California Health Care Foundation

HEALTH CARE THAT WORKS FOR ALL CALIFORNIANS

Personal Responsibility in Medicaid

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HMA Conference 2017

The Future of Medicaid Is Here

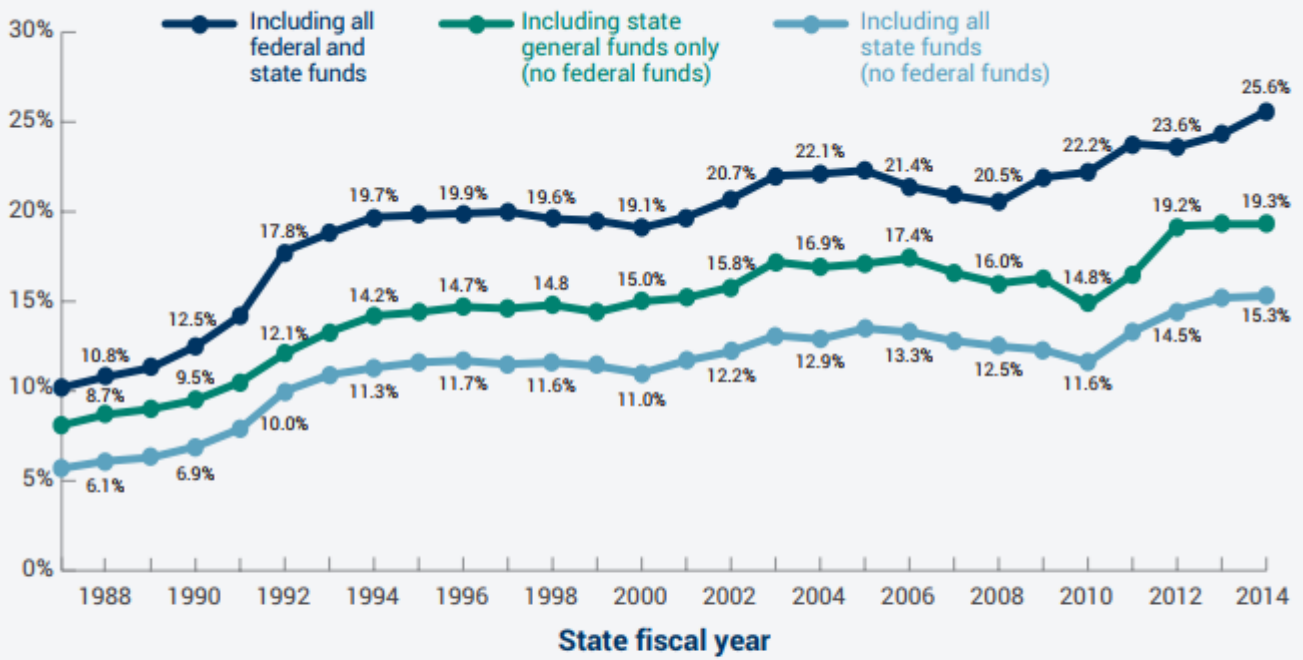
September 12, 2017

3 Questions

- **Context**: What problems are we trying to solve?
- **Evidence**: What do we know about the effects of premiums, cost sharing and work requirements on low-income populations?
- **Alternatives**: Are there better ways to address these challenges?

