

# medicaid and the uninsured

**May 2002**

## **Acceleration of Medicaid Spending Reflects Mounting Pressures**

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### **Overview**

After three years of relatively slow spending growth, Medicaid spending accelerated in 1999 and 2000, and more rapid growth appears likely to continue. Medicaid spending grew by 7.1% in federal fiscal year (FFY) 1999 and 8.6% in FFY 2000, compared to an average of 3.6% per year from 1995 to 1998. Data from the U.S. Department of the Treasury indicate faster growth in FFY 2001 and early FFY 2002, and the Congressional Budget Office (CBO) projects Medicaid spending growth to average 9% per year through 2012.<sup>1</sup> Although healthcare expenditures are also rising in the private sector, the acceleration of Medicaid spending growth is a serious concern for the federal government and state governments facing a combination of less revenues and increasingly austere budget forecasts.

There are several reasons for faster rates of growth in Medicaid spending. After declining between 1995 and 1998, Medicaid enrollment of children and families rebounded in 1999 and continues to rise. Enrollment of the aged, blind and disabled continued to increase at rates similar to those in the recent past. In part because of increased enrollment of children and families, acute care spending is growing more rapidly than in previous years, rising by an average of 10.1% per year between 1998 and 2000 versus 4.9% between 1995 and 1998. There are other factors behind the rise in acute care spending, several of which have been identified as also contributing to the rise in healthcare costs in the private insurance market.<sup>2</sup> Expenditures for prescription drugs are rising at double-digit rates. Hospital costs, both inpatient and outpatient, are increasing more rapidly than in the mid-1990s. Medicaid managed care does not seem to be providing states with the same savings as it may have in earlier years. Long term care spending is growing faster—averaging 7.4% between 1998 and 2000 versus 5.7% between 1995 and 1998—because of increased use of home care services as well as faster growth in nursing home spending. Growing use of upper payment limit arrangements is also contributing to rising Medicaid expenditures, at least at the federal level.

<sup>1</sup> U.S. Department of the Treasury. Financial Management Service (various release dates). "Monthly Treasury Statement of Receipts and Outlays of the United States Government" [Online]. Retrieved May 1, 2002 from the World Wide Web: [www.fms.treas.gov/mts/index.html](http://www.fms.treas.gov/mts/index.html); Congressional Budget Office (March 2002). "CBO March 2002 Baseline: Medicaid and State Children's Health Insurance Program Fact Sheet." Washington, D.C.: Congressional Budget Office.

<sup>2</sup> Strunk, Bradley C., Paul B. Ginsburg, and Jon R. Gabel (September 2001). "Tracking Health Care Costs." *Health Affairs Web Exclusive* [Online]. Retrieved February 15, 2002 from the World Wide Web: [www.healthaffairs.org/2005Strunk\\_rp.pdf](http://www.healthaffairs.org/2005Strunk_rp.pdf); Levit, Katharine, Cynthia Smith, Cathy Cowan, Helen Lazenby, and Anne Martin (January/February 2002). "Inflation Spurs Health Spending in 2000." *Health Affairs* 21(1): 172-181.

## Growth in Enrollment

After declining for several years, Medicaid enrollment began to increase in 1999. Between 1995 and 1998, total enrollment dropped by an average of 1.0% per year, dropping from 41.7 to 40.4 million (Figure 1). Modest increases in the aged, blind and disabled population throughout this period were more than offset by declines among children and families. The decline in enrollment among children and parents reflected a response to both an improved economy and state and federal welfare reform efforts.<sup>3</sup> The Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA) gave states new opportunities to expand eligibility but it also necessitated that states alter their administrative systems to accommodate separate eligibility requirements for Medicaid and cash assistance. Delays in adopting new systems created confusion on the part of both caseworkers and beneficiaries, adversely affecting Medicaid participation.<sup>4</sup> In 1999, enrollment of adults and children began to rebound, growing by 1.0% according to preliminary data from the Centers for Medicare and Medicaid Services (CMS) (Figure 1). The same data indicate that enrollment of the aged, blind, and disabled also grew more quickly in 1999.

<b>Figure 1</b>					
<b>Changes in National Medicaid Enrollment by Group, Federal Fiscal Years 1995 to 1999</b>					
<b>Group</b>	<b>Enrollment (millions)</b>			<b>Average Annual Percent Change, FFY 1995-FFY 1998</b>	<b>Percent Change FFY 1998-FFY 1999</b>
	<b>FFY 1995</b>	<b>FFY 1998</b>	<b>FFY 1999*</b>		
Total	41.7	40.4	41.1	-1.1%	1.7%
Aged, Blind & Disabled	10.4	11.1	11.5	2.2%	3.6%
Children & Families	31.2	29.3	29.6	-2.1%	1.0%

Sources: Urban Institute estimates based on data from HCFA-2082 Reports and the Medicaid Statistical Information System (MSIS).  
 General notes: Data include Title XXI (SCHIP) enrollees in Medicaid SCHIP expansions, but not SCHIP enrollees in separate state programs.  
 Growth rates are based on total, unduplicated enrollee counts for the entire federal fiscal year.  
 \* FFY 1999 estimates are based on limited, preliminary information and are subject to change with more complete data.

