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MEDICAID IN 2005: PRINCIPLES & PROPOSALS FOR REFORM

PREPARED FOR THE
NATIONAL GOVERNORS ASSOCIATION

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Introduction: A Critical Time for Medicaid

This is a critical time for Medicaid, the federal – state program that 53 million Americans now depend on for health and long term care coverage. Medicaid has become the country's largest single health program. Spending accelerated at double-digit rates in recent years to over \$300 billion, surpassing even the cost of Medicare.

Medicaid is now threatened by the inability of states to afford rapidly increasing costs, by federal rules that constrain state options to shape and control their programs, and by federal budget pressure to slow federal spending. Beneficiaries with chronic conditions and disabilities fear these pressures could cause the coverage they depend on to be taken away. Increasingly, budget pressures have made it necessary for Governors to propose difficult program cuts that would affect those who are enrolled in the program, including senior citizens, persons with disabilities, pregnant women, children and families. Some of these Medicaid cuts might also have significant implications for local health care systems, medical providers and state economies.

The purpose of this paper is to look at the issues, problems and challenges that face Medicaid in 2005, the outlook for the future, and to offer principles and options for reform. Focusing on issues and problems should not suggest an unawareness of the good that Medicaid does. Indeed, it is not an overstatement to say that millions of people can be affected when Medicaid policy changes are made, both at the state and national levels. From the beginning of life to its end, it is Medicaid that makes the difference for many of the nation's most vulnerable citizens who would otherwise lack the means to afford the health care they need. Medicaid has a special role to play in several important areas, including assuring prenatal care, caring for babies in neonatal intensive care units, providing well-child preventive care and acute care for children that helps them stay healthy in school, providing long-term care and intensive care for persons with chronic conditions and disabilities and for persons with mental illness, and filling the gaps in Medicare for the nation's low-income seniors.

¹ The views expressed in this paper are those of the authors and do not necessarily reflect the views of the National Governors Association. The authors acknowledge and thank Esther Reagan of Health Management Associates for her assistance in the preparation of the paper.

In carrying out its many roles, Medicaid has become so large that its impacts are seen not just in the faces of those it serves, but also in the budgets of states (and in some states, localities) that help finance it. For states, Medicaid costs seem destined to increase faster than state revenues ever could. As a result, Medicaid has consumed an ever-increasing share of state budgets. According to the National Association of State Budget Officers, total Medicaid spending is now the largest single item in overall state budgets, having surpassed elementary and secondary education in 2003.²

A Basic Definition of Medicaid

In reality, Medicaid is not one program, but many. Medicaid is:

- An insurance program for low-income, uninsured children and some parents, and pregnant women;
- A program of chronic and long-term care for persons with disabilities, including persons with mental illness, and low-income elderly;
- A supplement to Medicare for low-income seniors and persons with disabilities, and a support for those awaiting qualification for Medicare on the basis of permanent disability; and
- A source of funding for safety net hospitals and community health centers that serve a disproportionate share of the uninsured.

Medicaid is sometimes referred to as a federal – state partnership, a reference to the fact that Medicaid is authorized under federal law and is administered by each state. The federal law defines the terms and conditions a state must meet for its expenditures to qualify for federal Medicaid matching funds. When these terms and conditions are met, the state is *entitled* to the federal matching funds. These terms and conditions specify that a state Medicaid program must cover certain “mandatory” eligibility groups and “mandatory” benefits. The state must also meet many other requirements, such as those that relate to qualifications of and payment rates for providers, allowed levels of beneficiary cost sharing, and the use of managed care. In addition, the federal law specifies that a state is entitled to federal Medicaid matching funds when it makes expenditures for certain qualifying eligibility groups and benefits that are listed as “optional.”

“Mandatory” population groups that a state must cover in its Medicaid program include individuals that meet defined criteria in specific “categories” of eligibility, including:

- Low-income families with children,

² National Association of State Budget Officers, *2003 State Expenditure Report*, October 2004.

- Elderly, blind and disabled persons receiving SSI cash assistance (although some states use more restrictive Medicaid eligibility criteria),
- Infants born to Medicaid-eligible women (through their first year of life as long as other specified criteria are met),
- Children under age 6 and pregnant women whose family income is at or below 133 percent of the Federal Poverty Level (FPL),
- Recipients of adoption assistance and foster care under Title IV-E of the Social Security Act, and
- Certain low-income Medicare beneficiaries and specified protected groups.

A state may also cover additional “optional” population groups, each with its own requirements in law related to income and resources. These groups include, among others: the aged and disabled with incomes above SSI levels, the medically needy (persons with incomes higher than mandatory coverage groups but with very high medical expenses), pregnant women with incomes between 133 and 185 percent of the FPL, and children who need institutional care but who may be served at home at lower cost. Altogether, there are at least 28 categories of eligibility specified in federal law.

States must include coverage for a specified set of services. “Mandatory” services include inpatient and outpatient hospital care, physician services, nursing home services for adults, pregnancy-related services, home health care, laboratory and x-ray services, family planning and medically necessary services identified through well-child exams (EPSDT³) for children. States are allowed also to receive federal Medicaid matching funds when they pay for up to 38 “optional” services for their Medicaid beneficiaries. Services classified as “optional” include ambulance transports; the services of chiropractors, dentists, optometrists, podiatrists, and therapists; dentures, eyeglasses, hearing aids and medical equipment and supplies; and prescription drugs. States have broad discretion in determining the amount, duration and scope of their covered services, and over the last few years states have increasingly chosen to eliminate or restrict coverage of a number of the optional services for their adult Medicaid beneficiaries in order to contain program costs.

As a practical matter, the distinction as to whether a benefit is mandatory or optional is somewhat blurred, regardless of how a benefit may be classified in federal law, since services regarded as medically needed are in each classification. For example, every state includes both ambulance and prescription drug coverage, even though both are listed as

³ Federal law and regulations related to Early and Periodic Screening, Diagnosis and Treatment preclude states from eliminating coverage of medically necessary services for children.

