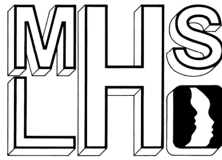
Michigan League for Human Services

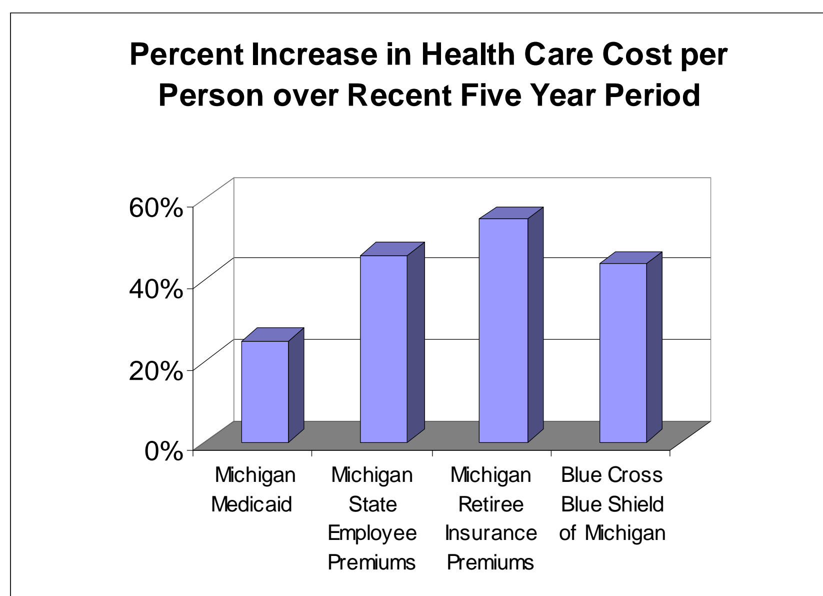


November 2004

Medicaid Under Siege

The Medicaid program is doing its job -- providing health care benefits and services to those who qualify, and doing it efficiently. While the program is considered "out of control" by some, due to its growth, the Medicaid program is not the cause, rather its growth is the result of the lack of affordable health care coverage and medical services needed by low-income families and elderly and disabled persons. For low-income elderly and disabled persons, in particular, Medicaid may represent the only financing option when nursing home or institutional care is required.

Though the Medicaid program continues to grow, its growth per eligible person has been considerably lower than other public and private health care plans. Over the last five years, the cumulative increase in Michigan Medicaid spending per eligible person is less than 25 percent, while state employee premiums have increased 46 percent over the same period, and state retiree premiums have increased 55 percent. During the five-year period from 1998 – 2002, per capita health care spending by Blue Cross Blue Shield of Michigan for privately insured individuals increased 44 percent. The following chart displays the variation in cost per person.



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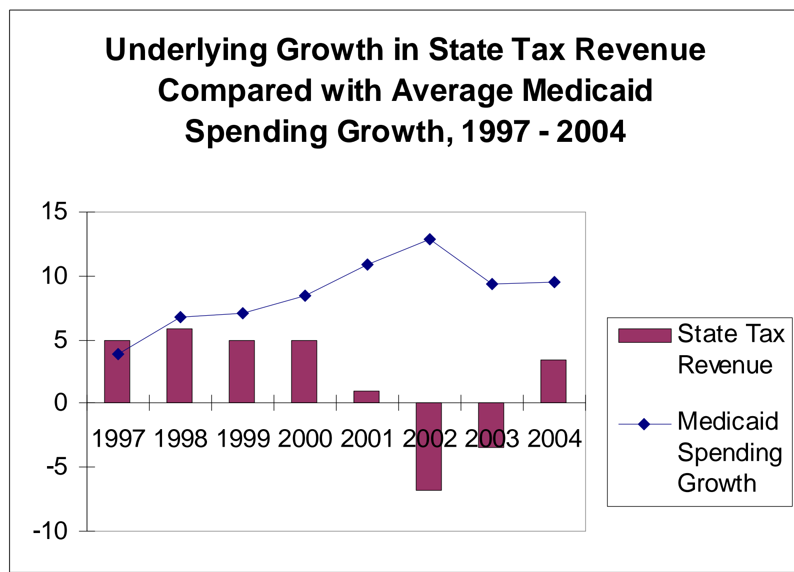
These comparisons are even more remarkable when one considers that the Medicaid program covers the elderly and disabled, including long term care. The elderly and disabled are very costly populations to serve both because of their greater need for health care services and because of the high cost of the services they require.

