CBO TESTIMONY

Statement of
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Congressional Budget Office

on
The Status of the Medicaid Program

before the
Committee on Finance
United States Senate

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NOTICE

This statement is not available for public release until it is delivered at 9:30 a.m. (EDT), Thursday, June 29, 1995.

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Mr. Chairman and Members of the Committee, 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 average 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. Without changes in policy, 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.

The conference agreement on the budget resolution for 1996 assumes a reduction in the rate of growth of Medicaid spending to 4.8 percent a year averaged over the seven-year period from 1995 to 2002. Thus, by 2002 Medicaid spending would grow to only $124 billion, 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, eligibility 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,

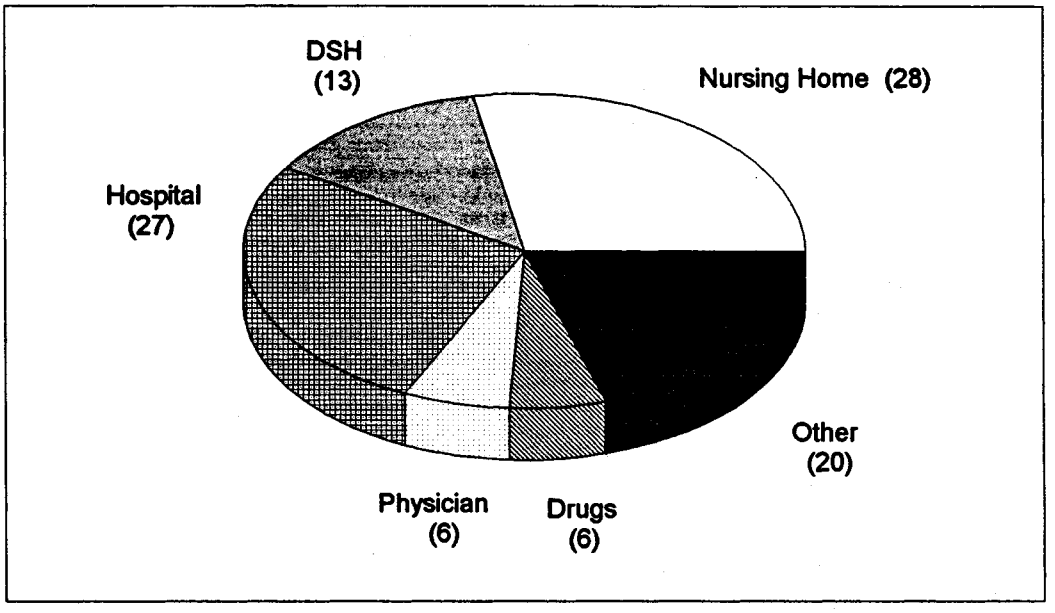
physician, and general nursing facility services. States have the option, however, to cover an extensive range of services in addition to the mandated ones, and all of the states do so. Optional services include drugs, dental services, eyeglasses, and personal care services. The typical Medicaid beneficiary 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.