“optional.” Most states also cover intermediate care facilities for the mentally retarded (ICF/MR facilities) that are considered optional. A similar situation occurs with optional eligibility groups. For example, in 2004 a total of 40 states and the District of Columbia covered pregnant women at income levels above the federal minimum of 133 percent of the FPL, including 16 states with eligibility levels at or above 200 percent of the FPL. As a result, the majority of Medicaid spending – almost two-thirds – is for services and population groups technically defined as optional. Ninety percent of all Medicaid spending for long-term care is technically optional. About 80 percent of all spending on optional services is for persons who are elderly or disabled, including dual Medicare – Medicaid eligibles.⁴

Certain Medicaid requirements can be “waived” with federal approval, and every state has at least one waiver program. Waivers sometimes are referred to by the section of the Social Security Act that allows them. For example, some states operate their entire Medicaid program under a comprehensive waiver obtained under Section 1115. Some states have taken advantage of the Health Insurance Flexibility and Accountability (HIFA) option under Section 1115 to provide coverage to additional populations. Managed care programs are operated by many states under Section 1915(b) waivers. Every state has at least one Section 1915(c) waiver for home and community based long-term care services.

Within these options and constraints, every state defines its own program. As a result, every state is different from every other state in its eligibility levels, which population groups it covers, what services it covers, how much it pays providers for services, and whether or how much it requires beneficiaries to pay as cost-sharing. The one constant is that Medicaid only pays for services that are medically needed.

Federal law also specifies a formula for the federal Medicaid matching rate for each state, known as the Federal Medical Assistance Percentage (FMAP). The FMAP is intended to provide greater federal funding for states with lower average personal incomes compared to the national average. The FMAP is always at least 50 percent and could be as high as 83 percent. In 2005 the minimum 50 percent FMAP applies to 12 states with the higher average personal incomes, and to the five territories. The FMAP exceeds 70 percent for 10 states with lower average personal incomes. The FMAP is recalculated every year, and variations in the FMAP can occur with dramatic impacts on state budgets.

Ten Things to Know about Medicaid in 2005

By many measures, Medicaid is a program of significant impacts and successes. Because Medicaid is so large, so expensive and does so many things, its impact on the health and

⁴ “Medicaid’s Optional Populations: Coverage and Benefits,” Kaiser Commission on Medicaid and the Uninsured, February 2005. Publication 7254.

health care of low-income Americans is beyond easy description, and certainly is beyond easy quantification. The following is intended to illustrate ten key indicators of the dimensions of Medicaid in 2005.

1. *As Measured by Expenditures, Medicaid Is America's Largest Single Health and Long-Term Care Program.* Total Medicaid spending (including both federal and state spending) is projected to be \$329 billion in 2005, an amount that will account for over 2.6 percent of the entire Gross Domestic Product of the United States. Total Medicaid spending is projected to be slightly larger even than the federal government spends on Medicare.⁵ By itself, total Medicaid spending accounted for 17 percent of all U.S. health care expenditures in 2003.⁶ The percentage was higher for certain expenditure categories. For example:

- Medicaid accounted for 19 percent of the entire prescription drug market in 2003, making Medicaid the largest single purchaser of prescription drugs in the country. (This will change in 2006 when approximately half of the Medicaid prescription drug market share will be transferred to Medicare, even though Medicaid will continue to partially fund the cost of these drugs through the “clawback”.)
- Medicaid is the nation's primary long-term care program. Medicaid payments accounted for 46 percent of all nursing home revenues nationally in 2003 (although since Medicaid payment rates are lower than other payers, persons with Medicaid coverage accounted for over two-thirds of all persons residing in nursing homes.)⁷ Medicaid also is the primary payer for long-term care services in the home and community, with special “waiver” programs focused on the frail elderly, disabled adults, children with developmental disabilities, and persons with HIV/AIDS. Long-term care accounts for 35 percent of all Medicaid spending.

⁵ *Budget of the United States for Fiscal Year 2006*, as submitted February 7, 2005, Table 8.5 shows Medicare spending and the federal share of Medicaid spending. Total federal fiscal year 2005 Medicare spending is projected to be \$290 billion, which reflects offsets for beneficiary premiums. Federal Medicaid spending is projected to be \$187 billion. Total Medicaid spending is estimated by Health Management Associates (based on an average federal matching rate of 57 percent) to be \$329 billion. Projections accessed at: www.gpoaccess.gov/usbudget/fy06/hist.html. The Congressional Budget Office projects Medicare spending for federal fiscal year 2005 to be \$325 billion. Federal Medicaid spending is projected at \$186 billion. Assuming a 57 percent federal Medicaid matching rate, projected Medicaid spending would be \$326 billion. See: CBO, *The Budget and Economic Outlook: Fiscal Years 2006 to 2015*, Table 3-1. January 25, 2005.

⁶ Cynthia Smith, Cathy Cowan, Art Sensenig, Aaron Catlin, and the Health Accounts Team, “Health Spending Slows in 2003,” *Health Affairs*, January/February 2005. Based on National Health Care Expenditure Data, CMS, Office of the Actuary.

⁷ Cynthia Smith, et al., 2005.

