CBO TESTIMONY

Statement of
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on
The Status of the Medicaid Program

before the
Subcommittee on Health and Environment
Committee on Commerce
U.S. House of Representatives

June 21, 1995

NOTICE

This statement is not available for public release until it is delivered at 10:00 a.m. (EDT), Wednesday, June 21, 1995.

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Mr. Chairman and Members of the Subcommittee, it is my pleasure to be here today to discuss the status of the Medicaid program. The rapid increases in Medicaid spending and the growing prominence of the program in the federal budget present a serious challenge to the Congress.

Between 1988 and 1993, overall Medicaid spending increased at an annual rate of 16 percent, while the federal share increased at the remarkable rate of 20 percent per year. Yet over the same period national health expenditures rose by less than 10 percent a year. Under current law, Medicaid expenditures are expected to continue to rise faster than other health expenditures. With federal spending of $89 billion in 1995, Medicaid now accounts for about 6 percent of the federal budget. By 2002, that share is projected to increase to 8 percent, or about $178 billion.

Both the House and Senate versions of the budget resolution for 1996 assume significant reductions in the rate of growth of Medicaid spending. Under the assumptions of the budget resolutions passed by the House and Senate, federal Medicaid spending in 2002 would be only $121 billion or $125 billion, respectively. Those amounts are well below CBO's current projection of federal Medicaid spending in that year. Clearly, reducing the growth in program spending will require both the Congress and the states to make significant policy changes.

My statement today addresses four topics:

- An overview of the Medicaid program,
- Past trends in program spending,
- CBO's projection of future spending under current law, and
- Considerations in modifying the Medicaid program to meet the requirements of the budget resolution.

OVERVIEW

Medicaid is the nation's major program providing medical and long-term care services to low-income populations. The federal and state governments jointly fund the program. The states administer it, however, and though they are subject to federal guidelines, they retain considerable discretion over all aspects of program operation. The federal share of total Medicaid spending in a state varies inversely with the per capita income of the state, subject to a lower limit of 50 percent and an upper limit of 83 percent.

Medicaid Beneficiaries

The Medicaid program has always covered most recipients and potential recipients of cash welfare benefits provided through the Aid to Families with Dependent Children (AFDC) and Supplemental Security Income programs. In addition, coverage has been extended to large numbers of poor and near-poor children and pregnant women, as well as to certain low-income Medicare beneficiaries. In 1993, more than 33 million people received Medicaid benefits. Children under the age of 21 are by far the largest group of Medicaid beneficiaries, accounting for almost half of the total in 1993. About 12 percent of beneficiaries were elderly and 15 percent disabled. Most of the remainder were nondisabled adults.

The majority of Medicaid beneficiaries are poor or near-poor. In 1992, according to the Census Bureau's Current Population Survey, 61 percent of the noninstitutionalized Medicaid population was in families with income below the poverty level and 74 percent was in families with income below 133 percent of the poverty level.

Provision of Services

Medicaid covers both acute medical services and long-term care. The federal government requires all states to provide a core group of services, including hospital,

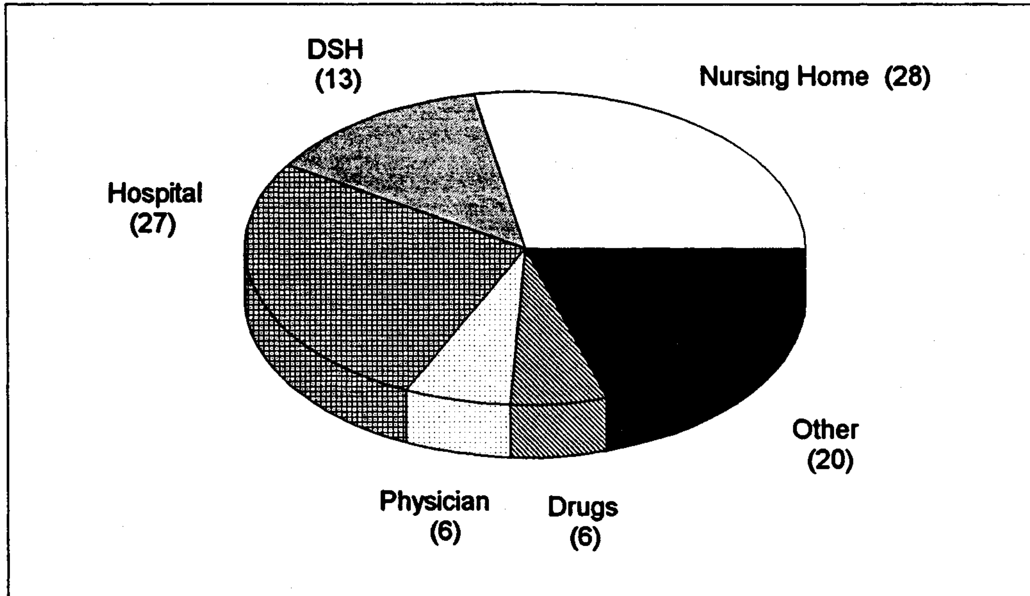
physician, and general nursing facility services. States have the option, however, to cover an extensive range of services in addition to the mandated ones, and all of the states do so. Optional services include drugs, dental services, eyeglasses, and personal care services. The typical Medicaid beneficiary receives acute care services free of charge or for a nominal copayment. However, beneficiaries often face limited access to providers, many of whom are unwilling to see Medicaid patients.

Concern about access to providers was an important factor in the decision of some states to develop managed care arrangements for providing acute care services to some of their Medicaid beneficiaries--generally nondisabled adults and children. By June 1994, about 8 million Medicaid beneficiaries--almost a quarter of the total--were enrolled in managed care plans in 42 states and the District of Columbia.

Expenditures by Type of Service

The largest share of Medicaid expenditures is for hospital and nursing home services, which accounted for more than half of the total in 1993 (see Figure 1). Hospital expenditures include payments to hospitals for inpatient and outpatient services received by Medicaid beneficiaries. In addition, disproportionate share hospital (DSH) payments are made to hospitals that serve disproportionately large numbers

FIGURE 1. DISTRIBUTION OF MEDICAID EXPENDITURES BY CATEGORY OF SERVICE, FISCAL YEAR 1993 (In percent)



SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-64.

NOTES: Nursing home expenditures include spending for nursing home facilities and intermediate care facilities for the mentally retarded.

