THE ECONOMICS OF MEDICAID
Assessing the Costs and Consequences

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Socioeconomic factors play a large role in health but historically have been mostly ignored by policymakers with a narrow focus on health care or worse, insurance access. Economic prosperity, neighborhood safety, environmental protection, educational opportunity, and income are all crucial determinants of people’s health. By focusing on insurance and access, while failing to address these important socioeconomic factors, the passage of the Patient Protection and Affordable Care Act (ACA) in March 2010 will have a limited influence on the health and well-being of Americans. Furthermore, the ACA’s focus on measuring the process of health care delivery is no substitute for proper health outcome measurement.

As an obstetrician-gynecologist practicing in California’s Inland Empire, I have the privilege of caring for a diverse population of women coming from a broad array of economic, cultural, and racial backgrounds. They are part of the population that, ostensibly, the ACA intends to help. Unfortunately, access to health insurance has a limited impact on overall population health, which is influenced by a variety of socioeconomic factors. Worse yet, the policies currently in
place focus heavily on providing insurance, with little regard to access to health care or outcomes. There has been even less regard for the effect of these policies on the practice of medicine, and for the variety of unintended consequences that have been detrimental to the care of patients and provision of health care.

This chapter, with a preliminary sketch of the philosophical underpinnings of the debate that too often regards health care as a right, will briefly describe the history of Medicaid and the concomitant state program, Medi-Cal, that provides health insurance coverage for many of my patients, along with exploring other government attempts to expand health insurance. The sections that follow discuss the shortcomings of this focus on insurance, first describing my direct experiences as a physician. I then examine how the system sets up disincentives for cost containment and provokes over-treatment. The next section considers the tensions with respect to physician autonomy that were present when Medicaid and similar programs were created. Lastly, I discuss the fact that health insurance is a relatively small factor in health outcomes. It is critical that we shift focus to health outcomes and away from a narrowed focus on health insurance.

CONCEPTUAL TENSIONS
It is useful to briefly discuss why some policy makers support a strong governmental role in the health care marketplace, buttressing their arguments with claims of market failures. The philosophical roots of the quest for universal health coverage, the ACA, and the creation of the Medicaid program lie in the concept of a human right to health. Though this paper is not advocating that health care is a “right,” it is nonetheless critical to understand the conceptual tension that exists because many people do believe that.

The United States has largely avoided the language of human rights in its efforts to reform its health care system, possibly because the Bill of Rights precisely denotes what is, and therefore what is not,
a “right.” The concept of rights springs up in public policy regularly (for example, the right to know what is in your food, the right to basic telecommunications). Nevertheless, human health as a right and the laws that subsequently arise from that basis are founded on two beliefs and concepts: (1) human rights are universal and immutable; and (2) human rights transcend state sovereignty and oblige governments to protect, respect, and fulfill the human rights of all people within their jurisdictions. Historically, a human right to health was initially formalized within international law in Article 25 of the 1948 Universal Declaration of Human Rights (UDHR). In the year 2000, the United Nations (UN) Committee on Economic, Social, and Cultural Rights drafted General Comment 14, which presents four elements key to achieving the right to health: availability, accessibility, acceptability, and quality. Many ACA provisions address some of the criteria established by the United Nations for each of these key elements. It is important to note that the United States has not ratified the United Nations’ assertion of a human right to health. A logical outcome of the United Nations’ concept is a single-payer health care system.

Philosophically, there are two kinds of rights—negative and positive. Negative rights oblige inaction; in other words, others may not damage our health, take our private property, or inhibit freedom of speech. Positive rights entail a right to receive some good or service from another and involve correlative duties obliging provision of that good or service. The notion of a right to health care falls under the category of a positive right. Importantly, it is inherently controversial as to who is obliged to provide health care services. Jan Narveson asserts that there is no right to health care and that compelling someone else to pay for it through compulsory taxation is a right no one has. “It is a familiar contradiction of the welfare state to argue: ‘Hey, this is such a good thing that of course you want it! Therefore, we will make you take it.’ The conclusion is inconsistent with its premise.” Then there is the problem of distributive justice: how should health care be distributed once its provision is compelled? Should it be on the
basis of need, merit, or strict equality? Narveson states the following: “No one should be in the position that his fellows can exact payments from others for avoidable voluntary imposed risks.” Smoking, overeating, excessive alcohol intake and other high-risk lifestyle choices have completely foreseeable health consequences. Is it just to drain the financial resources of those who are willing to devote effort, time, and energy to maintaining their physical health in order to support those who do not care?

FROM MEDICAID TO THE AFFORDABLE CARE ACT
A desire to help the poor has resulted in the creation of a complex network of federal and state programs, with the ACA being the most recent and ambitious attempt to expand health insurance.