- Medicaid has become the primary payer for care of persons receiving treatment for HIV/AIDS, covering 55 percent of all care in the U.S., including 90 percent of children with HIV/AIDS.⁸
- Medicaid pays for over half of all publicly financed mental health care in the U.S., including care delivered through community mental health centers in localities across the country. Medicaid plays an especially important role in paying for the psychotropic medications that are central to modern mental health treatment. Medicaid is on track to soon account for two-thirds of all public mental health care spending.⁹

2. *As Measured by Enrollment, Medicaid Provides Health and Long-Term Care Coverage for More Individuals than Any Other Program – 53 Million Americans in 2005.* Medicaid will serve more people than any other single health care program in America in 2005, providing coverage for more than 53 million low-income persons. By comparison, Medicare will serve approximately 41 million people.¹⁰ In 2005, Medicaid will cover medical costs for:

- 25 million children (over one-fourth of all children in the U.S.), including the delivery and care for 1.5 million newborns. This represents 37 percent of all U.S. births, a proportion that has been relatively constant for more than a decade.
- 13 million low-income, uninsured adults, including pregnant women and some of the parents of covered children.
- 15 million seniors and persons with disabilities, including almost seven million people also on Medicare (“dual eligibles”), plus persons awaiting enrollment in Medicare on the basis of permanent disability and persons disqualified from private or employer-sponsored health insurance because of disabling pre-existing conditions.

The 15 million seniors and persons with disabilities account for most of Medicaid spending. They account for less than 30 percent of enrollees, but for over 70 percent of Medicaid spending.

3. *Medicaid Has Been a Major Factor in Limiting Growth in the Number of the Uninsured.* Because of Medicaid, the increase in the number of persons with no

⁸ CMS, *Fact Sheet: Medicaid and Acquired Immunodeficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) Infection*, January 2002.

⁹ Jeffrey A. Buck, “Medicaid, Health Care Financing Trends and the Future of State-Based Public Mental Health Services,” *Psychiatric Services*, July 2003.

¹⁰ CBO March 2004 Baseline.

health coverage during the recent economic downturn was not as large as otherwise would have occurred. From 2000 to 2003, the number of persons in the country without health coverage increased from 40 million to 45 million.¹¹ Over the same period (June 2000 to June 2003), Medicaid enrollment increased by over nine million.¹² Clearly, the number of uninsured would have been much higher in 2003 were it not that Medicaid covered low-income uninsured children and families who lost health insurance when they lost their jobs, or when an employer stopped offering health insurance because it had become unaffordable.

4. ***Medicaid Enrollment Jumped 40 Percent in the Past Five Years.*** Medicaid is designed to be counter-cyclical, so it was no surprise that Medicaid enrollment would increase during the recent economic downturn. However, the dramatic increase in enrollment was unexpected. Enrollment jumped by one-third from 2000 through 2004. Based on the most recent state projections, enrollment will grow by another five percent in 2005, making overall enrollment growth for the years 2000 through 2005 nearly 40 percent.¹³ The evidence is that increasing enrollment accounted for most of the spending growth in recent years.¹⁴
5. ***Most Medicaid Beneficiaries Are Not on Welfare.*** Medicaid is now a health program. Since welfare reform in 1996, Medicaid is no longer linked to welfare. Twenty years ago, most persons on Medicaid – well over three-fourths – were receiving welfare. The reverse is the case in 2005. Now, the vast majority – perhaps over three-fourths – of all persons enrolled in Medicaid are not receiving any cash (welfare) assistance.¹⁵ Among children and families on Medicaid, it is estimated that fewer than 20 percent are also on welfare (i.e., receiving TANF cash assistance.) Even among the elderly and disabled groups on Medicaid, where Medicaid eligibility is often based on qualification for SSI assistance, almost half

¹¹ U.S. Census, August 2004.

¹² Eileen Ellis, Vernon Smith and David Rousseau, *Medicaid Enrollment in 50 States: June 2003 Data Update*, October 2004.

¹³ Vernon Smith, Rekha Ramesh, Kathy Gifford, Eileen Ellis, Robin Rudowitz, and Molly O'Malley, *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal years 2004 and 2005*, Kaiser Commission on Medicaid and the Uninsured, October 2004.

¹⁴ John Holahan and Arunabh Ghosh, "Understanding the Recent Growth in Medicaid Spending, 2000-2003," *Health Affairs Web Exclusive*, 26 January 2005.

¹⁵ Based on data from 13 states, the proportion of all Medicaid beneficiaries also receiving cash welfare assistance declined from 53 percent in December 1997 to 27.8 percent in December 2002. See: Eileen Ellis, Vernon Smith and David Rousseau, *Medicaid Enrollment in 50 States: December 2002 Data Update*, Kaiser Commission on Medicaid and the Uninsured, 2003. The declining percentage of persons on Medicaid also receiving cash assistance has been occurring since the mid-1980s. As one indication, data from Michigan show the total share of Medicaid beneficiaries receiving either TANF or SSI declining from 73 percent in 1993, to 63 percent in 1996, to 41 percent in 1999, and to 32 percent in 2002.

are simply low-income individuals with medical needs they could not otherwise afford.¹⁶

6. ***Medicaid Fills the Gaps in Medicare.*** Fully 42 percent of all Medicaid expenditures are for individuals who are also on Medicare.¹⁷ For dual eligibles, Medicaid pays the Medicare premiums, coinsurance and deductibles. Medicaid also pays for services not covered by Medicare, most notably nursing home care and prescription drugs. In addition, Medicaid is required by federal law to pay coinsurance amounts and/or premiums for other Medicare beneficiaries with low incomes who do not qualify for Medicaid.
7. ***Medicaid is Efficient Compared to Private Health Coverage.*** Medicaid has done an excellent job of holding down the per capita growth in spending. Over the period from 2000 to 2003, Medicaid per capita growth in the cost of acute care was just 6.9 percent. This compares with per capita growth for all Americans with private insurance coverage of 9.0 percent, and with the per capita growth in employer-sponsored health insurance of 12.6 percent.¹⁸ Medicaid programs have achieved this level of performance with administrative costs that are among the lowest of any health care payer in the country, typically in the range of four to six percent of claims paid.¹⁹ By comparison, a health maintenance organization (HMO) with administrative costs of eight to twelve percent of claims paid would be regarded as efficient and a well-run commercial health insurer typically would have administrative costs of 15 to 20 percent of claims paid. No program has done a better job than Medicaid at controlling health care spending, and no program has more limited administrative costs.
8. ***Total Medicaid Spending Has Increased Dramatically Since 2000.*** Medicaid spending increased rapidly in recent years. Total Medicaid spending increased by

¹⁶ Since welfare reform “de-linked” Medicaid from welfare in 1996, it has become difficult to track the proportion of Medicaid beneficiaries receiving cash assistance on a national basis. Some but not all states are able to provide data. Michigan is one state able to provide such data: in November 2004, families and children on Michigan Medicaid also receiving TANF accounted for 14 percent of all Medicaid beneficiaries. Elderly and disabled individuals on Medicaid also receiving SSI accounted for 16 percent of all beneficiaries. Together, 30 percent of Medicaid beneficiaries in November 2004 were receiving either TANF or SSI.

