and ignoring an applicant’s

assets (e.g. home, car, etc.). Currently, about 247,000 Kansans are enrolled in Medicaid, or about 10 percent of the population.^{7,8}

Approximately 64 percent of Medicaid enrollees in Kansas are children and working-age poor,⁹ and account for about 25 percent of the costs.¹⁰ Another 28 percent of Kansas Medicaid beneficiaries are elderly and disabled, and accounts for nearly 75 percent of Medicaid’s costs of over \$1 billion dollars each year.¹¹ As with much medical spending in the U.S., the expenditures are highly skewed in each year.

LONG-TERM CARE

Medicaid covers about 50 percent of all nursing home costs and two-thirds of all those in nursing homes.¹² This includes expensive home-based, assisted living and nursing home care expenses, costing Kansas about \$805 million in 2003.¹³ While only about 10 percent of the Medicaid population uses long-term care, these benefits account for almost 50 percent of all Medicaid costs in Kansas.¹⁴ As a comparison, about two-thirds of all Medicaid eligibles use prescription drug coverage, but it constitutes only 9 percent of the costs.¹⁵ It should be obvious that attempts to reform Medicaid will need to deal extensively with long-term care and/or nursing home beneficiaries.

BENEFITS STRUCTURE

In a defined benefits structure, the eligibility and benefits are essentially fixed and costs are the variable. This means that if you are eligible you are “entitled” to all the benefits available regardless of the aggregate cost to the taxpayer. According to federal law, states must cover fourteen mandatory benefits such as hospitals, physicians and long-term care.¹⁶ Kansas also offers additional benefits such as hearing aids, eyeglasses, dentures and dental care.¹⁷ With expenses as the



uncontrolled variable, Medicaid costs grew from \$1 billion in 1967 to \$267 billion in 2003. Once an optional benefit is conferred upon one eligibility group, it must be conferred upon all eligibles. Unlike private health insurance, Medicaid does not have an overall dollar benefits limit. This leads some providers to treat Medicaid service provision as a long-term annuity.

New and better but expensive benefits that often end up saving money are generally not offered until almost everyone with private plans offers them. Many new therapies, drugs or treatments may not ever be covered. Since the buyer is the State there is no competitive pressure to maintain or increase patient satisfaction. There is almost no penalty for giving second-tier care. Medicaid reforms need to include a design that makes the beneficiary, not the State, the “customer.”

Medicaid offers a broad benefits package that almost no one will fully need, but must ignore offering particular benefits to cover specific, but small, patient populations. Medicaid patients do not get any of the medical rewards of “tailoring benefit packages” as those covered by private sector plans. By not actuarially covering all benefits for all programs, the price for each person can be less while providing more effective care.

COST AND PAYMENT STRUCTURE

Medicaid does not rely on a “market” in the traditional sense of buyers and sellers acting in their own interest in a decentralized marketplace. Instead, it is an “administered pricing system” where various schemes determine reimbursements. This system ranges from cost-based reimbursement for nursing homes to prospective payments for acute care. We believe this is the “Achilles Heel” of the current program. Any efforts to fix Medicaid need to address this payment system.

The trouble is that while centralized systems and price determination often appear attractive, they suffer from a fundamental flaw: the “information problem.” In order to know where resources should go, the central planners and price determiners need to know both what goods and services people want and how they can most cheaply be produced. But this knowledge resides in the minds of individual consumers, businesses and providers, not in the filing cabinets or computers of a government planning agency such as Medicaid. The only practical way for consumers and providers to relay this knowledge to each other is through a decentralized system of market-determined prices.¹⁸

MEDICAID’S PRICING AND PAYMENT DISTORTIONS

The “prices” that Medicaid pays for services to its enrollees are not determined in a marketplace. They are “administered.” Nursing homes often receive reimbursements on a cost-based formula. The result is excess nursing home capacity and the survival of marginal providers who would fail in a free market. Providers paid on the basis of “costs” do not face the traditional market incentive to economize and become more efficient. The current system therefore rewards heavily leveraged facilities with high operating costs at the expense of well financed facilities with low costs and overhead.

