

## Medicaid and Entitlement Reform

By John Holahan

On October 17, 2008, the Center for Medicare and Medicaid Studies (CMS) released a report that projected that Medicaid spending would increase by 7.9% per year over the next decade.<sup>1</sup> Medicaid spending would grow from \$339 billion in 2008 to \$674 billion in 2017. Medicaid spending would increase as a share of the federal budget and grow faster than the gross domestic product. Such an increase seems unsustainable and a clear implication of the report is that Medicaid, along with Social Security and Medicare, needs to be seriously examined as part of any discussion of entitlement program reform.

My view is that the CMS actuaries estimates are in the ballpark but probably a bit too high. Many of the underlying reasons that the actuaries give for growth are at odds with recent history and this has important implications.<sup>2</sup> They project that Medicaid enrollment will increase by 1.2%. Recent evidence suggests that enrollment growth would probably be twice that rate. On the other hand, CMS's estimate of the increase in spending per enrollee of 6.6% seems too high given recent experience for both acute and long term care.

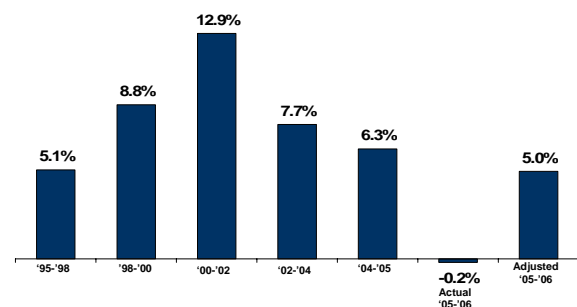
I believe that Medicaid spending will grow at a rate closer to 7% per year, the result of faster increases in enrollment but slower growth in spending per person than the actuaries project. Even a 7% per year growth rate still presents federal and state governments with a serious problem. But the policy implications are different if Medicaid spending growth is largely due to enrollment increases and underlying inflation rather than excessive increases in use of services.

### Background

Medicaid spending is much more variable from year to year than Medicare. This makes it much harder to make projections based on history, but it is still possible. Figure 1 shows the growth in

Medicaid spending over the past decade. Underlying these very different annual rates of growth is the fact that Medicaid spending has almost always grown at rates driven by enrollment growth, inflation, and key policy changes.

Figure 1  
**Medicaid Expenditures For Medical Services,  
Average Annual Growth Rates, 1995-2006**



SOURCE: Urban Institute, 2008. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64). Adjusted expenditures exclude all prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.

Medicaid spending increased by an annual rate of only 5.1% between 1995 and 1998 because of a combination of low enrollment growth and low rates of health care inflation. Enrollment barely increased in these years because of both welfare reform, which unintentionally removed individuals from TANF and Medicaid rolls, and the improving economy, which increased employment and incomes and in turn reduced

the numbers eligible for Medicaid. Health care inflation was also low during this period because of the impact of managed care on national health care spending. Both contributed to a low rate of increase in Medicaid spending per enrollee.

Between 1998 and 2000, Medicaid spending growth picked up and averaged 8.8% per year. Enrollment increased because the initial impacts of welfare reform on enrollment were reversed and because strong increases in state revenues and the legislation enacting the State Children's Health Insurance Program (SCHIP) allowed states to take steps to expand Medicaid enrollment. Health care costs also began to increase more rapidly than in the 1990's, particularly for prescription drugs and hospital services. States also discovered upper payment limit programs as a mechanism to bring in new federal funds without a true state matching contribution.

Between 2000 and 2002 Medicaid spending increased again and averaged almost 13% per year. This was mostly driven by enrollment increases of 8.4% per year largely, among families. This was due to rising unemployment which led to more people being eligible for Medicaid. The coverage expansions of the late 1990's also meant that there were more pathways to eligibility during the economic downturn. Health care costs continued to grow particularly for prescription drugs, hospitals, and nursing homes. Some of this was related to the use of upper payment limit programs, particularly for nursing homes.

Between 2002 and 2005, Medicaid enrollment grew more slowly and underlying health care cost inflation also slowed. In 2005 prescription drug spending actually declined. In addition, between 2002 and 2005, the federal government was more successful in controlling state use of upper payment limit programs.

