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State Health Care Spending: A Systems Perspective

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According to recent reports, the state of the states in 2002 is one of budget crisis. Forty-five states and the District of Columbia report that revenues have failed to meet projections. Twenty-eight states and the District of Columbia report that spending is above budgeted targets. Medicaid is over budget in 23 states, with another five reporting that the program could exceed budgeted levels in coming months. At least 20 states have already implemented budget cuts or holdbacks to address fiscal problems in 2002, and nine others report that cuts are possible before the fiscal year ends. In 19 states, tax proposals are under consideration to help balance 2003 budgets.[1]

This state of affairs is a far cry from that which characterized most of the past decade, when states enjoyed robust revenue growth and moderate demand for services. Many states took advantage of the strong economy by making significant investments in education, health care, tax cuts and transportation, or by stashing money away in reserve funds. Now, 15 states and the District of Columbia have already tapped their reserve funds to help balance their 2002 budgets, and another 10 may use these funds this fiscal year.

Facing increased public demand for services and a slowing economy, states are looking at options to scale back their expenditures. Many have nominated health care, which consumes about one-third of most states' spending, as a primary candidate for cuts. But reducing state health care spending is not always as simple as it may seem. Because of the interrelated nature of the health care system, spending cuts to one program often end up "bouncing back" and ultimately costing the state more by driving up expenditures in other areas.

This issue brief will attempt to disentangle the web of the health care system by outlining various ways that state governments and non-state entities finance and deliver health care services. It will also explore the benefits of evaluating proposed cuts from a systems perspective – that is, taking into account not just the direct effects of a proposed cutback but also the indirect effects it may have on other parts of the health care system. Finally, the brief will present several systems perspective solutions that states may want to consider as they deal with their budget crises.

A Snapshot of the Health Care System

An important step in deciphering the intricacies of the health care system at the state level is to discern the difference between who is providing or arranging to provide health care services and who is paying for health care services. Making this distinction is important because it reveals the underlying budget links between programs, and can help policymakers understand which funding streams are flexible, and what the short- and long-term effects of potential cuts are likely to be. To follow are descriptions of the four major players in the state health care system – the state government, federal government, private sector, and local government.

State Government

State governments arrange and pay for health care services through programs and initiatives, funded either solely by state tax dollars, or, more frequently, through a combination of state and federal finances. In the case of state-only programs and initiatives, the state has complete control over the financing and delivery of services. With state-federal partnerships, the state and its agencies have general administrative responsibilities for the programs, but must operate within certain federal guidelines and meet state financial participation requirements to receive federal funds. This can limit the policy options that states have in times of crisis.

State-federal partnerships. The foremost state-federal partnership is the Medicaid program. Medicaid, which is by far the health care program on which states spend the most money, funds a variety of health care services for low-income adults

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and children. On average, about two-thirds of any given state's Medicaid expenditures are used to finance care for the aged, blind, and disabled, although these groups comprise only about one-third of the total Medicaid population. Almost all state health and human service-related agencies, including state mental health agencies, state university medical schools, and state health departments, rely on Medicaid for some portion of their financing.

Because the Medicaid program is so large, it is often state policymakers' first target for cuts as they look to balance their budgets. Medicaid cuts must be made with caution, however, since the program affects so many different areas of the state budget and bears such a tremendous load in the health care system.

Other state-federal partnerships include the State Children's Health Insurance Program (SCHIP), which pays for health insurance for children in families with incomes too high to qualify for Medicaid but too low to afford private coverage, and federal block grants to states (e.g., the Substance Abuse Prevention and Treatment Block Grant). These block grants require some financial participation from states and are generally administered through a state agency that focuses on the population to which the grant is targeted. States and the federal government also jointly finance and deliver public health services aimed at preventing disease and chronic illness, such as smoking cessation campaigns and diabetes screening programs.

