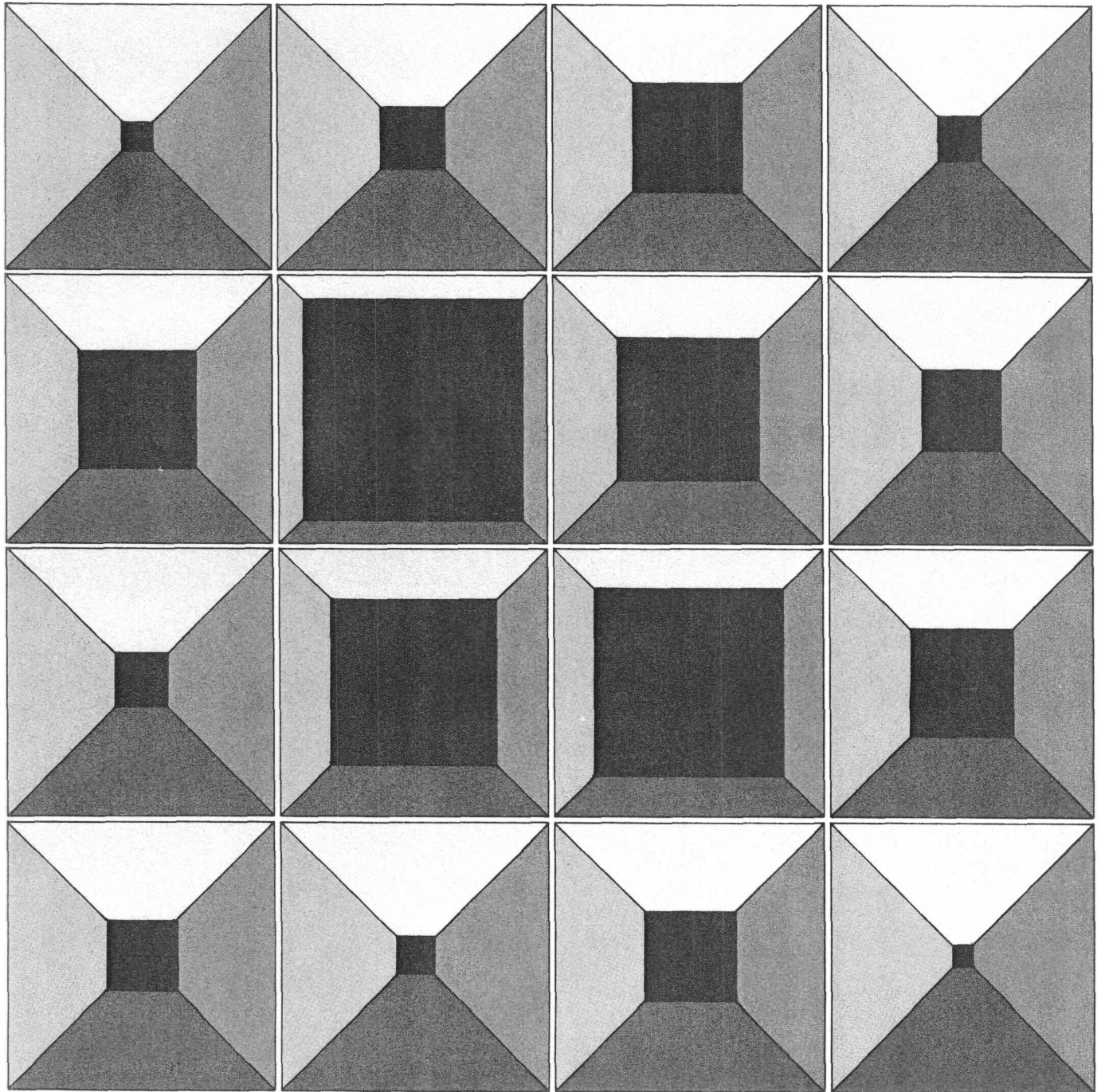
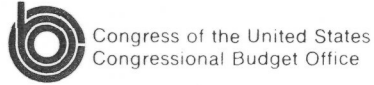


MEDICAID: CHOICES FOR 1982 AND BEYOND



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**The Congress of the United States
Congressional Budget Office**



CONGRESSIONAL BUDGET OFFICE
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ERRATA

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MEDICAID: ISSUES FOR 1982 AND BEYOND

Page 3: The last sentence in the first paragraph should read: "The federal share of Medicaid--the total amount of the federal government grants to states--is expected to exceed \$18 billion in 1982 and to reach \$24 billion in 1986, drawing attention to what is now widely called the 'Medicaid crisis'."

Page 14: The second line in TABLE 2 should read "Unemployed^b"

PREFACE

The Congress is now considering alternatives for reducing the cost of the Medicaid program. This paper, prepared at the request of the Senate Budget Committee, examines the background and consequences of a wide range of choices that would curb and refocus federal outlays for Medicaid. In keeping with the Congressional Budget Office's mandate to provide objective and impartial analysis, this study offers no recommendations.

Thomas J. Buchberger, of the Human Resources and Community Development Division of CBO, prepared the paper, under the supervision of Paul B. Ginsburg and Nancy M. Gordon. The author wishes to acknowledge the technical and critical contributions of many people, particularly Malcolm Curtis, Cynthia F. Gensheimer, John Holahan, Jack Knowleton, Sophie Korczyk, Lynn Paquette, Andy Schneider, and Bruce Vavrichek. Numerous people at the U. S. Department of Health and Human Services and officials of state Medicaid programs gave useful technical assistance. Johanna Zacharias edited the manuscript, and Toni Wright typed the many drafts and prepared the final paper for publication.

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SUMMARY

Medicaid is the joint federal and state program that, since 1966, has paid for much of the medical care of specific categories of low-income Americans. Federal law governs certain aspects of Medicaid. In particular, it mandates coverage of two particular groups of low-income persons: single-parent families, and some two-parent families with one unemployed parent, that receive cash assistance through the Aid to Families with Dependent Children (AFDC) program; and aged, blind, or disabled persons who receive aid from the Supplemental Security Income (SSI) program. The federal government requires states to provide a basic set of services to people eligible for Medicaid, and to reimburse providers of those services in certain ways. Reimbursement levels for certain services are subject to federally established ceilings and in some instances, floors.

In other respects, however, states have certain flexibility in administering Medicaid. Their influence on eligibility, for example, is considerable, because states establish eligibility for AFDC, which, in turn, establishes eligibility for Medicaid. (The same does not hold true for SSI recipients, whose eligibility is determined primarily by federal criteria.) Furthermore, states may voluntarily extend Medicaid coverage to additional groups of people and expand the range of services covered. States also have considerable discretion in how they reimburse physicians and certain other medical providers.

FEDERAL COSTS

The magnitude of Medicaid expenditures has reached what many legislators consider to be critical levels. Funding for Medicaid reimbursement comes from both state and federal sources. The federal share--determined by formula and based on state expenditures, and varying inversely with state per capita income--will exceed \$18 billion in 1982, and under current policies, it is likely to rise to \$24 billion by the end of 1986.

THE MEDICAID POPULATION AND PROGRAM TARGETING

Recipients of AFDC and SSI constitute about 60 percent of the noninstitutional population eligible for Medicaid and 70 percent of those who receive program benefits; however, they account for only 57 percent of program expenditures. The remaining eligible population is demographically similar to the cash assistance population but for some reason does not actually receive transfer payments. For example, children who are members of low-income families that do not qualify for AFDC, perhaps because both parents are present, constitute a large portion of this group.

The Medicaid population--some 28.6 million in 1980--is a mix of persons above and below the federal poverty level. Because of the program's combination of federal and state eligibility criteria, many low-income people fail to qualify for Medicaid; at the same time, a certain number of people with relatively high annual incomes are covered. About 12 million persons with incomes below the federal poverty threshold are now ineligible. On the other hand, about 5 million of those eligible have annual family incomes in excess of two times the poverty standard, in part because of the use of monthly accounting periods in state determinations of AFDC eligibility. Most of these 5 million persons are children.

HOW PROGRAM FUNDS ARE SPENT AND TO WHAT EFFECT

Program expenditures are heavily weighted toward institutional services, especially long-term care. Expenditures for care in nursing homes constitute 42 percent of program costs, and inpatient hospital care represents 28 percent. The remaining 30 percent goes primarily for physicians' services, outpatient hospital care, and medications.

The use of health-care services by low-income persons has increased during Medicaid's history. Large numbers of Medicaid recipients are cared for by practitioners specializing in Medicaid patients, rather than in the settings that serve many patients with higher incomes.

The health of the poor, along with that of the rest of the population, seems to have improved somewhat, although Medicaid's role in this change cannot be readily distinguished from other factors. By at least one measure--infant mortality--Medicaid appears to have had a beneficial effect on recipients' health. Nevertheless, the health of the poor continues to lag behind that of the general population.

FACTORS AFFECTING MEDICAID OUTLAYS

High and rising Medicaid expenditures have dominated attention during the current budgetary debate over funding for health services. Total program costs depend on four factors over which federal and state governments have varying degrees of control:

- o Eligibility,
- o Benefits,
- o Price and use of medical care, and
- o Reimbursement levels.

Not counting nursing home care, per recipient expenditures--which are determined by benefits, the price and use of care, and reimbursement levels--have risen less rapidly than national per capita health-care expenditures.

Eligibility

The size of the Medicaid population is a factor in the program's high cost. The largest increases in cost occurred before 1975, largely because of expansions of eligibility. The program reached its all-time peak in 1977, with 22.9 million recipients, and it could reach that level in 1982 as a result of increases in the AFDC recipient population.

Beyond 1982, a decline in the size of the largest segment of the eligible population will tend to reduce program costs. The number of persons eligible for Medicaid on the basis of receipt of AFDC and SSI is projected to decline. An increase in the proportion of disabled recipients of SSI--who are more expensive to serve--will limit any spending reductions associated with declines in the cash-assistance population.

Benefits

Broad coverage of medical services contributes to Medicaid's high cost. The addition of new services by the federal government since the beginning of the program has not been a major factor,

however; Medicaid has always offered a wide array of services. Likewise, the occasional decisions by some states to add benefits after their programs were in operation have also played a relatively minor role.

The Price and Use of Medical Services

Purchasing in the private medical care market subjects Medicaid to the prevailing trends in the prices and use of medical care services. With the exception of nursing home care, Medicaid expenditures make up only a small share of the medical care market, and this limits the extent to which Medicaid can influence trends in the prices and use of medical care. Both the prices and use of medical care are expected to continue rising over the next five years, which will lead to higher Medicaid outlays.

Reimbursement Levels

States have not had full freedom to use what purchasing power they have to obtain the lowest prices for some types of care. Federal law limits state flexibility in setting reimbursement rates for institutional services such as hospital care. Also, because states cannot purchase most types of care through competitive bidding, they cannot buy certain supplies, laboratory services, or other services at the lowest possible prices. States have already used their wide discretion in physician reimbursement to set fees significantly below those charged private patients; this in part explains the constrained increase in per recipient expenditures.

OPTIONS FOR REALLOCATING MEDICAID EXPENDITURES

The modifications in Medicaid now before the Congress would reduce program expenditures. Just as states have in the past tried to curb Medicaid costs without limiting eligibility, most current choices avoid direct reductions in numbers of people eligible. The Administration's proposal would limit federal financing of state programs. Other options would change the programs's benefits or the federal government's requirements for reimbursement to providers. In recent years, the eligibility

changes the Congress has considered would have increased the number of low-income persons eligible for Medicaid. Observance of tight budgetary constraints would necessitate reducing expenditures for some current recipients if eligibility were granted to persons who cannot now qualify for Medicaid.

The options the Congressional Budget Office has examined include such reallocations to improve targeting. Other options would trim benefits, adjust reimbursement methods, or alter the federal role in Medicaid in some fundamental ways. (Ways to curb growing cost of long-term care, which are not now a focus of Congressional attention, are not examined here.)

