PUBLICLY PROVIDED HEALTH INSURANCE FOR THE NONELDERLY POOR: CAN WE SAVE MONEY SAFELY?

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With many states and the federal government facing budget deficits, lawmakers across the country are looking to reduce government expenditures wherever feasible. In this article, Professor Kaestner examines the current state of publicly provided health insurance and makes several recommendations designed to reduce government spending with respect to two programs: Medicaid and the State Children's Health Insurance Program (SCHIP). Focusing on spending directed at the non-elderly poor, Professor Kaestner argues that significant savings can be achieved in two general areas: reducing the amount of inefficient care and narrowing the income range necessary to participate in Medicaid or SCHIP. Professor Kaestner sets forth several specific policy changes designed to generate savings in these two areas, and argues that these savings can be realized without jeopardizing the physical or financial health of the nonelderly poor.

I. INTRODUCTION

Health insurance provides a relatively low-cost way for individuals to pay for medical care to restore their health after the onset of adverse health events.[1] Health insurance enables families to greatly reduce the financial burden associated with treating many common illnesses and to finance medical care for some illnesses that would otherwise be beyond their means.[2] In short, health insurance provides families with the financial resources to remain healthy and productive members of society.

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I thank Sanders Korenman, John Holahan, Jack Knott, and the participants at the First Law and Medicine Symposium held at the University of Illinois at Urbana-Champaign.

1. *See* sources cited *infra* note 27 and accompanying text.

2. David M. Cutler & Richard J. Zeckhauser, *The Anatomy of Health Insurance*, *in* HANDBOOK OF HEALTH ECONOMICS 563, 572 (Anthony J. Cuyler & Joseph P. Newhouse eds., 2000).

Health insurance is not free, however, and like many other goods and services, low-income families have less of it than high-income families.[3] In addition, informational problems associated with providing insurance (e.g., adverse selection) raise the cost of health insurance beyond what is actuarially fair, further hindering low-income families from purchasing insurance.[4] A lack of health insurance could prevent these families from remaining healthy and productive members of society. To address this problem, government subsidizes health insurance for the poor through Medicaid and the State Children's Health Insurance Program (SCHIP).[5]

The federal and state governments jointly finance Medicaid and SCHIP; the federal government absorbed fifty-seven percent of the total cost in 1998.[6] While the cost of these programs has long been an issue of public concern, the current economic downturn and renewed double-digit percentage annual increases in the growth of health care expenditures have brought the issue of cost to the forefront.[7] State budget shortcomings have the nation's governors looking for ways to balance their budgets;[8] not surprisingly, big-budget programs are high on the list of budget cuts.[9] One such program is Medicaid, the second largest expenditure of state governments, representing twenty percent of all state expenditures.[10] More worrisome to state officials is that Medicaid's share of state budgets is growing as health care costs increase at double-digit rates.[11] Lately then, the question on every governor's mind is: How can Medicaid expenditures be reduced?

The purpose of this article is to provide an answer to that question. Specifically, I develop a set of policy recommendations to reduce spending on publicly provided health insurance for the nonelderly poor.[12] I focus on the nonelderly poor (though this group accounts for only about thirty percent of all Medicaid payments) because enrollment numbers within this group, particularly children, have experienced the greatest increase in the last fifteen years.[13] The primary cause of this enrollment increase is expanded eligibility, and there is widespread political support to

3. Margaret E. Brown et al., *Monitoring the Consequences of Uninsurance: A Review of Methodologies,* 55 MED. CARE RES. & REV. 177, 178–79 (1998).

4. Cutler & Zeckhauser, *supra* note 2, at 607.

5. 42 U.S.C. §§ 1396, 1397aa (2000).

6. *See* DEP'T OF HEALTH & HUMAN SERVS., A PROFILE OF MEDICAID: CHARTBOOK 2000 48 (Sept. 20), *available at* http://cms.hhs.gov/charts/medicaid/2Tchartbk.pdf (last visited Nov. 18, 2003).

7. *See* THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE ROLE OF MEDICAID IN STATE BUDGETS 1 (2001) [hereinafter KAISER COMM'N].

8. *Id.* at 2.

9. *Id.*

10. *See* NAT'L GOVERNORS ASS'N, MEDICAID LEGISLATIVE ANALYSIS (Dec. 23, 2002), *available at* http://www.nga.org/nga/lobbyIssues/1,1169,D_1996,00.html (last visited Nov. 18, 2003).

11. States reported, for example, that prescription drug costs grew fifteen to twenty percent during fiscal year 2001. *See* KAISER COMM'N, *supra* note 7, at 6.

12. Medicaid also covers the elderly and low-income disabled individuals.

13. *See* DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6, at 13.

maintain or even further expand eligibility.[14] Indeed, few states have reduced eligibility in response to recent budget pressures.[15] An implication of this widespread support is that most lawmakers view Medicaid and SCHIP as unqualified successes that do not merit budget-cutting scrutiny. This article presents evidence challenging that view.