State-only services and programs. These services vary in scope and target population, but they generally serve the uninsured and underinsured, with a particular focus on populations with acute health care needs. One prominent example is catastrophic care programs, which assist individuals, hospitals, and local governments with the high cost of catastrophic care (e.g., trauma care), by providing either assistance on request to eligible entities in times of need, or regular payments to hospitals and other providers in relation to their catastrophic care burden. Other examples of state-only services include the health care provided to inmates in adult and juvenile correctional facilities and non-Medicaid senior prescription drug assistance programs. States also finance public health services independent of the federal government.

Federal Government

In addition to partially financing Medicaid and SCHIP, the federal government is wholly responsible for administering and financing the Medicare program. Medicare, which is the health care program on which the federal government spends the most money, pays for health care services for Americans aged 65 and over (with the notable exceptions of prescription drugs and long-term stays in nursing facilities). The federal government also finances health care services for veterans through the Veterans Administration, services for native Americans through Indian Health Services, health insurance for federal employees, and federal block grants and other health care related grants, such as those awarded to federally qualified health centers.

Private Sector

Employers' spending on health insurance for their employees accounts for more than 50 percent of the dollars flowing through the national health care system. Other examples of direct private-sector health care spending include out-of-pocket spending by consumers for premiums, co-payments and deductibles, and free and reduced-price health care services delivered to the uninsured and underinsured by private-sector hospitals, clinics, and physicians. The private sector may also help indirectly finance programs such as high-risk pools through assessments on insurance premiums.

Local Government

Local governments are considered the "safety net" of the health care system because in most states they have a statutory or constitutional obligation to provide health care to the indigent. This is no small order in a nation where 15 percent of the population lacks health insurance. Not surprisingly, the majority of health care arranged for and financed by local governments is for the uninsured and underinsured. This care is delivered via local public hospitals, mental health authorities, and health departments, for example.

How Health Care Spending Cuts Can Bounce Back

The interrelated nature of the health care system can be demonstrated with the following hypothetical example of a state proposal to cut Medicaid eligibility. Assume that State X has decided to eliminate coverage for parents of Medicaid kids who were covered through a previous Section 1931 expansion.[2] This action will remove 10,000 adults from Medicaid and, on its face, save the state an estimated $12 million annually ([10,000 adults] x [$100 per month state share] x [12 months]).

Although no longer on Medicaid, some of these 10,000 newly uninsured adults still have significant health care needs. Applying general prevalence data, it can be assumed that approximately 22 percent of this population has a mental illness, 20 percent has a disability, and 25 percent has cardiovascular disease.[3] These people will continue to access the health care system, but now they will do so without the aid of health insurance; research has shown that this means they will delay getting care until their conditions become serious.[4]

When these individuals need health care, they will present at local public or private hospitals, state university medical schools, local mental health authorities, local health departments, and state-only services and programs. It is difficult to know exactly how many of these 10,000 adults will present at one of these facilities over the course of a year. But when they do present, it will be expensive. The average cost of hospitalization is $25,000 for a heart attack, $13,600 for a schizophrenia-related psychotic episode, and $7,300 for a severe asthma attack.[5] Some portion of these costs may end up being borne by the state directly – through increased expenditures at state mental health institutions, for example.

The majority of these costs are borne by private sector and local government-operated hospitals, but they still have significant long-term financial implications for

Advanced Tools for Systems Analysis

Policymakers who want to construct more complex analyses of the effects of budget reductions have several tools at their disposal. These tools can provide a more concrete way to compare different policy options (as with cost-effectiveness analysis) or illuminate the broad, long-term effects of particular policy options (as with the investment budgeting approach).

Cost-Effectiveness Analysis. In cost-effectiveness analysis, a ratio is derived that compares the net cost of a proposed policy to the health improvement it will achieve, or, conversely, that compares the estimated net savings associated with a particular cut to the negative effect it will have on health. This analysis may yield ratios such as "for each $10,000 saved, one fewer Hepatitis B infection will be identified in a newborn baby." Because there is no absolute measure of health, these ratios are only useful for comparative purposes.[8] Even so, they can give policymakers a clearer understanding of the relative effects of cutting various programs.