States Worry About Rising Medicaid Costs

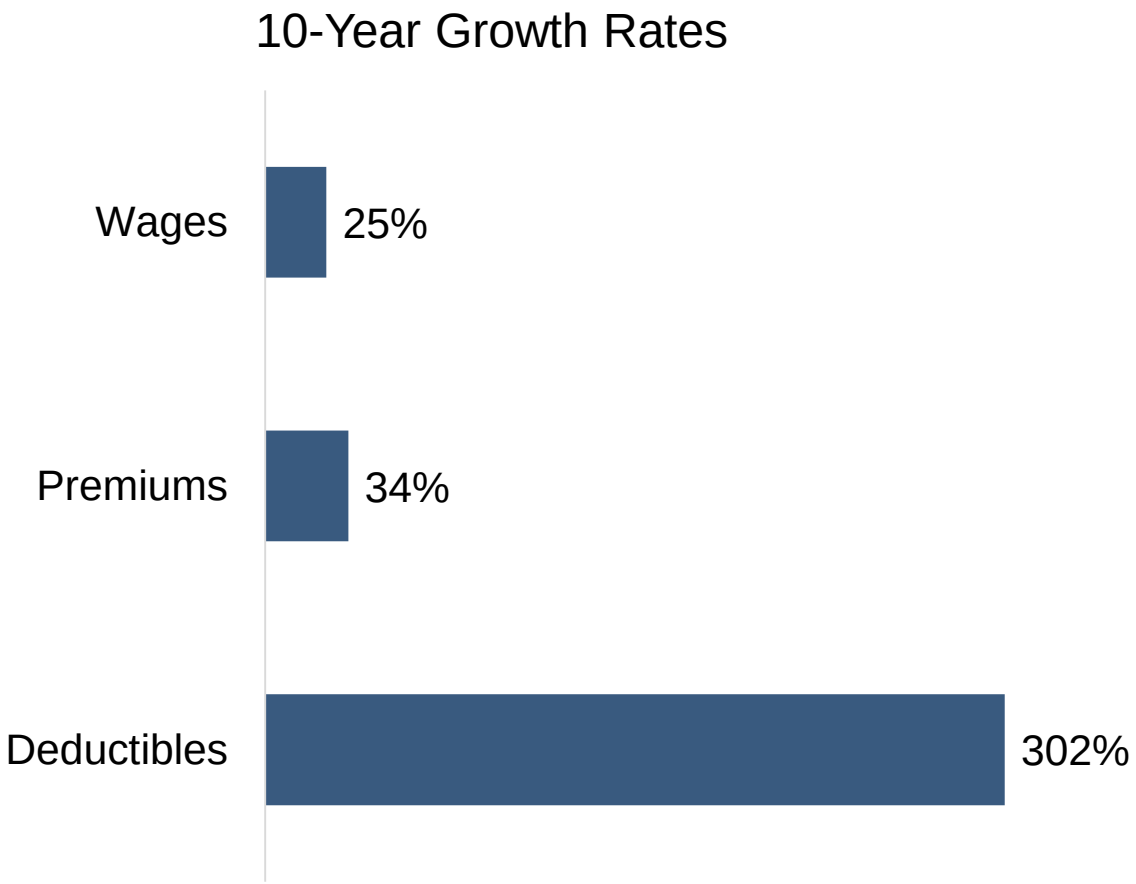
FIGURE 1-2. Medicaid's Share of State Budgets Including and Excluding Federal Funds, SFYs 1987–2014



Note: SFY is state fiscal year. The all federal and state funds category reflects amounts from any source. The state general funds only category reflects amounts from revenues raised through income, sales, and other broad-based state taxes. The all state funds only category reflects amounts from any non-federal source; these include state general funds, other state funds (amounts from revenue sources that are restricted by law for particular government functions or activities, which for Medicaid includes provider taxes and local funds), and bonds (expenditures from the sale of bonds, generally for capital projects). Amounts shown here reflect the most recent information available in cases where data for a given year were published and then updated in a subsequent report.

Source: MACPAC 2016e.