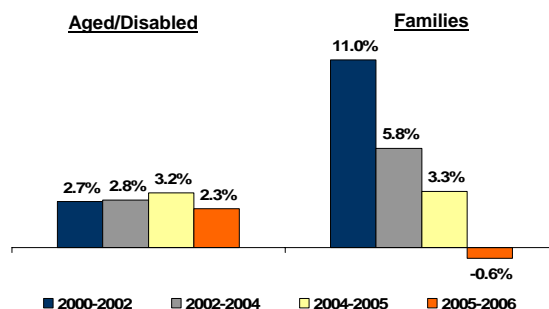
In 2006, the Medicare Modernization Act shifted the cost of prescription drugs for dual eligibles to Medicare. Enrollment

growth was also relatively flat in 2006. Thus overall Medicaid spending fell slightly, about 0.2%. When we removed prescription drug spending for dual eligibles from both the 2005 and 2006 data, we see that Medicaid spending increased by 5.0% in 2006.

### Enrollment Growth

In the past six years we have seen increases in enrollment among the aged and disabled that have averaged about 2.5% per year (Figure 2). This is considerably faster than U.S. population growth which has averaged about 1% per year. The reasons for the growth in the disabled are not well understood. The possibilities include the fact that the baby boomers have now reached their 50s, the age at which the likelihood of disability begins to increase. There are also new technologies and new drugs that can prevent death but can also leave individuals disabled. Often these individuals enroll in and remain on Medicaid for the rest of their lives. Finally, there is an increased ability to diagnose and treat chronic illness, particularly mental.

Figure 2  
**Medicaid Enrollment, Average Annual Growth Rates, 2000-2006**



SOURCE: Kaiser Commission on Medicaid and the Uninsured and Urban Institute, 2008. Estimates based on KCMU Medicaid enrollment data collected by Health Management Associates from 45 states inflated proportionally to national totals.

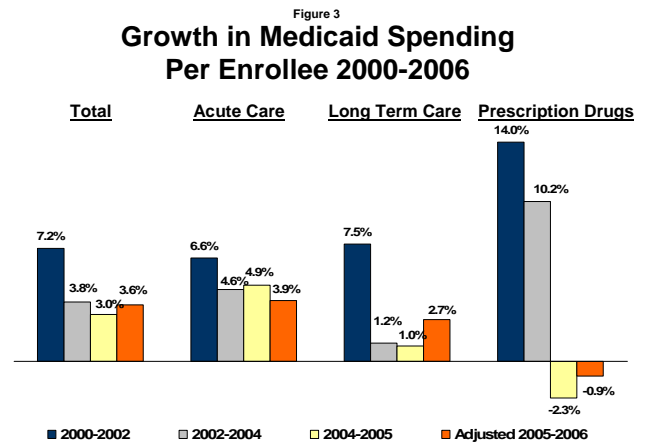
Growth in enrollment among parents and children averaged about 6% per year over the 2000-2006 period. This covered a period of bad economic times as well as good. Enrollment growth was 11% per year between 2000 and 2002 but then declined and actually fell slightly between 2005 and 2006. In the early years of the decade, enrollment growth was driven by the bad

economy. The recession led to loss of jobs and incomes and more people becoming eligible for Medicaid. As the economy improved, enrollment growth declined. Another underlying factor is the growth in the number of low income people over the time period, possibly driven by overall changes in the larger economy including globalization. Specifically, there were large increases in numbers of low income people. Between 2000 and 2007, the overall population grew by 11.4 million; 9.4 million of this was among those below 200% of poverty.<sup>3</sup> Some people experienced income increases and others decreases. But the net effect was that most of the net population growth between 2000 and 2007 was among those below 200% of poverty. To the extent this trend continues, enrollment growth in Medicaid will remain high. Also looming is the current economic crisis which could mean that enrollment growth and Medicaid spending will increase significantly in the next few years.<sup>4</sup>

### Spending Per Enrollee

Figure 3 shows the growth in Medicaid spending per enrollee. Overall Medicaid spending increased by 7.2% per year between 2000 and 2002 and by less than 4% per year over the next four years. The rate of increase in acute care spending per enrollee fell because of several state policy actions including the shift to Medicaid managed care, low provider payment increases and limits on optional benefits. Spending on long term care services per enrollee fell because of flat nursing home caseloads and that there have been cuts (or small increases) in nursing home payment rates. This in part reflects the phasing out of upper payment limit, arrangements by which states increase nursing home payment rates with little or no actual state contribution. There have also been very slow growth rates in other institutional services. Home care and personal care services increased by 12% between 2000 and 2002, but increased at single digit rates thereafter. Finally, growth in prescription drug spending fell