Target Eligibility on the Most Needy

Incremental changes in Medicaid's eligibility criteria could extend coverage to some low-income persons not now qualified for Medicaid. For example, states could be required to cover all low-income children, regardless of whether or not their families qualify for AFDC. Mandatory Medicaid coverage for the 4.7 million low-income children now not eligible would raise federal Medicaid costs by somewhat more than \$100 million in 1982.

Alternatively, better targeting could be achieved by terminating eligibility for some of the less needy, such as recipients of only the optional state payments that supplement SSI. Some 600,000 persons would lose automatic Medicaid eligibility, and federal Medicaid costs could fall by some \$300 million in 1982.

Alternatively, the federal government could require states to adopt a minimum national eligibility standard; this would impose a degree of uniformity on eligibility policies. For example, providing acute care (but not nursing home care) through Medicaid to all those whose annual incomes were below 55 percent of the federal poverty standard, while excluding those with yearly incomes in excess of twice the poverty standard, would result in coverage of an additional 7 million persons now ineligible. At the same time, eligibility for about 5 million persons would end. Federal expenditures would rise by \$1.9 billion in 1982, and state costs by \$1.5 billion. Most of the people who would be newly eligible would be among categories that are currently ineligible for Medicaid regardless of income, such as single adults.

Change Benefits, Expand Cost Sharing, or Liberalize Reimbursement Policies

Federal support could be eliminated for certain services. For example, coverage of dental care could be cut to save about \$360 million. The savings could be used either to trim expenditures or to expand eligibility.

Modifying federal law to require Medicaid recipients to share the costs of hospital and physicians' services could decrease expenditures by \$700 million in 1982 because of lower payments to providers and reduced use of services. Although cost sharing may now be applied to some services, it has rarely been applied to the use of hospital and physicians' services. Use of this technique could cause some recipients to defer necessary care or result in some shifting of costs to other patients, however.

Allowing states to depart from the current "reasonable cost" method and exercise greater freedom in hospital reimbursement rate setting would probably lead to lower Medicaid expenditures for inpatient care. A number of states have demonstrated an interest in containing program costs by seeking to lower hospital reimbursement rates, but federal guidelines and administrative procedures have impeded such efforts. If states had greater flexibility in setting hospital reimbursement rates, they could set rates at whatever minimal levels would attract an adequate number of hospitals. Lower hospital reimbursements could, however, limit Medicaid patients' access to care and cause some of the costs of treating Medicaid patients to shift to other patients.

If states could buy laboratory services, drugs, and other equipment in volume through competitive bidding, about \$90 million could be saved in 1982. The use of contract purchasing of care could be extended to hospital care. This could reduce federal costs by an additional \$50 million in 1982, although Medicaid patients might lose some freedom of choice.

Modify the Federal Role in Financing Medicaid

Rather than modify eligibility, benefits, or reimbursement requirements, the federal government could alter the extent to which it shares Medicaid costs with the states. Either federal outlays could be limited, or calculation of the federal share could be modified.

Impose a Ceiling on the Federal Matching Funds to States. The Administration has proposed a cap--that is, an indexed limit--for federal Medicaid outlays that would save \$900 million in 1982 by allowing only a 5 percent increase from the 1981 level. Spending in 1981 would be held at \$100 million below the current base estimate for 1981. In future years, the cap on Medicaid expenditures would be adjusted to reflect changes in inflation as measured by the GNP deflator. Each state's share of the capped federal expenditures would be based on that state's percentage of federal Medicaid expenditures in 1981. The Administration plan would also give states greater flexibility to limit eligibility, restrict services, and lower reimbursement levels.

What effect the cap would have on people who are currently eligible cannot now be estimated, because states' responses to the cap are unpredictable. In part because the allocation of federal expenditures to some states would be significantly different from that of recent years, the effects would vary from state to state. States that would be most adversely affected by the cap are those in which Medicaid expenditures can be expected to rise most rapidly under current policies. Both higher-than-average growth in states' low-income populations and large price increases would not be accommodated under the cap. Also, states that have actively sought to restrain Medicaid costs in the past and those with the most limited programs would soon have to consider eligibility and benefit cuts.

Reduce the Minimum Federal Share. By lowering the statutory minimum matching rate from 50 to 40 percent, federal Medicaid expenditures could be reduced by about \$700 million in 1982 and by \$1.6 billion in 1986. The 13 states affected by the elimination of the minimum federal share could use state funds to replace lost federal support, but they would probably reduce eligibility, benefits, or reimbursement levels somewhat because of state budgetary constraints.

End States' Responsibility for Costs and Administration. The federal government could assume all responsibility for financing and administering Medicaid. This shift of responsibility could be effected either with or without a change to uniform eligibility criteria. The federal government might be better able than states to restrain increasing medical care prices and use of services, although there is no general agreement on this point. Also, the

federal government would be in a better position to take advantage of any economies of scale in program administration. On the other hand, states might be in a better position to experiment because of their long experience administering Medicaid.

Provide Incentives for State Program Expansion. By matching state Medicaid outlays for some persons not now eligible, such as single persons and childless couples, the federal government could encourage expansion of Medicaid. The federal government could also give each state a supplemental grant for increased eligibility; but the reluctance of states to make additional expenditures and the uncertainty of future funding for supplemental grants would tend to limit the effect of this option.

PART I. BACKGROUND AND REVIEW OF PROGRAM EXPERIENCE

Under Medicaid, the federal government shares with states the costs of providing medical care to low-income people. States and territories may choose whether or not to operate Medicaid programs, and at present, all but Arizona do so. States directly reimburse medical-care providers for services rendered to Medicaid patients. At the federal level, the program is administered by the Department of Health and Human Services (HHS). The federal share of Medicaid--the total amount the federal government grants to states--is expected to exceed \$18 billion in 1982 and to reach \$28 billion in 1986, drawing attention to what is now widely called the "Medicaid crisis."

THE EVOLUTION OF FEDERAL SUPPORT FOR
MEDICAL SERVICES FOR THE POOR

The enactment in 1965 of Medicaid and its companion program, Medicare, followed 15 years of gradual growth in federal involvement in supporting medical care for the poor.¹ The administration of Medicaid is patterned after the joint federal/state structure of the cash assistance programs, Aid to Families with Dependent Children (AFDC), and Supplemental Security Income (SSI). Eligibility for AFDC and the separate assistance programs for the aged, blind, and disabled that preceded SSI was enacted in 1935 and evolved around the concept of "the deserving poor."² The primary focus of AFDC and SSI was intended to be on persons whose economic

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1. The Medicare program was designed to provide medical services primarily for the elderly and for certain disabled persons. Both programs were enacted as amendments to the Social Security Act in 1965.
 2. Joel Handler and Ellen Jane Hollingsworth, The Deserving Poor: A Study of Welfare Administration (Markham, 1971), pp. 16-26.

status is beyond their control--dependent children, and the aged, blind, and otherwise disabled. Although the administration of welfare benefits under AFDC has generally been a state function, the federal government assumed responsibility for the aged, blind, and disabled in implementing SSI.³

Until 1950, states and local governments alone financed the small amount of publicly supported medical care available to low-income people. In 1950, the federal government began to share state expenditures that paid for medical services for public assistance recipients. Federal participation remained limited to a percentage of the amount of cash and in-kind medical benefits, up to maximum dollar amounts.

In 1960, however, federal involvement in financing health care for low-income elderly people increased significantly with the implementation of the Kerr-Mills program.⁴ Under the Kerr-Mills program, states were allowed by federal law to expand their medical assistance programs to include elderly people whose incomes, after subtracting medical expenses, were below state standards. These beneficiaries were identified as the "medically needy." The federal government, sharing program costs with state governments, contributed open-ended matching funds for each state's Kerr-Mills program. The federal government paid a percentage of each state's program; the federal share--a grant to cover a portion of state medical assistance expenditures--was determined by a formula, and it varied inversely with state per capita income.

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3. The SSI program, adopted as part of the Social Security Amendments of 1972, replaced separate federal/state cash assistance programs for the aged, blind, and disabled with a single program financed and administered by the federal government.
 4. The Social Security Amendments of 1960 (Public Law 86-778). The program of health care for low-income elderly persons was named for the sponsors of the legislation that created it, Senator Robert Kerr of Oklahoma and Representative Wilbur Mills of Arkansas. For a discussion of this history, see Robert Stevens and Rosemary Stevens, Welfare Medicine in America (Free Press, 1974).

In the mid-1960s, the federal role in providing medical services to the poor expanded markedly with the introduction of Medicaid. The new program, designed along lines similar to the Kerr-Mills program's, broadened the scope of coverage to other welfare recipients who were not aged and allowed states to extend medically needy coverage to them. An original goal of the Medicaid program was to provide comprehensive care to all those whose incomes were below certain state-established standards but this goal was later dropped. (Chapter II discusses Medicaid's eligibility criteria in greater detail.)

MEDICAL CARE AND THE POOR

Before Medicaid was introduced, most low-income persons received less medical care than did the rest of the population. For example, low-income people averaged 4.3 physician visits in 1964, compared to 4.6 visits for other persons. Prior to implementation of Medicaid, more low-income people than the average had had no medical care at all within a two-year period. The limited amount of medical care financing provided through the welfare system left many poor people to rely on public facilities such as municipal hospitals or on charity care offered by private doctors.

Instead of creating a separate system of medical care for the poor, however, the Medicaid program established a system of direct reimbursement, through state agencies, to mainstream private-sector health-care providers. The program is known to have succeeded in increasing the use of medical care by the poor, although not always from mainstream providers. Some feel that Medicaid has improved health among the poor, but data with which to test this hypothesis is scant. (In Chapter III, this difficult question is examined further.)

Special characteristics of medical care that distinguish it from other purchased goods and services led to governments financing medical services directly, rather than indirectly by increased cash assistance. An individual's need for medical care and its costs are uncertain, with physicians (in effect, the vendors) making many of the purchasing decisions that in other markets are usually made by consumers.⁵ Many people buy health insurance to

5. See also Kenneth Arrow, "Uncertainty and the Welfare Economics of Medical Care," American Economic Review, v. 53, no. 5, December 1963.

deal with this uncertainty. But the framers of the Medicaid legislation believed that increases in cash assistance might not necessarily be spent on medical care or health insurance.⁶ Without some assurance that augmented benefits would be spent on medical care, people eligible for Medicaid might not increase their use of medical care, and providers would continue to provide uncompensated care to low-income persons. Hence, the direct reimbursement approach of Medicaid was designed.

ISSUES FOR THE 1980s

The high and rising cost of Medicaid, and whether the program benefits the people who need it most, are central issues in the current Medicaid crisis and the focus of this study. In spite of the program's high cost, about one-half of all people in families with incomes below the federal poverty standard cannot benefit from Medicaid. At the same time, some people with annual incomes above the federal poverty level have access to Medicaid. These observations suggest that the way Medicaid is administered could be better tailored to meeting program goals as well as to curbing costs.

Some of the options for resolving Medicaid's present cost problems and its coverage of the low-income population are examined in this paper. To establish a basis for analyzing possible changes in the Medicaid program, the remainder of Part I reviews the mechanisms of the program and their effects--how eligibility is determined, who benefits and who does not, and to what extent the program has succeeded in its goal of improving access to medical care of the poor. Part I also analyzes the causes of Medicaid's current high cost. In Part II, four sets of options reflecting different approaches to modifying the Medicaid program are presented.

This analysis of Medicaid and options for modifying the program excludes institutional long-term care services, even though these now account for more than 40 percent of program

6. For further discussion, see Stevens and Stevens, Welfare Medicine (Free Press, 1974).

costs. This is because most options under discussion by the Congress in recent years have not directly dealt with long-term care. Also, an adequate analysis of long-term care would have required consideration of several issues that are not confined to Medicaid.