Medicaid’s Historical Impact
Medicaid’s enactment in the Social Security Amendments of 1965 mandated the coverage of certain categorical groups (e.g., poor families receiving cash assistance from the Aid to Families with Dependent Children). Its enactment arose out of the long struggle to adopt universal health insurance in the United States, affirming efforts by the federal government to bolster the public health infrastructure. Since then, incremental expansion of the program has occurred with the view, by some policymakers, toward the creation of a path to more universal health care for Americans. Medicaid is to serve as a cornerstone beyond welfare medicine. Medicaid’s instigation was built upon the Kerr-Mills program (1960–63), which offered broad health care benefits to the low-income elderly. With the establishment of Medicaid, coverage was expanded to protect the blind, permanently disabled, and adults in mostly single-headed families and their dependent children. Each state was given the discretion to determine the poverty level required to be eligible for the program. This resolution led to great variation in Medicaid’s implementation across the country. The flexibility provided
to the states was eventually limited by the Supplementary Security Income program of 1972, which joined state-run assistance programs for the elderly, blind, and disabled into one nationally uniform program with eligibility determined by a federal standard.13

Medicaid expansions to children, infants, and pregnant women increased gradually between 1984 and 1990, ultimately covering about five million children and 500,000 pregnant women across the United States.14 This expansion was driven by the prodigious costs linked to the care of low birth weight (LBW) babies and their increased risk for multiple health problems throughout their lives. LBW infants, defined as a birth weight less than 2,500 grams (about 5.5 pounds), are at higher risk for high blood pressure, cerebral palsy, deafness, blindness, and lung disease, as well as behavioral problems and cognitive developmental problems.15 Access to prenatal care was touted to make good economic sense because it was believed to lessen the incidence of LBW infants. For example, the expected costs of delivery and initial care of a baby weighing 1,000 grams at birth was greater than $100,000 in year 2000 dollars.16 Eventually, Medicaid has come to finance about 40 percent of all births and has supported the creation of the modern neonatal intensive care unit.17 During this time, increases in Medicaid expenditures occurred mainly through budget reconciliation bills, masking the program’s expansion.18 Meanwhile, state and federal health care spending for the poor increased from $75 billion in 1986 (in 1996 dollars) to almost $180 billion in 1996.19 In 2011, federal and state Medicaid spending totaled almost $414 billion.20

Medicaid has facilitated the building of health care infrastructure in poor urban and rural communities. In doing so, health care providers and health insurers play a crucial role in gaining expansions of the program and opposing reductions.21 The ACA furthers the expansion of Medicaid by presenting a federal option to cover any low-income adult under age 65 without regard to personal characteristics (e.g., disability, pregnancy). States can now choose to extend Medicaid to these adults with incomes at or below 133 percent of the
federal poverty level (FPL). This establishes Medicaid as a platform for aiding coverage of more than 30 million uninsured Americans. Notably, through a series of landmark judicial decisions, some have come to view Medicaid as a social contract with individually enforceable legal entitlements and rights to care.\(^2\) For those who view Medicaid as an individual right, this philosophical positioning can be seen in such initiatives as the community health centers program, the deinstitutionalization of health care provision through public health care centers, and the delivery of health care to children with special needs. When I was a medical school resident in California, the drop in obstetrical volume was notable as Medi-Cal patients were delivered in private hospitals away from the training hospitals that had traditionally supported indigent care. Access to “mainstream” health care became a perceived right.

**The ACA’s Impact on Medicaid**

With the ACA’s move toward using Medicaid as a means to ensure universal health care as sponsored by the federal government, federalism tensions have arisen as states fight the expansion. States have traditionally varied in their commitment to Medicaid, with some states being more administratively dexterous in enhancing participation rates, whereas others are much less flexible. The ACA, operating alongside Medicaid, is likely to create enormous administrative problems as fluctuating enrollee incomes will cause individuals to alternate between Medicaid and health exchange products.\(^3\) States with low Medicaid participation rates are particularly threatened by the ACA because of the fact that residents currently eligible for Medicaid, but not enrolled, would be added to the program without triggering the federal government’s generous matching payments. Additionally, the federal funding share for those newly eligible under ACA guidelines will decline to 90 percent by 2020, further threatening states’ budgets. (For more on the ACA’s implications for state budgets, see chapter 5, page 83.)
In 2011, California was at the top of the list of states for a budget shortfall, in the amount of $14.4 billion. In the future, the effects of Medicaid expansion will be uniquely magnified in California by the large number of uninsured and undocumented immigrants living there. This group will comprise approximately 1.24 million people or 40 percent of those who will remain uninsured after ACA. Of the remainder of the uninsured who are not undocumented immigrants, 36 percent will be those subject to the individual mandate who will have chosen to remain uninsured, 13 percent are projected to be documented residents not subject to the mandate, and 11 percent will have had coverage but then lost it. Thirty-eight percent of the 3.77 million currently uninsured in California will be on public insurance in 2016; a very large budgetary impact indeed!