The objective of this article is to identify ways to reduce spending on publicly provided health insurance for the nonelderly poor without either significantly increasing the financial risk or adversely affecting the health of individuals within this group. As this article will show, the proposed policies can generate significant savings while meeting these criteria. Specifically, I argue that the government should cap Medicaid and SCHIP income eligibility levels at a maximum of 200% of the federal poverty level (FPL).[16] For families with incomes between 150% and 200% of the FPL, the government should implement premiums and cost sharing (e.g., copayments) equivalents to those in many employer-provided plans.[17] In addition, the following steps could be taken individually or in concert: first, the government should replace the open-ended entitlement to unlimited outpatient care with medical savings accounts; second, it should expand the use of mandatory managed care in plans that are reimbursed on a per capita basis; third, it should reduce per capita payments to managed care plans; and finally, states should be allowed greater flexibility to design optimal insurance plans.[18] I estimate that these steps can shave approximately $10 billion (1999 dollars) per year off the cost of providing health insurance to the nonelderly poor, and even more if some of these recommendations are applied to other populations covered by Medicaid and SCHIP.[19]

II. POSITIVE AND NEGATIVE ASPECTS OF PUBLICLY PROVIDED HEALTH INSURANCE

Publicly provided health insurance has several benefits. First, and most importantly, it eliminates the financial risk associated with unpredictable adverse health events and the desire to restore health to pre-event levels.[20] Thus, when illness strikes, low-income families can seek appropriate medical care without being constrained by financial considerations. This results in an increase in the use of medical services by low-income families who would otherwise be unable to afford medical care.[21]

14. *See id.*
15. *See* KAISER COMM'N, *supra* note 7, at 10.
16. *See infra* text accompanying notes 61–68.
17. *See infra* notes 69–71 and accompanying text.
18. *See infra* notes 73–84 and accompanying text.
19. *See* discussion *infra* Part III.
20. Cutler & Zeckhauser, *supra* note 2, at 631.
21. *See* JOSEPH NEWHOUSE, FREE FOR ALL?: LESSONS FROM THE RAND HEALTH INSURANCE EXPERIMENT 45–47 (1993).

Second, publicly provided health insurance allows low-income families to use income to buy other essential items, such as food and shelter.[22] Finally, the use of medical services and the additional consumption (e.g., better nutrition) made feasible by publicly provided health insurance increases the likelihood and speed of restoring one's health after the onset of illness.

It is also important to understand what publicly provided insurance cannot do. Insurance cannot prevent the onset of many illnesses because these illnesses are not preventable by timely medical care. For example, the four leading causes of death among children are accidents and injuries, congenital anomalies, malignant neoplasms, and homicide, all of which are largely not preventable by medical care.[23] The incidences of these diseases are, therefore, virtually unaffected by insurance; health insurance mainly serves to restore health after the onset of disease. This point is underscored by findings from the RAND Health Insurance Experiment.[24] Results from this large scale social experiment indicate that increases in medical care use associated with more generous health insurance had little effect on the health of children or adults.[25]

Thus, it is not clear whether publicly provided health insurance, and the increased use of medical services associated with that insurance, have any positive effects on general health. For example, health insurance is not likely to significantly affect obesity, smoking, and other causes of many of today's most important health problems. Moreover, several evaluations of Medicaid eligibility expansions for pregnant women and children find no health improvements associated with expanded insurance coverage, and inconclusive evidence concerning the effect of public insurance on prenatal care utilization.[26] Finally, two recent surveys of the effects of health insurance on health conclude that the evidence of a pro-

22. *See* Jonathan Gruber & Aaron Yelowitz, *Public Health Insurance and Private Savings*, 107 J. POL. ECON. 1249, 1270–71 (1999); *see also* HELEN LEVY & THOMAS DELIERE, WHAT DO PEOPLE BUY WHEN THEY DON'T BUY HEALTH INSURANCE? (Joint Ctr. for Poverty Research, Working Paper No. 296, 2002), *available at* http://www.jcpr.org/wpfiles/levy_deleire.pdf (last visited Nov. 18, 2003).

23. Robert N. Anderson, *Deaths: Leading Causes for 2000*, NAT'L VITAL STAT. REP., Sept. 16, 2002, at 13.

24. *See generally* NEWHOUSE, *supra* note 21.

25. *Id.* at 259 ("[T]he substantial increase in acute and preventive services induced by free care did not manifest itself in measurable improved health outcomes for children."); *id.* at 243 ("Our results show that the 40 percent increase in services on the free-care plan had little or no measurable effect on health status for the average adult.").

26. *See* Lisa Dubay et al., *Changes in Prenatal Care Timing and Low Birth Weight by Race and Socioeconomic Status: Implications for the Medicaid Expansions for Pregnant Women*, 36 HEALTH SERVICES RES. 373 (2001); Arnold Epstein & Joseph Newhouse, *Impact of Medicaid Expansion on Early Prenatal Care and Health Outcomes,* HEALTH CARE FINANCING REV. 7 (1998); Jennifer Haas et al., *The Effect of Providing Health Coverage to Poor Uninsured Pregnant Women in Massachusetts*, 269 JAMA 87 (1993); Joyce Piper et al., *Effects of Medicaid Eligibility Expansion on Prenatal Care and Pregnancy Outcome in Tennessee,* 264 JAMA 2219 (1990). *But see* Janet Currie & Jonathan Gruber, *Saving Babies: The Efficacy and Cost of Recent Changes in the Medicaid Eligibility of Pregnant Women*, 104 J. POL. ECON. 1263 (1996) (finding a positive effect of Medicaid on infant health).

tective effect of health insurance is weak.[27] Thus, it appears that the main health benefit of health insurance is the restoration of health after the onset of illness.