CHAPTER II. ELIGIBILITY CRITERIA AND COVERAGE OF THE POOR

Because of Medicaid's eligibility criteria, program benefits are largely but not fully directed toward the most needy. Although more than 12 million poor persons are currently eligible, about one-half of all people with annual incomes below the federal poverty standard are ineligible for Medicaid.¹ At the same time, nearly 20 percent of the population eligible for Medicaid belongs to families with incomes above the poverty threshold. This uneven coverage of low-income persons results from a mixture of eligibility criteria set by both the federal government and states with Medicaid programs.

In requiring that Medicaid be available to persons receiving assistance under federal income maintenance programs, the federal government gives states significant flexibility to determine eligibility for some groups of persons but not for others. Low-income elderly, blind, and disabled persons who receive assistance through SSI must generally be included in the state-run Medicaid programs. Single-parent families, or some two-parent families in which one parent is unemployed, that receive AFDC must also be included in state Medicaid programs. The difference is that, under SSI, most eligibility decisions are made by the federal government, whereas, states determine the income eligibility standards for AFDC, which is a joint federal/state program.

States may also add to their Medicaid programs specific groups of people who do not receive cash assistance. Except for not being recipients of cash assistance, persons in the groups to whom states may grant Medicaid eligibility must resemble SSI and AFDC recipients. That is, they must be children or other members of single-parent families, or they must be aged, blind, or otherwise disabled. States may not extend Medicaid eligibility to single individuals, childless couples, and others who do not fit the categorical eligibility structure of AFDC or SSI. Table 1 summarizes the composition of the Medicaid recipient population with respect to mandatory coverage associated with SSI and AFDC and coverage voluntarily extended by states.

1. For 1980 income, the federal poverty standard for a nonfarm family of four was \$8,450.

TABLE 1. THE MEDICAID POPULATION, BY CATEGORY OF ELIGIBILITY:
PERSONS ELIGIBLE AT SOME TIME DURING FISCAL YEAR 1980

Category of Eligibility	Millions of Persons in Category
MANDATORY COVERAGE	
SSI Recipients	3.2
AFDC Recipients	14.0
Children in AFDC families	(9.3)
Adults in AFDC families	(4.7)

OPTIONAL COVERAGE	
Financially Eligible Children	6.3
Persons Eligible for But Not Receiving AFDC or SSI Assistance	3.0
Other ^a	2.1

TOTAL	28.6

SOURCE: CBO simulation of Medicaid eligibility. See Appendix A.

NOTES: Includes only noninstitutionalized Medicaid recipients (see Chapter I). Details may not add to totals because of rounding. Totals do not include estimates of those eligible under "medically needy" provisions.

- a. Includes caretaker relatives of financially eligible children, recipients of only state supplemental payment for the SSI population, and persons who would be eligible for cash assistance if their states' AFDC programs included families with children deprived of support because of an unemployed parent.

RECIPIENTS OF SSI

Recipients of SSI, who make up 11 percent of those eligible for Medicaid, account for 30 percent of program expenditures. By mandating the inclusion of SSI recipients, the federal government exerts considerable control over Medicaid eligibility policy toward the aged, blind, and disabled. Under SSI, the federal government sets the income and assets criteria that such people must meet to qualify for cash assistance. In 1980, the federal income standard for a single person to qualify for SSI--and hence for Medicaid--was income of less than \$238 per month.² About one-third of the states have been permitted to apply somewhat more stringent Medicaid eligibility criteria to SSI recipients.³

AFDC RECIPIENTS

Under the AFDC program, states establish income and assets criteria for the eligibility of single-parent families. Within guidelines established by the federal government, state monthly income criteria for AFDC ranged from \$140 in Texas to \$569 in Oregon in 1980. States also have the option of providing AFDC to families with an unemployed parent; in states where these families are eligible for AFDC, they must also be provided with Medicaid.

Although persons in AFDC families represented about half of the noninstitutional population eligible for Medicaid in 1980, only about one-fourth of Medicaid expenditures were made on behalf of members of AFDC families. The largest single group of people

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2. Most states provided a supplement to the federal SSI payment, and the federal rules permit states to grant eligibility to persons who receive SSI-state supplements but whose incomes disqualify them for federal SSI benefits.
 3. When federal/state assistance programs for the aged, blind, and disabled became exclusively federal in 1974, states were permitted to use more restrictive standards than SSI, provided those standards were in effect before the enactment of SSI. At present, 15 states apply some type of limitation on Medicaid eligibility of SSI recipients. Many refer to these as "209(b) states," reflecting the section of the Social Security Act of 1972 which provided this option.

eligible for Medicaid consists of children in AFDC families, who make up one-third of the eligible population. Adults in AFDC families make up another 16 percent.

OTHER GROUPS DEEMED ELIGIBLE

Most states have chosen to include in their Medicaid programs one or more groups of people not required by federal law. In general, the optional groups that states voluntarily cover comprise low-income persons who do not receive cash assistance but who have the same demographic characteristics as those covered by AFDC or SSI; they are children and other members of families with dependent children, and aged, blind, or disabled people. About 6.3 million of the 11.5 million persons eligible in 1980 for optional Medicaid coverage were children in families that met the AFDC income and assets eligibility criteria of their states but not the other AFDC criteria. Examples include children in certain two-parent families, self-supporting children, and children in foster homes. Another 3.0 million people are eligible for Medicaid because they live in states that have chosen to grant eligibility to persons who qualify for but do not actually receive cash assistance. The other optional groups make up a relatively small proportion of the Medicaid recipient population.⁴

Many states have chosen to extend coverage to individuals and families with incomes above cash assistance levels by adding the "medically needy" to their Medicaid programs. Medically needy is defined as applying to anyone who meets all categorical requirements for Medicaid eligibility and whose income, after deducting medical expenses, is less than the state's medically needy income standard.⁵ In 1979, the income standard for a family of four to

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4. These groups include recipients of emergency cash assistance; persons eligible for AFDC under the broadest interpretation of federal law; persons who would be eligible for AFDC except for failure to register for manpower training; disabled alcoholics and other addicts who refuse treatment required for SSI eligibility; and blind or otherwise disabled persons who refuse vocational rehabilitation services required for SSI eligibility.
 5. In general, the medically needy income standard for a family of three or more may be no less than the state's (continued)

qualify as medically needy ranged from \$2,400 in Tennessee to \$6,600 in Hawaii. No reliable estimates of the size of the population eligible through coverage for the medically needy are available, but the number of people in the category eligible for Medicaid appears to be much larger than the number of actual recipients.⁶

ELIGIBILITY AND TARGETING ISSUES

The unevenness of Medicaid eligibility among the poor raises issues concerning the program's targeting. Medicaid's critics have suggested that the program's mix of criteria excludes many people with incomes similar to those of people who do qualify, even though those disqualified may be equally in need of financial aid for medical care. In addition, many who actually do qualify have incomes higher than those of some people who fail to meet other eligibility criteria.

Some observers have opposed the use of criteria other than income in determining Medicaid eligibility. In their view, health care is a basic necessity, and guaranteeing access to a minimum level of care for all low-income persons is justified. Otherwise,

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5. (continued) AFDC payment standard. For individuals and two persons, the medically needy income level must equal or exceed the highest payment standard used in any cash assistance program (including AFDC, SSI, or an approved state SSI supplement program). Income eligibility levels may not be greater than 133.3 percent of the highest amount that would be paid to a family of the same size under the state AFDC program.
 6. Because Medicaid eligibility for the medically needy depends upon a family's medical expenses, as well as its income, attempts to estimate the number of persons eligible under this provision on a national basis have been unsuccessful. A 1974 study in Massachusetts found that of those who meet categorical and income criteria to qualify as medically needy, only a small portion--less than 20 percent--actually took advantage of Medicaid. See Urban Systems Research and Engineering, Evaluation of the Medicaid Spend-Down: The Spend-Down Participation Rate (February 15, 1976).

low-income persons might never get care they need, or they might experience extreme financial hardship in obtaining it. Accordingly, adherents to this view maintain that income ought to be the only criterion for Medicaid eligibility.

The Ineligible Poor

Medicaid fails to reach roughly half of all Americans with incomes below federal poverty standards--some 12 million people. Most of the so-called "ineligible poor" are those who do not fall into any of the specific groups identified as eligible in the law. The ineligible poor fall into three groups:

- o People living in states that do not provide optional coverage for which they would qualify elsewhere;
- o People, such as single individuals and childless couples, to whom the federal government denies Medicaid; and
- o People disqualified on the basis of income only.

Among the ineligible poor, there is a larger proportion of working adults and a smaller proportion of children than there is in the eligible population. This pattern reflects Medicaid's origins in social welfare programs that were directed towards the so-called "deserving poor," particularly children, who were not held responsible for their economic status. About 50 percent of those eligible for Medicaid with incomes below federal poverty guidelines were not in the labor force in 1980, whereas only about 31 percent of the poor who were not eligible were not in the labor force. Also, more of the ineligible poor were employed full time in 1980 than were their eligible counterparts. Children constituted a much larger portion of the eligible poor (65 percent) than of the ineligible poor (36 percent). Table 2 presents a comparison of the eligible and ineligible poor grouped by demographic characteristics.

The Eligible Nonpoor

In 1980, about 16 million people with annual incomes above the federal poverty guidelines were eligible for Medicaid during some portion of the year. Some 5 million--one fifth of those

TABLE 2. BREAKDOWN OF DEMOGRAPHIC CHARACTERISTICS OF THE POOR POPULATION^a ELIGIBLE AND INELIGIBLE FOR MEDICAID: FISCAL YEAR 1980, IN PERCENTS

Characteristics	Eligible	Ineligible
EMPLOYMENT STATUS		
Not in the Labor Force	50	31
Unemployed ^a	7	3
Employed Part-Time Only ^b	9	8
Employed Full-Time Only ^b	22	37
Employed Part and Full Time ^b	12	21

AGE AND SEX		
Under 21	65	36
Males Aged 21-64	4	23
Females Aged 21-64	22	30
65 and Over	10	11

RACE		
Nonwhite	41	23
White	59	77

FAMILY		
Members of Families Headed by Women	75	33
Members of Families Not Headed by Women	25	67

SOURCE: CBO Simulation of Eligibility.

- a. Poverty as defined by U.S. Bureau of the Census.
- b. Periods of unemployment and full- or part-time employment do not necessarily correspond to Medicaid eligibility periods.

eligible for Medicaid--were in families with annual incomes at least double the federal poverty standards (that is, higher than \$16,900 in 1980). Persons with relatively high annual incomes may qualify for Medicaid because eligibility determinations are made on the basis of periods shorter than a year. For example, a family with little or no income during the first three months of 1980 but with earnings above \$8,450 throughout the rest of the year might have qualified for Medicaid during the period with low income. Such a family would have been defined as nonpoor according to federal standards for 1980, but it would still have been eligible for Medicaid.

The composition of the Medicaid-eligible population with annual incomes in excess of twice the federal poverty standard also reflects the orientation of welfare on the young; about 70 percent of the members of these families were children. An additional 17 percent were adults in families with dependent children. In 1980, the eligible nonpoor population--Medicaid recipients with incomes above double the federal poverty level--was constituted as follows:

- o 46 percent children in families that did not receive AFDC benefits but whose families met AFDC income eligibility criteria for at least a portion of a year;
- o 23 percent children in families receiving AFDC benefits;
- o 17 percent adults in families that received AFDC benefits;
- o 9 percent blind and disabled; and
- o 5 percent age 65 and over.

Most people with incomes higher than double the federal poverty level live in states with relatively high income eligibility standards for AFDC, and hence for Medicaid. Approximately 36 percent of such recipients reside either in California or New York.

CHAPTER III. BENEFITS, REIMBURSEMENTS, AND EFFECTS
ON USE OF HEALTH CARE

Like eligibility, the benefits available under Medicaid, and the methods and rates of payment to providers of services, are determined by a mix of federal guidelines and state discretion. This chapter reviews the range of services that state Medicaid programs cover, either by law or by choice, as well as the various ways in which those services are paid for. The closing portion of the chapter recapitulates evidence of the program's effectiveness in increasing the use of health services by the poor and in improving their health.

