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UHG Working Paper 3:

*Coverage for Consumers, Savings for States:
Options for Modernizing Medicaid*

Summary of Key Findings
April 2010



UHG Working Paper 3

'Coverage for Consumers, Savings for States: Options for Modernizing Medicaid'



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What is this report?

- It's the third major publication released by the UnitedHealth Center for Health Reform & Modernization
- It identifies \$366 billion in potential government savings from modernizing Medicaid over the coming decade
- Follows on from two previous UHG working papers which looked at:
 - potential savings from modernizing Medicare (\$540 billion over 10 years)
 - savings opportunities from using technology to modernize the US health care system's administrative 'back office' (\$330 billion over 10 years)

Why is this an important topic?

- Because 16 million of the 32 million people expected to gain coverage under the new health reform law may do so through Medicaid
- Because Medicaid is typically States' second largest budget item, and they are struggling to balance their books
- Because the cost pressures will grow as the population ages, as two-thirds of Medicaid spending is on long term care & nursing homes
- And because there is a need to ensure not only that people have health coverage, but that sufficient care providers are available to support Medicaid enrollees

What's new in the report that we didn't know before?



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The working paper helps answer these important questions regarding health reform implementation:

- how big will the Medicaid coverage expansions be?
 - provides new national and state estimates
- what will they cost?
 - provides new national and state estimates
- will patients be able to get treated?
 - contains new national survey of primary care physicians, asking about their readiness to look after 16 million more Medicaid patients, and potential policy solutions
- what are the savings opportunities?
 - includes new estimates of savings opportunities in Medicaid, for each state and for the federal government





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How big will the Medicaid expansion be?

- From 2014, the new national health reform law requires states to offer Medicaid benefits to people with incomes up to 133% of the Federal Poverty Level
- Using a health coverage micro-simulation model, the working paper estimates this will mean an additional 16 million Medicaid enrollees by 2019, compared with what would have happened under previous law
- Some states will see very large increases in the *absolute numbers* of Medicaid enrollees
 - Florida + 1.1 million people
 - Texas + 1.9 million people
 - California + 2 million people
- Some states will see very large *percentage* increases
 - 10 states may see their Medicaid enrollment grow by over 50%
- We estimate the cost of the Medicaid expansion will be \$436 billion between 2014-2019, of which states would pay \$24 billion and the Federal government \$412 billion

Projected Medicaid expansion and costs



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	Federal Fiscal Year						
	2014	2015	2016	2017	2018	2019	2014 – 19
Net changes in enrollment under Medicaid expansion¹							
Adults without dependent children	1,881,240	6,967,930	10,876,890	12,923,770	13,051,230	13,178,700	
Parents	446,050	1,652,110	2,578,930	3,064,250	3,094,490	3,124,740	
Children ²	<u>18,080</u>	<u>66,960</u>	<u>104,530</u>	<u>124,200</u>	<u>125,440</u>	<u>126,680</u>	
Total	2,345,370	8,687,000	13,560,350	16,112,220	16,271,160	16,430,120	
Expansion costs (in millions of dollars)							
Total	11,745	45,890	75,575	94,735	100,935	107,525	436,405
Federal	11,570	45,210	74,455	88,785	93,610	98,690	412,320
State	175	680	1,120	5,950	7,325	8,835	24,085
Effective state share³	1.5%	1.5%	1.5%	6.3%	7.3%	8.2%	5.5%

Notes:

¹ Enrollment figures represent changes in average monthly caseload in each year relative what coverage would have been under prior law in that year.

² Changes in enrollment of children under the new poverty threshold is net of the effect of the enrollment of already eligible children due to greater outreach under the new legislation, and the shift of some children with their families to other insurance coverage status. This effect will vary across states.

³ States will receive the current federal match rate for coverage of children and parents who would have been eligible under current eligibility standards. The state share for the newly eligible adults rises to 10% in 2020 and stays at that level in subsequent years.

