

Our American States | An NCSL Podcast



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Martha King: State Health Care Costs and Programs | Episode 10 | May 25, 2017

Welcome to Our American States, a podcast of meaningful conversations that tell the story of America’s state legislatures, the people in them, the politics that compel them, and the important work of democracy. For the National Conference of State Legislatures, I’m your host Gene Rose.

From the smallest towns to the nation’s capital, there’s growing concern about healthcare. The U.S. House recently passed an omnibus healthcare bill which is now under consideration in the U.S. Senate. Detail on what the two chambers will ultimately do is a big unknown to the nation’s state legislatures, but they know it could bring dramatic changes.

But, as our guest today will explain, states are not waiting to make healthcare systems more efficient and effective. Martha King directs the healthcare program at the National Conference of State Legislatures. Martha, let’s jump right in and talk about the numbers. How much of state budgets are directly tied to spending on healthcare?

King: You know, Gene, most people are surprised to learn that about a third of state budgets are spent on healthcare. This includes both state and federal funds. So the amount varies by state, of course, but it’s a lot of money. It’s exceeded dollars for education, both K-12 and higher ed combined.

Gene: What are the states’ biggest expenditures for health?

King: Well, not surprisingly, the biggest share goes to Medicaid, and that's the program for low-income Americans. Medicaid typically accounts for about 75 percent of that healthcare slice in state spending.

The federal government contributes more than half of that total for Medicaid. So if you really look at what are states spending through their general fund, it's about 17 percent of state budgets on average go to Medicaid, and as health costs continue to rise at a faster pace than overall inflation, health expenditures have squeezed out other programs, as legislators are very aware of.

For example, if you look back to 1995, about 20 percent of total state spending, that state and federal dollars, about 20 percent went to Medicaid. Now in 2016 it was up to 29 percent and as states have to balance their budgets, of course that money has squeezed out other programs such as education, transportation and some other areas where you've actually seen a decrease in the percentage of money going into those programs.

Gene: So Martha, why does Medicaid cost so much?

King: Well, I guess I could start with a broader question, Gene, to say: Why does healthcare for all of us in the U.S. cost so much? That may be another podcast topic. But as for Medicaid, for one thing budgets are driven by the number of people who are covered, and especially in an economic downturn where people lose their jobs and lose their health insurance, you see more people qualify for the program and get enrolled. And, of course, with the Affordable Care Act Medicaid expansion, more people came into the program in the 31 states and the District of Columbia that chose to expand Medicaid.

Another factor for consideration is the types of people who are covered. Most people know Medicaid as a program that covers kids, low-income kids and pregnant women, and in fact, they take up more than half of the people covered. But Medicaid has also become the nation's default payer for long-term care for low-income seniors and also for people with serious disabilities: disabilities such as cerebral palsy or developmental disabilities. So the elderly and people with disabilities make up only about 25 percent of the population covered, but they account for more than 60 percent of Medicaid spending. So these are high-cost, high-needs people that the state is covering.

Another surprise to a lot of people is that Medicaid covers more than half of nursing home costs in this country and, as we all know, that gets quite expensive.

Gene: So don't some people assume that Medicare, the program for older Americans, covers nursing home costs?

King: Well I think many people do, and that's an understandable misperception because after all, Medicare covers people who are older. But its coverage of nursing home costs really is pretty limited. It's restricted to mostly short-term rehabilitation, say after a hospital stay. So, in fact, there are about 10 million Americans who qualify for Medicare and Medicaid at the same time, and these are the people that we refer to as "dual eligible" or "dually eligible recipients." For them Medicaid picks up a lot of the costs that Medicare doesn't cover, such as nursing home care and some of the cost sharing that the Medicare program has.

Gene: In addition to Medicaid, what other health programs do states fund?

King: The next biggest slice of the healthcare pie is coverage for state employees and their families. That accounts for about 10 percent of state expenditures on average. Most employees also pay a portion of those costs through copayments and premium sharing.

Some of the other programs are mental health services, healthcare for prisoners, for example, who don't qualify for Medicaid, drug and alcohol treatment, and prevention in public health. And public health is a really important component of overall health for the population, but it really gets only 3-5 percent of the healthcare dollar. But that's what keeps the primary population healthy – for example, clean air programs, clean water, immunizations, water fluoridation, injury prevention. So that's another slice of the pie.