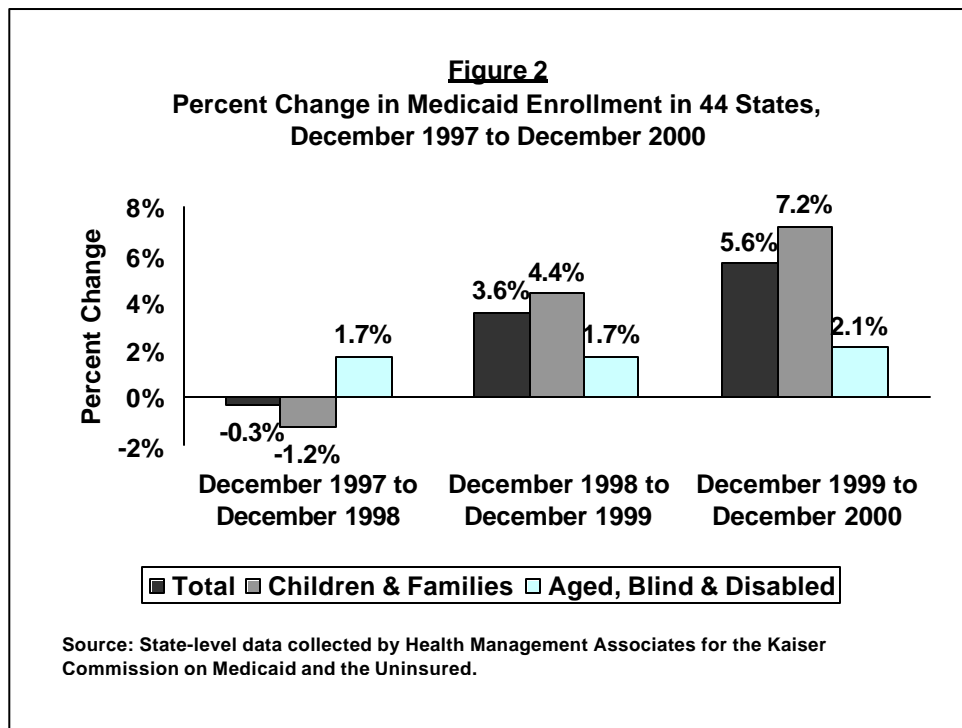
States' own Medicaid enrollment reports provide more timely data than national data from CMS. Data from 44 states show that enrollment increased by 3.6% between December 1998 and December 1999, and by another 5.6% by December 2000 (Figure 2). These data also indicate that enrollment of the aged, blind and disabled grew by about 2.0% per year throughout this period, but that the primary reason for the growth in Medicaid enrollment was an increase in enrollment among children and families, which grew by 4.4% in 1999 and by

<sup>3</sup> Garrett, Bowen, and Alshadye Yemane (forthcoming). "How Economic Factors and Policy Choices Affected States' Medicaid Enrollment and Expenditure per Enrollee: 1991-1998." Washington, D.C.: The Urban Institute. Unpublished working paper.

<sup>4</sup> Ellwood, Marilyn (December 1999). "The Medicaid Eligibility Maze: Coverage Expands but Enrollment Problems Persist." Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Occasional Paper 30; Ellwood, Marilyn, and Kimball Lewis (August 1999). "On and Off Medicaid: Enrollment Patterns for California and Florida in 1995." Washington, D.C.: The Urban Institute. *Assessing the New Federalism* Occasional Paper 27; Ellwood, Marilyn, and Leighton Ku (May/June 1998). "Welfare and Immigration Reforms: Unintended Side Effects for Medicaid." *Health Affairs* 17 (3): 137-51.

7.2% in 2000 (Figure 2).<sup>5</sup> Data from the Current Population Survey (CPS) suggest that enrollment in Medicaid and S-CHIP increased for children but not for non-elderly, non-disabled adults. This finding suggests that the increase in enrollment of children for children and families shown in Figure 2 was principally among children.

Several factors explain the rebound in Medicaid enrollment reflected in Figures 1 and 2; most reflect the higher priority given to expanding enrollment of children and their parents. CMS responded to the new administrative barriers by issuing directives urging states to increase outreach to beneficiaries who remained eligible after cash assistance was terminated. Several states expanded eligibility to low-income populations through either provisions of Section 1931(b) of the Social Security Act or Section 1115 research and demonstration waivers. Many states simplified their Medicaid application and redetermination processes.



Lastly, in some states, more children enrolled in Medicaid as a result of expansions funded by the State Children's Health Insurance Program (S-CHIP) and/or S-CHIP outreach efforts.

