Michigan League for Human Services

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Michigan's Medicaid Program: PAC Man or Protector?

While there are some who argue that Medicaid is the PAC Man of state revenues and it must be reined in, there are others who argue that Medicaid is the Protector of thousands of Michigan's most vulnerable citizens, providing life-saving (cancer treatment) or life-sustaining (Home and community based waiver, adult home help) or life-giving (neonatal intensive care) medical services.

Background

In the last 10 years, there has been a dramatic shift in the categories of persons eligible for Medicaid and the basis for their eligibility. In FY1994, 72 percent of those eligible for Medicaid were receiving a cash benefit, Aid to Families with Dependent Children (AFDC), or Supplemental Security Income (SSI). By FY2003, only 32 percent of those eligible for Medicaid were receiving a cash benefit. The remaining 68 percent, the "Medically Needy" were eligible *only* for Medicaid, no cash payment. Of the "Medically Needy," 78 percent were families with children or pregnant women and children. The remaining 22 percent were elderly, blind, disabled, or foster or adopted children. The Medicaid program has evolved into *the* health care program for low-income families and individuals.

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Perhaps the most startling and troubling statistic among the "medically needy" categories is the increase in the number of persons eligible for Medicaid due to blindness. From FY1994 through FY2001, there were fewer than 300 persons eligible for Medicaid only due to blindness; by FY2003, that number had increased 732. This represents a 209 percent increase in just two years, and the February 2004 number has risen to 917. These dramatic increases raise significant concerns about the health status and health trends of Michigan residents. A current health trend for Michigan residents is the high incidence of diabetes; Michigan ranks 8th in the nation.

The other category that has experienced unprecedented growth is that of "pregnant women and children." The growth in this category is due, in part, to federally mandated expansions of coverage for pregnant women and children. Ten years ago, the federal government mandated phased-in coverage of children over the age of one and under the age of 19 in families with incomes below 150 percent of the poverty level. This expansion was accomplished in Michigan under the already existing Healthy Kids program which had been implemented several years prior for a more limited population. The program experienced steady growth in the range of 24,000 to 31,000 new eligibles per year until FY1998, when the growth was only 18,700.

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When MiChild, a non-Medicaid health program for children in families with incomes between 150 percent and 200 percent of the poverty level, was implemented statewide in September of 1998, significant increases in the "pregnant women and children" category occurred. This resulted from a high percentage of MiChild applicants being found eligible for Medicaid. If a MiChild applicant appears to be eligible for Medicaid, that child's Medicaid eligibility must be determined first, a requirement of the special federal grant, State Children's Health Insurance Program (SCHIP), that funds nearly 70 percent of the MiChild program.

The increase in the "pregnant women and children" category from FY1998 to FY1999 was 48,500, the largest one year increase ever experienced. Significant growth in this category continues, but at a lower rate. Increases for the past two years have been about 32,000 per year. The number of persons eligible for Medicaid in this category reached an all-time high of over 396,000 in February 2004.

The continued sustained growth in the poor aged and disabled populations explains, in part, the significant growth in expenditures in the program. The aged and disabled populations have historically used a disproportionate share of the medical resources, due to their high health care needs, compared to the share of the Medicaid caseload they represent. According to the House Fiscal Agency, aged, blind and disabled persons represent about 27 percent of the eligible population, but account for more than 70 percent of the program's expenditures. Continued and perhaps increased pressure will be placed on the Medicaid budget as the "Baby Boomers" reach retirement age and begin needing services either in the community, or in nursing facilities.

The following charts show the actual changes in the enrollments in the Medicaid program over the last ten years, and projections for fiscal years 2004 and 2005.