Hospital expenditures include spending for inpatient and outpatient care.

DSH = disproportionate share hospital payments.

of Medicaid and uninsured patients. Nursing homes include general nursing facilities as well as intermediate care facilities for the mentally retarded.

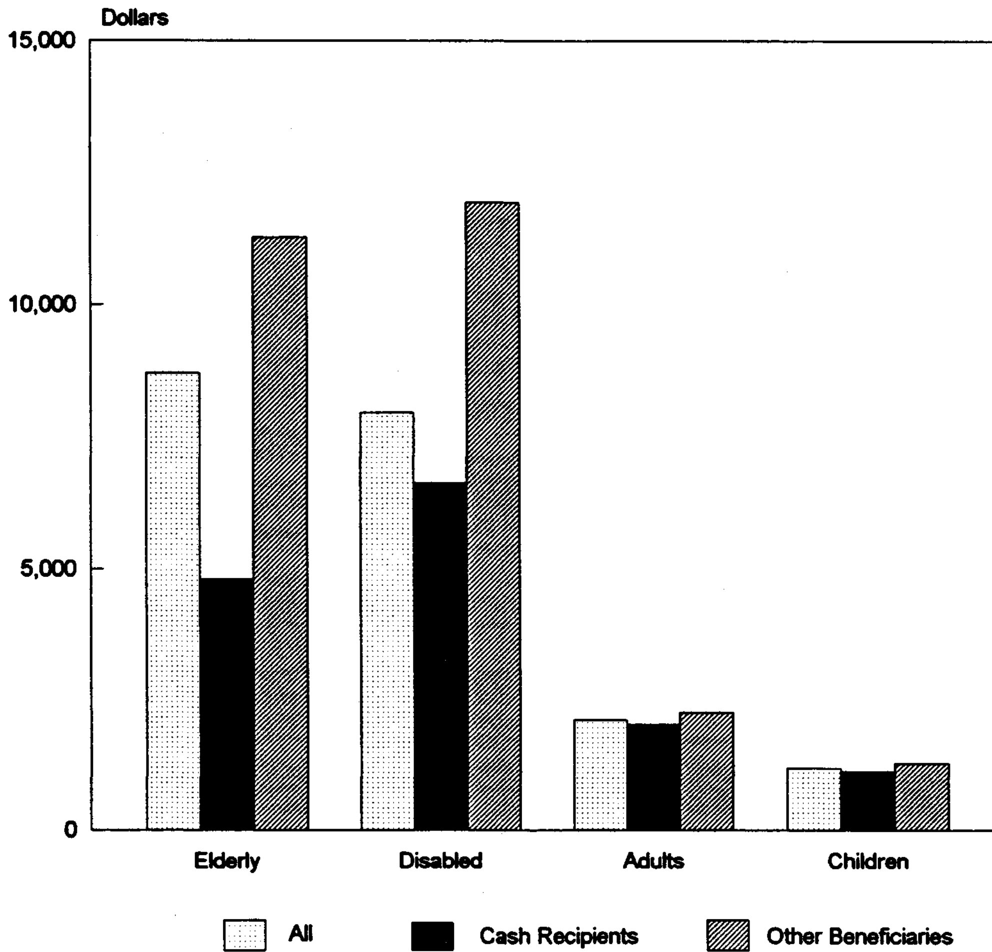
Expenditures by Eligibility Status

Because of their use of nursing home services and their extensive acute care needs, elderly and disabled Medicaid beneficiaries generate much higher medical expenditures than do children and other adults (see Figure 2). Some elderly and disabled beneficiaries become eligible for Medicaid because of their need for costly nursing home services, even though they have not received cash welfare benefits. As a result, although the elderly and disabled represented less than 30 percent of Medicaid beneficiaries in 1993, they accounted for about two-thirds of all Medicaid expenditures, excluding DSH payments (see Figure 3).

Variation in State Expenditures

Both the levels of and recent trends in Medicaid expenditures vary considerably from state to state (see the appendix). A number of reasons account for that variation: the size and makeup of the beneficiary population, the coverage of optional services, the use of services by beneficiaries, payment levels for providers, differences in

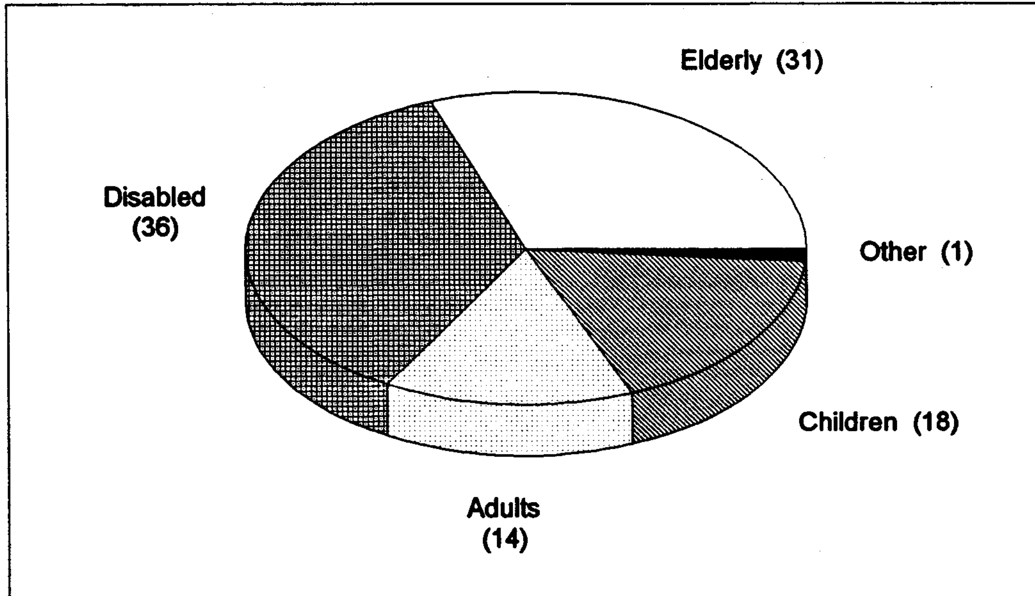
FIGURE 2. MEDICAID EXPENDITURES PER BENEFICIARY, FISCAL YEAR 1993



SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082 and HCFA Form-64.

NOTE: Excludes administrative costs and disproportionate share payments.