¹⁷ Based on the most recent available data, expenditures for dual eligibles accounted for 42.4 percent of all Medicaid expenditures on services in 2002. See: “Medicaid’s Optional Populations: Coverage and Benefits,” Kaiser Commission on Medicaid and the Uninsured, February 2005. Publication 7254.

¹⁸ Holahan and Ghosh, January 2005.

¹⁹ State Medicaid administrative cost percentage of 5.9 percent for Fiscal Year 2005 calculated from CMS data in the Federal Budget for Fiscal Year 2006, as submitted on February 7, 2005. Note that some states classify certain service costs, such as for medical transportation or case management, as administrative costs. The administrative percentage is also sensitive to payment rates per claim, and Medicaid payment rates typically are below those of other payers. These factors would tend to cause the calculated Medicaid percentage to be overstated.

almost twelve percent per year on average in 2001 and 2002, and then by about 9.5 percent on average in 2003 and 2004. In just four years, Medicaid spending increased by over 50 percent. This dramatic increase in spending was driven primarily by the significant growth in Medicaid enrollment, and also by the spike in health care costs, particularly for prescription drugs and hospitals. The growth in spending hit states especially hard because it coincided with the drop in state revenues that occurred in 2002 and 2003 due to the economic downturn. In the aggregate, overall Medicaid spending (net of third party collections, beneficiary cost sharing, pharmacy manufacturer rebates and other offsets) is projected to reach nearly \$330 billion in 2005. By comparison, Medicare spending (net of offsets, including beneficiary premiums) is projected to be \$290 billion.²⁰

9. ***Medicaid Spending Growth Has Outpaced Overall Inflation and State Revenue Growth.*** Medicaid spending is tied to the medical market, where annual cost growth has far exceeded growth in wages and general price inflation. State revenues are tied to tax bases that reflect growth rates for income and sales, which have lagged significantly behind the growth in medical costs. Total Medicaid spending has increased faster than state revenues every year since 1997. The difference has been especially dramatic since 2001, a period when spending growth was driven by very large increases in enrollment and medical costs. State revenues increased only one percent in 2001 and plummeted by 6.8 percent in 2002, while total Medicaid spending growth averaged about 12 percent per year. State revenues dropped 3.4 percent on average in 2003 and increased only 3.4 percent on average in 2004, a period when Medicaid spending growth averaged 9.5 percent.²¹
10. ***Medicaid Spending Growth Has Crowded Out Funding for Other Important Programs.*** Over the past two decades, the average share of state budgets set aside for Medicaid spending increased from eight percent in 1985 to 22 percent in 2003. In 2003, for the first time, total Medicaid spending surpassed spending for elementary and secondary education as the largest single item in overall state budgets. (Medicaid was 21.9 percent compared to 21.5 percent for K – 12 Education.) Looking specifically at state general fund budgets, Medicaid general fund spending averaged 16.5 percent in 2003.²² All signs suggest this trend will continue. Even with the best possible job of managing the program, Medicaid will

²⁰ President's Budget for Fiscal Year 2006, as submitted February 7, 2005. Historical Tables, Table 8.5 – Outlays for Mandatory and Related Programs.

²¹ Rockefeller Institute of Government and National Association of State Budget Officers, 2004.

²² National Association of State Budget Officers, *2003 State Expenditure Report*, October 2004. Individual state percentages of general funding spending vary in part due to different state definitions of the general fund.

continue to command a greater share of state budgets for the foreseeable future. Inevitably, this means fewer funds for other worthwhile public purposes.

The Outlook for the Future of Medicaid: Major Challenges in 2005 and Beyond

It would be encouraging both for the federal government and for states if the immediate prospect were for a leveling of Medicaid enrollment and spending growth. Unfortunately, such stability is not in the outlook. Instead, the more likely prospect is that Medicaid will continue to grow, and that spending growth will continue at rates far exceeding state revenue growth. As a result, Medicaid can be expected to account for an ever-increasing share of state budgets and continue to place pressure on the ability of states to fund other important spending priorities such as education.

Medicaid Growth Is Expected to Continue at High Rates, Driven by Factors Outside State Control. According to CMS and CBO, Medicaid spending is expected to average at least 7.6 percent to 8.4 percent over the next decade, driven by caseload growth and medical inflation, neither of which states control. Key trends that will drive Medicaid enrollment and spending over the next decade include the following:

- **Enrollment:** Medicaid enrollment has increased rapidly since 2001, driven by the confluence of a number of powerful forces. Key factors included the loss of jobs associated with the economic downturn, including jobs that had provided health coverage for workers and their families; by increasing numbers of persons without health insurance, caused by declining rates of employer-sponsored health insurance and by a shifting employment sector away from large industrial employers toward smaller, service-oriented businesses less likely to offer health coverage; and by increasing health care costs that caused some employers to stop offering health insurance and some employees not to take up coverage when it was offered because it was not affordable.