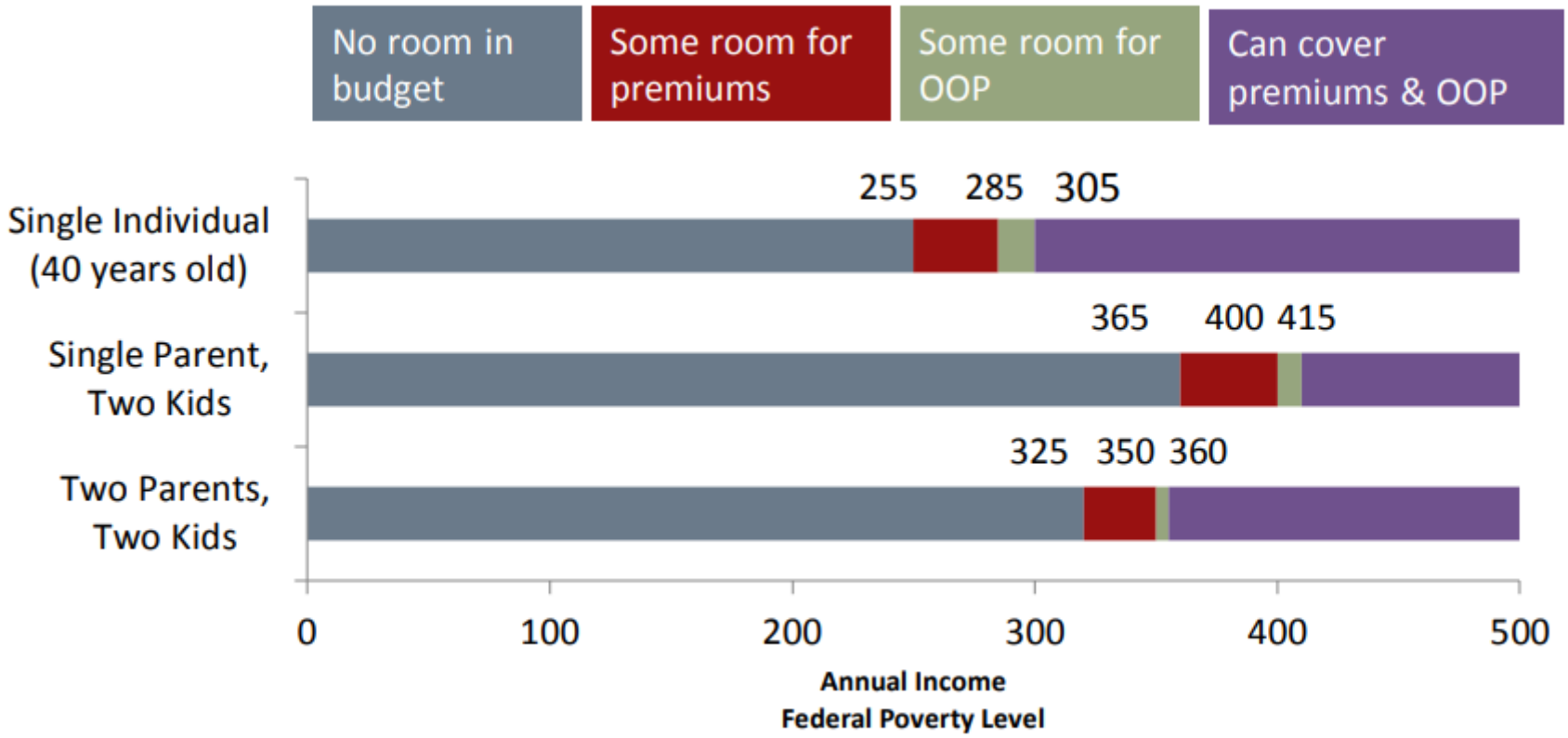
Employees With ESI Are Squeezed



Sources: Average Premiums and Deductibles 2006-16 from Kaiser/HRET Survey of Employer Sponsored Health Benefits, 2016. Median Net Wages 2005-15 from Social Security Administration, Office of the Actuary.

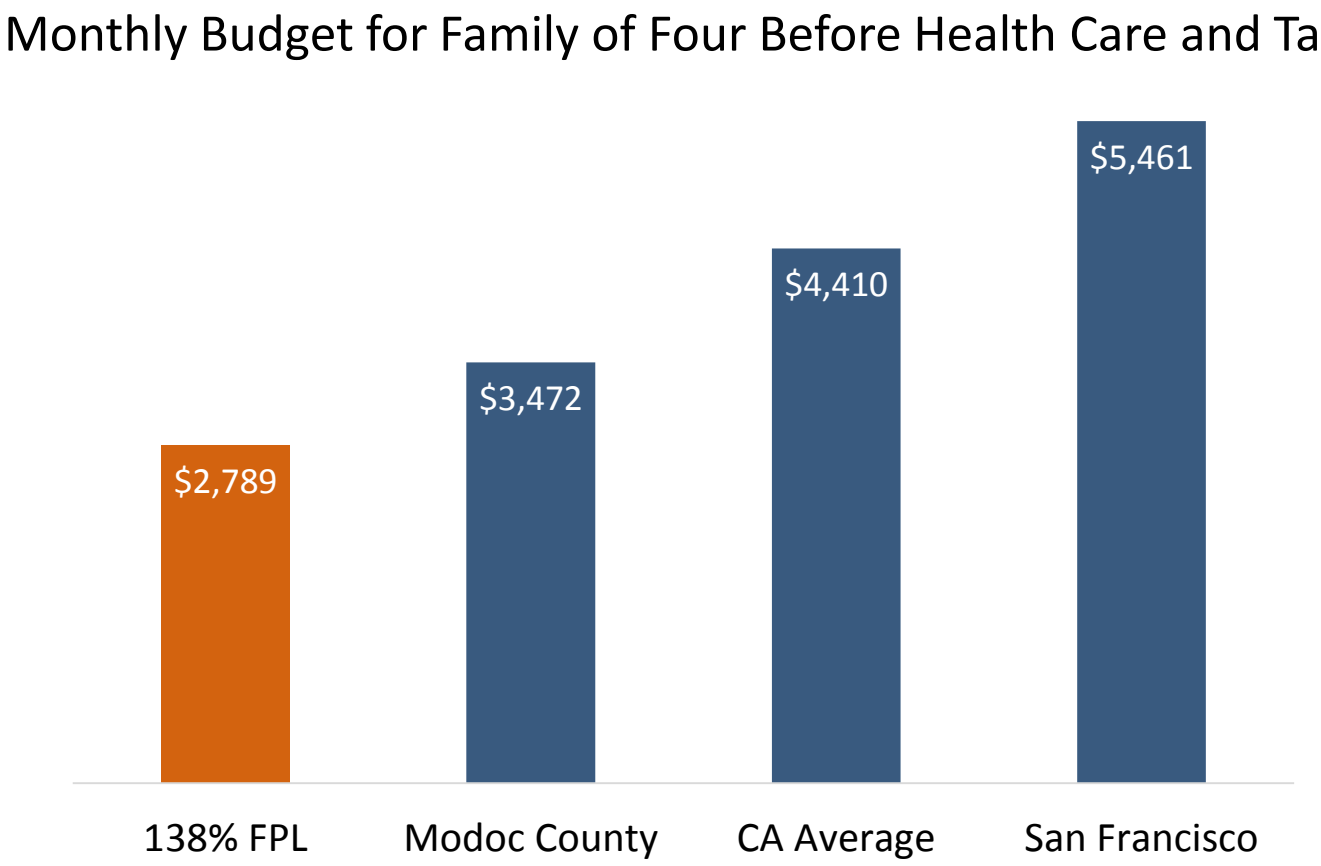
Health Care Costs Are A Problem for Many