Investment Budgeting Approach. With the investment budgeting approach, spending by state government is viewed as an investment and outcomes are measured in terms of return on investment. Return on investment is calculated by comparing the cost of a proposed policy to the savings it will generate across all state programs and the new economic activity it will yield (e.g., new tax revenue) over a chosen time frame, generally 5 to 10 years. Texas policymakers used the investment budgeting approach in 1999 to guide them in creating the state's SCHIP program, which now insures more than 500,000 Texas children. The Texas legislative budget office estimated that the state would generate a $4.4 billion return on investment if it spent $1.0 billion in SCHIP over the next 10 years. The major source of this positive impact will be reduced emergency room use, reduced hospital days, increased immunizations, and reduced charity care.

the state. Hospitals that assume this financial burden must pass on the increased costs to all payers in the system. This translates into more expensive health insurance for employers (including state government). As health insurance costs rise, fewer employers can afford to purchase health insurance for their employees, possibly causing a rise in the number of uninsured. Consequently, government health care programs (e.g., Medicaid, Medicare, and SCHIP) become more costly to operate as well.

By removing populations from Medicaid, the state also loses any control it might have had over how these individuals utilize the health care system. Thus, the state loses the opportunity to keep health care costs down by encouraging the use of preventive care.

A Systems Perspective on the State Health Care System

The benefits to policymakers of taking a big-picture, systems perspective on proposed cuts in state health care spending are informed decisions and a thorough understanding of where the impact of a particular cut will be felt. This approach can also help legislators to identify early on which constituencies will feel the pain of a cut and from where support and opposition may come. When governors and legislatures are adding health care services, the systems approach can help guide them toward wiser investments.

EXAMPLE: TENNESSEE

Tennessee recently used a systems perspective to evaluate proposed cuts in health care spending. Facing a budget crisis, state officials proposed eliminating benefits for 180,000 enrollees in TennCare – the state Medicaid program – to produce an estimated savings of $142 million. In response to this proposal, the state Comptroller's office conducted a cost analysis from the systems perspective. The analysis indicated that while dropping these enrollees from TennCare would save the state $142 million, Tennessee would lose more than $340 million in federal Medicaid matching funds, which support other state departments as well as the entire health care system.

The Comptroller's report also noted that individuals who lose coverage through TennCare would most likely continue to receive health care services in an expensive hospital emergency room setting. Thus, instead of sharing the cost of services for the lost enrollees – an estimated $582 million – with the federal government, the state would have to bear much of this financial burden on its own. Private providers would also contribute, but they would likely respond to cost increases by either cutting back services or passing costs on to health plans and other payers. This, in turn, would result in higher premiums and possibly an increase in the number of uninsured, the report concluded.

The Comptroller's report also documented TennCare's important role in encouraging preventive care and improving care management. It argued that removing these 180,000 individuals from the

program may actually increase overall health care costs in Tennessee, as patients' chronic conditions go from managed to unmanaged, and individuals lose access to primary care providers.[6] By focusing on the broad effects of cuts, the Comptroller's report has informed the policy debate in Tennessee and should prove useful to policymakers in other states. (At the time this brief went to press, the future of TennCare was still uncertain.)

Example: Texas

The Texas budget debate that took place during the 2001 legislative session provides another recent example of systems thinking. The legislative leadership appointed a special joint committee to identify opportunities for cost savings in the state Medicaid program. The committee developed a series of policy options that ranged from the dramatic (e.g., eliminating all optional Medicaid coverages) to the modest (e.g., instituting competitive pricing for medical equipment and supplies in Medicaid).