<sup>5</sup> The data in Figure 2 reflect a fundamentally different measure of enrollment than the data in Figure 1. Figure 2 provides a snapshot of the change in enrollment from a single month (December) in one year to the same month in the subsequent year. The data in Figure 2 more closely resemble changes in average monthly enrollment—that is, the number of people served at any point in time. Figure 1 shows the change in the total number of unique individuals that enrolled in Medicaid for any length of time during each federal fiscal year (October-September). This measure is often called "ever-on" enrollment. Average monthly enrollment is lower than ever-on enrollment because enrollees cycle on and off the program over the course of the year. Trends shown by these two measures can also differ considerably. For example, if Medicaid enrollees "turn over" at a faster rate, enrollment on an "ever-on" basis (as in Figure 1) could grow even if average monthly enrollment does not.

Figure 3 highlights which services these enrollment changes are most likely to affect by showing how expenditures are distributed between (1) children and families and (2) the aged, blind and disabled. The data in figure 3 are from 1998, the last year for which nationwide data are available with sufficient detail to estimate spending for particular enrollment groups. Children and families account for over 40% of the spending on inpatient hospital, physician, lab and x-ray, and outpatient hospital services, as well as about two-thirds of the spending on managed care. Aged, blind and disabled enrollees account for almost 75% of total spending for medical services, including 85% of spending for prescribed drugs, over half of spending for hospital services (inpatient and outpatient), and nearly all expenditures for long term care services. Thus, growth in enrollment among children and families would be particularly likely to affect growth in acute care spending, while growth in enrollment of aged, blind and disabled enrollees will influence spending for nearly every type of service.

<b>Figure 3</b>		
<b>Distribution of Medicaid Expenditures by Group and Type of Service, FFY 1998</b>		
<b>Service</b>	<b>Share of Expenditures for Each Group, by Service</b>	
	<b>Children &amp; Families</b>	<b>Aged, Blind &amp; Disabled</b>
Total	27.0%	73.0%
Inpatient Hospital	44.8%	55.2%
Nursing Facilities	0.2%	99.8%
Physician, Lab, and Xray	53.8%	46.2%
Outpatient Hospital	40.1%	59.9%
ICF-MR <sup>1</sup>	0.4%	99.6%
Mental Health (Inpatient)	36.6%	63.4%
Home Care <sup>2</sup>	7.4%	92.6%
Prescribed Drugs	15.1%	84.9%
EPSDT <sup>3</sup>	79.6%	20.4%
Payments to Medicare	0.0%	100.0%
Prepaid/Managed Care	67.4%	32.6%
Other Services	42.6%	57.4%

Source: Urban Institute estimates based on data from HCFA-2082 Reports and Medicaid Financial Management Reports.  
 General note: Excludes payments made under Title XXI (SCHIP), disproportionate share hospital payments, administrative costs, accounting adjustments, and the U.S. territories.  
 1) Intermediate care facilities for the mentally retarded  
 2) Includes home health services, home- and community-based waiver services, personal care, and related services  
 3) Early and periodic screening, diagnosis and treatment services

## Spending Growth

After averaging 3.6% per year between 1995 and 1998, overall Medicaid spending increased by 7.1% in 1999 and 8.6% in 2000 (Figure 4). Spending on medical services alone increased by 8.1% in 1999 and 9.5% in 2000 (Figure 4). These high rates not only follow a period of unusually low growth rates, but they are exacerbated by a nationwide economic recession that has led to revenue shortfalls and increasingly tight budgets in many states. As of January 2002, the

National Association of State Budget Officers reported that 45 states projected an aggregate shortfall of approximately \$40 to \$50 billion for fiscal year 2002.<sup>6</sup>

**Figure 4**  
**Medicaid Expenditures by Type of Service for Selected Years, FFY 1995-FFY2000**

Service	Expenditures (millions)			Average Annual Growth	
	FFY 1995	FFY 1998	FFY 2000	1995-1998	1998-2000
Total Medicaid Expenditures*	\$159,164	\$176,959	\$205,840	3.6%	7.9%
Medical Services & DSH Payments	\$151,915	\$169,351	\$197,003	3.7%	7.9%
Medical Services Only	\$133,136	\$154,354	\$182,585	5.1%	8.8%

Source: Urban Institute estimates based on Medicaid Financial Management Reports.  
 Note: Excludes the U.S. territories and payments made under Title XXI (SCHIP).  
 \* Includes administrative costs, accounting adjustments, disproportionate share hospital (DSH) payments, and all medical services. Medicaid spending on upper payment limit programs is included in medical services.

Figure 5 shows Medicaid spending trends for more specific types of services. Because of data quality concerns, the data in Figure 5 exclude Texas and Massachusetts.<sup>7</sup> Between 1998 and 2000, acute care services grew by 10.1% per year while long term care services increased by 7.4% per year (Figure 5). Payments to Medicare increased by 2.3% and thus were not a major reason for the acceleration of Medicaid spending growth. Disproportionate share hospital (DSH) payments fell by 1.1% per year, also moderating overall spending growth.