Figure 1.4; Source: UnitedHealth Center for Health Reform

Will there be enough primary care physicians to treat the new Medicaid enrollees? (1)



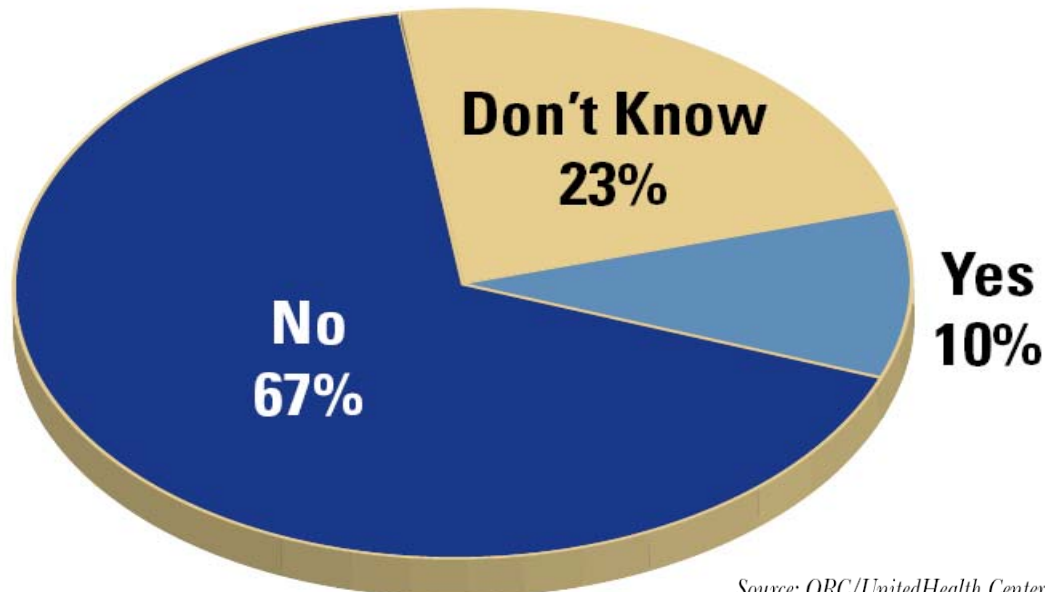
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- We commissioned a national survey of primary care physicians from Opinion Research Corporation (CNN's pollster)
- n = 944, margin of error in the national sample +/- 3.6 percent

Primary care physicians answers to the question:

