Medicaid Issues and Challenges

By Beau Egert

Medicaid continues to drive state budgets across the country. As state revenues have declined, Medicaid costs per enrollee have almost doubled in the last five years.[1] Largely as a result, the National Governors Association reported in November 2002 that "nearly every state is in a fiscal crisis."[2] Nationally, Medicaid and other health care services comprise 30% of state budgets, and these costs increased by 13% in 2002, which was the largest increase in a decade.[3] "Growth in Medicaid continues to put a severe strain on state budgets," and 28 states anticipate shortfalls in Medicaid spending for the current fiscal year.[4]

Texas is no exception to these trends. Without reform, Medicaid threatens to consume an ever increasing share of the state budget, potentially jeopardizing every other budgetary item. Some predict that left unreformed, Medicaid will bankrupt every state in as little as 20 years.[5] The right policy response to Medicaid demands first a proper understanding of the problem. How did Texas' Medicaid program get to where it is today? What is driving these costs and where should the state begin in addressing them? An attempt to answer these questions is the purpose of this paper.

Rising Costs

Medicaid began in the 1960s as a part of President Johnson's continuing "War on Poverty." It was intended as a social safety net to provide health insurance for the poor, disabled and elderly. Not long after its inception, Medicaid expenditures quickly outgrew Congressional expectations, and its history is largely that of failed government

attempts to rein in spiraling costs.

In Texas, Medicaid spending grew rapidly in the 1980s and early 1990s due to increased caseloads and costs, but by the mid-1990s, more modest single digit growth replaced double digit figures. This decline "briefly suspended [Medicaid's] image as the top state budget growth driver."[6] It is important to note that although Medicaid spending slowed dramatically from 1996 to 2000 (26%) compared to 1991-1996 (118%),[7] it still substantially outpaced nominal budgetary growth. Since 2000, Texas has experienced a steady upward trend in enrollment and the return to annual double digit growth rates.[8] The primary drivers of this growth mirror the national trends of increased enrollment due to the economic downturn, rising prescription drug and hospital costs, and increased costs of both acute and long-term care for the elderly and disabled populations.[9] The elderly and disabled populations in particular accounted for almost 60 percent, or $50 billion, of the national growth in Medicaid spending from 2000-2002.[10]

The Texas Health and Human Services Commission along with other health policy experts expect this growth in Medicaid expenditures to continue for several reasons:

- Increased enrollment, primarily non-disabled adults and children,
- Increased utilization and cost of prescription drugs,
- Increased provider payments,
- Medical inflation; and,
- Increased long-term care expenditures.[11]

High Overall Costs

While these factors account for Medicaid's spending growth, they do not necessarily explain

why Medicaid is so expensive overall. A number of issues contribute to making Medicaid such an expensive program. First, Medicaid simply covers a medically needier population, many of whom would be unable to attain health insurance on the private market. This population includes the elderly and disabled, but also Medicaid's general adult population who has a poorer health status compared to low-income adults with private insurance.[12] In addition, unlike employer-based health insurance, where coverage begins upon hiring, Medicaid coverage is often triggered by a specific health need. Secondly, Medicaid's eligibility requirements create perverse incentives for beneficiaries. Since eligibility is based on having low-income and few assets, Medicaid penalizes those who succeed and encourages the spending down of assets in order to retain or initially qualify for benefits. When a beneficiary earns a dollar over the income threshold, he/she loses 100% of coverage. Medicaid eligibility rules also allow individuals to divest themselves of assets, by transferring to heirs and/or other family members. They can subsequently qualify for Medicaid within 36 months. While empirical confirmation of this problem is difficult to attain, burgeoning law practices in this area combined with ample anecdotal evidence suggest its presence is real.

Third, delivery of Medicaid services completely isolates consumers from the cost of care. Since health care is for practical purposes "free" for Medicaid beneficiaries, they consume until their marginal benefit equals zero, resulting in procedures that cost more than their value to patients. Managed care programs have attempted to reign in such spending, but savings thus far have been modest.[13] Managed care also introduces

increased complexity for providers and beneficiaries, and while beneficiaries have been generally satisfied with the program, providers indicate high levels of dissatisfaction.[14] Overall, these factors contribute to high Medicaid spending in Texas and in the U.S.

What Can Be Done?

In the face of such rising costs for an already expensive program, Texas has four options:

- **Do nothing.** While no one suggests that doing nothing is a viable option, with further delay this becomes the *de facto* course of action. The reality is that without change, as mentioned above, Medicaid will consume an ever increasing share of the state budget, endangering all other budgetary items.
- **Raise taxes.** Some argue that with increasing costs, Texas simply needs to increase tax revenues, and its reluctance to do so complicates the Medicaid issue. However, tax increases will not solve Medicaid's problems; it will only delay them. The delay would be extremely costly for taxpayers as well as unsustainable in the long-run. Since the foreseeable future points to double digit growth in Medicaid, tax increases would have to keep pace, with no end in sight. Thus, it is important to note that when it comes to Medicaid, opposition to tax increases is not a philosophical argument of big versus small government. Rather, it is a practical approach that recognizes Medicaid's current spending growth is unsustainable, and the legislature must pursue alternative measures for reform.