#### *Acute Care Services*

The greater enrollment of children and families partially explains the 10.1% growth in acute care services, but several other factors also contributed to the accelerated growth. In addition to enrollment growth, acute care spending increased because of a precipitous rise in expenditure for prescription drugs. Medicaid spending for outpatient prescribed drugs (those purchased through pharmacies) increased by 19.7% per year between 1998 and 2000 (Figure 5). The \$4.6 billion increase for these drugs represented 17% of the increase in total Medicaid expenditures over this period (Figure 5). State officials attribute the recent rise in Medicaid prescription drug spending to increases in both prices and utilization.<sup>8</sup> Medicaid is particularly susceptible to rising drug expenditures because it covers a population that is generally in worse health than privately insured populations and includes large (and growing) numbers of aged and disabled individuals who rely on the program for prescription drug coverage.<sup>9</sup>

<sup>6</sup> National Association of State Budget Officers (May 2002). "State Budgets—Update." *National Association of State Budget Officers* [Online]. Retrieved May 23, 2002 from the World Wide Web: [http://www.nasbo.org/Publications/State%20Budgets%20-%20January%202002\\_files/state%20budgets%20-%20may.%202001.pdf](http://www.nasbo.org/Publications/State%20Budgets%20-%20January%202002_files/state%20budgets%20-%20may.%202001.pdf).

<sup>7</sup> Figure 5 excludes Texas and Massachusetts because of concerns about amounts reported for several services, primarily those that we categorize as acute care. Excluding these two states does not significantly affect growth rates for overall spending. The rate of growth in Medicaid spending for all medical services combined was 8.8% between 1998 and 2000 either with (Figure 4) or without (Figure 5) Texas and Massachusetts. However, the growth rates for specific services—particularly acute care services—are more accurate when they are excluded.

<sup>8</sup> Smith, Vernon and Eileen Ellis (October 2001). "Medicaid Budgets Under Stress: Survey Findings for State Fiscal Years 2000, 2001, and 2002." Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured.

<sup>9</sup> Bruen, Brian K. (February 2002). "States Strive to Limit Medicaid Expenditures for Prescribed Drugs." Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured.

**Figure 5**  
**Medicaid Expenditures by Type of Service for Selected Years, FFY 1995—FFY2000**  
**(Excluding Massachusetts and Texas)**

Service	Expenditures (millions)			Average Annual Growth	
	FFY 1995	FFY 1998	FFY 2000	1995-1998	1998-2000
Total	\$144,872	\$161,004	\$188,762	3.6%	8.3%
Medical Services & DSH	\$137,832	\$153,998	\$179,541	3.8%	8.0%
Medical Services Only	\$121,175	\$140,937	\$166,763	5.2%	8.8%
Acute Care	\$68,493	\$78,953	\$95,635	4.9%	10.1%
Inpatient Hospital	\$24,283	\$22,021	\$24,376	-3.2%	5.2%
Physician, Lab, and Xray	\$7,467	\$6,013	\$6,220	-7.0%	1.7%
Outpatient Hospital	\$9,913	\$11,138	\$12,387	4.0%	5.5%
Prescribed Drugs	\$7,747	\$10,579	\$15,169	10.9%	19.7%
EPSDT <sup>1</sup>	\$827	\$729	\$771	-4.1%	2.9%
Prepaid/Managed Care	\$9,793	\$18,212	\$24,478	23.0%	15.9%
Other Services	\$8,463	\$10,261	\$12,236	6.6%	9.2%
Long-Term Care	\$49,194	\$58,036	\$66,995	5.7%	7.4%
Nursing Facilities	\$27,602	\$31,628	\$36,840	4.6%	7.9%
ICF-MR <sup>2</sup>	\$9,030	\$9,088	\$9,167	0.2%	0.4%
Mental Health (Inpatient)	\$2,995	\$3,029	\$3,165	0.4%	2.2%
Home Care <sup>3</sup>	\$9,568	\$14,290	\$17,823	14.3%	11.7%
Payments to Medicare	\$3,489	\$3,948	\$4,132	4.2%	2.3%
DSH Payments <sup>4</sup>	\$16,656	\$13,061	\$12,779	-7.8%	-1.1%
Inpatient DSH	\$13,152	\$10,121	\$9,989	-8.4%	-0.7%
Mental Health DSH	\$3,504	\$2,940	\$2,790	-5.7%	-2.6%

Source: Urban Institute estimates based on data from Medicaid Financial Management Reports.

Note: Excludes payments made under Title XXI (SCHIP), administrative costs, accounting adjustments, and the U.S. territories.

Medicaid spending on upper payment limit programs is included in medical services and is most likely included in the totals for inpatient hospital, outpatient hospital and nursing facility services shown above.

1) Early and periodic screening, diagnosis and treatment services

2) Intermediate care facilities for the mentally retarded

3) Includes home health services, home- and community-based services (including waivers), and personal care.

