

Medicaid in 2005: New Challenges, New Opportunities

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**for
Joint Meeting of Vermont
House Health Care Committee
House Human Services Committee
House Appropriations Committee**

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Medicaid in 2005: The Nation's Largest Health Care Program

- Comprehensive health and long term care coverage for over 53 million in U.S. (Medicare ~ 42 million)**
- Medicaid Spending in FY 2005: \$329 billion (Medicare: \$309 billion)**
 - \$132 billion state and local funds**
 - \$197 billion federal**
 - Medicaid accounts for 44% of all federal funds to states)**

Source: CMS, Office of the Actuary, 2004

The Key Roles for Medicaid

- **Maternal and Child Health**
 - Pays for prenatal care and delivery for over 1.5 million births annually (37% of U.S. total)
 - Provides comprehensive coverage for more than 1 of 4 children (25 million in 2004)
 - “EPSDT” assures coverage for preventive services and needed care for children
- **Chronic and Long Term Care**
 - Covers almost 14 million seniors and people with disabilities
 - Covers 2/3 of nursing home patients– 1/2 of all dollars
 - Pays for home and community-based care for frail elderly and persons with chronic conditions, disabilities, HIV/AIDS

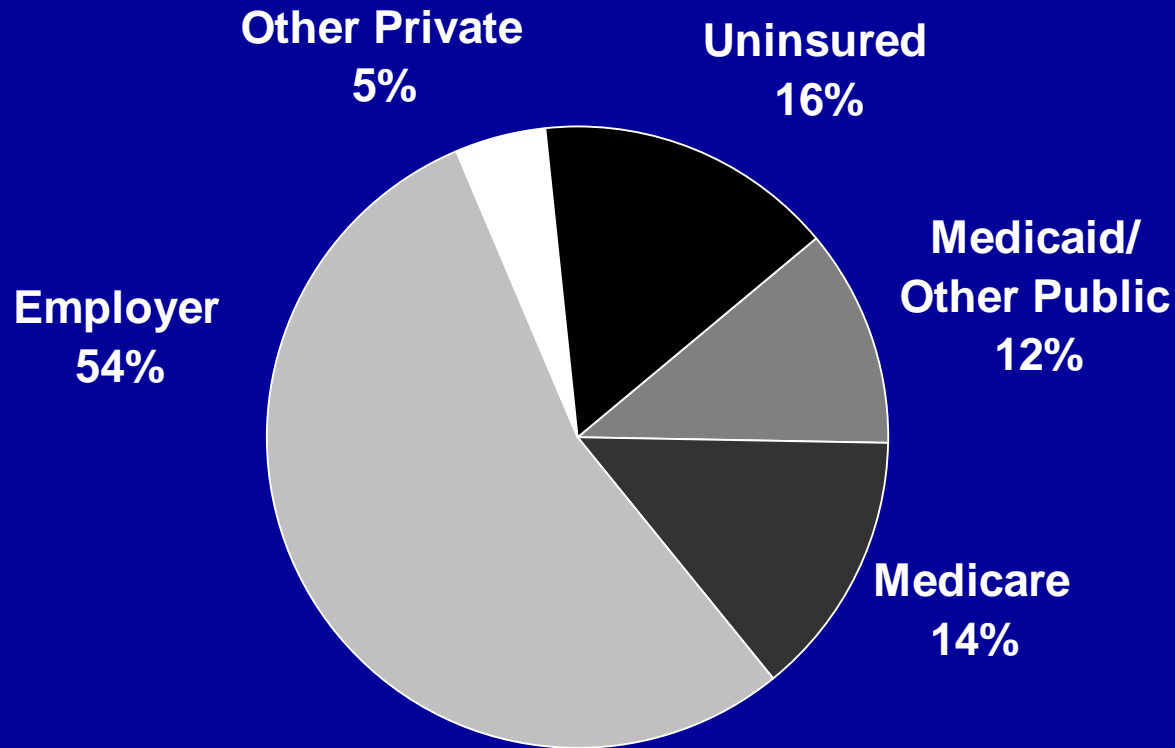
Sources: CBO Medicaid Baseline March 2004, CMS , NGA , SAMHSA, U.S. Census, Kaiser Commission on Medicaid and the Uninsured.

Medicaid: *The Workhorse* for Financing State and Local Health Care

- **The major source of health care financing**
 - *Mental health care*: over half of publicly financed care
 - *Public health and schools*: significant support
 - *Health care safety net*: \$13 billion in DSH for uninsured, plus Community Health Centers
- **Fills the gaps in Medicare**
 - For “dual eligibles”– the 7 million low-income elderly and disabled persons also on Medicare
 - Medicaid covers premiums, coinsurance and deductibles plus Rx, nursing home care, other services,

Sources: SAMHSA, CMS, Kaiser Commission on Medicaid and the Uninsured, CBO Medicaid Baseline March 2004.

Health Coverage of the U.S. Population, 2003



Total = 287 million persons

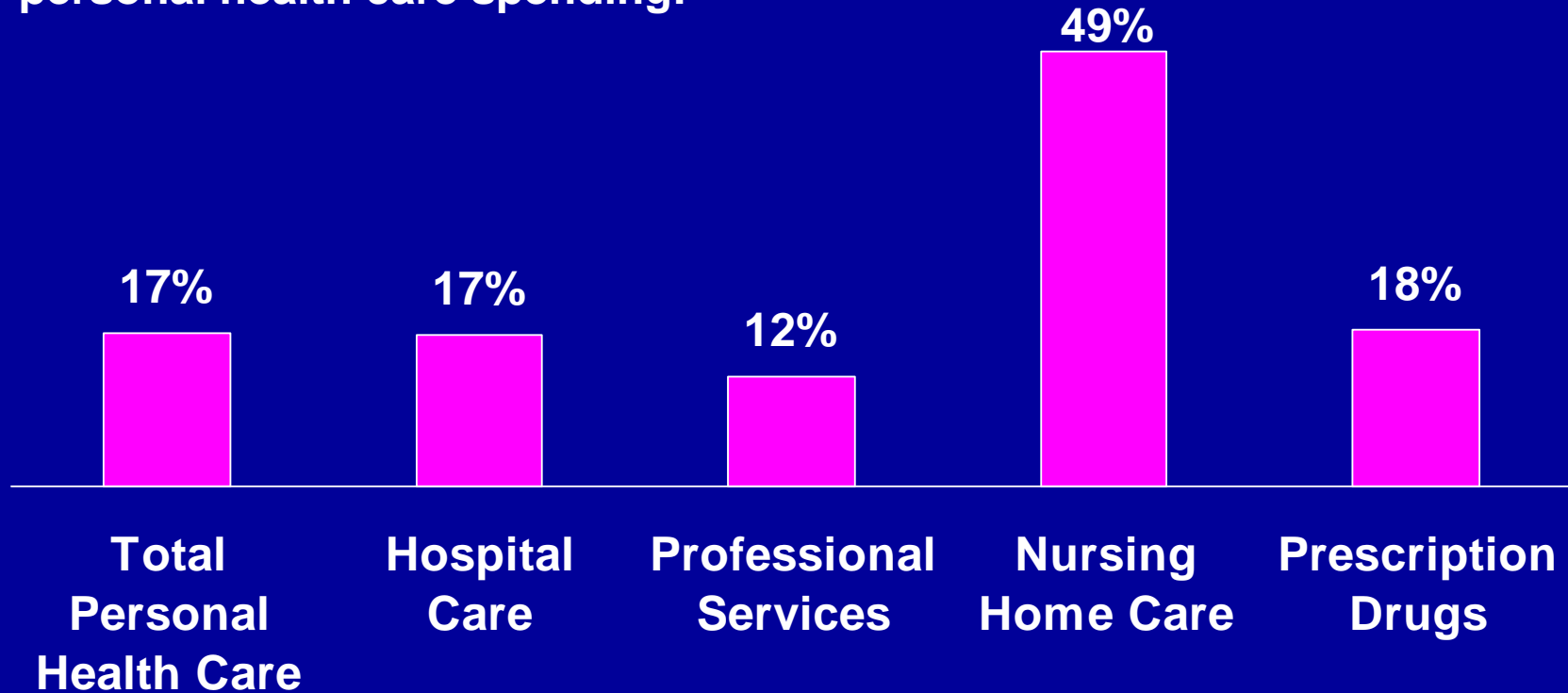
Note: Data do not total 100% due to rounding.

SOURCE: KCMU and Urban Institute estimates based on March 2004

Current Population Survey.

Medicaid's Role in the Health System, 2002

Medicaid as a share of national personal health care spending:



**Total
National
Spending
(billions)**

\$1,340

\$486.5

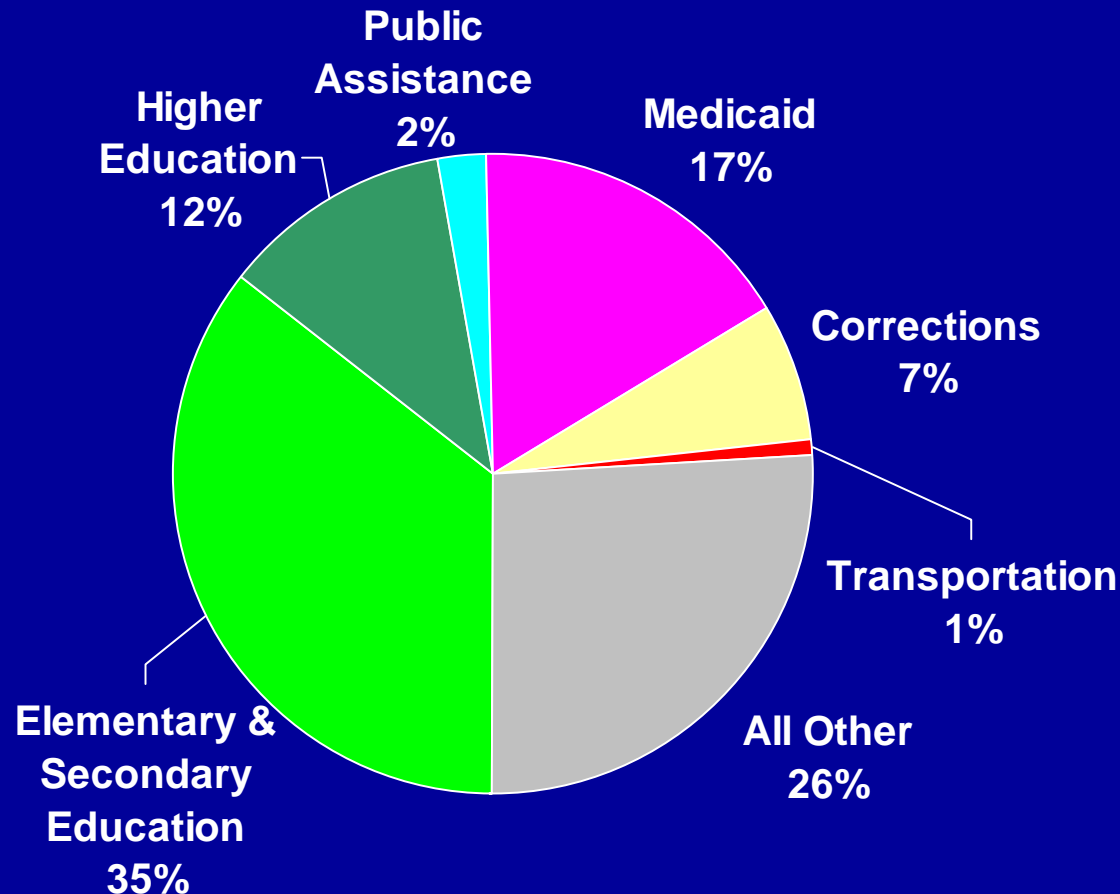
\$501.5

\$103

\$162

SOURCE: Levit, et al, 2004. Based on National Health Care Expenditure Data, Centers for Medicare and Medicaid Services, Office of the Actuary.