- **Cut spending.** As a federal entitlement program, spending cuts for Medicaid are by nature limited to optional coverage areas. In response to increasing costs, states have historically restricted their eligible Medicaid population, cut optional benefits, or reduced provider payments. The Kaiser Commission on Medicaid and the Uninsured reported that 49 states in 2003 planned to pursue one of these options. These traditional responses are undesirable in Texas for several reasons.[15] First, restricting the eligible Medicaid population results in a higher percentage of uninsured residents.[16] These residents remain without care while still not bringing about lower costs as "regions that spend less on Medicaid spend more on free care for the uninsured and vice versa."[17] Second, many of the optional benefits under Medicaid are substitutes for more expensive services, so no net savings result. Third, already low provider payments threaten to erode participation rates and additional cuts could jeopardize the entire system. So overall, cutting Medicaid spending hurts some of the most vulnerable populations in Texas with little savings as a result.
- **Reform Medicaid.** Significant Medicaid reform is the only viable option for Texas. The question, of course, is what kind of reform does Medicaid need?

Areas for Additional Research

The following research areas have been identified for potential Medicaid reform. They recognize the need to rein in Medicaid spending while also maintaining high levels of quality and

access to care.

- **Use of personal assets and risk transfer mechanisms to off-set costs of long-term care.** State policymakers should focus considerable attention on ensuring that individuals' assets are available and utilized for their care prior to receiving assistance from state and federal governments.
- **Managing the utilization of services.** As mentioned above, attempts have been made to manage the utilization of services primarily through managed care programs. These programs are only offered in urban areas as opposed to the fee-for-service model in rural areas. The fee-for-service model prevents the transfer of financial obligation to patients and creates incentives for providers to perform unnecessary procedures. Alternative delivery models exist and should be examined to better align patient and provider incentives with the taxpayers' interests.
- **Encouraging employer-sponsored health care programs.** Currently in Texas employer-sponsored health insurance covers 58% of the population compared to 64% nationally.[18] Employer-sponsored programs hold perhaps the greatest potential for reducing Medicaid costs and decreasing the number of uninsured persons in Texas.
- **Ensuring state maximization of entitled federal share (FMAP).** State policymakers should continue to strive

for the most efficient system to deliver medical assistance to low-income populations. They should also examine ways to increase flexibility, increase local control, and ensure that taxpayers of the state and its political subdivisions are receiving fair treatment in terms of federal funds for low-income programs.

The problems posed by Medicaid challenge even the most experienced policy-makers of our state and nation. There are no easy answers. The stakes are high both for the over 50 million people nationally who depend on Medicaid for their health insurance and the taxpayers who fund the program. While the task is difficult, there is no alternative to reform because Medicaid as we know it cannot be sustained.

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ENDNOTES

[1] Michael Bond, et. al., "Reforming Medicaid," National Center for Policy Analysis, Report No. 257, February 2003, 5. See www.ncpa.org/pub/st/st257

[2] Robert Pear, "States are Facing Big Fiscal Crises, Governors Report," *New York Times,* 26 Nov. 2002.

[3] Ibid.

[4] "Tough Economic Times Remain for States," National Governors Association, 26 June 2003.

[5] Bond, 2.

[6] Anne Dunkelberg, "Medicaid and State Budgets: A Case Study of Texas," Kaiser Commission on Medicaid and the Uninsured, March

2002, 1.
[7] Ibid, 9.
[8] Ibid, 9.
[9] Diane Rowland, Executive Director, Kaiser Commission on Medicaid and the Uninsured, Testimony before House Subcommittee on Energy and Commerce, 8 October 2003.
[10] Ibid.
[11] Texas Medicaid in Perspective 5.4.
See www.hhsc.state.tx.us/medicaid/med_info.html
[12] Rowland, 7.
[13] Texas Medicaid Managed Care Report, November 1, 2000. See www.hhsc.state.tx.us, page 2.
[14] Ibid, 2.
[15] http://www.kaisernetwork.org/daily_reports/rep_index.cfm?hint=3&DR_ID=15497 January 14, 2003.
[16] Dunkelberg, 14.
[17] Bond, 3.
[18] U.S. Census Bureau, "Historical Health Insurance Tables", n.d., http://www.census.gov/hhes/hlthins/historic/hihistt4.html (April 25, 2002).

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