Cost Containment Strategies in the ACA and Medicaid

Approximately half of the increase in health insurance provisions resulting from the ACA will be obtained through expansion of the Medicaid program and will account for an estimated 45 percent of the overall cost of reform. Both public and private national spending on health care is projected to grow by 5.8 percent per year through 2020 according to the actuaries for the Centers for Medicare and Medicaid Services (CMS). The federal and state governments together are estimated to spend about $3.4 billion more in providing public insurance to the formally uninsured. Unfortunately, current cost-containment strategies are focused on reduction of federal health expenditures rather than creating the means for decreasing per capita spending on health care in the United States, which is more than twice that observed in other developed nations.

As an example of federal cost-containment strategies, Section 3403 of the ACA has created the controversial “Independent Payment Advisory Board” (IPAB), which will recommend ways to reduce costs if the CMS chief actuary predicts that the per capita rate of growth for Medicare spending will exceed the “targeted rate.”
Under the law, IPAB recommendations are limited, and may not raise costs to beneficiaries, restrict benefits, or modify eligibility criteria. Instead, the law directs IPAB’s focus on Medicare Advantage Plans, Medicare Part D, skilled nursing facilities, home health, dialysis, ambulance services, ambulatory surgical centers, and durable medical equipment.

Other ideas for reining in US medical care spending included in the ACA are policies promoting accountable care organizations (ACOs), primary care medical homes, bundled payment, pay for performance, comparative effectiveness research, and health information technology. Secretary of Health and Human Services (HHS) Kathleen Sebelius stated that “every cost-cutting idea that every health economist has brought to the table is in this bill.” But systemwide, reliable cost control is lacking, with tepid reform a realpolitik necessity in order to get the ACA approved by the legislature. At the same time, the Obama administration and congressional Democrats extracted more than $400 billion in projected savings out of Medicare, largely by reducing payments to hospitals and private insurers that operate as Medicare Advantage plans. Decreasing reimbursement rates will likely threaten provider access. Ironically, the American Medical Association agreed to support the ACA after the US Congress promised to change the sustainable growth rate used to calculate updates to fee-schedule payments in Medicare.

As James Capretta explains in chapter 7, another proposed federal budget cost-saving device is to shift the risk of Medicaid onto the states in the form of block grants. With block grants, the federal government would allot a fixed amount of dollars per capita to the states, which in turn would have more flexibility in determining Medicaid eligibility and benefits. Yet, as states face a budgetary Armageddon through increasing health care expenditures, many may choose to limit eligibility, leading to the same old problems of expensive emergency room care and minimal access to primary care, and no improvement in health outcomes.
When I was a new graduate from the University of California at Los Angeles’s OB/GYN residency program in 2004, I opted to practice in Riverside, having an affection and admiration for the hardworking people in California’s Inland Empire, combined with an awareness of the region’s great need for doctors. The Inland Empire encompasses Riverside and San Bernardino counties and is California’s fastest-growing metropolitan area, driven by what economist John Husing has described as “dirt theory” (i.e., cheap land attracting growth through affordable housing).38 The region has suffered for decades from slow economic growth, with a poor population supported mainly by agricultural work. The region I work in is what the Brookings Institution calls “the Third California,” extending from the outer suburbs of Los Angeles to the Northern Californian foothills.39 Composing the southern part of the Third California, Riverside and San Bernardino counties have 3.7 million residents. The population tends to be substantially less well educated than that of the coastal regions; 25 percent of those 25 or older have less than a high school degree.40

The Inland Empire has significant health problems linked to its challenging socioeconomic and environmental conditions. Its role as a transportation hub for the Los Angeles–Long Beach port complex has led to increased air pollution from heavy automobile and truck traffic corridors. Two-thirds or more of adults ages 18 and older in the region are overweight or obese, a source of much preventable disease and death.41 Other health problems linked to poverty are also of concern. According to the University of Wisconsin Population Health Institute County Health Rankings, Riverside placed 27th and San Bernardino 44th in health outcomes out of 57 counties in California.42

As the “Third California” continues to grow rapidly (with a population of almost 10 million, greater than that of 42 states in the United States),43 incredible strains will be placed on the region’s existing health care infrastructure. Disturbingly, the Inland Empire has the
worst shortage of physicians in California (about 40 primary care doctors and 70 specialists per 100,000 residents, approximately one-half the recommended primary care ratio).\textsuperscript{44} As a physician, I am overwhelmed by these numbers and the thought of so many needing care. This insupportable provider shortage, which will likely worsen under the ACA, probably will lead to even greater delay in health care, ranging from longer wait times, poor access to providers, and an increased quantity of emergency department visits. Although the expansion of Medicaid through the ACA of 2010 is projected to increase insurance coverage, accounting for one-third of the overall growth in insurance coverage, the gap between the number of available doctors and patients will be exacerbated. Notably, only one-half of existing primary care physicians accepted new Medi-Cal (California’s Medicaid) patients during 2008.\textsuperscript{45} However, as will be discussed later, access to providers is far from the most important issue in health for this population.