Publicly provided health insurance also engenders several negative consequences. One of the most important of these negative consequences is the overuse of medical services because of *ex post* moral hazard.[28] Since insurance greatly reduces the price of medical care in times of illness, the consumer overuses care, seeking and receiving it when the benefits are less than the costs.[29] This problem is likely to be particularly severe in the case of public insurance because the cost to the insured is zero due to the virtual absence of consumer cost sharing (e.g., deductibles and copayments).[30] A related adverse consequence of publicly provided insurance is *ex ante* moral hazard; individuals may invest less in health because insurance has reduced the financial loss associated with illness caused by unhealthy behaviors, such as smoking, improper diet, and lack of exercise.[31] Finally, publicly provided health insurance may cause a substitution of public for private insurance—sometimes referred to as crowd out.[32] One can consider this a negative consequence if the targets of publicly provided health insurance are those families that otherwise would not have health insurance. On the other hand, if the goal is to provide all families below a certain level of income with subsidized health insurance, then crowd out is not problematic.

A point that is somewhat obscured by other criticisms of the Medicaid and SCHIP programs is that these programs provide very generous health insurance coverage.[33] These programs cover an extensive array of inpatient and outpatient services, and virtually all states provide coverage for optional services, such as dental care, eye care, chiropractic care, prescription drugs, and physical therapy.[34] In addition, all states extend

27. *See* HELEN LEVY & DAVID MELTZER, WHAT DO WE REALLY KNOW ABOUT WHETHER HEALTH INSURANCE AFFECTS HEALTH? (Joint Ctr. for Poverty Research, Working Paper No. 275, 2001); Brown et al., *supra* note 3.

28. Cutler & Zeckhauser, *supra* note 2, at 576–90.

29. It is important to recognize that, *ex ante*, consumers would not purchase insurance to cover the cost of medical care for which the benefits are less than the costs. So any such care received, even if the benefits of that care are positive, is wasteful.

30. Cutler & Zeckhauser, *supra* note 2, at 569–71.

31. While systematic evidence on this point is scarce, it is naïve to believe that this does not occur. *See*, *e.g.*, John Broder, *Problem of Lost Health Benefits Is Reaching into Middle Class*, N.Y. TIMES, Nov. 25, 2002, at A1. A couple who lost health insurance coverage and could therefore no longer afford some prescription drugs reported changing their diet and exercise habits as a way to offset the consequences of not buying the prescription drugs.

32. *See* Linda J. Blumberg et al., *Did the Medicaid Expansions for Children Displace Private Insurance? An Analysis Using the SIPP*, 19 J. HEALTH ECON. 33 (2000); David M. Cutler & Jonathan Gruber, *Does Public Insurance Crowd out Private Insurance?*, 111 Q. J. ECON. 391 (1996); Lisa Dubay & Genevieve Kenney, *The Effects of Medicaid Expansions on Insurance Coverage of Children*, FUTURE CHILD., Spring 1996, at 152, 155–59; Esel Y. Yazici & Robert Kaestner, *Medicaid Expansions and the Crowding out of Private Health Insurance Among Children*, 37 INQUIRY 23 (2000).

33. *See* THE KAISER COMM'N ON MEDICAID & THE UNINSURED, POLICY BRIEF: MEDICAID "MANDATORY" AND "OPTIONAL" ELIGIBILITY AND BENEFITS (2001) [hereinafter POLICY BRIEF].

34. *Id.*

coverage to optional populations.[35] For example, these programs typically cover near-poor children and near-poor disabled persons, and the definition of near-poor sometimes includes families with incomes up to 350% of the FPL.[36] They also rarely use deductibles and other cost sharing mechanisms.[37] In fact, there is mandated first dollar coverage and no cost sharing (i.e., copayments) for approximately fifty percent of Medicaid recipients—those automatically covered, such as children, pregnant women, and disabled SSI recipients.[38] Moreover, there are very low allowable rates of cost sharing for most other recipients, for example, deductibles of two dollars per month and copayments between fifty cents to three dollars. Finally, persons with private health insurance coverage can easily switch to Medicaid and SCHIP because there is no effective mechanism to prevent such switching.[39]

Unfortunately, the generosity of Medicaid and SCHIP exacerbates the problems associated with publicly provided insurance in return for relatively little gain. The virtual absence of cost sharing and the extensive coverage of services (including those that are quite responsive to price changes) increase the frequency of *ex post* moral hazard—the use of marginally beneficial services.[40] Just how much medical care associated with publicly provided insurance is inefficient, or produces benefits outweighed by the costs of care, is difficult to establish with certainty. Estimates from the economics literature suggest, however, that it is between ten to thirty percent of all medical spending.[41] To make matters worse, these estimates only represent averages; thus, the amount of overuse is likely to be much higher for some services, such as outpatient care.[42] In addition, research on the extent of small area variation and the appropriateness of care suggests that as much as thirty percent of all surgical procedures are inappropriate or unnecessary.[43]