FIGURE 3. DISTRIBUTION OF MEDICAID EXPENDITURES BY ELIGIBILITY GROUP, FISCAL YEAR 1993
(In percent)



SOURCE: Congressional Budget Office estimates based on data from the Health Care Financing Administration, HCFA Form-2082 and HCFA Form-64.

NOTE: Excludes administrative costs and disproportionate share payments.

underlying health care costs, and variations in federal matching rates. In addition, some states have raised DSH payments substantially by taking advantage of certain financing schemes, whereas others have not.

Because of those factors, total Medicaid expenditures vary much more widely among the states than one might expect, given the relative size of their low-income populations. In California, for example, about 5.8 million people were in families with income below the poverty level in 1993 compared with about 3 million in New York. But in 1993, New York spent $18 billion on Medicaid (excluding administrative costs), whereas California spent only $14 billion. Medicaid expenditures (excluding DSH payments) per enrollee also vary widely among the states, ranging from less than $2,000 in Alabama, California, and Mississippi in 1993 to more than $5,000 in New York.[1]

TRENDS IN SPENDING

Since 1975, Medicaid expenditures have grown at an uneven rate, and recent patterns of growth have not reflected those of Medicare, private health insurance, or national

1. Colin Winterbottom, David W. Liska, and Karen M. Obermaier, *State-Level Databook on Health Care Access and Financing* (Washington, D.C.: Urban Institute, 1995).

health expenditures (see Table 1).[2] For analytic purposes, the trend in Medicaid expenditures for the 1975-1993 period can be divided into three distinct periods: 1975 to 1981, when Medicaid spending grew rapidly but still remained at virtually the same rate as national health expenditures; 1981 to 1988, when Medicaid spending grew relatively slowly and somewhat less rapidly than national health expenditures; and 1988 to 1993, when Medicaid spending grew extremely rapidly and much faster than national health expenditures.

Between 1975 and 1981, Medicaid spending grew at about 14 percent a year, the same as national health expenditures. Private health insurance and Medicare expenditures both grew at about 18 percent a year during that same period. Since the number of beneficiaries remained virtually unchanged at around 22 million, the growth in Medicaid spending was attributable to increases in prices and utilization per beneficiary.

Medicaid expenditures grew relatively slowly during the 1981-1988 period, at an annual rate of about 9 percent. Medicare and private health insurance spending grew at 10 percent and 12 percent, respectively, and national health expenditures grew at about 10 percent. As in the previous period, the growth in Medicaid

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2. CBO's analysis of spending trends is based on data from the national health accounts. In developing those estimates, the Health Care Financing Administration reduced the amount of disproportionate share payments to hospitals when such payments were offset by taxes and donations paid by the same facilities. The effect is to reduce the estimates of state Medicaid spending in the 1990s below the levels actually reported by the states. See Katherine R. Levit and others, "National Health Spending Trends, 1960-1993," *Health Affairs*, vol. 13 (Winter 1994), pp. 14-31.

TABLE 1. NATIONAL HEALTH EXPENDITURES BY SOURCE OF PAYMENT, 1975-1993 (By calendar year)

Source of Payment	1975	1980	1985	1990	1993
Billions of Dollars					
National Health Expenditures	132.6	251.1	434.5	696.6	884.2
Private Health Insurance	32.0	72.1	139.8	236.9	296.1
Medicare	16.4	37.5	72.2	112.1	154.2
Medicaid	13.5	26.1	41.3	75.4	117.9
Federal	7.4	14.5	22.8	42.7	76.1
State and local	6.1	11.6	18.4	32.7	41.8
Other	70.7	115.3	181.2	272.1	316.0
Average Annual Growth Rate from Previous Year Shown (Percent)					
National Health Expenditures	n.a.	13.6	11.6	9.9	8.3
Private Health Insurance	n.a.	17.6	14.2	11.1	7.7
Medicare	n.a.	18.0	14.0	9.2	11.2
Medicaid	n.a.	14.1	9.6	12.8	16.0
Federal	n.a.	14.3	9.5	13.3	21.2
State and local	n.a.	13.9	9.7	12.2	8.5
Other	n.a.	10.3	9.5	8.5	5.1

Average Annual Growth Rate over Indicated Periods (Percent)

	1975-1981	1981-1988	1988-1993
National Health Expenditures	14.0	9.8	9.5
Private Health Insurance	17.7	11.7	9.9
Medicare	18.3	10.3	11.5
Medicaid	14.5	8.9	16.4
Federal	15.0	8.8	19.6
State and local	13.8	9.0	11.7
Other	10.8	8.6	6.3

SOURCE: Congressional Budget Office based on data from the Health Care Financing Administration, Office of National Health Statistics.

NOTE: n.a. = not applicable.

expenditures primarily reflected price increases and increases in utilization per beneficiary; the number of beneficiaries grew only slightly during the period, reaching about 23 million in 1988. Indeed, in spite of the effects of the 1981-1982 recession, the number of Medicaid beneficiaries actually fell slightly between 1981 and 1983. Several factors contributed to that decline, particularly cutbacks in the AFDC program combined with new Medicaid options that granted states greater flexibility in determining which groups of children to cover. Although the Congress authorized expanding eligibility for children and pregnant women beginning in 1984, the early expansions were tied to categorical eligibility for welfare and did not have a major impact on the number of beneficiaries.

The 1988-1993 trends represented a break with past patterns. Previously, the growth in Medicaid spending had trailed behind that of private health insurance and Medicare. During the 1988-1993 period, however, Medicaid expenditures soared, rising at an average annual rate of about 16 percent, although national health expenditures grew at less than 10 percent. Private health insurance expenditures grew at about 10 percent during the period, and Medicare spending grew at less than 12 percent. The most striking increases occurred between 1990 and 1992, when Medicaid spending jumped by over 40 percent. Several factors contributed to Medicaid's dramatic growth: sharp rises in Medicaid enrollment, increased payments to providers, and financing schemes and disproportionate share payments.

Rapid Increases in Medicaid Enrollment

In contrast to earlier periods, 1988 to 1993 was marked by swift growth in the number of Medicaid beneficiaries. Not only did the number of children covered by the program increase sharply, but enrollment of population groups that are more costly to serve also grew rapidly.

Expansions in Eligibility. Beginning in 1984 and continuing through 1990, the Congress authorized a series of mandatory and optional expansions in Medicaid eligibility. Low-income children and pregnant women were the primary focus of those expansions, but the target populations also included the elderly and the disabled.