Medicaid programs nationally are out-of-sync with their respective states' revenues. While states' revenues are projected to grow, state Medicaid programs are projected to grow faster. Since the Medicaid program is generally the second largest program in states' budgets, accelerated growth rates cause great concern for policymakers. A recent report by the Kaiser Commission on Medicaid and the Uninsured indicates that the gap between revenue growth and Medicaid spending growth is narrowing, but it is still substantial. The report indicates that for FY2004, states' revenues grew by 3.4 percent, while the average growth in Medicaid spending was 9.5 percent. This represents a significant improvement over FY2003, when the variance ranged from a revenue *decline* of 3.4 percent to a Medicaid expenditure increase of 9.4 percent. In spite of the improvement, the structural gap continues as is displayed in the following graph of national data.



Note: Chart reflects national data. State Tax Revenue data is adjusted for inflation and legislative changes. 2004 is preliminary estimate.
Source: Kaiser Commission on Medicaid and the Uninsured, October 2004

The Michigan Medicaid program and Michigan state revenues follow the national trend. State revenues have experienced significant declines since FY2000 in part due to the economy and in part due to planned reductions in tax revenues or increases in tax expenditures. As state revenues have declined, efforts have been made to curb the increases in the Medicaid program. Over the last four years, the Medicaid program has experienced significant reductions while attempting to maintain the safety net for vulnerable citizens. The reductions have impacted all aspects of the program ranging from eligibility restrictions (freezing enrollments in the Home and Community Waiver program, the Adult Benefits Waiver (Adult Medical) program, and the

Elder Prescription Insurance Coverage program), to service reductions/eliminations (Adult Home Help and Adult Dental), to increasing copays ($3 for brand-name drugs), to provider payment reductions. Program reductions, in the last four years, total more than $800 million.

Many of these reductions have had significant impacts not only on the recipients and their families, and the providers, but also on local communities. Families USA, a Washington based health care consumer organization, calculates that for every $100 million reduction in Medicaid spending, the State loses $260 million in business activity, more than 2,500 jobs and nearly $98 million in lost salaries and wages. Based on this calculator, Michigan has lost a significant number of jobs as well as millions of dollars of taxable wages and business activity.

At the same time, in part because of the economy, Medicaid caseloads and costs are increasing. In spite of the reductions identified above, expenditures have increased by about 37 percent over the last four years.

Contributing factors to the increase in Medicaid enrollment are the decline in employer-sponsored programs and the increases in employee-required premiums. A recent Kaiser Commission report estimates that nationally there are at least 5 million fewer jobs providing health insurance benefits in 2004 than in 2001. The report further indicates that since 2000, premiums for family coverage have increased 59 percent, compared with inflation growth of 9.7 percent and wage growth of 12.3 percent. (*Employer Health Benefits –2004 Summary of Findings, Kaiser Family Foundation and Health Research and Educational Trust, 2004 Survey)*.

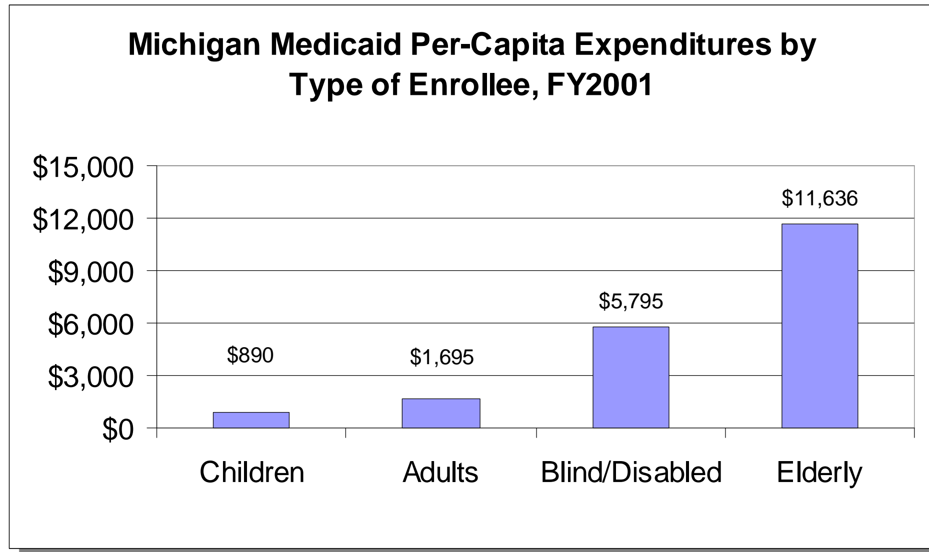
Recently released census data for Michigan show:

- § an increase in the number of persons in poverty (one of seven states to show an increase),
- § a slight increase in the number of persons who are uninsured, and
- § a 2 percent reduction in the household median income.