Income at which San Francisco workers have room in budget for health care



Source: UC Berkeley Labor Center. Based on "Making Ends Meet" from California Budget and Policy Center.

Affordability is Statewide (& National) Challenge



Note: Expenditures include food, housing, child care, transportation and other miscellaneous costs. Health care, taxes, food stamps and child care subsidies excluded.
Source: UC Berkeley Labor Center based on estimates provided by California Budget and Policy Center, "Making Ends Meet," 2013, updated for 2015.

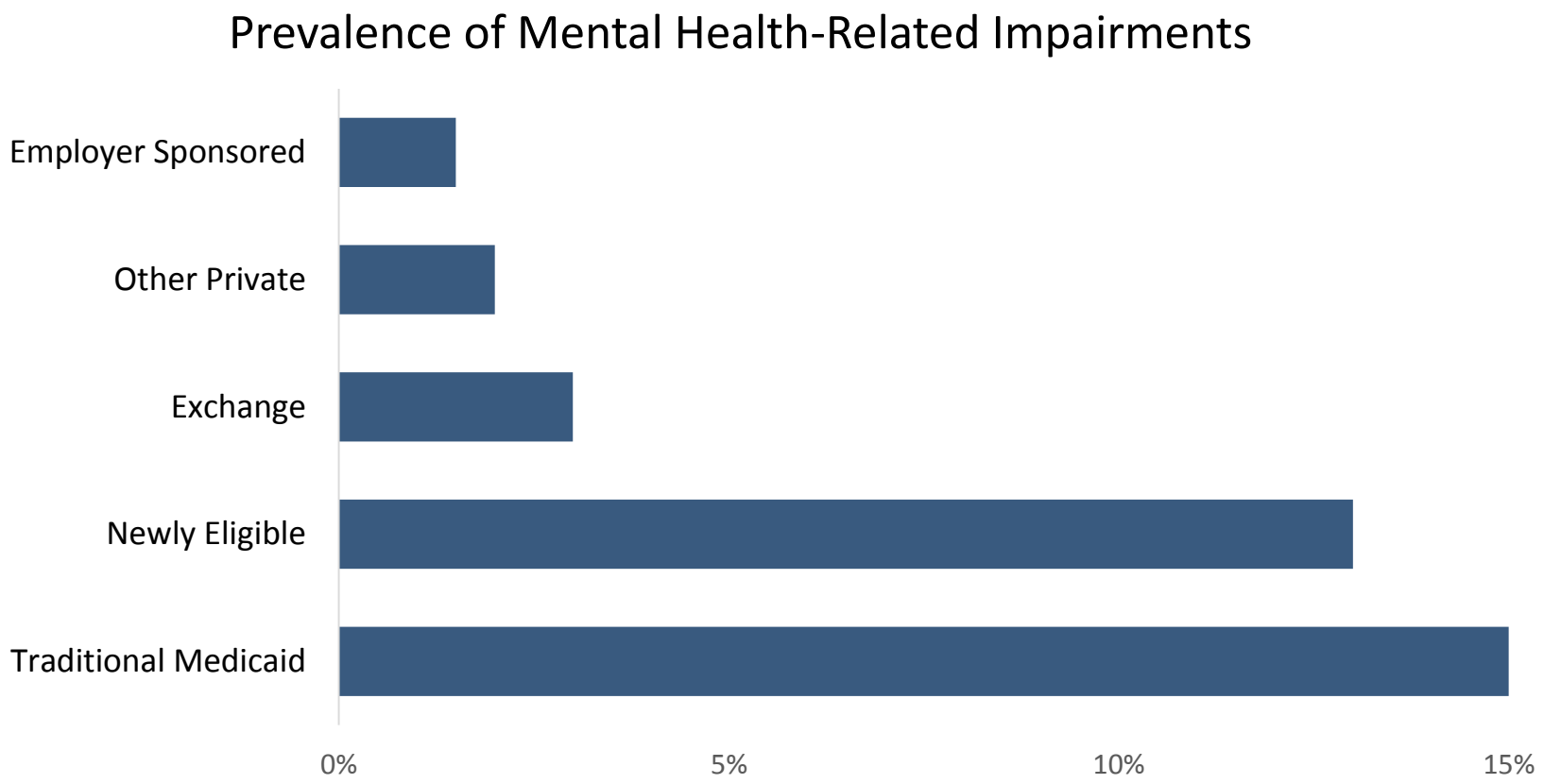
There Is Resentment Over Perceived Inequities