As an obstetrician, I take care of pregnant women covered by Medi-Cal. Yet, sometimes I have felt alone in the care of these high-need patients, since Medi-Cal, as it currently stands, covers only obstetrical aspects of medicine. As an example, I recall a lovely stay-at-home mom who came to me for care early in her third pregnancy. Later, at the end of her first trimester, she started to randomly lose consciousness for short periods throughout the day. The work-up for loss of consciousness, however, is quite comprehensive. It is not in the field of obstetrics as it requires comprehensive evaluation of the heart and the brain. As a specialist in a multidisciplinary clinic, I knew only obstetricians and pediatricians took Medi-Cal insurance. I had no access to colleagues in neurology or cardiology who might provide their expertise to my patient, because Medi-Cal simply did not provide them with adequate reimbursement for their services. Subsequently, I had to transfer her to a county hospital, disrupting care continuity and adding stress to the patient and her family. Such are the vagaries of our current system.
COST OF MEDICINE
Why is medicine so expensive? Culturally, the western biomedical model framing disease as an invader to be defeated is the foundation of modern medicine and explains much about the typical physician's restricted focus on intervention. Additionally, the incentive system doctors face through reimbursement formulas explains a lot of the growth in the costs of health care. The scientific and positivistic approach to medicine has in many ways launched the modern medical–industrial complex, fostering a business model of high-cost health care delivery that does not match social needs. Large, extremely specialized, capital-intensive institutions have been created with the resulting neglect of less-costly primary and chronic care. According to the book Medicine and Culture, the American emphasis on aggressive medicine (compared with that of our European colleagues) is rooted in our cultural predilection for bold action and acute care over contemplation and judicious intervention that waits for solid empirical evidence of treatment efficacy.

In my own field of obstetrics and gynecology, American obstetricians often embrace technology with little evidence as to efficacy. The reasons behind this are a complex mixture of cultural attitudes, economic incentives to perform procedures, and professional liability concerns. For example, maintenance tocolytics (uterine muscle relaxants) used to treat preterm uterine contractions have not been found to prevent prematurity or reduce perinatal mortality, yet many obstetricians still use them. Antenatal nonstress tests (NSTs) are routinely ordered for women considered to be at increased risk for stillbirth without significant evidence of efficacy. The rate at which labor is induced increased from 9.5 percent to 21.2 percent between 1990 and 2004 in the United States, despite little evidence of clinical benefit, and the national Cesarean-section (C-section) rate has increased from 20.7 percent to 30.2 percent from 1996 to 2005. Unnecessary induction of labor and C-sections add significantly to the cost of care. Much of physician reimbursement is still driven by procedure (Current Procedural Terminology, or CPT, codes).
words, health care providers must do something for higher compensation. As for professional liability, when was the last time an obstetrician was sued for ordering too many fetal ultrasounds or monitoring her patient too closely with NSTs? We are always criticized for not performing a C-section in a timely fashion, rarely for performing an unnecessary one.

The modern medical–industrial complex in the United States is notoriously poor at calculating and controlling cost; using opaque byzantine reimbursement formulas that lack transparency even to many health care executives. Costs are allocated to procedures, departments, and services based on payer reimbursement, not on the actual resources used to deliver care. Kaplan and Porter eloquently state that “without proper measurement, the healthy dynamic of competition—in which the highest-value providers expand and prosper—breaks down. Instead, we have a zero-sum competition in which health care providers destroy value by focusing on highly reimbursed services, shifting costs to other entities, or pursuing piece-meal and ineffective line-item cost reductions.” They go on to assert that in order to manage value (patient outcomes achieved per dollar expended), both outcomes and cost must be measured at the patient level. This requires careful measurement of costs over a complete cycle of individual patient care for a particular medical condition. Most institutions are not administratively equipped to do this. Instead, providers measure only particular interventions they control, focusing on evidence-based guidelines and care processes. Process measurement is no substitute for outcome measurement. Porter defines three tiers to outcome measurements most relevant to patients: (1) health status achieved or retained; (2) process of recovery; and (3) sustainability of health. Having feedback on patient outcomes leads to innovation in care and lessens cost.