Of particular importance were the options granted to the states in the Omnibus Budget Reconciliation Act of 1986, which severed the required link between Medicaid and welfare eligibility. A rapid succession of mandates and options for covering low-income children and pregnant women followed, as well as requirements for covering low-income Medicare beneficiaries. The most recent mandatory expansion of the program, authorized in the Omnibus Budget Reconciliation Act of 1990, requires states to provide coverage to all poor children under 19 who were born after September 30, 1983. That requirement means that

mandatory expansions in Medicaid eligibility will continue under current law through 2002.

Such expansions in eligibility, along with efforts to streamline the eligibility process, have brought about large increases in the number of Medicaid beneficiaries who do not receive cash welfare benefits. The number of those beneficiaries rose at an average annual rate of about 17 percent between 1988 and 1993, having risen at an average rate of about 3 percent between 1981 and 1988. By 1993, over 40 percent of Medicaid beneficiaries did not receive cash welfare benefits, compared with less than 30 percent in 1988. Much of that increase, however, was among children, who are the least expensive beneficiaries to cover. The proportion of total expenditures attributable to beneficiaries who do not receive cash benefits increased only slightly over the period.

Although Medicaid expansions increased the number of Medicaid beneficiaries substantially over the late 1980s and 1990s, many of those new beneficiaries might otherwise have been covered by private insurance. A recent academic study found that workers were less likely to participate in employer-sponsored insurance if they had family members who were eligible for Medicaid.[3] The study also found some evidence that when those workers did participate in

3. David M. Cutler and Jonathan Gruber, *Does Public Insurance Crowd Out Private Insurance?* Working Paper No. 5082 (Cambridge, Mass: National Bureau of Economic Research, 1995).

employer-sponsored insurance, many opted for individual rather than family coverage.

Effects of the Recession. The 1990-1991 recession sparked greater enrollment in the Medicaid program because more families received cash welfare benefits and fewer families had access to employer-sponsored health insurance. It is not possible, however, to isolate the effects of the recession from other factors affecting enrollment growth.

The number of Medicaid beneficiaries who received cash welfare payments remained virtually constant at about 16.5 million throughout the 1980s. Consistent with the effects of a recession, that number increased to 17.2 million in 1991 and 18.8 million in 1992. But the number continued to rise to 19.6 million in 1993, even when the economy was expanding. Moreover, to some extent, the growth in the enrollment of Medicaid beneficiaries who were eligible for cash welfare benefits itself spurred growth in welfare caseloads. Some states began conducting aggressive outreach efforts to enroll children and pregnant women in Medicaid in the early 1990s and, in so doing, identified families who were eligible for cash welfare benefits but were not receiving them. The recession also caused other low-income individuals and families to enroll in the Medicaid program, as they lost their jobs or faced reduced hours of work.

Increases in High-Cost Beneficiaries. Medicaid expenditures depend not only on the total number of beneficiaries but also on their distribution among the different categories of eligibility. For a given number of beneficiaries, the higher the proportion of elderly and disabled beneficiaries, the greater spending will be. The proportion of pregnant women among the nondisabled adult population also has an important impact on spending.

The number of disabled Medicaid beneficiaries expanded rapidly in the early 1990s, rising from 3.5 million in 1988 to 5 million in 1993--an increase of 44 percent. Over that period, Medicaid expenditures for the disabled grew from about $19 billion to about $40 billion--an increase of over 100 percent. Factors contributing to the growth in the disabled population included expansions in the Supplemental Security Income program for children and increasing numbers of beneficiaries with mental illness. The number of disabled beneficiaries is expected to expand more rapidly than total beneficiaries for the remainder of the decade.

The expansions in eligibility for pregnant women during the 1988-1993 period also brought into the Medicaid program a beneficiary group that, by definition, has extensive acute medical care needs. The number of nondisabled adult beneficiaries who did not receive cash welfare payments more than doubled over the period--from 1.4 million to 2.9 million--and payments for that group rose from $1.5 billion to $6.5 billion.

Increases in Payments to Providers

During the 1980s, providers in several states filed lawsuits challenging the reasonableness and adequacy of Medicaid's reimbursement rates for hospitals and nursing homes. Those lawsuits were filed under the Boren Amendment (originally enacted as part of the Omnibus Reconciliation Act of 1980 and expanded in the Omnibus Budget Reconciliation Act of 1981), which required states to pay rates that were "reasonable and adequate" to meet those costs that would be incurred by "efficiently and economically operated" facilities. A decision by the U.S. Supreme Court in 1990 established that providers have an enforceable right to such rates and that they may sue state officials for declaratory and injunctive relief.

Following the Supreme Court's ruling, decisions favoring providers were handed down in several states. The mere threat of a suit under the Boren Amendment may have been sufficient to make some states increase payments. Even though recent court decisions have favored the states in suits brought under the Boren Amendment, the National Governors' Association is trying to have the amendment repealed. Some states are concerned that the Boren Amendment limits their ability to use managed care effectively to control Medicaid expenditures. It is not clear, however, what effect repealing the Boren Amendment would have on Medicaid spending.

Financing Schemes and Disproportionate Share Payments

In the late 1980s and early 1990s, many states developed financing schemes to generate part of their share of Medicaid expenditures. Those schemes, which involved voluntary donations from providers, taxes on providers, and intergovernmental transfers, drew down federal matching dollars for what were often illusory Medicaid expenditures.[4] Such financing mechanisms were closely linked to the rapid growth in DSH payments that occurred during the period (sometimes as a response to actual or potential litigation under the Boren Amendment). According to researchers at the Urban Institute, DSH payments rose from less than $1 billion in 1990 to more than $17 billion in 1992.[5] But taxes or donations from providers almost certainly offset some of the state share of those amounts. Consequently, the actual spending on health services attributable to DSH was less than nominal DSH payments.

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4. General Accounting Office, *Medicaid: States Use Illusory Methods to Shift Program Costs to the Federal Government* (August 1994).

5. John Holahan, David Liska, and Karen Obermaier, *Medicaid Expenditures and Beneficiary Trends, 1988-1993* (Washington, D.C.: Urban Institute, September 1994).