State Medicaid Spending as a Percent of General Fund Expenditures, 2003

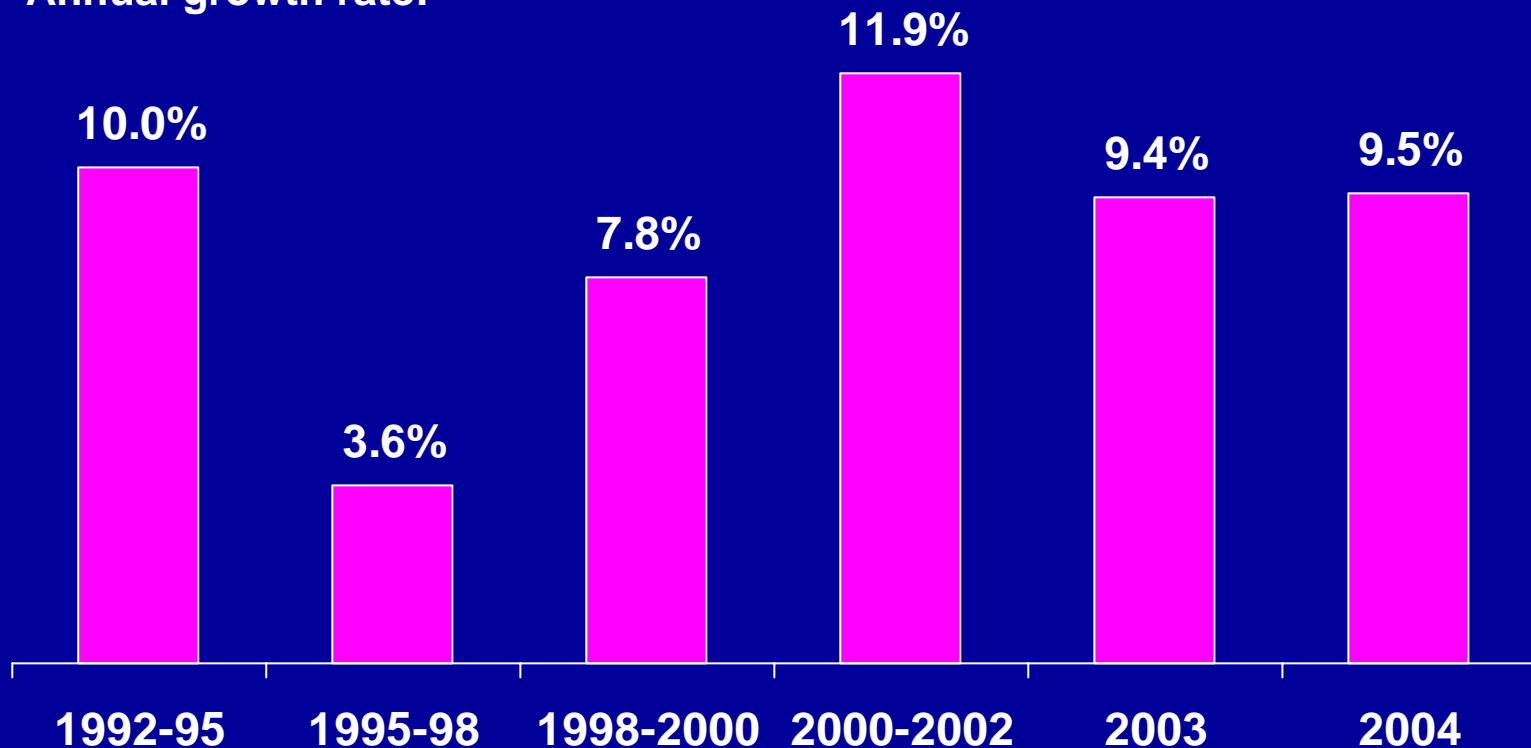


Total State General Fund Spending = \$496 billion

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

Average Annual Growth Rates of Total Medicaid Spending

Annual growth rate:



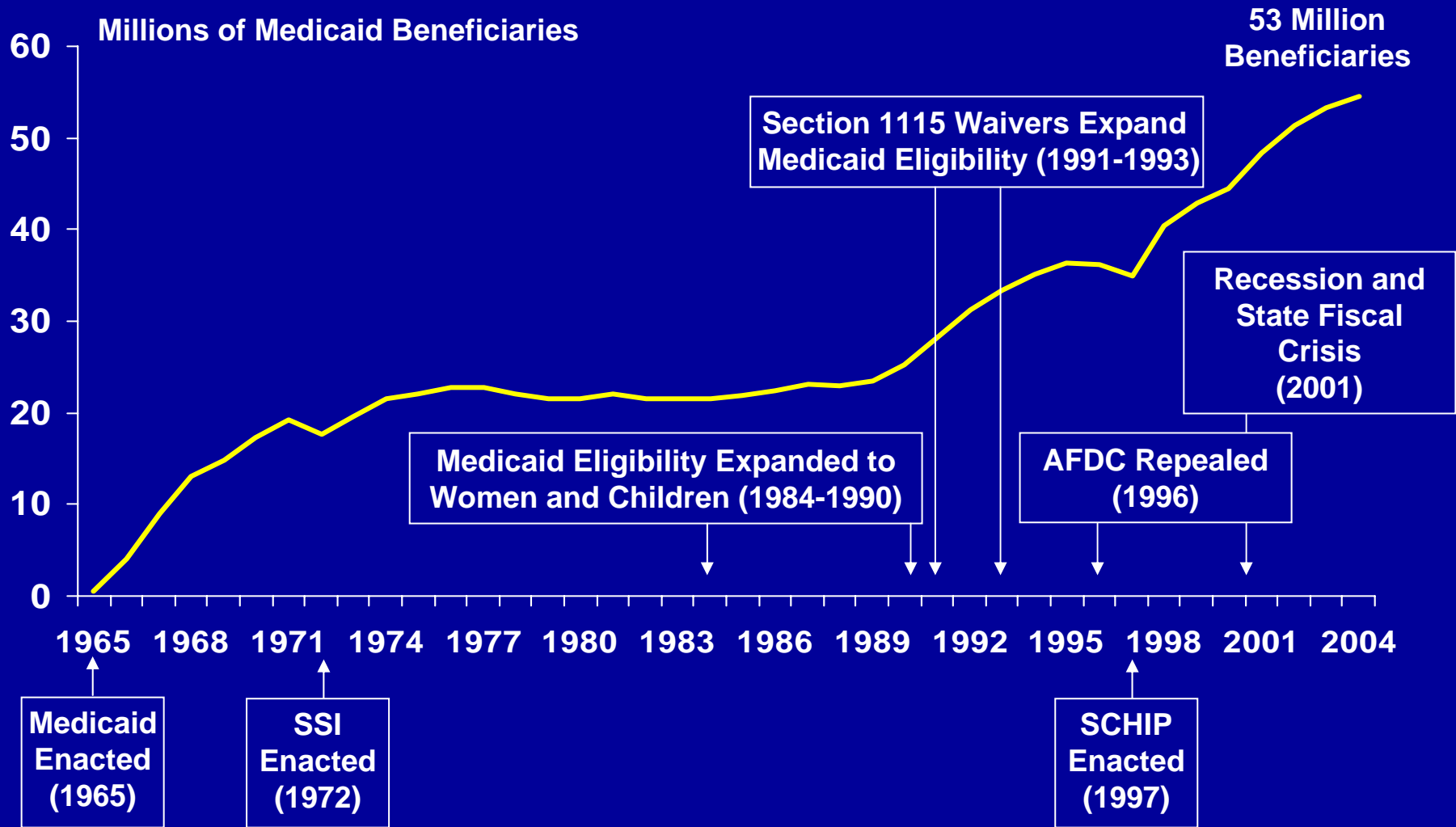
SOURCE: For 2003 and 2004: Health Management Associates estimates based on information provided by state officials, 2004. For 1992-2002: Urban Institute estimates based on data from Medicaid Financial Management Reports (HCFA/CMS Form 64).

Drivers of Medicaid Expenditure Growth: Top three Factors in 2004 – 2005

- Increasing number of persons on Medicaid
- Increasing prescription drug costs
- Increasing overall health care costs

Source: 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.

Medicaid Eligibility Milestones, 1965-2004



SOURCE: KCMU analysis of data from the Health Care Financing Administration and Centers for Medicare and Medicaid Services, 2004.

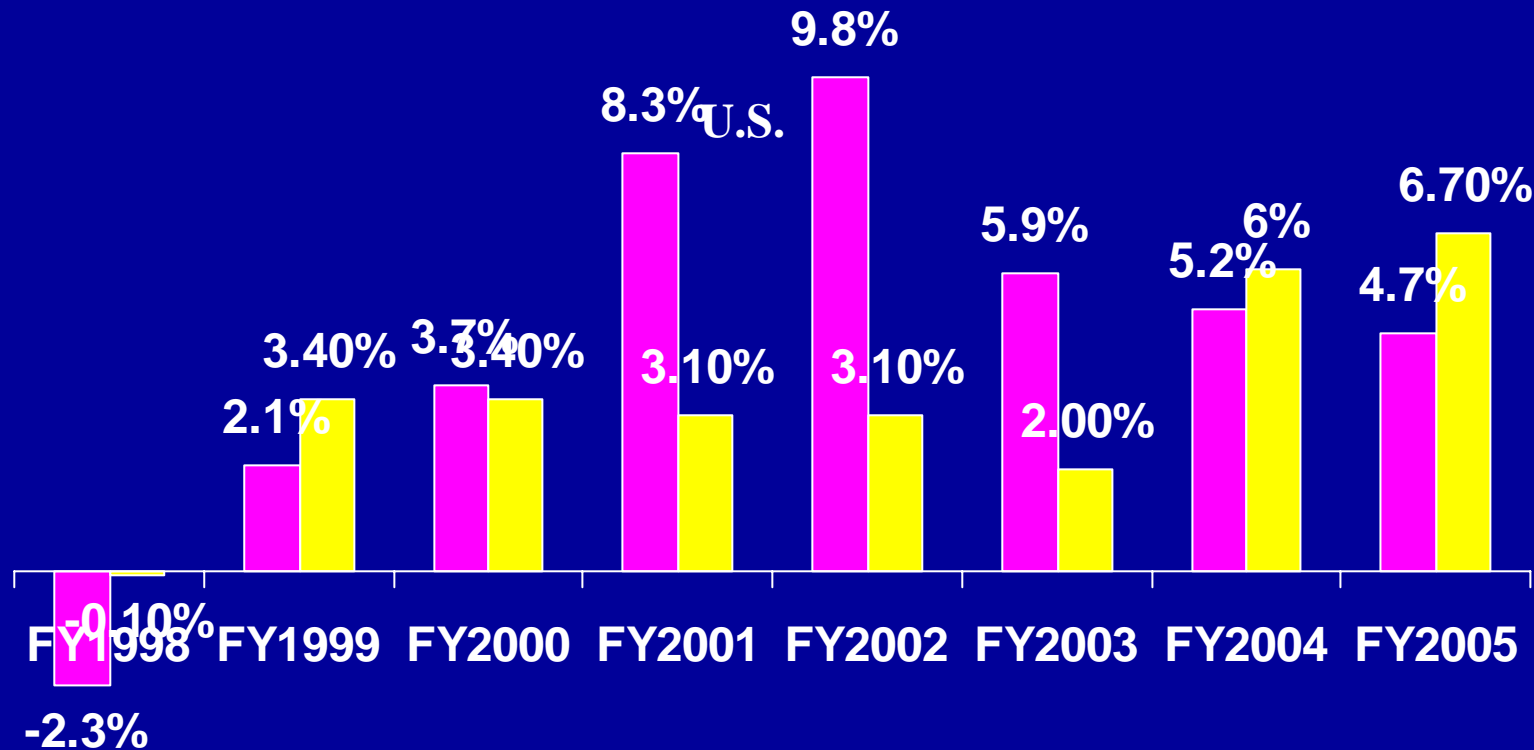
Percent Change in U.S. Medicaid Enrollment, FY 1998- FY 2005

Annual growth rate:



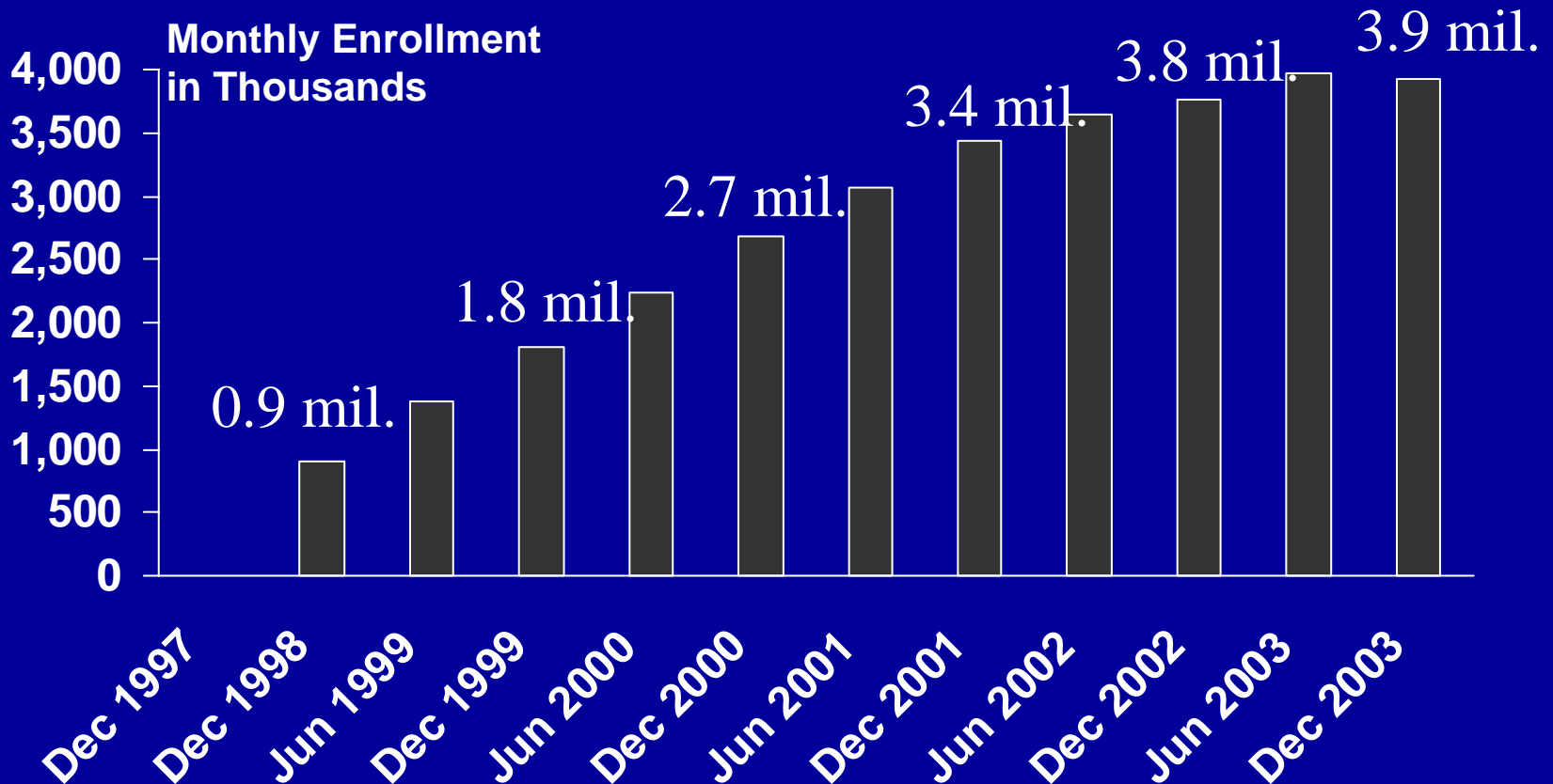
SOURCE: For 1998-2003: Eileen R. Ellis, Vernon K. Smith and David M. Rousseau, *Medicaid Enrollment in 50 States, June 2003 Data Update*, Kaiser Commission on Medicaid and the Uninsured, 2004. For 2004 and 2005: Health Management Associates estimates based on information provided by state officials, 2004. Smith

Medicaid Enrollment: Annual % Changes U.S. and Vermont: 1998 – 2005



SOURCES: FY 1998-2003: Eileen Ellis, Vernon Smith and David Rousseau, *Medicaid Enrollment in 50 States: June 2003 Data Update*, Kaiser Commission on Medicaid and the Uninsured, September 2004. FY2004 and 2005: 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.

Total SCHIP Enrollment in 50 States and the District of Columbia 1998 – 2003

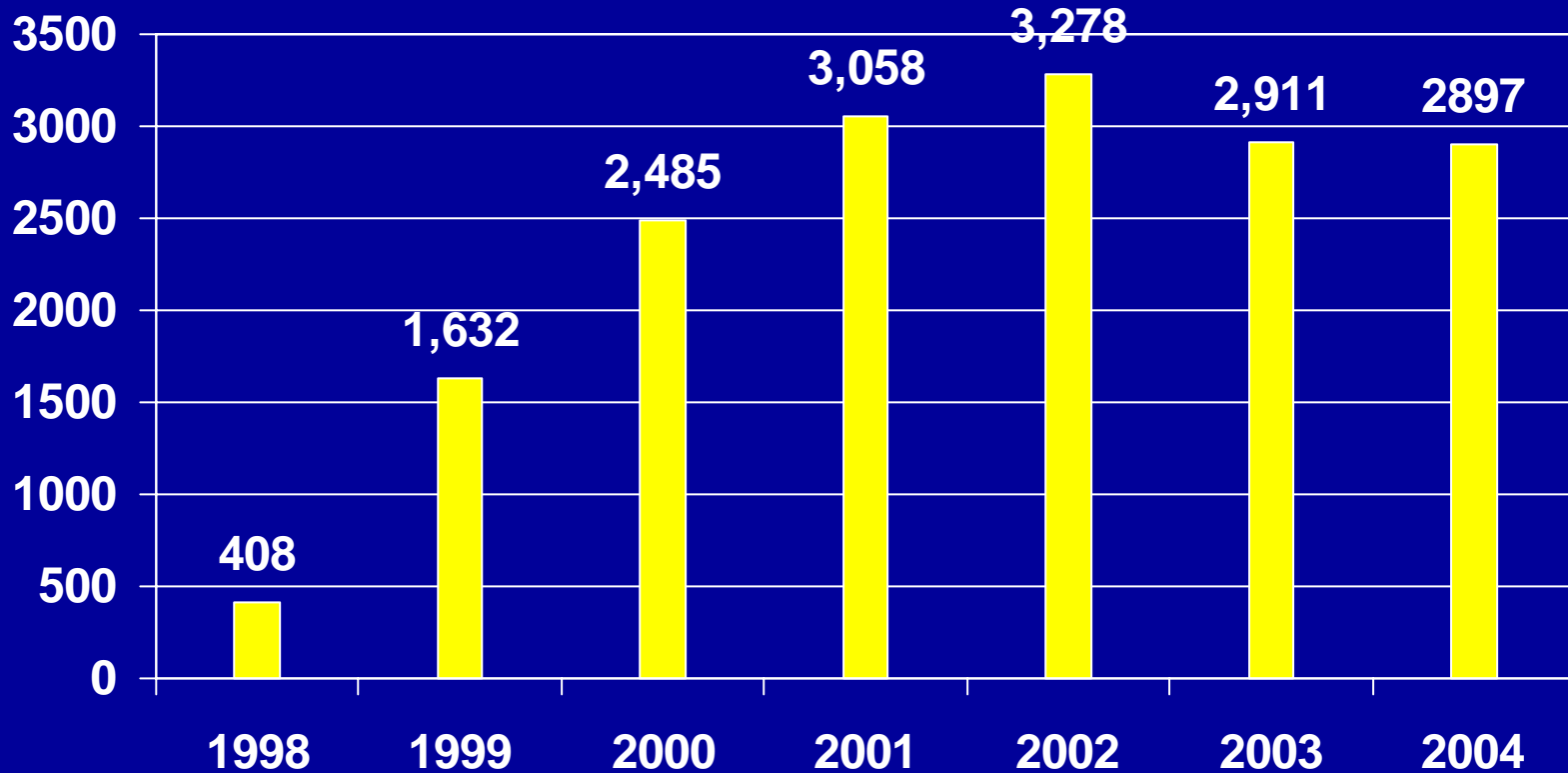


SOURCE: Vernon K. Smith and David M. Rousseau, *SCHIP Program Enrollment: December 2003 Update*, Kaiser Commission on Medicaid and the Uninsured, July 2004.

SCHIP Enrollment in Vermont

1998 - 2003

Number of Children Enrolled, December of Each Year

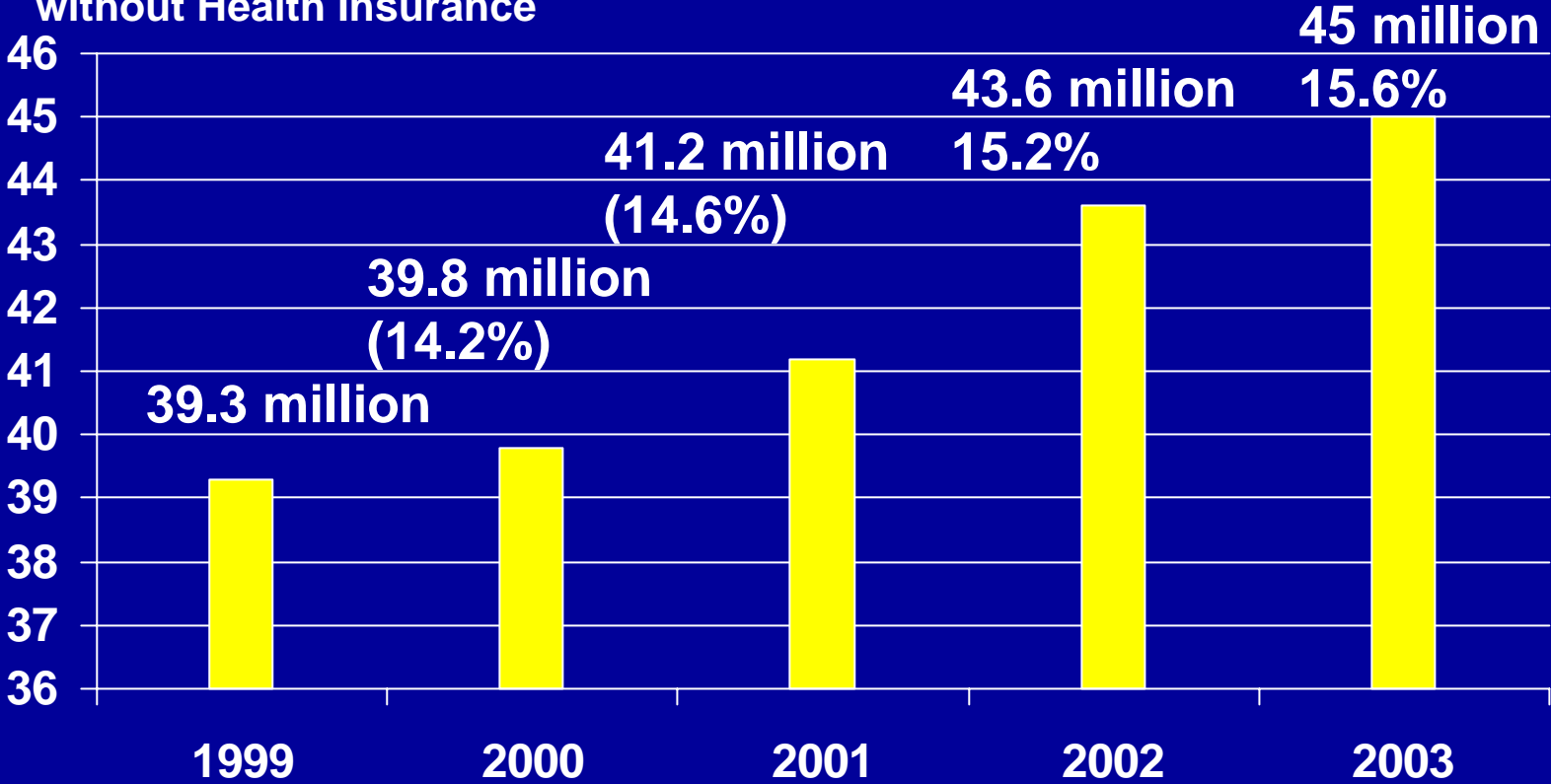


Note: 2004 data for June 2004.

Source: Vernon Smith and David Rousseau, *SCHIP Program Enrollment: June 2004 Update*, Kaiser Commission on Medicaid and the Uninsured, December 2004.