Both Medicare and Medicaid made an initial attempt to address this problem of perverse incentives in 1983 with the transition from hospital reimbursements to “prospective payments.” In theory, these fixed reimbursements were similar to market prices that would encourage providers to deliver service more efficiently. In reality, the government simply switched from one pricing scheme to another.



Diagnosis Related Groups Payments

Hospitals under Medicare and Medicaid receive payment through a DRG payment (Diagnosis Related Groups) system. Consultants to Medicaid determine appropriate DRG rates for various services and procedures around the state.¹⁹

Unfortunately, Medicaid and their consultants can never know the “correct” price for a bypass in Topeka or an appendectomy in Wichita. Only a decentralized market with buyers and sellers can determine accurate prices. Since the DRG rates set by Medicaid are almost all certainly “wrong,” the impact on the health care system is to produce surpluses, shortages and inefficiency.

Relative Value Scale Payments

Payments to physicians utilize a similar administered price scheme called Resource Based Relative Value Scale (or some variant of this method).²⁰ While quite impressive on paper, this scheme is nothing more than a variant of the more than century old discredited “Labor Theory of Value” developed by Karl Marx. We are essentially paying doctors to provide services to Medicaid beneficiaries using the principles of Communism and then wondering why we have problems.

PAYMENTS – TOO LOW OR TOO HIGH?

It is important to remember what happens when the price is not “right.” If the price is set too high there will be surpluses and excess capacity. If the price is set too low there will be shortages and a lack of capacity. Since both Medicaid and Medicare use administered pricing schemes and since they are a huge part of the health market, the entire system is inefficient. The fact that the dominance of this method leads some private payers to copy the government’s pricing schemes or, at best, use them as a starting

point in price negotiations exacerbate this problem.

In the case of Medicaid it appears that payments are often set below the going rate that would exist in a real market. This indicates that there should be outright shortages of services to beneficiaries, and sometimes there are. Individuals on Medicaid can find it very difficult to find providers to serve them. But with heterogeneous services like health care, the “shortage” may also take the form of low quality. Examples of this include failure to treat illnesses properly as well as long waiting times for receiving services.²¹

Another outcome of reimbursements being set “too low” is cost-shifting to the private sector. Medicaid providers paid below market rates are likely to attempt offsetting this loss through increases in rates to private payers. This more subtle market manipulation has the impact of making Medicaid (and Medicare) look cost effective relative to the private sector. In fact, Medicaid consistently argues that the program is a more cost effective provider than the private sector and produces data that accurately shows their costs increasing at a lower rate in the last few years.

While technically correct, these assertions are extremely misleading. Part of Medicaid’s “plan” for dealing with its budget problem involves “freezing” payments to providers. How many private sector buyers have been able to “freeze” their premiums in the last few years? Medicaid simply does not pay the going rate and then erroneously either actually believes or at least presents the image that the program is a “value buyer.” The results include both low or no quality care to beneficiaries and higher inflation in the private sector due to cost shifting.

The Lewin Group researched stingy government payments and the possibility of



cost shifting. They found that low public reimbursements correlated about -.75 with private payment ratios. This research strongly indicates that Medicaid's "low cost" is in reality a driver of private sector medical inflation. It is important to understand that reforming Medicaid so the plan pays actual market rates will produce benefits partially through reduced private sector cost shifting.²² Medicaid also asserts that its overhead rate (4 percent or so) compares much more favorably than the private sectors. Such items as profits to private insurers and HMOs are considered as an excess cost that is avoided by public provision of services to Medicaid beneficiaries. The logical conclusion of this line of thinking is to simply nationalize all of our industries and get rid of that wasteful profit overhead! It is astounding that after a huge part of this planet has thrown off the shackles of government-run economies we allow ideologies that yield so few returns and so much suffering to continue to hold sway over our approaches to public policy.