BENEFITS

Federal law requires that states operating Medicaid programs offer participants a basic set of services. These include:

- o Hospital services (both outpatient treatment, and for inpatients, room and board and ancillary services),
- o Physicians' services,
- o Diagnostic services (including radiological and other laboratory studies),
- o Family planning consultation,
- o Nursing home care in so-called "skilled nursing facilities,"¹ and
- o Screening and treatment of children for various illnesses and impairments.

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1. Care in "skilled nursing facilities" is more intensive than the care provided in "intermediate care facilities" that may be covered at state option.

Anyone eligible for Medicaid, regardless of his state of residence, is entitled by law to these basic services. Altogether, payment for mandated services accounted for 60 percent of all Medicaid outlays in 1978.

In addition, all states elect to provide other forms of care. Care in "intermediate care facilities" is available in all states with Medicaid programs; such care accounted for 17 percent of Medicaid expenditures. Another 6 percent went for prescribed drugs. Assorted other services that states chose to offer made up the remainder of Medicaid costs.²

Critics of Medicaid's current structure cite the program's broad range of benefits as one source of expenditures that should be curtailed. Altogether, the benefits mandated by federal law, together with those that states may choose to provide, constitute more extensive coverage than is available to the general population through private health insurance. For example, unlike insurance policies in the private sector, Medicaid covers nursing home care, and in many states dental care, eyeglasses, hearing aids, and prescription drugs are also provided. Also unlike most private health insurance, Medicaid reimburses preventive care for patients without symptoms.

On the other hand, Medicaid is not a health insurance plan, but rather a means of financing medical care for low-income persons. Services not usually found in insurance plans, such as routine dental care or prescription drugs, entail out-of-pocket expenses for private patients. Such services are excluded from most insurance plans for one of two reasons. Either the service is relatively predictable, such as routine dentistry, and its

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2. Other optional services may include: care given by other practitioners (such as podiatrists) within the scope of their licenses; home health care; private duty nursing; clinic services; dental care, including preventive; physical therapy and related services; other diagnostic, screening, preventive, and rehabilitative services; hospitalization for tuberculosis; hospitalization for mental disorders for patients 65 years or over; and psychiatric hospitalization for youths under 21 years.

inclusion in health insurance would not provide protection against unforeseen expenses; or the cost of administering some benefits, such as reimbursement for prescription drugs, is high relative to the cost of the service. Though it would not be efficient to include these benefits in health insurance, their exclusion from Medicaid might simply make them unavailable to low-income people.

In order to limit recipients' use of services and contain program costs, states may adopt limits on the use of some covered services or may impose cost sharing in some form. Some states impose a limit of, for example two weeks, on Medicaid patients' length of stay in a hospital. Other states limit the number of physician visits per month. Prior approval by the state Medicaid program for admission to a nursing home is required by many state programs. Cost sharing, usually in the form of shared payment (copayment) for prescription drugs, is required in 15 state Medicaid programs. But states cannot require coinsurance or deductibles for mandatory services, such as hospital and physicians' care, given to AFDC or SSI recipients.

REIMBURSEMENT

The reimbursement rates for services provided to Medicaid recipients are set by the states, within guidelines laid down by the federal government. As a result, there is wide state-to-state variation in how much providers are paid. Reimbursement of practitioners, such as physicians, is the area in which the guidelines give states the greatest flexibility. Hospital reimbursement levels are subject to much tighter control; and the states' choice of reimbursement methods is subject to approval by HHS.

The difference between Medicaid fees and Medicare fees for physicians' services is substantial, and the difference between Medicaid fees and those charged private patients is even greater. For example in 1975, Medicaid fees for specialists were only about 77 percent of the Medicare levels.³ Though fewer data are available to compare Medicaid fees with fees charged private

3. Ira Burney and others, "Geographic Variation in Physicians' Fees, Journal of the American Medical Association, September 22, 1978, vol. 240:1368.

payment patients, a 1976 survey found Medicaid's fee for a routine follow-up office visit to be 40 percent below physicians' usual fees.⁴

Medicaid reimbursements for physicians cannot exceed the federally established reimbursement levels for Medicare, but most states have set them lower. Under the Medicare physician fee profile, which sets a limit for Medicaid reimbursements in all states, physicians are paid the lowest of their actual charge, their average charge, or the 75th percentile of charges for the same procedure. This latter method is generally referred to as a system of "usual, customary, and reasonable" charges.

Under Medicaid, a state may set physician reimbursement levels in one of two ways: fee schedules or fee profiles. A fee schedule assigns a value for each medical procedure relative to some basic procedure. A price is assigned to the basic procedure and consequently to all other procedures. A physician fee profile, on the other hand, uses the distribution of charges for a particular procedure to set a maximum level, for example, at the 75th percentile. States using this approach generally compare the physician's actual charge against the level set by the profile and pay whichever amount is lower.

Hospitals are reimbursed according to the "reasonable cost" method used by the Medicare program for setting rates, unless the states receive approval from HHS to use an alternative method. Under the reasonable cost approach, hospital rates are determined on the basis of the average cost for treating Medicaid patients. This reimbursement method gives hospitals little incentive to minimize costs, however. (This and other cost factors are considered in greater detail in Chapter IV.)

MEDICAID'S EFFECT ON ACCESS TO MEDICAL CARE AND ON HEALTH STATUS

Since the implementation of Medicaid, the use of health-care services by the poor has increased noticeably, and the health of poor people appears to have improved somewhat. By some measures,

4. Frank A. Sloan, Jerry Cromwell, and Janet Mitchell, Private Physicians and Public Programs (Lexington Books, 1978), and Jack Hadley, "Physician Participation in Medicaid: Evidence from California," in Health Services Research, Winter 1979.

Medicaid has contributed to this improvement, but the poor continue to experience higher levels of illness than the rest of the U.S. population. The goal of mainstream care for the poor (discussed in Chapter I) has not been fully realized.

Increased Use of Medical Care by the Poor

Poor people's use of physicians and hospital care has risen substantially since Medicaid began in 1966. Between 1963 and 1976, the proportion of low-income persons seeing a physician during the year rose 30 percent (see Table 3).⁵ Hospitalizations rose 35 percent between 1964 and 1973, but the rate has changed little since then. In contrast, visits and hospitalizations among the nonpoor rose by 4 percent and 2 percent, respectively, during the same period.⁶

Some evidence indicates that, within the poor population, eligibility for Medicaid makes a difference in access to physician's care. In 1969, people who were eligible for Medicaid visited physicians 6.6 times, on average, compared with 4.7 visits for low-income persons not receiving public assistance.⁷ A comparison of the use of health services by the poor in Baltimore

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5. Ronald Wilson and Elijah White, "Changes in Morbidity, Disability, and Utilization: Differential Between the Poor and Nonpoor; Data from the Health Interview Survey: 1964 and 1973," Medical Care, vol. xx, no. 8 (August 1977), and unpublished data for 1977 from the National Center for Health Statistics. Income levels used to define poverty are \$3,000 for 1964, \$6,000 for 1973, and \$7,000 for 1976. Approximately 20 percent of the total U.S. population had incomes below these thresholds in the years surveyed.
 6. In order to compare the effect of Medicaid upon use of medical care, years prior to the implementation of the program have been compared to years following implementation.
 7. Most, but not all, of the public assistance recipients included in the survey were in categories eligible for Medicaid. See Karen Davis and Roger Reynolds, "The Impact of Medicare and Medicaid on Access to Medical Care," in Richard Rosett, editor, The Role of Health Insurance in the Health Services Sector, (National Bureau of Economic Research, 1976), p. 391.

TABLE 3. PERCENTAGE OF U.S. POPULATION SEEING A PHYSICIAN, BY INCOME CLASS: 1963, 1970, and 1976

Income Class	1963	1970	1976	Percent Increase 1963-1976
Low	56	65	73	30
Medium	64	67	75	17
High	71	71	79	11

SOURCE: Adapted from LuAnn Aday and others, Health Care in the U.S.: Equitable for Whom (Sage Publications 1980), p. 100.

NOTES: The low-income standards used in this table are somewhat higher than the Bureau of the Census poverty standards and do not vary with family size. They are less than \$4,000 for 1963, less than \$6,000 for 1970, and less than \$8,000 for 1976. In each year, persons in the low-income classification represent approximately one-third of the families surveyed.

found that Medicaid recipients used medical care more frequently than poor persons who were not eligible. On average, they were also more likely to see a physician than persons in middle- and upper-income levels--but not more likely than persons with similar levels of illness. The use of preventive services by healthy Medicaid patients was somewhat higher than for healthy middle- and upper-income persons.⁸

8. David L. Rabin and Elizabeth Schach, "Medicaid, Morbidity and Physician Use," Medical Care, January 1975, vol. 13, no. 1, p. 68.

Health Status of the Poor and the Care They Receive

The overall level of health in the U.S. population appears to have improved since the 1960s, and low-income persons have probably shared in these gains. Medicaid has contributed to better health in at least one respect, but incomplete data do not permit more general conclusions about the program's effectiveness. Between 1964 and 1976, however, infant mortality rates--a measure often used as an index of health status in general--have decreased for both blacks and whites.⁹ Medicaid appears to have played a part in this improvement. In states where benefits are provided to low-income women during their first pregnancies, the Medicaid program has lowered infant mortality. Infant mortality rates within the first four weeks of birth are somewhat more than one percent higher in states that do not provide Medicaid to low-income women during first pregnancies.¹⁰

Despite improved access to care, however, the health of the poor remains below the rest of the population's. In 1976, persons in families with incomes below \$7,000 reported 96 percent more days of restricted activity than was average for persons with incomes above \$7,000. Some of the observed differences may reflect reductions in income accompanying illness.

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9. Because infant mortality data are not available by family income, the infant mortality rate for blacks is often used as a proxy for the rate for low-income persons.
 10. Jack Hadley, Assessing the Adequacy of Health Manpower Supply (Urban Institute, 1980), unpublished study. An earlier study found that Medicaid eligibility did not have a significant effect on infant mortality; however, that analysis divided into three groups those states in which Medicaid benefits are provided during first pregnancies, thus reducing the significance of the Medicaid variable. See Michael Grossman and Steven Jacobowitz, "Determinants of Variations in Infant Mortality Rates Among Counties of the United States: The Roles of Social Policies and Programs," paper presented at the World Congress on Health Economics, Leiden University, the Netherlands, September 8-11, 1980.

The care that Medicaid recipients get differs somewhat from mainstream medical care. In general, the quality of Medicaid services is not substandard,¹¹ although low quality persists in some medical practices treating large numbers of Medicaid patients. A small share of all practices care for a disproportionately large share of Medicaid patients, and these practices tend to have high volumes of Medicaid patients. In 1976, almost 60 percent of all Medicaid patients were cared for by practices in which Medicaid patients accounted for 30 percent of all patients.¹² Many physicians in these large Medicaid practices are foreign medical graduates, and relatively few are certified in a medical specialty.¹³ No link between the credentials of physicians in such practices and low-quality care has been demonstrated, however.

Burdensome paperwork and comparatively low reimbursement rates may discourage many physicians from accepting Medicaid patients. Although three-quarters of all physicians responding to surveys indicate a willingness to take Medicaid patients, the fraction of those who regularly do so is much lower.¹⁴ One study estimated that only about 40 percent of California's physicians treated 10 or more Medicaid patients during a three-month period.¹⁵

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11. For a discussion of the available evidence on the quality of care in the Medicaid program, see Avedis Donabedian, "Effects of Medicare and Medicaid on Access and Quality of Health Care," Public Health Reports, vol. 91, no. 4, pages 322-331.
 12. On average, Medicaid patients represent 13 percent of the patients in a medical practice.
 13. Janet B. Mitchell and Jerry Cromwell, "Medicaid Mills: Fact or Fiction," in Health Care Financing Review, Summer 1980, vol. 2, no. 1.
 14. Sloan, Cromwell, and Mitchell, Private Physicians.
 15. Hadley, "Physician Participation in Medicaid."