Over this period, the proportion of Americans under age 65 covered by employer-sponsored health insurance dropped dramatically – from 67 percent in 2001 to 63 percent in 2003. Analysts attribute the shift primarily to the economic downturn and to rapidly rising health insurance premiums. The drop in employer-sponsored coverage was associated with an increase both in the number of persons with no coverage and a significant increase in the proportion of Americans with coverage from Medicaid and SCHIP, which jumped from 8.9 percent in 2001 to 11.9 percent in 2003.²³

²³ Bradley Strunk and James Reschovsky, "Trends in U.S. Health Insurance Coverage, 2001 – 2003," Center for Studying Health System Change, Tracking Report No. 9, August 2004.

These trends contributed to the one-third increase in U.S. Medicaid enrollment in just four years.²⁴

- **Demographic changes:** At the same time, demographic changes beyond the control of states are contributing to increases in Medicaid enrollment of the elderly and disabled. Each year, an increasing number of individuals are turning age 65. Even though the big baby boomer “age wave” will not hit until 2011, the leading edge of the baby boom population is looming and will contribute to an increase in eligible populations based on age. Since disability is related to age, substantial increases in Medicaid enrollment can be expected among the disabled population. In addition, better medical care has increased life expectancies for the disabled, so there will be more persons living with disabilities and requiring health coverage for a longer period of time. The result is that the composition of the Medicaid caseload is expected to shift toward an increasing proportion of elderly and disabled, the most expensive eligibility categories. Even if the total caseload were to remain constant, this case mix shift has major implications for Medicaid costs over the next few years.
- **Medical inflation:** Medical inflation and other changes in the health care market place are also beyond the control of a state. Medicaid operates in the same health care market place as other health care purchasers, and is subject to the same forces that drive overall health care cost increases. Medical inflation in recent years has increased on average twice as fast as general inflation. Over the past four years from 2001 to 2004, the medical component of the Consumer Price Index has increased on average by 4.4 percent annually, while the overall CPI had average annual increases of 2.3 percent.²⁵ However, medical inflation is but one component of overall per capita growth in health care costs. Other factors include increasing utilization, changes in the types of services used and technology. In 2003 and the first half of 2004, the annual growth in U.S. per capita health care spending was 7.5 percent. This was a substantial drop from the ten percent per capita growth experienced in 2001. However, the leveling of growth in 2004 led economists to conclude that the slowdown in medical spending growth may have ended.²⁶ Thus, the prospect is that high rates of medical cost growth will continue in the health care market place in which Medicaid must operate.

Because Medicaid spending is tied to the cost and use of medical services, high rates of growth in per capita medical costs alone could cause Medicaid costs to

²⁴ Eileen Ellis, Vernon Smith and David Rousseau, *Medicaid Enrollment in 50 States: December 2003 Data Update*, Kaiser Commission on Medicaid and the Uninsured, 2005 (Forthcoming).

²⁵ U.S. Bureau of Labor Statistics, January 19, 2005. Calculated by HMA from data for annual price growth for the twelve months ending in December of 2001 – 2004, available at: www.bls.gov

²⁶ Bradley Strunk and Paul Ginsburg, “Tracking Health Care Costs: Spending Growth Slowdown Stalls in First half of 2004,” CSHSC Issue Brief No. 91, December 2004.

exceed the growth in the overall state budget. When medical cost growth is high, a state could fall behind financially even if the Medicaid caseload were to remain constant. However, caseload growth compounds Medicaid per capita spending growth and virtually assures the certainty that overall Medicaid cost growth would exceed state revenue growth.

- **Projections of Medicaid Spending:** The combination of these factors is reflected in projections of Medicaid spending. All forecasts are for continued growth in Medicaid enrollment and costs. The CMS projection in the Administration's budget for 2006 is for annual rates of growth that would average 7.6 percent over the next decade.²⁷ However, this includes an artificially low projection of 1.7 percent growth in 2006 due to a reclassification of prescription drug spending for Medicare- Medicaid dual eligibles, including the state "clawback payments," as Medicare spending. Over the period from 2006 to 2014, the CMS actuary projection is for Medicaid federal spending to increase at an annual rate of 8.4 percent, and for state spending to increase at an annual rate of 8.5 percent.²⁸ The projections from the CBO are similar, with projected growth of 7.8 percent over the ten years from 2005 to 2015, including average annual growth of 8.4 percent from 2007 to 2015.²⁹ Most of the growth is accounted for by projected increases in enrollment, medical prices and greater use of services by the elderly and disabled. Spending and enrollment in children and family categories, which are driven more by economic factors than demographics, are projected to be relatively flat over the next decade.³⁰

All projections are for Medicaid cost growth to far exceed overall state budget growth, which averaged 6.3 percent over the 26 years from 1979 to 2005.³¹ The simple arithmetic is that Medicaid is a cinch to consume an ever-increasing share of state budgets, based on current trends.

From a public policy point of view, several key issues emerge as urgent problems that need to be addressed. These issues are especially pressing for states, but they are fundamentally problems of national significance. The issues highlight how Medicaid could be modernized in a way that would allow states to make the program even more effective. How these issues are resolved will greatly influence how health care is delivered and financed in the U.S., and the extent Medicaid can continue to play a role in assuring health coverage for over 50 million Americans. Eight key issues are discussed below.

²⁷ Budget of the United States Government for Fiscal Year 2006, February 2005.

²⁸ Stephen Heffler, Sheila Smith, Sean Keehan, Christine Borger, M. Kent Clemens, and Christopher Truffer, "U.S. Health Spending Projections for 2004 – 2014," *Health Affairs Web Exclusive*, 23 February 2005.

²⁹ The Budget and Economic Outlook: Fiscal Years 2006 to 2015, Congressional Budget Office, January 25, 2005. Chapter 3.

³⁰ HMA analysis of Congressional Budget Office, Medicaid Baseline, March 2004.

³¹ NASBO, *The Fiscal Survey of States*, December 2004.