"I am a physical therapist in California. Today, I had an employed patient on ACA with a $35 copay/$2500 deductible and 4 visit MAX. Next, I had a Medicaid patient with zero copay, zero out-of-pocket and NO limits in the number of visits. Why do Medicaid patients get so many more visits than the patients actually contributing to the cost? Total inequity!"

Response to Facebook post of Senator Kamala Harris (D-CA) encouraging support for defending the ACA

Medicaid-Eligible Face Unique Challenges

Working Age Adults in Ohio

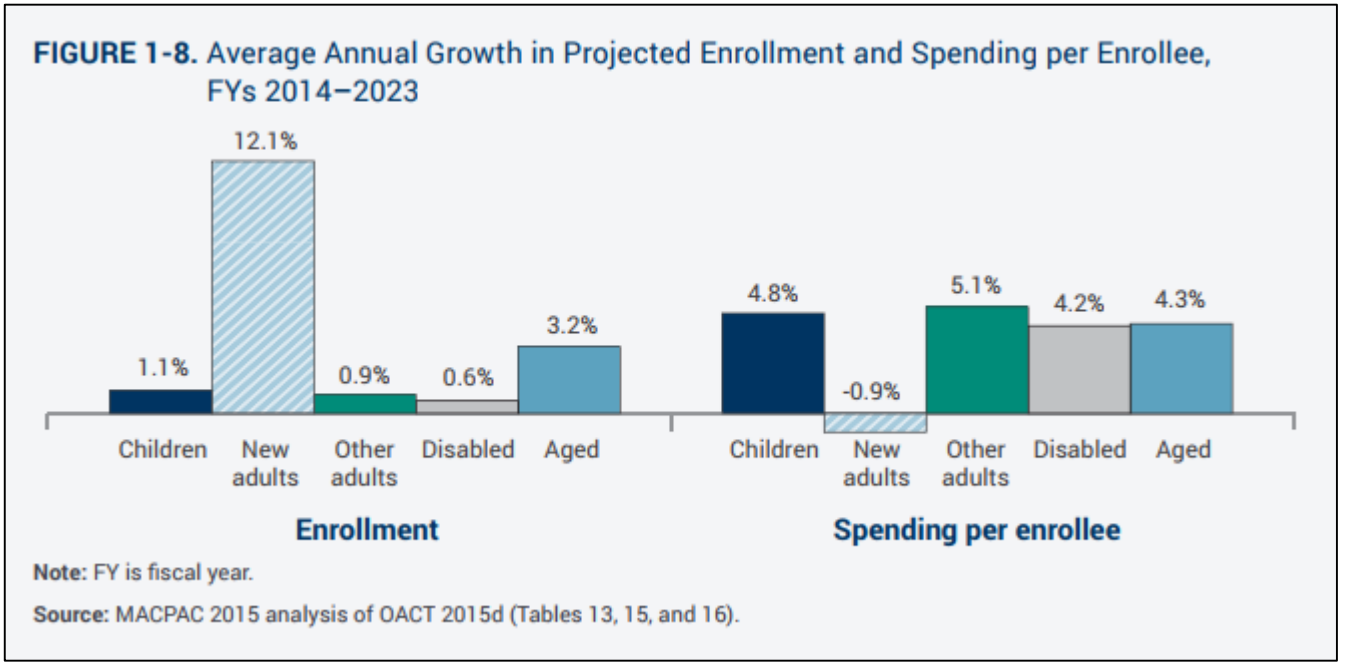


Source: R. Rohrbach, et al., "Health Status and Health Behaviors among Medicaid-Enrolled Working-Age Adults and Comparative Groups in Ohio," Ohio Medicaid Assessment Survey, The Ohio State University (June 2016).