Another barrier thought to limit cost containment in health care is moral hazard due to insurance distorting health care markets. Having health insurance is believed to lead to excessive consumption of health care goods because insured individuals will consume medical services
past the point at which the marginal utility of an additional service is equal to its marginal cost. This prevents optimal pricing.

Under the current reimbursement environment stimulated by the ACA, groups of providers are consolidating within the US market at an accelerated rate, with multispecialty group practices or hospitals buying smaller practices and forming regional monopolies. Such super groups will have a robust advantage in rate negotiations. Hospitals affiliated with a system and hospitals in very concentrated markets typically have higher charges and profits. States, in turn, are outsourcing Medicaid to managed Medicaid plans, whose contracts are further fueling consolidation as commercial insurers buy their way into the market or make acquisitions to increase their market share and achieve economies of scale. Medicaid managed care capitation rates are linked to fee-for-service (FFS) historical rates and must be high enough to attract commercial participants. State officials assert that privatizing Medicaid through managed care leads to decreased cost and improvement in quality of care. This assumption has increased the percentage of Medicaid recipients enrolled in health maintenance organizations and other forms of Medicaid managed care from 11 to 71 percent from 1991 to 2009. A recent study by Duggan suggests that shifting Medicaid recipients from FFS to managed care did not, on average, reduce Medicaid spending. The data on quality of Medicaid managed care is also mixed. Aizer et al. studied pregnant women in California and found that those in Medi-Cal managed care received fewer prenatal visits and delivered fewer healthy babies than patients in the traditional Medicaid program.

Consolidation has also been stimulated by payment reform efforts through ACO contracts established between CMS and ACOs. Providers that meet quality standards are eligible to share savings with Medicare. So far, CMS has contracts with approximately 250 ACOs covering four million Medicare beneficiaries. The goal is to move from FFS payment to models supporting provider integration, care coordination, and patient education within a “medical home.” But as organizations consolidate, costs will increase through greater
bargaining power in regional markets. And as Porter has shown, our current assessment of value is deeply flawed. The imprecise quality metrics proposed to resolve this problem are unlikely to lead to improved health outcomes.

PHYSICIANS’ RESPONSE TO MEDICAID

The forces that drive costs up in medicine also play a role in distorting physicians’ incentives in other ways, as their autonomy is limited, affecting how they practice medicine. Historically, individual physicians have treated a certain amount of uninsured patients in their practice without charge or for a reduced fee as part of the medical profession’s ethical obligation to care for the poor. With the advent of Medicare and Medicaid in 1965, what had been private nonsystematized volunteer work by doctors and charitable organizations shifted to a broader social responsibility embodied in public insurance. These programs subsidized physicians’ ability to care for the indigent and needy. They also profoundly transformed American medicine at the socioeconomic level, making medicine dependent on social institutions and recasting it as a profession.65

The federal government’s attempt to seek control over the cost of medicine stimulated by Medicare and Medicaid funding inaugurated the era of managed care in the 1970s, leading to the loss of medicine’s independent professional and moral identity and altering the physician’s relationship with his or her patient. Jotterand states the following: “Cost containment appeared suddenly as a moral obligation imposed on the physician. This means that the physicians are no longer exclusively committed to their patients but also dependent on and controlled by the social institutions that structure health care, in particular its economic aspects.”66

Physicians’ real incomes have been largely stagnant since the 1990s and have even declined in the past 10 years with the rapid expansion of managed care and private insurers adopting Medicare’s physician fee schedule as a benchmark in negotiating payment rates.67 If Medicaid is
to be an effective cornerstone of health care reform, doctors will need to be fully on board. The most obvious barrier to physician acceptance is the typically low reimbursement levels offered by Medicaid for physician services. States have broad scope in setting physician reimbursement rates, causing Medicaid fees to vary much more widely than Medicare fees. In many states, Medicaid pays only about one-third of what Medicare pays for the same service. Data from the National Center for Health Statistics on the use of office-based physician care imply that higher Medicaid fees increase the number of private physicians in medical and surgical specialties accepting Medicaid patients.

Sommers et al. examined primary care physicians’ willingness to see Medicaid patients by sampling 1,460 primary care providers (PCPs) who worked in an outpatient setting from the 2008 Center for Studying Health System Change Health Tracking Physician Survey, supplemented by 15 in-depth telephone interviews. The study found that PCPs who were already serving a high volume of Medicaid patients were most likely to take on new Medicaid patients. Four out of 10 of these PCPs work in hospital-based practices and community health centers, tending to practice in lower-income areas. Practices based in hospitals can provide extra personnel, such as residents; and administrative efficiency, like centralized billing, that subsidize primary care provision to the poor. In addition, many Medicaid enrollees live in areas more likely to be served by community health centers and public hospitals (e.g., the inner city) than by office-based physician practices. PCPs that practice in higher-income areas tended to take few or no Medicaid patients, citing low reimbursement, difficulty arranging specialist care, burden of dealing with psychosocial issues of poverty, and administrative hassles with Medicaid billing requirements.