CHAPTER IV. FACTORS AFFECTING MEDICAID EXPENDITURES

Four factors have contributed, at different times and to varying degrees, to the past decade's steep rise in Medicaid expenditures:

- o Eligibility,
- o Benefits,
- o Trends in the health-care sector, and
- o Reimbursement policies.

Federal and state Medicaid policies govern the effects that several of these components have on total program expenditures, but Medicaid's ability to influence trends in health-care prices and use of services is limited. With the exception of nursing home care--Medicaid pays about half of all national expenditures for nursing home care--Medicaid's purchases of services accounted for only small portions of the market for medical care: 6 percent of all expenditures for physicians' services, and 9 percent of all hospital expenditures.

In recent years, increases in Medicaid expenditures have been caused largely by increased use of some services, particularly nursing home care, and by rising medical care prices. In the early years of Medicaid, the growing number of people eligible for the program drove expenditures upward.

Except for the addition of care in intermediate care facilities in 1972 (see Chapter III), expansion of benefits has not been a major factor in rising Medicaid expenditures. In fact, if nursing home expenditures are disregarded, Medicaid expenditures per recipient have risen less rapidly than national per capita health-care expenditures--at an annual rate of 11 percent between 1973 and 1978, as compared to the national rate of 13 percent.

ELIGIBILITY

Although eligibility changes are not expected to cause higher expenditures in the future (unless standards are liberalized), the sizable number of people the program now serves is a cause of high Medicaid outlays.

The AFDC segment of the Medicaid population increased at an average annual rate of about 9 percent during the early 1970s, accounting for most of the increases in the number of people eligible for Medicaid during that period. The number of AFDC recipients reached a peak in 1976 of about 11.4 million. Liberalized AFDC eligibility standards and greater participation contributed to this growth.¹ Later in the 1970s, the number of aged, blind, and disabled people who qualified for Medicaid rose following implementation of federal national eligibility standards for SSI. The number of Medicaid recipients in 1982 could equal the maximum of 22.9 million reached in 1977 due to the rising AFDC caseload.² Following 1982, declines are expected in many of the categories of eligibility.

The number of AFDC and SSI recipients who are also eligible for Medicaid is projected to diminish somewhat over the next five years. After peaking again in 1982, the AFDC caseload will probably resume its earlier decline. The number of SSI recipients is also expected to decrease but not so quickly, because one group--the disabled who are eligible for SSI--is expected to increase slightly. Because disabled recipients have higher average expenses than other patients--the average Medicaid payment for them in 1978 was \$1,600, compared to \$920 for an aged recipient, and \$580 for an adult in an AFDC family--their increasing numbers will offset some of the savings from there being fewer AFDC and SSI recipients.

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1. John Holahan, Financing Health Care for the Poor, Lexington Books, 1975, p. 28, and Karen Davis and Kathy Schoen, Health and the War on Poverty (Brookings Institution, 1979).
 2. The estimates of numbers of recipients were made by the HHS.

BENEFITS

The broad range of services covered by Medicaid (see Chapter III) has certainly contributed to the program's high cost. With the exception of intermediate care facilities, a type of nursing home care added in 1972, benefit expansions have not been a significant cause of increases in Medicaid expenditures, because states have not greatly increased their provision of optional services during the last decade.³ Although states have occasionally chosen to expand benefits, such as reimbursement for part or all of the cost of prescription drugs, these changes in optional services by individual states have not had a significant effect on federal costs. Indeed, some states withdrew some optional services during the 1970s.⁴ For example, some states stopped covering dental care, and others have limited the benefit to children.

Since Medicaid was initiated, the federal government's list of mandatory services has grown only slightly. The most noteworthy change was the addition, in 1969, of screening and treatment services for children, but the expenses for screening have not been large--\$52 million in 1979; the additional costs for treatment cannot be determined from existing data.

TRENDS IN THE PRIVATE MEDICAL CARE SECTOR

Because Medicaid purchases care from private-sector providers, the rising prices of medical services, as well as increasing use of care in the private sector, have driven up Medicaid expenditures for each recipient. For example, as the price of an average hospital admission rises, or as physicians tend to hospitalize their patients more often, Medicaid expenditures rise.

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3. The addition of intermediate care facilities to Medicaid's benefit package in 1972 was actually the transfer of a service that states had previously financed with federal assistance through another program.
 4. The minor role of added services in higher expenditures may reflect general satisfaction among the states with their initial choice of optional services. On the other hand, the broad range of services allowed and the availability of unlimited matching funds may have led some states to provide generous benefits that they are now trimming to reduce costs.

Although determining precisely the extent to which medical care price increases have affected Medicaid expenditures is not possible, inflation in the medical sector was responsible for about two-thirds of the increased per capita expenditure for personal health care in the 1970s.⁵ An example of this is the rise in rates for hospital room and board, caused partly by higher wages and partly by rising prices for medical supplies. Medicaid reimbursements have generally followed medical care prices, which rose at an average annual rate of about 8 percent during the past decade.

Medical care price inflation is projected to continue to be an important component of future growth in Medicaid expenditures. For the period 1982-1986, CBO expects average annual increases in medical care prices to exceed growth in the CPI.

The remaining increase in per capita personal health-care expenditures--about one-third--can be attributed to greater use of services and facilities. Increased use of care is attributable, in turn, to two factors: increases in services (such as hospital admission) provided to each recipient, and greater intensity of resources (including tests involving costly equipment) used in treatments.⁶ Unfortunately, much of the increase in intensity is

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5. Directly estimating the effect of price increases on Medicaid is impossible because of the large share of program expenses that go for nursing home care. The medical care component of the Consumer Price Index (CPI) reflects a different combination of services from Medicaid's.
 6. With respect to hospital care during the 1970s, both use of care and intensity increased. Hospital use, as measured by number of discharges per 1,000 population, rose from 154 in 1973 to 160 in 1978--a 4 percent increase. As an example of the intensity factor, national community hospital costs per adjusted admission rose between 1970 and 1978 at an average annual rate of 3.5 percentage points in excess of input price increases, with this residual presumably due to increased intensity of care. See, Mark S. Freeland, Gerard Anderson, and Carol Ellen Schendler, "National Hospital Input Price Index," Health Care Financing Review, Summer 1979, vol. 1, no. 1, page 41.

incorrectly registered as higher prices, because the medical care component of the Consumer Price Index cannot distinguish when changes in price are caused by changes in quality.

In large part because of increased use, long-term care accounts for a disproportionate share of the rise in Medicaid outlays. Nursing home care in particular is a major component of the increase; Medicaid is the primary source of payment for more than half of all nursing home patients. Between 1973 and 1978, Medicaid expenditures for nursing home care rose from \$3 billion to \$7.4 billion--a rise of 150 percent. Costs of other services, in contrast, increased in the same period by 90 percent--from \$5.6 billion to \$10.6 billion. Thus, the portion of all Medicaid outlays for nursing home care shifted from 35 to 42 percent.⁷

Though corroborating evidence is limited, the very existence of Medicaid may in part have caused this increase in the use of long-term care. A substantial increase in the rate of use of nursing homes occurred between 1963 and 1969, coinciding with the introduction of the program. In that period, the number of people over age 65 in nursing homes rose from 25 to 37 persons per 1,000, an increase of nearly 50 percent.

REIMBURSEMENT POLICIES

Federal reimbursement requirements limit the ability of states to contain Medicaid expenditures. In requiring states to reimburse hospitals according to Medicare's "reasonable cost" method (outlined in Chapter III), federal law effectively dictates

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7. Expenditures for one component of nursing home care, the care of retarded persons in intermediate care facilities, increased by more than 600 percent. It has been suggested that the shifting of state-sponsored patients to the federal/state Medicaid program has caused much of this increase in care for retarded persons.

Perhaps it would be more useful to examine changes in per recipient expenditures for long-term care to determine the relative effects of rising prices and increased use, but program data are inadequate for this purpose.

that Medicaid's hospital spending roughly keep pace with general private-sector trends. Those states that seek to set hospital reimbursements using an alternative to the reasonable cost method encounter a slow approval process and ambiguous approval criteria. Thus, the potential of alternatives such as prospective rate setting, which would contribute to cost containment, has not been fully realized. Further, states cannot exclude high-cost providers (either physicians or hospitals) from program participation; nor can Medicaid purchase most supplies or services in volume at reduced rates.

States have lowered or maintained low reimbursements in areas, such as physicians' services, where federal law permits them significant discretion. Lower reimbursement for physicians has helped to restrain increases in per recipient expenditures.

THE DETERMINATION OF FEDERAL COSTS AS A PERCENTAGE OF STATE PROGRAM COSTS

The federal government contributes a formula-determined fraction--transferred in the form of a cash grant--of the cost of each state's Medicaid program.⁸ The portion of program costs paid by the federal government is greater in states with lower per capita incomes. For 1982 and 1983, the fraction the federal government pays will range from a statutory minimum of 50 percent in 13 states to 77 percent in Mississippi.

Under this matching formula, federal Medicaid expenditures are determined by state Medicaid expenditures. Because the federal government pays a percentage of each state's Medicaid

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8. The federal share for each state is recalculated every two years and is used for a period of two fiscal years. The percentages that were calculated in fall 1980 will be used in fiscal years 1982 and 1983 (October 1, 1981 through September 30, 1983). The formula is:

$$\text{state share} = \frac{(45 \text{ percent})(\text{state per capita income})^2}{(\text{national per capita income})^2}$$

$$\text{federal share} = 100 \text{ percent} - (\text{state share}).$$

costs on an open-ended basis, federal expenditures rise as state Medicaid costs increase. The assurance of an unlimited matching grant from the federal government has been criticized as not giving state Medicaid operators adequate incentive to reduce costs and as encouraging states to broaden eligibility and benefits.⁹

Although the nature of the federal subsidy may cause states to spend more on Medicaid than they otherwise would, evidence indicates that states nonetheless remain sensitive to rising costs. First, many states have not extended eligibility to all optional groups and some states with limited eligibility have relatively high matching rates. Second, during the 1974-1975 recession, and again in the last two years, states have made efforts to improve program administration, reduce unnecessary use of services, and provide medical benefits at the lowest costs available.¹⁰ Until recently, states have avoided eligibility and large-scale benefit reductions; however, in order to satisfy balanced budget requirements, states now appear to be considering these approaches.

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9. A recent econometric study concluded that higher percentage matches by the federal government lead to higher state Medicaid spending, holding other factors constant. See Thomas E. Grannemann, "Reforming National Health Programs for the Poor," in Mark V. Pauly, editor, National Health Insurance: What Now, What Later, What Never? American Enterprise Institute for Public Policy Research, 1980, pp. 104-136.
 10. Gretchen Engquist-Seidenberg and others, State Initiatives in Medicaid Cost Containment, Center for Policy Research, Office of Research Studies, National Governors' Association: Washington, D. C., 1980.

PART II. OPTIONS FOR MODIFYING MEDICAID

CHAPTER V. OVERVIEW OF OPTIONS

In debating the possible modifications of Medicaid, legislators, analysts, and other observers disagree about what the program's underlying problems are and what changes would constitute improvements. The state-to-state variation in eligibility criteria, for example, can be considered inequitable; from another perspective, it can be regarded as a proper and desirable reflection of different states' priorities and resources, and ultimately, of their autonomy.

In Medicaid, as in all other welfare programs, state-to-state variation is a matter of debate. Federal policy in many programs has been to encourage states to extend eligibility beyond minimal levels. As an incentive in some income-support programs, the federal government has agreed to finance part of the cost of including additional categories of persons, or of enriching benefits. As states respond differently to these incentives, variations result, ultimately shifting federal tax revenues from states with limited programs to states with broad programs.