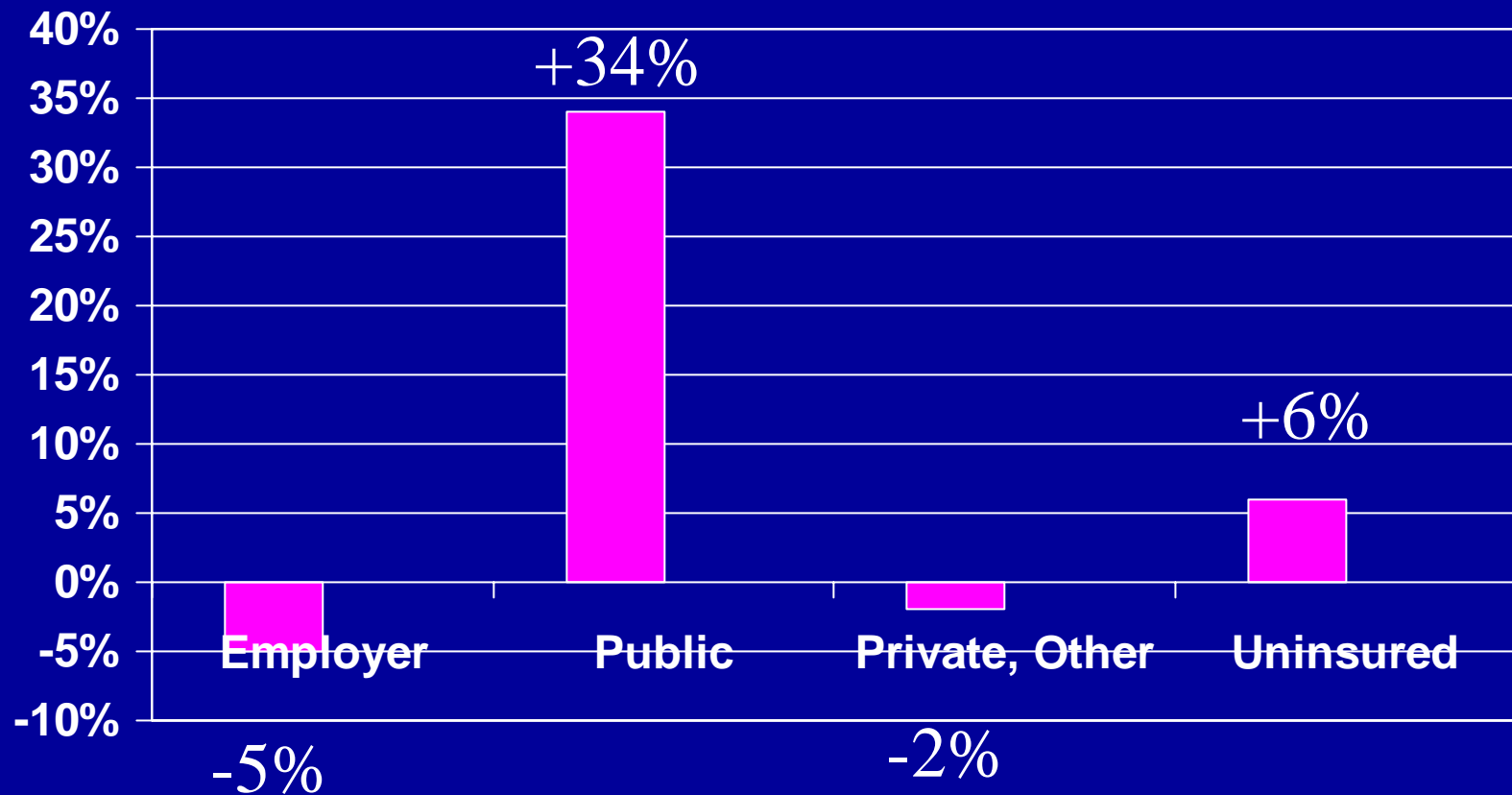
Increasing Number of Persons Without Health Insurance Adds to Medicaid Enrollment

Millions of People in U.S. without Health Insurance



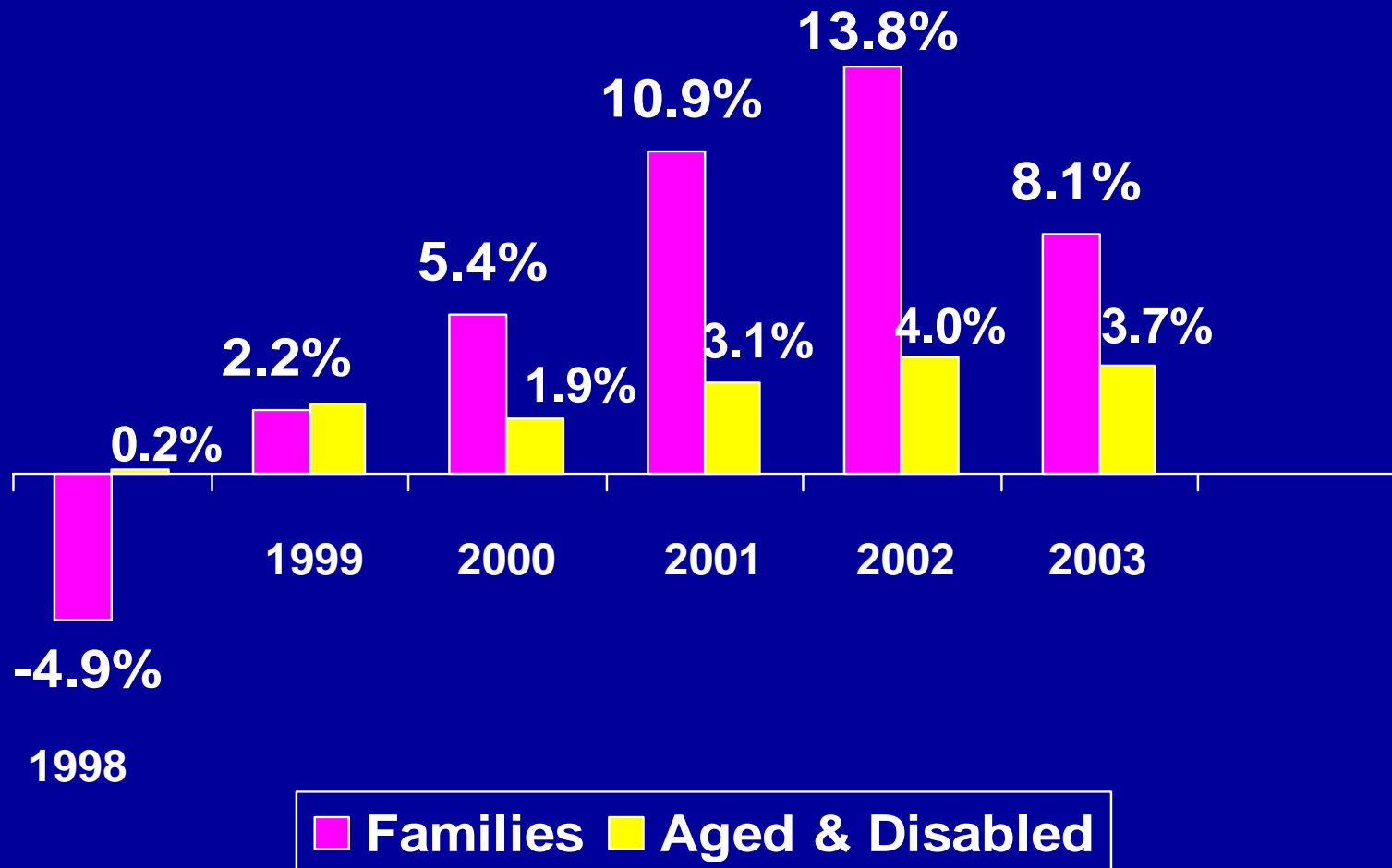
U.S. Census Bureau, August 27, 2004.

Percent Change in Insurance Status of Americans under Age 65 2001 to 2003



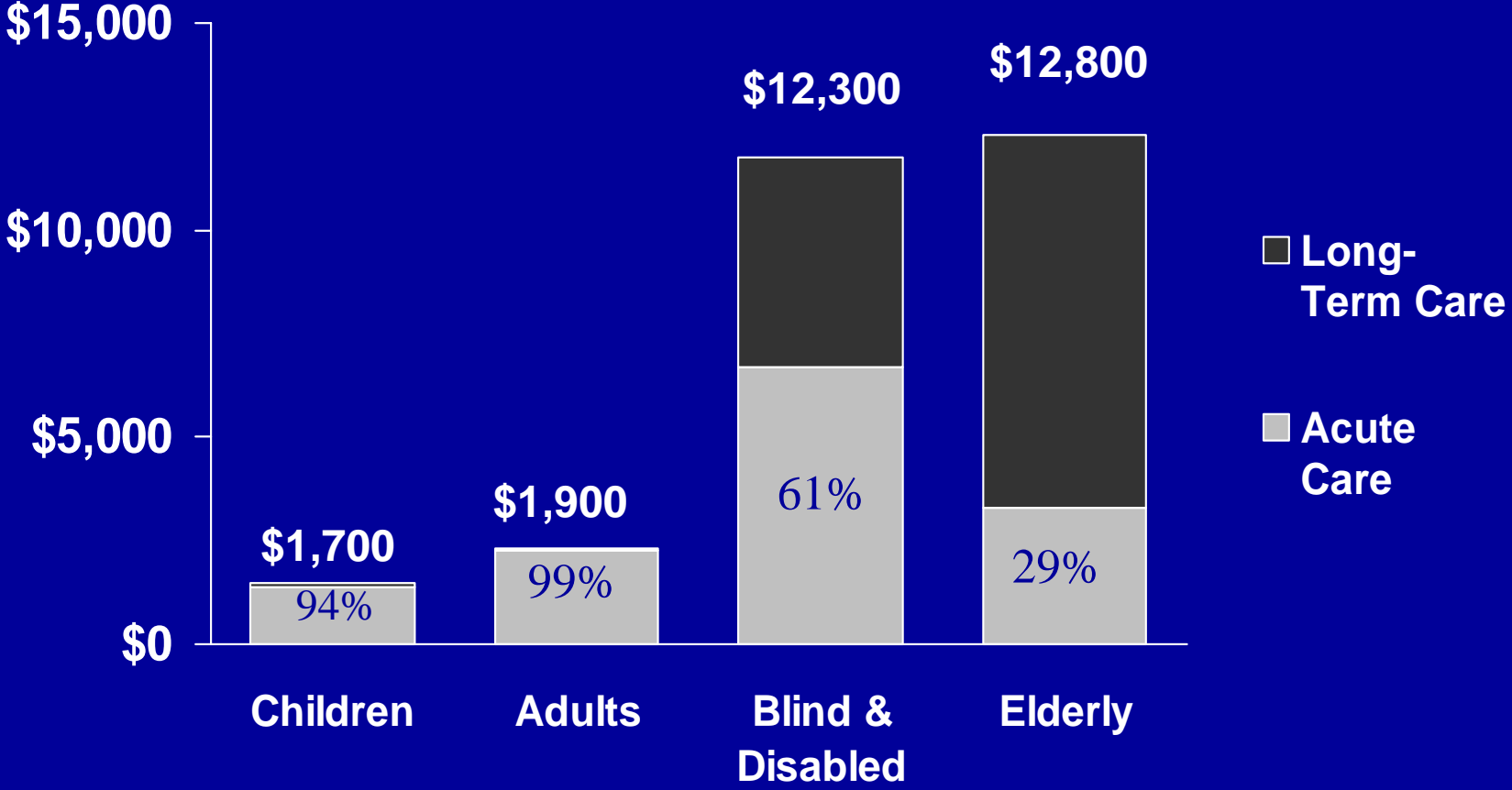
Source: Center for Studying Health System Change, August 2004.

**Percent Change in U.S. Medicaid Enrollment by Category:
 Families, Children, Pregnant Women vs. Aged and Disabled
 FY 1998 – FY 2003**



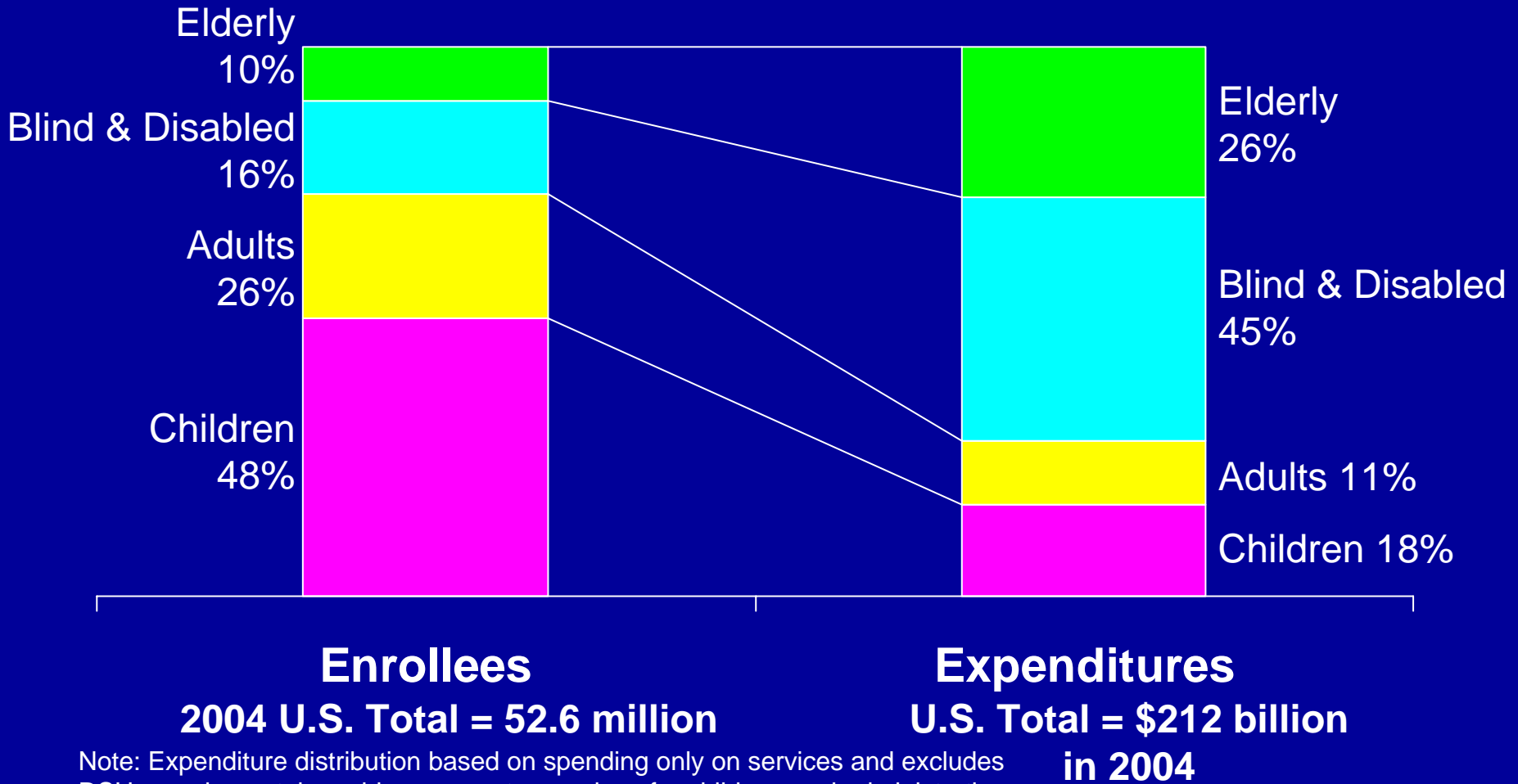
Note: Percentages reflect annual changes from June to the June of the indicated year.
 Source: Eileen Ellis, Vernon Smith and David Rousseau, *Medicaid Enrollment in 50 States: June 2003 Data Update*, Kaiser Commission on Medicaid and the Uninsured. 2004.