EXPLAINING MEDICAID'S LOW OVERHEAD

First, Medicaid's effective overhead rate is "low" because many of the costs of running the program are simply put onto providers. For example, I recently spoke with a drug/alcohol center director who currently waits around 6 months for reimbursements from Medicaid. If the center provided \$1 million in services they would be carrying \$500,000 in accounts receivables.

This gentleman is therefore running a bank in addition to a rehab center. Even if he was able to finance the receivables at a prime rate of 7 percent, he carries an additional 3.5 percent in overhead because of Medicaid's payment policies. Running Medicaid also involves significant tax revenue, budgeting and auditing costs that show up under spending for different agencies and governments.



There are also substantial compliance costs placed on providers in terms of time and overhead needed to meet the paperwork burden imposed by Medicaid. In addition, Medicaid in its current form imposes significant costs in terms of unnecessary utilization and reduced quality. This has already been pointed out with regard to the perverse incentives that exist in the nursing home industry because of cost-based reimbursement.

Since a large portion of Medicaid is fee for service with very little or no cost sharing, this produces a significant increase in the demand for health care services. Further, setting payment levels that are too low to providers produces either reduced quality of care or outright shortages of services. When all of these and other costs of the Medicaid design are factored into the program, it has substantially higher overhead than the private sector. Indeed, one estimate placed the effective overhead as much two-thirds above private insurance.²³

BARRIERS TO BETTER HEALTHCARE

To summarize, the current Medicaid system is an inherently inefficient program because it relies on administered prices as opposed to a decentralized marketplace. No government, ever, anywhere, has been able to effectively set prices. Health care is no exception. The result of this system is provider inefficiency, explicit and implicit shortages of health care and higher private sector medical inflation. Unless the system is drastically reformed the long-run budgetary impact on the State of Kansas will be nothing less than dire.

It is important to recognize that Medicaid is only one impediment to the low cost, efficient delivery of health care in the United States. As stated above, Medicare also operates as a price control system. Just as important, there

is actually very little free market provision of health care in the private sector.

Due to a historical quirk, employers may provide health insurance as a tax-free benefit to employees. As a result, the vast majority of Americans obtain health care coverage through their employer.

The problem with this is that when you buy at the “company store” you get what the company wants. In the U.S. this has taken the form of extremely limited choice in health providers. Around 80 percent of employees have precisely one choice in their health plan. What kind of outcomes would occur in a market where you had one choice when you went shopping for a car, one choice in your grocery store or one choice in your appliances? The answer, of course, is that you would have higher prices and lower quality.²⁴

THREE CHOICES FOR KANSAS

Kansas has three options to deal with the Medicaid crisis: 1. cut benefits; 2. raise taxes; 3. reform Medicaid. While there are areas in Medicaid where benefit reduction may be feasible, such as asset and income rules for nursing home coverage, some attempts to limit coverage will simply backfire. Eliminating drug benefits, for example, may lead to expensive institutionalizations or surgery.²⁵ Simply removing beneficiaries from the rolls may just crowd hospital emergency rooms and further shift costs to the private sector. Raising taxes is also not a realistic option given already high marginal taxes in Kansas coupled with ongoing pressure to increase funding for education.

The best alternative is to reform Medicaid so that market forces lower its long run growth rate and, simultaneously, improve the quality of services for beneficiaries. A framework for implementing these reforms appears below.

FIXING THE PROBLEM

The solution to quality and cost problems in government-run plans like Medicaid and Medicare as well as in private sector run plans involves “opening the markets and leveling the playing field.” One way would be for private employers to band together and create “insurance exchanges,” marketplaces at which employees may browse the numerous competing plans and choose the health care plan right for their needs. In theory, employers would provide funding for employees to spend at these “marts,” either in the form of a voucher or an expense account, for example. A similar consumer-driven-style program could work as a possible reform plan for Medicaid.