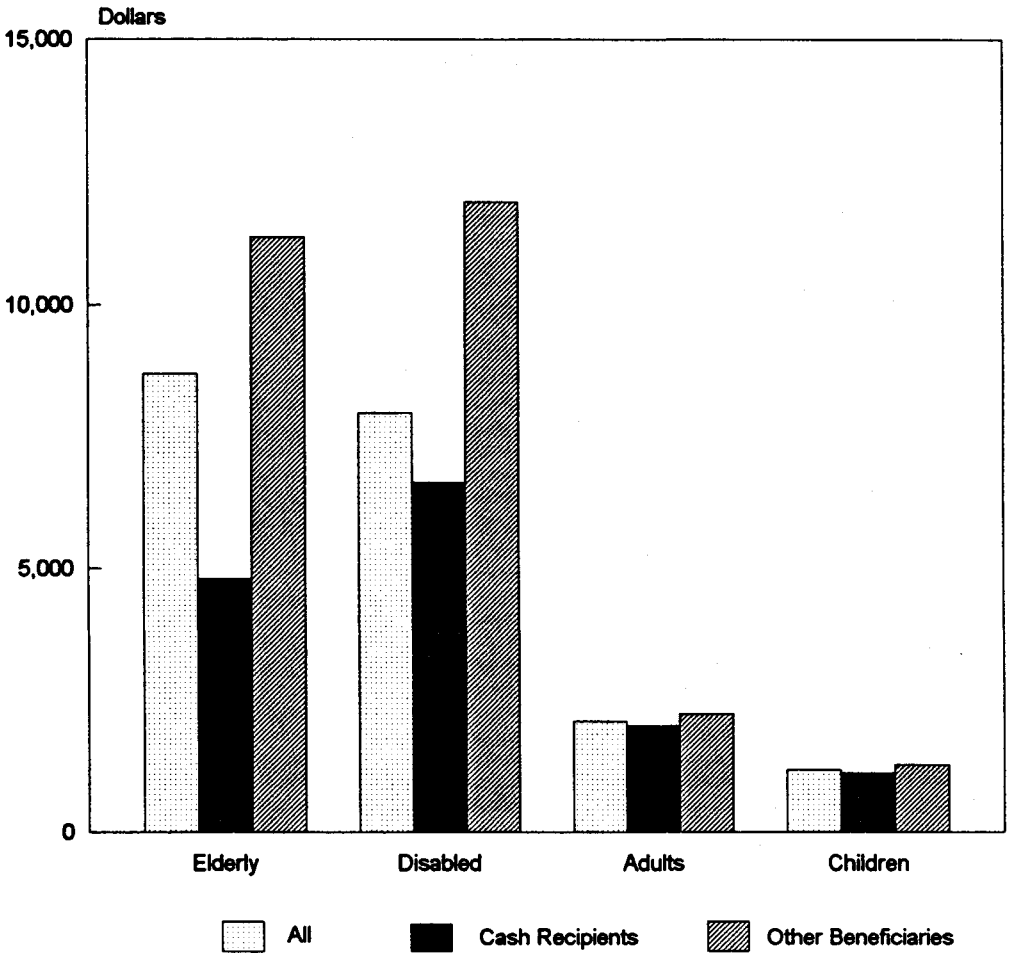
Expenditures by Eligibility Status

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

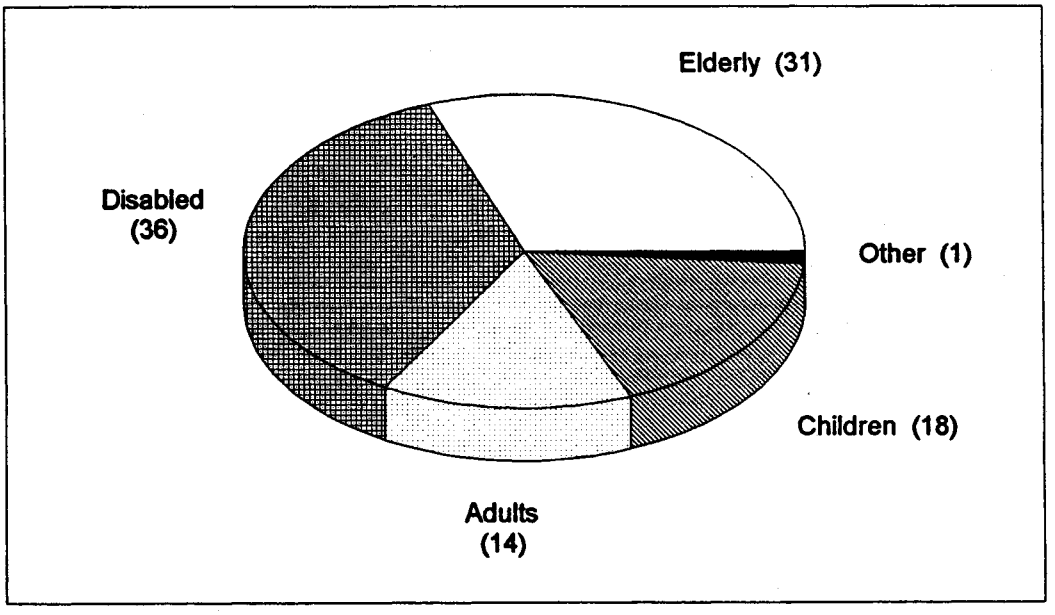
FIGURE 2. MEDICAID EXPENDITURES PER BENEFICIARY, FISCAL YEAR 1993



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 differed from 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. During that last period, federal Medicaid spending increased by close to 20 percent per year, while Medicaid spending by state and local government increased at an annual rate of less than 12 percent.

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

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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.

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 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.