Medicaid Expenditures Per Enrollee, by Acute and Long-Term Care, 2004



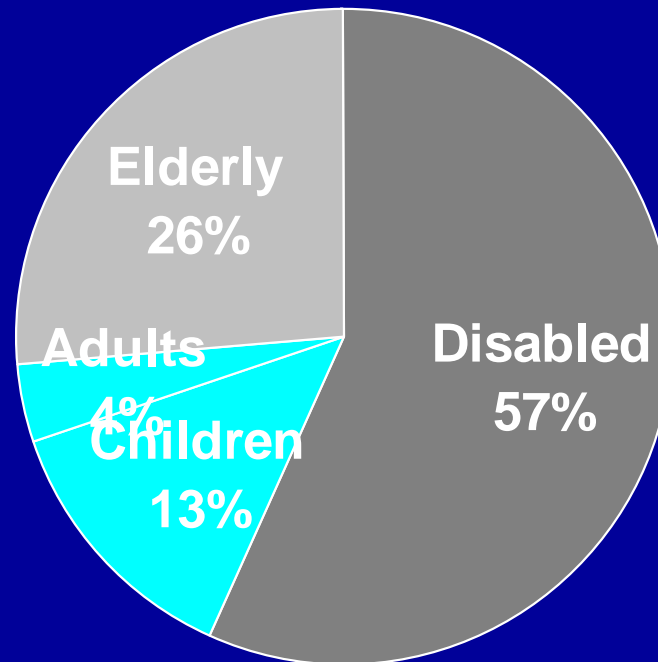
SOURCE: Urban Institute estimates for Kaiser Commission on Medicaid and the Uninsured, based on CBO and HCFA-2082 and HCFA-64 Reports. Expenditures do not include DSH, adjustments, or administrative costs. Per enrollee expenditures calculated based on CBO March 2004 baseline. Long-term care and acute care splits calculated based on Urban Institute estimates using historical data.

Medicaid Enrollees and Expenditures by Enrollment Group, U.S., 2004



Note: Expenditure distribution based on spending only on services and excludes DSH, supplemental provider payments, vaccines for children, and administration.
SOURCE: Health Management Associates estimates based on CBO Medicaid Baseline, March 2004.

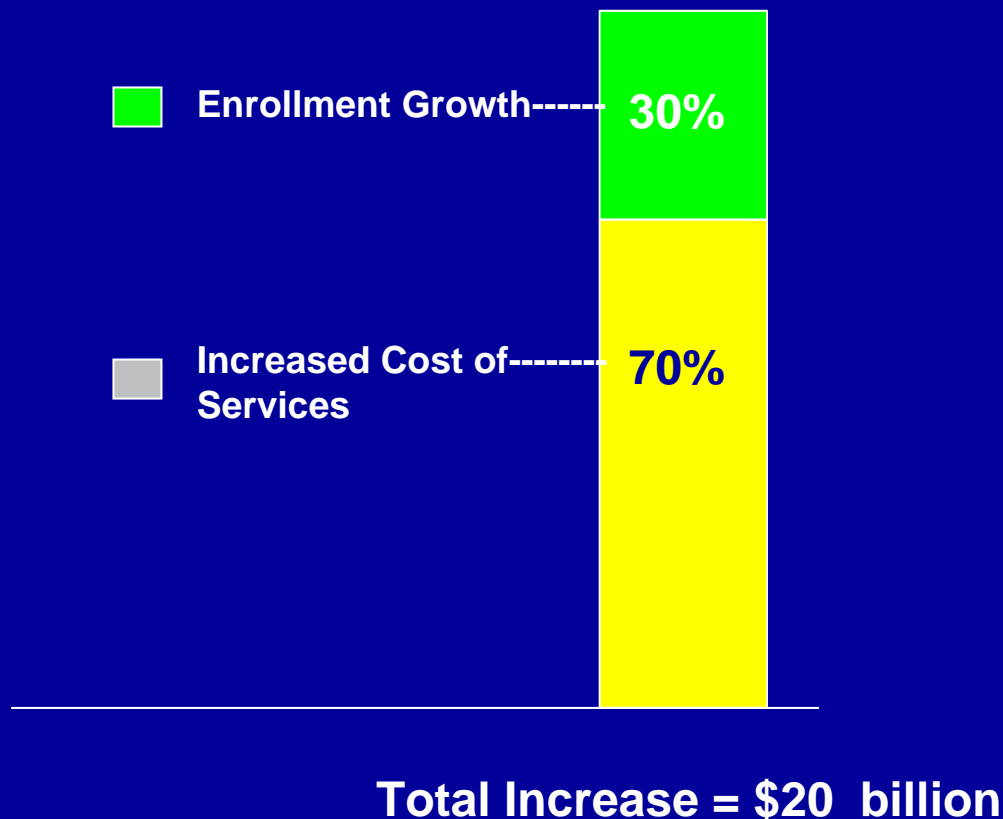
Source of Growth in U.S. Medicaid Expenditures, by Eligibility Group 2003 to 2004



\$20 Billion Increase in Total Cost of Benefits in 2004

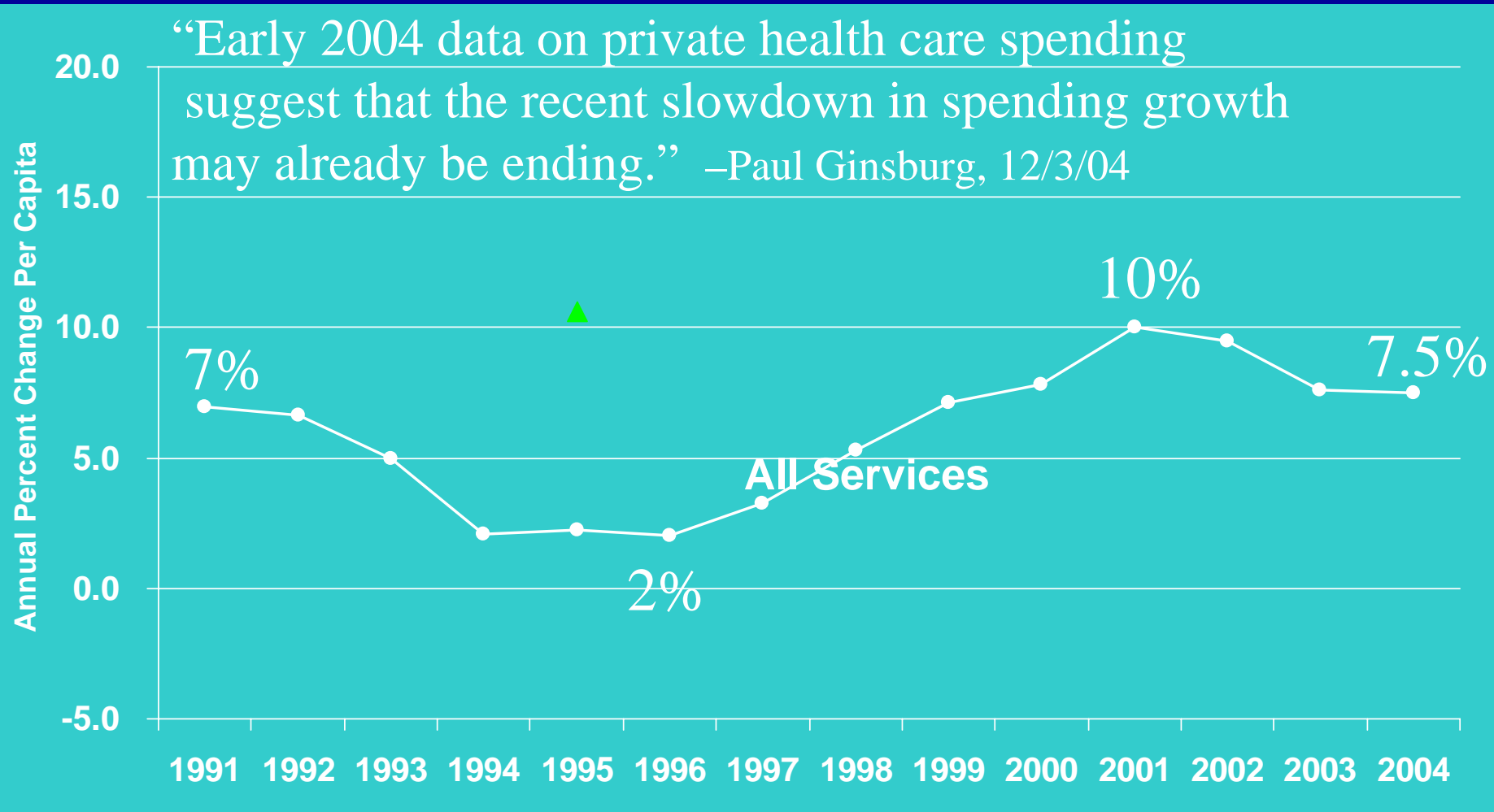
SOURCE: Kaiser Commission on Medicaid and the Uninsured and Health Management Associates, analysis of CBO Medicaid baseline, March 2004. Excludes changes in spending due to DSH, administrative costs, the VFC program, and technical adjustments.

Sources of Growth in U.S. Medicaid Expenditures, by Enrollment and Service-Related Costs, 2003 to 2004



SOURCE: Kaiser Commission on Medicaid and the Uninsured, analysis of the Administration's Medicaid baseline, 2004. Excludes changes in spending due to DSH, administrative costs, the VFC program, and technical adjustments.