Gene: I noticed in a recent issue of the State Legislatures Magazine where it said that 5 percent of patients can account for 50 percent of a state's healthcare cost. So explain that dynamic to me and what states are trying to do to address reducing those costs.

King: It really is an astounding figure, and that figure isn't just for states with Medicaid; it really is a national figure for healthcare spending. It goes to what I just said about higher-cost Medicaid enrollees. These are people with really intensive, long-term care needs. So the top five conditions that account for healthcare spending are sort of your usual suspects: heart disease, cancer, trauma, mental disorders, and pulmonary disorders such as emphysema. Some of these too are at the end of life when service demands can be quite intensive.

Other examples, again, are serious accidents, you know, maybe in a car accident, and people who have complicated disabilities. And then, for example, premature babies – we've all heard of the million-dollar baby and that does happen.

But many of the most expensive patients are those who have multiple chronic diseases such as, again, diabetes, heart disease and cancer. Quite a few also have complications involving a mental illness or maybe a substance misuse disorder. So they have multiple issues and these are referred to as really high-needs patients or super-utilizers – they utilize an awful lot of care.

One example in mind would be an uninsured man or woman with several health problems including depression, and maybe they self-medicate with too much alcohol. So these folks become quite expensive, especially when they don't have a regular source of care and they end up in emergency rooms, which, again, is quite expensive.

Gene: So what can states do to help control these diseases and the costs associated with them?

King: Well, this might sound funny, but sometimes the answer is to give them more care, but the right care in the right place. So not the ER, but to try to get their needs met in more of a primary care or preventive or disease management situation. A lot of these folks don't have a regular or reliable source of care, so some may receive good care in a clinic, but then they don't follow through, maybe they don't understand the instructions, maybe they're homeless, maybe they can't afford the drugs that were prescribed, maybe they don't understand the prescriptions.

So we start talking about social determinants of health and that really is where people live in the community, what their housing situation or environmental circumstances and social situations are like... so all of these factors play in.

Gene: So what about how the providers are paid? Does that make a difference in this equation?

King: Yes, it certainly can. More providers are moving away from fee-for-service and now we're looking at more models and better models of coordinating care for these high-needs patients. We used to refer to managed care and now we're hearing about medical homes where teams of providers come in, where providers are then paid for their performance rather than services a la carte that they may do.

So you might have a healthcare team that includes doctors, nurses, social workers, mental health counselors, and this team really helps people manage their diseases. Again, the key is the right care in the right place, and often with social supports.

And the federal government, to its credit, through Health and Human Services, has really put some effort into supporting pilot programs for states to be able to experiment in these areas. Foundations like the Commonwealth Fund have put a lot of effort and money into reorganizing the system so that it is more efficient.

Medicaid programs have started rewarding providers who meet or exceed certain things, like getting kids immunized. Several Medicaid programs... I think it was led by Texas, for example, won't pay for caesarean sections that aren't medically necessary, and this has dramatically reduced the number of so-called "convenience C-sections" and really has saved the Medicaid program quite a bit of money.

Gene: So also in State Legislatures Magazine I read about New Jersey's hot-spotting initiative that targets high-needs patients. Tell us what hot-spotting means and how this program works.

King: Yeah, this really was quite innovative. It started in Camden, New Jersey; they formed a Camden Coalition of Healthcare Providers. Their strategy really is to identify: Where are the hot spots, the concentrated areas in the community that have more, a disproportionate share I guess of high-needs patients; for example, a high-rise apartment complex that has a large number of low-income older people?

So the Coalition supported volunteers; they sort of have the healthcare team together to assist patients with identifying them, making appointments, keeping appointments, making sure they understand instructions, providing emotional support and other practical needs. A typical example would be an older woman with a heart condition who ended up in the ER in the summer when her apartment got unbearably hot and she didn't have an air conditioner. As a result, the program said well, wait a minute, if we get an air conditioner, maybe that would help her and, in fact, it did. She quit showing up in the ER multiple times. And believe me, an air conditioner is a lot cheaper than footing the bill for emergency room visits.

So with their efforts on the front end in the Camden Coalition, they reported a 50 percent drop in avoidable hospitalizations in the groups that they really targeted. And, of course, this can be a huge cost savings for states if their Medicaid program or other funding foots that bill.

Gene: So you also mentioned people who have both physical and mental health challenges.