These estimates suggest that a significant amount of medical care is inefficient and that the moral hazard problem associated with publicly provided insurance is not a trivial one. But there have been few estimates of this effect that are specific to the low-income population, the group most affected by publicly provided health insurance. To ascertain

35. *Id.*

36. *See* The Henry J. Kaiser Family Found., State Health Facts Online, *at* http://www.statehealthfacts.kff.org (displaying chart of Income Eligibility Levels for Children Under SCHIP, as a Percent of Federal Poverty Level) (last visited Nov. 18, 2003) [hereinafter State Health Facts Online].

37. *See* POLICY BRIEF, *supra* note 33.

38. *See id.*

39. *See* Cutler & Gruber, *supra* note 32, at 401–02.

40. Cutler & Zeckhauser, *supra* note 2, at 576–90.

41. *See* Roger Feldman & Bryan Dowd, *What Does the Demand Curve for Medical Care Measure?,* 12 J. HEALTH ECON. 193 (1993); Willard Manning et al., *Health Insurance and the Demand for Medical Care: Evidence from a Randomized Experiment,* 77 AM. ECON. REV. 251 (1987).

42. *See* Manning et al., *supra* note 41.

43. *See* Lucian L. Leape, *Unnecessary Surgery*, 24 HEALTH SERVICES RES. 351 (1989); Charles Phelps, *Diffusion of Information in Medical Care*, J. ECON. PERSP., Summer 1992, at 23; John Wennberg, *Dealing with Medical Practice Variation: A Proposal for Action*, HEALTH AFF., Spring 1984, at 6.

whether these estimates were approximately correct for the population of interest, I examined the association between health insurance—private and public—and medical care use for a sample of nonelderly, low-income (less than 200% of FPL) persons drawn from the 2000 National Health Interview Survey.[44] I obtained separate regression estimates for persons in four categories of self-reported health: excellent, very good, good, and fair or poor. Each regression model included controls for age, race, gender, family income, parental education, family structure, and employment status. I also conducted separate analyses for children and adults. The results from these analyses indicate that, relative to the uninsured, physician visits are 50% and 100% more frequent for those with private and public insurance, respectively. Acknowledging that there may be some selection, as economic theory predicts that the uninsured are likely to be healthier persons, these large estimates indicate that insurance coverage, particularly public insurance, results in significant overutilization of physician services.[45] These estimates are also consistent with estimates previously reported by Manning et al.[46]

One can also find another way in which the generosity of publicly provided insurance is problematic in the liberal income eligibility thresholds, which increase the likelihood of crowd out of private insurance.[47] Most SCHIP programs almost always cover children in families with incomes of 200% of the FPL ($30,520 in 2003); in some states the threshold extends to 350% of the FPL ($53,410 in 2003). Approximately eighty percent of children from families with incomes between 200% and 400% of the FPL had private insurance before the government expanded income eligibility thresholds in the late 1990s.[48] Thus, expanding public insurance to children from families in this income group risks a significant amount of crowd out.[49] Moreover, among children in this income group who are uninsured, seventy-five percent were reported to be in excellent or very good health, suggesting that these families may rationally forego insurance for some period to free up resources for other purposes.[50] The upshot is that there appears to be little reason to extend publicly provided insurance to families with incomes above 200% of FPL; a large majority are able to obtain private insurance and at least some portion that do not, do so for rational reasons—trading off relatively little risk of financial loss due to illness for more current income.

44. Data from the 2000 National Health Interview Survey are available at http://www.cdc.gov/nchs/nhis.htm (last visited Sept. 30, 2003).

45. *See* Cutler & Zeckhauser, *supra* note 2, at 576–80.

46. *See* Manning et al., *supra* note 41, at 269.

47. Cutler & Gruber, *supra* note 32, at 391–92.

48. *See* John Holahan & Mary Beth Pohl, *Changes in Health Insurance Coverage: 1994-2000*, HEALTH AFF: WEB EXCLUSIVES, Apr. 3, 2002, *at* http://www.healthaffairs.org/WebExclusives/2103Holahan.pdf (last visited Nov. 18, 2003).

49. Cutler & Gruber, *supra* note 32, at 392, 400–01.

50. Author's calculation from National Health Interview Survey of the proportion of uninsured reporting excellent or very good health. *See supra* note 44 (providing data from survey).

In sum, the generosity of publicly provided health insurance exacerbates the moral hazard and crowding out problems associated with such insurance. And in return for this generosity, there are few health benefits, as there is little evidence that generous insurance coverage improves health more than catastrophic coverage, or reduces the number of uninsured since few near-poor families have difficulty obtaining insurance. Thus, it may be possible to reduce the generosity of publicly provided health insurance without adversely affecting the financial or physical health of low-income families.