1. ***Medicaid Has Become Too Expensive for States to Afford.*** Unrelenting cost increases in Medicaid have taken state general revenue resources from education, public health and other important state priorities. It has not been unusual for the annual state general fund cost growth for Medicaid to consume half or more of the annual growth in state revenues, even in good economic times. The increasing cost of Medicaid is an issue for both federal and state governments, with one critically important distinction – states must balance their budgets annually. Medicaid total spending was eight percent of state budgets in 1985, but increased to 22 percent in 2003. As a share of state general fund budgets, Medicaid general fund costs have escalated to 17 percent. Even with states enacting strong measures to control the growth in Medicaid spending, it has been impossible to avoid the transfer of state resources from education (and other state programs) to Medicaid. Based on current trends, states cannot hope to sustain their support of Medicaid. It has become impossible for states to absorb even normal Medicaid cost increases.
2. ***The Federal Matching Formula Does Not Take into Account State Fiscal Capacity or Changing State Economic Conditions in a Timely Manner.*** The formula for the FMAP is based on average state personal income, which is a poor measure of state fiscal capacity. Even to the extent that the FMAP reflects changes from year to year, it does so with a significant lag. The result is that some states experience a drop in the federal matching rate at a time when state revenues are declining due to an economic downturn, further exacerbating state fiscal difficulties.
3. ***Medicaid Has Become a Major Subsidy for Persons on Medicare.*** One key reason that Medicaid costs have increased so much is that Medicaid has assumed a disproportionate share of costs for people already covered by Medicare. Medicaid payments for dual Medicare – Medicaid eligibles now constitute over 42 percent of all state Medicaid spending. Medicaid was never designed to spend such a large share of its resources on this population. In 1965, Congress created Medicare to cover the medical needs of seniors, expanding the program later to also cover people with disabilities. However, Medicare’s coverages are limited and it has been left for Medicaid to pick up most of the cost for nursing homes, home and community based long-term care, prescription drugs and other medical services Medicaid covers for people on Medicare who can’t afford them. Medicaid also pays the medical costs for low-income persons waiting for Medicare eligibility based on disability. In addition, state Medicaid programs are now mandated to cover the costs of Medicare premiums, coinsurance and deductibles for both Medicare Part A and Part B for low-income seniors. Though numbering fewer than 7 million, Medicare-Medicaid dual eligibles have become the single most expensive population group in Medicaid.

4. ***Eligibility Rules Are Outdated and Complex.*** Medicaid eligibility was de-linked from welfare eligibility in 1996, but Medicaid eligibility is still controlled by rules that were designed when Medicaid was the health coverage for welfare recipients. It no longer makes sense for states to be mandated to determine Medicaid eligibility based both on income and on an individual's categorical status as aged, blind, disabled, a child or a pregnant woman. Because of federal eligibility rules, it is not possible for a state to cover low-income non-disabled adults without children (single adults and childless couples) without a special waiver. Categorical eligibility no longer makes sense in today's Medicaid world.
5. ***Benefit Rules Are Outdated and Make Coverage Expansions Difficult.*** States have been thwarted in their attempts to extend coverage to additional optional eligibility groups without also extending the full benefit package. States (like Utah) have had to obtain a waiver to develop limited benefit packages when they attempted to extend coverage to uninsured populations with higher incomes. As a result, Medicaid rules have made it frustratingly difficult for states to extend coverage to the uninsured.
6. ***Beneficiary Cost Sharing Rules Are Outdated.*** Current rules for beneficiary cost sharing were written in the 1980s. Maximum copayments are still limited to \$3.00 for most services. These limits do not reflect reality in the current health care market. States believe the rules are outdated, since they prevent a state from considering even minimal cost sharing for optional populations. Policy makers in some states believe it is an issue of personal responsibility that optional populations with incomes above the poverty level pay a share of the cost of medical care they receive.
7. ***Medicaid Could Be Used to Encourage Employer-Sponsored Health Insurance.*** Current Medicaid law provides limited opportunities for states to subsidize and encourage employer-sponsored insurance. Premium subsidies are possible under Medicaid, and several states have tried them on a limited basis, but the opportunities that do exist are very cumbersome.
8. ***Territories Are Disadvantaged Under Current Medicaid Law.*** In general, current federal Medicaid law and regulations severely disadvantage the territories. They are limited statutorily to a 50 percent FMAP rate regardless of their average personal income, they have a capped allotment for federal matching funds that they regularly exceed (making their effective FMAP less than 50 percent), and they are prohibited from participating in Disproportionate Share Hospital (DSH) payments for their hospitals.

Guiding Principles and Recommendations for Medicaid Reform in 2005

Medicaid reform is overdue. For decades, states have struggled to adapt their programs to meet the health care needs of low-income uninsured, to reflect a changing health care marketplace, and to contain costs, but the rigid and inefficient design of the program often frustrated these efforts. Medicaid is rooted in a 1965 insurance model that simply does not fit the realities of today's health care world. Consequently, Medicaid has pushed state budgets to the brink and opened a window of opportunity for significant reform.

The principles listed below are intended to focus the Medicaid reform debate on the administrative and operational tools that states need to administer an effective program. Implicit in each principle is the necessity to adapt to changing circumstances over time. The static nature of the current program has nearly been its undoing. A more dynamic and fluid approach is needed going forward.

Modernize Medicaid

Today Medicaid is largely what it was in 1965. Unlike other programs, it has not been modernized. It still has many of the original eligibility and benefit mandates, discourages personal responsibility, limits cost sharing, emphasizes treatment rather than prevention, and does not reflect the changing demographics of Medicaid beneficiaries. States should be given the ability to correct these flaws, and to modify the program over time to keep pace with changes in delivery systems, beneficiary preferences especially for care in the home or community rather than an institution, industry practices and innovations in the health care marketplace.