Monthly Average Number of Persons Eligible for Medicaid Only 1/ by Basis for Eligibility Fiscal Years 1994 – 2005*

Fiscal Year	Aged	Blind	Disabled	Families with Dependent Children	Other Children Under Age 21	Pregnant Women and Children	Total Number of Person Eligible	Percent Change from Prior Year	Percent Change from FY1994
1994	49,970	287	38,617	117,368	44,260	83,622	334,100	N/A	N/A
1995	52,882	280	43,294	125,396	39,680	114,623	376,200	13%	13%
1996	55,158	265	47,110	127,849	39,375	138,999	408,800	9%	22%
1997	56,665	265	52,634	145,469	40,566	165,102	460,700	13%	38%
1998	57,573	279	55,021	195,974	41,246	183,812	533,900	16%	60%
1999	59,429	264	56,763	212,501	38,889	232,329	600,200	12%	80%
2000	61,026	259	60,029	216,739	39,448	274,384	651,900	9%	95%
2001	62,364	237	63,069	232,328	42,177	314,661	714,800	10%	114%
2002	64,251	453	69,742	273,070	45,263	346,449	799,200	12%	139%
2003	65,739	732	77,051	308,220	48,296	378,719	878,800	10%	163%
2004*	67,000	1,050	83,500	329,800	51,000	399,800	932,200	6%	179%
2005*	68,500	1,300	89,300	352,900	53,800	422,200	988,000	6%	196%

1/ Includes persons eligible for Medicaid only; no cash assistance is provided to these persons.

* Michigan League for Human Services projections.

*Monthly Average Number of Persons Eligible 1/ for Medicaid by Eligibility Group Fiscal Years 1994 -- 2005**			
Fiscal Year	**Cash 2/ Assistance Recipients**	**Medicaid Only**	**Total Persons Eligible for Medicaid**
1994	860,700	334,100	1,194,800
1995	802,700	376,200	1,178,900
1996	739,500	408,800	1,148,300
1997	658,200	460,700	1,118,900
1998	569,100	533,900	1,103,000
1999	468,000	600,200	1,068,200
2000	415,400	651,900	1,067,300
2001	402,100	714,800	1,116,900
2002	412,600	799,200	1,211,800
2003	414,400	878,800	1,293,200
2004*	425,700	932,200	1,357,900
2005*	432,400	988,000	1,420,400

1/ Eligible recipients are those who qualify for Medicaid; they may or may not have received a benefit.
2/ Includes recipients of Family Independence Program and Supplemental Security Income program benefits. These persons are automatically eligible for Medicaid.
*Michigan League for Human Services projections.

It is worth noting that the FY2004 caseload projection reflects significant increases in both categories of eligibles – the "medically needy" and those receiving cash assistance. The February 2004 Medicaid only caseload reflects not only continued growth, but also an all-time high. While the Executive Budget assumes that the number of persons eligible for Medicaid will decline during FY2005, that assumption may be overly optimistic and premature in reflecting the impact of an economic recovery on the Medicaid program. Even if the unemployment rate declines, it is not clear that there will be a corresponding reduction in the number of persons eligible for Medicaid. According to a recent Kaiser Commission [1/] study, the number of people nationally with employer-based insurance is declining, and in 2002, the country experienced the largest annual increase in the number of uninsured in more than a decade. Furthermore, high premiums and cost sharing requirements present insurmountable barriers for many low-wage workers. From their study, the Kaiser Commission noted that 81 percent of the uninsured are in working families.

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What can be done to control costs in the Medicaid program?

To reduce the cost of the program, or to slow the rate of growth, Michigan has three options:

- Restrict eligibility to reduce the number of people (i.e., no longer cover some/all of the optional eligible groups)
- Restrict the covered services (i.e., no longer cover some/all of the optional services)
- Reduce provider reimbursement (i.e., to hospitals, nursing homes, physicians, etc.)

Since FY2002, more than $700 million in gross reductions have been made in the Medicaid budget associated with program reductions in all three of the above categories. Whether the reductions will actually reduce Medicaid spending, or even reduce the level of growth, is difficult to assess. For each reduction policy, there may be corresponding negative consequences that outstrip the savings from the reduction policy. For example, an untreated dental abscess may result in a hospitalization, even intensive care, which could have been avoided with appropriate dental care. A diabetic in need of podiatric care may require hospitalization for an infected toe, which could have been easily treated in a podiatrist's office. Both routine dental and podiatric services have been eliminated for adults. Funding reductions will likely continue in FY2005 with the Executive Budget recommending $95.3 million in gross reductions.