Under current law, the Congressional Budget Office projects that the federal share of Medicaid payments will rise from $89 billion in 1995 to $232 billion in 2005, which represents an average annual rate of growth of 10 percent (see Table 2). The Medicaid projections developed by the Office of Management and Budget (OMB) are lower than CBO's. OMB assumed that lower-than-anticipated spending in 1994 represented a change in the program that would be sustained throughout the projection period. By contrast, CBO projects that growth will return to more historical levels.

Four factors drive CBO's projections of Medicaid expenditures for the next several years: growth in beneficiaries, price increases, disproportionate share payments, and residual growth. The contribution of those factors to increased growth cannot be estimated with precision, in part because each factor interacts with all of the others. Moreover, the usual uncertainty associated with projections of federal spending is compounded in the case of Medicaid, in which decisions affecting federal spending are made at both federal and state levels.

TABLE 2. PROJECTIONS OF THE FEDERAL SHARE OF MEDICAID EXPENDITURES AND THE NUMBER OF BENEFICIARIES, 1995-2005 (By fiscal year)

	1995	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	Average Annual Growth Rate, 1995-2005 (Percent)
						Billions of Dollars						
Benefits	77	87	96	108	119	132	146	160	176	193	211	10.6
DSH Payments	9	9	9	10	10	11	11	11	11	11	12	3.2
Administration	3	4	4	5	5	6	6	7	7	8	9	10.1
Total	89	99	110	122	135	148	163	178	195	212	232	10.0
						Millions of People						
Beneficiaries	36.8	38.4	40.0	41.2	42.4	43.7	44.9	45.9	47.0	48.1	49.1	2.9
						Billions of Dollars						
Comparison of Medicaid Projections												
CBO	89	99	110	122	135	148	163	178	195	212	232	10.0
OMB	88	96	105	115	125	136	149	163	178	194	212	9.2

SOURCE: Congressional Budget Office and the Office of Management and Budget.

NOTES: Numbers may not add to totals because of rounding.

DSH = disproportionate share hospital.

Growth in Beneficiaries

The total number of Medicaid beneficiaries is expected to increase from 36.8 million in 1995 to 49.1 million in 2005. Some expansion in eligibility will occur because current law requires states to phase in coverage of poor children. However, since children are the least costly group of beneficiaries and only one age cohort is being added each year, those additions should not prompt rapid growth in expenditures. The numbers of children and pregnant women covered by the program are also likely to increase as a result of expansions initiated by states and authorized under section 1902(r)(2) of the Social Security Act. But the number and magnitude of such expansions are highly uncertain.

The growth in the number of disabled Medicaid beneficiaries is expected to exceed that of the overall number of beneficiaries--4.1 percent a year versus 2.9 percent. Such rapid growth reflects the continuing effects of the Social Security Administration's outreach to the disabled population, a broader interpretation of disability than in earlier years, and a growing number of individuals reaching ages at which a higher incidence of disability occurs. In part because of that increase in high-cost beneficiaries, about 45 percent of projected growth in overall Medicaid spending stems from increases in caseload.

Price Inflation

CBO uses various inflation factors to reflect increases in the cost of providing Medicaid services. Each state has discretion in setting payment rates for providers and in updating those rates. Those increases may use some form of the hospital market basket index, other state price inflators, state legislation, and negotiations between agencies and providers. Generally, national measures of inflation at most affect states' payment rates only indirectly, making projections of price inflation for Medicaid highly uncertain. CBO estimates that over the 1995-2005 period, changes in prices will account for approximately 30 percent of the projected increase in Medicaid outlays.

Disproportionate Share Payments

The Congress took action in 1991 to limit the use of provider taxes and donations and also to place a cap on the growth of DSH payments. The Omnibus Budget Reconciliation Act of 1993 enacted further restrictions on DSH payments. It is still too early to assess the full impact of those provisions, but DSH payments fell in 1993 and 1994 and rapid growth in the future is unlikely. CBO projects that DSH payments will increase by 5 percent a year through 1999 and then grow at 2 percent annually for the remainder of the projection period. Thus, DSH payments are

assumed to be a decreasing share of overall Medicaid expenditures over time. CBO projects that DSH payments will account for a small percentage of overall Medicaid growth during the 1995-2005 period.

Residual Growth

Finally, CBO's projections assume that all other factors combined will increase Medicaid spending by about 3 percent a year over the projection period. That residual growth factor encompasses state innovations, changes in utilization, the use of more complex technologies, changes in the benefit packages that states offer, increases in payment rates above general inflation, changes in the use of alternative financing mechanisms to generate federal dollars, and the impacts of section 1115 waivers and managed care.

Although some of those factors may be budget neutral or serve to reduce Medicaid outlays, the net effect of all of them combined accounts for about 25 percent of overall growth in Medicaid expenditures over the projection period. Three of the factors are of particular importance for federal policy: alternative financing mechanisms, section 1115 waivers, and the use of managed care.

The Medicaid Voluntary Contribution and Provider Specific Tax Amendments of 1991 limited the ability of states to generate federal matching dollars without corresponding state expenditures. But other mechanisms for achieving that goal--such as intergovernmental transfers--still exist. Quite possibly, the use of intergovernmental transfers will expand in the future or states will develop new mechanisms to draw down federal matching payments.

Several states have obtained--or are seeking--statewide demonstration waivers under section 1115 of the Social Security Act. The purposes of those waivers are generally to enroll more Medicaid beneficiaries in managed care and to expand insurance coverage to poor and near-poor population groups. Although 12 states now have waivers approved and an additional 9 states have waiver applications under review, the number of states that will actually obtain and implement waivers (and over what time period) is extremely uncertain. Some of the states that have had waivers approved, for example, are now backing away from or postponing implementation.

The implications of the waivers for projections of Medicaid outlays are further complicated by the terms and conditions of the Health Care Financing Administration (HCFA) governing budget neutrality. Any expansions of coverage under the waivers are supposed to be budget neutral. Because of the ways in which budget neutrality is defined, however, as well as the uncertainty surrounding

projections of the states' Medicaid expenditures in the absence of waivers, determining whether a waiver would indeed be budget neutral is difficult.

Many states, with the encouragement of the federal government, are also moving quickly to enroll Medicaid beneficiaries in managed care plans, both to improve access to care and to control costs. Managed care has been shown to be effective in a variety of acute care settings, but the evidence to date on the effectiveness of managed care in containing Medicaid costs is limited.[6] Moreover, most states have concentrated thus far on developing managed care options for children and nondisabled adults, and those groups account for only about one-third of Medicaid spending. It will be more difficult to develop appropriate and cost-saving models of managed care for elderly and disabled beneficiaries, who account for the bulk of Medicaid expenditures.[7] Although such models are being developed, states may find it difficult to achieve major savings from managed care in the near future.