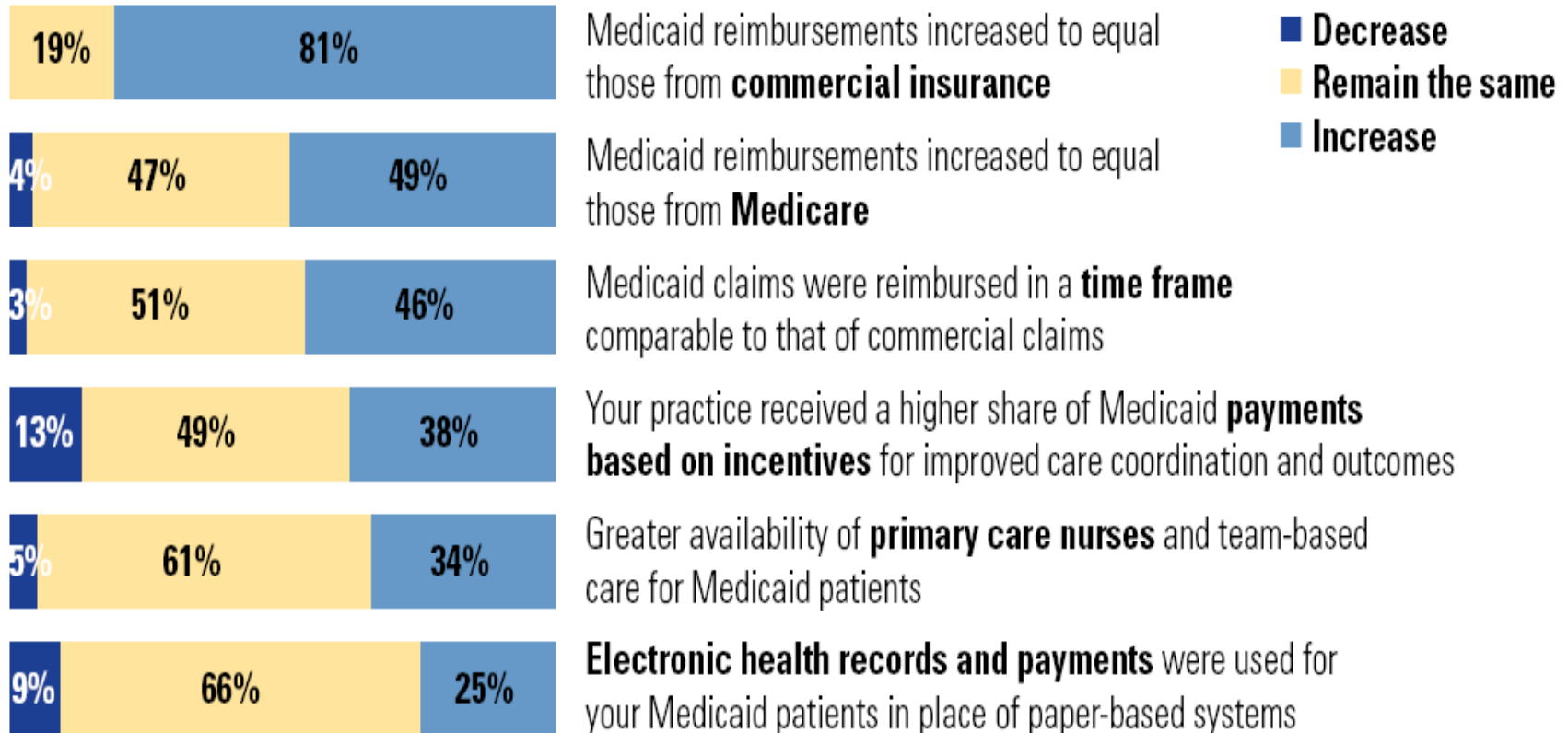
'Absent other changes, will new Medicaid enrollees be able to find a suitable primary care physician in your area?'



Will there be enough primary care physicians to treat the new Medicaid enrollees? (2)

What policies could make a difference?

Primary care physicians willingness to take on more Medicaid patients if...



Solutions to the primary care challenge include...



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- increasing States' Medicaid primary care reimbursements
- primary care payment reform and patient-centered medical homes to improve the quality of care and level of utilization, with some of the resultant savings being reinvested back into stronger primary care infrastructure
- expanded primary care medical training
- federal funding for community health centers
- health IT and care management support to primary care practices
- innovative new primary care telemedicine models
- modifying scope of practice laws, making full use of advanced nurse practitioners, using pharmacists for education and medication management
- and many other ideas...



Action that can be taken



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- The new health reform law funds States to temporarily increase primary care physician Medicaid payments to equal those of Medicare, in 2013 and 2014
- After that, we estimate there is an unfunded cost of around \$50 billion if those payments continue through the rest of the decade
- Our working paper therefore provides options for generating savings that could partly be used to fill that funding gap and strengthen primary care, so that newly covered patients can access high quality care
- We show that greater use of Medicaid managed care could improve care for patients while saving states and the federal government money
- In doing so, the paper uses data from States' own experience, published research evidence, and internal information from UHG's AmeriChoice division, which serves 3 million people and is America's largest Medicaid health plan.

Evidence of how Medicaid managed care can improve quality - example from New York



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Preventive care in Medicaid Managed Care Versus Fee-for-Service Care in New York State

Share of Enrollees with Screenings and Preventive Visits Managed Care and Fee-for-Service