In the context of fundamental difference in outlook, two generally conflicting issues have arisen: Should program modifications be tailored primarily to curb expenditures? Or should they be designed to raise the portion of persons with incomes below the federal poverty standard that is eligible for Medicaid? The options examined in the following four chapters can therefore be categorized according to which of these goals they would further. The following chapters present options that would modify Medicaid by

- o Revising eligibility to retarget benefits,
- o Trimming benefits,
- o Adjusting reimbursement policies, and
- o Modifying the federal role.

To reduce federal outlays for Medicaid--the objective of most Medicaid proposals now before the Congress--legislators could modify the program's eligibility, benefit, or reimbursement requirements; they could also change the method of calculating the federal grants for states' Medicaid programs. Most current proposals for constraining federal costs would affect services other than nursing home care, and most avoid direct tightening of eligibility criteria. Proposals for constraining federal outlays include limiting some covered services, charging recipients for part of the costs of treatment, and lowering the rates of reimbursements to providers. Savings could also be realized by withdrawing the eligibility of some people with relatively high incomes (see Chapter II). Federal costs could also be lowered by annually limiting federal Medicaid outlays.

Broadening Medicaid's coverage of the poor within a fixed or shrinking federal budget would require some retargeting of current expenditures to newly eligible persons. If eligibility were expanded for people below federal poverty standards, the now eligible nonpoor could be displaced from Medicaid rolls. Another course would be to trim the present benefit package. Similarly, reimbursements to providers could be lowered.

One option that goes quite far beyond those discussed in the following chapter is the provision of Medicaid vouchers.¹ Under such a system, recipients would be given vouchers with which they would purchase either health insurance policies or membership in prepaid health plans such as health maintenance organizations (HMOs). Participating insurers or health plans would be required to cover or provide the basic set of services mandated by federal law (see Chapter III). A recipient who chose an insurance policy or health plan that cost less than the value of a voucher would be given all or part of the difference in cash. Proponents do not

1. Such a plan is embodied in the National Health Care Reform Act of 1981 (H.R. 850), introduced early in the 97th Congress by Representatives Richard Gephardt and David Stockman. The bill proposes vouchers for low-income persons but delays them until the fifth year of operation (1988) to allow for development of competitive health plans. CBO is currently studying vouchers for low-income persons as part of its analysis of the "pro-competitive" approach to health-care cost containment.

regard this as an immediately viable option but instead propose delay of vouchers for low-income persons until after more competitive health plans develop, in response to changes in tax law and in the Medicare program.

PLAN OF PART II

Chapter VI examines five possible incremental changes in eligibility:

- o Mandating coverage of all children in low-income families,
- o Mandating coverage of all the medically needy,
- o Terminating certain optional eligibility categories,
- o Requiring relatives to assume some financial responsibility for care provided to Medicaid recipients, and
- o Requiring states to adopt minimum eligibility standards.

The changes in benefits examined in Chapter VII include:

- o Requiring cost sharing, and
- o Eliminating certain benefits.

A variety of changes in Medicaid reimbursement policies is discussed in Chapter VIII, including:

- o Expanding competitive bidding,
- o Stopping the reimbursement of hospitals on the basis of "reasonable costs,"
- o Terminating the requirement that states must reimburse all certified providers selected by recipients, and
- o Raising reimbursement rates for physicians.

Four options to modify the federal role in financing Medicaid are discussed in Chapter XIX:

- o Imposing a ceiling on the amount of federal matching funds available to each state (this option has been proposed by the Administration),
- o Reducing the minimum federal share of state Medicaid expenditures,
- o Ending states' responsibility for program costs and administration, and
- o Adding incentives for state program expansions.

CHAPTER VI. TARGET ELIGIBILITY TOWARD THE MOST NEEDY

In the past, changes in Medicaid eligibility have usually been formulated to close gaps in coverage rather than to reduce program costs. Faced with increasing costs and diminishing revenues during economic downturns, states have been reluctant to tighten eligibility standards. In today's economic climate, however, outlays could be trimmed either by curtailing coverage of the less needy or by targeting aid more precisely on the neediest.

MANDATE COVERAGE OF ALL CHILDREN IN LOW-INCOME FAMILIES

One approach would require states to extend Medicaid coverage to all children in low-income families--those, for example, in families with incomes below state AFDC income eligibility standards. At present, states have the option of covering low-income children in families that are not receiving AFDC benefits, and most have chosen to cover some such children; but only about one-third of the states have chosen to cover them all.¹ This approach, consistent with welfare's traditional orientation toward children, would produce more uniformity among state Medicaid programs. It would, however, raise program costs at both the state and local levels. An additional 4.7 million children under age 21 would become eligible for Medicaid in 1982. Federal outlays would be about \$100 million higher than at present, and state expenditures about \$80 million higher.²

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1. This expansion of eligibility to all "financially eligible" children differs from proposals for a Child Health Assurance Program (CHAP), which included a minimum national income eligibility standard. For example, the House version of CHAP, contained in H.R. 4962, would have established a minimum income eligibility standard of two-thirds of the federal poverty level.
 2. This estimate assumes a low rate of participation in the Medicaid program (about 12 percent) for these newly eligible children.

Although some of the flexibility states now enjoy in administering Medicaid would be lost, some state-to-state differences in eligibility for children would persist. Varying state AFDC standards would be used to determine eligibility for these children.

MANDATE COVERAGE OF THE MEDICALLY NEEDY

Mandating coverage for all the medically needy--the aged, blind, and disabled, and members of low-income families with dependent children--would affect the Medicaid programs of the 20 states that do not now cover this category of persons.³ The affected states would not be required to provide nursing home care to those qualifying as medically needy.

In the example examined here, states would use their existing AFDC income standards in determining Medicaid eligibility. States could be allowed to set an income standard for the medically needy at a level above their current income-assistance standards; however, many of the states that have chosen not to offer medically needy benefits under current law probably would not do so.

Under this option, federal costs in 1982 would rise by nearly \$700 million (excluding the costs of long-term care). The additional costs to states would be about \$500 million. As under the previous option, state discretion and state-to-state variation would decrease somewhat. But the income levels at which families could qualify for Medicaid would continue to be quite different among the states.

This option would ease access to health care for low-income people with low or moderate levels of medical expenses who are now likely to be deterred from the use of care by its cost. It would

3. The states that do not now provide coverage for the medically needy are Alabama, Alaska, Colorado, Delaware, Florida, Georgia, Idaho, Indiana, Iowa, Mississippi, Missouri, Nevada, New Jersey, New Mexico, Ohio, Oregon, South Carolina, South Dakota, Texas, and Wyoming.

also provide financial relief to facilities that care for low-income patients with large medical expenses but who have been unable to pay their bills. The effects on health-care resources would be mixed. This option would give some financial relief to other third-party payers and to some public hospitals that now care for low-income patients whose unpaid bills are finally written off as bad debts.

In states now without coverage for the medically needy, the working poor are subject to loss of Medicaid, as well as cash assistance, when their incomes exceed the states' standards. Some critics have suggested that the so-called "Medicaid notch" serves as a work disincentive in states without coverage for the medically needy.⁴ Mandatory coverage for the medically needy would somewhat offset this drawback, because low-income people could continue to work and yet qualify for Medicaid if their incomes, after deducting medical expenses, fell below state standards.

TERMINATE CERTAIN OPTIONAL ELIGIBILITY CATEGORIES

Better targeting of benefits could be achieved by terminating eligibility for some people now entitled to Medicaid. One group that might be considered for termination consists of the elderly, blind, and disabled persons who receive cash assistance from state programs that supplement federal SSI benefits even though their incomes exceed the federal eligibility levels for SSI. Today, three-quarters of the states provide optional supplements, and almost all of them have chosen to provide Medicaid to people who receive only the state supplement to SSI.

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4. See, for example, Theodore R. Marmor, "Public Medical Assistance Programs and Cash Assistance: The Problems of Program Administration," in Integrating Income Maintenance Programs, edited by Irene Lurie, Academic Press, 1975. Marmor notes that, even in states with medically needy programs, the tax rate on Medicaid benefits is high. Increases in cash income raise the amount of medical expenses that an individual must incur in order to spend down to eligibility by \$1. Families with expected medical expenses less than the difference between the level of protected income and their own income may be discouraged from use of routine medical services.

If recipients of only the SSI supplemental payments were no longer eligible for Medicaid, federal expenditures could be reduced by about \$300 million in 1982 and, over five years, the savings could exceed \$1.9 billion.

This option could reduce or eliminate Medicaid benefits for about 600,000 people; however, many could qualify as medically needy. Most of the persons whose eligibility would terminate under this proposal now live in states with Medicaid coverage for the medically needy, so if they were to incur substantial medical expenses, they would continue to receive some benefits from Medicaid, although less than they do now. On the other hand, most of those who would lose automatic eligibility have relatively low incomes. Even in the states with coverage for the medically needy, this option could deter some from seeking needed care.

Eliminating Medicaid coverage for persons receiving only state supplemental SSI payments would lead to more uniform treatment of residents of different states. Currently, the aged, blind, and disabled with incomes similar to recipients of only the optional supplement to SSI, but residing in states that do not cover this group, may be unable to qualify for Medicaid.

REQUIRE RELATIVES TO ASSUME SOME FINANCIAL RESPONSIBILITY

The eligibility criteria of the SSI program make it possible for members of families with substantial income to qualify for Medicaid. Most states cannot require relatives of potential SSI recipients to assume financial responsibility for nursing home care. Generally, after a disabled or elderly person has been institutionalized for a certain period, the income of a parent or a spouse is not considered in determining eligibility for SSI. Fifteen states do not automatically grant Medicaid eligibility to SSI recipients, and some of these states impose a requirement that relatives be financially responsible to some extent when determining Medicaid eligibility for SSI recipients.⁵

5. The 15 states are the so-called "209(b)" states that were permitted to retain more restrictive Medicaid eligibility criteria when SSI was created.

Requiring relatives to take financial responsibility for these costs could reduce federal and state expenditures for institutionalized people. Although such long-term care expenses are known to have made up 42 percent of all Medicaid-financed care in 1978, estimating the savings that could accrue from requiring some degree of financial responsibility by relatives is difficult because of limited national data.

A provision that relatives share financial responsibility for the care of institutionalized patients would be quite controversial. From the standpoint of program cost containment, it would have the clear advantage of discouraging families from institutionalizing chronically ill or disabled relatives, because the Medicaid assistance that now covers such care would be unavailable. On the other hand, home care, though it might be some families' preference, can be strenuous and very costly--beyond the means of many low-income families.

In the case of the elderly, the issue is particularly problematic. Nine out of 10 old people now institutionalized are single, and their financially responsible relatives would have to be their adult children. This raises questions of definition and responsibility. Are only biologically related children responsible for their parents? Should step-children be held responsible? Should children be required to support their biological parents, even in instances in which these parents provided little or no support to their children?

REQUIRE STATES TO ADOPT MINIMUM ELIGIBILITY STANDARDS

At some cost in state discretion, a set of uniform eligibility criteria could be established by the Congress to broaden Medicaid's coverage of the poor. This option would entail quite extensive revision of current eligibility standards. In the example examined here, all states could be required to grant Medicaid eligibility to all members of families with annual incomes below 55 percent of national poverty standards, but those with higher AFDC income standards would be required to continue use of the higher standards in determining Medicaid eligibility.

People with annual incomes in excess of twice the federal poverty level would be ineligible. Income eligibility would be determined over a 12-month period, rather than on a monthly basis.⁶

Benefits would be comprehensive--although less so than under certain current Medicaid programs--and to improve access to health-care services, reimbursements for physicians' services would be raised to the level of Medicare. States could continue to provide certain optional coverage, but with the federal government continuing to share the costs of these services.

Such uniform eligibility standards would increase Medicaid eligibility and costs substantially. If these standards had been in effect in 1980, about 7 million additional low-income persons would have been eligible; federal outlays would have been \$1.9 billion higher, and state expenditures would have been \$1.5 billion higher. About 5 million of the nonpoor--people with annual incomes in excess of twice poverty--would have been disqualified. By terminating eligibility for even more persons with relatively high incomes, adoption of uniform national eligibility standards based solely on income could be accomplished without raising expenditures.