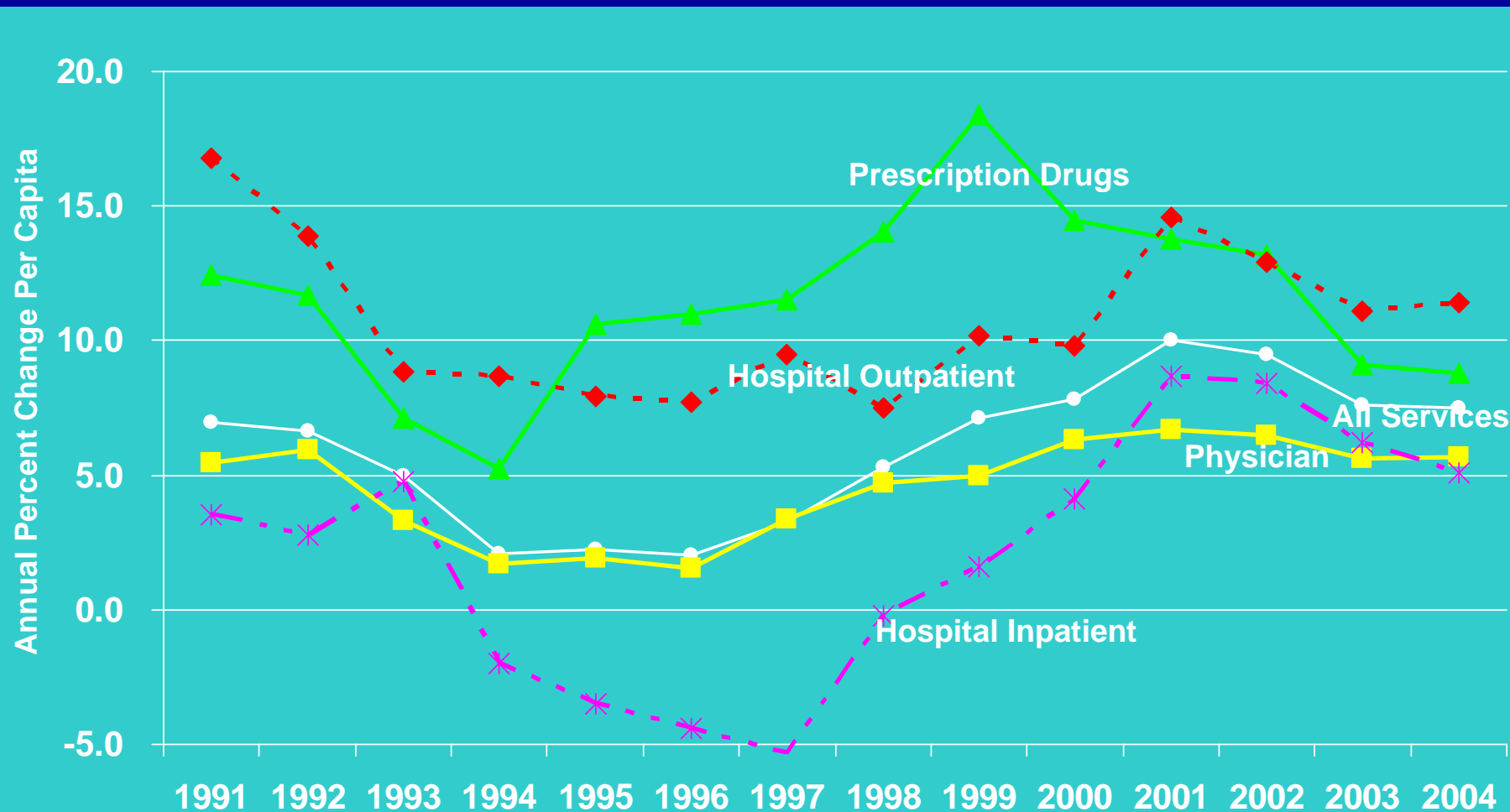
Per Capita Growth in U.S. Health Care Spending, All Services: 1991-2003



Source: 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.

Note: 2004 data for first half of year.

Per Capita Growth in U.S. Health Care Spending, by Type of Service: 1991-2003



Source: 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.

Note: 2004 data for first half of year.

Primary Factors in 2004 Cost Growth: Hospital and Prescription Drugs Spending:

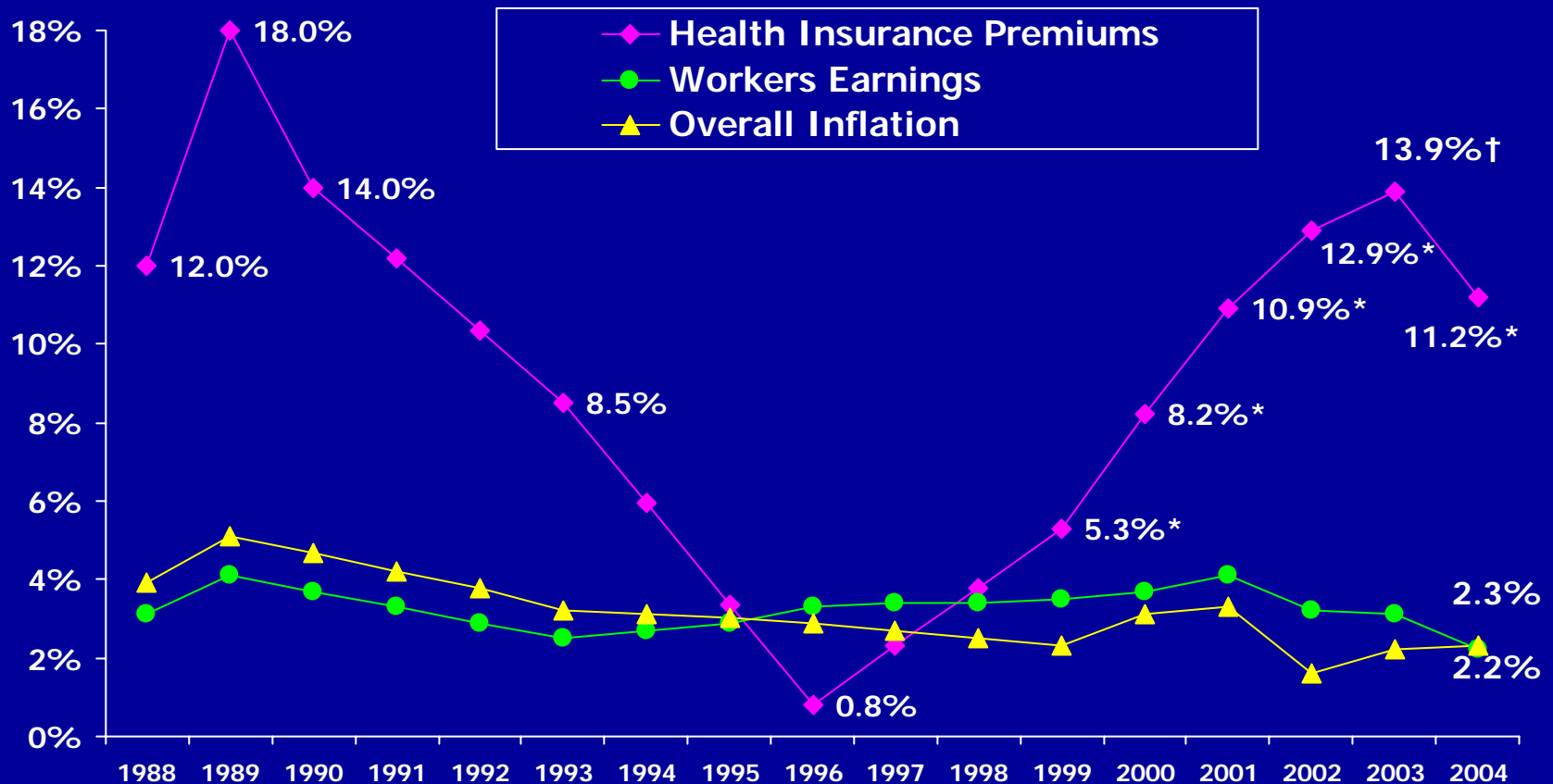
- **Hospital spending:**
 - Hospital prices up 8%
 - Hospital utilization up 0.8%

- **Prescription drug spending:**
 - Drug prices up 3.1%
 - Drug utilization up 5.5%

Source: 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.

Note: Data for first half of 2004.

Increases in Health Insurance Premiums Compared to Other Indicators, 1988-2004



* Estimate is statistically different from the previous year shown at $p < 0.05$.

† Estimate is statistically different from the previous year shown at $p < 0.1$.

Note: Data on premium increases reflect the cost of health insurance premiums for a family of four. Source: KFF/HRET Survey of Employer-Sponsored Health Benefits: 1999-2004; KPMG Survey of Employer-Sponsored Health Benefits: 1993, 1996; The Health Insurance Association of America (HIAA): 1988, 1989, 1990; Bureau of Labor Statistics, Consumer Price Index (U.S. City Average of Annual Inflation (April to April), 1988-2004; Bureau of Labor Statistics, Seasonally Adjusted Data from the Current Employment Statistics Survey (April to April), 1988-2004.

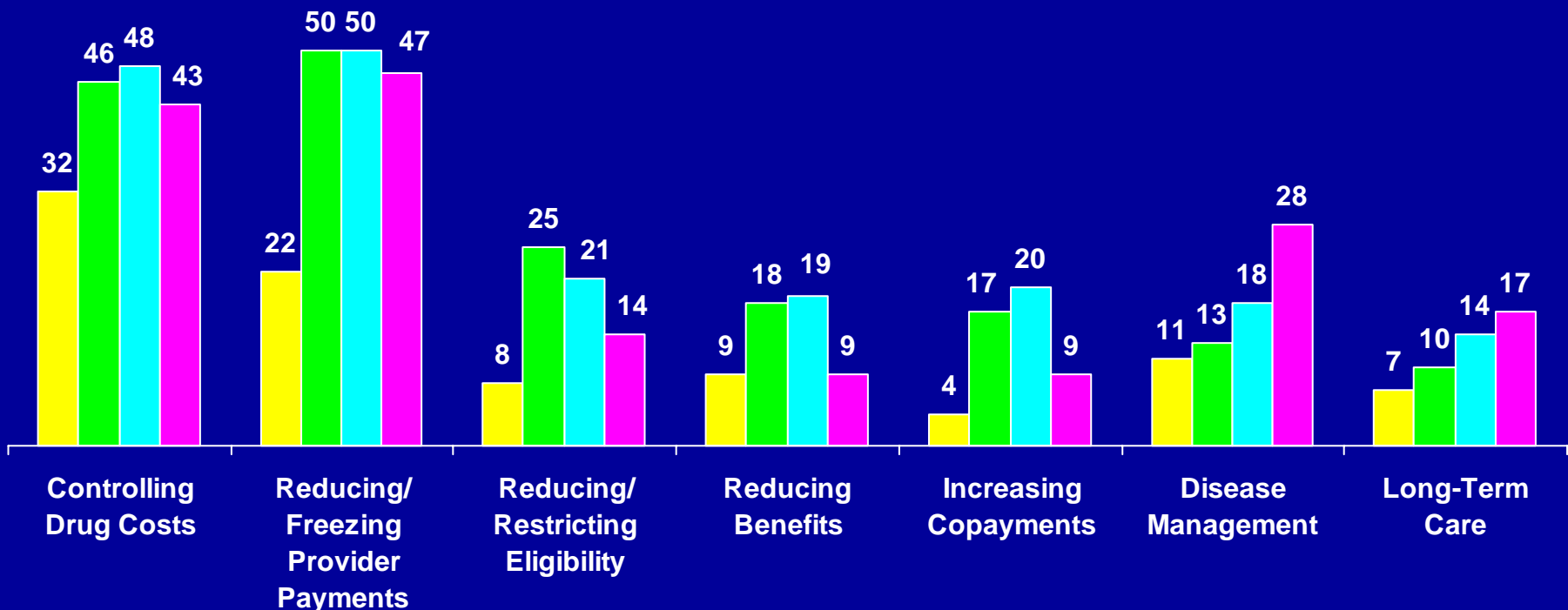
Employer Strategies to Control Costs

- Employers increased consumer cost sharing:
 - Increased employee cost of insurance premiums (68% of employers)
 - Increased deductibles (32% of employers)
 - Increased employee cost of prescription drugs (46% of employers)
 - Increased cost for office visits (42% of employers)
- “Buy-downs” of coverage averaged 2.5% to 3.5% in 2002, 2003 and 2004.

Sources: Employer Health Benefits Survey, HRET, 2004; and Bradley Strunk and Paul Ginsburg, “Tracking Health Care Costs: Trends Turn Downward in 2003,” Health Affairs, Web Exclusive, 9 June 2004.

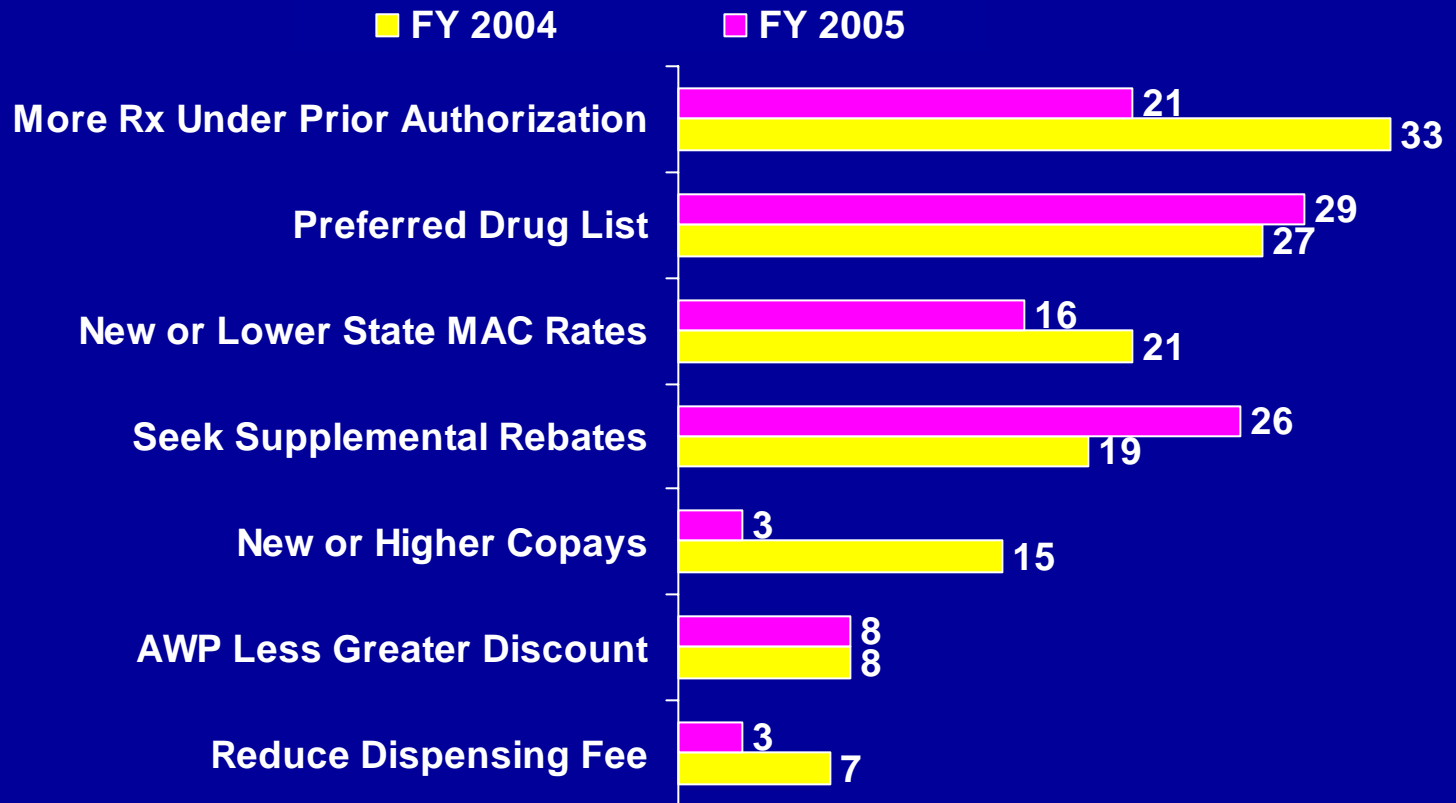
Medicaid Strategies to Contain Costs: New Initiatives by Year FY 2002 – FY 2005