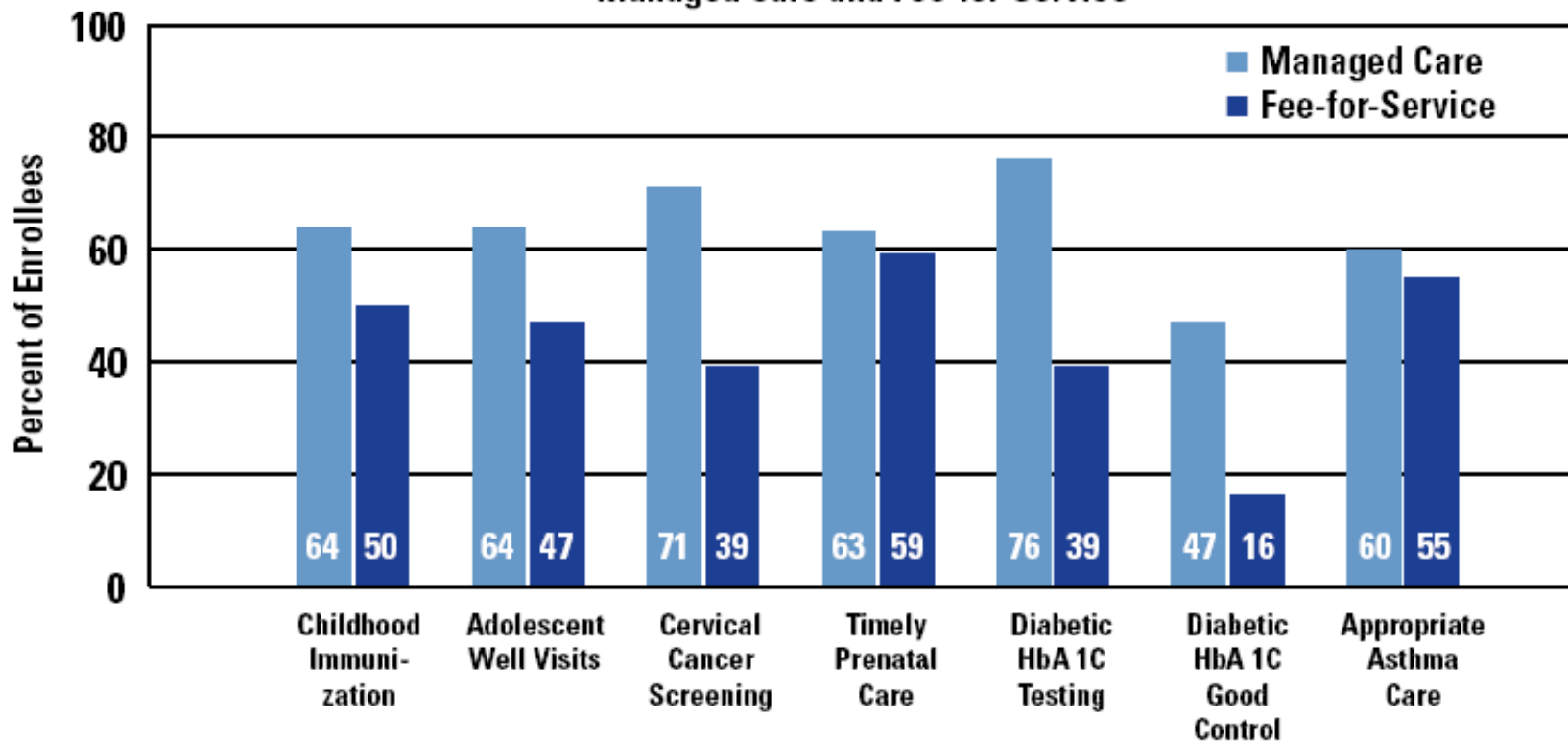


Figure 3.2; Source: New York State Department of Health, November 2008.

Evidence of how Medicaid managed care can improve quality - example from South Carolina



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Well Child Visits in Medicaid Managed Care versus Medicaid Fee-For-Service in South Carolina

Likelihood of Having At Least 1 Well Child Visit By Setting
Children Ages 3 through 6 Years