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6. Robert E. Hurley, Deborah A. Freund, and John E. Paul, *Managed Care in Medicaid: Lessons for Policy and Program Design* (Ann Arbor, Mich.: Health Administration Press, 1993).

7. Deborah A. Freund and Robert E. Hurley, "Medicaid Managed Care: Contribution to Issues of Health Reform," *Annual Reviews of Public Health*, vol. 16 (1995), pp. 473-495.

The report of the House Budget Committee on the House budget resolution suggests that total federal Medicaid spending for the 1996-2002 period should be about $770 billion. That amount would represent a reduction of about $185 billion from CBO's projected expenditures under current law. The Senate's version of the budget resolution envisions similar amounts, suggesting a reduction in federal Medicaid spending of about $175 billion over the same period.

Those goals are ambitious. The House resolution assumes an average annual growth rate for federal Medicaid outlays of 4.5 percent between 1995 and 2002. That figure compares with an estimated 10.4 percent average annual rate of growth for the same period under current law. Recent growth rates for federal Medicaid outlays have been even higher, reaching an estimated 16.8 percent on average between 1990 and 1995.

The Congress could consider a number of programmatic and financial policies to achieve the budget resolution's federal spending levels for Medicaid. Programmatic policies could alter eligibility rules for enrollment or reduce the services covered by the program. Financial policies could alter the way in which the federal government pays for Medicaid but let the states decide whether to change eligibility rules, coverage, or the way in which services are delivered. Examples of

such policies include making reductions in the federal matching formula, imposing caps on federal matching payments to states, and providing block grants to states. Material from the House Budget Committee, for example, discusses the option of turning federal Medicaid expenditures into a block grant to the states.

Developing a specific Medicaid policy to meet the federal spending targets poses a number of issues: the extent of state flexibility in administering Medicaid, the allocation of federal funds among states, and the impacts on access to and quality of health care for the eligible population.

Giving the States More Flexibility

Although state Medicaid programs vary considerably in eligibility criteria, benefits, delivery systems, and reimbursement rates for providers, federal requirements restrict those variations. Advocates would argue that such requirements are essential to ensure access to care for the most vulnerable populations, provide some safeguards on the quality of care, and place limits on the growth of the program. Many states, however, believe that federal restrictions limit their ability to design fiscally prudent Medicaid programs to meet the health care needs of their low-income populations.

The federal government, for example, specifies which population groups Medicaid must cover and the optional groups that a state may cover if it chooses. Similarly, federal law specifies the services that must be provided as part of the Medicaid benefit package and the services that may be included at a state's option. With a few specific exceptions, services offered to all categorically needy beneficiaries must be comparable in terms of amount, duration, and scope. The benefit package must be uniform throughout the state, and beneficiaries must be free to choose their providers from among those who are qualified and agree to provide services to Medicaid beneficiaries.

Federal policy has also affected the reimbursement rates for providers. The Boren Amendment specifies that states must pay hospitals and nursing homes rates that are reasonable and adequate to meet the costs of efficiently and economically operated facilities. In addition, federal law requires that Medicaid payments to providers be sufficient to ensure access to covered services for Medicaid beneficiaries (to the extent that those services are available to the general population in the area in which they live). States must also submit annual plans to HCFA specifying their Medicaid fees for obstetric and pediatric services.

In certain circumstances, states can obtain waivers from particular federal requirements for the Medicaid program. Many states, for example, have obtained waivers to provide a broad range of home- and community-based services to elderly

and disabled beneficiaries who are at risk for institutionalization. Similarly, states have used waiver authority to develop managed care programs for selected categories of Medicaid beneficiaries. As discussed earlier, some states are now using the 1115 waiver process both to develop managed care programs and to expand Medicaid coverage to new population groups.

Although waivers have certainly given the states some flexibility to adapt their programs to changing needs and fiscal realities, the waiver process itself can be slow and cumbersome. Moreover, even with waiver authority, the requirements that states must meet are still considerable. Many governors, therefore, want the Congress to grant the states much more independence to design their own Medicaid programs.

The Congress could grant more flexibility to the states in a variety of ways. It could maintain the basic structure and entitlement features of the program, for example, but give the states the freedom to enroll beneficiaries in managed care and to contract with providers without having to obtain waivers. That type of approach would potentially allow the states to develop innovative delivery systems, while maintaining considerable federal control over eligibility for the Medicaid program.

Alternatively, states could be given a pure block grant to pay for health services to the poor, without any federal requirements. That option would essentially allow the states to design their own programs with minimal federal oversight.

Other models for block grants might place restrictions on the states and require some accountability to the federal government. The Congress could, for example, design a block grant program that required a certain minimum level of state expenditures for a state to receive its Medicaid block grant funds. Some policy-makers believe that maintaining a matching requirement would be necessary to ensure that states continued to spend their own resources for Medicaid.

Medicaid block grants could also be structured to ensure some minimum level of coverage for certain population groups. The Congress could establish, for example, separate block grants for the aged, disabled, adults, and children. Or states could be required to spend some minimum proportions of a single block grant on each of those groups. Alternatively, states might be required to spend some minimum proportion of a block grant on particular types of services. At the broadest level, for example, states might be required to allocate minimum proportions of a block grant to acute and long-term care services, or separate block grants might be established for each of those service categories.

Allocating Federal Funds Among the States

The way federal Medicaid dollars are currently distributed among the states results from interactions among a wide range of programmatic, sociodemographic, fiscal, and behavioral factors. The distribution also reflects 30 years of decisions by the federal government and the states, which vary greatly in the priorities that they place on providing health care to the poor. Consequently, any attempt to change the way federal Medicaid dollars are allocated among the states would pose both programmatic and political challenges.

Changing Medicaid from an open-ended entitlement to a program in which federal Medicaid expenditures were capped, or otherwise constrained, would inevitably raise controversial questions about how federal funds should be allocated among the states. One could surely develop allocation formulas based on such seemingly objective criteria as a state's fiscal capacity and the distribution of poor people with particular health care needs. But using those criteria, which the current federal matching formula reflects in only a limited way, could result in a major redistribution of federal Medicaid dollars among the states.