Recommendations:

- Amend federal Medicaid law to provide states the option to eliminate categorical eligibility and to base eligibility simply on income.
- Amend federal Medicaid law to allow states to design benefit packages for higher-income population groups that might not be as comprehensive as provided for population groups with lower incomes.
- Eliminate the need for certain waivers, such as for family planning services, and simplify the process for obtaining those that remain. States also should be given the option to provide home and community based services under regular Medicaid coverage.

- Encourage state innovation in program design by simplifying state plan and waiver standards and processing requirements, which today are extensive, unwieldy and time-consuming.
- Allow states to partner with cities and counties in providing health care through locally designed networks.
- Restructure program financing in a way that reflects federal and state fiscal strengths, capacities and limitations.
- Ensure Medicaid reimbursement methodologies that encourage prudent payment for Medicaid covered services.

Promote Personal Responsibility

Medicaid was originally created to provide benefits to people receiving public welfare assistance. Today, most Medicaid beneficiaries are not on welfare as we now know it (i.e., TANF or SSI) and many beneficiaries work and have incomes above the poverty level. Medicaid beneficiaries increasingly enter the program with an expectation and desire to be treated as active participants with personal responsibility for their own health care decisions. States should be able to embrace this new relationship and develop policies that encourage personal responsibility.

Recommendations:

- Allow states to adopt policies that encourage Medicaid beneficiaries to be active participants in the program by making informed choices, directing their own care, sharing in the cost of their care, and helping to control program costs.
- Provide Medicaid beneficiaries and their families access to the information they need to navigate the health care system and to make informed decisions about their care.
- Allow states to adopt beneficiary cost sharing based on income, and consistent with cost sharing in employer-sponsored health insurance plans.
- Allow states to promote preventive care using enhanced reimbursement strategies with providers and care managers, and cost sharing strategies with beneficiaries.

Embrace Market Solutions

Medicaid per capita spending growth is low compared to any private health insurance coverage, and administrative costs are among the lowest of any health care payer in the country. Still, there is much that Medicaid can learn from innovations in the private

sector, particularly regarding benefit design, customer service, quality improvement, and efficiency in care management. States should be allowed to incorporate private sector innovations and collaborations into their program design.

Recommendations:

- Provide incentives for states to craft comprehensive, affordable benefit packages that look more like commercial plans, using SCHIP as a model.
- Provide incentives for states to adopt current private sector technologies, like health information systems, quality tracking and review, provider report cards, and other methods to measure and improve quality through the use of technology.
- Allow states to encourage choice through greater use and coordination with employer-sponsored health insurance, supplementing costs when necessary to encourage such coverage.
- Simplify the process for subsidizing employer-sponsored health insurance.
- Allow states to test innovative approaches within Medicaid that incorporate health savings accounts or tax credits as strategies to increase coverage for the uninsured.

Create Alternatives for Long-Term Care

Today Medicaid covers 14 million seniors and persons with disabilities, including two-thirds of all nursing home patients, many of whom are related to upper- and middle-income families. Medicaid pays Medicare premiums, coinsurance and deductibles for 6.4 million low-income people who also qualify for Medicare, and for services not covered by Medicare, most notably nursing home care (and prescription drugs until 2006). Medicare-Medicaid dual eligibles account for a surprisingly large (42 percent) and growing share of total Medicaid spending. Most of the spending growth in Medicaid is projected to be accounted for by increases in the elderly and disabled categories, which are primarily driven by demographics and their higher use of expensive medical services. Medicaid reform must directly address challenges associated with providing care for the elderly and disabled.

Recommendations:

- Amend federal Medicare law so the federal government assumes specific responsibility for low-income Medicare-Medicaid dual eligibles, including full payment of premiums, coinsurance and deductibles.
- Provide incentives for states to adopt policies that ensure those who can afford to pay for long-term care do so, including policies that advantage individuals with

long-term care insurance. Provide incentives for states that encourage greater reliance on long-term care insurance, including the greater availability “Partnership” programs.

- Integrate New Freedom Initiative principles into Medicaid program design, to provide opportunities for employment and greater consumer choice and direction for long-term and chronic care for persons with disabilities.
- Allow states to offer long-term care services in the most appropriate setting, respecting the preferences of individuals who can receive such care in their home or community, without the need for time-limited waivers.

Focus on Sustainability and Affordability

Medicaid growth is being driven by two main factors, both of which are beyond the control of states. First, Medicaid spending is a function of caseload, which has increased almost 40 percent in just five years. Second, Medicaid spending is tied to the medical market, where annual inflation has averaged at least two or three times higher than economic growth and wages (and therefore state tax bases) in recent years. As a result of these factors, total Medicaid spending has increased faster than state revenues every year since 1997. Medicaid spending growth has been especially dramatic since 2001, when it accelerated due to the downturn in the economy and resultant caseload growth. The current situation is simply unsustainable and creates an urgent and compelling case for reform. Medicaid reform must embrace strategies to manage program costs—as recommended under each of the four principles above—and to provide the prospect of sustainability and affordability over time. This will require a review of the relative roles of the federal government and states in the financing of Medicaid. From the perspective of states, there is a high level of urgency in addressing issues relating to financing and sustainability.

Recommendations:

- Update the formula for calculating the state-specific federal matching rates (FMAP) to make it more responsive to economic downturns and to state fiscal capacity.
- Re-align fiscal responsibility for persons covered by Medicare and Medicaid, so the federal government pays a more appropriate share of the costs for these low-income Medicare beneficiaries.

Summary and Conclusion

The year 2005 is indeed a critical time for Medicaid. The states that administer and finance Medicaid from their own resources have demonstrated a strong commitment to Medicaid, even during the most difficult fiscal period since the Great Depression. Over the past five years, economic and demographic forces have driven the costs of the program to the point that states are scarcely able to pay their share of the costs. State after state has been placed in a situation where difficult program reductions have been proposed and adopted, even when program cuts imposed burdens on beneficiaries with significant medical needs and no ability to pay for the care they needed.