III. POTENTIAL SAVINGS

The next task is to identify how much money can be saved by reducing the amount of wasteful or inefficient care and the amount of crowd out associated with publicly provided insurance for the nonelderly poor. I begin with an analysis related to reducing the amount of inefficient care. In 1999, Medicaid payments to health care providers totaled $153 billion, of which approximately $45 billion was spent on care for nonaged adults and children.[51] Of this amount, approximately $11 billion, or twenty-five percent, was for hospital inpatient services.[52] Assuming there is no overuse of inpatient hospital services and that all such care received has benefits greater than or equal to costs, this leaves $34 billion in spending. The critical question is how much of the $34 billion is spent on marginally beneficial services.

To answer this question, I use estimates from the literature, for example in Manning et al.[53], and from my own analysis of how much care is inefficient—benefits less than the costs. Based on these estimates, it seems reasonable to assume that 20% of medical services are of low value (inefficient). If so, then $6.8 billion can be saved by eliminating such care. If we assume that 30% of such services are unnecessary, then savings go up to $10.2 billion. Further savings will be realized if a greater portion of services are assumed to be characterized by overuse. For example, if we assume that twenty percent of inpatient services, or about $2 billion, are characterized by over overuse and unnecessary care, then the previous figures on savings would be $7.2 billion and $10.8 billion, respectively. These figures represent between 4% and 7% of total Medicaid expenditures and between 15% and 25% of Medicaid expenditures on nonaged adults and children.

One can apply a similar analysis to spending in the SCHIP program. In 2002, 3.8 million children were enrolled in SCHIP programs.[54] Assum-

51. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., KEY DATA ON HEALTH CARE FINANCING tbl.85, *available at* http://www.cms.hhs.gov/Review/Supp/ (last modified Oct. 23, 2003).

52. *Id.* The twenty-five figure is lower than for other demographic groups reflecting the fact that children are relatively healthy.

53. *See* Manning et al., *supra* note 41.

54. *See* DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6.

ing that spending for each child in SCHIP was the same as it was for Medicaid, about $1300 per year in 1999,[55] then payments to vendors for the SCHIP program in 2002 would be approximately $4.9 billion using 1999 dollars. As indicated above, between 15% and 25% of this figure represents spending on services where the benefits are less than the cost.[56] Adding this to the previous figures for Medicaid yields a total savings of between $7.5 and $12.5 billion for both programs.

To summarize, the Medicaid and SCHIP programs spend about $50 billion (1999 dollars) per year on medical care for nonaged adults and children.[57] Estimates obtained in the analysis reported earlier suggest that between $7.5 and $12.5 billion (in 1999 dollars) per year, or between 15% and 25%, of the $50 billion in spending is wasteful—the benefits of such care are less than the costs. Although this is a significant amount of money, this estimate may also be conservative, as these figures assume that almost all inpatient care is efficient and that the benefits of such care outweigh the costs.

Another potential avenue for savings is to reduce income eligibility thresholds for Medicaid and SCHIP programs. The rationale for this is that few families above 200% of the FPL are having trouble obtaining private insurance, as shown by the fact that eighty percent of these families had private insurance prior to the eligibility expansions in the 1990s.[58] This suggests that there is little need to expand insurance to this group. Doing so risks engendering a significant amount of substitution of public for private insurance. Indeed, the SCHIP legislation is clear on this point and restricts eligibility to families who are uninsured.[59] Congress's intent was not to provide public insurance for all families under a certain income level, but only to those families that otherwise could not obtain private insurance.[60] In practice, however, there is little that states can do to enforce such rules, and families can freely switch between private and public insurance.

How many children in SCHIP are from high-income families? The estimates I obtained from the 2000 National Health Interview Survey indicate that approximately eleven percent of all Medicaid and SCHIP children come from families with incomes over 200% of the FPL.[61] Ten states have expanded eligibility levels to children in families earning between 200% and 350% of the FPL.[62] In 2002, there were approximately

55. *See id.*
56. *See* Manning et al., *supra* note 41.
57. *See* DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6.
58. *See* Holahan & Pohl, *supra* note 48; State Health Facts Online, *supra* note 36.
59. *See* DEP'T OF HEALTH & HUMAN SERVS., *supra* note 6, at 72.
60. *Id.*
61. *See supra* note 44 (providing data from the 2000 National Health Interview Survey).
62. *See* State Health Facts Online, *supra* note 36. The ten states are: California, Connecticut, Minnesota, Missouri, New Hampshire, New Jersey, New Mexico, Rhode Island, Vermont, and Washington.

twenty-four million children in Medicaid and SCHIP;[63] thus, based on the eleven percent figure obtained from the 2000 NHIS, approximately 2.6 million children participating in Medicaid and SCHIP are from families with incomes greater than 200% of FPL. This is a conservative estimate because enrollment in SCHIP has increased significantly since 2000.[64] At a per child cost of $1300 (1999 dollars) per year, eliminating coverage for children from families with incomes over 200% of FPL will yield a savings of approximately $3.4 billion (1999 dollars).[65] Even more savings can be achieved by eliminating coverage for adults in these families, as some states have allowed parents to be covered at relatively minimal cost.[66]

The primary purpose of the preceding section was to examine whether it is worth trying to save money by reducing the generosity of care for nonaged adult and child recipients of publicly provided health insurance. Many observers believe that unless something can be done to reduce the cost of caring for the aged and disabled recipients of public health insurance, there is little scope for savings. I believe this view is incorrect. I have identified between $7.5 and $15 billion in potential savings, which is not a trivial amount. Moreover, these savings assume that there will be no changes to inpatient care or provider payments. Achieving these savings requires reducing wasteful spending on marginally beneficial outpatient care and prescription drug use, and limiting the receipt of publicly provided health insurance to truly needy families. How to do this is the subject to which I now turn.