4) Disproportionate share hospital payments

Payments to capitated managed care plans increased by 15.9% from 1998 to 2000 (Figure 5).<sup>10</sup> Some of this increase reflected continued growth in enrollment in managed care plans, which grew by 6.5% per year between 1998 and 2000.<sup>11</sup> Medicaid managed care plans have also been faced with rising costs for the services they cover, including hospital services and prescription drugs. Assuming that Medicaid managed care spending grew at an average of 15.9% for all states (that is, including Massachusetts and Texas), we estimate that spending per managed care enrollee grew by about 9% per year between 1998

<sup>10</sup> Because it is impossible to obtain a distribution of spending on services covered by prepaid/managed care expenditures, some of this spending (and corresponding growth) may be attributable to services that we would otherwise classify as long-term care services. However, we are confident that, given the lack of capitated long-term care systems, the vast majority of expenditures in this category were for acute care services.

<sup>11</sup> Centers for Medicare and Medicaid Services. Finance, Systems, and Quality Group (2001). "Managed Care Trends." 2000 Medicaid Managed Care Enrollment Report [Online]. Retrieved January 30, 2002 from the World Wide Web: <http://www.hcfa.gov/medicaid/trends00.pdf>.

and 2000. This result suggests that Medicaid managed care plans are having difficulty restraining spending increases.

The movement to prepaid/managed care is reflected in the relatively low rates of growth in inpatient hospital, physician, lab and x-ray services and outpatient hospital care from 1995 to 1998. Expenditures for inpatient hospital services fell by 3.2% per year between 1995 and 1998, but grew by 5.2% per year from 1998 to 2000 (Figure 5). In part, this change is attributable to increasing enrollment, but also reflects the general rise in hospital costs from factors not specific to Medicaid, as discussed below.

Hospital spending may also have grown because of states' mounting use of upper payment limit arrangements. In the late 1990s, states developed upper payment limit programs that are similar to DSH payments, except that payments are made to hospitals through increased reimbursement rates, not as a separately identifiable line item. Under these arrangements, localities or their hospitals transfer funds to the state and the state makes payments to the hospitals through higher reimbursement rates and collects federal matching funds. The hospital keeps a certain amount of the enhanced payment and, in many cases, returns the rest to the state. Because the states often use public hospitals to carry out these transactions, the result could be reflected in the increase in inpatient hospital spending.

Many of the factors behind the acceleration of Medicaid spending also underlie more general trends in health care costs and private health insurance premiums. Health care spending per privately insured person increased by 7.2 percent in 2000, the largest year-to-year increase since 1990 and the third straight year of significantly high growth.<sup>12</sup> Hospital spending (inpatient and outpatient combined) represented the largest share of growth in overall health care spending in 2000, while per capita spending on prescription drugs remained very high as well.<sup>13</sup> Recent studies identify increased labor costs as an important factor behind rising costs in hospitals and other health services establishments.<sup>14</sup> The same studies also point to a retreat from tightly managed care by consumers, providers, and purchasers as a factor behind both rising private insurance costs and increased hospital expenditures.

### *Long-term Care Services*

Long-term care services are a particularly important—and expensive—component of Medicaid benefit packages. Few private insurance plans cover these services, leaving Medicaid as the primary source of coverage for patients who have exhausted their ability to pay for these services out-of-pocket. Long term care spending increased by 7.2% per year between 1998 and 2000 (Figure 5). Spending for home care services—including home health services, home and

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<sup>12</sup> Strunk, Richard, et al.. *Op. Cit.*.

<sup>13</sup> Strunk, Richard, et al.. *Op. Cit.*.

<sup>14</sup> Strunk, Richard, et al.. *Op. Cit.*; Levit, Katharine, et al.. *Op. Cit.*.

community based services (including waivers) and personal care services—grew by 11.7% per year (Figure 5). These services have increased at double digit rates for several years, and the rate of growth between 1998 and 2000 was actually somewhat lower than in previous years.

Figure 5 also shows that spending on nursing homes increased faster between 1998 and 2000 than it had from 1995 to 1998. This acceleration could reflect the pressure to increase nursing home quality by increasing staffing and increasing wages in response to labor shortages. But it may also reflect more widespread use of upper payment limit programs using higher payments to certain nursing homes to draw down additional federal funds.<sup>15</sup>

### *DSH Payments*

Excluding Massachusetts and Texas, DSH payments fell by 1.1% per year between 1998 and 2000 (Figure 5); including these two states, DSH payments declined by 2.0% per year (not shown). In the Balanced Budget Act of 1997, Congress reduced DSH allotments between 1998 and 2002. The Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act (BIPA) of 2000 froze DSH allotments in 2000 and 2001. The 2.0% decline reflects the impact of the BBA on DSH payments between 1998 and 2000.