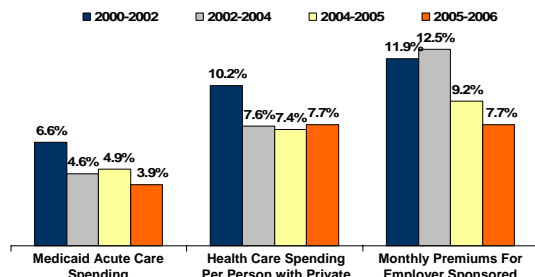
precipitously. While increasing at double digit rates between 2000 and 2004, prescription drug spending actually fell in 2005 overall (prior to the Medicare Modernization Act) and by about 1% among non duals between 2005 and 2006. This seems to be related to a set of aggressive state policies including preferred drug lists, increased emphasis on generic prescribing, copayments and prior authorization.



SOURCE: Urban Institute, 2008. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64), Medicaid Statistical Information System (MSIS), and KCMU/HMA enrollment data. Adjusted expenditures exclude all prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.

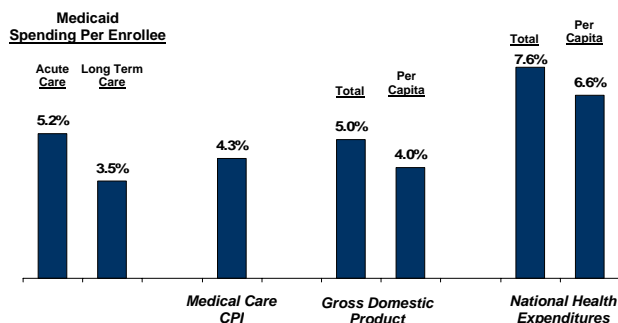
The result is that Medicaid spending on acute care services has grown slower than health care spending among those with private coverage. It has also grown more slowly than monthly premiums for those with employer sponsored insurance<sup>5</sup> (Figure 4). Medicaid spending for all services averaged about 4.8% per year between 2000 and 2006, including 5.2% for acute care services, and 3.5% per year for long term care services (Figure 5). These growth rates are in keeping with key economic benchmarks over the 2000-2006 period. The Consumer Price Index for Medical Care (CPI-MC) averaged 4.3% over the period and gross domestic product increased by 5.0% or on a per capita basis by 4.0%.<sup>6</sup> Overall Medicaid spending has grown faster (7.7%), than medical care price inflation and gross domestic product, but the reason for that lies largely with enrollment growth.

Figure 4  
**Growth in Medicaid Acute Care Spending per Enrollee vs. Private Health Spending and Premium Growth, 2000-2006**



<sup>1</sup> Kaiser Commission on Medicaid and the Uninsured and Urban Institute analysis of MSIS, CMS-64, and KCMU/HMA data, 2007. 05-06 data are adjusted to remove the effect of the shift in spending for Rx drugs for dual eligibles from Medicaid to Medicare.  
<sup>2</sup> Ginsburg, Strunk, Banker, and Cookson, "Tracking Health Care Costs: Continued Stability But At High Rates in 2005", *Health Affairs*, October 3, 2006.  
<sup>3</sup> Kaiser/HRET Survey of Employer-Sponsored Health Benefits, 1999-2006.

Figure 5  
**Medicaid Expenditure Growth vs. Various Benchmarks, 2000-2006**



SOURCE: Urban Institute, 2008. Estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64). Adjusted expenditures exclude all prescription drug spending for dual eligibles to remove the effect of their transition to Medicare Part D in 2006.

## Implications For Future Growth

So what does this mean for future projected Medicaid spending growth? Enrollment growth among the aged and disabled is likely to continue to increase by 2-3% per year. The same forces, e.g. the baby boomers and new medical technologies and pharmaceuticals, that have kept enrollment in this range for the past decade are likely to remain. Enrollment among parents and children are also likely to increase by 2-3% at a minimum, but will be largely dependent on the economy and state and federal policy responses. Slow economic growth coupled with declining incomes among the middle class will certainly mean that Medicaid enrollment could grow significantly, how much depends on the depth of the sharp economic downturn that is now expected.

Medicaid spending per enrollee should grow about 4%-5% per year, consistent with past trends. This largely depends on the underlying inflation (or deflation) but it is likely to be close to the medical care CPI or GDP as it has been throughout the past decade. Taken together we would project that Medicaid spending would increase by about 7%, somewhat lower than the 7.9% the CMS actuaries forecast.