... But Are Similar In Other Ways

People on Medicaid used the same average amount of care as similar people with private insurance.

Source: Sharon Long et al., “How Well Does Medicaid Work in Improving Access to Care.” Health Services Research, 2005.



Recent Reviews of Research

Summary of Evidence

Premiums and Cost Sharing

- Premiums serve as a barrier to obtaining and maintaining Medicaid and CHIP coverage among low-income individuals
  - Premiums at 1% of income -> Participation rates dropped by 15%
  - Premiums at 3% of income -> Participation rates drop by 50%
- Even relatively small levels of cost sharing are associated with reduced use of care, including necessary and effective services
  - Cost sharing can hinder effective management of chronic conditions and increase ED use
  - Copayments are particularly challenging for persons with chronic conditions.
- State savings from premiums and cost sharing in Medicaid and CHIP are limited -- except to the extent they reduce enrollment

Sources: S. Artiga, et al., "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation (June 2017); M. Buntin, et al., "Cost Sharing, Payment Enforcement, and Healthy Behavior Programs in Medicaid: Lessons from Pioneering States," Vanderbilt University School of Medicine (June 2017).

Summary of Evidence

Healthy Behavior Incentives

- Financial rewards in Medicaid have been effective incentives for one-time or short-term activities
- There is little support showing that healthy behavior incentives are effective in changing behaviors that influence health care costs the most
- Challenges
  - Enrollees are often not aware of the healthy behavior incentives
  - Low income populations face environmental factors that could make it difficult to comply

Sources: M. Buntin, et al., "Cost Sharing, Payment Enforcement, and Healthy Behavior Programs in Medicaid: Lessons from Pioneering States," Vanderbilt University School of Medicine (June 2017); M. Buntin, et al., "Developing and Implementing Health Savings Accounts in Medicaid: Lessons from Pioneering States," Vanderbilt University School of Medicine (June 2017).

Summary of Evidence

Work Requirements

- Most enrollees who would be subject to work requirements already work
- Among those not working:
  - 29% are taking care of family member
  - 20% are looking for work
  - 18% are in school
  - 17% are ill/disabled
  - 10% are retired

"…any increases in employment following the introduction of work requirements **are small and short-lived**, and that such requirements **fail to improve low-income people's employment prospects in the long run**. Voluntary job programs could help some get the skills needed to become more independent, without kicking people off the health insurance coverage they need."

Sources: L. Ku and E. Brantley, "Medicaid Work Requirements: Who's At Risk?", Health Affairs Blog (April 12, 2017); J. Bernstein and B. Spielberg, "Why Medicaid Work Requirements Won't Work," New York Times (March 22, 2017).

“Best Practices”

Cost Sharing

- Target copays to overused services
- Establish “grace period”
- Keep program simple
- Evaluate