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6. These eligibility criteria are similar to those included in the Carter Administration's Healthcare program. This proposal was one of the most extensive revisions of the low-income health coverage to have been considered by the Congress in recent years.

The Healthcare proposal had provisions that went beyond an expansion of Medicaid such as an expansion of Medicare and mandating employment-based coverage that would have provided protection against catastrophic illness. The discussion in this paper is focused upon a proposal for expanded health coverage for low-income persons and excludes employer-mandated health insurance.

The Healthcare proposal would have given the federal government responsibility for the financing and administration of Medicaid. Complete federalization of Medicaid is discussed in the final section of this chapter.

This option would increase Medicaid coverage of persons with incomes below the federal poverty levels from the present 50 percent to 72 percent. Most of the newly-eligible population would be people previously excluded from Medicaid by categorical rather than income requirements (see Chapter II). Members of two-parent families, now ineligible for Medicaid in some states, would account for 40 percent of those newly eligible, single persons for 38 percent, and childless couples for 9 percent. Since adult males are likely not to meet current categorical requirements, they would make up 32 percent of those newly eligible (compared to the current 6 percent); whereas children under 21 would make up 30 percent (compared to 65 percent). About 6.8 million persons with incomes below the federal poverty line would remain ineligible.

Persons with equal incomes would be treated in a more uniform manner under this proposal. In 1980, 23 states had income eligibility standards lower than 55 percent of the federal poverty standard, and 20 states did not grant Medicaid to two-parent families with unemployed parents--all of whom would be covered under this example. Nevertheless, some variation among states would remain.

Use of annual rather than monthly income in determining eligibility would improve the targeting of benefits toward those most in need of subsidized health care. This change would reduce the number of persons with relatively high annual incomes who qualify for Medicaid on a part-year basis. Targeting would be further improved by the termination of eligibility for all people with incomes in excess of twice the poverty level.

Medicaid's extensive benefit package (described in Chapter III) has led to suggestions for restricting some benefits and for eliminating others. Recipients might be required to pay a portion of the costs of services they receive. Such restrictions could reduce Medicaid expenditures or permit reallocation to fund benefits for low-income people who are currently ineligible.

COST SHARING

If states were required to impose nominal cost sharing on all Medicaid patients, both federal and state Medicaid costs would fall; recipients would curtail their use of services, and the program would pay less for each service rendered. States may now impose nominal cost sharing on all recipients for optional state-chosen services, such as prescription drugs, but federal law prohibits cost sharing for physicians' services and hospital care provided to AFDC or SSI recipients. If recipients were required to pay 5 percent of the cost of physicians' services and half the cost of the first day of an inpatient hospital stay, federal Medicaid expenditures would be reduced by about \$700 million in 1982 and by \$4.6 billion over the five-year period ending in 1986.

To date, when cost sharing has been applied to all medical care, use of medical services appears to have been discouraged. The most recent literature suggests that medical spending would fall by between 15 and 20 percent if persons now required to pay nothing were required to contribute 25 percent. Results from one study suggest that low income persons' response to "coinsurance" does not vary from that of the general population.¹ If cost sharing were imposed only on outpatients, however, costly substitution of inpatient for outpatient care could occur; at least one experiment has confirmed this effect.²

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1. Personal communication with Joseph Newhouse of the Rand Corporation.
 2. Jay Helms and others, "Copayments and Demand for Medical Care: The California Medicaid Experiment," The Bell Journal of Economics, Spring 1978, volume 9, no. 1, pages 192-208.

Although cost sharing might discourage the use of nonessential care, use of needed health care might also be curtailed. Faced with required cost sharing, Medicaid recipients might choose to forego care they need and make other purchases instead. In some instances, postponing medical care could ultimately result in higher treatment costs in the future, but the extent of the effect cannot be determined.

Cost sharing in Medicaid could result in higher charges to non-Medicaid patients. Providers who could not collect cost-sharing amounts from Medicaid patients could, for example, raise charges to other patients to cover the losses. In addition, providers might be less willing to treat Medicaid patients.

ELIMINATE CERTAIN BENEFITS

The potential for cost saving by terminating coverage of some services could be considerable. By withdrawing Medicaid funding for dental care, an optional service in 31 states, the federal government could save \$360 million in 1982 and \$2.3 billion by the end of 1986.

The health effects of cancelling certain benefits would vary. A patient who stopped using certain medication--for instance, a drug to control blood pressure--because Medicaid no longer covered it, could suffer adverse effects. On the other hand, the detrimental health effects that could result from the termination of dental care would be smaller. Elimination of dental services, or any similar optional benefit, would reduce some of the state-to-state variation in the extensiveness of benefits.

Elimination of at least one optional service could lead to greater Medicaid expenditures, because it is a substitute for a more costly mandatory service. Coverage for intermediate care facilities is an optional benefit that all states have elected to provide. It substitutes for the more expensive care of skilled nursing facilities, coverage of which is federally mandated. Care in intermediate care facilities accounts for 24 percent of all Medicaid expenditures and represents about 45 percent of all Medicaid spending for optional services.

If such care were eliminated for the mentally retarded only, however, federal outlays would be \$1.3 billion lower in 1982. Some analysts suggest that the rapid growth of expenditures for this service--from 2 percent of Medicaid costs in 1973 to more than 7 percent in 1978--reflects states' shifting these patients from state facilities, for which Medicaid funds are not available, to intermediate care facilities, for which Medicaid does pay.

CHAPTER VIII. ALTER REIMBURSEMENT POLICIES

Many states have already taken advantage of what options federal law allows for limiting reimbursements to providers of medical care; but federal policies or procedures have prohibited the use of some alternatives and slowed the implementation of others. Liberalizing guidelines governing states' reimbursement methods could achieve several objectives. It could permit states to trim Medicaid expenditures without limiting eligibility or benefits. Or it could permit states to reallocate Medicaid resources to direct benefits more specifically toward low-income people. Finally, physician reimbursements could be raised in order to expand access to services under Medicaid.

EXPAND COMPETITIVE BIDDING

At present, the use of competitive bidding in the purchase of certain supplies and services is limited by federal law to some types of durable medical equipment, such as hearing aids and eyeglasses. Removing this limitation could enable states to use bargaining power to buy more services and supplies at volume discount rates.¹ Federal Medicaid outlays could thus be reduced by some \$90 million in 1982 and by as much as \$600 over the 1982-1986 period.

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1. Several proposals of this type have been considered by the Congress in the past. The House version of the Omnibus Reconciliation Act of 1980 (H.R. 7765) included a provision that would have permitted states to purchase clinical laboratory services through competitive bidding, on a demonstration basis. The Senate bill (S. 2885) would have permitted very broad use of competitive bidding and contracting for medical services and supplies. Agreement could not be reached on this type of proposal, and it was not included in the Conference Report. The Carter Administration's fiscal year 1982 budget also contained a competitive bidding proposal.

An argument against greater use of competitive bidding is that bulk purchasing could restrict choices for Medicaid recipients. Already, however, the choice of the source for particular services or supplies--especially clinical laboratory services--is often made by physicians, not patients.

STOP REIMBURSING HOSPITALS ON THE BASIS OF "REASONABLE COST"

The "reasonable cost" method of setting reimbursement rates (detailed in Chapter III), which federal law requires unless approval of an alternative has been obtained, has kept Medicaid hospital reimbursements higher than they would be otherwise. With greater freedom to exercise discretion in this area, however, states could likely lower Medicaid hospital reimbursement rates. Even the 12 states that have obtained approval from HHS to use alternative reimbursement methods might use lower reimbursement levels if even greater discretion were permitted.

Eliminating required reasonable cost reimbursement of hospitals could enable states to act as prudent buyers of hospital care, perhaps by setting a maximum reimbursement level and letting hospitals decide whether or not to care for Medicaid patients. States might be able to set hospital reimbursement rates at levels below average costs but high enough to be acceptable to a sufficient number of hospitals to meet the needs of Medicaid patients. Also, if approval from HHS were no longer required, states could more easily include Medicaid reimbursement in state-wide hospital rate-setting programs.

Hospitals might respond in various ways. Some might choose not to treat Medicaid patients, which would deny some recipients access to care. Others might respond by continuing to accept Medicaid patients at the reduced Medicaid reimbursement rates but shift any unmet costs to charges paid by some patients and by commercial health insurance plans. Resistance of other payers to higher rates could limit hospitals' abilities to do this. Still other hospitals might take action to cut costs so that reduced Medicaid reimbursements would not adversely affect net hospital revenues. Cost reduction would be most likely in the context of a prospective reimbursement program affecting other purchasers of hospital care as well.

Lower hospital reimbursements could adversely affect the financial condition of some facilities, especially those hospitals serving many Medicaid patients. This would occur if these hospitals were unable to lower costs sufficiently and were also unable to recoup their losses from other patients. Urban public hospitals, in particular, many of which already face financial difficulties, could experience large increases in their unreimbursed expenses.

The potential savings of this option are highly uncertain because of the unpredictable response of other Medicaid agencies and of the hospitals within their jurisdiction. If states were successful in lowering Medicaid hospital reimbursement levels by 5 percent, however, savings to the federal government would be about \$250 million in 1982.

PERMIT STATES TO SELECT PROVIDERS ON THE BASIS OF COST

The freedom of choice provision that now guarantees Medicaid reimbursement for any qualified provider or service that a patient selects has contributed to keeping program expenditures at high levels. A curtailment of this provision, allowing state programs to limit participation to low cost providers only or to contract for medical services with a few providers, could help curb Medicaid expenditures. Besides enabling states to engage in competitive bidding, as described above, states could contract with a limited number of hospitals to care for Medicaid patients. In metropolitan areas, provision of hospital care on a contract basis could yield savings of \$50 million in 1982 and \$300 million by the end of 1986.

Advocates of this plan have noted that it has the potential for even greater savings, because it would permit basic changes in the way that care is provided to Medicaid recipients. For example, states could assign recipients to particular physicians, who would then assume primary medical responsibility. Such an arrangement could give physicians a financial incentive to avoid unnecessary hospitalization of Medicaid patients. In contrast, opportunities appear limited for greater reliance by state Medicaid programs on organized health care delivery plans, such as HMOs. At present, HMOs represent a relatively small portion of the medical care market.

Critics of limitation of selection of providers by recipients argue that limiting the choices available to Medicaid recipients could degrade the quality of their care. A separate medical care system of lower quality for low-income persons could also result. On the other hand, one can argue that, by limiting the number of providers permitted to participate in the program, states could better monitor the quality of the care that recipients receive; the attention of Medicaid administrators would simply be focused on fewer providers. Furthermore, specific quality standards could be included among the selection criteria.

RAISE PHYSICIAN REIMBURSEMENT LEVELS

A significant number of physicians--at present, one-quarter of all primary care physicians--now refuse to accept Medicaid patients because of low reimbursement rates. The portion that does not actively participate in the program is even larger. Requiring that states raise physician reimbursement rates to the levels used under Medicare could improve Medicaid patients' access to care appreciably, but federal outlays would increase significantly.

Medicaid expenditures could rise by as much as \$730 million in 1982 and by a total of \$1.9 billion by the end of 1986. The increase in costs would result from higher payment for services now being rendered, as well as from an increase in the amount of care for Medicaid patients--about two-thirds for higher reimbursement levels and about one-third for greater use of services. This estimate takes account of the fact that some offsetting savings would occur as care provided in physicians' offices substituted for some care now delivered in emergency rooms.²

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2. An Urban Institute study of physician participation in Medicaid shows that a 10 percent increase in per recipient revenues would increase by 3 percent the number of Medicaid patients treated by physicians. See Hadley, "Physician Participation in Medicaid."