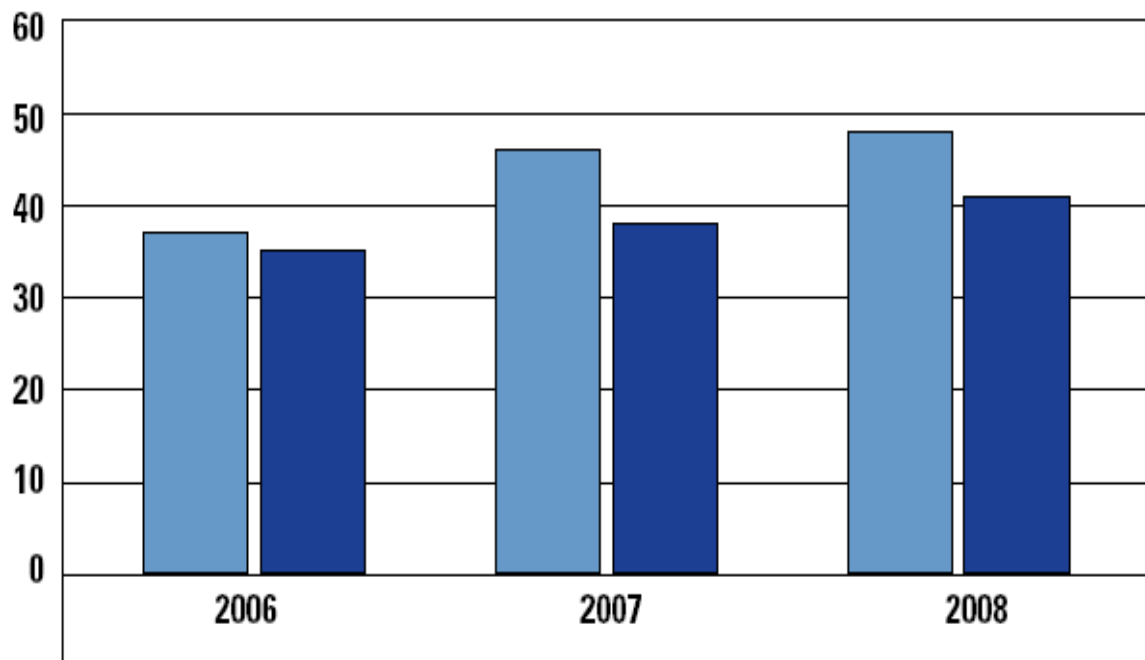


Figure 3.3; Source:
South Carolina,
Healthy Connections
program, 2008.

■ Managed Care	37	46	48
■ Fee-for-Service	35	38	41

The Medicaid long term care savings opportunity - expanding on the success of states such as Arizona