■ Implemented 2002 ■ Implemented 2003 ■ Implemented 2004 ■ Adopted for 2005



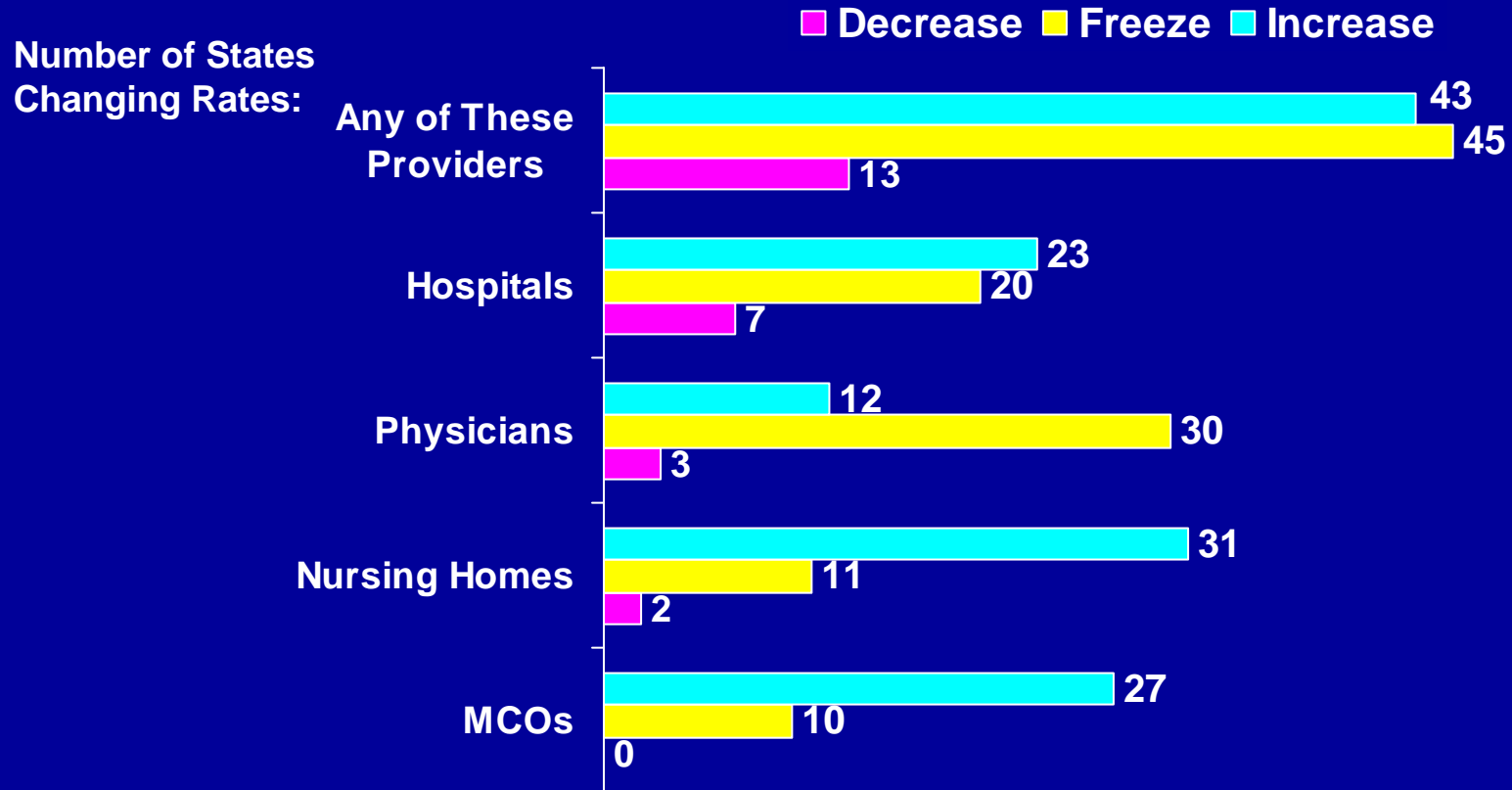
SOURCE: Vernon Smith, Rekha Ramesh, Kathy Gifford, Eileen Ellis, Robin Rudowitz and Molly O'Malley, *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005*, Kaiser Commission on Medicaid and the Uninsured, October 2004.

Medicaid Prescription Drug Policy Changes FY 2004 and FY 2005



SOURCE: 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.

Most States Selectively Increased or Froze Provider Rates in FY 2005



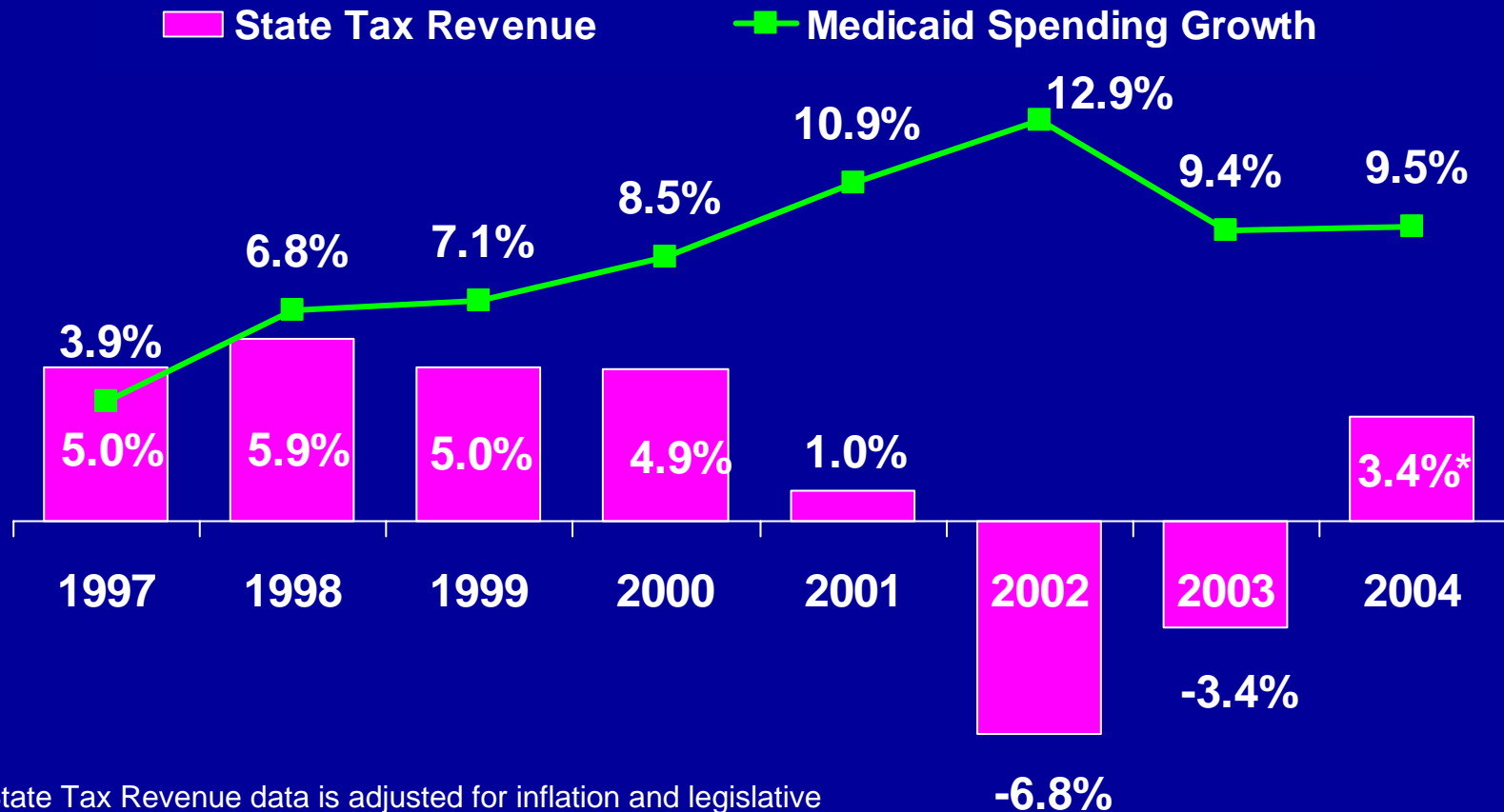
SOURCE: Vernon Smith, Rekha Ramesh, Kathy Gifford, Eileen Ellis, Robin Rudowitz and Molly O'Malley, *The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal years 2004 and 2005*, Kaiser Commission on Medicaid and the Uninsured, October 2004.

Other Cost Containment Actions

- Managed care and care management initiatives (frequently focusing on asthma, diabetes, and congestive heart failure):
 - **13 states in '03**
 - **15 states in '04**
 - **14 states in '05**
- New or enhanced fraud and abuse controls
 - **19 states in '03**
 - **17 states in '04**
 - **21 states in '05**
- New Provider Taxes (most frequently nursing home, but also HMO, hospital, ICF/MR and pharmacy):
 - **10 states in '03**
 - **11 states in '04**
 - **14 states in '05**

SOURCE: KCMU surveys of Medicaid officials in 50 states and DC conducted by Health Management Associates, 2003 and 2004. See: 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.
Smith

Growth in State Tax Revenue Compared to Medicaid Total Spending Growth 1997-2004



NOTE: State Tax Revenue data is adjusted for inflation and legislative changes. 2004 is a preliminary estimate.

SOURCE: Analysis by the Rockefeller Institute of Government of data from the Bureau of the Census, Bureau of Economic Analysis and the National Association of State Budget Officers.

Finally, Some Good News: State Revenues Are Recovering

- “State tax revenue is once again growing strongly...”