If the Congress decided to convert the Medicaid program into some form of block grant, allocation issues would probably become paramount. Both the initial

distribution of block grant funds among the states and how those amounts should grow over time would raise important policy questions.

A fundamental question for the initial allocation of a Medicaid block grant would be whether that allocation should reflect the current distribution of federal dollars among the states or whether some immediate adjustment to reflect the relative needs and resources of the states would be appropriate. Related issues would include the choice of a base year, how DSH payments should be allocated, the treatment of states with 1115 waivers, and the treatment of states that have already made aggressive efforts to control Medicaid spending by improving efficiency.

Whether the amounts allocated to individual states should grow at the same or varying rates would also be a complex and controversial policy decision. Differential growth rates would allow policymakers to reallocate Medicaid funds over time among the states to reflect varying growth rates in the states' low-income populations and other federal policy priorities. Complicating that long-term policy consideration is the question of whether Medicaid should also respond to short-term changes in the relative economic circumstances of the states. Mechanisms that would allow growth rates to vary over either the short or the long term would be much more difficult to construct than an approach based on a uniform growth rate for all of the states.

Ensuring Access to and Quality of Care

Limiting the growth of federal Medicaid expenditures would raise concerns about possible adverse impacts on access to care or the quality of care. Those issues are not new for Medicaid, but they would probably become more significant with tightening fiscal constraints. The states may be given more flexibility to manage their Medicaid programs. Under those circumstances, what the federal role--if any--should be in ensuring access and quality remains an open question.

An important consideration in determining the impact on access and quality is whether Medicaid can take advantage of competitive developments in the health care market that may help balance cost, access, and quality of acute care services. States have increasingly recognized the importance of improving the coordination of health services and the management of care as central features in meeting health care demand in a cost-effective manner. Managed care arrangements offer greater predictability in budgeting and greater control over future cost growth. They can also ensure access to care for Medicaid beneficiaries because providers have contractual obligations to provide care to those beneficiaries.

In markets where strong competition exists among providers, state Medicaid programs may find competitive bidding mechanisms effective in keeping costs down while maintaining service levels. However, providers who are paid on a capitated

basis may control the use of health services too stringently, particularly if capitation payments are low. Consequently, to ensure that state Medicaid programs purchase health services prudently, mechanisms for monitoring the services provided by health plans would probably be necessary. For that segment of the Medicaid beneficiary population whose health care needs are not extraordinary--mothers and children--competitive strategies could be effective in meeting program objectives.

How to address access and quality issues for the elderly and disabled populations in Medicaid is less clear. Per capita expenditures for elderly and disabled beneficiaries are over five times the level for adults and children. Such higher costs reflect the mix of services used by elderly and disabled Medicaid beneficiaries, which includes nursing home and other long-term care services. In addition, individuals with severe disabilities and chronic illnesses are more likely to depend on the care of specialists, even for services that would otherwise be considered primary care in nature. Managed care approaches for those populations remain under development, leaving near-term prospects for cost savings uncertain. Consequently, in terms of access to and quality of care, substantial reductions in Medicaid spending could have particularly serious implications for elderly and disabled beneficiaries.

Other strategies to maintain access to and quality of care for Medicaid beneficiaries are possible. Options include limiting covered services and shifting the

focus of the program toward prevention and primary care services. A critical choice may be whether to provide comprehensive services for a limited number of beneficiaries or to provide a more limited range of services for a broader group of beneficiaries. Those considerations, coupled with adopting new service delivery models and eliminating some restrictions on the management of services, could all factor into a redesigned Medicaid program.

CONCLUSION

Many of the nation's governors are now seeking less federal control of the Medicaid program to enable the states to meet the health care needs of their low-income populations more effectively. The desire of the states for greater flexibility plus the intent of the Congress to reduce significantly the rate of growth of federal Medicaid spending make the program ripe for change. But improving efficiency by itself almost certainly could not achieve reductions in the rate of growth of the order of magnitude being discussed. Some combination of cutbacks in eligibility, covered services, or payments to providers would probably be necessary. How to limit program growth in an appropriate way is the challenge facing the Congress and the states.

APPENDIX

STATE MEDICAID AND POVERTY DATA

TABLE A-1. STATE STATISTICS ON MEDICAID EXPENDITURES AND POVERTY, 1993

State	Total Medicaid Expenditures (In millions of dollars)	Federal Medicaid Expenditures (In millions of dollars)	Percentage of All Federal Medicaid Expenditures	Federal Matching Percentage	Poverty Population (In thousands)	Percentage of U.S. Poverty Population
Alaska	301.1	160.6	0.2	50.0	52	0.1
Alabama	1,635.9	1,170.9	1.6	71.5	725	1.8
Arkansas	1,017.8	758.0	1.0	74.4	484	1.2
Arizona	1,375.4	918.3	1.3	65.9	615	1.6
California	14,060.9	7,043.4	9.8	50.0	5,803	14.8
Colorado	1,281.1	700.5	1.0	54.4	354	0.9
Connecticut	1,992.9	999.8	1.4	50.0	277	0.7
District of Columbia	654.6	327.7	0.5	50.0	158	0.4
Delaware	251.0	126.2	0.2	50.0	73	0.2
Florida	4,861.8	2,680.7	3.7	55.0	2,507	6.4
Georgia	2,766.1	1,723.8	2.4	62.1	919	2.3
Hawaii	385.7	193.6	0.3	50.0	91	0.2
Iowa	959.0	603.8	0.8	62.7	290	0.7
Idaho	291.0	207.7	0.3	71.2	150	0.4
Illinois	4,908.1	2,461.9	3.4	50.0	1,600	4.1
Indiana	2,785.7	1,763.4	2.4	63.2	704	1.8
Kansas	1,073.4	624.5	0.9	58.2	327	0.8
Kentucky	1,823.7	1,309.3	1.8	71.7	763	1.9
Louisiana	3,906.3	2,888.3	4.0	73.7	1,119	2.8
Massachusetts	3,976.1	1,996.8	2.8	50.0	641	1.6
Maryland	1,972.2	989.8	1.4	50.0	479	1.2
Maine	827.9	511.9	0.7	61.8	196	0.5
Michigan	4,403.5	2,465.8	3.4	55.8	1,475	3.8
Minnesota	2,138.8	1,184.5	1.6	54.9	506	1.3
Missouri	2,244.6	1,356.5	1.9	60.6	832	2.1
Mississippi	1,175.2	928.9	1.3	79.0	639	1.6
Montana	328.0	235.6	0.3	70.9	127	0.3
North Carolina	2,839.0	1,875.3	2.6	65.9	966	2.5
North Dakota	258.2	188.6	0.3	72.2	70	0.2
Nebraska	560.0	344.2	0.5	61.3	169	0.4
New Hampshire	412.3	207.3	0.3	50.0	112	0.3
New Jersey	4,883.0	2,447.0	3.4	50.0	866	2.2
New Mexico	582.2	434.0	0.6	73.9	282	0.7
Nevada	389.6	205.2	0.3	52.3	141	0.4
New York	18,015.0	9,033.3	12.5	50.0	2,981	7.6
Ohio	5,161.5	3,114.7	4.3	60.3	1,461	3.7
Oklahoma	1,075.8	753.4	1.0	69.7	662	1.7
Oregon	946.8	592.3	0.8	62.4	363	0.9
Pennsylvania	6,468.0	3,599.2	5.0	55.5	1,598	4.1
Rhode Island	820.4	440.7	0.6	53.6	108	0.3
South Carolina	1,639.4	1,170.8	1.6	71.3	678	1.7
South Dakota	264.0	188.0	0.3	70.3	102	0.3
Tennessee	2,645.3	1,787.7	2.5	67.6	998	2.5
Texas	7,030.3	4,544.2	6.3	64.4	3,177	8.1
Utah	475.5	358.2	0.5	75.3	203	0.5
Virginia	1,788.5	898.0	1.2	50.0	627	1.6
Vermont	259.2	155.9	0.2	59.9	59	0.2
Washington	2,263.1	1,249.8	1.7	55.0	634	1.6
Wisconsin	2,094.0	1,269.7	1.8	60.4	636	1.6
West Virginia	1,199.7	915.6	1.3	76.3	400	1.0
Wyoming	133.1	90.0	0.1	67.1	64	0.2