Notably in the Sommers et al. study, Medicaid reimbursement fee levels are only one of many factors affecting the number of physicians willing to accept Medicaid patients. If increasing patient access to physicians is to be achieved, simple fee increases alone will not be enough to expand physician supply. Cunningham and Nichols examined the effects of Medicaid reimbursement on access to care of
A PHYSICIAN’S PERSPECTIVE

Medicaid enrollees and found other determinants had a strong influence as well, including practice type, the extent of Medicaid managed care penetration in a particular geographical region, and the racial and ethnic composition of physicians and their communities.72

In addition to practice type, difficulty in coordinating care for Medicaid patients is another barrier to physician participation. Organizations having a large Medicaid population achieve the most effective health results, given their familiarity with the patients’ special needs and their having an existing infrastructure for psychosocial support. Problems in disease management in the indigent patient population are further exacerbated by patients fluctuating between insured and uninsured status, resulting in loss of care continuity. Many in this population have difficulty communicating because of phone access, language barriers, illiteracy, and disability. One proposed method for quality improvement in Medicaid care is the creation of disease management programs dealing with chronically ill enrollees. As is well recognized, 50 percent of total health care spending is due to 25 percent of the population that has heart disease, diabetes, asthma, and hypertension.73 Two major models exist for Medicaid chronic disease management programs. One is a primary care–focused action plan built on the chronic care model with participation by Federally Qualified Health Centers. The other is state investment in private disease management vendors.74 The difficult goal of disease management programs is to improve health status by reducing unnecessary hospitalizations, increase primary care utilization, and improve medication compliance and patient self-management skills.

A later analysis by Cunningham and Hadley75 led to some startling conclusions. The percent of physicians providing any charity care fell significantly from 76.3 percent in 1996–97 to 68.2 percent in 2004–05 and a growing number of doctors are receiving no income from Medicaid or are not accepting new Medicaid patients. This is likely secondary to further erosion of physician autonomy. Physicians are shifting to larger practices or institutional settings in order to gain the following: (1) leverage in negotiating with health plans; (2) economies
of scale to counteract the increasing administrative and regulatory requirements of practicing medicine; (3) financial security through salaried positions; and (4) higher quality of life with a more flexible work schedule. Interestingly, being part of a large group prohibits individual physician decision making in providing charitable care (i.e., free care) against organizational policy, but large group membership improved the likelihood of physician acceptance of Medicaid. Autonomous physicians who owned their own practices were oppositely aligned and more likely to provide charity care and less likely to accept Medicaid. Cunningham and Hadley conclude, “free care will become increasingly concentrated in safety net providers—such as public hospitals and community health centers. . . . Unless steps are taken to reduce the number of uninsured, safety net providers are likely to be overwhelmed by this increasing concentration of care at their facilities, and as a consequence, more uninsured patients will not receive any care at all.” Loss of physician professional autonomy leads to an erosion of traditional physician professional values, such as free care for the poor. And poverty is a critical factor when it comes to health.

POVERTY’S IMPACT ON HEALTH

A family’s income level is associated with morbidity and premature infant mortality, both internationally and within the United States. Important and modifiable risk factors can be discovered and addressed during prenatal care visits, thereby improving pregnancy outcomes. In the late 1980s, rising concern about the United States’ high infant mortality rate, compared with that of other industrialized countries, prompted passage of federal laws expanding Medicaid coverage for pregnant women. California thus followed suit by implementing several health policies aimed at increasing prenatal insurance coverage and utilization of care. To understand the magnitude of Medi-Cal, it is useful to know that one out of every eight babies in the United States is born in California. Throughout the 1980s and 1990s, California expanded Medi-Cal coverage to pregnant women
by: (1) extending public insurance to undocumented foreign-born women; (2) increasing income eligibility from 110 to 200 percent of the FPL; and (3) eliminating the assets test for women with incomes below 200 percent of FPL. Additionally, barriers to prenatal care coverage were addressed by: (1) increasing payments to obstetric providers by 85 percent; (2) implementing continuous eligibility throughout the pregnancy; (3) shortening the Medi-Cal application form; and (4) instituting presumptive eligibility, allowing temporary but immediate coverage for women who believe they are eligible for Medi-Cal. In response to concerns about fraud as Medi-Cal coverage expanded, the state created the California’s Department of Health Care Services’ antifraud program and implemented the annual Medi-Cal Payment Error Study in 2004.