### **Spending by Beneficiary Group**

Medicaid administrative data that are currently available do not allow us to observe the change in expenditures for families and children compared to the change for aged, blind and disabled enrollees after 1998. Thus, we used the data that are available to us, that is, data on changes in enrollment, on the growth of spending for each service and on the relative importance of each service for each group to estimate the change in expenditures for two groups—specifically, families and children compared to aged, blind and disabled enrollees. The results are shown in Figure 6. We estimate that between 1998 and 2000 expenditures increased by 10.7% per year for children and families and by 8.0% per year for aged, blind and disabled enrollees. The higher estimated growth rate for families and children is due to faster growth in enrollment among families (Figure 2), faster growth of spending for acute care services compared to long-term care services (Figure 5), and the greater relative importance of acute care services for families and children. Nonetheless, spending for aged, blind and disabled enrollees remains much larger than that for families and children, primarily because they account for almost all long-term care spending and a higher share of acute care services than is attributable to children and families.

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<sup>15</sup> U.S. Department of Health and Human Services. Office of the Inspector General (September 2001). "Review of Medicaid Enhanced Payments to Local Public Providers and the Use of Intergovernmental Transfers." Washington, D.C.: Department of Health and Human Services. Document number A-03-00-00216; see also Holahan, John, Joshua M. Wiener and Amy Lutzky. *Op. Cit.*.

<p align="center"><b>Figure 6</b>  <b>Estimated Medicaid Expenditures by Beneficiary Group and Type of Service, FFY 1998-FFY2000</b>  <b>(Excluding Massachusetts and Texas)</b></p>						
Service	Expenditures (billions)				Average Annual Growth	
	FFY 1998		FFY 2000		FFY 1998-FFY 2000	
	Children & Families	Aged, Blind & Disabled	Children & Families	Aged, Blind & Disabled	Children & Families	Aged, Blind & Disabled
All Medical Services	\$38.6	\$98.3	\$47.4	\$115.3	10.7%	8.0%
Acute Care Services <sup>1</sup>	\$36.4	\$42.6	\$44.7	\$51.0	10.8%	9.4%
Long-term Care Services <sup>2</sup>	\$2.3	\$55.8	\$2.7	\$64.3	8.6%	7.4%

Source: Urban Institute estimates, 2002.

General note: Excludes payments made under Title XXI (SCHIP), disproportionate share hospital (DSH) payments, administrative costs, accounting adjustments, and the U.S. territories. Medicaid spending for upper payment limit programs is included in medical services and likely inflates spending for all of the beneficiary groups and types of services shown above.

1) Includes inpatient and outpatient hospital services, physician services, laboratory and x-ray services, early and periodic screening, diagnosis and treatment (EPSDT) services, payments to Medicare (aged, blind & disabled only), payments for prepaid/managed care, and other services.

2) Includes nursing facility services, intermediate care facilities for the mentally retarded (ICF-MR), inpatient mental health services, home health services, home and community-based services (including waivers), and personal care.

## Spending Growth 2001 and Beyond

Medicaid Financial Management Reports from CMS currently provide detailed expenditure data only through federal fiscal year 2000.<sup>16</sup> Data on aggregate outlays from the U.S Department of the Treasury for Medicaid is available through the first quarter of FFY 2002.<sup>17</sup> Figure 7 shows growth rates in total outlays from the federal treasury for Medicaid from FFY 1998 through FFY 2001. The data show roughly the same increases as the administrative data described earlier, but include more up-to-date expenditures that show that spending in FFY 2001 grew faster than in FFY 2000 (9.7% vs. 9.1%) (Figure 7). Treasury data also show that Medicaid outlays through the second quarter of FFY 2002 were 14.6% higher than outlays through the second quarter of FFY 2001 (not shown).<sup>18</sup> This jump may reflect further acceleration of spending growth, but could also reflect shifts in the timing of states' submission of their Medicaid expenditure claims.

The March 2002 baseline from the Congressional Budget Office's (CBO) Health Cost Estimates Unit also includes expenditure and enrollment projections for Medicaid. The baseline estimates that total federal payments for Medicaid grew by 11% in 2001, consistent with data on Treasury outlays, and another 12% in 2002, seemingly reflecting the impact of the recession.<sup>19</sup> The baseline projects that Medicaid spending will increase by only 6% in 2003, which CBO attributes to the economy coming out of recession, the expiration of "transitional eligibility" provisions and the implementation of restrictions that limit both UPL spending and DSH payments.<sup>20</sup> The CBO baseline projects that Medicaid spending growth