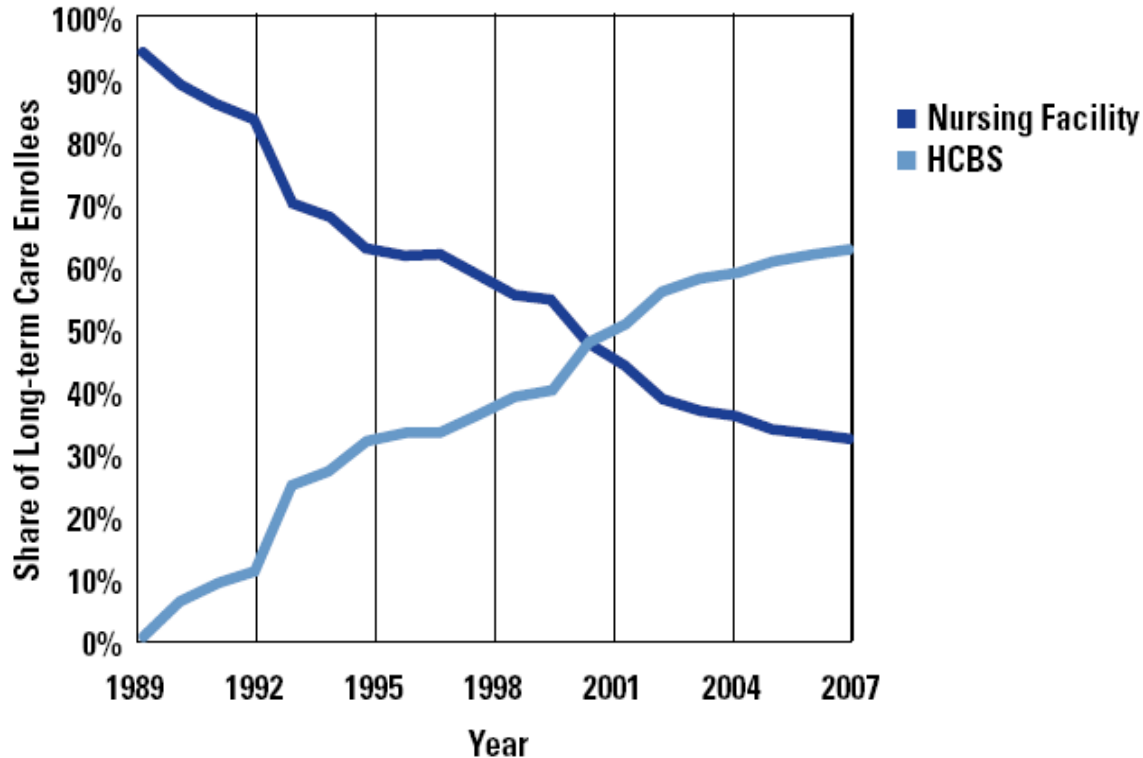


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Arizona Has Reduced Use of Costly Institutions for Medicaid Long-Term Care Enrollees

Shift in Use of Nursing Homes and Home and Community-Based Services (HCBS) Over Time in Arizona



The Working Paper finds that re-balancing the nation's long-term care system using targeted community-based care to help avoid nursing home admissions could save \$140 billion over the next decade.

Three main categories of Medicaid savings opportunities in Working Paper 3



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1. **Greater use of coordinated care in current and expansion Medicaid population**
 - eg. by supporting high risk pregnant mothers to get needed prenatal care, as AmeriChoice has done in TN
2. **New managed care options for the Long Term Care Medicaid population**
 - eg. by providing home-based and community services to frail seniors so that they can continue to live in their own homes rather than having to be admitted to a nursing home, as Evercare does
3. **Modernizing Medicaid's administrative processes and technology**
 - eg. by using electronic claims payment, and pre-payment fraud detection methods, as Ingenix has pioneered

The Working Paper's estimates of Medicaid savings opportunities



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Savings in billions of dollars (2011 – 2019)

	Total	Federal	State
Increase use of coordinated care in current Medicaid population	82	46	35
Adopt coordinated care in Medicaid expansion population	11	11	1
Wider use of community-based, coordinated care in Medicaid long-term care	140	80	60
Administrative modernization of Medicaid programs	133	80	53
Total savings	\$366 billion	\$217 billion	\$149 billion

You can download a copy of the full report at www.unitedhealthgroup.com/reform

Appendix – summary of state-specific costs and savings opportunities (1)



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Figures in millions of dollars

Savings Estimates

	Expansion Costs ¹			Capitation Savings ²			Long-Term Care Savings ³			Administrative Savings ⁴			Total Savings		
	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State
Alabama	12,215	11,565	650	-1,115	-850	-275	-2,255	-1,530	-725	-2,050	-1,410	-630	-5,420	-3,790	-1,630
Alaska	1,475	1,370	105	-620	-355	-265	0	0	0	-460	-260	-200	-1,080	-615	-465
Arizona	5,090	4,875	215	0	0	0	0	0	0	-2,460	-1,570	-890	-2,460	-1,570	-890
Arkansas	8,425	7,970	455	-1,145	-900	-245	-1,580	-1,040	-540	-1,630	-1,160	-480	-4,355	-3,100	-1,265
California	34,190	32,415	1,775	13,400	-7,225	-6,175	-10,455	-5,225	-5,230	-15,100	-8,070	-7,020	-38,955	-20,520	-18,425
Colorado	5,095	4,820	275	-1,535	-890	-645	-455	-225	-230	-1,400	-780	-610	-3,390	-1,895	-1,485
Connecticut	3,170	3,035	135	-1,135	-630	-505	-3,815	-1,905	-1,910	-1,160	-630	-530	-6,110	-3,165	-2,945
Delaware	285	265	20	-265	-135	-130	-690	-345	-345	-510	-260	-250	-1,465	-740	-725
District of Columbia	555	530	25	-455	-315	-130	-365	-255	-110	-490	-320	-160	-1,310	-890	-400
Florida	29,785	28,060	1,725	-4,360	-2,765	-1,605	-5,880	-3,235	-2,645	-6,300	-3,830	-2,470	-16,540	-9,830	-6,720
Georgia	19,505	18,350	1,155	-1,220	-800	-430	-2,725	-1,770	-955	-4,190	-2,770	-1,420	-8,135	-5,340	-2,805
Hawaii	410	385	25	-160	-90	-80	-350	-190	-160	-420	-230	-200	-930	-510	-440
Idaho	2,780	2,665	115	-485	-360	-125	0	0	0	-660	-460	-210	-1,145	-820	-335
Illinois	12,560	12,035	525	-4,570	-2,645	-1,925	-4,475	-2,245	-2,230	-4,230	-2,330	-1,910	-13,275	-7,220	-6,065
Indiana	12,565	12,040	525	-1,210	-835	-385	-4,100	-2,705	-1,395	-2,610	-1,730	-870	-7,920	-5,270	-2,650
Iowa	2,610	2,500	110	-1,000	-675	-325	-1,770	-1,125	-645	-1,090	-670	-410	-3,860	-2,470	-1,380
Kansas	5,170	4,785	385	-580	-355	-215	-635	-385	-250	-1,010	-650	-360	-2,225	-1,390	-825
Kentucky	9,775	9,210	565	-1,730	-1,300	-430	-2,200	-1,560	-640	-2,390	-1,650	-740	-6,320	-4,510	-1,810