For example, states could create “insurance and provider exchanges” for the provision of services to beneficiaries in Medicaid. Unlike the current price control system, those eligible for Medicaid will receive risk-adjusted credits to purchase services from competing plan providers.

This will turn Medicaid into a real market where buyers are acting in their own interests and providers compete to enroll beneficiaries. This will produce gains in efficiency that will make the programs sustainable in Federal and State budgets and, just as important, such a move will improve the quality of health care that beneficiaries receive by giving them the ability to interact with the marketplace as empowered consumers. Pie in the Sky? Not at all. The State of Florida just received approval from Washington to begin converting their Medicaid plan to the exchange model. The State of South Carolina is currently negotiating with D.C. for a similar reform to its plan. Kansas cannot continue to pursue a course of simply rearranging the outward shape of its program without addressing the deeper problems at its core. It is now time for Kansas to submit a bold



reform for Medicaid along these free market lines.

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Notes

¹ Source: Congressional Budget Office.

² Matthew Hisrich, "How Will Medicaid Spending in Kansas Fare Relative to That of Its Neighbors in Coming Years?," The Flint Hills Center for Public Policy, 20 August 2004.

³ Consumer Price Index for Medical Care, available at: <http://www.bls.gov/cpi/home.htm>.

⁴ "Kansas Medicaid: A Primer," Kansas Legislative Research Department & Kansas Health Institute, p. 18.

⁵ Flint Hills Center for Public Policy.

⁶ See, for example, Levy, C. and Luo, M., "New York Medicaid Fraud May Reach Into Billions," *The New York Times*, July 18, 2005.

⁷ "Kansas: Health Insurance Coverage of the Total Population, states (2003-2004), U.S. (2004)" (statehealthfacts.org).

⁸ "Kansas Medicaid: A Primer," Kansas Legislative Research Department & Kansas Health Institute, p. 8.

⁹ "Kansas: Health Insurance Coverage of Nonelderly Medicaid Enrollees by Age, states (2003-2004), U.S. (2004)" (statehealthfacts.org).

¹⁰ "Kansas: Distribution of Medicaid Payments by Enrollment Group (in millions), FY2001."

¹¹ Ibid.

¹² Stephen Moses, The Center for Long-Term Care Reform, Inc.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ Ibid.

¹⁶ "Benefits by State: Kansas" (October 2004) (<http://www.kff.org/medicaid>).

¹⁷ Ibid.

¹⁸ Hayek, F. A. 1945. "The Use of Knowledge in Society," *American Economic Review* 35 (September): 519-30. Reprinted in Hayek, 1948a, pp. 77-91.



¹⁹ "Report and Recommendations to the Congress," Prospective Payment Assessment Commission, March 1, 1992.

²⁰ See W. Hsaio, et al, "Results, Potential Effects and Implementation Issues of the Resource-Based Relative Value Scale," *Journal of the American Medical Association* 260, no. 16 (October 28, 1988): 2429-38.

²¹ See John Iglehart, "The Dilemma of Medicaid," *The New England Journal of Medicine*, May 22, 2003.

²² See Al Dobson, Ph.D., "Cost Shifting: An Integral Part of the US Health Care Finance," The Lewin Group.

²³ See Patricia Danzon, "Hidden Overhead Costs: Is Canada's System Really Less Expensive?," *Health Affairs*, Spring 1992, pp. 21-43.

²⁴ See Alain Enthoven, "Employment Based Health Insurance is Failing: Now What?," *Health Affairs*, May 2003.

²⁵ See Michael Bond, John C. Goodman, Ronald Lindsey, and Richard Teske, *Reforming Medicaid*, Policy Report No. 257, The National Center for Policy Analysis, February 2003. Available at: <http://www.ncpa.org/pub/st/st257/>.

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