Following statewide policy changes, studies were done to assess the impact of increased access to prenatal care through expansion of Medi-Cal. For example, Braveman et al. conducted a cross-sectional postpartum survey of 3,071 low-income women with Medi-Cal or private coverage throughout pregnancy in California from 1994 to 1995. This was accomplished in order to identify critical noninsurance barriers to timely prenatal care. Of those women, 28 percent had late prenatal care (e.g., the first health care provider visit occurred after 13 weeks of pregnancy). The following prepregnancy factors, beyond the reach and impact of publicly supported programs for pregnant women, were found to be the most important risk factors for untimely prenatal care: (1) unwanted or unplanned pregnancy; (2) no regular health care provider before pregnancy; (3) education at or below high school level; and (4) transportation problems. Another study performed by Nothnagle et al. investigated risk factors for late or no prenatal care after the expansion of Medi-Cal. A statewide postpartum survey of 6,364 women delivering in California hospitals from 1994 to 1995 was conducted and found that absolute poverty (at or below the FPL) was associated with a ninefold increased risk of no prenatal care after adjusting for insurance, age, parity, marital status, ethnicity, and other significant potential barriers. The authors surmised that
women in absolute poverty were socially marginalized, therefore did not enroll in Medi-Cal and obtain prenatal care because they lived in a family or community unsupportive of prenatal care. Nearly 29 percent of women surveyed who had no prenatal care before delivery reported that their receiving prenatal care had not been very important to those close to them.\footnote{85}

Despite the value of prenatal care on an individual basis, the short time these women in poverty spend with a health care provider can be like a Band-Aid on the gaping wound of harsh daily life. I have pregnant patients who work in factories with no air-conditioning or long hours in retail with little job security. Telling them to sit down or hydrate when having uterine irritability must seem straight out of fantasy-land for them.

As those in population health sciences already recognize, the social and environmental determinants of health are critically important demanding a move beyond the narrow focus on access to health care. Illuminating this point further, Kindig et al. found that female mortality rates rose in 42.8 percent of US counties from 1992 to 2006.\footnote{86} The authors sampled 3,140 counties (or county equivalents), compiling data from County Health Rankings, the Behavioral Risk Factor Surveillance Survey, and the Centers for Disease Control and Prevention’s compressed mortality database. The county-level percentage change in all-cause, age-adjusted mortality rate per 100,000 residents ages 75 or under for two time periods, 1992–96 and 2002–06, were examined. The authors used regression analysis to examine which county-level factors were associated with changes in mortality rates for males and females during this timeframe. Interestingly, none of the medical care factors (e.g., rates of primary care providers, preventable hospitalizations, percentage of uninsured) predicted changes in male or female mortality.\footnote{87} Geography had the strongest association with female mortality rates. Counties in the South and the Western United States had 6 percent higher female mortality rates than those in the Northeast.\footnote{88} Kindig et al. provided further evidence with this analysis that socioeconomic factors, such as education levels and rates of children living in poverty,
have an equally strong or stronger association with county mortality rates compared to access to medical care (no perceived impact) or individual behavior (e.g., smoking rates having some impact).

America’s Health Rankings has established four health determinant categories with weights of factors impacting health assigned by an expert panel as follows: 36 percent personal behaviors (somewhat contradictory to the Kindig et al. study); 25 percent community environment; 18 percent public and health policies; and 21 percent clinical care. The University of Wisconsin along with the Robert Wood Johnson Foundation has used the following weights of health factors in their county health rankings: 40 percent social and economic factors; 30 percent health behaviors; 20 percent clinical care; and 10 percent physical environment. Although the exact weights of the socioeconomic factors may not be precise, the implications for addressing health are clear. They count, and perhaps much more than clinical care. Certainly intrinsic or individual biological factors affecting health, such as genes, age, and sex, cannot be altered. Yet, economic conditions are modifiable and have a critical influence as well. These factors are outside the typical realm of physicians and are rarely addressed by hospitals, health plans, or even the public health community to a deep and meaningful extent. Economic prosperity, neighborhood safety, environmental issues, educational opportunity, and income all are crucial determinants of a region’s morbidity and mortality. In sum, “place matters,” as has been seen in the recent region-specific rise in female mortality in the United States. As a physician who has devoted her life to the health and well-being of women, I find it discouraging that clinical care has only a 20 percent impact for all that effort. Yet, doctors inherently focus on individual patients and their needs. This is both our strength and our evident loss of effectiveness.

The problem with focusing exclusively on health care access is that it ignores socioeconomic factors. As Evans and Stoddart have stated, “The concern is rather that the remaining shortfalls, the continuing burden of illness, disability, distress, and premature death, are less and
less sensitive to further extensions in health care—we are reaching the limits of medicine. At the same time the evidence is growing in both quantity and quality that this burden may be quite sensitive to interventions and structural changes outside the health care system.”