King: Yeah, this can be a huge challenge for patients, for providers, for family members, for providers. And typically our healthcare services for mental health and physical health are in separate places with little or no coordination between them. They may not share records; they may not know what medications they're taking, etc. So among people covered by Medicaid, treatment costs for people who have both chronic physical and mental illness conditions typically run 60 percent to 75 percent higher than for people with chronic conditions alone without the mental illness.

Gene: So have any states made headway in treating such patients more efficiently?

King: Yes and, again, with some support from foundations and the federal government, there are a number of states that have taken this on. I'll call out Missouri because it actually won a gold achievement award from the American Psychiatric Association for its work to integrate care for Medicaid patients who have both chronic disease conditions and also severe mental illness.

Missouri started a program called Healthcare Homes to integrate care. These healthcare homes are based in community mental health centers and staff in those centers coordinate both the physical and mental health needs for these patients. For example, case managers make sure the patients have access to the services they need; maybe it's transportation to appointments. And in its first year, the Missouri Medicaid program reported that they had saved 31 million dollars mostly due to reductions, again, in emergency room visits and hospitalizations for their patients.

Gene: Okay, we're talking with Martha King who directs the health program at the National Conference of State Legislatures. We'll ask her about consumers' ability to compare healthcare prices and what states are doing in preventive care right after this break.

BREAK

Gene: Okay, we're back with Martha King who directs the healthcare program at the National Conference of State Legislatures. Now Martha, I know certain states like New Jersey, California, Florida, Maryland and Oregon allow consumers to do some price comparisons online regarding obtaining various healthcare services. What's been the result of those actions and do you see this as a growing trend?

King: Well, I think so. This is referred to as "price transparency." The idea is similar to buying consumer goods. We can shop around for shoes or cars, search online for an apartment and compare prices.

Gene: So shouldn't this work for healthcare?

King: Well it can under certain circumstances. Healthcare is a little more complicated. So, for example, if I know what I have to pay out of pocket for a prescription drug that I have and I find out that I would have to pay a lot more for a brand-name drug, perhaps I may choose the lower-cost generic drug. So that's a pretty simple example. Or if I have a high deductible under my

insurance plan, and a lot of people do, I'm likely going to do some comparison shopping for non-emergency services if I can find out what they cost.

The states you mentioned sponsor websites that enable consumers to comparison shop among hospitals and it's amazing how much prices can differ. For example, one study a few years ago showed that the average cost of a hip replacement in Montgomery, Alabama was just over \$16,000 compared to more than \$55,000 in Northern Colorado. So if you're paying out of pocket for something like that, you can bet that you're going to comparison shop, but you need to have the information to be able to do that.

On the other hand, if you're having an emergency, you're not going to be in the ambulance searching on your cellphone about the cheapest hospital that you're going to go to. You just want to get to the closest hospital, right? In addition, most insurance plans determine which providers or hospitals to use and this is referred to as the plan's network, and we're hearing more and more about networks, whether they're too narrow in terms of covering the providers that maybe the patient wants to see. But insurance plans negotiate prices with providers and hospitals within their network, and so this is something that individual consumers can't do, and if I'm covered by a plan, it's going to want to pay only for the in-network or it may hit me with a bill if I go outside that network.

Gene: I've been reading a lot about surprise billing where consumers are stuck with a high bill they don't know about. What are states' reactions to that?

King: Yeah, that's become more prevalent in the press I think and this also has to do with transparency. So I did just talk about the insurance plan's network. A good example is say I go to the hospital under my insurance plan to get surgery, which is covered by the plan. But then afterwards I get home and I get this huge bill from the anesthesiologist. Turns out that doctor wasn't covered under the plan and so as a patient, I have no idea about this. So, again, this refers to out-of-network billing, and we're beginning to see states address that.

For example, California, Connecticut, Florida and Utah all have passed legislation that deals somehow with trying to protect patients from these surprises, but the legislation varies in the amount of protection and typically it's that providers have to give patients notice. So, for example, maybe the hospital has to post a sign in the hospital to let people know, and if you don't notice the sign or you're not aware otherwise, it can really come and bite you.

Gene: And prevention is another word that we hear a lot about that would help lower state healthcare costs. Why does it seem to be so difficult to get people to take preventive measures?

King: Well I think the real answer is we're all human. We know that smoking isn't good for us, we know we should wear a seatbelt, we know we shouldn't drink too much, we know most of us should eat less and exercise more. And that's really hard to regulate. Most policymakers and most of us don't want government acting like big brother and telling us what to do. On the other hand, when government is footing the bill for the results of our actions, it's really kind of hard because a lot of these actions are tied to chronic diseases such as diabetes, heart disease and cancers, those big-ticket items.