IV. POLICIES TO ACHIEVE SAVINGS

As stated above, the objective of this article is to identify policies that can realize significant savings in publicly provided health insurance without adversely affecting the health or financial resources of low-income families. This paper has focused on reducing wasteful spending on inefficient care and limiting receipt of publicly provided insurance to truly needy families—families that otherwise would not be able to obtain insurance.[67] I begin with the latter and discuss how limiting receipt of publicly provided insurance can be accomplished and whether doing so

63. THE KAISER COMM'N ON MEDICAID AND THE UNINSURED, THE MEDICAID PROGRAM AT A GLANCE 1 (Feb. 2003), *available at* http://www.kff.org/content/2003/200403/200403.pdf (last visited Nov. 18, 2003).

64. *See* State Health Facts Online, *supra* note 36 (displaying table of Percent Change in SCHIP Enrollment, December 2001 through December 2002).

65. The $3.4 billion figure is obtained by multiplying $1300 per child expenditure times 2.6 million, which is the number of children in Medicaid and SCHIP from families with incomes greater than 200% of the federal poverty level (FPL).

66. *See* Alliance for Health Reform, Covering Health Issues: 2002–2003, *at* http://www.allhealth.org/sourcebook2002/ch5_7.html (last updated Jan. 2003).

67. *See* discussion *supra* Parts II–III.

will adversely affect the financial and physical health of low-income families.

Limiting the receipt of public insurance to truly needy families can most easily be accomplished by setting a maximum income eligibility threshold of 200% of the FPL. This action can be taken at the state level because states currently set the income eligibility criteria for Medicaid and SCHIP. As noted, taking this step will save at least $3.4 billion (1999 dollars).[68] Additional savings can be achieved by requiring families with incomes between 150% and 200% of FPL to pay monthly premiums and by increasing cost sharing via deductibles and copayments. This will make publicly provided insurance comparable in cost to employer-sponsored insurance. Cost sharing is widely used in private plans and can reduce the extent of moral hazard.[69] Unfortunately, the federal government limits the ability of states to raise premiums and make recipients participate in cost sharing unless the state has a waiver. Current premiums are extremely low; for example, California's SCHIP program has a maximum monthly premium of only $20 per family per month ($240 per year) and an income eligibility threshold of 250% of the FPL ($35,673 for a family of three with two kids).[70] Importantly, raising premiums will not lead to a significant drop in coverage because evidence suggests that premiums have relatively little effect on take-up.[71]

Are there any adverse effects of taking this action? One potential disadvantage of this policy is that a small percentage of near-poor families who would otherwise not have health insurance would be at significant financial risk if one of their children became seriously ill. If children in these families became seriously ill, however, their families would almost certainly be eligible for publicly provided insurance through medical needs programs, which exist in forty states, that provide Medicaid coverage for otherwise ineligible families with large medical expenses.[72] Given that there is little evidence that having health insurance prevents illness, making eligibility contingent upon sickness is not as backward as it appears—even despite the conventional wisdom. Further, families affected by the limits set on eligibility have the financial means to pay for most routine care, or care associated with many common illnesses. Thus, this policy achieves the goal of saving money without adversely affecting the physical or financial health of the families affected.

68. *See supra* note 65 and accompanying text.

69. *See* James C. Robinson, *Renewed Emphasis on Consumer Cost Sharing in Health Insurance Benefit Design*, HEALTH AFF. WEB EXCLUSIVES, Mar. 20, 2002, *at* http://www.healthaffairs.org/WebExclusives/2103Robinson.pdf (last visited Nov. 18, 2003).

70. *See* State Health Facts Online, *supra* note 36.

71. *See* Linda J. Blumberg et al., *Worker Decisions to Purchase Health Insurance*, 1 INT'L J. HEALTH CARE FIN. & ECON. 305, 321–22 (2001).

72. A list of states with such programs can be found at http://www.welfareacademy.org/research/greenboo/sect16/16oc.htm (last visited Nov. 18, 2003).