The importance of income levels on mortality is well recognized, with Peter Muening et al. estimating that Americans living on incomes less than 200 percent of the FPL claimed more than 400 million quality adjusted life-years (number of years of life that would be added by intervention) between 1997 and 2002, compared with those living on incomes 200 percent or more of the FPL.93 This statistic is greater in impact than tobacco use and obesity.94 Education levels also have a huge effect on health. Adults who do not have a high school diploma or GED are three times more likely than those with a college education to die before age 65. Every additional year in educational attainment reduces the odds of dying by 1 to 3 percent.95

Because of the relative importance of these other factors, the ACA quite obviously will have only a limited influence on the health and well-being of Americans. As has been demonstrated, access to health care providers and institutions is not the main issue in population health. Notably, the ACA does not take a public health approach in focusing on deficiencies in the United States health system, but rather attends to issues of health insurance.96 However, if national health outcomes and improvement are lightly weighed in the balance, the policy ramifications of the law are quite notable. As a consequence of the ACA, eligibility will be expanded to cover individuals making a higher income and eliminate restrictions to allow for coverage of everyone with incomes under the specified level, not just the categorically eligible.97 Interestingly, while trying to increase access to health care providers, the ACA seeks to contain costs related to health care expenditures by reducing payments to certain health plans and providers accepting Medicaid. The effectiveness of this approach has serious limitations. If cost restraints imposed are too harsh, physicians and hospitals will be forced to opt out of public insurance, an effect precisely the opposite of the one intended.
CONCLUSION
The essential question is, how can we ever achieve adequate health care with so many layers of need and at such crippling cost? The problems are real, immense, and complex. The United States spends ever-increasing sums of money for marginal benefits at best. Too much medical intervention can be unnecessary, possibly harmful, and without good scientific evidence as health care provision focuses on processes, not outcomes. The business model of the medical–industrial complex is opaque and notoriously complex with no clear link between price and value. Physicians are overwhelmed and dispirited as they see their time, which should be devoted to caring for patients, consumed by bureaucratic hurdles, multiplying regulations, and diminishing compensation. In vast numbers, doctors are shedding their traditional autonomy and becoming disempowered employees by merging their practices into corporate medicine. Medicine will be and has been diminished as a vital profession.

To understand these unwholesome phenomena, we should pull back the conceptual lens and look at the definition of health care. If you ask most people how they would want to spend their money or time, being in a medical center or hospital is at the bottom of the list. Our personal idea of health and well-being is different from health care. Well-being encompasses work that satisfies and sustains, having respect and support from friends and family, clean air and green vistas, safe neighborhoods to call home, and much more. To view the body narrowly as a machine with parts that needs to be fixed misses the critical ramifications of well-being on physical health. Concepts as nebulous as stress and despair rumble beneath the statistical surface as we see mortality rates layered along socioeconomic levels.

Yet the scientific biomedical model of health fosters the notion that well-being can somehow be obtained (purchased?) in a doctor’s office or hospital. Within this philosophical framework, modern societies devote ever-increasing proportions of economic resources to health care. As is clear from the amplifying focus on cost containment, health care is not free. It requires a major commitment in time, energy,
skills—and capital. Advances in medical technology and interventions have made huge strides in prolonging life and combating disease. But this is not the full picture. Population mortality is linked to levels of social support, stress, and powerlessness in very fundamental ways. Scholars categorize the four determinants of health as lifestyle, environment, human biology, and health care organization. Health care is only one component.

As a nation, we must ask ourselves if our unsustainable commitment of economic resources to health care is making us less healthy as a country. The solution will not come by devoting more time or intellectual energy on fixing the health care system. One hundred percent of governmental effort going toward 20 percent of the problem is a fatal sort of blindness. By impoverishing ourselves and our nation on health care expenditures, are we not neglecting the vital elements that are maintaining our health and well-being? State and federal budgets consumed with paying medical bills cannot fund, for example, education, environmental protection, or the creation of safe neighborhoods. Money dedicated to health care simply cannot be spent elsewhere.

NOTES
5. Gable, “The Patient Protection and Affordable Care Act,” 348.

11. Ibid., 825.

12. Ibid.


16. Ibid., 1031.


36. Ibid., 479.


39. Ibid., 1.

40. Ibid., 7.


53. Ibid.
55. Ibid., 2478–79.
62. Ibid.
66. Ibid., 116.
69. Ibid., 96.
72. Ibid., 693.
74. Dylan Roby, Gerald Kominski, and Nadereh Pourat, “Assessing the Barriers to


76. Ibid., 118.


84. Ibid., 256.

85. Ibid., 257.


87. Ibid., 453–55.

88. Ibid., 455.


94. Ibid.


97. Ibid., 346.
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