Payment Enforcement

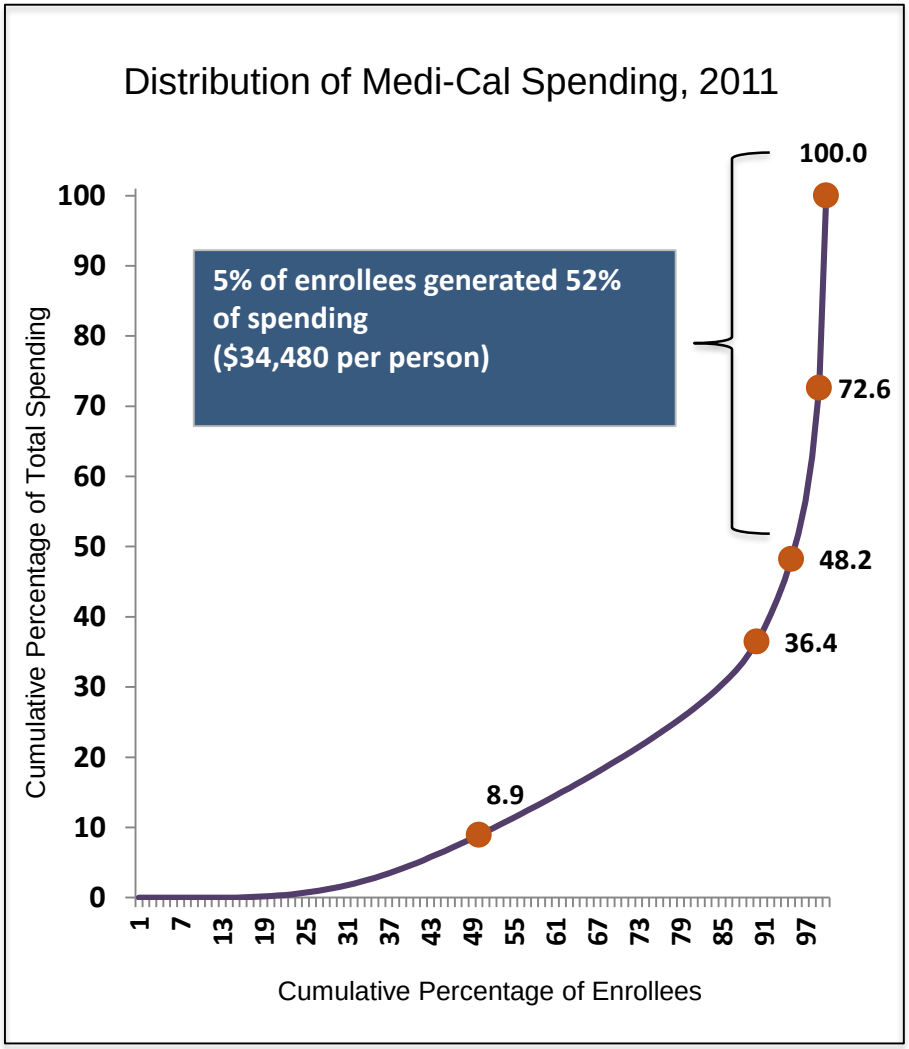
- Communicate expectations upfront
- Ensure penalties don’t disrupt care or limit work, school or child care
- View enforcement as communication opportunity
- Evaluate

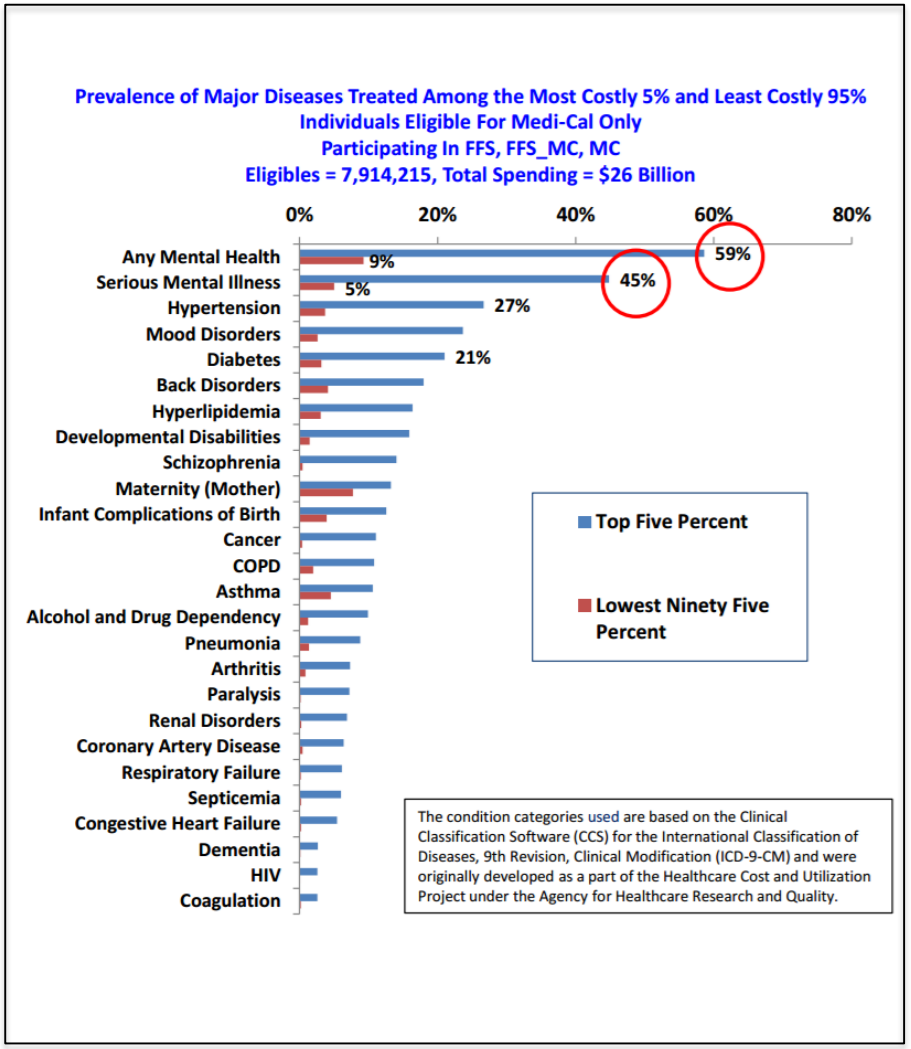
Healthy Behaviors

- Ensure enrollees understand incentives
- Create positive incentives for one-time or short-term activities
- Make incentives worthwhile
- Keep it simple
- Evaluate