Medicaid is a very efficient program, with year-to-year growth far below that of the private or the public health care sectors. Since FY2000, Medicaid expenditure growth (excluding special financing payments) totaled nearly 49 percent. A significant component of that growth resulted from implementation of provider taxes in FY2003. The current appropriated increase from FY2003 to FY2004 is less than 6 percent. On a per-eligible-person basis, the program is even more efficient, with a cumulative increase since FY2000 of only 15 percent ($3,591 spending per eligible person to $4,133 appropriated per eligible person for FY2004). These increases are even more remarkable when one considers that the Medicaid program covers the elderly and disabled, including long term care. To provide a comparative context, active state employee premiums over the same five-year period increased, on a cumulative basis, by 46 percent, while premiums for state retirees increased by 54.5 percent. Neither of these programs has a long-term care component. During a similar period (1998 – 2002), per capita health care spending by Blue Cross Blue Shield of Michigan for privately insured individuals increased by 43.9 percent.

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What needs to be done to protect the citizens who are eligible for the Medicaid program?

Michigan needs stable revenues to support the Medicaid program to insure that comprehensive benefits are available and accessible to everyone enrolled in the program. In addition, the State needs to ensure adequate coverage for low-income working parents and seek the means to restore benefits that have been or are proposed for elimination.

Absent stable revenues, the benefits and categories of people covered by the Medicaid program are likely to be reduced. This paints a very bleak picture for the State when one considers the current health status of Michigan residents. Michigan falls in the worse half of national rankings [2/] that indicate a high incidence of chronic and costly diseases. Michigan ranks 3rd in obesity, 5th in the number of adults diagnosed with asthma, 5th in the percent of adults reporting poor mental health, 11th in the number of deaths per 100,000 from heart disease, 23rd in the number of deaths per 100,000 from strokes, and 27th in the number of deaths per 100,000 from cancer.

Poor health status in so many key areas will continue to drive up the cost of health care for both the Medicaid program and private insurers. In addition, many of the chronic diseases, particularly those related to tobacco use and obesity/physical inactivity are preventable. They are also far less costly when detected early and carefully managed. Certainly if Medicaid benefits or eligibility are reduced, neither early detection nor careful management will be an option for these vulnerable citizens. In its research, the Kaiser Commission found that in 2003, nearly half of the uninsured adults postponed seeking medical care and one-third needed, but did not get, medical care. Delaying or not receiving care can lead to more serious and more expensive health issues.

A comprehensive health policy, with fair and adequate funding, for all Michigan's citizens needs to be a top priority of Michigan's policymakers. The Partnership for Michigan's Health, comprised of the Michigan State Medical Society, the Michigan Health and Hospital Association, and the Michigan Osteopathic Association, last fall declared a health care crisis in the State. This crisis, which affects all of Michigan's citizens, presents a great opportunity not only for the Governor and Legislature, but also other key state leaders, to establish and effectively promote state health care policies to improve the health status of Michigan residents, to stop continued shifting of health care costs to the private sector as providers attempt to recoup Medicaid reductions, and to make Michigan a more appealing state for business location.

Michigan has taken a step forward in the establishment of health care policies by releasing the first-ever health status report which will serve as the foundation for efforts to improve residents' well being, and by issuing the first-ever strategic plan for the treatment and prevention of diabetes.

The FY2005 Executive Budget supports a state health care agenda by proposing partial revenue solutions, rather than only cuts to balance the budget. This is, however, a stop-gap measure as the proposed new tobacco revenues will likely decline over time, and solutions to structural deficits will again be sought. A long-term solution that provides fair, stable and adequate revenues to the Medicaid program is critical to the state's health.

[1/] *The Uninsured and Their Access to Health Care*, Kaiser Commission on Medicaid and the Uninsured, December 2003.
[2/] Kaiser Family Foundation, State Health Facts Online.

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