Raising Medicaid fees could ultimately lead to higher charges to non-Medicaid patients.³ Critics of this proposal therefore consider it inflationary and contrary to the objective of containing health-care costs.

Because Medicaid reimbursement levels vary from state to state, the higher costs and greater use of services that could result from this option would not be experienced equally in all states. Indeed, a number of states already use Medicare reimbursement rates to determine Medicaid payments. Overall, the amount of variation among states would be reduced.

3. See Jack Hadley and Robert Lee, "Toward a Physician Payment Policy: Evidence from the Economic Stabilization Program," Policy Sciences 10 (1978-79), pp. 105-120; and Frank Sloan, Janet Mitchell, and Jerry Cromwell, "Physician Participation in State Medicaid Programs," Journal of Human Resources Supplement 1978, pp. 211-245.

CHAPTER IX. MODIFY THE FEDERAL ROLE IN FINANCING MEDICAID

Modifications in the terms of federal support for Medicaid could be used to either reduce program expenditures or permit reallocation of health-care support for low-income persons. The allocation of federal resources could be changed by placing a limit on federal matching for state Medicaid expenditures. Alternatively, the formula could be modified, or it could be supplemented.

IMPOSE A CEILING ON THE AMOUNT OF FEDERAL MATCHING FUNDS AVAILABLE TO EACH STATE

To limit federal outlays and discourage Medicaid expenditures by states, the Administration has proposed an annual limit on federal Medicaid expenditures (S. 1291). The limit, or cap, would be adjusted each year for inflation. The federal government would continue to provide funding for each state's Medicaid program on a matching basis, except that no state would receive an amount that exceeded its assigned ceiling.¹ The limit would be set at \$100 million below the currently projected level of outlays for 1981. In 1982, the limit would be raised by 5 percent and, in following years, it would rise by the prior year's increase in the gross national produce (GNP) deflator. Each state's share of the capped level of expenditures would be held constant at the 1981 level projected in November 1980. Because the ceiling would rise at a lower rate than is projected for federal outlays under current

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1. Although the example discussed here applies a cap to all Medicaid expenditures, a cap could be imposed on only some of the covered services, such as nursing home care. For example, Chairman James R. Jones of the House Budget Committee proposed a cap only on long-term care expenditures for inclusion in the first budget resolution for fiscal year 1982.

policies, adoption of the Administration's proposal would lower outlays by \$0.9 billion in 1982 and by \$8.3 billion by the end of 1986.²

As part of this plan, the Administration proposes to grant states increased flexibility to modify eligibility, benefits, and reimbursements under their Medicaid programs. States could use this discretion to cut costs by using many of the eligibility, benefit, and reimbursement options discussed in previous chapters and many others, though adoption of some options would depend upon approval by HHS.

If federal grants were capped, states would probably try to cut Medicaid costs; but two types of states would have difficulty accommodating the cap without reducing eligibility or benefits that are currently mandatory. Most states that have already taken cost-containment measures have already exhausted the alternatives to eligibility and benefit cuts. Also, states that have added few optional eligibility categories or benefits would have few new avenues to explore.

Some states could cut costs by trying to improve management, but the potential for additional savings in this area may not be great. Several states--notably California, Michigan, New York, and North Carolina--have already adopted numerous administrative improvements over the years, yet their program costs continue to rise rapidly. Operation of fraud and abuse units is already quite attractive to states: while the states pay only 10 percent of the cost of these units, they receive 25 to 50 percent of each dollar saved. Nevertheless, the units charged with detecting fraud and abuse do not appear to be self-supporting.³ Finally, states accounting for 98 percent of all Medicaid expenditures have either already developed or are actively planning Medicaid management information systems.

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2. Estimates of savings from a Medicaid cap are very sensitive to economic assumptions, particularly the rates of inflation and unemployment. This and other estimates were prepared on the basis of the assumptions adopted by Senate and House Conferees for the First Concurrent Resolution on the Budget - Fiscal Year 1982.
 3. General Accounting Office, Federal Funding for State Medicaid Fraud Control Units Still Needed (October 6, 1980).

A portion of the federal savings achieved by this proposal would probably result from shifts in costs to state governments and to the private sector. States' expenditures would increase to the extent that they chose to replace federal aid with state revenues. A portion of the federal savings could become costs to the private sector if physicians and hospitals continued to treat Medicaid patients at lower reimbursement levels but increased their charges to other patients to offset lost Medicaid revenues.

The choice of a base period for determining capped grant amounts has great consequences for each state, because as little as one-tenth of one percentage point difference in a state's share of expenditures represents \$17 million in federal funds in 1982. States that anticipated receipt of a smaller percentage of total federal Medicaid funds in 1981 than in prior years would likely find the cap more confining than states that expect to incur a higher percentage. For eight states, anticipated 1981 federal Medicaid expenditures represented a share of total federal Medicaid expenditures that exceeded by 10 percent or more their share of total federal Medicaid expenditures in the period 1976-1980. In two states, their share of Medicaid expenditures was more than 10 percent lower than their share in preceding years.

The use of the GNP deflator to adjust grants would be more restrictive for those states experiencing higher-than-average increases in Medicaid expenditures because of faster-than-average growth in the eligible population, a rapidly growing elderly population, or other factors affecting expenditures beyond state control.

How state-to-state variations in eligibility and benefits would be affected is difficult to gauge. The largest relative change in the cost of Medicaid, in comparison with other state programs, would occur in states in which the federal government now finances the largest portion of Medicaid program costs. Consequently, such states are the most likely ones to restrict eligibility and benefits in response to the cap. The likelihood of this response increases because some states with high matching rates (up to 75 percent) have relatively small tax bases. To the extent that states with the highest matching rates are now those with the most limited eligibility and benefits, a ceiling on federal Medicaid grants that led to reductions would tend to increase state-to-state variation.

LOWER THE MINIMUM FEDERAL SHARE OF STATE MEDICAID
EXPENDITURES FROM 50 TO 40 PERCENT

If the minimum federal share of program outlays were lowered from the current statutory minimum of 50 percent to 40 percent, the federal government could save \$700 million in 1982, and a total of \$5.9 billion by the end of 1986. If this option were implemented in 1982, 13 jurisdictions would have less than half their program costs covered by the federal government.⁴ The lower federal subsidy would probably lead some states to reduce program costs by restricting eligibility, benefits, or by cutting reimbursements. To the extent Medicaid expenditures are reduced in these states, reductions in federal outlays from the proposal would be even larger.

The states that would be affected by this option account for a large portion of total Medicaid expenditures.⁵ In fiscal year 1977, about one-third of all Medicaid expenditures were made in these states. Three in particular--California, Illinois, and Michigan--accounted for about one-quarter of all expenditures, in part because of the broad eligibility and range of services their Medicaid programs offer.

State differences in eligibility and benefits would be somewhat lessened by lowering the minimum federal share. California, Illinois, and Michigan would be particularly motivated to reduce costs by trimming their programs, which would bring their programs

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4. The Senate Finance Committee approved a reduction of the matching rate to 40 percent to comply with reconciliation instructions of the revised second budget resolution of 1981 (S. Con. Res. 9).
 5. For fiscal years 1982 through 1983, the states that would be affected are Alaska (40.00), California (41.79), Connecticut (40.81), Delaware (48.16), District of Columbia (40.00), Hawaii (48.29), Illinois (42.59), Maryland (47.95), Michigan (47.69), Nevada (40.00), New Jersey (43.74), Washington (46.82), and Wyoming (44.71). Numbers in parentheses are the federal percentages that would be applied to total state expenditures in determining each state's federal Medicaid grant, if the minimum were lowered to 40 percent.

closer to the national average. Some interstate differences would probably continue, however. For example, five of the affected states--Alaska, Delaware, Nevada, New Jersey, and Wyoming--do not now provide coverage for the medically needy, and reducing the federal share of Medicaid in these states would discourage future coverage of this group.

FEDERALIZE MEDICAID

The federal government, rather than the states, could assume all responsibility for both financing and administering Medicaid.⁶ Whether converting Medicaid into a strictly federal program would add or detract from efficiency and effectiveness is debatable. Observers have widely divergent views on whether the federal government or the states are best suited to run Medicaid. On the one hand, this option would permit the federal government to take full advantage of economies of scale in administration. Being fully at risk for changes in expenditures would present the federal government with greater incentive for efficiency. On the other hand, critics of this approach maintain that states are more sensitive to budgetary implications even though their Medicaid costs are subsidized. Further, state governments have 15 years of experience administering Medicaid; they may therefore be in a better position to experiment with alternative administrative approaches to find more efficient ones.

PROVIDE LUMP SUM GRANTS FOR STATE PROGRAM EXPANSIONS

The Congress could appropriate a fixed amount each year to provide lump sum grants to states that choose to expand the groups eligible for Medicaid.⁷ Under a recent proposal, the annual

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6. This approach has been included in past proposals that would otherwise have raised state expenditures by expansions of eligibility. An example is the Carter Administration's Healthcare proposal.
 7. A specific proposal embodying this approach was suggested by the staff of the Senate Finance Committee during the Committee's consideration of low-income health insurance options in the 96th Congress.

amount available for supplemental grants would be determined through the Congressional appropriations process. Each state that chose to expand eligibility would receive a grant equal to a portion of the total supplemental grant appropriation--the portion to be determined by the state's percentage of total Medicaid expenditures in the preceding year--provided the expansions the state adopted cost at least the amount of the grant.

States would find substantial incentives to expand the number of persons eligible for Medicaid, especially since there would be no categorical restrictions on the expansions and no requirement for additional expenditure of state funds. But three factors could limit the extent of their response: uncertainty regarding future funding; concern that the size of the grants to states might be less than the cost of some specific eligibility expansions; and the fact that states now with limited eligibility would receive relatively smaller grants.

Uncertainty about future levels of funding for these grants and about future Medicaid costs would probably limit the eligibility expansions some states would adopt. Because anticipated growth in the cost of providing Medicaid to new eligible groups might require the states either to provide additional funding or cut back on eligibility in future, some states might be reluctant to expand coverage. This reaction is most likely in states that have not chosen to expand coverage to all optional groups under the current, open-ended matching provisions.

A second reason to expect only limited eligibility expansion is that the cost of certain expansions might exceed the lump sum grant available to a particular state, even in the first year. For this reason, states might select eligibility expansions that would cost significantly less than the initial year's grant.

A final reason to anticipate limited eligibility expansions is that the size of the grants would be related to a state's past Medicaid expenditures. As a result, states that now cover only a small fraction of the poor would receive relatively small grants, offering little incentive to expand coverage, whereas states that had already expanded eligibility significantly beyond the minimum required level would receive the largest grants but have relatively fewer ineligible poor.

Within a given state, availability of a supplemental grant might increase the extent to which persons with comparable incomes would be eligible for Medicaid. By relaxing federal eligibility requirements and providing an incentive for increased eligibility, the proposal would encourage inclusion of people with low incomes who are now disqualified on a categorical basis. Among states, though, this proposal could either increase or decrease such variation. State-to-state variation could become more extreme, because the greatest incentives would be directed to states now with highest proportions of eligible poor. On the other hand, if the states that responded to the incentive were primarily those with limited current programs, interstate variation might decline.

APPENDIX I. ESTIMATION OF MEDICAID ELIGIBILITY

Estimates of the noninstitutional population that is eligible for Medicaid were obtained from a model of eligibility developed by Mathematica Policy Research, Inc. For a description of the microsimulation model and the estimation procedures, see Pat Doyle and others, Final Report: Creation of the 1980 and 1984 Data Bases from the March 1978 Current Population Survey, Volume 1. Mathematica Policy Research, Inc. CBO has made modifications in the model. Estimates produced by the model represent the number of persons who meet the eligibility criteria during a given full year or for any part of that year.

The population estimates used as the basis for the model were obtained from the Census Bureau's March 1978 Current Population Survey. These estimates were adjusted to reflect expected changes in population, employment, and income between calendar year 1977 and fiscal year 1980.