The policy implications of a 7% per year growth rate however depend largely on whether the growth is fueled by increases in enrollment or spending per enrollee. If Medicaid expenditures have risen because of increases in spending per enrollee this may reflect inefficiency in the system and better policies can be designed to control the cost growth. But in reality, Medicaid is not growing faster than medical care inflation. This suggests that Medicaid cost increases are largely driven by systemic factors that have contributed to the nationwide increase in health system costs.

But if the primary cause of Medicaid growth is enrollment increases, which seem to be the case, then it is harder to deal with. In the past, Medicaid enrollment increases have offset declines in employer sponsored insurance; without Medicaid growth, the number of uninsured would be substantially higher. Limits on enrollment will increase the number of uninsured adversely affecting the health of many and shifting the costs of dealing with uncompensated care to localities with no federal matching payments. Cutting enrollment is also inconsistent with the general consensus that we should reduce the number of uninsured.

While entitlement reform is a serious issue, it is hard to see how Medicaid fits in, particularly when there is a need to broaden coverage. The reality is that Medicaid programs have been very aggressive at controlling health care costs. States have tried a broad array of strategies over the years and have generally kept program cost growth in line with medical care inflation and growth of the economy. Doing better will

require lowering cost growth in the system in general.

The one exception lies in the way we care for and pay for the dual eligibles – those who are eligible for both Medicaid and Medicare. The duals are seven million individuals, many of whom have multiple chronic conditions; they will cost the Medicaid and Medicare programs over \$200 billion in 2008. Because states have only partial responsibility for these populations, it is difficult for them to design programs to more efficiently meet their needs. Since the responsibilities are split between the two programs, coordination is difficult. One solution may be to shift the costs of managing these programs to the federal government which could then be charged with developing the best ways of caring for these populations. In exchange states might

take on greater responsibilities for other groups.

A second area for potential cost containment in the program would be to continue federal efforts to eliminate or restrict state Medicaid financing practices that are designed to bring in federal match with little or no real state contribution.<sup>7</sup> Over the past several years, both the Bush and Clinton administrations have sought to control these strategies through both legislation and regulation.<sup>8</sup> Despite these efforts, however, states have managed to devise new ones. The only way to truly solve this seemingly intractable problem would be to federalize Medicaid. Given that at this juncture such a major overhaul does not seem realistic, the problem of state Medicaid maximization problem will likely persist and the federal government will need to remain vigilant to help keep Medicaid costs in check.

## Notes

<sup>1</sup> Center for Medicaid and Medicare Studies, Office of the Actuary “2008 Actuarial Report on the Financial Outlook for Medicaid” Washington, DC, October 17, 2008.

<sup>2</sup> John Holahan, Mindy Cohen, and David Rousear, “Why Did Medicaid Spending Decline in 2006?”, Kaiser Commission on Medicaid and the Uninsured, October 2007.

<sup>3</sup> John Holahan and Allison Cook “The U.S. Economy and Changes in Health Insurance Coverage, 2000-2006,” *Health Affairs* March/April 2008; 27 (2): w135-w144.

<sup>4</sup> Stan Dorn, Bowen Garrett, John Holahan, and Aimee Williams, “Medicaid, SCHIP and the Economic Downturn: Policy Challenges and Policy Responses,” Kaiser Commission on Medicaid and the Uninsured, April 2008.

<sup>5</sup> Ginsburg, Strunk, Banker, and Cookson, “Tracking Health Care Costs: Continued Stability But At High Rates in 2005”, *Health Affairs*, October 3, 2006.

<sup>6</sup> Bureau of Labor Statistics “CPS Detailed Report”, Editor Malik Crawford, September 2008,

<http://www.bls.gov/cpu/cpi0809.pdf> ; U.S. Department of Commerce, Bureau of Economic Analysis “National Income and Product Accounts Table, Table 1.1.5 Gross Domestic Product”, <http://www.bea.gov/national/nipaweb/TableView.asp> .

<sup>7</sup> Teresa A. Coughlin et al. 2007. Restoring Fiscal Integrity to Medicaid Financing? *Health Affairs*. 26(5): 1469-1480.

<sup>8</sup> See, for example, Testimony of Thomas Scully, Administrator, CMS, “Challenges facing the Medicaid Program in the 21<sup>st</sup> Century,” Before the House Energy and Commerce Committee Subcommittee on Health, October 8, 2003. Schwartz S, Gehshan S, Weil A and A Lam. 2006. “Moving Beyond the Tug of War: Improving Medicaid Fiscal Integrity.” National Academy for State Health Policy, Washington, DC, August. Federal Register. 2001. January 12, 2001. 66(9):3147-770. Federal Register. 2002. January 18, 2002. 67(13): 2602-11.