Larger savings than those associated with limiting the pool of eligible recipients can be achieved by reducing wasteful spending on marginally beneficial services. The National Governors Association (NGA) has put forth one such proposal.[73] The NGA wants the federal government to provide states with greater flexibility to design benefit packages, particularly with respect to outpatient care and optional services.[74] Among other things, the NGA plan proposes the following:

- grant states greater flexibility over the "range and cost of services required in EPSDT program";
- eliminate comparability of service requirement for optional groups by allowing states to offer different benefits packages to groups not mandated to be eligible;
- allow use of more effective drug formularies.[75]

The second recommendation is particularly important. It would allow states to cover a more limited range of services for groups where eligibility is not mandatory, such as near-poor children and adults. This would greatly reduce the amount of inefficient care because demand for many of these services is elastic, implying that an increase in the price of such care due to the loss of coverage will result in a significant decrease in services. Near-poor families would likely have the financial resources to obtain essential care, as shown by the fact that the uninsured among this group do obtain a significant amount of care.[76] In this way, there is little likelihood that this change would adversely affect health.

A more radical proposal to reduce spending would be to replace the current open-ended entitlement for outpatient care and prescription drug use with medical savings accounts. The accounts would be structured as follows. First, 80% of current spending on outpatient services and prescription drug use would be allocated to the accounts. This assumes that 20% of current spending is wasteful and locks in the 20% savings discussed above.[77] Each year, recipients would be told of their allocations and, as they use services, informed about the balance in their accounts. Providers could be induced to help provide this information if the government refused to reimburse them for care subsequent to exhaustion of benefits without prior approval. Providers would thus have an incentive to inform patients of their balances. The availability of reimbursement for needed care protects families that have a legitimate need (i.e., families with a seriously sick child or adult). The programs would maintain

73. *See* JOHN HOLAHAN, THE KAISER COMM'N ON MEDICAID & THE UNINSURED, RESTRUCTURING MEDICAID FINANCING: IMPLICATIONS OF THE NGA PROPOSAL 7–12 (June 2001), *available at* http://www.kff.org/content/2001/2257/2257.pdf (last visited Nov. 18, 2003); *see also* NAT'L GOVERNORS ASS'N, HR-16: MEDICAID POLICY (on file with author).

74. *See* NAT'L GOVERNORS ASS'N, *supra* note 73.

75. *Id.*

76. Author's calculation comes from the National Health Interview Survey. *See supra* note 44 (providing data).

77. *See supra* note 53 and accompanying text.

the current reimbursement fee schedules. A critical aspect of this policy is that a portion of any unused funds in a family's account would be returned to the recipient so as to induce the recipient to use the money carefully. Finally, future allocations would be linked to the rate of medical inflation minus some portion of the average consumer rebate in the previous year.

An alternative to medical savings accounts is switching to a federally mandated Medicaid managed care program. Research suggests that managed care can reduce costs without harmful effects.[78] In the year 2000, only fifty-six percent of Medicaid recipients were enrolled in a managed care plan, and not all of these persons are in mandatory plans that are reimbursed on a per capita basis, the financing method most likely to generate savings.[79] In the absence of a federal requirement, it is necessary to provide greater flexibility for states to set up managed care plans to facilitate the switch to managed care. The NGA sees the current "state plan" option as burdensome and an obstacle to developing and extending Medicaid managed care.[80] The NGA appears to have a point as current regulations impose greater regulation on Medicaid managed care plans than on commercial managed care plans.[81] Along with this switch to Medicaid managed care, the states should reduce the rates of capitation. Currently, many states have capitation rates that are high relative to payments for medical care for other groups.[82] Consistent with the discussion above, capitation rates should be based on eighty percent of the current level of spending on this group.

Will medical savings accounts or the switch to managed care and the reductions in spending associated with these policies adversely affect the physical and financial health of low-income families? Based on existing evidence regarding the efficacy of outpatient care, the answer is no.[83] Both medical savings accounts and mandatory managed care are based on providing incentives to ration the use of medical care. Under either plan, costs savings will come from the elimination of inefficient and wasteful consumption. In the case of medical savings accounts, consumers will do the rationing, whereas under managed care the provider will do the rationing. In either case, the physical and financial health of low-

78. *See* Sherry Glied, *Managed Care, in* HANDBOOK OF HEALTH ECONOMICS, *supra* note 2, at 707, 739–43. *See generally* Robert Miller & Harold Luft, *Does Managed Care Lead to Better or Worse Quality of Care?*, 16 HEALTH AFF., Sept.–Oct. 1997, at 7.

79. *See* CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID MANAGED CARE STATE ENROLLMENT (Dec. 31, 2000), *available at* http://www.cms.hhs.gov/medicaid/managedcare/mmcpr00.pdf (last visited Nov. 18, 2003).

80. *See* NAT'L GOVERNORS ASS'N, *supra* note 73.

81. *See* JOHN HOLAHAN ET AL., MEDICAID MANAGED CARE PAYMENT METHODS AND CAPITATION RATES: RESULTS OF A NATIONAL SURVEY 1–5 (Urban Inst., Occasional Paper No. 26, 1999), *available at* http://www.urban.org/uploadedPDF/occa26.pdf (last visited Nov. 18, 2003).

82. *Id.* at 5.