Sources: M. Buntin, et al., “Cost Sharing, Payment Enforcement, and Healthy Behavior Programs in Medicaid: Lessons from Pioneering States,” Vanderbilt University School of Medicine (June 2017); M. Buntin, et al., “Developing and Implementing Health Savings Accounts in Medicaid: Lessons from Pioneering States,” Vanderbilt University School of Medicine (June 2017).

Want to Curb Spending? Go Where the Money Is





Source: DHCS, 2015.
Note: Among Medi-Cal-only enrollees in managed care, FFS or both

Delivery System Transformation in Medi-Cal

	Pay for Value, Not Volume		Better Care for Higher Cost Populations	
	Medi-Cal PRIME	Medi-Cal FQHC APM	Whole Person Care Pilots	Medi-Cal Health Home Program
Goal	Transform public hospitals into entities that take responsibility for the quality and cost of their patients inside the hospitals and in the community and move toward alternative payment models	Establish payment system for FQHCs that fosters greater accountability for performance (cost and quality) and provides greater flexibility in how care is provided	Coordinate health, behavioral health, and social services for Medi-Cal beneficiaries who are frequent users of multiple systems	To coordinate the full range of physical health, behavioral health, and community-based long term services and supports needed by beneficiaries with chronic conditions.
Funding	Up to $3.7 billion in Federal funding over 5 years	Standard Federal match	$3 billion over 5 years (50% federal; 50% local)	90% Federal match
Partners	Designated public, district and municipal hospitals	Federally Qualified Health Centers	County agencies, designated public hospitals, district municipal public hospitals	Medi-Cal plans and community-based care management entities
Locations	Statewide	Participants TBD	18 counties (more TBD)	29 counties
Start	2016	2018 (Proposed)	2017	2018
Link	http://www.dhcs.ca.gov/provgovpart/Pages/PRIME.aspx	http://www.dhcs.ca.gov/services/Pages/FQHC_APM.aspx http://www.careinnovations.org/programs-grants/payment-redesign	http://www.dhcs.ca.gov/services/Pages/WholePersonCarePilots.aspx	http://www.dhcs.ca.gov/services/Pages/HealthHomesProgram.aspx

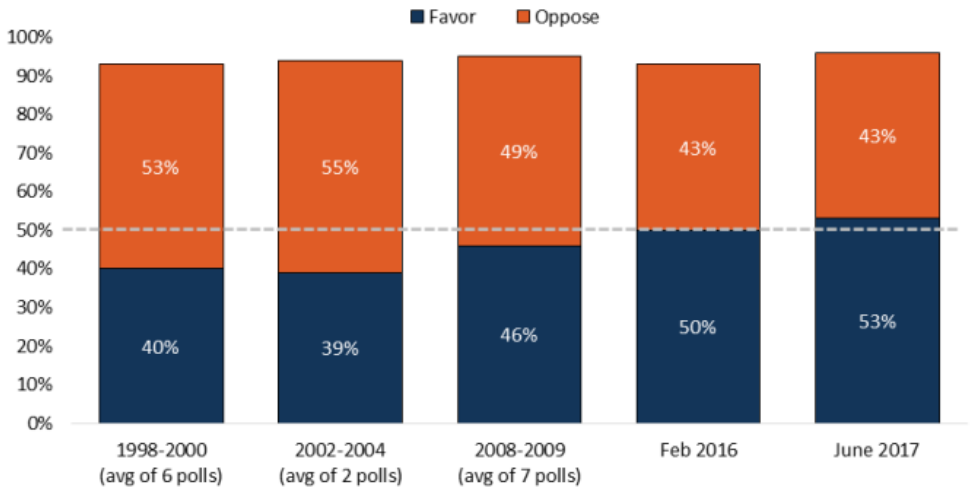
Others include: Drug Medi-Cal Organized Delivery Systems, Dental Transformation Initiative, Global Payment Program, CCS Pilot Project

Unite Rather Than Divide

Figure 1

Modest Increase in Support for Single Payer Health Care in 2017

Percent who favor or oppose a national health plan in which all Americans would get their insurance from a single government plan



NOTE: Question wording varied slightly over time. See topline for full question wording.
SOURCE: Kaiser Family Foundation Polls

Discussion