Appendix – summary of state-specific costs and savings opportunities (2)



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Savings Estimates – continued

	Expansion Costs ¹			Capitation Savings ²			Long-Term Care Savings ³			Administrative Savings ⁴			Total Savings		
	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State
Louisiana	14,465	13,660	805	-2,450	-1,830	-620	-3,440	-2,325	-1,115	-2,810	-1,910	-900	-8,700	-6,065	-2,635
Maine	865	830	35	-960	-640	-320	-685	-445	-240	-1,020	-640	-370	-2,665	-1,725	-930
Maryland	6,065	5,545	520	-1,235	-640	-595	-2,715	-1,355	-1,360	-2,150	-1,180	-990	-6,100	-3,175	-2,945
Massachusetts	125	120	5	-2,575	-1,295	-1,290	-6,220	-3,110	-3,110	-3,130	-1,570	-1,570	-11,925	-5,975	-5,970
Michigan	11,170	10,660	510	-1,295	-875	-430	-4,615	-2,915	-1,700	-4,000	-2,460	-1,520	-9,910	-6,250	-3,650
Minnesota	3,980	3,815	165	-1,730	-860	-860	-1,160	-580	-580	-2,390	-1,260	-1,140	-5,280	-2,700	-2,580
Mississippi	9,290	8,765	525	-1,945	-1,565	-380	-2,000	-1,510	-490	-1,800	-1,300	-500	-5,745	-4,375	-1,370
Missouri	8,955	8,500	455	-2,000	-1,340	-660	-1,955	-1,260	-695	-2,560	-1,650	-920	-6,515	-4,250	-2,275
Montana	2,490	2,340	150	-290	-225	-65	-370	-250	-120	-350	-260	-110	-1,010	-735	-295
Nebraska	3,310	3,140	170	-600	-410	-190	-845	-515	-330	-610	-400	-220	-2,055	-1,325	-740
Nevada	2,815	2,580	235	-660	-365	-295	-385	-195	-190	-670	-390	-290	-1,715	-950	-775
New Hampshire	2,095	1,960	135	-465	-285	-180	-520	-260	-260	-400	-230	-160	-1,385	-775	-600
New Jersey	8,140	7,800	340	-1,700	-850	-850	-7,135	-3,565	-3,570	-2,750	-1,500	-1,250	-11,585	-5,915	-5,670

Appendix – summary of state-specific costs and savings opportunities (3)



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Savings Estimates – continued