In addition, it is important to note that the vast majority, 75 percent, of uninsured persons in Michigan are working or members of working families. Based on the above factors, there is little reason to expect significant declines in the near future in the number of non-elderly persons eligible for Medicaid or in the amount of spending. The number of children and non-elderly adults applying for Medicaid is likely to increase as employers, who continue offering health insurance benefits, impose higher cost sharing requirements on families, which may preclude families financial ability to maintain family coverage. Forty-one percent of the employers in the Kaiser Health Benefits Survey indicate that they are very likely or somewhat likely to increase the percentage of family premiums that employees must pay in the next two years.

The economy and lack of adequate employer based insurance coverage, however, are only a part of this complicated picture. A comparison of eligible groups and spending among categories of eligible groups provides a stark contrast. While nearly 75 percent of the enrollees in the Medicaid program are children and non-elderly adults, that population accounts for only 30 percent of the spending; their medical costs are relatively inexpensive. The elderly, however, *who likely qualify for Medicare, making Medicaid secondary coverage*, and disabled persons,

while accounting for 25 percent of the enrollees, account for 70 percent of the expenditures. The following table displays the contrast in per-capita expenditures.



Source: Georgetown Health Policy Institute analysis based on MSIS 2001 data as of 4/19/2004.

The distribution of eligible persons and expenditures has changed little over the last 10 years. The next 10 years, however, are likely to be very different as the first wave of "baby boomers" begin turning age 65, and may begin needing services either in the community or in nursing facilities. According to the House Fiscal Agency, in FY2002, Michigan Medicaid spending for the elderly who were also eligible for Medicare totaled nearly $1.9 billion. Of that total, $1.2 billion was for long term care services, and $358 million was for prescribed drugs; neither service had extensive coverage under Medicare.

The Medicare Program, under Part D, will assume responsibility for coverage of prescribed drugs in January 2006. The fiscal benefit to the state, in the short run, is questionable. While the Medicare Modernization Act (MMA), which includes the provisions for prescribed drug coverage under Medicare, could have provided significant fiscal relief to states, instead it requires states to share in financing a Medicare benefit. The Act requires states to reimburse the federal government for most (90 percent in FY2006, phasing down to 75 percent in 2015) of the state savings that would have been realized by state Medicaid programs for no longer covering prescribed drugs for those who are also eligible for Medicare Part D. This is often referred to as the "claw back" provision.

Actual savings are questionable, and perhaps non-existent in the short run, both because the State's liability will be based on actual cost experience for prescribed drugs in the Medicare program (in which best price negotiations are prohibited), and because of new eligible persons who will likely be identified as part of the State's responsibility for completing a Medicaid eligibility determination for anyone who comes to the "Medicaid agency" to apply for the Medicare Part D low income subsidy. It is important to note that states are prohibited from receiving Medicaid federal match for drugs provided to persons eligible for both programs, even

if a specific drug is not covered by the person's drug plan. This is a major change from the current provisions of Medicare/Medicaid coordination, which permit state Medicaid programs to fill gaps in Medicare coverage and receive federal match. Depending on the formularies and coverages by the various drug plans, there may be significant pressure on the Medicaid program to provide 100 percent state-funded (since federal match will not be available) supplemental benefits.

Whether the federal government, under Medicare or a new program, should assume responsibility for all nursing home care for the elderly is a widely debated topic. From the states' perspectives, it will be a formidable task to finance the long-term care or community-based service needs of the "baby boomers." While the debate goes on, however, the states remain responsible for the long term care of their elderly in ever-rising numbers and cost. Should the federal government assume responsibility for these costs, it is not certain that states would experience significant fiscal relief in view of the "claw back" provision included in the Medicare Modernization Act. Long term care insurance policies have been suggested as a partial solution to curbing the Medicaid long-term care increase. To date, however, long term care insurance policies have not proven very popular or affordable either for senior citizens or for younger couples. *(Private Long-Term Care Insurance: Who Should Buy It and What Should They Buy? Kaiser Family Foundation, March 2003)*

Policy makers have a very difficult task ahead to balance responsible economic policies with preserving a medical safety net. In an effort to grapple with these issues, the Governor has appointed a Long Term Care Task Force to study some of these issues and provide recommendations for a future course. Planning for the future must begin to address the impact of the first wave of "baby boomers" on the economy as state revenues from their taxable incomes are reduced, at the same time that their demands and cost to the public system increase.

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