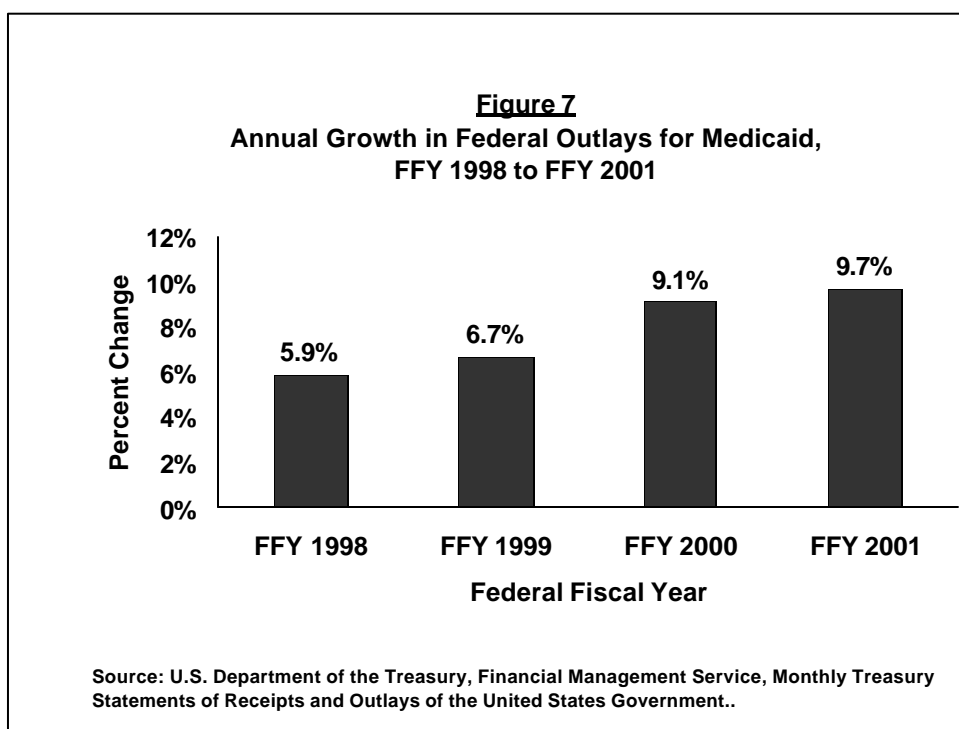
<sup>16</sup> At the time of this writing, preliminary 2001 data have been posted to the CMS web site, but have not yet been made available to us in a format that allows us to analyze them at the level of detail used in Figures 4 and 5 in this report.

<sup>17</sup> U.S. Department of the Treasury. *Op. Cit.*

<sup>18</sup> U.S. Department of the Treasury. *Op. Cit.*

<sup>19</sup> Congressional Budget Office. Budget Analysis Division. Health Cost Estimation Unit (March 2002). "CBO March 2002 Baseline: Medicaid and State Children's Health Insurance Program Fact Sheet." Washington, D.C.: Congressional Budget Office.

<sup>20</sup> Congressional Budget Office (January 2002). "The Budget and Economic Outlook: Fiscal Years 2003-2012" [Online]. Retrieved February 19, 2002 from the World Wide Web: <http://www.cbo.gov>.



will then stabilize at a rate of 9% per year between 2003 and 2012, with acute care growing slightly faster (10% per year) than long-term care (9% per year).<sup>21</sup>

The CBO baseline assumes virtually no growth in coverage of children between 2001 and 2012, probably reflecting lower birth rates.<sup>22</sup> Enrollment of non-disabled adults (mostly caretaker relatives) is expected to increase by 2% per year, possibly because of expectations of states taking advantage of current provisions in Medicaid law allowing them to expand coverage for parents. Furthermore, CBO expects enrollment of the aged to increase by 1% per year and the blind and disabled to increase between 2% and 3% per year, roughly in line with recent growth patterns.<sup>23</sup>

The CBO Health Cost Estimates Unit did not provide an explanation for their growth projections, however there are several reasons based on recent evidence to believe that CBO projections are quite reasonable. At least in the short term, states are likely to see enrollment increase because of the recession. As unemployment increases, many low-income families will become eligible for Medicaid. Urban Institute researchers have projected that Medicaid enrollment could grow by 3.3 million if the unemployment rate increased to 6.5%.<sup>24</sup> Several states have expanded coverage for Medicaid, using new opportunities under Section 1931(b) of the Social Security Act or Section 1115 waivers. As a result of

<sup>21</sup> Congressional Budget Office. Budget Analysis Division. Health Cost Estimation Unit. *Op. Cit.*

<sup>22</sup> Centers for Disease Control and Prevention. National Center for Health Statistics (April 2001). *National Vital Statistics Report*. 49(1). Hyattsville, MD: National Center for Health Statistics.

<sup>23</sup> Congressional Budget Office. Budget Analysis Division. Health Cost Estimation Unit. *Op. Cit.*

<sup>24</sup> Holahan, John, and Bowen Garrett (October 2001). "Rising Unemployment and Medicaid" *Urban Institute Health Policy Online* [Online]. Retrieved January 30, 2002 from the World Wide Web: [http://www.urban.org/pdfs/HPOOnline\\_1.pdf](http://www.urban.org/pdfs/HPOOnline_1.pdf).

this increased enrollment, Medicaid spending is also likely to increase in the short run. When the economy improves, pressure on Medicaid spending from enrollment growth should subside. However, much depends on the pace of the economic recovery.

There are additional forces that are likely to affect the Medicaid program for the foreseeable future. First, there is recent evidence that overall hospital costs—that is, not specific to Medicaid—are increasing because of wage pressures and rising drug costs.<sup>25</sup> The same pressures affect the rates that states must pay hospitals participating in Medicaid. States face limitations in their ability to negotiate rates with hospitals because Medicaid beneficiaries often rely on safety net hospitals. States are often reluctant to reduce Medicaid payments to these hospitals because they are heavily reliant on Medicaid revenues and are the major source of care for the uninsured within most localities.