	Expansion Costs ¹			Capitation Savings ²			Long-Term Care Savings ³			Administrative Savings ⁴			Total Savings		
	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State
New Mexico	4,165	3,900	265	-330	-230	-90	-355	-255	-100	-1,440	-990	-450	-2,125	-1,475	-640
New York	2,405	2,305	100	-11,290	-5,675	-5,615	-22,970	-11,485	-11,485	-12,680	-6,370	-6,300	-46,940	-23,530	-23,400
North Carolina	18,900	17,895	1,005	-3,785	-2,685	-1,100	-4,040	-2,630	-1,410	-4,770	-3,140	-1,630	-12,595	-8,455	-4,140
North Dakota	830	785	45	-130	-100	-30	-590	-370	-220	-150	-110	-60	-870	-580	-310
Ohio	17,360	16,625	735	-3,500	-2,255	-1,245	-8,360	-5,300	-3,060	-5,820	-3,690	-2,140	-17,680	-11,245	-6,445
Oklahoma	6,510	6,135	375	-1,850	-1,300	-550	-1,175	-755	-420	-1,680	-1,090	-600	-4,705	-3,145	-1,570
Oregon	7,260	6,835	425	-550	-365	-175	0	0	0	-1,360	-910	-470	-1,910	-1,275	-645
Pennsylvania	27,385	26,025	1,360	-970	-530	-440	-9,205	-5,045	-4,160	-6,620	-3,950	-2,670	-16,795	-9,525	-7,270
Rhode Island	1,060	1,015	45	-470	-250	-220	-1,325	-700	-625	-570	-310	-260	-2,365	-1,260	-1,105
South Carolina	7,745	7,320	425	-1,890	-1,410	-480	-885	-620	-265	-2,150	-1,440	-710	-4,925	-3,470	-1,455
South Dakota	1,240	1,185	55	-265	-180	-85	-425	-265	-160	-310	-190	-110	-1,000	-635	-355
Tennessee	9,080	8,700	380	-870	-650	-220	-3,895	-2,555	-1,340	-3,340	-2,130	-1,220	-8,105	-5,335	-2,780
Texas	59,520	55,350	4,170	-7,705	-5,160	-2,545	-7,360	-4,325	-3,035	-10,130	-6,580	-3,550	-25,195	-16,065	-9,130
Utah	2,540	2,400	140	-780	-600	-180	-405	-290	-115	-660	-440	-210	-1,845	-1,330	-505
Vermont	-165	-160	-5	-185	-105	-80	-160	-95	-65	-310	-170	-140	-655	-370	-285
Virginia	12,980	12,160	820	-1,370	-805	-565	-2,390	-1,195	-1,195	-2,460	-1,460	-1,000	-6,220	-3,460	-2,760

Appendix – summary of state-specific costs and savings opportunities (4)



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Savings Estimates – continued

	Expansion Costs ¹			Capitation Savings ²			Long-Term Care Savings ³			Administrative Savings ⁴			Total Savings		
	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State	Total	Federal	State
Washington	7,475	7,070	405	-2,040	-1,055	-985	0	0	0	-2,660	-1,450	-1,210	-4,700	-2,505	-2,195
West Virginia	5,460	5,175	285	-910	-700	-210	-995	-735	-260	-1,050	-760	-300	-2,955	-2,195	-770
Wisconsin	4,255	4,075	180	-1,090	-680	-410	-1,580	-950	-630	-1,790	-1,060	-720	-4,460	-2,690	-1,760
Wyoming	975	935	40	-290	-175	-125	-85	-45	-40	-230	-130	-100	-605	-350	-265
US	436,405	412,320	24,085	-93,160	-57,215	-35,975	-139,995	-79,640	-60,355	-132,980	-79,900	-53,150	-366,135	-216,755	-149,480

¹ Includes the costs of the new income and eligibility requirements of the program, the effects of increased enrollment of eligible uninsured, and net effects of individuals moving other coverage status under health care reform, including exchange coverage, employer-based coverage and CHIP.

² Figures include the potential effect of states adopting capitated managed care for existing populations in 2011 and for new expansion populations not otherwise enrolled in a managed care plan after 2014.

³ Savings estimates assume that states reorient their long-term care systems to achieve community long-term care placement rates of about two-thirds by 2019. States showing 0 savings are already estimated to be at or below that level.

⁴ Administrative saving include reductions in administrative transactional costs and reduction in medical spending attributable to more efficient program administration that results in more appropriate payment. Savings figures include spending for existing and expansion populations.