Increases in the AFDC Caseload. After remaining relatively stable through most of the 1980s the AFDC caseload soared from 3.7 million families in 1988 to about 5 million in 1993 and 1994--a 35 percent increase. (Over the same period, the number of AFDC recipients increased from 10.9 million to 14.2 million). Several factors contributed to the caseload rise including the recession and the weak job market of 1990 to 1993.[3]

Consistent with the pattern of change in AFDC participation, the number of Medicaid beneficiaries who received cash welfare payments remained virtually

3. See Congressional Budget Office, "Forecasting AFDC Caseloads, With An Emphasis on Economic Factors," CBO Staff Memorandum (July 1993).

constant (at about 16.5 million) throughout most of the 1980s, but rose after 1988 to 19.6 million in 1993. To some extent, the growth in the enrollment of Medicaid beneficiaries who were eligible for cash welfare benefits itself may have 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 number of AFDC families has recently begun to turn down somewhat.

Expansions in Eligibility. Beginning in 1984 and continuing through 1990, the Congress authorized a series of mandatory and optional expansions in Medicaid eligibility that allowed for a considerable increase in coverage among those who do not receive cash benefits. 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, private insurance might otherwise have covered many of those new beneficiaries. As shown in Table 2, the proportion of all children under age 18 receiving Medicaid increased from 15.5 percent in 1988 to almost 24 percent in 1993--a gain of 8.3 percentage points. At the same time the gain in Medicaid coverage was almost fully offset by a decline in the

TABLE 2. HEALTH INSURANCE COVERAGE OF CHILDREN UNDER 18, 1988 AND 1993 (In percent)

	1988	1993
All Children		
Any coverage	87.0	86.4
Private health insurance	73.5	67.6
Group health insurance	63.9	57.3
Medicaid	15.5	23.8
Not covered	13.0	13.6
Children Above Poverty		
Any coverage	90.0	88.3
Private health insurance	85.9	81.3
Group health insurance	75.9	70.5
Medicaid	5.5	11.1
Not covered	10.0	11.7
Children Below Poverty		
Any coverage	74.6	79.9
Private health insurance	22.5	21.1
Group health insurance	14.5	12.4
Medicaid	56.8	67.0
Not covered	25.4	20.1

SOURCE: U.S. Bureau of the Census.

NOTE: The percentages of children with private health insurance and with Medicaid do not add to the total percentage covered. Some children had other sources of coverage, and some had coverage from more than one source.

proportion of children covered by a parent's group health plan (from 63.9 percent to 57.3 percent).

Consequently, the status of coverage for children overall remained about the same--nearly 87 percent were covered from some source in both 1988 and 1993. Among poor children, however, there was a net increase in coverage as the proportion covered by Medicaid increased by 10 percentage points while the low proportion covered through a parent's employment policy declined slightly. Among nonpoor children, the increase in Medicaid coverage--from 5.5 percent to 11.1 percent--was fully offset by a decline in coverage under a parent's group policy. As a result, the proportion of nonpoor children with insurance did not increase (it actually decreased slightly--from 90 percent to 88.3 percent). Nevertheless, the fact that the rise in Medicaid coverage among children was significantly offset by a decline in coverage under a parent's group policy does not prove cause and effect. Children might have been enrolled in Medicaid because their parents lost jobs or coverage and therefore took advantage of the more generous conditions of Medicaid eligibility.

However, a recent academic study suggested that workers were less likely to participate in employer-sponsored insurance if they had dependent family members

who were eligible for Medicaid.[4] The study also found some evidence that when those workers did participate in employer-sponsored insurance, many opted for individual rather than family coverage. The analysis focused on the 1987-1992 period, during which Medicaid eligibility for children and pregnant women expanded dramatically. An estimated 50 percent to 75 percent of the increase in Medicaid coverage was linked to a reduction in private insurance coverage. Although a wide range of estimated effects exists, the extent to which public insurance crowds out private insurance coverage is important in assessing future Medicaid policy changes.

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

4. 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).

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 Acts of 1981 and 1987), 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. Although repealing the Boren Amendment might reduce Medicaid spending, it is difficult to determine what the magnitude of the effect would be.

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 inter-governmental transfers, drew down federal matching dollars for what were often

illusory Medicaid expenditures.[5] 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.[6] 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.