Second, states do not appear to be obtaining the same savings for Medicaid managed care as they did in the mid 1990s. Many plans have left Medicaid because of concerns over rates, administrative burdens, and difficulty in negotiating with hospitals and physicians because of provider consolidation. In many states capitation rates have often been increased to maintain the participation of the plans that remain. In some states there has been increased pressure to regulate more tightly because of quality concerns and marketing abuses; this in turn increases plan costs and increases pressure for rate increases. These pressures are likely intensified by the general retreat from tightly managed care identified in the general health care marketplace. The end result is that states are not expecting to receive the same savings from Medicaid managed care as they did in the mid 1990s.<sup>26</sup>

Third, prescription drugs are likely to continue to grow at double digit rates. As noted above, enrollment of the aged, blind and disabled—the primary users of prescribed drugs—is expected to continue to grow at 2-3% per year. Moreover, the federal Medicaid drug rebate program created by the Omnibus Budget Reconciliation Act of 1990 limits states' options for controlling spending. In essence, the rebate program prohibits states from using restrictive formularies.<sup>27</sup> If they do use formularies, states must cover virtually any drug excluded from the formulary (as long as the manufacturer has an active federal rebate agreement) if the prescribing physician obtains prior authorization. States are beginning to explore these options but with the exception of highly publicized actions in Florida and Michigan, few have implemented dramatic changes at this point.<sup>28</sup> The programs that have been implemented have not been active long

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<sup>25</sup> Strunk, Richard, et al.. *Op. Cit.*

<sup>26</sup> Holahan, John, Joshua M. Wiener and Amy Lutzky (forthcoming). "Recent Changes in Health Policy for Low-Income People: An Overview of the Assessing the New Federalism States." Washington, D.C.: The Urban Institute. Unpublished working paper.

<sup>27</sup> Bruen. *Op. Cit.*

<sup>28</sup> Bruen. *Op. Cit.*; Bernasek, Cathy, Catherine Harrington, Rajeev Ramchand, and Dan Mendelson (February 2002). "Florida's Medicaid Prescription Drug Benefit: A Case Study." Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured.; Schwalberg, Renee, Hilary Bellamy, Mary Griffin, Chris Miller, Susan Schreiber Williams and Linda Elam

enough to determine how successful they will be at controlling drug spending. The Bush administration's FFY 2003 budget includes a proposal to change the way Medicaid drug rebates are calculated, which is expected to save \$290 million in FFY 1993 and \$5.5 billion over 5 years.<sup>29</sup> The prospects for passage of this provision are unclear at this time.

Lastly, states also face pressures to increase long term care spending. Nursing homes are faced with serious labor shortages and quality of care issues have been raised in several states; both are forcing states to consider rate increases. Labor force shortages extend beyond nursing homes and are affecting the cost of home care services as well. Furthermore, the Supreme Court's *Olmstead* decision—which found unnecessary institutionalization of persons with disabilities to be discrimination under the Americans with Disabilities' Act—is only beginning to affect decision-making in most states, but is likely to grow as a factor affecting home care expenditures in the future.

At the same time that there are all of these serious pressures to increase Medicaid spending, the federal government is becoming more determined to control DSH and UPL programs. Federal DSH allotments are scheduled to decline in fiscal 2003 and the Bush administration is making a concerted effort to limit the use of upper payment limit programs. Since DSH and UPL programs in many states are a source of revenue, limits on these programs potentially reduce states' ability to finance other Medicaid services. States seem reluctant to increase taxes—with the possible exception of tobacco taxes—to pay for state services, including Medicaid. Thus, state revenue growth is likely to be slow, particularly if the economy recovers slowly.

## Conclusion

The current combination of forces affecting the Medicaid program—accelerating expenditures and slow, or even shrinking, revenue growth—could make it hard for states to maintain current eligibility levels, and certainly will make them reluctant to take advantage of many of the new opportunities through Section 1931 of Medicaid or SCHIP to expand coverage. Yet states will continue to face pressures to provide greater access to services for Medicaid-eligible populations, while at the same time limiting cost growth. Consideration of ways of restructuring Medicaid financing, i.e. a greater federal role, seems essential if public programs are to continue to provide for low income populations as well as to expand to reach more of the uninsured.

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(October 2001). "Outpatient Prescription Drug Benefits: Findings from a National Survey and Selected Case Study Highlights." Washington, D.C.: Kaiser Commission on Medicaid and the Uninsured.

<sup>29</sup> U.S. Department of Health and Human Services. Office of Budget (February 2002). "Budget in Brief—PDF Version." FY 2003 President's Budget for HHS [Online]. Retrieved February 11, 2002 from the World Wide Web: <http://www.hhs.gov/budget/pdf/hhs2003bib.pdf>.

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