SOURCES: Health Care Financing Administration, HCFA Form-64; *Federal Register*, vol. 59, no. 221 (November 17, 1994); and the 1994 Current Population Survey of the Bureau of the Census.

NOTES: Expenditures do not include administrative costs. Totals do not include U.S. territories. Expenditure data are for fiscal years. Poverty data are based on calendar years.

TABLE A-2. MEDICAID EXPENDITURES BY STATE, 1988 AND 1993 (By fiscal year)

State	Total Medicaid Expenditures, 1988 (In millions of dollars)	Total Medicaid Expenditures, 1993 (In millions of dollars)	Average Annual Rate of Growth, 1988-1993	Percentage of Total Medicaid Expenditures, 1988	Percentage of Total Medicaid Expenditures, 1993
Alaska	102.8	301.1	24.0	0.2	0.2
Alabama	466.8	1,635.9	28.5	0.9	1.3
Arkansas	428.4	1,017.8	18.9	0.8	0.8
Arizona	183.1	1,375.4	49.7	0.4	1.1
California	5,592.7	14,060.9	20.0	10.9	11.2
Colorado	480.9	1,281.1	26.1	0.9	1.0
Connecticut	834.7	1,992.9	19.0	1.6	1.6
District of Columbia	379.2	654.6	11.5	0.7	0.5
Delaware	100.9	251.0	20.2	0.2	0.2
Florida	1,524.7	4,861.8	26.1	3.0	3.9
Georgia	1,136.0	2,766.1	19.5	2.2	2.2
Hawaii	159.8	385.7	19.3	0.3	0.3
Iowa	477.1	959.0	15.0	0.9	0.8
Idaho	118.5	291.0	19.7	0.2	0.2
Illinois	1,915.0	4,908.1	20.7	3.7	3.9
Indiana	1,024.0	2,785.7	22.2	2.0	2.2
Kansas	328.9	1,073.4	26.7	0.6	0.9
Kentucky	714.2	1,823.7	20.6	1.4	1.5
Louisiana	939.4	3,906.3	33.0	1.8	3.1
Massachusetts	2,078.4	3,976.1	13.9	4.0	3.2
Maryland	931.2	1,972.2	16.2	1.8	1.6
Maine	325.4	827.9	20.5	0.6	0.7
Michigan	2,047.5	4,403.5	16.6	4.0	3.5
Minnesota	1,183.2	2,138.8	12.6	2.3	1.7
Missouri	714.7	2,244.6	25.7	1.4	1.8
Mississippi	443.9	1,175.2	21.5	0.9	0.9
Montana	152.1	328.0	16.6	0.3	0.3
North Carolina	965.7	2,839.0	24.1	1.9	2.3
North Dakota	159.6	258.2	10.1	0.3	0.2
Nebraska	240.8	560.0	18.4	0.5	0.4
New Hampshire	172.0	412.3	19.1	0.3	0.3
New Jersey	1,748.2	4,883.0	22.8	3.4	3.9
New Mexico	229.0	582.2	20.5	0.4	0.5
Nevada	96.5	389.6	32.2	0.2	0.3
New York	9,717.2	18,015.0	13.1	18.9	14.3
Ohio	2,363.5	5,161.5	16.9	4.6	4.1
Oklahoma	593.1	1,075.8	12.6	1.2	0.9
Oregon	364.6	946.8	21.0	0.7	0.8
Pennsylvania	2,544.0	6,468.0	20.5	4.9	5.1
Rhode Island	334.0	820.4	19.7	0.6	0.7
South Carolina	472.3	1,639.4	28.3	0.9	1.3
South Dakota	125.9	264.0	16.0	0.2	0.2
Tennessee	1,009.5	2,645.3	21.2	2.0	2.1
Texas	2,017.2	7,030.3	28.4	3.9	5.6
Utah	196.6	475.5	19.3	0.4	0.4
Virginia	776.3	1,788.5	18.2	1.5	1.4
Vermont	113.4	259.2	18.0	0.2	0.2
Washington	932.1	2,263.1	19.4	1.8	1.8
Wisconsin	1,139.0	2,094.0	13.0	2.2	1.7
West Virginia	315.0	1,199.7	30.7	0.6	1.0
Wyoming	46.7	133.1	23.3	0.1	0.1

SOURCE: Health Care Financing Administration, HCFA Form-64.

NOTES: Expenditures do not include administrative costs. Totals do not include U.S. territories.