The members of the joint committee concluded that cutting coverage for particular services or populations would only cause those health care costs to bubble up somewhere else in the system. Instead, the committee recommended changes that would better manage existing populations within Medicaid, such as creating a case management program for individuals with chronic conditions, expanding Medicaid managed care to previously unmanaged populations, and limiting disenrollment from Medicaid managed care plans.[7]

State Budget Solutions Using the Systems Perspective

States that desire to take a systems approach to managing their health care spending can turn to four major solutions, each of which is described below.

Implementing Statewide Disease Management

Florida, Mississippi, and Virginia have implemented statewide disease management programs for Medicaid enrollees with chronic conditions such as asthma, diabetes, hypertension, and cardiovascular disease. Other states, such as Texas, are experimenting with more limited disease management approaches.[9]

The purpose of disease management is for states to spend limited Medicaid dollars more efficiently by coordinating care for people with chronic conditions. This approach is intuitively appealing to states facing budget shortfalls because it avoids the pain of having to make direct cuts. Savings are not likely to be realized immediately, though, and disease management programs often require an up-front investment.

Because disease management is a relatively new approach, the verdict is still out on its effectiveness. However, a preliminary study from Virginia suggests that every dollar spent on disease management activities will ultimately lead to direct Medicaid savings of $3 to $4.[10]

Expanding the Reach of Medicaid Managed Care

Some states, such as Mississippi, New Jersey, New York, Texas, and Wisconsin, have expanded the reach of managed care to currently unmanaged populations and placed some of their aged, blind, and disabled populations in managed care. (As discussed earlier, these groups account for a disproportionate amount of Medicaid spending, although in most states they are not subject to managed care.)

In Houston, Texas, for example, a pilot project has been underway since 1997 that placed aged and some disabled recipients under fully capitated managed care. The pilot project has met with some success, as measured by positive consumer satisfaction surveys and the achievement of cost neutrality compared to previous expenditure levels.

As a result, the Texas legislature recently recommended expanding the reach of managed care to all aged, blind, and disabled Medicaid recipients through the use of primary care case management.

Several states, such as California, Missouri, Ohio, and South Carolina, are also experimenting with the Program of All-inclusive Care for the Elderly (PACE), which capitates the delivery of services to seniors who are dually eligible for Medicaid and Medicare.[11]

These approaches may be particularly appealing because they aim to manage Medicaid long-term care, which is likely the single largest health care expenditure that state governments make.

Developing Community-Based Options for Long-Term Care

Another approach states can take is to develop home- and community-based options for delivering long-term care. Forty-nine states currently have federal waivers allowing them to deliver long-term care to some 500,000 Medicaid recipients in the community for less than it would cost them to care for those individuals in an institution.

There is much room for expansion, however, as Medicaid still pays for long-term care in nursing facilities for approximately 1.5 million people and accounts for almost half of all nursing home expenditures nationally.[12] The 1999 Supreme Court decision in Olmstead v. L.C. and subsequent guidance from the federal government also strongly encourage the broader use of community-based alternatives to institutionalization.[13]

Changing Service Utilization of Existing Populations

A fourth systems approach is making programmatic changes that will affect service utilization. Several states, including Florida, Oklahoma, and Massachusetts, have contemplated or instituted prior authorization for certain classes of expensive prescription drugs in their Medicaid programs and mental health agencies. These restrictions have generally resulted in reduced use of the drugs for which prior authorization is required.

Another option is to increase co-payments and cost-sharing in Medicaid, SCHIP, and state agency programs; research has demonstrated that this will result in reduced uptake and usage of those programs.[14]

Yet another option is to reduce the benefits that are covered by each program. States must be cautious when using the latter approach, however. Some individu-

als will still need services that are no longer covered by the state, and this could result in a bounce-back effect.

Taking a systems approach does not make policymakers' choices any easier, but it gives them a broader perspective on the short- and long-term implications of their actions – which translates into more informed decision-making and more effective budget management.

Endnotes

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