83. *See* NEWHOUSE, *supra* note 21, at 346–49.

income families will not be adversely affected since the savings will come from reducing the consumption of marginally beneficial services.[84]

V. CONCLUSION

The economy is in a recession, health care costs are rising, and federal and state budgets are in the red.[85] Federal and state policymakers are looking for ways to save money.[86] Because health care costs are a big ticket item, particularly for states, this article has attempted to identify one area where some savings can be achieved.[87] Specifically, I have identified ways to achieve a significant amount of savings, somewhere in the range of $10 billion (1999 dollars), or approximately six percent of total Medicaid spending, by reducing the generosity of publicly provided health insurance for nonelderly poor.[88] The savings would come from a combination of the following: restricting eligibility to families under 200% of FPL; raising premiums and cost sharing requirements for families with incomes between 150% and 200% of FPL; implementing medical savings accounts for non-inpatient care; switching to mandatory managed care; and providing states with greater flexibility to design their health insurance plans.[89]

I have argued that these savings can be achieved with few adverse consequences for low-income families.[90] Most of the savings would come from reducing the number of relatively high-income (>200% FPL) families participating and by reducing spending on services of little value.[91] Importantly, the reduction in savings can be achieved at little financial risk to individual families mainly by shifting such risk to providers under a managed care plan, or by making recipients price sensitive by using medical savings accounts.[92] The savings can also be realized without jeopardizing the health of low-income families.[93]

Nevertheless, many will feel that it is punitive to focus on poor families in order to save money: Why help balance budgets on the backs of poor families? I have two answers to this criticism. First, if we assume that my arguments are correct and that there is significant waste, then

84. *Ex post*, the consumer will be made worse off, but this is not the criterion that is appropriate. The appropriate criterion is whether the consumer will not receive care in which the benefits of such care are greater than the costs. This is the appropriate standard since consumers would not pay for insurance that covered care in which the benefits were less than the costs. If this is the standard used, then eliminating the inefficient care will not harm the consumer *ex ante*.

85. *States Report Budget Deficits Jumped 50%,* CHI. TRIB., Feb. 5, 2003, at 18.

86. John M. Broder, *As California Borrows Time Other States Scrape Together Some Budget Solutions*, N.Y. TIMES, July 2, 2003, at A21.

87. *See* discussion *supra* Part III.

88. *See supra* notes 53–57 and accompanying text.

89. *See supra* notes 67–71 and accompanying text.

90. *See supra* note 72 and accompanying text.

91. *See supra* notes 51–66 and accompanying text.

92. *See supra* notes 77–82 and accompanying text.

93. *See supra* notes 83–84 and accompanying text.

eliminating such waste frees up money for other purposes. The $10 billion saved as suggested can, therefore, help stave off cuts in other vital programs. To put the $10 billion in perspective, the Centers for Disease Control's (CDC) budget for 2002 was only $4.3 billion, and the budget for the National Institutes of Health (NIH) was $23 billion.[94] Therefore, once could say that the money saved on publicly provided health insurance could be used to triple the CDC's budget or increase the NIH budget by fifty percent. My prediction is that low-income families would benefit more from increases in the CDC and NIH budgets than they would lose from the policy changes I have recommended.

My second answer to the criticism is that the tone of many of the recommendations made with respect to publicly provided health insurance also applies to subsidies of private insurance, which benefits mainly nonpoor families. Private insurance is overly generous and results in significant waste. One reason for this generosity is that the government subsidizes private insurance provided by the employer by exempting it from income taxes.[95] Eliminating these subsidies would reduce waste and free up public money for other uses, perhaps additional spending on public health. Similarly, as I have argued for less government regulation of state Medicaid programs, I would also argue for the elimination of some government restrictions on private health insurance plans, such as mandated coverage of certain benefits and mandated coverage of certain providers, so that relatively low-cost catastrophic plans can be more easily offered.

What is often ignored in debates about health policy in the United States is the gross imbalance between spending on public health (e.g., CDC and NIH) and spending to provide access to health care (Medicaid and Medicare). Small savings in public spending on Medicaid, Medicare, and private health insurance can be used to finance huge increases in public health spending. The weak link between health and health insurance, and the important role public health spending has had at improving health, suggests that this imbalance is detrimental and in need of redress. The health and financial security of families can be improved in other ways besides the provision of health insurance. Indeed, some of the most important causes of current health problems, such as obesity and smoking, are not likely to be affected by health insurance. One could argue that public subsidies for health insurance have resulted in a significant waste of resources.[96] Part of my goal in this article was to break health insurance's stranglehold on health policy, and to illustrate that significant

94. *See* CTRS. FOR DISEASE CONTROL & PREVENTION, FY 2004 BUDGET REQUEST—FUNDING BY BUDGET ACTIVITY, *available at* http://www.cdc.gov/fmo/FundingbyBudgetActivityTable.pdf (last visited Nov. 18, 2003); *see also* NAT'L INSTS. OF HEALTH, SUMMARY OF THE FY 2004 PRESIDENTS' BUDGET 1 (Feb. 3, 2003), *available at* http://www.nih.gov/news/budgetfy2004/fy2004presidentsbudget.pdf (last visited Nov. 18, 2003).

95. Milton Friedman, *How to Cure Health Care,* PUB. INT., Winter 2001, at 1, 6.

96. *Id*. at 10–13.

savings can be achieved and that these savings can be used in ways that may have large returns.