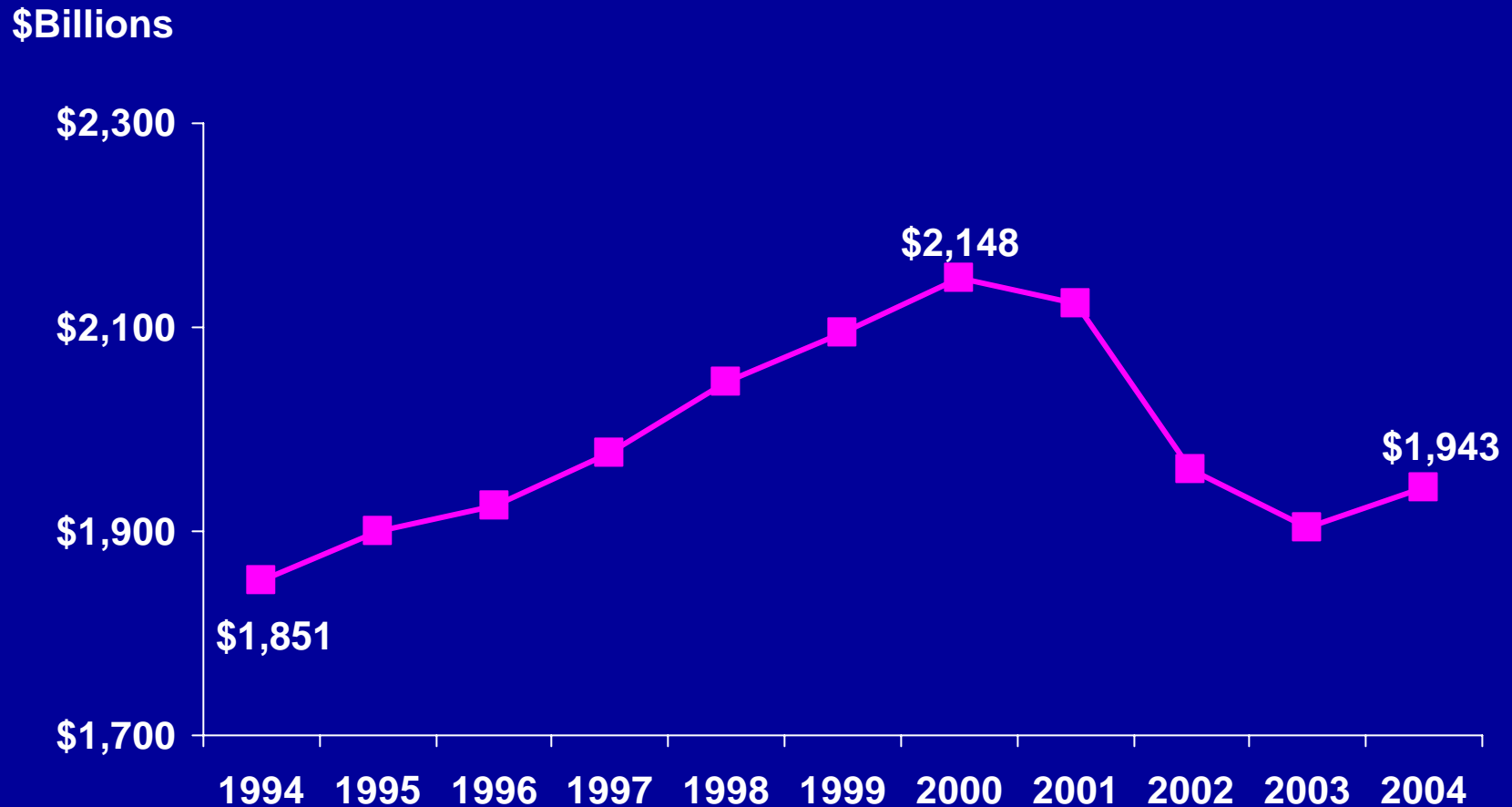
But...

- “Not all states are clear of their fiscal problems....states still have to deal with depleted reserve funds, the expiration of temporary tax increases, and rising Medicaid costs....”

Source: Nicholas W. Jenny, *2004 Tax and Budget Review*,
Rockefeller Institute of Government, November 2004.

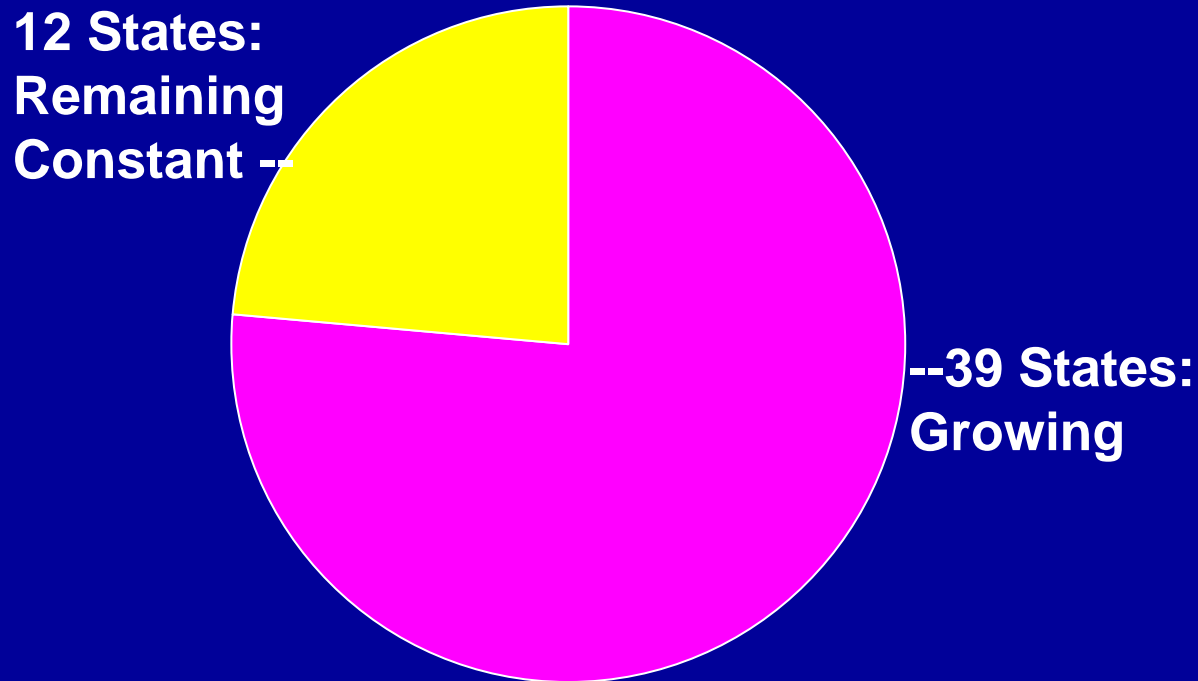
Real State Collections Per Capita

by Fiscal Year, 1994-2004



SOURCE: Analysis by the Rockefeller Institute of Government of data from Advisory Commission on Intergovernmental Relations, the Tax Foundation, NCSL, and NASBO, December 2003

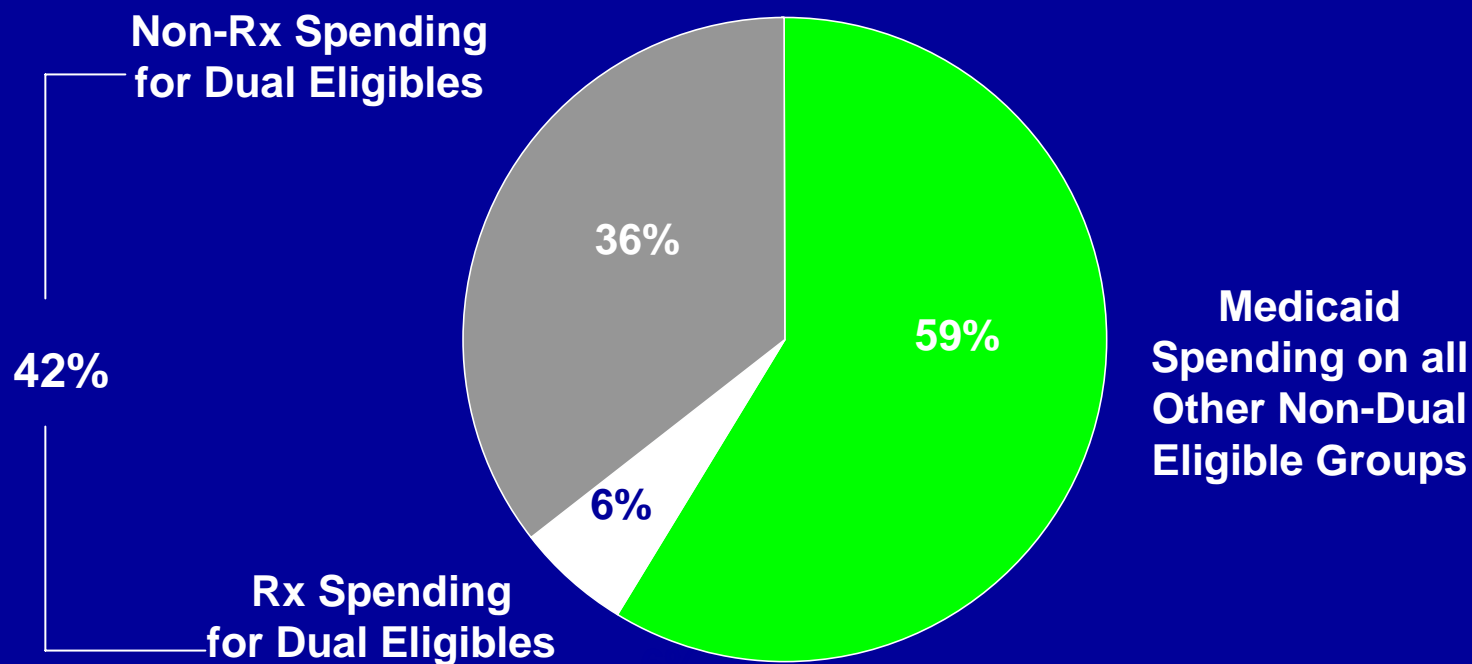
Are Pressures On Your Medicaid Program Growing, Remaining Constant, Or Subsiding?



NOTE: No state reported pressure on their Medicaid program was subsiding.

SOURCE: KCMU survey of Medicaid officials in 50 states and DC conducted by Health Management Associates, October 2004.

Spending on Dual Eligibles as a Share of Medicaid Spending on Benefits, FY2002



Note: Percentages do not total 100% due to rounding,. Total Medicaid spending on benefits in 2002 was \$232.8 billion.

SOURCE: Urban Institute estimates prepared for Kaiser Commission on Medicaid and the Uninsured, based on an analysis of 2000 MSIS data applied to CMS-64 FY2002 data.

The Medicare Part D Prescription Drug Benefit Adds to Medicaid Stress

- Fiscal implications
 - Clawback will erode hoped for savings
 - Woodwork effect will add low-income Medicare enrollees to Medicaid
 - States are feeling pressure to “wrap-around” the less-comprehensive Medicare benefit (i.e., pay for drugs Medicaid covers but not on the formularies of Medicare PDPs)

Source: Focus group discussion with Medicaid directors conducted by Health Management Associates for Kaiser Commission on Medicaid and the Uninsured, November 2004

The Medicare Part D Prescription Drug Benefit Adds to Medicaid Stress

- Administrative implications
 - MMA requires states to do eligibility determinations for low-income subsidies
 - Inadequate time to do needed system changes for
 - Low-income subsidy eligibility
 - Part D enrollment
 - Income eligibility for lower copays
 - Data files to SSA and CMS
 - Clawback
 - Nursing home issues
 - Critical information states need to make changes is not yet available

Source: Focus group discussion with Medicaid directors conducted by Health Management Associates for Kaiser Commission on Medicaid and the Uninsured, November 2004

Medicare Part D Transition Issues

- State policy makers may hear from beneficiaries who
 - Discover a gap in coverage if they do not enroll by January 1, 2006
 - Find that the drug Medicaid covered isn't covered by their PDP
 - Have higher out-of-pocket costs for copays or non-covered drugs
 - Don't know how to use plan
- Pharmacists and prescribers may have to assist 7 million beneficiaries with new Rx coverages and copay rules
- States face increased costs for clawback, wrap-around, "formulary fall-out," staff and IT

Source: Focus group discussion with Medicaid directors conducted by Health Management Associates for Kaiser Commission on Medicaid and the Uninsured, November 2004

Medicaid Reform: Expect Proposals

- State-based organizations have proposals for federal re-structuring of Medicaid:
 - National Conference of State Legislatures (NCSL)
 - National Academy for State Health Policy (NASHP)
- New federal proposals expected from the Administration
 - Focus on federal budget reduction
 - Medicaid and Medicare are “juicy targets” (WSJ, 12/3/04)

“If you can’t get Medicaid reform at the federal level, what can you get on a state-by-state basis?”

- Leslie Norwalk, Deputy Administrator, Centers for Medicare and Medicaid Services, speaking to Medicaid directors annual meeting, November 18, 2004. She added that “...any reform would be based on consumer-directed care and quality.”

Key Indicators from 1/19/05 Hearing Secretary Michael Leavitt Confirmation

- “We can expand the number of people served with quality basic care by giving states additional flexibility [for optional populations].”
- “It’s always been my belief that we can expand the number of people we serve within available resources.”
- “Medicaid is not meeting its potential to do good in the lives of the poor.”
- “I passionately believe that we could and should use Medicaid as a part of the transformational movement in the delivery of health in general.”

The Outlook for Medicaid: All Signs Point to Continued Cost Growth for States

- **Medicaid spending:** Projected to grow 8% to 9% per year over the next decade
- **Medicaid enrollment:** Growth is shifting toward elderly and disabled
- **Federal financial help:** Not likely –
 - Fiscal relief ended, federal surplus turned into a deficit
 - Fiscal scrutiny of states increased
 - Possible new policy flexibility
- **Medicare prescription drug financing:** will add to state financing challenges
- **Result:** Medicaid cost growth will outpace revenue growth – will drive Medicaid politics and policy decisions – and will add urgency for reform – with no obvious solution in sight.