But let me say too that some preventive care is a no-brainer and we can all identify with that. For example, prenatal care can help reduce the incidences of newborn babies that need expensive care. Immunizations, Medicaid programs, investing in some of these preventive measures including screening can really save money down the line.

Gene: And you said earlier that state governments foot so much of the healthcare bill for people with chronic conditions?

King: Yeah, that's right. Between the federal and state governments, we're paying half of the healthcare in this country. So that's when preventive efforts are important. And it turns out, and here's where sort of the big government comes back into play, more than 75 percent of the healthcare costs are spent on treating chronic diseases, many of which are preventable or would be much less severe if everyone practiced healthy habits. So when the government is footing the bill, how much interest does the government then have in regulating our behavior?

We know smoking is associated with cancer. We know obesity is associated with diabetes and heart disease. And so I think policymakers really have to strike a balance between what is government business in our behaviors and how much money are we footing the bill for. It also is a wakeup call to policymakers when they hear that military recruiters are turning away too many kids who don't qualify for military service because they're too heavy and physically unfit.

Gene: So what are some of the strategies that states have undertaken to improve all of this, Martha?

King: Well, we've seen a lot of action by states in terms of... a good example is investing in the generation of kids, the next generation coming up. We've seen a lot of effort put into improving the nutritive value of school meals, vending machines, and requiring physical activities such as PE classes.

We've also seen a lot of state-sponsored anti-smoking campaigns. You see the PR announcements and restricting tobacco sales to minors. In fact, a new trend we're beginning to see is a few states are moving to increase the age to purchase tobacco to 21, hoping that if kids don't smoke before that age, maybe they won't start at all.

Some states are also trying some incentives or disincentives in their Medicaid programs to encourage healthy behaviors. Some of these states include Florida, Idaho, Indiana, Iowa, and the incentives they're enacting include things like an incentive about lowering your copayment or maybe providing a gym membership for enrollees to do certain things such as enroll in a smoking cessation program, or enrolling in a weight reduction program, or maybe getting a flu shot, or getting preventive care for their kids.

Gene: So have any of these strategies worked?

King: Well, easier said than done I think. They've shown mixed results. A good example is the Massachusetts Medicaid program did report some success with a smoking cessation program. It showed a 10 percent reduction in the smoking rate for the people who participated in the program. In Florida, people were much more likely to earn credits for bringing their kids in for preventive services than say for weight loss or quitting smoking.

So it is a tough situation and policymakers need to weigh what does work/what do we invest in. There was a recent study that was just published on Iowa's program. Iowa enacted a healthy behaviors program and they were a little disappointed in the results because only about 17 percent of the participants in the program completed the healthy activities, and these included getting a risk assessment and a wellness exam.

The conclusion that the researchers came up with was that a lot of people, both the participants and the providers, didn't understand the program very well. They didn't understand the incentives. They didn't understand what they needed to do exactly. So the researchers said this may work better, but you really need to pay attention to how you design the program and what are the factors that actually would make something like that successful.

Gene: Alright, Martha, so let's close on the million or maybe I should say billion dollar question: What do you think is going to happen with efforts in Washington, D.C. to repeal and replace the Affordable Care Act?

King: It's likely that we'll see additional health changes coming from Washington. We're just not sure what form they'll take. It's really likely that we'll see more additional flexibility to make changes in Medicaid programs, and I think most people welcome that. Some worry that we could see the number of uninsured rise again, which would put additional pressure on states and state budgets to tackle that problem. We've been there; we've done that. It's a tough one.

It's also good to remember that states have long been in the forefront of crafting health policy innovation. Many of the reforms that people like under the Affordable Care Act, such as allowing young adults to remain on their parents' health insurance plan or protecting people's preexisting conditions, actually came from state innovation and were then incorporated into the Affordable Care Act.

But no matter what, I think states will continue to innovate and we're all in this together, so we'll just keep working at it.

Gene: Thank you Martha. And that concludes this edition of Our American States. A reminder that the NCSL health program tracks legislative action on a variety of health issues and provides customized assistance for state legislatures, and we encourage you to subscribe to this podcast on iTunes, Google Play or on the NCSL website, www.ncsl.org. And until our next episode, this is Gene Rose. Thanks for listening.