Madam chair, mister co-chair, and members of the task force: thank you for giving me the opportunity to speak with you today. I am Marc Joffe, a policy analyst at the Cato Institute. As a federal taxpayer from out of state, I appreciate you devoting a part of your summer seeking ways to slow the increase in Idaho's Medicaid costs and improve their predictably.

Unfortunately, I do not believe that switching more Medicaid beneficiaries to managed care is a great way to achieve these objectives. While the idea of professionally managing a beneficiary's care is intuitively attractive, it does not work well in the context of Medicaid.

Managed care providers often control costs by imposing copayments and deductibles on plan members. These forms of patient responsibility make members think twice before seeing a provider or visiting a hospital emergency room. But, per federal law, copayments and deductibles are generally not permitted under Medicaid.

While Medicaid Managed Care Organizations have fewer ways to achieve savings, they still must pay their stakeholders. Consider for example, Molina Healthcare, a managed care company that is already active in Idaho. According to the company's 2022 earnings report, it realized over $1 billion of Net Income on $31 billion of Premium Revenue. In addition to its 3.3% pre-tax profit margin, the company paid 7.2% of its revenue for General and Administrative expenses, and 1.5% for other expenses, leaving just 88% for medical care costs.

Now, as a proponent of the free market, I certainly do not object to companies paying their shareholders and employees. But I do question whether Idaho taxpayers should assume these costs unless they are going to be clearly offset by a much greater benefit.

Studies of Medicaid Managed Care have found little evidence that it provides overall cost savings. This was even admitted by Sellers Dorsey who stated in their report: "managed care typically does not (at least, not initially) reduce costs to the State".

Sellers and Dorsey go on to argue that managed care is more likely to improve budget stability and predictability. And I agree that if the state can lock in a capitation rate ahead of its budget process, managed care will provide better predictability for that fiscal year. But over the course of multiple fiscal years, capitation rates can and do fluctuate, and it is not clear that these fluctuations will be much less than they would be if Idaho stayed with fee for service.

Big fee for service programs like Idaho Medicaid benefit from the "law of large numbers." As the number of beneficiaries increases, the average cost of providing their health care converges toward the statewide average for individuals with similar characteristics.

A couple of recent cases cast doubt on the case for managed care. In 2012, Connecticut stopped using comprehensive Medicaid Managed Care Organizations and appears to have realized substantial cost savings as a result. After Connecticut ended its reliance on MCOs, Medicaid costs per member per month dropped and, as of fiscal year 2022, were still below 2012 levels despite substantial inflation across the economy and in the healthcare sector particularly.

In a national context, Connecticut's per beneficiary spending is lower than most other states despite the state's relatively high cost of living. Connecticut is also below national averages in terms of Medicaid administrative costs and the proportion of the state budget devoted to Medicaid.

We can also look at evidence from Idaho itself. Starting in 2018, DHW ramped up its use of Medicaid Managed Care for the state's population of "dual eligibles"—those eligible for both Medicaid and Medicare. Between SFY 2017 and 2021, Medicaid costs per dual eligible beneficiary more than doubled from less than $13,000 to over $30,000. It is not clear from the publicly available information we reviewed whether the increase was caused by the shift of most dual eligible beneficiaries to Comprehensive Managed Care Organizations, but it certainly does not appear that the increased reliance on managed care saved the state money.

Before shifting other Medicaid populations to comprehensive managed care, I hope that task force members will review the recent experience in Idaho as well as Connecticut's apparent success in transitioning back to a fee for service system.

Thanks again for your time today.

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