Without question, Medicaid makes a positive difference in the health and health care for over 53 million of the nation's most vulnerable citizens. Medicaid has many strengths, and those strengths need to be preserved and used as building blocks to make the program better for the future. In terms of meeting its objectives, Medicaid is one of the most successful and cost-effective programs administered by government. Yet, Medicaid is in a sense a victim of its success. Its annual cost increases have become unaffordable for state, local and federal governments. States have been frustrated by program rules both when they attempted to control program costs and when they tried to use the program as a vehicle to reduce the number of uninsured. The current situation has served to put the shortcomings of the program into focus, and has elevated political attention to the point that needed change might be considered.

This paper has tried to describe the good that Medicaid does, while also identifying the areas of highest priority for action. The program is so large, so significant and so complex that it could never be easy to make changes. Yet, the need for change has become so urgent that it will be worth the effort to address the key areas, difficult as it will be, to make the nation's largest and in some ways most significant health care program even better, and most importantly, financially and programmatically sustainable into the future.

References and Resources on Current Medicaid Issues

The following is a list of references used in the preparation of this paper. They provide additional detail on the issues and are recommended for further reading.

Budget of the United States Government for Fiscal Year 2006, February 2005.
<http://www.gpoaccess.gov/usbudget/fy06/browse.html>.

Dual Eligibles: Medicaid's Role in Filling Medicare's Gaps, an Issue Paper, Judy Kasper, Risa Elias and Barbara Lyons, Kaiser Commission on Medicaid and the Uninsured, March 2004. <http://www.kff.org/medicaid/7058.cfm>.

Financing HIV/AIDS Care: A Quilt with Many Holes, an HIV/AIDS Policy Issue Brief, Kaiser Family Foundation, May 2004. <http://www.kff.org/hivaids/1607-02.cfm>.

Funding for Children's Mental Health Services: Making the Most of Medicaid, an Issue Brief, National Governors Association, January 26, 2005.
<http://www.nga.org/cda/files/0501childMentalHealth.pdf>.

MCH Update 2002: State Health Coverage of Low Income Pregnant Women, Children and Parents, National Governors Association, June 2003.
http://www.nga.org/center/divisions/1,1188,C_ISSUE BRIEF^D_5568,00.html.

Medicaid and HIV/AIDS, an HIV/AIDS Policy Fact Sheet, Kaiser Family Foundation, September 2004. <http://www.kff.org/hivaids/7172.cfm>.

Medicaid and Long-Term Care, Ellen O'Brien and Risa Elias, Kaiser Commission on Medicaid and the Uninsured, May 2004. <http://www.kff.org/medicaid/7089a.cfm>

Medicaid Enrollment in 50 States: June 2003 Data Update, Eileen Ellis and Vernon Smith, Kaiser Commission on Medicaid and the Uninsured, October 2004.
<http://www.kff.org/medicaid/7237.cfm>.

Medicaid's Optional Populations: Coverage and Benefits, Kaiser Commission on Medicaid and the Uninsured, February 2005. <http://www.kff.org/medicaid/7254.cfm>
This is an update of a more lengthy report published in 2001 called *Medicaid "Mandatory" and "Optional" Eligibility and Benefits*. <http://www.kff.org/medicaid/2256-index.cfm>

Program Information on Medicaid & State Children's Health Insurance Program (SCHIP), Centers for Medicare & Medicaid Services, 2004.
http://www.cms.hhs.gov/charts/medicaid/infomedicaid_schip.pdf.

The Budget and Economic Outlook: Fiscal Years 2006 to 2015, Congressional Budget Office, January 2005. <http://www.cbo.gov/showdoc.cfm?index=6060&sequence=0>.

The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005: Results from a 50-State Survey, Vernon Smith, Rekha Ramesh, Kathleen Gifford, Eileen Ellis, Robin Rudowitz and Molly O'Malley, Kaiser Commission on Medicaid and the Uninsured, October 2004. <http://www.kff.org/medicaid/kcmu100404pkg.cfm>.

The Fiscal Survey of States, National Association of State Budget Officers, December 2004. <http://www.nasbo.org/publications/fiscalsurvey/fsfall2004.pdf>.

The Uninsured: A Primer – Key Facts About Americans Without Health Insurance, Kaiser Commission on Medicaid and the Uninsured, November 2004. <http://www.kff.org/uninsured/7216.cfm>.

“There’s Something About Medicaid,” Alan Weil, *Health Affairs*, January/February 2003; 22(1): 13-30. <http://www.healthaffairs.org>.

Trends and Indicators in the Changing Health Care Marketplace, Kaiser Family Foundation, February 2005. <http://www.kff.org/insurance/7031/index.cfm>.

2003 State Expenditure Report, National Association of State Budget Officers, October 2004. <http://www.nasbo.org/publications/PDFs/2003ExpendReport.pdf>.

“Understanding the Recent Growth in Medicaid Spending, 2000 – 2003,” *Health Affairs Web Exclusive*, John Holahan and Arunabh Ghosh, 26 January 2005. <http://content.healthaffairs.org/cgi/reprint/hlthaff.w5.52v1>.

This article and related documents are also available on The Henry J. Kaiser Family Foundation web site at: <http://www.kff.org/medicaid/kcmu012605pkg.cfm>.

“U.S. Health Spending Projections for 2004 – 2014,” *Health Affairs Web Exclusive*, Stephen Heffler, Sheila Smith, Sean Keehan, Christine Borger, M. Kent Clemens, and Christopher Truffer, 23 February 2005.

<http://content.healthaffairs.org/cgi/content/abstract/hlthaff.w5.74>.

This article and related information are also available on The Henry J. Kaiser Family Foundation web site at:

http://www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=1365.