CBO'S SPENDING PROJECTIONS

The Congressional Budget Office (CBO) projects that without policy changes the federal share of Medicaid payments would rise from $89 billion in 1995 to $232 billion in 2005, which represents an average annual growth rate of 10 percent (see Table 3). 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

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

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

TABLE 3. 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						
Expenditures												
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												
Aged	4.3	4.6	4.8	5.1	5.3	5.5	5.8	6.0	6.2	6.4	6.7	4.4
Blind and disabled	6.0	6.4	6.8	7.1	7.5	7.9	8.1	8.3	8.5	8.7	8.9	4.1
Adults	7.8	8.0	8.2	8.3	8.5	8.7	8.9	9.1	9.2	9.4	9.6	2.0
Children	17.9	18.7	19.5	19.9	20.4	20.8	21.3	21.8	22.3	22.7	23.2	2.6
Total	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

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

NOTES: Numbers may not add to totals because of rounding. The total beneficiary line includes Medicaid beneficiaries whose classification is unknown.

DSH = disproportionate share hospital.

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: disproportionate share payments, growth in beneficiaries, cost increases, 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 and current policy allows for considerable latitude in making many of these decisions.

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.

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. Little of this expansion is attributable to population increase. In fact, according to census data, the population age 65 and over is expected to increase at an annual rate of only 0.6 percent between 1995 and 2002, while over the same period the number of children under age 19 is projected to decline slightly. Nonetheless, under current policy, CBO projects increases in beneficiaries because of continuing expansion in eligibility and participation.

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.

Cost Increases

It is not possible to measure pure price inflation in medical services since increases in the cost of providing those services also reflect changes in quality and new modes of treatment. The data needed to separate price and quality changes have been unavailable in the medical sector.

CBO uses various factors in an effort to try to measure 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 the payment rates of states only indirectly, making projections of price inflation for Medicaid highly uncertain. CBO estimates that over the 1995-2005 period, changes in cost will account for approximately 30 percent of the projected increase in Medicaid outlays.

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.[7] 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 (particularly those in long-term care), who account for the bulk of Medicaid expenditures.[8] Although such models are being developed, states may find it difficult to achieve large savings from managed care in the near future in the Medicaid program as a whole.

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7. 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).

8. 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 conference agreement on the concurrent budget resolution for fiscal year 1996 assumes that the federal share of Medicaid spending would increase from $89 billion in 1995 to $124 billion in 2002. The average annual rate of growth assumed over those years would be 4.8 percent, which is well below the 10.4 percent growth rate that CBO has projected would occur in the absence of any policy change. Recent growth rates for federal Medicaid outlays have been even higher, reaching an estimated 16.8 percent on average between 1990 and 1995. However, some of that Medicaid explosion is attributable to the DSH bubble, which appears to have been deflated.

Reducing the average annual growth rate of Medicaid expenditures over the next seven years to 4.8 percent will not be easy. Although the populations under age 18 and over age 65 are expected to grow slowly--below 1 percent--the number of Medicaid beneficiaries is projected to grow more rapidly, considering the increases in participation likely to occur under current policy. Meeting the target growth rate could limit the extension of Medicaid eligibility to additional groups as well as limit the expansion of services and increases in reimbursements to providers. Improvements in the efficiency with which Medicaid is operated, however, could help stretch resources.

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 allow the states more latitude in deciding 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 and imposing caps on federal matching payments to states. An even greater departure from the current system would convert Medicaid into a block grant to the states. That is the option assumed in the House budget resolution.

As a budgeting tool, block grants offer a more certain way for the federal government to control the level of expenditures. Under the current system, the federal government matches what the states spend and the states have considerable control over eligibility, services offered, and reimbursement rates for providers. Yet the states have frequently argued that the rules laid down by the federal government greatly restrict their ability to innovate and to develop the program and delivery systems that would most efficiently meet the needs of their residents.

Although a block grant approach would be likely to enhance the ability of the federal government to control costs and could give the states greater flexibility and incentives to improve efficiency, it nonetheless raises a number of other concerns.

With tightening fiscal constraints, would the states allow adverse impacts on access to care or the quality of care? Could the federal government retain a role in ensuring access and quality and still allow the states the flexibility they desire? Those issues of accountability are likely to become more prominent under a block grant.

If the Congress decided to convert the Medicaid program into some form of block grant, the issue of how to allocate federal funds among the states would probably become paramount. It is clearly possible to 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 the most limited way, could result in a major redistribution of federal Medicaid dollars among the states. Both the initial distribution of block grant funds among the states and how those amounts should grow over time would raise very difficult and important policy questions.

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. 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.